970065

LEGISLATIVE REFERENCE LIBRARY
3 0307 00005 6286

STATE OF MINNESOTA

OMBUDSMAN FOR CORRECTIONS

FISCAL YEARS 1995 - 96
BIENNIAL REPORT

HV
7273
.A35a
1995/96

Pursuant to Minn. Stat. 241.45 Subd. 2

Table of Contents

RECEIVED
JAN 28 1997
LEGISLATIVE REFERENCE LIBRARY
STATE OFFICE BUILDING
ST. PAUL, MN 55155

STATE OF MINNESOTA
OMBUDSMAN for CORRECTIONS
1885 UNIVERSITY AVENUE, SUITE 395
SAINT PAUL, MINNESOTA 55104
(612) 643-3656

December, 1996

Honorable Arne Carlson, Governor
and
The Legislature of the State of Minnesota

I am pleased to submit the second biennial report of the Ombudsman for Corrections.

In this report you will find:
An overview of our more significant work in "Issues Facing the Ombudsman, 1995-96."
Vignettes which highlight the narrative aspects of a variety of typical grievances.
Statistical information and charts which explain in detail the types of cases, and recommendations we work with on an ongoing basis.
Minnesota Statute 241.41, which created the office of the Ombudsman for Corrections.

Although we continue to work mainly with a wide variety of inmate grievances, much of the activity in our office during the biennium involved recommendations for far-reaching changes in the way mentally ill inmates are treated in institutions. Significant policy changes were made at the Department of Corrections after our reports were issued and we continue to monitor these changes.

I look forward to working with all of you this coming biennium. Please contact me for any additional information or assistance you require regarding the activities of the agency.

Sincerely,

Patricia Seleen

Patricia Seleen
Ombudsman for Corrections

Issues Facing the Ombudsman, 1995 - 96

Drowning Incident

A county official from a juvenile detention facility notified the Ombudsman that a resident was missing from a swimming activity at a local beach. A week later the body of the resident was found and an autopsy indicated that the cause of death was drowning.

Following investigation of this incident, the Ombudsman made the following recommendations to the facility:

- A definition of the buddy system be developed and communicated to staff.
- At least one staff person taking residents to the beach be trained in water safety skills.
- Residents receive pre-approval from the facility nurse or doctor if the resident is on any medication which might affect the ability to swim or if the resident has a history of seizures.
- Each staff person involved in an incident that involves death, escape, physical injury or use of force prepare an incident report.
- Parents be advised that swimming is part of the Hennepin County recreation program in their information package.

These recommendations were accepted and implemented by the facility in their original or slightly modified form.

The purpose of the Ombudsman for Corrections remains the same today as it was in 1972, when our mission was established by the State Legislature: to promote the highest attainable standards of competency, efficiency and justice in the administration of corrections. Because of that mission, the investigatory powers of the Ombudsman for Correction are necessarily both broad and deep. The power to investigate thoroughly enables us to not only understand and resolve grievances, but to make recommendations for change and become a proactive voice for safer and more humane correctional system. As a result, state and local governments can avoid costly lawsuits and lessen the likelihood of disturbances in institutions.

Our primary work involves understanding and helping to resolve grievances from inmates, their families and outside interested parties. The majority of complaints we investigate are telephone contacts from inmates. (See the graph on page 7). Some grievances are relatively simple to resolve, such as the issues related to well-established rules and policies of the institutions. A good example of this is inmates complaining about medical treatment. In an effort to contain rising medical expenses, the legislature directed the department to develop a policy requiring that inmates have a copayment for medical care.

Having the same concerns about costs, many local corrections facilities also implemented similar policies requiring inmates to pay for medical treatment. This change in policy is reflected by the increase in contacts with the Ombudsman regarding medical care. The Ombudsman has worked with the various institutions in implementing these new policies.

Other complaints become much more far-reaching and systemic in scope. Two of the three major reports the Ombudsman for Corrections issued during the biennium involve the issues surrounding the care of mentally ill inmates. The initial complaint stemmed from the death of a severely mentally ill inmate at the segregation unit in Stillwater Prison in 1994. After a thorough investigation, which included the treatment of mentally ill inmates at several correctional institutions, our office issued two reports to the Commissioner of Corrections in August, 1994. These reports were released as public reports in September, 1995.

In response to the recommendations in these reports, the Commissioner convened a group of department staff to further review the policies and practices of the department that related to inmates with mental illness. The group made recommendations to the Commissioner which were accepted. The recommenda-

tions were comprehensive as the group was directed to look at many issues. Areas where policy changes have been made include:

- Initial psychiatric assessments
- Coordination of mental health care with other programming services
- Crisis intervention and mental health emergencies
- Criteria for admission to the Mental Health Unit
- Ongoing review and evaluation of these services

Our office was pleased with the opportunity to work with the Department of Corrections (DOC) in defining needs, instituting new policies and training personnel. To further assist this process, the Ombudsman for Corrections coordinated a training session for DOC wardens, associate wardens, due process and hearing officers, psychologists and other staff to help further their education about mental illness, competency and the use of commitment laws.

On average, Ombudsman for Corrections investigators have more than ten years of experience in correctional institutions and were proud to be able to offer their considerable expertise to investigate, resolve current problems, recommend policy changes and assist the DOC in monitoring results.

Another significant report issued by our office during the biennium included an overview of the Juvenile Sexual Offender Program at Sauk Centre. We concluded that:

- The current design of the program is comprehensive and contains the treatment components that allow for successful programming for juvenile sex offenders.

- The institution and the Executive Office of Juvenile Release are working together to assure that residents have met their goals and an appropriate plan has been developed before release.

Recommendations were made to the Department regarding the staffing of the program to ensure that there was appropriate therapeutic supervision of staff and residents. At the time of this writing (November 1996), we have been advised that a clinical director has been hired at MCF-Sauk Centre. We will continue to monitor the program at Sauk Centre.

