Minnesota Department of **Human Services**

April 24, 2006

The Honorable Keith Langseth, Chair
Senate Capital Investment Committee
122 Capitol
St. Paul, MN 55155

The Honorable Dan Dorman
Minnesota House of Representatives Capital Investment Committee
517 State Office Building
St. Paul, MN 55155

Dear Senator Langseth and Representative Dorman:

Governor Pawlenty's 2006 Capital Budget included a project request for the Department of Human Services for System-wide Security/Safety Improvements. The purpose of this request is to provide funds for security/safety upgrades of a capital nature at Department of Human Services facilities located in St. Peter, Moose Lake, Anoka and Cambridge, including, but not limited to, security fencing improvements, control center upgrades, replacement of electronic monitoring systems, perimeter security equipment, and exterior lighting upgrades. Our original budget request for this project was for $2.5 million in 2006.

We would like to amend the original recommendation for this project by adding:

1. corrections grade perimeter fence around the Minnesota Sex Offender Program (MSOP) units at the Minnesota Security Hospital (MSH) complex; and,
2. upgrades to window security at the MSOP and the MSH complex; and,
3. upgrades to surveillance cameras, campus lighting, and nuisance fencing on the St. Peter campus originally proposed for the 2008 bonding year.

These additional projects will provide necessary redundancy in physical plant security for the MSOP program. The projected cost for these projects is $2.70 million. The total cost for security upgrades including the original request and the amended request is $5.20 million.

Your consideration of this request to increase the level of funding for these much needed security upgrades at the Department of Human Services facilities is appreciated. If you have any specific questions regarding this request to amend the Governor's 2006 capital budget request, please direct them to Assistant Commissioner Wes Kooistra, Department of Human Services.

Yours sincerely,

Kevin Goodno
Commissioner

Our View — State failed on offender security

Editorial board
CNHI News Service (MankatoFreePress.com)
4/24/2006

The escape last week of four dangerous sex offenders from the St. Peter Security Hospital should astound, shock and frighten residents of St. Peter, the Mankato area and the rest of the state.

That public safety was so easily compromised for the second time in a little more than a year is more than troubling.

Sex offender Michael Dale Benson remains at large. He is considered one of the state's most dangerous and most likely to re-offend. He was able to saw through a concrete-encased steal bar on the window of his room, use the bar to break the window, and climb down the side of the Security Hospital on bedsheets. Three others followed him. This escape would be comical if it weren't true.

This breach comes at a time when Minnesota lawmakers have increased spending on the sex offender program by millions of dollars per year. The state is spending about $13.5 million more this year than last year. Gov. Pawlenty proposed in March spending an additional $53 million this year, representing a 12 percent increase. Lawmakers and the governor say this money will protect the public by keeping sex offenders locked up. More money didn't appear to help last year.

When two sex offenders escaped from St. Peter in March of 2005 in a manner similar to the recent escape, the state came in with security upgrades.

Sex offenders Alexander Martinelli and Rodger Robb rappelled from a second story window using bedsheets and slipped through recently repaired fencing.

In April 2005, Department of Human Services Commissioner Kevin Goodno told The Free Press: "We have taken precautions both from a physical perspective — in ensuring that the same type of escape can't happen again — as well as changing the routines of staff to also provide additional safety measures."

The recent escape shows those efforts have failed.

The escape last week could have been prevented with razor wire, but also if employees of the facility had checked on Benson, according to "protocol," according to Assistant Commissioner of Human Services Wes Kooistra.

Several employees are to make random checks on all inmates. They're supposed to check the room and the windows. That wasn't done.

But the unwillingness or inability of security employees to "follow protocol" is only the symptom of a much larger problem.

The crackdown on sex offenders created a system that nearly doubled the number of criminals designated as sex offenders and put them into a system that made them more desperate. An earlier Free Press in-depth report showed that of those going through sex offender treatment, no one had successfully completed the program in the several years it had been operated.

While the new laws created more sex offenders and made them more desperate, the state was unable to control them at the rate they were coming into the system.
In one case, sex offenders were transferred from Moose Lake to a building in St. Peter that was still being remodeled for tighter security. Inmate Rick McDeid told The Free Press in April 2005 that officials were still "slapping a piece of Plexiglas over a window and shooting in some screws to hold it in place" shortly after he arrived there.

While the St. Peter campus hired some 260 new employees in the last year, the number of mentally ill and dangerous people as well as sex offenders nearly doubled in the last three years, according to Kooistra.

That created problems. It's difficult to train that many new employees in a short period of time, Kooistra said. It's tough to schedule guard duty so there was a good mix of new employees working with more experienced employees.

Lawmakers shoulder some blame as well. They took an approach that was high on toughness but low on simple logistical planning. Gov. Tim Pawlenty delayed the planned security upgrades to St. Peter and Moose Lake during a time of tight budgets. A planned $5 million upgrade one year was turned into a plan that called for spending half of that in the first year and the rest in 2008.

The governor's budget acknowledged a security audit done on the sex offender programs suggested upgrades. Still, the governor's budget message stated the changes will be completed as "time and funding allows."

While the state and the governor are now finding time is of the essence in sex offender security, they have in the meantime created a system that's more costly and less safe.

RESIDENT ADVISORY COUNCIL

1111 Highway 73
Moose Lake, MN 55767

April 13, 2006

Senator Linda Berglin (DFL)
309 State Capitol
St. Paul, MN55155

Re: Minnesota Sex Offender Program

Dear Senator Berglin:

Please find enclosed the following documents for your review in consideration for continued funding and political support for the Minnesota Sex Offender Program (MSOP).

1. Report in Nicolaison v. Mooney ,Court File No. 09-CO-05-2-4. This report was conducted by the Office of the Ombudsman for Mental Health and Developmental Disabilities.
2. Report in Nicolaison v. Mooney ,Court File No. 09-CO-05-2-4. This report was conducted by the MSOP Patient Advocate Mr. Randy Valentine.
3. Ombudsman for the State of Minnesota Roberta Opheim's letter to: State Operated Services Director Michael Tessneer concerning problematical conditions within the MSOP's St. Peter and Moose Lake sites/facilities.

We, patients/residents and members of the Resident Advisory Council of the Minnesota Sex Offender Program (MSOP), recently had the opportunity to review at length the above reports and letters. Most troubling was the report conducted by Michael L. Woods, Regional Ombudsman and Brian Relay, Director of Client Services of the Office of the Ombudsman for Mental Health and Developmental Disabilities which resulted from a court order in the matter of Nicolaison v. Mooney, Court File No. 09-CO-05-2-4. This report suggests illegitimate conduct by various MSOP employees.

We were exceedingly concerned by the report generated by the MSOP patient advocate Mr. Randy Valentine in the matter of Nicolaison v. Mooney , because the report was contrary to and in violation of the court ordered report of the Ombudsman's Office by Justice Lawrence R. Yetka. In addition to your consideration with respect to continued funding for the MSOP, we would ask your support in the replacement of the current MSOP patient advocate Mr. Randy Valentine. In support of this request we submit the following information.

On October 17, 2005, we the members of the Resident Advisor Council forwarded recommendations to Commissioner Kevin Goodno of the Minnesota Department of Human Services (DHS) supporting our request for Mr. Randy Valentine's dismissal as the MSOP Moose Lake, Facility Patient Advocate. In addition, attached to the Council's recommendations to the

commissioner were copies of petitions from six independent living units comprising of approximately 150 patients/residents of the Moose Lake facility. These petitions were signed by the vast majority of the patients/residents of the MSOP expressing their profound disapproval of Mr. Valentine's advocacy. These petitions also requested Mr. Valentine's dismissal and replacement with an independent, impartial advocate. Again, we the members of the Resident Advisory Council request your assistance in the dismissal and replacement of the MSOP Patient Advocate Randy Valentine with an independent and impartial advocate completely independent of the program.

We are concerned with respect to the illegitimate activities suggested by both the report and the letter of the Ombudsman's Office. We patients/residents of the MSOP for many years have been subjected to the unprofessional treatment/conduct suggested by the enclosed report and letter and have raised numerous concerns to several state entities which have for the most part gone unaddressed. We believe that because of the atrocious labels given us such as "sexually dangerous person," "sexual psychopathic personality," or the "worst of the worst" it creates a class of individuals politically and publically disfavored which causes our legitimate concerns to be suppressed and our continued abuses justifiable at the hands of state employees.

Due to our insubstantial financial status we respectfully request that your office make and forward copies of the enclosed documents to respective members of the Health and Human Services Budget Division; and Crime Prevention and Public Safety committees. If you should have any questions with respect to the enclosed documents or our views, please do not hesitate to contact our Resident Advisory Council Chair Mr. Willard Hince Jr., at the above address.

Lastly, we would very much appreciate a written response from your office with respect to any concerns these documents have raised, and any advocacy for constructive change your office can help facilitate.

Sincerely,

Willard Hince Jr., Chair

Jimmie Ramey

Crawford Wilson

Chris Coker

James Poole

Lincoln Brown

Rick McDeid

Matt Johnson

STATE OF MINNESOTA
OFFICE OF THE OMBUDSMAN FOR
MENTAL HEALTH AND MENTAL RETARDATION
121 7th Place E. Ste 420, Metro Square Building, St. Paul, MN 55101-2117
651-296-3848 or Toll Free 1-800-657-3506
TTY/voice - Minnesota Relay Service 1-800-627-3529

December 21, 2005

Mr. Rick Mc Deid
1111 Highway 73
Moose Lake, MN 55767

Re: Report in Nicolaison v. Mooney

Dear Rick:

I received a letter from Wayne, indicating that he has been trying to send you a copy of the report I filed with the court in the above-entitled matter. He states that staff keep returning it to him for "frivolous reasons." He wanted me to provide you with a copy, which I have enclosed.

