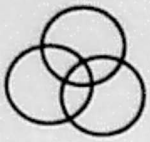


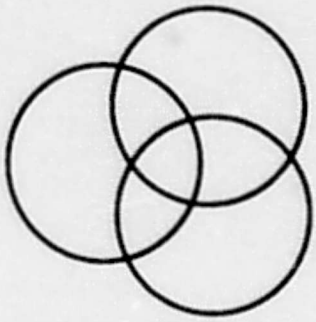
Office of the Ombudsman for Mental Health and Mental Retardation

ANNUAL REPORT

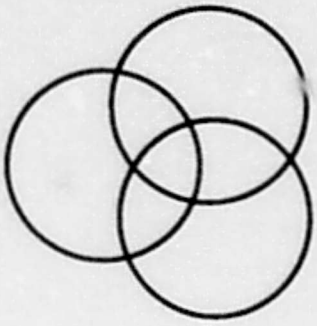
TO THE GOVERNOR

1988

Submitted by the Ombudsman
for Mental Health and Mental Retardation,
Pursuant to Minn. Stat. Section 245.95, Subd. 2
January 31, 1989



Contents



Introduction

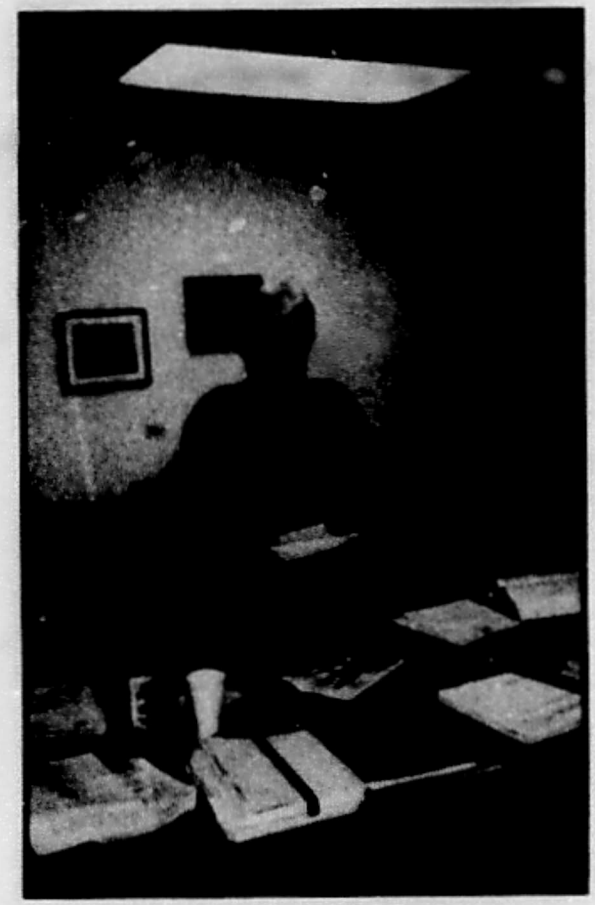
The Office of Ombudsman for Mental Health and Mental Retardation was created by the 1987 Minnesota Legislature. (Minn. Stat. Section 245.91 et. seq.). Governor Perpich signed the bill into law on June 2, 1987, with a July 1, 1987 effective date. Shirley Hokanson was appointed Ombudsman on September 1, 1987.

The Ombudsman has been given a broad mandate to "promote the highest attainable standards of treatment, competence, efficiency, and justice for all people receiving care and treatment for mental illness, mental retardation, chemical dependency, or emotional disturbance."

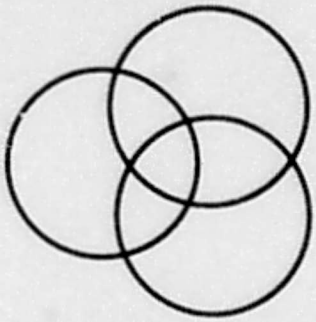
To carry out the mandate of the Office, the Ombudsman was given the power to:

- prescribe the methods by which complaints to the office are made, reviewed, and acted upon;
- mediate or advocate on behalf of clients;
- investigate the quality of services provided to clients;
- determine the extent to which quality assurance mechanisms work to promote the health, safety, and welfare of clients;
- gather information about and analyze the actions of an agency, facility, or program;
- enter and view premises of an agency, facility, or program;
- examine records of an agency, facility, or program.

The following report, submitted pursuant to Minn. Stat. Section 245.95, Subd. 2, describes the activities undertaken by the Office of Ombudsman during 1988.



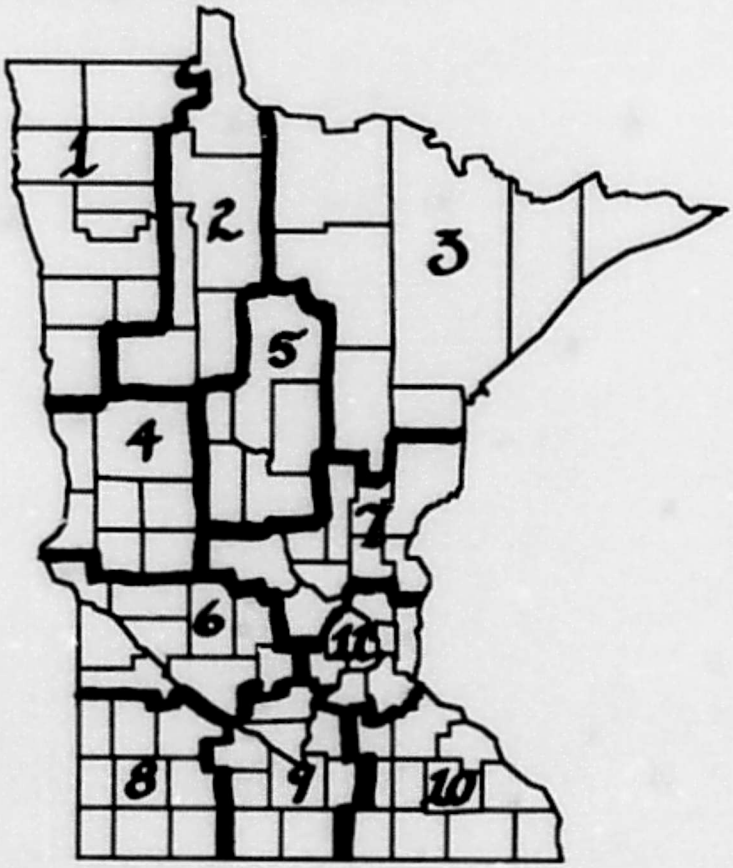
Shirley Hokanson, Ombudsman



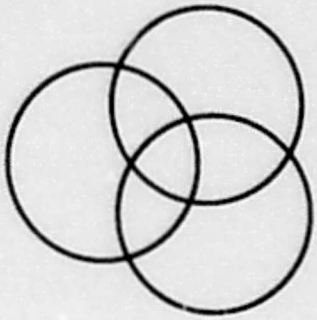
Organization of the Office

The Office of Ombudsman for Mental Health and Mental Retardation consists of a central office in St. Paul and regional offices throughout the state. The regional offices are located in the Regional Treatment Centers in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, Moose Lake, St. Peter, and Willmar. The St. Paul staff consists of the Ombudsman, Deputy Ombudsman, two policy analysts, a client advocate supervisor, a metropolitan client advocate, an agency manager, and a secretary. A strong, cohesive relationship exists between the central office staff and the regional client advocates. Common goals and coordinated work encourages and enhances cooperation in resolving both individual and system complaints.