During this biennium, the Ombudsman conducted several other major investigations at local juvenile institutions. These investigations resulted in systemic recommendations to lessen the likelihood for recurrence and improve the safety for residents and staff. Two of these investigations, "Drowning Inci-

PEPPER SPRAY

Several residents in juvenile facilities complained about how oleoresin capsicum (pepper spray) was being used on them. After investigating recent incidents, the investigator did extensive research on pepper spray including contraindications for use and staff training on use. As a result, the Ombudsman made several recommendations:

- That terminology describing pepper spray as a "non-injurious chemical agent" be changed to reflect possible side effects such as nerve damage, loss of protective reflexes, risk of laryngospasm and suffocation and risk of skin blistering.

- That situations justifying the use of pepper spray be clearly spelled out in greater detail.

- That procedures for decontamination after the use of pepper spray be addressed.

- That a supervisory review be conducted following any incident involving the use of pepper spray.

These recommendations have been accepted and are being incorporated into new policies in the institutions.

DISCRIMINATION

The Ombudsman received a complaint from a female inmate in a county jail who stated that female inmates were being discriminated against in clothing regulations and job placement. An investigator visited the facility and found that men and not women were allowed to work as "trustees" in the jail. Women were also required to wear three heavy garments while exercising, even on very hot days, so as to not "unduly excite" male inmates. Male inmates were permitted to exercise without their shirts.

The investigator proposed a compromise of requiring female inmates to wear a minimum of a brassiere and t-shirt for upper body covering. It was also proposed that the jail have at least one female "trustee", who would work only in the female unit, thus avoiding the security problem of having male and female inmates working together with little supervision, as well as avoiding a discrimination lawsuit. The jail accepted both recommendations.

dent" and "Pepper Spray" are highlighted on these pages. Each was initially brought to our attention as an isolated incident, yet our investigations resulted in recommendations for systemic policy review and change.

The Ombudsman for Corrections is also active in the wider role of ombudsman services in the state of Minnesota and around the world. Patricia Seleen sits on the Ombudsman Roundtable, an organization of Minnesota state ombudsman programs which strives to create cooperation among the other ombudsman's offices, eliminate duplication of services and increase information sharing to save costs. In December 1995, the Roundtable issued a public report, "Making Government Responsive to Citizens." The report is an overview of state ombudsman programs and includes recommendations for efficiencies.

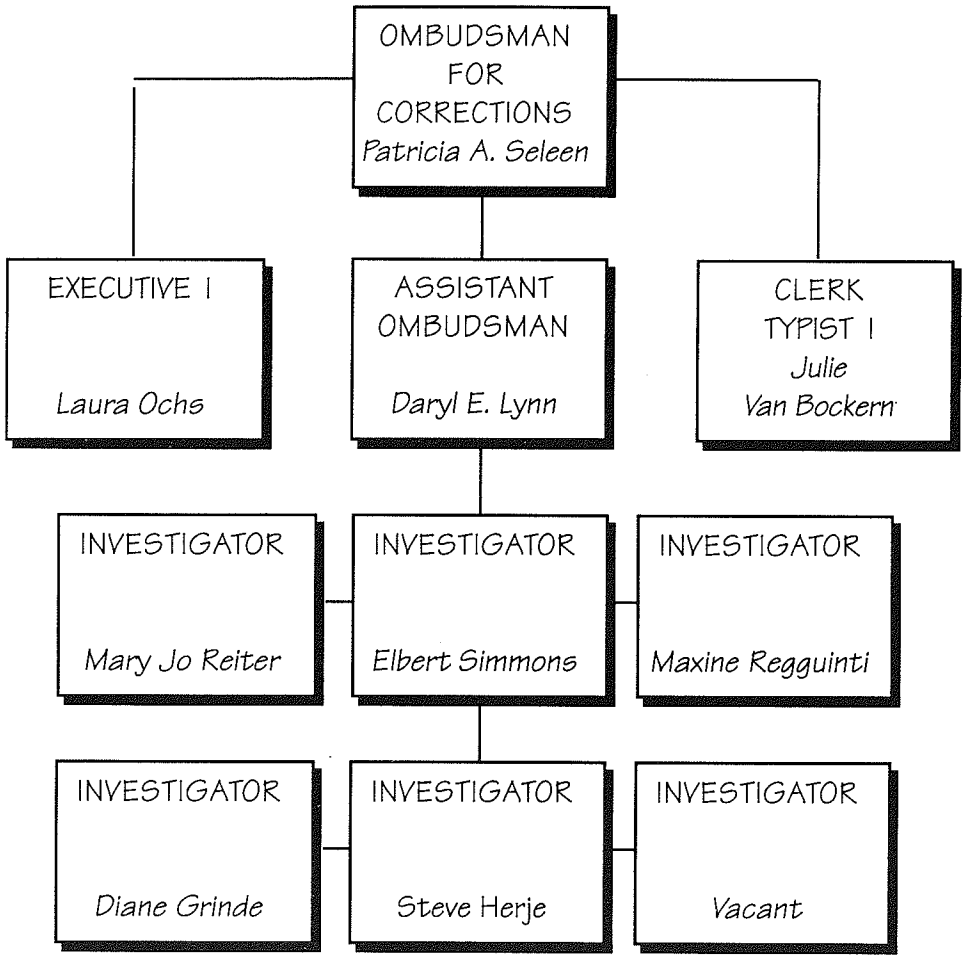
Our office was pleased to cooperatively sponsor a training program for Russian officers. Since most of their work involves basic human rights violations such as freedom of speech, freedom of religion and freedom of the press, the importance of the ombudsman function in the developing world is significant.

A member of the United States Association of Ombudsman, our office hosted the 1995 annual conference cooperatively with the Mental Health/Mental Retardation Ombudsman and the Crime Victim Ombudsman. Both national and international members representing a wide variety of ombudsman functions were present at this very successful conference.

We also participated in the development of a segment on the Office of the Ombudsman for Corrections for public television. A video is available from our office for viewing.