Sincerely,

Michael

Michael L. Woods
Regional Ombudsman
Office of the Ombudsman for MH/DD

Enclosure

STATE OF MINNESOTA
OFFICE OF THE OMBUDSMAN FOR
MENTAL HEALTH AND MENTAL RETARDATION
121 7th Place E. Ste 420, Metro Square Building, St. Paul, MN 55101-2117
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TTY/voice - Minnesota Relay Service 1-800-627-3529

December 6, 2005

Minnesota Supreme Court Justice Lawrence R. Yetka, (retired)
Carlton County District Court
P.O. Box 190
Carlton, MN 55718

Re: Nicolaison v. Mooney
Court File Number: 09-CO-05-204

Dear Justice Yetka:

The Office of the Ombudsman for Mental Health and Developmental Disabilities[1] is charged, under Minnesota Statute § 245.92, with promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental illness, developmental disabilities, chemical dependency and emotional disturbance from an agency, facility or program. Accordingly, individuals who are under civil commitment to the Minnesota Sex Offender Program ("MSOP") are included in the populations that are served by the Ombudsman's Office. In accordance with Minnesota Statute § 245.94, our agency may investigate the quality of care provided to clients and review matters that influence the delivery of services.

This report is in response to your Honor's order issued from the bench in the above-entitled litigation on September 16, 2005, and your written order, dated October 28, 2005. The written order states, in relevant part, that our agency "investigate the condition of the property in question before its transportation from the St. Peter's Facility to the Moose Lake Facility and file a written report with the court." As explained more fully, infra, it is impossible to ascertain for certainty the condition of the property before it was transported to Moose Lake because we were not able to observe it before it was repaired by the MSOP Moose Lake staff. Therefore, our report is drawn from eye-witnesses' reports and testimony.

A. Investigation Procedure

Investigators:

Michael L. Woods
Regional Ombudsman
320 W. 2nd St., Suite 105
Duluth, MN 55802
(218) 279-2526

Brian Relay
Director of Client Services
121 7th Place E., Suite 420
St. Paul, MN 55101
(651) 297-7349

[1] The Ombudsman's Office is an independent state agency and reports directly to the Office of the Governor. The title of our agency was recently changed to reflect legislation that was passed which replaces the term "mental retardation" with "developmental disabilities."

MSOP Facility Visits: Moose Lake, 11/3/05, 11/08/05, and 11/21/05. St. Peter, 11/18/05.

Interviews conducted: MSOP resident Wayne Nicolesion by Michael Woods on 11/3/05 and by telephone on 12/06/05. Telephone conversation between Michael Woods and Dean Mooney on 11/7/05. MSOP staff Thome Torgerson and Jane Stinar and MSOP residents Rick Mc Deid and Wayne Nicolasion by Michael Woods and Brian Relay on 11/8/05. St. Peter residents Henry Woodruff and James Burnham and MSOP staff Kristen Wright by Michael Woods and Regional Ombudsman Rochelle Fisher on 11/18/05. MSOP Client Advocate Randy Valentine by Michael Woods and Brian Relay on 11/21/05 and by telephone on 12/06/05.

Documents reviewed: MSOP staff Randy Valentine's report to Justice Yetka dated 11/2/05, including MSOP staff member statements and photograph exhibits. The Nicolaison v. Mooney Carlton County Court File on 11/08/05 and 11/09/05. MSOP's Contraband Policy #3020. Miscellaneous documentary evidence excluded from Mr. Valentine's report.

B. Background

Plaintiff Wayne Nicolaison was transferred, along with the property in question, from the MSOP's Moose Lake facility to the Shantz Hall Unit at the St. Peter facility in January of 2005. On March 10, 2005, Mr. Nicolaison was called into a conference room by the unit staff and informed that he would be double-bunked with another peer. During this meeting, Mr. Nicolaison became upset and staff called what is commonly referred to as a "condition red." During a condition red, all available staff respond in a show of force in order to subdue a resident that is not in behavioral control. On March 10th, approximately six (6) staff subdued Mr. Nicolaison by forcing him to the ground. Mr. Nicolaison was immediately transported from the Shantz Hall Unit, on the lower part of the St. Peter campus, to the Protective Isolation cell on the South Unit, located approximately one half (1/2) mile away on the upper part of the campus. Once Mr. Nicolaison entered the meeting with staff and subsequently placed in Protective Isolation, he never had access to the property in question again.

St. Peter staff removed all of Mr. Nicolaison's property from his Shantz Hall room, including the property that is the subject of this investigation, and momentarily piled it near the entrance to his unit. Sometime between March 10th and when staff inventoried the property on March 14th, the property was transported from Shantz Hall and placed in the office hallway for the South Unit. The reason Mr. Nicolaison's property didn't remain in his room was because he was going to be transferred straight from Protective Isolation on the South Unit to the Behavioral Unit in Moose Lake. Staff members are the only individuals with access to the South Unit's office hallway and residents cannot access it because it is a locked area of the unit.

There are three staff shifts at St. Peter: 1) from 6:00 a.m. until 2:00 p.m., 2) from 2:00 p.m. until 10:00 p.m. and 3) from 10:00 p.m. until 6:00 a.m. On March 14th, staff

member Kristen Wright inventoried Mr. Nicolaison's property in the South Unit's office hallway. She completed the inventory at approximately 9:30 p.m. The property was undamaged at this time. Ms. Wright stated in her interview that she would have documented on the inventory list any damaged property because, "I wouldn't want them to think I broke it." The following morning, at approximately 10:00 a.m., the property had been placed by St. Peter staff on the loading dock in preparation for it being transported, along with Mr. Nicolaison, to Moose Lake.

When the Moose Lake staff arrived to transport Mr. Nicolaison and his property, it was obvious to both the St. Peter staff and the Moose Lake staff that the property in question had been severely damaged. Mr. Nicolaison was hand-cuffed and shackled during the transport from St. Peter to Moose Lake and he did not have access to his property during the transport. Once he was processed at Moose Lake, he was shown three (3) of the property items in question and informed that he could no longer have possession of the property because it had been damaged and thus deemed "critical contraband" pursuant to the MSOP policy #3020. [See Exhibit A.] According to the Notice of Receipt of Secured Items (herein after, "Receipt") dated March 15th, the bookcase Mr. Nicolaison had constructed, the small bookshelf and his computer desk were given the security code "C," referring to "critical contraband." [See Exhibit B.] Two days later on March 17th Kevin Larson, the staff member responsible for stored property, moved the damaged property from the Moose Lake loading dock and placed it in cold storage. [See Exhibit B.]

The fourth item in question is Mr. Nicolaison's stereo system. There are two issues in question regarding the stereo: 1) the stereo's inoperable condition and 2) the missing speakers to the system. Inoperable Condition: It appears that his stereo system was in working condition on March 10, 2005, the day Mr. Nicolaison was transferred to Protective Isolation. Mr. Nicolaison and two of his peers interviewed, Rick Mc Deid and Henry Woodruff, all indicated his stereo was working. Mr. Woodruff stated in his interview that he and Mr. Nicolaison were listening to the stereo system "somewhere between twenty (20) and thirty (30) minutes" prior to when Mr. Nicolaison was taken to Protective Isolation. Had the stereo system been inoperable while in Mr. Nicolaision's possession in St. Peter, he would have been required to place the system in storage because it would have been deemed "critical contraband" under MSOP policy #3020.

Additionally, Mr. Nicolaison's property inventory list, prepared by St. Peter staff member Kristen Wright on March 14, 2005, makes no mention of the fact that the stereo was inoperable. [See Exhibit C.] Once the stereo arrived in Moose Lake, however, the Receipt issued by staff member Sara Fetters indicates that the stereo's "CD [compact disc] door will not close & will not power up." [See Exhibit D.]

Missing Speakers: The inventory list indicates that the stereo speakers were included in the property shipped to Moose Lake on March 15, 2005. [See Exhibit C.] Ms. Fetters' Receipt also makes no mention that the speakers are missing. [See Exhibit D.] The following day, on March 16, 2005, staff member Zoe Johnson confirmed that Moose

Lake received all of the property on Mr. Nicolaison's inventory list, including the stereo speakers. [See Exhibit C.]

The following day, however, the speakers are missing. On March 17, 2005, Mr. Nicolaison was given a second Receipt for the stereo by staff member Paul Donahue. On the second Receipt, it indicates that the stereo system has "no speakers" in contradiction of both the inventory list prepared by Ms. Wright and confirmed by Ms. Johnson and the Receipt issued by Ms. Fetters. [See Exhibit E.]

Mr. Nicolaison did not have access to the speakers upon his arrival at Moose Lake because detachable stereo speakers are non-allowable property items for his living unit. Acting Group Supervisor, Barry Anderson, confirmed that residents on the Behavioral Unit, where Mr. Nicolaison resides, are not permitted to possess detachable stereo speakers on the unit.

On March 16, 2005, Mr. Nicolaison filed a grievance with the MSOP Administration complaining that staff had damaged a) his small bookcase, b) his computer desk, and c) his larger bookcase. The stereo system was not listed in the grievance. The MSOP Group Supervisor did not respond to the grievance until June 23, 2005, over three months later, asking Mr. Nicolaison to tell him "the names of staff that handled your property transport to Moose Lake." He also asked Mr. Nicolaison to "provide more information." Because of the delay in the response to the grievance, Mr. Nicolaison filed a tort claim with the Minnesota Department of Administration. On June 26, 2005, Mr. Mooney denied Mr. Nicolaison's grievance because his issue was "to be resolved in tort claim process." On July 11, 2005, the Department of Administration denied Mr. Nicolaison's tort claim because "based on the information provided by [the] MSOP there is no verification that these items were damaged by staff from either St. Peter or Moose Lake based on their investigation of this claim." [This letter is attached as Exhibit 1A to Mr. Nicolaison's complaint filed with this court.]

C. Conclusions and Findings.

On March 10, 2005, Mr. Nicolaison was taken to Protective Isolation on the South Unit of the MSOP St. Peter. Prior to this incident, the property in question, i.e., the bookcase Mr. Nicolaison built, his computer desk, and a smaller bookcase were all in good enough condition so as not to be in violation of MSOP Critical Contraband Policy #3020. Witnesses interviewed indicated that the stereo was operational on March 10th as well. Thus, Mr. Nicolaison had the use and enjoyment of all four property items in question prior to being placed in Protective Isolation.