The client advocates have responsibility for the geographical areas, as indicated below.



NOTE: *Although the offices of the regional client advocates are located in the regional treatment centers, staff respond to complaints from the communities, as well as from the regional treatment centers.*



Outreach Efforts

Informational Meetings Around the State

The Ombudsman and her staff conducted a series of regional meetings throughout the State during the preceding year. The meetings were held to introduce the Office of Ombudsman for Mental Health and Mental Retardation, to review the legislation creating the Office, and to describe the Office's proposed implementation plan. Providers and other interested parties were invited to these regional meetings. Meetings were held in St. Cloud, Detroit Lakes, Mankato, Brainerd, St. Paul, Duluth and Rochester. Approximately 200 persons attended these regional meetings.

Facility Visits

To follow-up on the regional meetings, the Ombudsman and her staff began making visits to randomly selected community residential facilities and acute care inpatient facilities. Over 300 facility visits were made during the past year. The purpose of these visits was threefold:

1. to meet the facility directors and other staff and to introduce the Office of Ombudsman for Mental Health and Mental Retardation;

2. to tour the facility; and

3. to meet with the clients who reside in or receive services from the facility.

Information regarding policies on abuse and neglect, grievances, clients' rights, and procedures used to report deaths and suicides were requested in advance of the facility visit. Recommendations were often made at the time of the visit or communicated to the facility at a later date.

The facility visits have proven to be a valuable outreach tool and learning experience for the Ombudsman Office. The Office plans a thorough review of the data, policies and procedures.

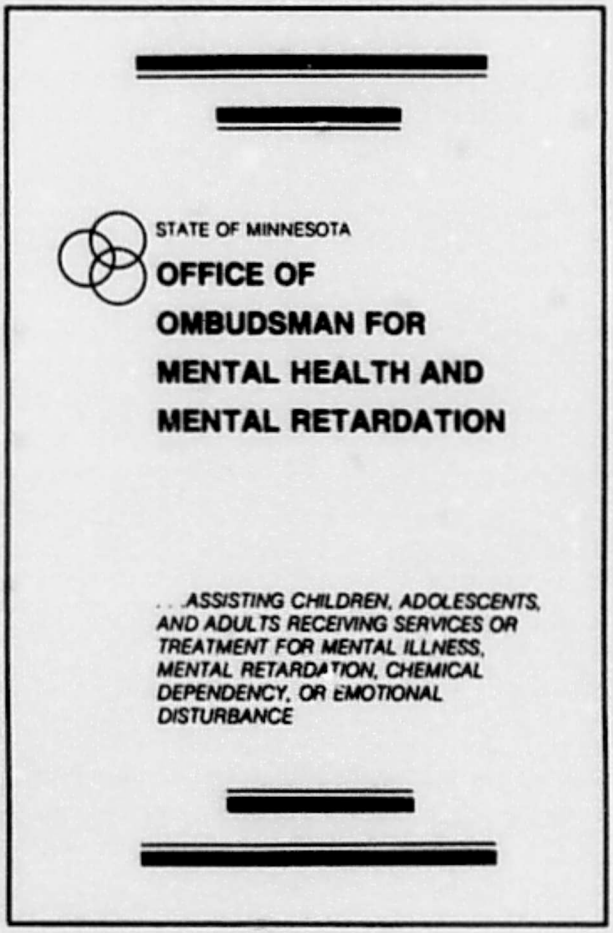
Bill Wyss, the metro client advocate, visiting Chez Nous, a Rule 34 facility in St. Anthony Park

Outreach to Community Groups

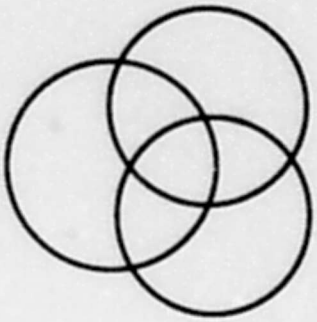
The Ombudsman and her staff made many appearances and gave numerous speeches to advocacy, provider, and human services practitioner groups throughout the past year. These appearances and speeches were made to increase the awareness of the Office and the services provided to clients. In many instances, these outreach efforts were followed by requests for Ombudsman assistance in resolving individual client complaints. The outreach efforts also provided the undergirding for an ongoing dialogue with the community groups and organizations.

Office Brochure

An office brochure was designed and distributed by the Ombudsman Office in late 1988. Copies of the brochure were mailed to each community residential facility and county social service agency, along with a form on which to request additional copies. Provider and advocacy organizations were also supplied with copies. A copy of the brochure was mailed to each member of the Legislature. Other State agencies requested and received copies of the brochure to distribute to staff and clients. A slightly revised version of the brochure will be available in early 1989.



Office Brochure



Investigation of Complaints

General Complaint Overview: Matters Appropriate for Review

Pursuant to the Ombudman's power to prescribe the methods by which complaints to the Office are made, reviewed, and acted upon, the Ombudsman developed a complaint review protocol (see Appendix C for full text). This protocol was slightly revised, based upon nine months of experience in using the original protocol.

In selecting matters for review by the office, the Ombudsman is directed to give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

1. may be contrary to law or rule;

2. may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

3. may be mistaken in law or arbitrary in the ascertainment or facts;

4. may be unclear or inadequately explained, when reasons should have been revealed;

5. may result in abuse or neglect of a person receiving treatment;

6. may disregard the rights of a client or other individual served by an agency or facility;

7. may impede or promote independence, community integration, and productivity for clients; or

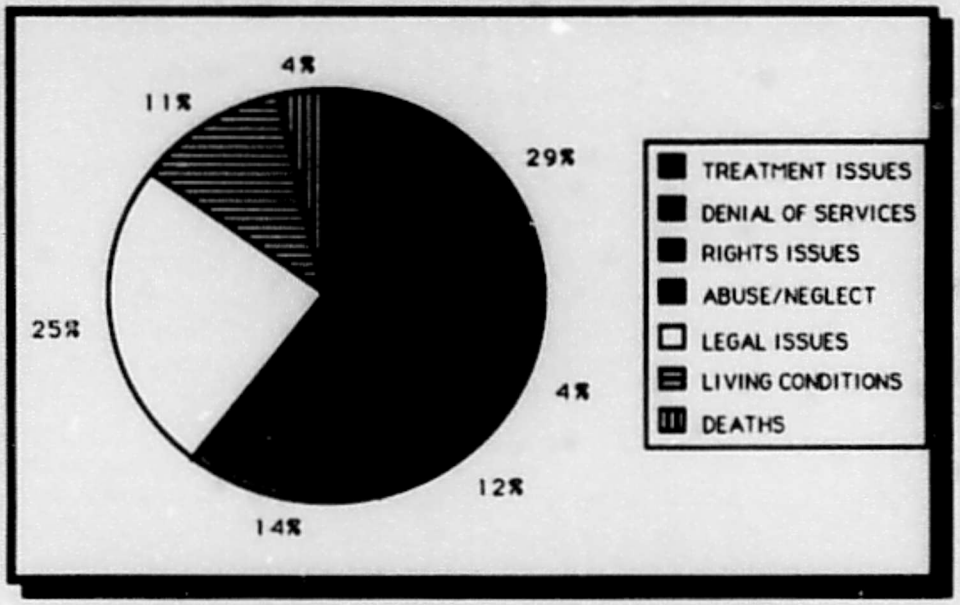
8. may impede or improve the monitoring or evaluation of services provided to clients.