Promoting the highest attainable standards of competency, efficiency and justice in the administration of corrections is a mission that takes us from our ongoing work inside the correctional institutions to cooperating with other state, national and even international agencies. The independence of our agency makes it possible for us to objectively report and make recommendations to resolve the problems facing inmates as individuals and to assist the Department of Corrections and others in creating, implementing and maintaining sound, practical and humane correctional policies.

Ombudsman For Corrections -- Organizational Chart



Diabetic Menu

While interviewing a diabetic inmate who had concerns about his diet and blood sugar levels, the investigator from the Ombudsman's office learned that the time frame between lunch and dinner was only about three hours. Because of her extensive knowledge of diabetes, the investigator knew that this short period of time between meals makes is difficult for diabetics to maintain healthy blood sugar levels.

She discussed her concern with administrative staff at the facility and made suggestions regarding the eating schedule for diabetic inmates. The institution subsequently developed and implemented a different schedule for meals, blood sugar monitoring and medication administration for diabetic inmates.

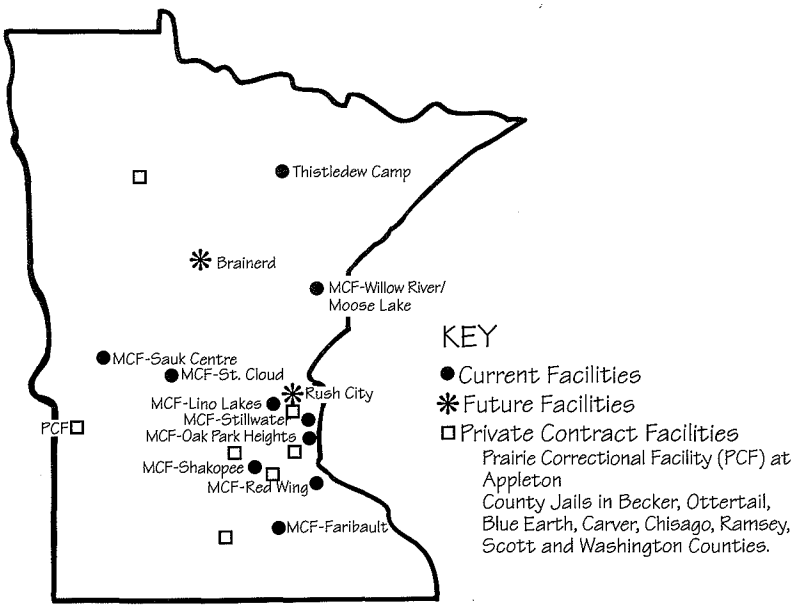
K-9 Unleashed

As part of their security, Faribault has a K-9 unit which includes a certified handler and a dog. The Ombudsman received a call from an inmate who complained that while he was in a holding cell being stripsearched, the dog was released from its leash.

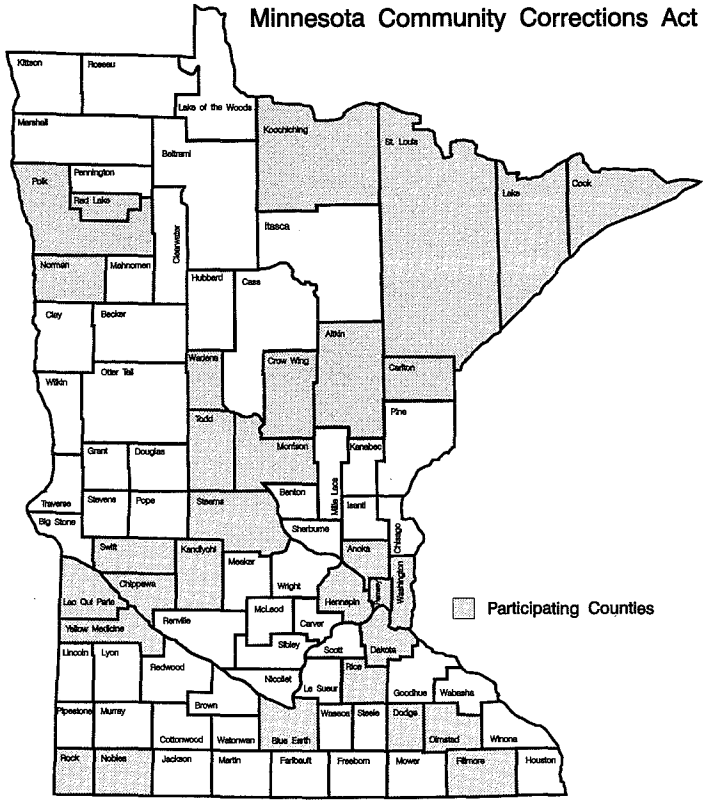
An investigator spoke with the institution about their K-9 policy and learned that dogs are only to be unleashed when they are being used to search for an escaped inmate. The investigator and the Lieutenant at Faribault spoke to the dog handler and were told that, to avoid having the handler entangled in the lead, he was taught to always unleash the dog during searches and in small spaces. The handler had not been trained at the institution and was not aware of their policy regarding unleashing the dog.

Because of the inconsistencies between the handler's training and the institution's policies, the issue was discussed with administration and they decided that the handler and dog would no longer be allowed inside holding cells during searches. The handler was advised that the institution policy is that dogs are to be leashed at all times, except when being used for escape searches.