Four (4) days after Mr. Nicolaison was placed in Protective Isolation, his property was in essentially the exact condition he last left it in his room. On March 14th, St. Peter staff member Kristen Wright inventoried his property in the South Unit office hallway at approximately 9:30 p.m. The only individuals with access to Mr. Nicolaison's property prior to its shipment to Moose Lake on the following day were MSOP's St. Peter staff. At the time of the inventory, his property was undamaged. As such, Mr. Nicolaison's

property could only have been damaged by St. Peter staff sometime between 9:30 p.m. on March 14th and just prior to when Moose Lake staff arrived to load the property in the van at approximately 10:00 a.m. the following morning. Because the MSOP lacks any form of chain of custody procedure and protocol, it was impossible to ascertain which St. Peter staff members damaged the property.

The property in question was so severely damaged by the MSOP staff, that, upon seeing its state of condition by the Moose Lake transporting staff, they debated whether to transport it to Moose Lake or dispose of it in a dumpster. As pointed out in the statement of Moose Lake staff member Tracy Anderson, the property's damaged condition evoked "laughter" from the St. Peter staff member monitoring the property on the loading dock and he stated that the property "looked as if it should just be thrown away." [See Exhibit F.] The top of the smaller bookcase was damaged and its backing had been knocked out. The top of the computer desk had been damaged. The larger bookcase was inspected by Mr. Relay and myself. It was constructed out of oak material and it was apparent that the shelves were constructed in such a way that they could not be removed unless done so forcefully. Even so, the shelves had been removed and the backing, which was nailed to the bookcase frame, had been knocked out.

Upon arrival at Moose Lake that same day, these three items had been damaged to the point that they were deemed "critical contraband" and Mr. Nicolaison would no longer be able to reclaim possession of them. The stereo system, with detachable speakers, was operational the last time Mr. Nicolaison had possession of it in St. Peter. When it arrived at Moose Lake, it was inoperable. Additionally, documentation by staff on March 14th and March 16th indicates that the stereo's speakers were listed as part of Mr. Nicolaison's property. The following day, on March 17th, however, the speakers were missing. Mr. Nicolaison was given his stereo system without his speakers either on March 17th or March 18th. He did not question the absence of the speakers because he was aware that they were not permitted on the Behavioral Unit where he resides and he planned to listen to the system using headphones. He noticed that the compact disc door would not close, but he assumed it would close once he powered the unit up. When he plugged the unit in, he discovered that it was no longer operational and he immediately returned it so staff could place it in storage.

Prior to our office receiving your Honor's order dated October 28th and prior to Mr. Mooney turning his investigation over to Mr. Valentine, the MSOP staff member Kevin Larson altered the condition of the evidence by repairing certain items that are the subject of this investigation. His actions thus prevented the Office of the Ombudsman from providing your Honor with a definitive response to the exact condition of the property. We attempted to interview Mr. Larson to ascertain who instructed him to repair the property and when he repaired it. Mr. Larson, however, was unavailable to meet with us when we were at the facility conducting interviews on November 8, 2005. Shortly thereafter, Mr. Larson took a leave of absence and has not returned to employment since then. We can conclude, however, that the property was useable by Mr. Nicolaison before he entered Protective Isolation in St. Peter and was no longer useable upon his arrival in

D. Ombudsman's Report Contradicts MSOP's Report to Court.

On November 2, 2005, a report by the MSOP, drafted by Mr. Randy Valentine, was sent to your Honor essentially exonerating his employer in this matter, with the exception of the smaller bookcase. Our report, however, includes interviews with the MSOP staff and residents that Mr. Valentine did not pursue.

In relaying the following account of the two reports, the Ombudsman wishes to raise concerns regarding the MSOP conducting a separate investigation after your Honor clearly ordered, in two instances, that the Ombudsman conduct an independent investigation. The MSOP Administration's actions had the potential to compromise the Ombudsman's process and subsequent report. Explanations as to why the MSOP Administration chose to conduct their own investigation do not satisfy the Ombudsman's concerns and puts the MSOP staff in the uncomfortable position of providing information which differs from the facility's findings. The MSOP Administration's actions also give rise to questions as to the purpose of the report and the repair of the property in question. This information is relayed in the interest of full disclosure and to allow your Honor to draw your own conclusion.

1. Mr. Valentine's Investigation.

On June 16, 2005, Mr. Nicolaison initiated the above-entitled cause of action in Carlton County Court. A trial was held on September 16, 2005, and your Honor ordered the Office of the Ombudsman to conduct an independent investigation into the matter. Both Mr. Nicolaison and Dean Mooney consented. Since our agency was not present at the trial, we were waiting for the court's written order to verify Mr. Nicolaison's claim that our office was, indeed, instructed by your Honor to conduct an investigation. In the meantime, Mr. Mooney instructed staff to prepare written statements, the contents of which minimized the value of Mr. Nicolaison's property and characterized it as "very poorly constructed," in "poor" condition, and "in a state of disrepair." Additionally, before the Office of Ombudsman could conduct the investigation as to its condition, MSOP staff member Kevin Larson repaired the damaged property. The repair was done without Mr. Nicolaison's permission. In fact, Mr. Nicolaison first learned that his property had been tampered with when he received Mr. Valentine's report on November 4, 2005. There appears to be no reason to repair the property because Mr. Nicolaison would not be able to reclaim possession of his property after its repair since it would still be in violation of MSOP Policy #3020.

According to the notes of your Honor's clerk, Sarah Helwig, she telephoned the defendant, MSOP, on October 24, 2005, at the "ombudsman Randy ext." Apparently, Ms. Helwig mistakenly believed that MSOP staff member Randy Valentine worked for the Office of the Ombudsman. Mr. Valentine, however, is employed by the Department of Human Services and his immediate supervisor is defendant Dean Mooney. According to Mr. Valentine, Ms. Helwig stated, "we are looking for the report you were ordered to do for the court." While Mr. Valentine provided Ms. Helwig with the telephone number

to our office, it is apparent that he did not correct her misconception that he was the ombudsman. After Ms. Helwig spoke to Mr. Valentine, she telephoned my office to inform me that she had "just finished speaking with ombudsman Randy Valentine" and she wanted to let me know he was conducting an investigation into Mr. Nicolaison's lawsuit. I corrected her and informed her that I was the Regional Ombudsman and that Mr. Valentine was employed by the defendant. I also informed her that our office needed a written order from your Honor before I could commence our investigation. She stated that she would have your Honor issue a written order when you resumed the bench on October 28th.

Because it was apparent from my discussion with Ms. Helwig that she mistakenly thought Mr. Valentine was the ombudsman, I contacted Mr. Valentine to make sure he understood that our agency was going to do the investigation. I informed him that I had spoken with Ms. Helwig and she confirmed your Honor had issued an order from the bench on September 16, 2005, instructing our agency to conduct the investigation. I also informed Mr. Valentine that your Honor would issue a written order within four (4) days, on October 28th, and that I would proceed with our investigation once I received the order.

Even though I had informed Mr. Valentine of your Honor's order, he nevertheless met with Mr. Mooney and asked him whether he was supposed to conduct the investigation in this matter. According to Mr. Valentine, Mr. Mooney's response was, "Yes. I forgot to tell you." Mr. Valentine called Ms. Helwig back and informed her that Mr. Mooney instructed him to do the investigation and asked her whether he should proceed. According to Mr. Valentine, Ms. Helwig informed him that she had spoken with your Honor and that "he is going to order a report from your office." Mr. Valentine stated that he was instructed by Ms. Helwig, on your Honor's behalf, to proceed with his investigation and that if your Honor "felt it [Mr. Valentine's report] wasn't independent, then the judge will give it the weight whatever he felt it deserves in his decision."

This version of events, as explained by Mr. Valentine, is inconsistent with your Honor's order issued from the bench on the day of the trial, in which it was agreed that *only* the Office of the Ombudsman would conduct the investigation. Mr. Valentine's account is also inconsistent with your Honor's written order issued October 28, 2005. Mr. Valentine, knowing that our agency was waiting for your Honor's written order, failed to inform us that he was also conducting an investigation on behalf of Mr. Mooney. He was given the contents of the file of the investigation that was commenced a month earlier by Mr. Mooney, including all the exculpatory exhibits he included in his November 2nd report to the court. When Mr. Valentine was asked why the month-long investigation was suddenly turned over to him, he replied, "I don't know. I can't answer that."

On October 27, 2005, three days after I informed Mr. Valentine that I would be doing the investigation, Mr. Valentine met with Mr. Nicolaison in an effort to ask him questions about the matter. Mr. Nicolaison became upset, stating that he specifically objected at the trial to Mr. Valentine's involvement in his case and that he only agreed to have the Ombudsman investigate the matter. According to Mr. Nicolaison, Mr. Valentine

informed him that he was asked by the Office of the Ombudsman to investigate the matter in our stead. In the interview with Mr. Valentine, he was asked if he had made this statement to Mr. Nicolaison and he replied, "No. Absolutely not." Mr. Valentine restated that Ms. Helwig and Mr. Mooney instructed him to investigate the case.

When Mr. Nicolaison received your Honor's written order dated October 28, 2005, he filed a grievance with the MSOP Assistant Group Supervisor Richard O'Connor. He objected to Mr. Valentine's involvement, believing that Mr. Valentine's actions were in violation of your Honor's two orders. Mr. Nicolaison had not yet received your Honor's written order. Mr. Nicolaison's grievance states, in part, that "On Thursday 10/27/05 Valentine came to the unit with a claim [that the] ombudsman asked him to interview and investigate my claim concerning St. Peter staff intentionally destroying my stereo, desk, 2 bookshelves and wardrobe . . .Today I received the court's order dated 10/28/05 . . . which clearly proves fraud on his part. Specifically, the order says 'ombudsman,' not patient advocate." [See Exhibit G. Emphasis in the original.] Mr. O'Connor questioned Mr. Valentine regarding Mr. Nicolaison's allegations. Mr. O'Connor responded to the grievance by stating, "Mr. Valentine states the ombudsman's office asked him to speak with you. Your complaint seems to be with the ombudsman's office." [See Exhibit G, page 2]. When asked during his interview about the apparent contradiction between his denial of Mr. Nicolaison's allegations and Mr. O'Connor's grievance response stating otherwise, Mr. Valentine responded, "No. There must have been a misunderstanding [between himself and Mr. O'Connor]."