Complaint Statistics

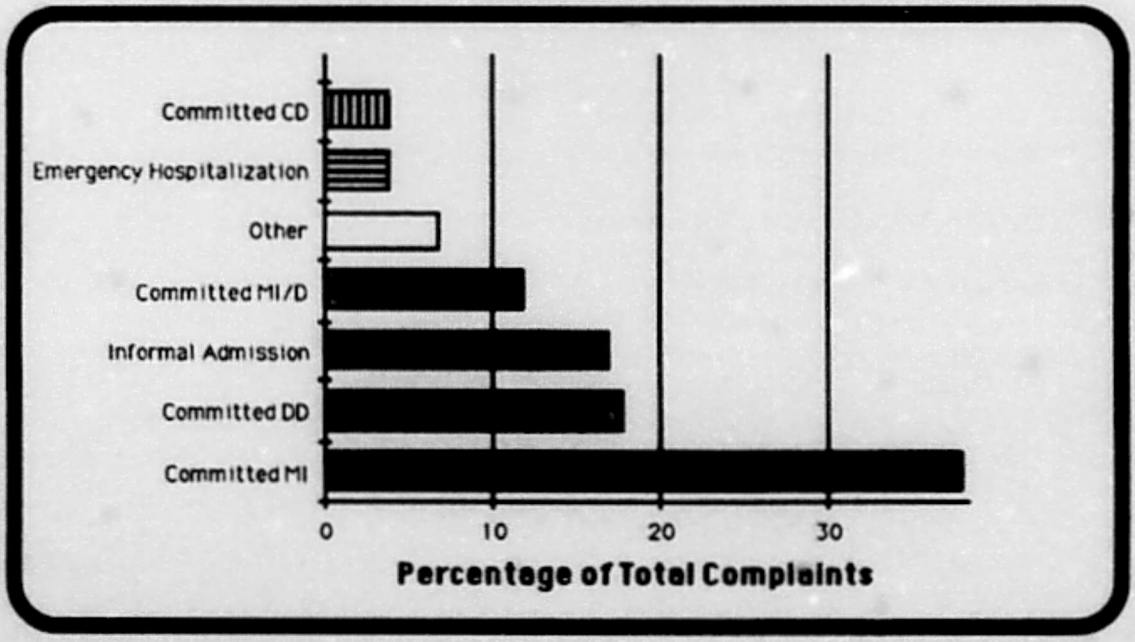
The Office of Ombudsman received over 2,800 complaints during the preceeding year. Most of these complaints were resolved at the local level. Some of the complaints evolved into systemic issues which required a more in-depth review, often resulting in a report or recommendations to the agency, facility, or program affected.

The graphs on the following pages detail the nature and substance of the complaints received by the Office during the preceding year.

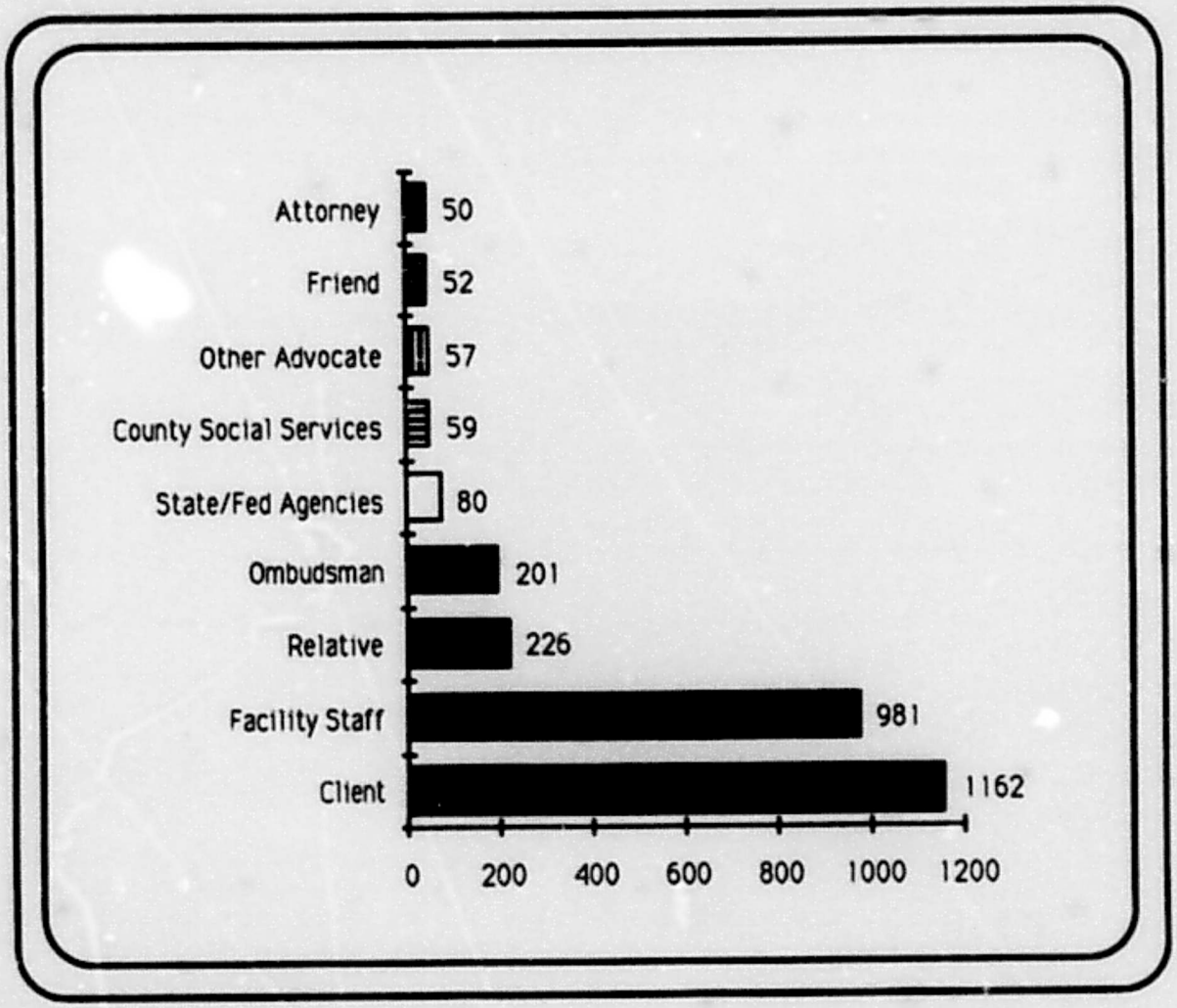
NATURE OF THE COMPLAINTS
(1988)