Minnesota Correctional Facilities



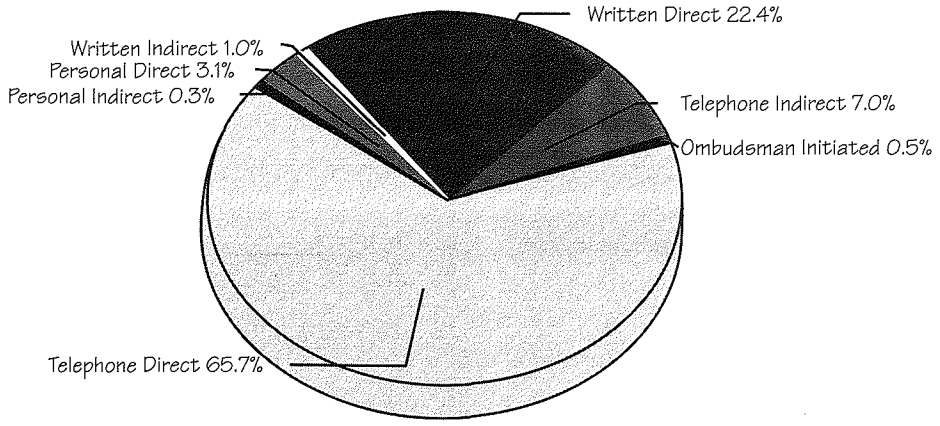
Minnesota Community Corrections Act Participating Counties



Fiscal Years 1995 - 1996 Summary

Caseload Summary FY	1995	1996
Carried Over Cases From Previous Year	165	73
Contacts Received In Year	2484	1869
Information Only Contacts	2967	2651
Total Fiscal Year Caseload	5616	4593
Cases Closed	5543	4472
Cases Carried Over to Next Fiscal Year	73	121

Initial Contact with the Agency*
Communication Methods



*Statistics do not include information only contacts. Pie chart is an average for years 1995 and 1996.

Eye Glass Policy

We investigated a complaint from an inmate who needed new glasses. He was told he couldn't get them for some time because he had transferred from another institution, The investigator learned that the policies for eye exams and obtaining eye glasses varied widely from institution to institution. The variance led to frustrations for both inmates and health services staff who had to interpret and explain policies to the inmates.

The investigator recommended that the Department of Corrections have a unified eye glass policy for all institutions. The Department agreed and has since developed a consistent policy.

Types and Descriptions of Contacts

The Ombudsman systematically categorizes each contact received to help further define the source(s) of changes in both the number and nature of cases and to facilitate year-to-year comparisons.

Categories

- RELEASE: Concerning any matter under the jurisdiction of the releasing authority, e.g., work release, supervised release, special review, etc.

- MEDICAL: Concerning availability of treatment or accessibility of a staff physician or other medical professional.

- LEGAL: Involving legal assistance or problems with getting a response from the Public Defender or other legal counsel.

- PLACEMENT: Concerning the facility, area, or physical unit to which an inmate is assigned.

- PROPERTY: Dealing with loss, destruction, or theft of personal property.

- PROGRAM: Relating to training, treatment program, or work assignment.

- DISCRIMINATION: Concerning unequal treatment based upon race, color, creed, religion, national origin, or sex.

- RECORDS: Concerning data on inmate or staff files.

- RULES: Regarding administrative policies establishing regulations which an inmate, staff member, or other person affected by the operation of a facility or program is expected to follow, e.g., visits, disciplinary hearings, dress, etc.

- THREATS /ABUSE: Concerning threats of bodily harm, actual physical abuse, or harassment to an inmate or staff.

- MAIL: Regarding anything that may impact the normal, legal flow of mail in or out of an institution or how it is handled by institution staff.

- HYGIENE: Having to do with access to supplies and necessities for personal hygiene or the hygiene of physical surroundings.

- SERVICES (Institution): Regarding heat, water, window screens, blankets, etc.

- OTHER: Concerning those contacts not covered in the previous categories, e.g. complaints regarding an Ombudsman investigation, etc.

"Hog-Tying"

The Ombudsman received a complaint from a juvenile facility regarding the use of "hog-tying" juveniles as a method of physical restraint.

After investigating the complaint, it was found that this practice was being used at two juvenile facilities. The Ombudsman determined that "hog-tying" was not an acceptable method of restraint and recommended the facilities discontinue their use of this restraint.

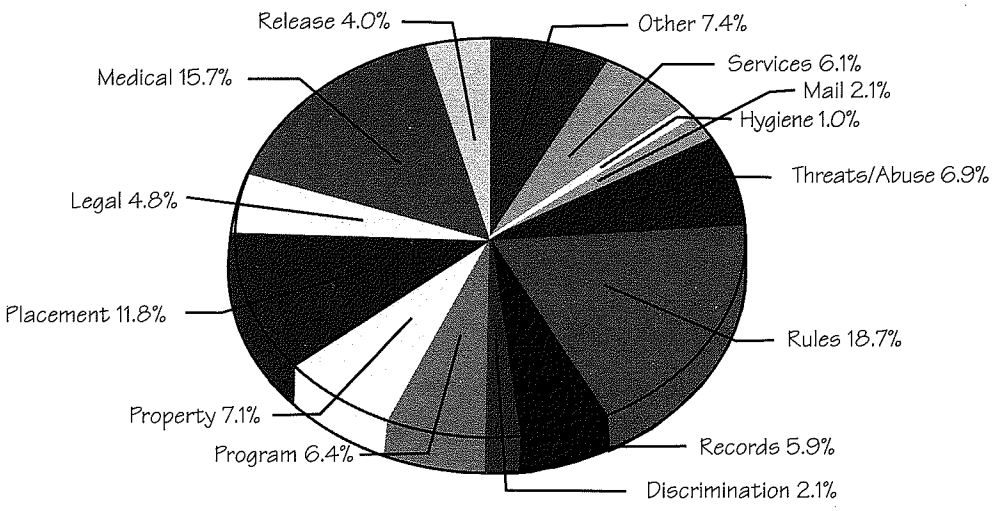
Both facilities agreed to cease using the "hog-tying" restraint.

Total Closed Cases by Category*

	1995	1996
Release	4%	4%
Medical	14%	18%
Legal	5%	4%
Placement	13%	10%
Property	8%	6%
Program	6%	6%
Discrimination	3%	2%
Records	6%	6%
Rules	20%	17%

	1995	1996
Threats/Abuse	6%	8%
Mail	2%	2%
Hygiene	1%	1%
Services	5%	8%
Other	7%	8%
Total	100%	

Percentages rounded to the nearest whole number.



*Statistics do not include information only contacts. Pie chart is an average of 1995 and 1996 closed cases.

False Accusation

The Ombudsman received a complaint from an inmate indicating that he had been assaulted and inappropriately restrained by prison staff. An investigator went to the prison, interviewed the inmate and reviewed videotapes of the incident.