2. Mr. Valentine's Report.

Mr. Valentine continued his investigation despite Mr. Nicolaison's strenuous objection. He also failed to reveal to our agency that Mr. Mooney directed him to investigate the matter on his behalf. On November 4, 2005, while at the facility on unrelated business, Mr. Valentine handed me an envelope from Mr. Nicolaison. The envelope contained Mr. Valentine's report, dated November 2nd, that he had submitted to your Honor. This was the first our agency learned of Mr. Valentine's investigation on behalf of Mr. Mooney.

On November 7, 2005, I telephoned Mr. Mooney to let him know that our agency was commencing the investigation into Mr. Nicolaison's case. Mr. Mooney replied, "I already had Randy conduct the investigation and he mailed the judge his report." I stated that the judge ordered only the ombudsman to conduct the investigation. Mr. Mooney's response to my statement was, "I was at the hearing and I must have misunderstood the judge when he ordered you to do it." I asked him if he received a copy of your Honor's written order dated October 28, 2005, and he replied, "Yes, if that's the one where he denied Wayne reimbursement for his magazines." I referred him to the first part of your Honor's order specifically stating that the ombudsman shall investigate the condition of his property. I asked him if he had read that part of the order and he replied, "Yes, there was something in there about the ombudsman doing an investigation."

All of the exhibits prepared on behalf of Mr. Mooney, and submitted by Mr. Valentine to this court, were critical of Mr. Nicolaison's case. Mr. Valentine failed to provide Mr.

Nicolaison copies of the exhibits to his report, even though the exhibits had the potential of greatly influencing your Honor's decision. When Mr. Valentine was asked why he neglected to provide Mr. Nicolaison a complete record of his report, he replied, "I didn't know I was supposed to. I figured he [Mr. Nicolaison] would get it [the exhibits] from the judge." Mr. Nicolaison complained that he wasn't provided the complete report and, two weeks later, Mr. Valentine provided him the exhibits.

Mr. Valentine was asked why his report misinformed the court that Mr. Nicolaison's stereo system never had speakers. He replied that the documentation showed that there were "no speakers." When confronted with Ms. Wright's inventory list showing otherwise, he attempted to divert the issue and repeatedly wanted to focus on the documentation created *after* the speakers became missing. When pressed further, he replied that he didn't know that the speakers mentioned on Ms. Wright's inventory list were "stereo" speakers, even though they are listed on the line just below the entry for the "Aiwa stereo." When questioned why his report failed to inform your Honor that Mr. Nicolaison's stereo speakers all of a sudden showed up missing, he replied, "I didn't notice that." Finally, when informed his report gives your Honor the false impression that Mr. Nicolaison's stereo never had speakers to begin with, he replied, "That's the way I understood it."

Mr. Valentine was asked if he had viewed the property before it had been repaired. He stated, "No. It had already been done. By the time I had found out about it, it had already been done and the pictures had been taken." Mr. Valentine was asked if he interviewed the staff members that inspected the property while it was in its damaged condition and he stated that he had not. He stated that he relied upon the statements prepared by staff at the direction of the MSOP Administration. Mr. Valentine was asked why he failed to inform your Honor in his report that, due to the condition of all of the property in question, Mr. Nicolaison would never be able to reclaim possession of it since it was "critical contraband." Mr. Valentine's answer was non-responsive and, instead, he chose to focus on only one of the four items. He stated he was told by staff that Mr. Nicolaison could not have the larger bookcase because it was "unfinished." When challenged with the fact that Mr. Nicolaison had possession of the "unfinished" bookcase in his Moose Lake room for some years, Mr. Valentine shrugged his shoulders and stated that he wished Mr. Nicolaison had told him that. Mr. Valentine, however, did not need confirmation from Mr. Nicolaison because one of the very exhibits he submitted with his report was a picture of the bookcase in question in Mr. Nicolaison's Moose Lake room.

Mr. Valentine was asked to speculate as to how Mr. Nicolaison's property became damaged. He responded that, "in all probability [the damage] is consistent with someone carrying it at an angle." He stated that the damage could be caused by someone "picking it up." When asked how he accounted for the nailed backing of both bookcases being torn off the frame, he replied, "I don't know. I guess just by moving it." He also stated that property, "loosens up over time." Mr. Valentine was asked, if the property was so structurally unsound as to fall apart simply by picking it up, why didn't it fall apart during its move from Moose Lake to St. Peter in January of 2005 and when staff moved it

from Shantz Hall to the South Unit? Mr. Valentine answered, "Why didn't it? I don't know. I can't answer that. I mean, why do things break?"

Mr. Valentine's explanation does not appear to be credible given the fact that the property was useable by Mr. Nicolaison while residing in St. Peter, (i.e., it was not deemed critical contraband), but when the staff arrived to transport it to Moose Lake it had been "trashed."

Mr. Valentine did admit, however, that currently there is "clearly" a problem within the MSOP with how staff members handle residents' property. He stated that "obviously there are issues with how things are stored, documentation and things like that." He stated that, "Sticking it [property] in a secured back hallway where any staff can have access to it is clearly not acceptable." Mr. Valentine referred to the MSOP's lack of a chain of custody protocol and the handling of residents' property as "growing pains," even though the program has been in existence for ten (10) years.

E. Conclusion.

The only parties who had access to Mr. Nicolaison's property during the time frame it sustained damage were staff members of the MSOP at St. Peter. We are unable to determine which staff members actually caused the damage and why. Additional remaining questions that the Ombudsman is not able to answer include:

1. Why wasn't an investigation conducted into how Mr. Nicolaison's property was damaged at the time he filed his original grievance on March 16, 2005? Instead, it was started after the trial and after your Honor issued an order from the bench on September 16, 2005, instructing the Ombudsman to conduct an independent investigation into the matter.

2. What was the intended purpose in having the property repaired by the MSOP staff member Kevin Larson, months after it had been damaged in March 2005 and after your Honor issued the order for the Ombudsman to investigate the matter? Additionally, why was the property repaired at all, given the fact that Mr. Nicolaison could not resume use of the property since it would remain critical contraband? Finally, why would staff repair the property when its damaged condition was the very point of controversy in this litigation and the very reason your Honor ordered the ombudsman's investigation?

3. Why didn't Mr. Valentine make clear in his report that, despite the repairs, Mr. Nicolaison would still not have use and enjoyment of his property?

4. Why did Mr. Mooney wait from September 16, 2005, until Ms. Helwig contacted Mr. Valentine on October 24, 2005, before instructing Mr. Valentine to take over the investigation? And more importantly, why would Mr. Mooney continue to have Mr. Valentine conduct the investigation after he received your Honor's written order instructing only the Ombudsman to investigate the matter?

5. Why is Mr. Valentine's report silent as to the damage done to Mr. Nicolaison's computer desk, which is clearly a part of the litigation and, therefore, should have been included in any report required to be submitted to the court?

6. Why would the MSOP Administration duplicate the efforts and expense of an investigation of the Ombudsman, for property whose value does not match the cost to conduct such an investigation?

This report is respectfully submitted in compliance with your Honor's September 16, 2005, order from the bench and the October 28, 2005, written order.

Sincerely,

Michael L. Woods
Regional Ombudsman

Brian Relay
Director of Client Services

Attachments

Cc: Mr. Dean Mooney, Defendant
Mr. Wayne Nicolaison, Plaintiff
Roberta C. Opheim, Ombudsman

This report has been reviewed and approved by Roberta C. Opheim, Minnesota Ombudsman for Mental Health and Developmental Disabilities.

Roberta C. Opheim, Ombudsman

prior record to me

Minnesota Department of Human Services

State Operated Forensic Services
Minnesota Sex Offender Program
1111 Highway 73
Moose Lake, MN 55767-9449

November 2, 2005

District Court Judge Lawrence R. Yetka
Carlton County District Court
P.O. Box 190
Carlton, MN
55718

RE: Wayne Nicolaison vs. Dean Mooney
Court File Number: 09-CO-05-204

Dear Judge Yetka,

I received a request on your behalf from Sara Helwig, Carlton County Court Clerk, requesting a report that you had ordered on the Wayne Nicolaison vs. Dean Mooney case, Court File Number: 09-CO-05-204.

I was informed that there was a conciliation hearing that was postponed in which information was requested on (1) small bookcase, (1) large bookcase (handmade), and (1) Aiwa brand mini stereo system (with no speakers), that Mr. Nicolaison declares as damaged or destroyed by MSOP staff.

I have reviewed the affidavits, photographs, patient charting, tort claim and response, interviewed staff from MSOP Moose Lake and St. Peter and personally inspected the property in question. Mr. Nicolaison answered initial questions regarding his Protective Isolation transfer and access to property but refused follow up questions on 11/2/05.

Synopsis:

Mr. Nicolaison was transported from the MSOP Shantz Hall 2 West unit to the Protective Isolation room on the South unit after a physical therapeutic intervention incident between Mr. Nicolaison and MSOP St. Peter staff. Although both units are located on the St. Peter campus, they are in different buildings that are approximately 1 mile apart.

I am unable to locate documentation stating who or when Mr. Nicolaison's property was removed from his room in Shantz Hall and transported to the south unit. His property was stored in the south units back hallway and inventoried by Security Counselor Krissy Wright on 3/14/05. SC Wright stated that she remembers inventorying Mr. Nicolaison's property and due to the amount, it took her entire shift to complete. SC Wright did

Minnesota Department of Human Services

State Operated Forensic Services
Minnesota Sex Offender Program
1111 Highway 73
Moose Lake, MN 55767-9449

document that the inventory was completed on 3/14/05 at 9:35pm and the personal property inventory log includes the 2 bookcases and Aiwa stereo that are in question. The log does not include the condition of property. SC Wright stated that she did not recall any damaged or destroyed items and would have documented this information had she seen it.