STATUS OF THE CLIENTS
(1988)



SOURCE OF THE COMPLAINTS
(1988)



Complaint Examples

A brother and sister residing in a Rule 34 facility received large back payments from Social Security. To remain eligible for medical assistance, the residents were required to reduce their assets to the allowable $3,000 level within ten days. This situation was called to the Ombudsman's attention six months after the spend-down occurred. The Office examined this matter from both an individual case and a systems-wide perspective. The Office made recommendations to seek recovery of some of the clients' funds that were spent inappropriately, as well as recommendations to safeguard the spend-down process from possible future abuses.

• •

A Rule 34 facility, due to close within six months, was forced to close without warning by the Department of Human Services (DHS). As a result, the six residents were left without transfer plans. Five of the residents were returned to an RTC. The Office is reviewing the situation in an effort to offer recommendations on how to prevent future such closings. The concern is that clients may be put at risk of reinstitutionalization or inappropriate transfers to other facilities.

• •

A 14 year old developmentally disabled boy, who was removed from a Rule 5 facility because of behavioral outbursts, spent over four months in an adult locked psychiatric hospital. The Ombudsman Office became involved when the boy's letter to Governor Perpich was referred to the Office. Staff intervened when it appeared that the county's efforts to find a suitable placement had been unsuccessful. Staff worked with the county, the boy, the patient representative at the hospital, and a potential provider to insure placement in an appropriate facility.

• •

A parent reported that his 10 year old developmentally disabled son, residing in a Rule 34 facility, was not receiving the proper medical orders necessary to sustain his weight. The parent had communicated his concerns to the staff of the facility but no agreement had been reached and the parent remained concerned. To address this issue, the Office suggested that the parent contact Child Protection. The parent filed a neglect report with the county, which then forwarded the report to the Office of Health Facility Complaints (OHFC). After the OHFC completed its report, the parent and the Ombudsman still had some concerns. The entire situation was reviewed again and the case was discussed with the facility. Specific recommendations were made to the facility. The situation was finally resolved to the parent's satisfaction, and the boy is gaining weight.

• •

A client living in a Rule 36 facility phoned the Office and stated that her car was being blocked by a board member at the facility. The client had been told to cancel her appointment rather than bother the board member during the board meeting. Staff contacted the administrator of the facility and quickly resolved the problem. The Ombudsman was assured that the situation would not happen again.

A resident of the St. Peter Security Hospital contacted the St. Paul office. He was concerned that information regarding his transfer within the facility was withheld from him. The regional client advocate was contacted and assisted the resident in getting the requested information.

••••••••••••••••••••••••••••••

The unit director of a private psychiatric hospital contacted the Office after a 15 year old girl was admitted for psychiatric treatment without consent. The unit director had contacted the county social services worker who served as the girl's legal guardian to gain consent. The worker claimed they were too busy to provide consent. Staff contacted the county social services supervisor, who agreed to provide immediate verbal consent and written consent the following morning.

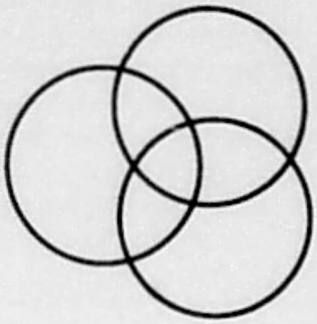
••••••••••••••••••••••••••••••

A father wanted his 20 year old autistic son placed in a certain facility. He was told by the county worker that the county had issued a moratorium on placements at the facility. The father appealed the decision and requested the Ombudsman's assistance. The county agreed to the requested placement.

••••••••••••••••••••••••••••••

The Office was contacted by a person who had recently been a patient in an acute care psychiatric unit. The client expressed concerns regarding the hospital's grievance procedures and the hospital's policy of informing residents of their rights. In response to the client's concerns, the regional client advocate made an unannounced visit to the hospital. The client advocate reviewed the client's medical records, interviewed staff, and reviewed the information given to clients. The client advocate then recommended changes in the facility's grievance procedures, patient rights information, and the policy and procedures for relaying messages from parties outside the facility.

••••••••••••••••••••••••••••••



Systemic Issues

The Office of the Ombudsman for Mental Health and Mental Retardation has taken an in-depth look at several systemic issues in an effort to improve the quality of services and treatment to persons with mental illness, mental retardation or related condition, chemical dependency, or emotional disturbance. The following issues have been examined:

Excessive Heat in the RTCs

Last summer's unusual heat raised a concern regarding excessive heat in the Regional Treatment Centers (RTCs). The lack of adequate air conditioning, combined with psychotropic medication usage, created a potentially critical situation. After reviewing the situation with the Medical Review Subcommittee, the Office made recommendations to the Department of Human Services (DHS). The Department has accepted most of the Ombudsman's recommendations and will implement changes prior to the Summer of 1989.

Asset Spenddown for Developmentally Disabled Clients

The Ombudsman was contacted six months after a spenddown situation had occurred involving two developmentally disabled clients. Due to a Social Security underpayment going back nearly ten years, these clients (a brother and a sister) received large windfalls. The manner in which the money was spent raised concerns, as did the spenddown process. After a thorough review of the situation, the Ombudsman issued a report to all interested parties. Recommendations were made to the county and the Department of Human Services regarding the safeguarding of clients in future spenddown situations. Recommendations were also made to the facility regarding its internal procedures and the repayment of funds to the clients.

Emergency Closings of Community Residential Facilities

After the emergency voluntary closing of a Rule 34 residential facility forced five clients to return to an RTC, the Ombudsman met with DHS officials to discuss our concerns regarding the closing. A second meeting with providers and advocates also was held. The Ombudsman will convene a work group to examine this issue in greater detail, with a goal of coming up with recommendations to help prevent future emergency closings.

Psychotropic Medication Use in the RTC and Community Settings

The Office of Ombudsman has initiated an in-depth review of psychotropic medications administered to persons with mental retardation or related conditions in both the RTC and community residential settings.

