State of Alaska
Ombudsman

INVESTIGATIVE REPORT

Finding of Record and Closure – PUBLIC REPORT

Ombudsman Complaint A2014-0269
December 31, 2014

This report has been redacted to remove information that is confidential by law or would infringe on the privacy rights of those involved. The complainant will be referred to as the Sister; the OPA ward who died as the Brother.

SUMMARY OF THE COMPLAINT

The Sister of an Office of Public Advocacy (OPA) adult ward who died in the fall of 2013 complained to the ombudsman in February 2014, that the OPA Public Guardian did not notify her family that her Brother died months earlier from a long-term terminal illness.

The Sister alleged her family was not notified of her Brother's death until late January 2014, when their mother received an envelope from the Brother's former assisted living home (Home). The envelope contained old cards and letters that had been sent to the Brother over the years. A "sticky note" offering condolences for the family's loss was attached to the cards. Prior to receiving the envelope, the family was unaware of the Brother's illness or death.

The Brother's remains were cremated in early February 2014.

The ombudsman opened an investigation into the following allegation stated in terms that conform to AS 24.55.150:

> ***Performed Inefficiently: An OPA guardian failed to plan for her ward's death, which was expected from the time that OPA was appointed guardian.***
>
> ***Unreasonable: An OPA guardian failed to notify the next of kin of a deceased OPA ward and failed to authorize his burial within a reasonable amount of time.***

Ombudsman Intake Assistant Melissa Wilson investigated this complaint before leaving the ombudsman's office on May 30, 2014. Assistant Ombudsman Kate Higgins completed the investigative review and forwarded her report to the ombudsman.

The investigators reviewed the Brother's OPA file; documents from his Alzheimer's Resources of Alaska case file; the court file for his guardianship case; his medical records from the hospital; the licensing file for his assisted living home of 15 years; Alaska statutes governing guardianship; and the OPA Policy and Procedures manual. Ombudsman investigators also spoke with the complainant, OPA Guardian Valerie White, and the directors of the crematorium.

BACKGROUND

In late December 2012, the complainant's Brother fell while smoking outside of his assisted living home and suffered a right hip fracture. He was admitted to an Anchorage hospital. Tests also showed significant electrolyte imbalance (low sodium). When the Brother's doctors looked for the cause they discovered he had terminal lung cancer.

The Brother remained in the hospital for several months. In March, hospital staff became concerned about his ability to understand and make decisions relating to his care and recommended that he be appointed a guardian through the Office of Public Advocacy. In late spring of 2013, the Superior Court appointed OPA as full guardian. Public Guardian Valerie White was assigned to his case.

In late July, 2013, the hospital discharged the Brother and he returned to his Home, where he received care coordinator services through the Alzheimer's Resources of Alaska and hospice care.

The Brother died in October, 2013. The next day the Home, the hospital, the Alzheimer's Resource of Alaska care coordinator, and the Cremation Society of Alaska all notified OPA Guardian Valarie White of his death.

The following is a chronology of events culled from documentation received from the various agencies listed above:

- **December, 2012**: The Brother is admitted to the hospital after slipping on ice outside of his assisted living home. He required hip surgery. During the Brother's stay at the hospital doctors determine he has lung cancer.
- **March, 2013**: The hospital files a petition for guardianship, stating the Brother, still a patient, had no known relatives.
- **May, 2013**: OPA is appointed full guardian to the Brother.
- **June, 2013**: The hospital discharges the Brother to his assisted living home.
- **July, 2013**: A hospital physician writes to OPA Guardian White that her ward has terminal lung cancer that will ultimately cause his further decline and death. The doctor recommends that the Brother be placed on a "do not resuscitate/do not intubate" order if his heart fails. She also recommends he not be hospitalized or receive antibiotics but be placed on comfort care status.
- **July, 2013:** OPA Guardian White responds the same day:

  > . . . (my) authority to make decisions in this arena is defined by AS 13.26.150(e)(3) which states a guardian may not. . . . consent on behalf of the ward to the withholding of lifesaving medical procedures; however, a guardian is not required to oppose the cessation or withholding of lifesaving medical procedures when those procedures will serve only to prolong the dying process and offer no reasonable expectation of effecting a temporary or permanent cure of or relief from the illness or condition being treated unless the ward has clearly stated that lifesaving medical procedures not be withheld.