The property was moved to the St. Peter loading dock and picked up by Moose Lake transporting staff on 3/15/05 at approximately 12:15pm. The condition of the 2 book shelves in question was in disrepair, extremely poor condition (falling apart), and the shelves were not attached to the bookcases. The overall strength and integrity of the large book case framing was further compromised by the unattached shelving. This was immediately questioned by transporting staff. Information provided in affidavits from St. Peter staff state the bookcases were in poor condition and had gouges, scuffs and scrapes in numerous locations prior to Mr. Nicolaison's original transfer off of Shantz 2W.

Upon arrival, Moose Lake staff placed the property in storage. The Moose Lake property staff, Kevin Larson, reattached the shelves and back of the larger book case. SC Larson also reattached the back to the smaller book case. The Aiwa stereo is in one piece and did not have any visual damages. Mr. Nicolaison's tort claim stated that the Aiwa stereo had been "damaged/smashed".

I visually inspected all 3 items. The larger book shelf has been repaired and appears to be structurally sound. The smaller book shelf is made of particle board and the top joint has been damaged (chipped) thus compromising the structural integrity and rendering the bookshelf unusable. The Aiwa stereo casing did not show any signs of obvious physical damages however, the CD slide out changer would not latch inside. The stereo did not work (power up) when plugged into a working outlet. I am unable to verify that the item was in working order prior to this incident.

Conclusion:

1 Large bookcase, described as handmade and poorly constructed to be valued at approximately $67.59 by Moose Lake Industry Wood Working Staff. The item has been repaired and is structurally sound. The facial defects were present prior to transporting.

1 Small bookcase is of poor quality, made of particle board, aged, and has a warped top. A new item similar to this is approximately $18 at Wal-Mart according to the attached documentation.

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Minnesota Sex Offender Program
1111 Highway 73
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1 Aiwa Mini Stereo System (without speakers), shows no sign of physical damage, however the CD changer disc will not latch in the closed position. The Stereo does not work and will not accept power. I am unable to verify that the item was in working condition prior to this incident. On 11/2/05 I attempted to gather more information on this item but Mr. Nicolaison refused to talk with me. This item retailed for $159.99 according to the attached documentation.

Mr. Nicolaison's property was in a secured back hallway in which only staff had access and was transported to the loading dock approximately 14 hours after inventory. Both the bookcases were compromised sometime after the inventory and when Moose Lake staff picked them up at the loading dock. Therefore, it is most likely the 2 bookcases came apart while being moved from the hallway to the loading dock, as they were in poor condition to begin with. However, this conclusion is not a certainty and only a probability. There is no documentation on when or by whom the items were moved to the loading dock. The large bookcase was repaired by MSOP staff. The small bookcase has a chip in the corner where the top joint is thus rendering it unstable/unusable. There appears to be no physical damage to suggest negligence by staff in regards to the Aiwa Mini Stereo and it cannot be determined that it was in working condition prior to the transfer as Mr. Nicolaison is uncooperative.

This information was presented to the MSOP Director, Dean Mooney, and he has offered reimbursement for the small bookcase.

I have enclosed the affidavits, photographs, and information related to this issue. You may contact me at 218-485-5300 ext. 5543 if you have any questions or concerns.

Sincerely,

Randy Valentine
Patient Advocate
MSOP
1111 Hwy. 73
Moose Lake, MN
55767

Cc: Dean Mooney, MSOP Director
Wayne Nicolaison, MSOP Patient

On 3-15-05 Mr. Nicoliason's property arrived at our site from the St. Peter campus. Mr. Nicoliason's tall wood shelf according to Moose Lake transport staff had come apart prior to them picking the shelf up from the loading dock at the St. Peter campus. The main structure was intact but the shelves had detached from the main frame. Also the back was off at this time. This was the condition of said shelf prior to transporting to our site. Because the shelves were loose/apart and the back was off the integrity/strength of the frame was compromised. This writer had the Moose Lake Industry Skills Development Supervisor Charlie Hoffman submit a bid/estimate as to the cost/value of this item. Mr. Hoffman performs the bidding/estimates required for wood working projects at our site. Please see the attached Interagency Billing Form. This writer also asked Mr. Hoffman to write an affidavit concerning his opinion as to the quality of the construction of this book shelf. Please see the attached affidavit provided by Mr. Hoffman. Also please see the attached photographs taken by this writer and provided as evidence. Also due to the shelf not being stained or sealed stains are visible on this item. These stains were evident prior to shipping to our campus. According to Moose Lake transport staff Mr. Nicoliason's small wood shelf was also in very poor condition prior to transporting said item from the St. Peter site. Mr. Hoffman states this item was made of compressed particle board and can be obtained from most vendors for under $30.00 new. This writer inspected the small shelf with Mr. Hoffman and came to the conclusion that the top was warped due to the placement of objects which were to heavy to be on this light weight constructed shelf. Both shelves were removed due to the pins used to hold these shelves being missing. The back had come off due to poor construction further decreasing the integrity/strength of the main frame for this shelf. Please see the attached photograph's of this item. This item when purchased comes disassembled and requires assembly prior to use. This writer as stated before believes the Aiwa stereo to be undamaged/uncrushed which is contrary to what Mr. Nicoliason stated in his Tort Claim and his ensuing small claims law suit against the State Of Minnesota/Minnesota Sex Offender Program. Once again please see the attached photograph's of this item. This writer reassembled the large book case and the small shelf. Using small brad nails I reattached the shelves and back of the large book case. This writer also obtained and replaced the pins that were needed to hold the two shelves in place in the small shelf and using brad nails replaced the back on this shelf. Please see the attached photograph's of the two items after this writer reassembled them. It is this writers opinion that the quality of construction for these two shelf items has been greatly enhanced due to this writers reassembling of said items.

Kevin Larson
Security Services Property Clerk
Minnesota Sex Offender Program

Kevin Larson sc/pc 10-21-05

PAMELA GAIL RICHARDSON
COMM. #20495158
Notary Public
State of Minnesota
My Commission Expires 1/31/2006

Pamela Gail Richardson 10/21/05

Moose Lake Industries

To: Kevin Larson, SC Patient Storage

From: Charlie Hoffman, SDS Vocational

Subject: Bookcase Construction

Kevin,

I was asked to give my opinion on the value and the construction techniques used on a 48"x36"x8" Oak plywood bookcase. The bookcase had several flaws and looked as though it were only ¾ completed; the solid trim used was un-sanded and nailed/stapled to the bookcase, it did not look as if it were glued properly. The bookcase itself was not sanded or finished in any way, this leaves the wood unprotected from stain damage. I also noticed that the person who constructed this did not attempt to wipe or sand out any of the glue marks left around the joints; this would cause defects when applying any sort of stain or finish. In my opinion I believe this bookcase to have been very poorly constructed.

Sincerely,

Charlie Hoffman SDS

Charlie Hoffman 505 19

PAMELA GAIL RICHARDSON
COMM. #20495168
Notary Public
State of Minnesota
My Commission Expires 1/31/2005

Pamela Gail Richardson

10-21-05

Minnesota Sex Offender Program

Wayne Nicolisson's Furniture

At the time that Mr. Nicolisson arrived on the Shasta 2 West unit (roughly January 2005) residents were being asked to downsize property on their own accord. Some of the property under question was Mr. Nicolisson's belongings—including a bookshelf (2 sections). The question came up whether or not the Shasta 2 West team would approve these items. The general condition of these items was poor. The bookshelf and furniture that Mr. Nicolisson possessed was in a state of disrepair. This included gouges out of the wood finish and scuffs and scrapes in numerous locations. The team decided to speak with Mr. Nicolisson about the furniture but had initially decided to encourage him to send it out. When approached by this writer Mr. Nicolisson spoke in a manner showing great pride in the fact that he had built the furniture years earlier (I believe 5-6years earlier he stated, in the MSH woodshop upon his arrival to the MSOP). Mr. Nicolisson also voiced his concern that he had no family and if we did not allow him to maintain the furniture despite its condition MSOP would in essence force him to dispose of it. The team reassessed the fact that he took such great pride in the furniture and allowed him to keep it despite the visual disrepair and the fact that it was somewhat outside the size requirements set out in the Non-Participant Level of Care Handbook for property.

Matt Schroeder, AGS

Notary: Stacey Sonnek, SW

Stacey Sonnek

STACEY DENISE SONNEK
Notary Public-Minnesota
My Commission Expires Jan 31, 2010

State of Minnesota
Office of the Ombudsman for
Mental Health and Mental Retardation
121 7th Place E. Suite 420 Metro Square Building, St. Paul, Minnesota 55101-2117
651-296-3848 or Toll Free 1-800-657-3506 TTY/Voice Minnesota Relay Service 711

June 9, 2005

Mr. Michael Tessneer
Director of State Operated Services
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

COPY

Re: Minnesota Sex Offender Program

Dear Mr. Tessneer:

Thank you for the opportunity to meet with you and the administration of the Minnesota Sex Offender Program, (MSOP), on April 11, 2005, to address recent developments within the program. The meeting was a good opportunity for our agency to express concerns about issues that impact the resident population and for you to share with us the challenges the MSOP faces in providing an effective treatment program that also ensures the safety of the public.

As you are aware, the Office of the Ombudsman for Mental Health and Mental Retardation is charged, under Minnesota Statute 245.92, with promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental illness, developmental disabilities and related conditions, chemical dependency and emotional disturbance from an agency, facility or program. Accordingly, individuals who are committed to the MSOP are included in the populations that are served by the Ombudsman's Office. In accordance with Minnesota Statute 245.94, our agency may investigate the quality of services provided to clients and review matters that influence the delivery of those services.