The investigator observed that staff behavior was thoroughly professional throughout the incident and determined that the allegations of assault were false.

However, after reviewing the tapes, the investigator noted the inmate had been placed in restraints after the search and remained there naked. Review of other taped incidents indicated this practice was routine. The investigator questioned the necessity of requiring the inmate to remain naked, since it appeared inhumane and could escalate an already tense situation. When the institution did not identify any security reason for this practice, the investigator proposed that the institution make underclothing available to all inmates immediately after being searched. The institution agreed with this recommendation and implemented it immediately.

The Ombudsman then recommended to the Department of Corrections that they develop a consistent policy regarding searches. The Department agreed and implemented this policy for all institutions.

Juvenile Suicide

When a resident of a juvenile facility committed suicide by hanging, the Ombudsman was notified. After conducting a joint investigation with the Minnesota Department of Corrections Jail Inspection Unit, seven recommendations were made.

The response to these recommendations is still pending. The Ombudsman will continue to be actively involved in discussions regarding implementation of the recommendations with the superintendent of the facility and other county officials.

Another aspect of this investigation involved talking to a product manufacturer. Because the resident hung himself with materials from the mattress in his cell, the Ombudsman discussed mattress safety issues with them. The manufacturer agreed to pursue the feasibility of producing a mattress with a special cover such as Kevlar, which could be offered to facilities for use in special circumstances such as observation rooms. The manufacturer subsequently reported that the facility administrators indicated an interest in having a product like this available to purchase.

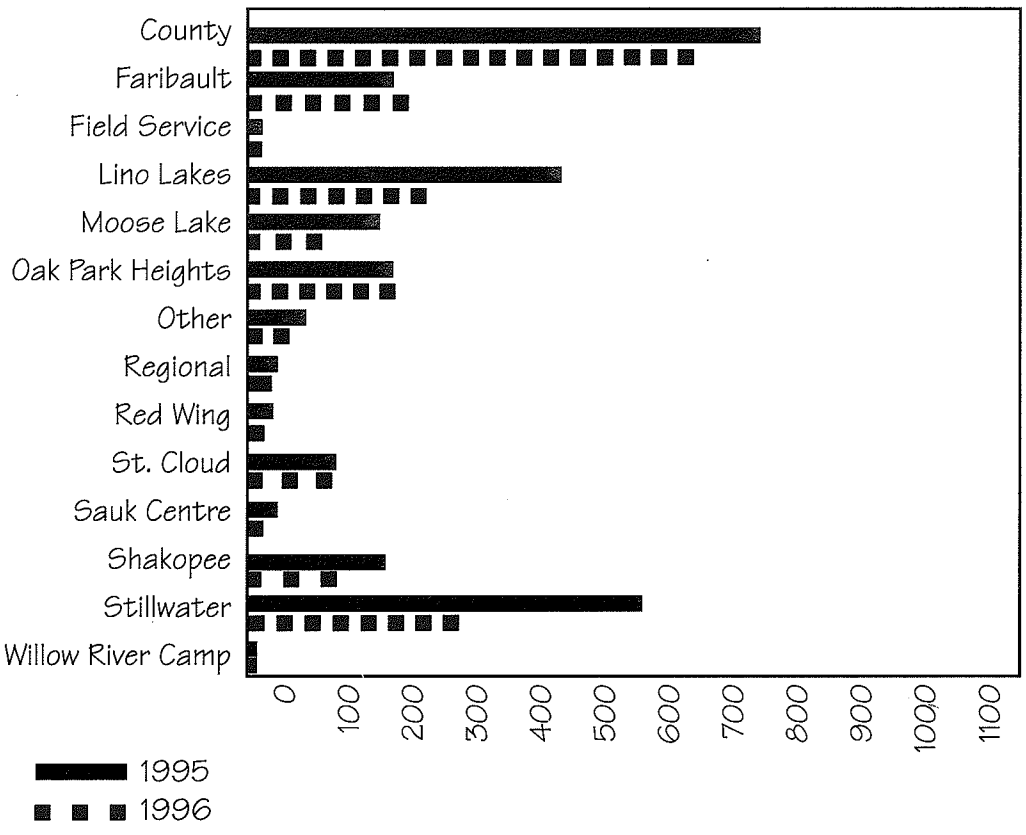
We will follow up with the manufacturer on this matter.

Closed Cases by Institution*

Institution	Code	1995	1996
County	CTY	738	620
Faribault	FRB	109	132
Field Service	FS	6	8
Lino Lakes	LL	486	228
Moose Lake	ML	141	89
Oak Park Heights	OPH	166	171
Other	OTH	53	32
Regional	RGL	25	23
Red Wing	RW	23	25
St. Cloud	SCL	93	93
Sauk Centre	SCR	26	14
Shakopee	SHK	141	96
Stillwater	STW	566	290
Willow River Camp	WRC	3	0
TOTAL:		2576	1821