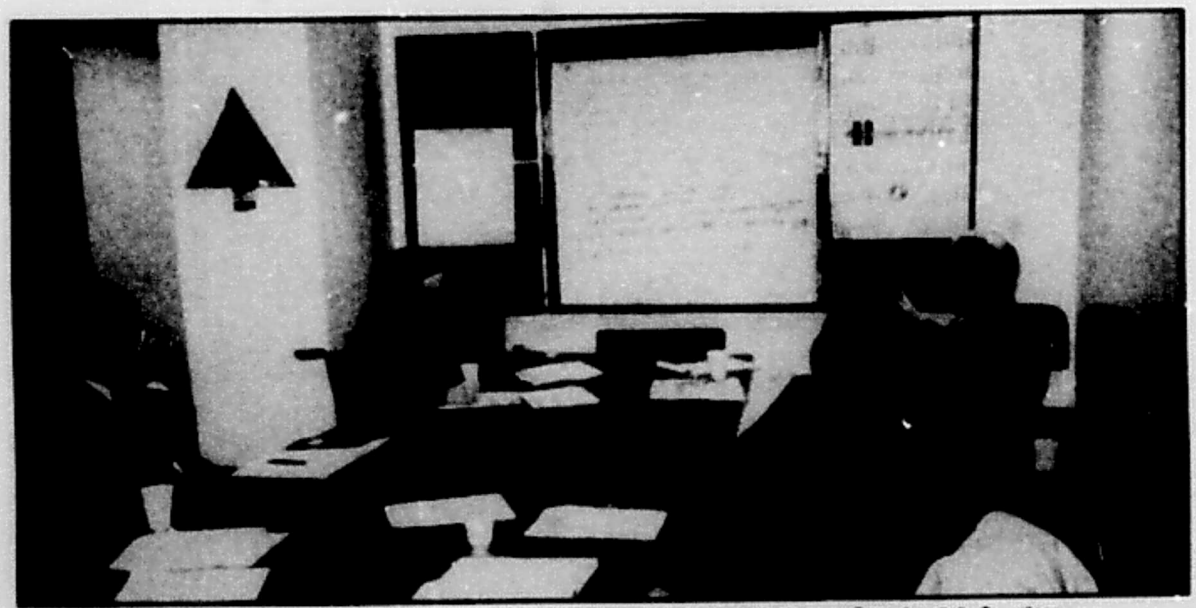
The Office's preliminary review of the data from the RTCs raised a concern that some persons with mental retardation or related conditions may be receiving excessive psychotropic medication in some of the RTCs. With increased efforts to place persons with mental retardation or related conditions in community settings, a similar concern regarding the use of psychotropic medications in the community was raised. The Office of Ombudsman will be surveying community settings which provide services or treatment to persons with mental retardation or related conditions in an effort to determine the extent of the use of psychotropic medications. The information will be analyzed separately as well as compared to the available information on the use of psychotropic medications in the RTCs. A full report is expected in early spring.

Wheelchair Accessibility of Rule 36 Facilities

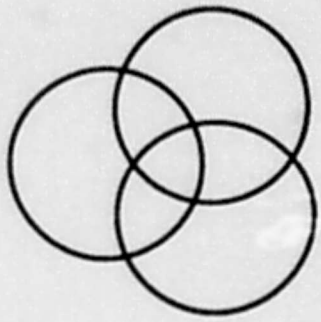
In the course of making random visits to facilities, staff from the Ombudsman Office observed that many Rule 36 facilities appeared to be inaccessible to persons in wheelchairs. Staff later learned that persons with mental illness who are confined to a wheelchair had been placed in nursing homes because there were no Rule 36 facilities available that could accommodate them.

Ombudsman staff conducted a telephone survey to determine the extent of the problem. Staff reached 78 of the 85 facilities licensed under Rule 36. Only 10 of the 78 claimed to be wheelchair accessible. Excluding Anoka-Metro RTC, St. Peter RTC, Willmar RTC, and Minnesota Security Hospital, only six facilities claimed to be wheelchair accessible.

In response to the results of the survey, the Ombudsman has assembled a task force to examine this issue in greater detail to determine what actions can be taken to remedy this problem. Representatives from advocacy organizations and other state agencies have joined this task force. A report analyzing the problem and proposing recommendations will be forthcoming.



Task force meets to discuss wheelchair accessibility of Rule 36 facilities



Other Activities

Monitoring Special Review Board Hearings and Institutional Review Board Meetings

Under statute, the Ombudsman has the right to attend Department of Human Services Review Board and Special Review Board proceedings. The Office of Ombudsman has been monitoring Special Review Board hearings in an effort to define the agency's role in those hearings. A protocol has been developed to identify those meetings which require the agency's efforts and attention.

Ombudsman staff also have participated in Department of Human Services Institutional Review Board meetings to insure that the rights of clients in the RTCs are protected.

Monitoring the RTC Negotiation Process

The Office of Ombudsman has been monitoring the RTC negotiations. Advocates representing persons with developmental disabilities have proposed that the Ombudsman Office play an external monitoring role in the licensing of new State Operated Community Services (SOCS) programs. Their proposal calls for a representative of the Ombudsman's Office to accompany the DHS Licensors on all licensing visits to SOCS programs. DHS and the Ombudsman have recently negotiated the terms of this proposal.

Advocates for the developmentally disabled also have proposed that the Ombudsman be involved in a quality assurance role to improve the quality of community-based services. The advocates have proposed that the Ombudsman conduct in-depth reviews of services provided to persons who are under state guardianship, have no active family involvement, and who leave an RTC after June 30, 1989. These reviews would be time limited to five years. DHS and the Ombudsman have recently agreed to the terms of this proposal.

Commenting on Proposed DHS Rules

The Ombudsman Office prepared written comments and testified at several hearings on proposed DHS Rules. Comments and recommendations were made on proposed DHS Rules relating to licensure of residential programs for persons with mental retardation or related conditions and proposed rules relating to licenses for residential-based habilitation services.

Training and In-Service

As a new State agency, the Office of Ombudsman for Mental Health and Mental Retardation faced the need for staff training and requests to provide inservice to providers and other interested parties. Ombudsman staff, as a whole, completed

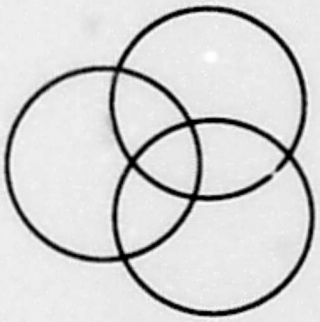
over 600 hours of training during 1988. This training ranged from substantive in-service training on DHS Rules and varied issues to organizational training on the use of new agency reporting forms. A comprehensive two-week orientation and training was developed for new field staff. Staff also presented over 150 hours of training and in-service to provider staff and other groups, on topics ranging from the Vulnerable Adults Act to patients' rights. The Office expects to provide more in-service training for provider and community groups and to require less staff training as the agency matures.

Legislative Efforts

As part of the negotiated settlement in Welsch v. Gardebring, the Department of Human Services and Legal Advocacy for Developmentally Disabled Persons agreed to work towards the creation of "an external monitoring office to assure the effective use of public resources in providing appropriate service to persons with mental retardation." The Ombudsman worked with DHS and Legal Advocacy to bring those monitoring functions within the Office of Ombudsman for Mental Health and Mental Retardation. In addition, the 1988 Minnesota Legislature transferred the money previously appropriated to DHS for the Welsch consent decree Monitor's Office to the Ombudsman for Mental Health and Mental Retardation.