As we discussed at our meeting, the purpose of the meeting and this letter is to set forth growing concerns we have with the operation of the MSOP. Over the past twelve years, issues have arisen that are of concern to the Ombudsman's Office because of the unique nature of the sex offender program. Some of these concerns pre-date the building of the Moose Lake facility and the development of Rule 26. As the program has evolved and changed over the most recent 10 years, we have seen the balance that must be struck between safety and treatment. However, there has been little or no clinical progress that would lead the residents to believe that there is hope for their ultimate completion of the program and release from treatment. This has led to a sense of frustration and hopelessness on the part of the residents making them more prone to problems associated with the day-to-day operations of the facility. While some of the residents have repeatedly refused treatment, others have been sincere in their efforts to progress in treatment - but the outcome appears to them to be the same. This sense of hopelessness can lead to conditions that present challenges to the safe

operation of the facility for both the residents and the staff who must work there. Great effort must be placed on the day-to-day operation to prevent dangerous conditions from developing. Because of the escalating number of issues being brought to our attention, the rapid growth and the recent programmatic changes, the Ombudsman feels it is important to address those issues in an effort to prevent negative and unintended outcomes.

Over the past two years you and I have discussed a number of proposed changes to the MSOP program. In general, this agency has been supportive of your vision and understood the unique difficulties associated with running such a program. When we discussed changes to the application of the Health Care Resident and Patient Bill of Rights, we were assured that there would not be a wholesale application of rights restrictions without justification on a case by case basis. However, as we have discussed, our concern arises from our observation that the day-to-day operation of the program does not seem consistent with the long term vision, as our agency understood it, and it seems appropriate to revisit those discussions. I want to emphasize that we are not focusing on any one of the individual actions of the facility or the staff but rather on a pattern of practice or trend that all of these actions, when considered together, can lead to conclusions or assumptions by the residents, the courts or the public. When factored with other external factors, which are outside of the facility's control, these can contribute to residents' feeling of hopelessness that contributes to our concern for safety.

In raising these issues, the Ombudsman's goals are as follows:

1. to protect the safety of the residents and staff of the facility;
2. to minimize Minnesota's risk of financial loss due to court action or harm that may come to residents or staff of the program;
3. assure fair living conditions for the residents and safe working conditions for staff; and
4. to promote the development of an institutional culture where therapy is effective for those who desire to change.

In approaching the problem, I sincerely considered information from past interactions with the program and issues raised by program staff. Often we have heard that "if we (MSOP staff) did not have to worry about the Health Care Resident and Patient Bill of Rights, we could do the things we need to do to address the problems." With that in mind, I decided to look at this from the view of any forensic facility, including correctional facilities. I also decided to consider basic rights (legal, civil and human) that are not unique to a health care setting but to all human interaction. When the population being served is particularly unpopular, it becomes too easy to move down a path that risks violating rights or engaging in problem practices because the public does not seem to care, especially in a closed institutional setting.

As part of our review, I considered information gathered in cases brought to our agency, interviewed members of the Hospital Review Board (HRB), met with citizen participants in the Resident Advisory Council, spoke with individuals in the Department of Corrections (DOC), met with a former Commissioner of Corrections and read The Big House, Life in a Supermax Security Prison by Jim Bruton, former Warden of Oak Park Heights Correctional Facility and former Assistant Commissioner of Corrections. I looked at how DOC can safely

house these same individuals for years and with fewer incidents or problems than are currently experienced by the MSOP. In the end, I have concluded that to run a safe facility, a fundamental component for control is dignity and respect[1] with an emphasis on fair rules, well trained staff, and policies that are firm, fair and applied consistently regardless of the unit or the staff person that implements them. It must be a facility where everyone is held accountable to follow the rules; staff as well as residents.

During a recent visit at the Moose Lake facility, Michael Woods, our Regional Ombudsman in Moose Lake, interviewed a number of residents in an attempt to gauge the frustration level of the residents.[2] The following are some of the statements made by residents:

- "This isn't a treatment facility. The clinical team hasn't accomplished anything in ten years so why should we put our faith in them that the next ten years is going to be any different. They are only interested in warehousing us. We can't distinguish between treatment and punishment. There are guys in here that know they'll never get out and they don't want to grow old and die in here, they want to die now."

- "Staff are going to keep pushing us and pushing us into a corner until one day someone's going to snap and a staff person is going to get killed. And it's going to happen soon. I predict it's going to happen within the next year."[3]

- "When we question staff on how we are being treated and how the program is run, they tell us, 'Take us to court if you don't like how things are run around here.'"

- "Even Lassie will eventually turn and attack Timmy if he's poked with a sharp stick long enough."

- "It is difficult to find hope in a hopeless situation. At least in prison you know when you're going to be released, whereas here there doesn't seem to be any end in sight."

With this in mind, we present some of the issues in a sincere effort to effect positive changes within the treatment program that will help ensure its continued viability and legitimacy as well as reduce the tension level among the residents and staff.

1. Lack of Diversity Training/Insensitivity Towards Cultural Diversity.

Our agency, along with the Hospital Review Board and the Resident Advisory Council, has expressed concern over the apparent lack of diversity training and cultural diversity within the MSOP. Members of the African-American community within the MSOP have expressed

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[1] Pages 136-146, The Big House, Life in a Supermax Security Prison Warden James H. Bruton, Voyageur Press 2004.

[2] The Ombudsman does not represent these statements as validated or investigated complaints but as examples of the emotional climate in the facilities.

[3] It is important to note that the individual was not conveying a specific threat on their part, nor was it directed at any individual but merely an observation of the frustration levels building in the program.

9/15/05
To Whom It May Concern:

On March 15, 2005, I, Tracy Anderson, a Security Counselor at MSOP Moose Lake, was the driver of a transport to pick up patient Wayne Nicoliason, from MSOP St. Peter campus. I, Jane Stinar and Thorne Torgerson, both Residential Security Counselors at MSOP Moose Lake were involved in this transport. Upon arrival, at approximately 10:00 am, we were informed by St. Peter staff where to pick up Mr. Nicoliason's property. When I backed up the van to the loading dock at St. Peter, a staff there for whom I do not know his name was waiting with the property belonging to Mr. Nicoliason. I observed a bookshelf and sort of wooden homemade desk that were in extremely poor condition, peeling, cracked, with shelves that were not connected to the braces; the metal fasteners in both pieces were not connected in the majority of places; along with several cardboard boxes. Mr. Torgerson commented to St. Peter staff about the condition of the property we were looking at; at that time St. Peter staff laughed and said it looked as if it should just be thrown away. All of us at that time loaded Mr. Nicoliason's property into the van as best we could in the condition that it was in and transported Mr. Nicoliason back with his property to MSOP Moose Lake, arriving March 15, 2005 at approximately 3:33 pm.

This statement is true to the best of my knowledge.
Tracy Anderson
9/15/05

their frustration, anger and resentment over what they perceive as staff insensitivity and lack of awareness for their cultural differences. Despite repeated attempts to get this issue addressed by the MSOP, this issue has been largely ignored.

For example, the Hospital Review Board recommended in its 2002 report that the MSOP permit an organization unaffiliated with the Department of Human Services, such as The People's Institute, to evaluate the program and assist the MSOP "in developing processes for dismantling racism and educate facility staff." The report goes on to recommend that "All Staff should participate to insure success. Since the program's approach is highly cognitive, perhaps different strategies could be used for those patients who have intellectual and/or language difficulties."

A good example of the lack of cultural diversity is the program's use of very complex concepts. The program has a list of "thinking errors" and "distorted styles of thinking" that it expects the resident to know, understand and incorporate into his everyday life. Staff is insensitive to the fact that a young minority male, growing up in poverty on the streets of Minneapolis with a very limited level of education, may be confused and frightened when placed in this foreign world within the MSOP. When staff accuse and confront this resident for "compartmentalizing" his behavior, or engaging in "polarized thinking," or "catastrophizing," or acting "superoptimistic," staff fail to appreciate how this person's life experiences, background and culture would cause him to feel alienated from the treatment process. The program is cognitively based with some assumptions about the ability of the participants and does not appear to adequately take into account how an under-educated minority, who speaks limited English, may have difficulty in understanding the program.

Another example of the cultural insensitivity within the MSOP is the case of a Mexican-American resident. Prior to the new changes in the program, the resident was permitted to order his Mexican spices and ingredients from a St. Paul specialty store, at his own expense, since they are not available in Moose Lake. Under the new program, staff refuses to grant the resident's request to purchase these items.

An additional example of the day-to-day interaction with staff that causes African-Americans to be suspect of the cultural sensitivity of staff is what happened recently between staff and residents. Aspects of black culture are grounded in early history of slaves in this country, including the practice of being disciplined if they looked their slave master in the eye without permission. They were taught to always look down. Two African-American residents were instructed by a staff person to look him in the eye when they ask to leave the unit "because it is part of socializing." Socializing is one of the categories residents are evaluated on by security staff and they need to score high enough on this topic before they progress in treatment. This scenario has a three fold negative impact on the African-Americans involved: 1) it invokes aspects of their cultural history, 2) it defines socialization in the staff's cultural norms and 3) the resident receives a low evaluation in the socializing category.

Despite requests over the last three years by our agency, the Resident Advisory Council and the Hospital Review Board to implement a strong diversity training program, MSOP has failed to address the problem. The program manual states that racial discrimination is not

tolerated, yet it is not evident that steps are taken to ensure that what is written on paper is actually implemented in the course of staff's daily interaction with people of color.

2. Broken and Inadequate Means To Address Concerns.

The residents don't believe that there are adequate means for them to address their concerns. While on paper, there appear to be a number of venues the residents [illegible] bringing their concerns to the attention of the Administration, in practice these [illegible] ineffectual.

For example, there is a formal grievance process but, for a host of reasons, the system is completely broken and the residents have absolutely no faith in the process. Residents believe that the unit directors do not adequately investigate their issues prior to responding and, when it reaches the final stage, senior administration simply rubber stamps the conclusion reached by the unit director (i.e. "I agree with the above response" or "As stated by the AGS").

The patient advocate is sometimes kept out of the loop until it is too late to advocate. He spends a disproportionate amount of time in the grievance process, rather than on the units with the residents and staff facilitating outcomes. The residents feel that when the advocate raises issues with administration, the issues are ignored.