*Statistics do not include information only contacts

Closed Cases by Institution



Response and Case Resolution Time

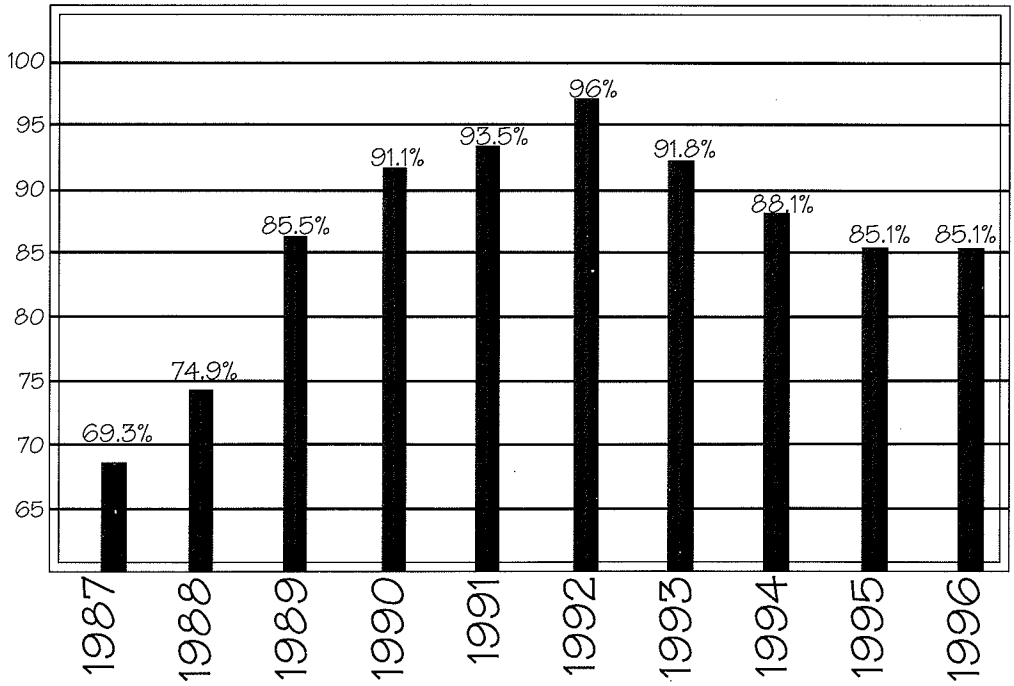
INITIAL RESPONSE TIME refers to the time taken to respond to a request. The Ombudsman's goal is to respond to cases within five days of receiving the request.

Fiscal Year	1995	1996
Same day response	2,205	1,555
Information only contacts	2,967	2,651
1 -9 day response	219	135
10 plus day response	152	131
Total Closed Cases:	5,543	4,472

CASE RESOLUTION TIME Timely resolution is a priority to the Ombudsman and is an indicator of efficiency. However, complex cases or cases with far-reaching implications naturally take longer and affect the statistics.

Fiscal Year	1995	1996
0 -15 days	1,752	1,165
Information only contacts	2,967	2,651
16 - 30 days	382	279
31 plus days	442	377
Total Closed Cases:	5,543	4,472

Percentage of Cases Resolved in Zero - 15 Days



Maternity Uniforms

The Ombudsman also accepts complaints from staff at correctional facilities. Several female correctional officers had requested assistance with the lack of maternity uniforms available to them.

There was no standard maternity uniform available for the female officers. The Ombudsman found that a makeshift uniform used by one institution was the most acceptable. In addition, the Ombudsman learned that there were plans for the Department to manufacture a maternity uniform as part of the textile industry at Mille Lacs.

All wardens received a letter summarizing the complaints and suggesting that, until new uniforms were manufactured, they consistently make a maternity uniform available to their female officers similar to the uniform currently being used by the institution thought most acceptable.

Book Limitations

The Ombudsman received a complaint from a Stillwater inmate because he could not purchase any book that cost more than $15.

The Ombudsman investigated this complaint and determined that this was a DOC policy that was being inconsistently applied in different Minnesota Correctional Facility Institutions. This particular policy was deemed to be unfair, particularly as it applied to religious, legal and educational books, for which inmates have constitutional protections.

The Ombudsman requested that the policy be reviewed and made recommendations for changes which included no limits for certain books.

The policy was changed. Inmates are now allowed to purchase books up to a $30 value. The DOC is considering a policy of no monetary limitations for religious, legal and educational materials.

Closed Case Status

The new data system we began using in July, 1993, allows us to track how we close cases. This information will assist us in developing our performance objectives and outcome measurements.

We document each contact as closed in one of six ways:

- INFORMATION: A request for information that is known by the agency.

- ASSIST: Relatively uncomplicated complaints resolved with few contacts and which provide an explanation of an administrative act or decision to the complainant.

- DISCONTINUED: Complaints which are not pursued because of lack of jurisdiction or other prescribed reasons.

- DECLINE: Complaints which are not pursued because of lack of jurisdiction or other prescribed reasons.

- INVESTIGATED: Completed investigations where findings and/or informal recommendations are made.

- INVESTIGATED WITH FORMAL RECOMMENDATIONS: Completed investigations which result in formal recommendations being made by the Ombudsman.

Percentage by Categories

	1995	1996
Information	53.53%	59.28%
Assist	36.44%	32.84%
Decline	1.16%	.89%
Discontinued	2.02%	2.24%
Investigated	6.78%	4.66%
Recommendation with Formal Investigation	.07%	.09%
Total	100%	100%

Ombudsman Activity 1973 - 1996

Poised for the Future

During this biennium, we experienced a decrease in the number of cases brought to the attention of the Ombudsman, which was the result of several factors.

The first and most important reason for the changed caseload was due to our expanding commitment to systemic and policy issues. Investigations of this nature often include extensive research and training and require additional staff time. The results of these investigations often include department-wide policy change recommendations which may prevent future problems and thus decrease the number of complaints overall.

Another major factor contributing to the caseload numbers was a temporary internal shift in priorities. Our new computer system, now completely able to help us manage much more effectively and efficiently, took a large commitment of time to initiate and learn.

External factors contributing to the caseload reductions include new phone systems in many of the DOC institutions. Inmates are now required to pay for their phone calls or arrange to make legal calls (including the Ombudsman) through their case manager. Our last biennial report indicated that direct telephone contacts comprised over 73% of our initial contacts.

Finally, we also had a temporary decrease in staff, which meant our investigators spent less time overall at institutions.

While the actual number of cases decreased over the biennium, the importance of our work did not. We will continue to proactively work on issues that affect those persons involved in our systems, seek to prevent problems, deal humanely and fairly with inmates and strive for the highest attainable standards of competency and efficiency in the administration of corrections.