AIDS Task Force

The Office of Ombudsman has also been an active participant in the Governor's AIDS Issue Team meetings in an effort to insure that the rights and lives of residents of the Regional Treatment Centers are protected.



Ombudsman Advisory Committee

Overview

The Ombudsman Advisory Committee consists of 15 members appointed by the governor to staggered three-year terms. All members of the committee have a special knowledge of and interest in facilities and programs serving persons with mental illness, mental retardation or related conditions, chemical dependency, or emotional disturbance. The Advisory Committee meets on a quarterly basis to advise and assist the Ombudsman.

Committee Members

The Ombudsman Advisory Committee currently consists of the following members:

Louise Brown
Barbara Case
James Dahlquist
Rebecca Fink
Melvin Goldberg
Rose Moen
Katie O'Brien
Genevieve O'Grady
Bette Rosse
Dr. Sam Scher
Terry Schneider
Dorothy Skarnulis
James Tweedy
Dr. Ruth Viste
Dr. Joseph Westermeyer

Medical Review Subcommittee

Dr. Ruth Viste, Subcommittee Chair

Overview

The Medical Review Subcommittee consists of five members of the Advisory Committee and a sixth person who in 1988 served as an ex-officio member. The Subcommittee has been meeting on a monthly basis to review the causes and circumstances surrounding the deaths of clients in residential and acute care facilities. The Subcommittee makes a preliminary determination as to whether each death is unusual or appears to have resulted from other than natural causes. The Subcommittee then aids the Ombudsman in the investigation of unusual deaths and deaths from unnatural causes. When appropriate, the Subcommittee makes recommendations in an effort to prevent similar deaths.

Members

The current members of the Medical Review Subcommittee are:

Rebecca Fink
Melvin Goldberg
Dr. Joseph Westermeyer
Dr. Ruth Viste
James Tweedy
Dr. Carl Hansen (ex-officio)

Example of Cases Reviewed

The Medical Review Subcommittee is currently reviewing three deaths caused by seizure disorders. Two of these deaths involved clients who were living in the community in least restrictive settings. The other death involved a client from a Regional Treatment Center (RTC). Circumstances surrounding these deaths seem to indicate inadequate post-seizure monitoring. As a partial response to these deaths, the Ombudsman Office is planning a workshop on providing care to seizure clients who are mentally ill or developmentally disabled and living in the community in a least restrictive setting. Specific recommendations will also be made in response to each death.

• •

The Medical Review Subcommittee completed a review of two suicides of RTC residents. Both individuals shot themselves while home on pass and while family members were not in the home. Although the clients had had previous home visits without any incidents, the Medical Review Subcommittee noted that the families had not been informed of the danger of easy access to guns by individuals with mental illness. The Subcommittee further noted

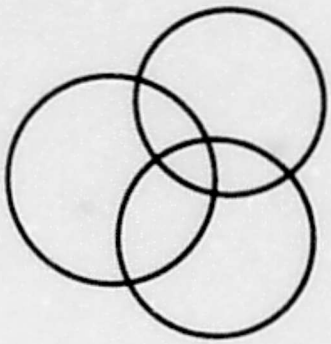
that no assessments were made by the RTCs as to the availability of guns in the family home.

The Ombudsman recommended to the State Medical Director that RTCs make an assessment of the availability of guns in family homes, and that families be provided information on how to secure or safe-keep guns and other lethal weapons. The State Medical Director agreed to incorporate the recommendations into the RTC policies and procedures manual.

••••••••••••••••••••••••••••••

The Ombudsman Office reviewed the circumstances surrounding the death of a mentally ill person who wandered away from a nursing home. The 58 year old man had previously undergone psychiatric treatment for psychotic depression. The facility failed to get a thorough psychosocial background on the client and the county failed to provide adequate case management services. The client was also misdiagnosed by the nursing home physician. The client had wandered away from the facility once before. The second time he wandered away, he was not found immediately. Forty-eight hours later he was found dead in a nearby park. The Ombudsman, after consultation with the Medical Review Subcommittee, recommended that the facility implement policies to address wandering and to assure a full psychosocial history upon admission. The Ombudsman also made specific recommendations to improve the case management system.

••••••••••••••••••••••••••••••



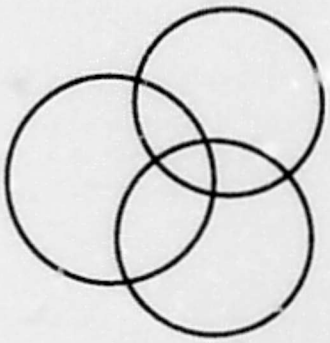
The Office of Ombudsman has been involved in monitoring Special Review Board hearings and Institutional Review Board meetings of the Department of Human Services, as well as monitoring the RTC negotiation process. The Office of Ombudsman has prepared written and oral testimony on proposed DHS Rules. The Office has worked actively with the Medical Review Subcommittee to review client deaths, in an effort to prevent deaths from occurring under similar circumstances.

With accelerating efforts to discharge clients from the RTCs, the Ombudsman Office expects even greater focus on community settings and programs in the years to come.

Summary

The first 18 months of existence has been a busy, active time for the Office of Ombudsman for Mental Health and Mental Retardation. Protocols have been developed to organize the internal procedures and policies of the Office. A complaint protocol was developed to handle complaints made to the Office. Regional meetings and visits to community residential facilities have been undertaken in an effort to publicize the existence of the Office and the availability of services to clients. An Office brochure was developed and distributed to facilities, counties, advocacy organizations, and other interested persons.

Over 2,800 complaints have come into the office in the past year. Some of these complaints evolved into systemic issues which required a more in-depth review, often resulting in a report and recommendations.



Appendices

245.91 DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of sections 245.91 to 245.97, the following terms have the meanings given them.

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state departments of human services and health, and of designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 3. **Client.** "Client" means a person served by an agency, facility, or program, who is receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, that is required to be licensed by the commissioner of human services, and an acute care inpatient facility that provides servic or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 5. **Regional center.** "Regional center" means a regional center as defined in section 253B.02, subdivision 18.

History: *1987 c 352 s 2; 1988 c 543 s 1-3*

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information about decisions, acts, and other matters of an agency, facility, or program. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

History: *1987 c 352 s 3; 1988 c 543 s 4*

245.93 ORGANIZATION OF OFFICE OF OMBUDSMAN.

Subdivision 1. **Staff.** The ombudsman may appoint a deputy and a confidential secretary in the unclassified service and may appoint other employees as authorized by the legislature. The ombudsman and the full-time staff are members of the Minnesota state retirement association.

Subd. 2. **Advocacy.** The function of mental health and mental retardation client advocacy in the department of human services is transferred to the office of ombudsman according to section 15.039. The ombudsman shall maintain at least one client advocate in each regional center.