The Hospital Review Board's recommendations and requests have gone unheeded. The MSOP administration has not responded to the Hospital Review Board's recommendations since September of 2004. At a recent meeting, the chair requested that the administration arrange a meeting with the residents of color to be held one hour before the next HRB meeting. This was intended to attempt to address the cultural issues being raised. The date of the next meeting was set at least a month in advance. Despite repeated written requests to set up the meeting, when the members of the HRB arrived for the meeting, no arrangements had been made for the meeting and the HRB was not advised in advance that the meeting was not arranged. The facility director was out of town and the assistant went home ill that morning. The administrator-in-charge refused to make any adjustments to accommodate the HRB's request without direction from facility leadership. Neither the director nor the assistant were available by pager or telephone. The creation of the Hospital Review Board was ordered by the Minnesota Supreme Court and the members are appointed by the Commissioner. While I can appreciate how busy administrative staff have been, this apparent lack of respect for the HRB and their role sets a tone throughout the facility and sends a clear message to the residents and the staff.

While residents may express some of their complaints to the Department of Health's Office of Health Facility Complaints, that department has not done a review inside the MSOP and refers all matters to the Ombudsman's Office for review.

All of the recommendations of the Resident Advisory Council appear to be ignored, regardless of the merit of the recommendations. For example, the Council made a recommendation requesting the expansion of the facility's visitation hours, including their rationale: two hours a day for visitation seemed too restrictive given the limited capacity of the visiting area. Visiting hours are only from 6:00 p.m. until 8:00 p.m. Monday through Friday and only seven

hours on Saturday and Sunday. Twenty-four (24) hours a week for 150 men seemed unreasonable. Capacity needed to be increased. Family and friends [illegible] to get to Moose Lake, only to then have to sit and wait for a spot in the visiting room to become available. If residents voice frustration over this issue, they are accused of having "treatment issues" in their documentation, i.e., "visitation issues are high external risk factors" for this resident. Yet this issue went unaddressed by the MSOP. On January 5, 2004, the Council wrote a letter to the clinical director addressing this issue and it received no response.

The Ombudsman is sensitive to the issue of the volume of complaints, that some of the residents abuse the process, and that some individuals "shotgun" their complaint to multiple outlets or "shop" for a different answer. A process to sort the legitimate issues from the frivolous must be found. To simply not respond or to overlook growing concerns can only lead to more problems in the future.

3. Property Issues.

The authority of MSOP to limit the property rights of residents is contained in M.S. 253B.185, sec. 18, subd. 7, which states that the property rights may be restricted only as "necessary to maintain a therapeutic environment or the security of the facility or to protect the safety and well-being of patients, staff, and the public." Recent changes to the program have led to property restrictions that appear to be more coercive or punitive, rather than related to either progress in treatment or safety. Having unit levels that encourage residents to participate and progress in treatment makes sense. But in our opinion, defining the number of handkerchiefs, socks, etc., seems overly detailed and not related to the therapeutic environment. We realize that the amount of property that was being accumulated led to problems, but we would suggest that each resident be allowed a defined volume of personal property with a specific documented list of banned or contraband property, and have your treatment incentives be related to something beyond the basics. Different residents have different views on what property is important to them and they are unlikely to respond to what administration might define as "incentives." In addition, when asking staff members what is allowable, residents get different answers from different staff members as to what is and what is not contraband. This only increases the anger and frustration felt by the residents who attempt to follow the rules.

Another example of what appears to be an arbitrary practice is the restriction on computer software. Windows XP is allowed on one unit but not on another, yet public safety and access to the internet is given as a reason. Use of their personal computers, purchased at their own expense, is useful for writing letters, for learning and development and sometimes for diversion from the reality of life. To get access to the internet hardware is needed, such as wires or a wireless base unit, modems and an internet service provider (ISP). To the best of our knowledge, residents can not gain access to the internet without an ISP, and the facility controls that access. If there is a legitimate problem, it has not been adequately presented in a way the residents or the Ombudsman can understand. These types of inconsistencies are inadequately explained in terms of either safety or therapeutic programming and leave the appearance that these issues are decided on the whim of the unit or individual staff. It would appear that the MSOP believes that every possible action can and will in fact happen and so they take arguments to the extreme. If the staff can imagine something might be able to

happen, they act as if not only is it possible, but also inevitable. If that is the case, it is imperative that these decisions are based on correct information and not speculation, with consistent written explanations provided to residents and their representatives alike.

4. MSOP's Possible Violation of Law and Statutes:

The Security Director allegedly said "We're going to do things around here the way we want until a court makes us do otherwise." Also as previously noted, the staff has responded to residents by saying, "Take us to court if you don't like how things are run around here." If this is the attitude of staff, then the MSOP is at risk of ignoring laws and rules that could lead to a violation of rights challenge. Indeed, this seems to be an invitation to the residents to file a law suit as the only way to effect change. This sets up an adversarial atmosphere and leads to expensive litigation that unnecessarily expends public money that could be more effectively used in the treatment program or elsewhere in the state.

An Ombudsman staff member reported to me that while out at a local establishment in a community that was experiencing the closure of an RTC, they overheard two DHS employee's discussing their options. One had taken a security counselor position at Moose Lake and another was considering their options. The security counselor was heard to say to the HST, "You should transfer up. It is so much better, you can do what you want to the clients and nobody cares or gives you S--! If you are tired of those advocates, come up to Moose Lake."

When staff is not held accountable for following the laws and rules, but residents are, it does not send a clear and consistent message. It is not clear that staff is adequately trained on the laws and rules that apply to the operations of the MSOP. In addition, residents are being given different answers by different staff members. This can lead to institutional chaos and the perception that either no one is in charge or the rules do not matter.

5. Use of Restraints

The MSOP indiscriminately uses restraints, both handcuffs and shackles, without regard to the individual resident's security risk. At least under the prior treatment program, residents were assessed a security rating and restraints were used based on their individual security rating. This isn't to say, however, that the MSOP's former practice of issuing security ratings was not without its faults. For example, a resident was assigned a low security rating, not because he was a security risk, but because he wasn't in treatment and, therefore, the resident never graduated beyond the rating level that would allow him to become restraint-free. Under the former program, there was some individualization in determining the use of restraints. Currently, only those residents that are on the Advanced Treatment Unit are transported free from restraints. All other residents—residents on the Non-Participation Unit, Behavioral Unit, Initial Treatment Unit and Mid-Level Treatment Unit—are transported in, at the very least, handcuffs and in some instances shackles, without any consideration of whether the person is an actual security risk.

In St. Peter, residents that pose no security risk whatsoever, due to their physical limitations, are placed in restraints. Staff recently shackled a geriatric resident even though, with his advanced age and limited mobility, he posed little security risk. One resident was shackled even though he is permanently confined to a wheelchair due to the lost use of his legs as a result of complications stemming from diabetes and cerebral palsy. Staff appears to be insensitive to the resentment and anger the resident population experiences from hearing about the shackling of a physically disabled man and a medically fragile senior citizen.

6. Security Measures

As a result of the recent security breach in St. Peter, the security situation has gone from inadequate security to excessive security measures. An over-reaction on the part of the program causes the residents to feel that they are being punished for the actions of two men. The new security measures are seen as a knee-jerk reaction which leads to frustrated and angry residents which, in turn, leads to an unsafe working environment for staff and unsafe living conditions for the residents.

One potential negative consequence of the new security measures being taken is the sleep deprivation suffered by the residents. Staff members enter residents' rooms at midnight and at six o'clock in the morning, for security checks, without any consideration that the resident is sleeping. It is well known that sleep deprivation can be a cause of problematic behavior. Staff's practice of waking people up during the night, startling the residents out of their sleep, whether intentional or accidental, can lead to sudden, inappropriate behavior on the part of the residents. Not only does sleep deprivation negatively impact the mental health of the residents, but it creates an unsafe, volatile working environment.

7. Issues At St. Peter Campus

One of the primary causes creating the tension, frustration and resentment on the part of the residents on the St. Peter campus was the lack of a smooth and orderly transition of their transfer from Moose Lake to St. Peter. In December of 2003, leadership staff provided our agency with a presentation forecasting the expansion and changes the MSOP would undergo in the coming year. If these developments were anticipated long before our meeting, the MSOP knew at least 15 months before the opening of Shantz Hall that the census was going to increase and that there would be a need to transfer men to Shantz Hall. Despite this knowledge, steps were not taken to ensure that acceptable conditions were in place prior to the transfer of the residents.

We understand that Pexton Hall is in the process of being renovated so that the residents can be transferred there from Shantz Hall. We want assurances, however, that the lack of planning that occurred when the men were transferred from Moose Lake to St. Peter is not repeated when the residents are moved a second time. Below are deficiencies within the St. Peter program that we hope will be addressed as soon as possible and, at the very least, before the opening of Pexton Hall.

• Unlike the acceptable mattresses provided at Moose Lake, the residents in St. Peter are forced to sleep on county jail style mattresses. The residents would be satisfied with the bedding that is provided at Moose Lake, but instead they have to sleep on steel framed beds that require a wooden board for support.[4]

• The mail system is inadequate in that, unlike Moose Lake, there are no locked mailboxes on the units, mail is not delivered on Saturday, and the postage system is haphazard. In Moose Lake, a resident places a postage request on the item to be mailed out, whether it be a package or a heavy envelope, and the staff in the mail room weighs the item and the resident's account is billed and a receipt given. The Moose Lake residents know when the item is mailed and are able to track it. In St. Peter, the residents have to speculate as to the amount of postage needed and they are not given a receipt.

• Unlike at Moose Lake, the residents are not given access to a library.

• In Moose Lake, there is an adequate banking system in place whereas in St. Peter the patients are not given receipts for the transfer of money from one person to the next and they are not provided a record for the transaction. They are only provided a monthly bank statement.