Contacts by Year

1973	927
1974	1026
1975	1299
1976	1132
1977	1308
1978	1402
1979	2207
1980	2939
1981	3429
1982	3211
1983	3722
1984	3211
1985	2694
1986	2593
1987	2438
1988	2529
1989	2869
1990	3318
1991	3449
1992	3729
1993	5417
1994	6161
1995	5543
1996	4472

Exercise in Segregation

An inmate from a closed custody facility complained that he was in segregation and had not been given his recreation time for a couple of weeks. Our investigator was told by staff that inmates in segregation were only getting out of their cells for exercise and showers two hours weekly. The restriction had been put in place following an assault on staff in the segregation unit.

Staff reported that the exercise area was inadequate and new areas were being constructed, which might take months. The investigator discussed the situation with the Warden and other administrators and learned they were unaware of the extent of restrictions in the segregation unit. The investigator reminded the Warden that court decisions and institution policy requires inmates be allowed out of their cells a minimum of five hours weekly. The investigator also advised the Warden that it seemed like the inmate frustrations were very high.

The investigator suggested that a temporary exercise schedule be implemented which would allow inmates to be out a half hour a day, five days per week. The Warden agreed and the schedule was immediately implemented. The investigator then spoke with a number of inmates and advised them the institution would make a good faith effort to comply with regulations governing segregation until the completion of construction.

Home Confinement

The Ombudsman was contacted by a resident at the Ramsey County Workhouse who stated that the director would not allow him to reenter the Home Confinement Program. He told us he had been in the program for three months and, during his last thirty days, was discharged from the program. He was also told that he had to remain in the Workhouse and start the program all over again. The resident wanted to be allowed to get back into the program.

An investigator contacted the Work Release Supervisor about the complaint and was informed that this was the inmates's second arrest while in the Home Confinement Program. The policy states that anyone who is arrested while in the program is automatically terminated. Only residents who complete the program receive credit and the inmate had been told that he would have to start over from the beginning if he was terminated. According to the director, regardless of the outcome of the criminal proceedings, arrests result in program termination.

The investigator contacted the inmate and asked if he was aware of the termination policy. The inmate was aware of it as it had been explained to him during his orientation period.

The investigator advised the resident that it appeared he had already been arrested twice, which was more lenient than program guidelines.

Statute

241.41 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTIONS

The Office of the Ombudsman for the Minnesota State Department of Corrections is hereby created. The Ombudsman shall serve at the pleasure of the Governor in the unclassified service, shall be selected without regard to political affiliation, and shall be a person highly competent and qualified to analyze questions of law, administration, and public policy. No person may serve as Ombudsman while holding any other public office. The Ombudsman for the Department of Corrections shall be accountable to the Governor and shall have the authority to investigate decisions, acts and other matters of the Department of Corrections so as to promote the highest attainable standards of competence, efficiency, and justice in the administration of corrections.

241.42 DEFINITIONS
Subdivision 1. For the purposes of sections 241.41 to 241.45, the following terms shall have the meanings here given them.
Subd. 2. "Administrative Agency" or "agency" means any division, official, or employee of the Minnesota Department of Corrections, the Commissioner of Corrections, the Board of Pardons and regional correction or detention facilities or agencies for correction or detention programs including those programs or facilities operating under chapter 401, but does not include:
(a) any court or judge;
(b) any member of the Senate or House of Representatives of the State of Minnesota
(c) the Governor or the Governor's personal staff;
(d) any instrumentality of the federal government of the United States;
(e) any political subdivision of the State of Minnesota;
(f) any interstate compact.
Subd. 3. "Commission" means the Ombudsman commission.
Subd. 4. (Repealed, 1976 c 318 s 18)

241.43 ORGANIZATION OF OFFICE OF OMBUDSMAN
Subdivision 1. The Ombudsman may select, appoint, and compensate out of available funds such assistants and employees as deemed necessary to discharge responsibilities. The Ombudsman and full-time staff shall be members of the Minnesota State Retirement Association.
Subd. 2. The Ombudsman may appoint an Assistant Ombudsman in the unclassified service.
Subd. 3. The Ombudsman may delegate to staff members any of the Ombudsman's authority or duties except the duty of formally making recommendations to an administrative agency or reports to the Office of the Governor, or to the legislature.

241.44 POWERS OF OMBUDSMAN; INVESTIGATIONS; ACTIONS ON COMPLAINTS; RECOMMENDATIONS.
Subdivision 1. Powers. The Ombudsman may:
(a) prescribe the methods by which complaints are to be made, reviewed, and acted upon; provided, however, that the Ombudsman may not levy a complaint fee;
(b) determine the scope and manner of investigations to be made;
(c) Except as otherwise provided, determine the form, frequency, and distribution of conclusions, recommendations, and proposals; provided, however, that the Governor or a representative may, at any time the Governor deems it necessary, request and receive information from the Ombudsman. Neither the Ombudsman nor any staff members shall be compelled to testify in any court with respect to any matter involving the exercise of the Ombudsman's official duties except as may be necessary to enforce the provisions of sections 241.41 to 241.45;
(d) investigate, upon complaint or upon