Subd. 3. **Delegation.** The ombudsman may delegate to members of the staff any authority or duties of the office except the duty of formally making recommendations to an agency or facility or reports to the governor or the legislature.

History: *1987 c 352 s 4*

245.94 POWERS OF OMBUDSMAN; REVIEWS AND EVALUATIONS; RECOMMENDATIONS.

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility, or program if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition.

(f) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(g) The ombudsman may attend department of human services review board and special review board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the department of human services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(h) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 12 and 13, regarding services provided to clients with mental retardation or a related condition.

(i) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(j) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Subd. 2. **Matters appropriate for review.** (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

(1) may be contrary to law or rule;

(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

(3) may be mistaken in law or arbitrary in the ascertainment of facts;

(4) may be unclear or inadequately explained, when reasons should have been revealed;

(5) may result in abuse or neglect of a person receiving treatment;

(6) may disregard the rights of a client or other individual served by an agency or facility;

(7) may impede or promote independence, community integration, and productivity for clients; or

(8) may impede or improve the monitoring or evaluation of services provided to clients.

(b) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

Subd. 3. **Complaints.** The ombudsman may receive a complaint from any source

concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in section 626.557, subdivision 17, paragraph (c), against a client or other person, who in good faith makes a complaint or assists in an investigation.

Subd. 4. **Recommendations to agency.** (a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

(1) consider the matter further;

(2) modify or cancel its actions;

(3) alter a rule, order, or internal policy;

(4) explain more fully the action in question; or

(5) take other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

History: *1987 c 352 s 5; 1988 c 543 s 5-8*

245.95 RECOMMENDATIONS AND REPORTS TO GOVERNOR.

Subdivision 1. **Specific reports.** The ombudsman may send conclusions and suggestions concerning any matter reviewed to the governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, program, or any person, the ombudsman shall consult with the governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the governor that is adverse to an agency, facility, program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation.

Subd. 2. **General reports.** In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall at the end of each year report to the governor concerning the exercise of the ombudsman's functions during the preceding year.

History: *1987 c 352 s 6; 1988 c 543 s 9*

245.96 CIVIL ACTIONS.

The ombudsman and his designees are not civilly liable for any action taken under sections 245.91 to 245.97 if the action was taken in good faith, was within the scope of the ombudsman's authority, and did not constitute willful or reckless misconduct.

History: *1987 c 352 s 7*

245.97 OMBUDSMAN COMMITTEE.

Subdivision 1. **Membership.** The ombudsman committee consists of 15 members appointed by the governor to three-year terms. Members shall be appointed on the basis of their knowledge of and interest in the health and human services system subject to the ombudsman's authority. In making the appointments, the governor shall try to ensure that the overall membership of the committee adequately reflects the agencies, facilities, and programs within the ombudsman's authority and that members include consumer representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individ-

uals served by an agency, facility, or program; human services and health care professionals, including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

Subd. 2. **Compensation; chair.** Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The governor shall designate one member of the committee to serve as its chair at the pleasure of the governor.

Subd. 3. **Meetings.** The committee shall meet at least four times a year at the request of its chair or the ombudsman.

Subd. 4. **Duties.** The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

Subd. 5. **Medical review subcommittee.** At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the governor to serve as a medical review subcommittee. Terms of service, vacancies, and compensation are governed by subdivision 2. The governor shall designate one of the members to serve as chair of the subcommittee. The medical review subcommittee may:

(1) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes; and

(5) submit a report regarding the death of a client to the committee, the ombudsman, the client's next-of-kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility.

Subd. 6. **Terms, compensation, removal and expiration.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. The ombudsman committee and the medical review subcommittee expire on June 30, 1993.

History: *1987 c 352 s 8; 1988 c 543 s 10; 1988 c 629 s 46*

Subd. 8. **Evidence not privileged.** No evidence relating to the neglect or abuse of a child or to any prior incidents of neglect or abuse involving any of the same persons accused of neglect or abuse shall be excluded in any proceeding arising out of the alleged neglect or physical or sexual abuse on the grounds of privilege set forth in section 595.02, subdivision 1, paragraph (a), (d), or (g).

Minn. Stat. § 626.556, Subd. 9

Subd. 9. **Mandatory reporting to a medical examiner or coroner.** When a person required to report under the provisions of subdivision 3 knows or has reason to believe a child has died as a result of neglect or physical or sexual abuse, the person shall report that information to the appropriate medical examiner or coroner instead of the local welfare agency, police department, or county sheriff. Medical examiners or coroners shall notify the local welfare agency or police department or county sheriff in instances in which they believe that the child has died as a result of neglect or physical or sexual abuse. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff and the local welfare agency. If the child was receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance from an agency, facility, or program as defined in section 245.91, the medical examiner or coroner shall also notify and report findings to the ombudsman established under sections 245.91 to 245.97.

Subd. 10. **Duties of local welfare agency and local law enforcement agency upon receipt of a report.** (a) If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, the local welfare agency shall immediately conduct an assessment and offer protective social services for purposes of preventing further abuses, safeguarding and enhancing the welfare of the abused or neglected minor, and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse or physical abuse, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

Minn. Stat. § 626.556, Subd. 10 (b)

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97.

(c) Authority of the local welfare agency responsible for assessing the child abuse report and of the local law enforcement agency for investigating the alleged abuse includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged perpetrator. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found and may take place outside the presence of the perpetrator or parent, legal custodian, guardian, or school official. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule 49.02 of the Minnesota rules of procedure for juvenile courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and

any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare or local law enforcement agency determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the county welfare board or the chair's designee. The notification shall be private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded. Until that time, the local welfare or law enforcement agency shall be solely responsible for any disclosures regarding the nature of the assessment or investigation.

Except where the alleged perpetrator is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

Minn. Stat. § 626.556, Subd. 10 (e)

(e) Where the perpetrator or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the perpetrator or any person responsible for the child's care at reasonable places and times as specified by court order.

(f) Before making an order under paragraph (d), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(g) The commissioner, the ombudsman for mental health and mental retardation, the local welfare agencies responsible for investigating reports, and the local law enforcement agencies have the right to enter facilities as defined in subdivision 2 and to inspect and copy the facility's records, including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

Subd. 10a. **Abuse outside the family unit.** If the report alleges neglect, physical abuse, or sexual abuse by a person responsible for the child's care functioning outside the family unit in a setting other than a facility as defined in subdivision 2, the local welfare agency shall immediately notify the appropriate law enforcement agency, which

behavior of these persons does not constitute "abuse" for the purposes of subdivision 3 unless it causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior in a manner that facilitates periodic review by licensing agencies and county and local welfare agencies.