• Under Minnesota Rule 4665.2200, the Minnesota Health Department requires there be at least one bathtub or shower for every eight residents. When the men first arrived at Shantz Hall, there was an inadequate shower facility. There were 34 men and only one working shower and one bathtub. In St. Peter, staff locks the shower at 9:30 p.m., apparently because that's "quiet time." The staff shift change is at 10:00 p.m. and the night staff, who don't work for the MSOP, refuses to accommodate residents' requests. When the men initially were transferred to Shantz Hall, there was only one washing machine and one dryer for two units—the 30 men plus those on the transition unit. The laundry room is locked at 9:30 at night.

• Residents in St. Peter are denied recreation. Residents have been told that they will never be able to use the tunnel to access the gym. The men are only given two, fifteen minute fresh air breaks a day, whereas in Moose Lake the guys have unlimited access to the outdoors during the daylight hours. For the residents in St. Peter, gone are the days when they could go outside and plant a garden or throw a Frisbee or walk around for exercise. We have been told that inmates in segregation at Oak Park Heights prison get more fresh air than the residents in the St. Peter treatment program.

• Shantz Hall has inadequate air ventilation and lighting in the rooms and in the shower rooms.

• Staff are not adequately trained before being assigned to the units. They are non-responsive to resident issues and some staff members have hostile attitudes. Unless staff is doing rounds, they separate themselves in the office and do not interact with residents. Staff

[4] Changes such as these, while small, lead to frustration. Page 54-55 The Big House Life Inside a Supermax Security Prison. 2004 Voyager Press.

does not understand the chain of command, the unit policies, or the unit procedures. When residents attempt to compare rules to those in Moose Lake, and point out inconsistencies, staff informs them that the security hospital administration is running the MSOP, not the administration in Moose Lake. There is a lack of consistency among staff in implementing policy and procedures. It is not uncommon for one staff member to overrule another staff member, leaving the residents confused as to how to proceed.

- In Moose Lake, the residents are able to secure their rooms and food lockers with locks, whereas the residents in St. Peter are without a means to secure their rooms in order to protect their property.

- The implementation of the new cable service is being viewed as unjust. The St. Peter campus has apparently negotiated a deal with the local cable company so that it receives a bulk rate of $14.00 per room. The program charges each resident $39.00 for the upgrade package deal. Even though there is only one jack in the room, both roommates must each pay the $39.00 or they will not connect the cable for either resident and they are made to place their television in storage. So for each double-bunked room, the cable cost the campus $14.00 and they, in turn, charge the two residents $78.00, a $64.00 profit a month, for each room. The Administration states that the profits are spent on "media" items for the men. However, what those media items consist of has not been clearly identified nor has information been solicited from the residents as to what media would be used by them (within limits of allowable material).

8. Telephone Restrictions

The Ombudsman is aware that MSOP intends to implement the installation of a phone system that is similar to those in prison and county jails that will inform those receiving calls that the call is from a sex offender treatment program. The system will also automatically time and record all calls. It is our understanding that this has been necessitated by the actions of some of the residents in attempting to inappropriately call potential victims. This agency is sympathetic to the dilemma faced by the MSOP. However we want to raise certain concerns with the new telephone system. One is the ever expanding appearance that the balance is shifting to one of a correctional facility more than a treatment facility. It is not clear to the Ombudsman whether or not the system being considered is similar to jail and prison systems which requires the call to be placed 'collect' which charges the call's recipient, most of whom are family or friends. Our experience with those systems is that the calls are very expensive to the recipient averaging between $ 10 and $ 20 per call. With the restriction on receipt of incoming calls, family and friends are forced to receive calls well outside regular rates. We also raise concerns about the confidential access of the residents to the Ombudsman's Office without fear of retaliation, which is outlined in MN. Stat. § 245.91-.97.

Because of the escape of two residents, the facility has instituted interim procedures for recording calls, having staff sit in on calls and the elimination of all incoming calls. Procedures for staff were not clearly conveyed so that some residents report that some staff would not grant privacy of communication with attorneys or the Ombudsman, even after

being informed that this privacy was guaranteed to them. Again this type of reactive policy development, done in haste and without clear direction to all staff on what is and is not allowed, leads to further chaos and frustration in the program, unnecessary complaints to multiple outlets and administrative time spent on calls from these outside parties. Residents then report that staff retaliates against them either by charting that residents are creating problems or are oppositional in their treatment program and/or with unit rules. Examples of this type of charting are evident throughout the program.

Summary

In summary, while not exhaustive of all issues, these are examples of issues both small and large. The Ombudsman believes these issues have brought the program to a point where [illegible] resident and staff safety is a serious concern, and that a major negative event could happen. It truly is our goal to assist DHS in preventing this from occurring and to help achieve a program where therapeutic treatment can occur for those who choose to participate.

After our last meeting we all agreed to meet again to continue these discussions. In preparation for such a meeting, the Ombudsman would like to advance the following recommendations for your consideration and further discussion:

1. Take steps to ensure that the resident takes ownership of his treatment plan. To help bring this about, the MSOP must ensure that each resident has an individualized treatment plan. Many residents have indicated to our agency and the Review Board that the only difference between each treatment plan "is the name on the plan." In its annual report for 2002, the Hospital Review Board recommended that the MSOP clinical staff engage in a process to "ensure the patient's . . . participation in [his] treatment planning and review. A patient invested in his treatment program tends to be more motivated, hence [a] more cooperative treatment participant." DHS has chosen not to accept the Review Board's recommendation. We recommend that they reconsider their stance on this issue.

2. Increase cultural diversity in the program. The Review Board recommended in it's 2002 report, and one the Ombudsman supports, that the MSOP permit a neutral, non-DHS, agency such as The People's Institute, to evaluate the program and assist MSOP.

The People's Institute is recognized as one of the foremost anti-racism training and organizing institutions in the nation. The People's Institute's website states that the organization "believes that effective community and institutional change happens when those who would make change understand how race and racism function as a barrier to community self determination and self sufficiency."

3. Separate the clinical and security functions and assure that clinical staff is in charge of the program level and programmatic progression decisions for the team. Dr. Donald Meichenbaum, from the University of Waterloo, stated that the degree to which a patient internalizes and practices the theories and techniques his therapist has presented to him is

directly proportional to the level of trust and acceptance the patient has for his therapist.[5] If there is, what Dr. Meichenbaum titled, a strong "therapeutic alliance" between clinical staff and residents, there is a higher likelihood that the patient will practice what the therapist has preached.

As a result of the MSOP clinical staff's participation in Op Team meetings[6] and their contribution to meting out punishment, residents are distrusting and resentful toward the very individuals entrusted with their treatment. The Department of Health, Office of Mental Health Practice, investigated this very issue and had serious concerns as well, and were articulated to the MSOP in a letter from that office.

Currently, security staff is listed as team leaders and have disproportionate authority over the progress of residents. While security staff is vital to providing input into what is going on, it is the clinical staff that is professionally trained to interpret the meaning of behaviors and the future directions needed. Security personnel should report activities to the clinical professionals and allow the clinical professional to interpret the meaning of those behaviors. The MSOP should have security staff focus more on long range security planning and crisis/situational safety and security situations, rather than treatment. While both security and clinical staff should be on the team and invested in the treatment concepts, the blurring of these two functions has added to the sense of chaos that led many to question who is in charge of the facility.

4. Improve the training of new and existing security staff. Currently the training at MSOP is similar in time as training for new correctional officers at the DOC. But somehow the content of training that leads to how security staff deal with residents is a different approach than what is taught at the DOC academy. Correctional Officers at DOC appear to have clearer boundaries as to what actions they can take against an inmate than what appears to happen at the MSOP. While this may seem contrary to the Ombudsman's overall concern that the MSOP not appear to be a correctional facility, this is one area where this agency believes that DOC could provide guidance on protocols that appear to have a consistent approach. We suggest consideration be given to hiring an associate program director who has served as a Warden or Asst. Warden of a DOC correctional facility or a former Administrator of a county jail. In these facilities security is a necessity but adherence to strict policies by staff is an important factor in keeping the facility safe.

5. Develop clearly articulated polices that are fairly and consistently implemented and plan for changes that must occur. Assure that these policies are adequately communicated to, and understood by, both staff and residents before the change is implemented.

6. Seek voluntary professional accreditation or certification. - Minnesota passed a law in 1999 that required sex offender treatment programs to be certified by the Department of Corrections. DHS sought, and was granted, exclusion from this legal requirement. However,

[5] 2001 Minnesota ATSA Conference
[6] Discipline meetings

the rules simply state minimum standards required for such programs and were a beginning step at best practices when public funds are being spent. While not required to be certified, the MSOP should seek outside certification from DOC, JCOHA, or ATSA to demonstrate quality assurance and development of reasonable (if not best) practices in the rapidly changing practice of sex offender treatment. This certification helps to assure that public funds are being spent effectively given that civil commitment is the most expensive of the methods of dealing with sex offenders.

7. Improve the quality of documentation in the program. There has been a long-term concern about the quality and consistency of documentation in the program. These problems, the staff's unwillingness to address residents' concerns and the broken grievance process, can lead to frustration and unnecessary formal administrative challenges to accuracy and completeness of records. While some residents will chronically pursue this avenue no matter what improvements are made, others would not, if they felt the charting was fair and inaccuracies would be addressed within the program.

It is my hope that we can focus on the overall trend in this message and not proceed to debate the validity of any one item. Our goal is to share the tone and direction rather than individual detail. Often perception is as important in reality and these examples are provided to demonstrate the perceptions that exist. In addition these examples are consistent with a number of complaints expressed so as to create a pattern. Despite the length of this communication, I do not want to minimize how difficult a task that DHS and the MSOP leadership have in the development and ongoing management for this program. The Ombudsman agrees with the vision the State Operated Services has for this program. However, we remain concerned that the vision SOS has is not playing out in the day-to-day operations of the facility. I look forward to our continuing discussions about how the Ombudsman can be of assistance in the development and operation of a safe and effective treatment program.

Please do not hesitate to contact me with questions or concerns regarding the issues raised. We see this as a process with continuing dialog rather than a critical report. Finally, please contact me to set up a follow up meeting.

Sincerely,

Roberta C. Opheim
Ombudsman

C: Wes Kooistra, Asst. Commissioner, DHS
Josefina Colond, Ph.D., Chair, Hospital Review Board