STATUTE, CONTINUED

personal initiative, any action of an administrative agency;
(e) request and shall be given access to information in the possession of an administrative agency deemed necessary for the discharge of responsibilities;
(f) examine the records and documents of an administrative agency;
(g) enter and inspect, at any time, premises within the control of an administrative agency;
(h) subpoena any person to appear, give testimony, or produce documentary or other evidence which the Ombudsman deems relevant to a matter under inquiry, and may petition the appropriate state court to seek enforcement with the subpoena; provided, however, that any witness at a hearing or before an investigation as herein provided, shall possess the same privileges reserved to such a witness in the courts or under the laws of this state;
(i) bring an action in an appropriate state court to provide the operation of the powers provided in this subdivision. The Ombudsman may use the services of legal assistance to Minnesota prisoners for legal counsel. The provisions of sections 241.41 to 241.45 are in addition to other provisions of law under which any remedy or right of appeal or objection is provided for any person, or any procedure provided for inquiry or investigation concerning any matter. Nothing in sections 241.41 to 241.45 shall be construed to limit or affect any other remedy or right of appeal or objection, nor shall it be deemed part of an exclusionary process; and
(j) be present at the commissioner of corrections parole and parole revocation hearings and deliberations.
Subd. 1a. Actions against Ombudsman. No proceeding or civil actions except removal from office or a proceeding brought pursuant to chapter 13 shall be commenced against the Ombudsman for actions taken pursuant to the provisions of sections 241.41 to 241.45, unless the act or omission is actuated by malice or is grossly negligent.
Subd. 2. Matters appropriate for investigation.
(a) In selecting matters for attention, the Ombudsman should address particularly actions of an administrative agency which might be:
(1) contrary to law or rule;
(2) unreasonable, unfair, oppressive, or inconsistent with any policy or judgement of an administrative agency;
(3) mistaken in law or arbitrary in the ascertainment of facts;
(4) unclear or inadequately explained when reasons should have been revealed;
(5) inefficiently performed;
(b) The Ombudsman may also be concerned with strengthening procedures and practices which lessen the risk that objectionable actions of the administrative agency will occur.
Subd.3. Complaints. The Ombudsman may receive a complaint from any source concerning an action of an administrative agency. The Ombudsman may, on personal motion or at the request of another, investigate any action of an administrative agency.
The Ombudsman may exercise powers without regard to the finality of any action of an administrative agency; however, the Ombudsman may require a complainant to pursue other remedies or channels of complaint open to the complainant before accepting or investigating the complaint.
After completing investigation of a complaint, the Ombudsman shall inform the complainant, the administrative agency, and the official or employee of the action taken.
A letter to the Ombudsman from a person in an institution under the control of an administrative agency shall be forwarded immediately and unopened to the Ombudsman's office.
A reply from the Ombudsman to the person shall be delivered unopened to the person, promptly after its receipt by the institution.
No complainant shall be punished nor shall the general condition of the

DUE PROCESS

A Ramsey County Workhouse resident contacted our office complaining of being held on administrative segregation (admin seg) status. No formal discipline charges had been filed and he had been told he would lose good time while on this status.

The Operations Supervisor, when contacted, said the inmate was put on admin seg following an assault. The Superintendent had told the Operations Supervisor that the inmate did not need a hearing, which was contrary to the institution's policy which requires due process.

Concerned about the disregard for due process, the investigator wrote a letter to the Superintendent questioning this decision. The Superintendent stated that he had the authority to take away good time and conduct an investigation into the assault while the resident was on admin seg.

The investigator informed the Superintendent that he needed to follow the due process policy of the institution. The Superintendent agreed to follow the policy in the future. No complaints of this nature have been filed since the incident.

State Patrol Training

An inmate called our office stating that police officers from various jurisdictions were performing drug testing on inmates when they returned to the facility from work. The Work Release Staff had informed the inmate that the testing was part of a training exercise.

The testing involved being put in a dark room with several officers and having a flashlight shined in his eyes. In addition, breath and urinalysis tests were performed.

Our investigator was told by staff that the testing was part of a class conducted by the State Patrol to train officers to recognize people under the influence of drugs.

Two investigators went to the facility to interview inmates who had been participants in the class. The Administrator stated that he understood that inmates were required to participate in the training. We discovered that the State Patrol had conducted the training at several facilities. The State Patrol had requested inmates/residents to participate in the training on a voluntary basis. It appeared to be mandatory to inmates at more than one institution.

We recommended that the facilities develop a volunteers-only policy and that this be communicated to inmates before another testing was scheduled. This information was communicated to the staff person at the State Patrol who coordinates the training.

Statute, continued

complainant's confinement or treatment be unfavorably altered as a result of the complainant having made a complaint to the Ombudsman.
Subd.4. Recommendations.
(a) If, after duly considering a complaint and whatever materials the Ombudsman deems pertinent, the Ombudsman is of the opinion that the complaint is valid, the Ombudsman may recommend that an administrative agency should:
(1) consider the matter further;
(2) modify or cancel its actions;
(3) alter a ruling;
(4) explain more fully the action in question; or
(5) take any other step which the Ombudsman recommends to the administrative agency involved.
If the Ombudsman so requests, the agency shall within the time the Ombudsman specified, inform the Ombudsman about the action taken on the Ombudsman's recommendation or the reasons for not complying with it.
(b) If the Ombudsman has reason to believe that any public official or employee has acted in a manner warranting criminal or disciplinary proceedings, the Ombudsman may refer the matter to the appropriate authorities.
(c) If the Ombudsman believes that an action upon which a valid complaint is founded has been dictated by a statute, and the statute produces results or effects which are unfair or otherwise objectionable, the Ombudsman shall bring to the attention of the Governor and the Legislature the Ombudsman's view concerning desirable statutory change.

241.441 ACCESS BY OMBUDSMAN TO DATA
Notwithstanding section 13.42 or 13.85, the Ombudsman has access to corrections and detention data and medical data maintained by an agency and classified as private data on individuals or confidential data on individuals when access to the data is necessary for the Ombudsman to perform the powers under section 241.44

241.45 PUBLICATION OF RECOMMENDATIONS, REPORTS
Subdivision 1. The Ombudsman may publish conclusions and suggestions by transmitting them to the Office of the Governor. Before announcing a conclusion or recommendation that expressly or impliedly criticizes an administrative agency, or any person, the Ombudsman shall consult with that agency or person. When publishing an opinion adverse to an administrative agency, or any person, the Ombudsman shall include in such publication any statement of reasonable length made to the Ombudsman by that agency or person in defense or mitigation of the action.
Subd. 2. In addition to whatever reports the Ombudsman may make on an ad hoc basis, the Ombudsman shall biennially report to the Governor concerning the exercise of the Ombudsman's function during the preceding biennium. The biennial report is due on or before the beginning of the legislative session following the end of the biennium.

Ombudsman for Corrections

Patricia Seleen

1885 University Avenue
Suite 395
St. Paul, MN 55104

612 / 643-3656 telephone
800 / 627-3529 TTY number

Printed on Recycled Paper.
Text 60% Pre.
30% Post-Consumer Waste.

Printed on Recycled Paper.
Cover 50% Pre.
10% Post-Consumer Waste.