(c) Nothing in this section shall be construed to require a report of abuse, as defined in subdivision 2, paragraph (d), clause (4), solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

Subd. 4. **Report.** A person required to report under subdivision 3 shall make an oral report immediately by telephone or otherwise. A person required to report under subdivision 3 shall also make a report as soon as possible in writing to the appropriate police department, the county sheriff, local welfare agency, or appropriate licensing agency. The written report shall be of sufficient content to identify the vulnerable adult, the caretaker, the nature and extent of the suspected abuse or neglect, any evidence of previous abuse or neglect, name and address of the reporter, and any other information that the reporter believes might be helpful in investigating the suspected abuse or neglect. Written reports received by a police department or a county sheriff shall be forwarded immediately to the local welfare agency. The police department or the county sheriff may keep copies of reports received by them. Copies of written reports received by a local welfare department shall be forwarded immediately to the local police department or the county sheriff and the appropriate licensing agency or agencies.

Subd. 5. **Immunity from liability.** (a) A person making a voluntary or mandated report under subdivision 3 or participating in an investigation under this section is immune from any civil or criminal liability that otherwise might result from the person's actions, if the person is acting in good faith.

(b) A person employed by a local welfare agency or a state licensing agency who is conducting or supervising an investigation or enforcing the law in compliance with subdivision 10, 11, or 12 or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions, if the person is acting in good faith and exercising due care.

Subd. 6. **Falsified reports.** A person who intentionally makes a false report under the provisions of this section shall be liable in a civil suit for any actual damages suffered by the person or persons so reported and for any punitive damages set by the court or jury.

Subd. 7. **Failure to report.** (a) A person required to report by this section who intentionally fails to report is guilty of a misdemeanor.

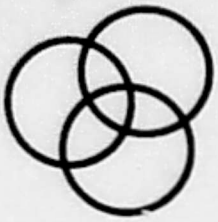
(b) A person required by this section to report who negligently or intentionally fails to report is liable for damages caused by the failure.

Subd. 8. **Evidence not privileged.** No evidence regarding the abuse or neglect of the vulnerable adult shall be excluded in any proceeding arising out of the alleged abuse or neglect on the grounds of lack of competency under section 595.02.

Minn. Stat. § 626.557, Subd. 9

Subd. 9. **Mandatory reporting to a medical examiner or coroner.** A person required to report under the provisions of subdivision 3 who has reasonable cause to believe that a vulnerable adult has died as a direct or indirect result of abuse or neglect shall report that information to the appropriate medical examiner or coroner in addition to the local welfare agency, police department, or county sheriff or appropriate licensing agency or agencies. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff, the local welfare agency, and, if applicable, each licensing agency. A person or agency that receives a report under this subdivision concerning a vulnerable adult who was receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance from an agency, facility, or program as defined in section 245.91, shall also report the information and findings to the ombudsman established under sections 245.91 to 245.97.

Subd. 10. **Duties of local welfare agency upon a receipt of a report.** (a) The local



STATE OF MINNESOTA
OFFICE OF
OMBUDSMAN
FOR MENTAL HEALTH
AND MENTAL RETARDATION

Do You Have A Complaint?

If you do, the Ombudsman for Mental Health and Mental Retardation will assist you.

CALL: 296-3848 IN METRO AREA OR 1-800-625-9747

OR

WRITE: OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH
AND MENTAL RETARDATION
SUITE 202 METRO SQUARE BLDG.
ST. PAUL, MN. 55101

OR

CONTACT:

Minnesota Statue 245.92 states that the Ombudsman for Mental Health and Mental Retardation "shall promote the highest attainable standards of treatment, competence, efficiency, and justice for people receiving care or treatment for mental illness, mental retardation, chemical dependency, or emotional disturbance."

Appendix C

Process for Handling Complaints Brought to the Office of the Ombudsman

Complaint Intake

1. A complaint may be received from any source concerning an action of an agency, facility, or program. A complaint may be made by telephone, letter, or direct contact with the regional staff or central office staff. The source is strongly encouraged to make the complaint to the regional staff office.

2. The regional staff shall determine if the complaint is an appropriate matter for review. In selecting matters for review, the regional staff shall give particular attention to unusual deaths or injuries of clients, or actions of an agency or facility or program that:

a) may be contrary to law or rule;

b) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program.

c) may be mistaken in law or arbitrary in the ascertainment of facts;

d) may be unclear or inadequately explained, when reasons should have been revealed;

e) may result in abuse or neglect of a person receiving treatment;

f) may disregard the rights of a client or other individual served by an agency, facility, or program;

g) may impede or promote independence, community integration and productivity for clients; or

h) may impede or improve the monitoring or evaluation of services provided to clients

Action on Complaint at Regional Level

1. If the regional staff determines that the complaint is not an appropriate matter for review, the regional staff shall so inform the source. If possible, the regional staff should refer the source to an appropriate agency or other resource.

2. If the regional staff determines that the complaint is an appropriate matter for review, and the review does not duplicate other investigations or regulatory efforts, the regional staff shall consult with the source, consult with the client (when appropriate), and consult with other persons (as necessary) to obtain information pertinent to the complaint. The regional staff shall then proceed to:

a. notify the agency, facility or program named in the complaint and mediate or advocate on behalf of the client;

b. refer complaint regarding the agency, facility, or program to a more appropriate resource for action;

c. continue to monitor for a reasonable length of time; or

d. notify appropriate parties once all action has been completed.

3. The regional staff may, at any time, refer a complaint directly to the Ombudsman for advice, counsel, or further review and action.

Action by Ombudsman on Complaint

1. Following the receipt and review of a complaint from regional staff, the Ombudsman shall notify the source as to the merit of the complaint and may notify the agency, facility, or program, and any other appropriate parties.

2. After reviewing a complaint, the Ombudsman may request a response from the agency, facility or program.

3. After considering the response of an agency, facility, or program and any other pertinent material, the Ombudsman may recommend that the agency, facility, or program do the following:

a) consider the matter further;

b) modify or cancel its actions;

c) alter a rule, order, or internal policy;

d) explain more fully the action in question; or

e) take other action.

4. The agency, facility, or program shall be notified in writing of the Ombudsman's recommendations and, at the Ombudsman's request, shall within a reasonable time inform the Ombudsman of the action taken on the recommendations.

5. If the actions or response from an agency, facility, or program to the Ombudsman's recommendations resolve the complaint in a manner that promotes the highest attainable standards of treatment, competence, efficiency and justice for people receiving care or treatment for mental illness, mental retardation or related condition, chemical dependency, or emotional disturbance, the Ombudsman shall consider the matter closed and shall so inform the agency, facility, or program.

6. If it is determined that the complaint needs further action, the Ombudsman may send conclusions and recommendations to the Governor as follows:

a) If the conclusions or recommendations to the Governor are adverse, the Ombudsman shall notify the agency, facility, or program in writing;

b) The agency, facility, or program shall be given an opportunity to provide any statement of reasonable length in defense or mitigation of the Ombudsman's conclusions or recommendations;

c) The Ombudsman's conclusions or recommendations and the statement by the agency, facility, or program shall be sent to the Governor;

d) Before making public conclusions or recommendations that expressly or implicitly criticize an agency, facility, or program, the Ombudsman shall consult with the Governor and the agency, facility, or program concerning the conclusions or recommendations.