Ms. White concluded that:

. . . as guardian for the Brother [she] was not opposing the recommended treatment course as outlined in [the doctor's] letter dated 07/19/2013, and switching to comfort care for her ward.

- **Late September, 2013**: A hospital social worker notifies OPA Guardian White that she visited the Brother that day. She said he was asleep during her entire visit and did not rouse to voice or touch. She asked for his social history or information about any needs or concerns that Ms. White had about him. The file does not contain any response from Ms. White.
- **Early October, 2013**: A second hospital nurse writes to Ms. White saying she received a doctor's referral for hospice care for the Brother. She asks that Ms. White sign an attached consent form for hospice care and return it to her. She reminds Ms. White that the consent form is good for only 48 hours in compliance with Medicare. The file does not contain any response from Ms. White.
- **Early October, 2013**: The Brother dies at his Home.
- **Early October, 2013**: The assisted living home, hospital, the Alzheimer Resource of Alaska care coordinator, and the crematorium all notify OPA Guardian Valerie White of the Brother's death.
- **Early October, 2013**: An Alzheimer Resource care coordinator provides names of the Brother's relatives to OPA Guardian White but the list contained no known addresses for the relatives.
- **Early October, 2013**: The crematorium requests that Ms. White direct them on final disposition of the Brother's remains or provide contact information for any family members.
- **Early October, 2013**: Ms. White places a note in the Brother's OPA file saying she informed the crematorium that OPA cannot consent to cremation and has no information about the whereabouts of the Brother's living relatives.
- **Late January, 2014**: The Home mails birthday cards and letters found in the Brother's possessions to his family out of state, effectively notifying them of his death.
- **Early February, 2014**: One of the Brother's family members contacts the Home and the crematorium and grants permission for cremation of the Brother's remains.
- **Early February, 2014**: The Brother's remains are cremated.
- **Mid-February, 2014**: The Alaska Bureau of Vital Statistics issues a death certificate for the Brother.
- **April, 2014:** The court issues a notice of Annual Guardianship Report due and notice of hearing date.
- **Late May, 2014**: OPA filed its final Guardianship Report with the Superior Court.
- **Late May, 2014:** The Superior Court closes the case nearly eight months after the Brother's death.

INVESTIGATION

The ombudsman investigator spoke with Ms. White about the Sister's complaint in mid-February, 2014. She asked Ms. White what actions she took after being notified of her ward's death and what had she done to notify the Brother's survivors of his death. Ms. White responded via email:

> Alzheimer's Association (sic) staff . . . inquired in the [October] email if OPA had any information on family. I verified with [the staff member] that neither the court visitor's report, Petition for Guardianship or [hospital] records contained family contact information. [The Brother] had been in patient at . . . [hospital] since 12/2012 and [hospital] filed the petition for guardianship in 3/2013 stating there had been no known family relatives of [the Brother] that had been provided or known. The court visitor's report specifies that he doesn't have children, has never been married but is believed to have an elderly mother and two sisters residing in . . . Oregon area but the contact information remains unknown. I called [the crematorium] on [October] and spoke with [the owner] and informed her that per statute we couldn't consent to cremation and that we did not have contact information on any family. [Alzheimer's Association staff] also confirmed with me via email on the afternoon of [October] that she confirmed with [the assisted living home](where he had lived for at least 15 years prior to his December 2012 hospitalization and where he resided at the time of his death) that they had names of relatives, but no contact information. My understanding was that [Alzheimer's group staff] (sic) and Hospice were working on finding this information for the funeral home, as well. As I normally do in cases of a client's death, I awaited the invoice from the funeral home so that I could issue payment or apply for burial assistance if needed. However, the invoice was never sent and I received no other communication from the funeral home, therefore I didn't issue payment for burial. We were informed of the unresolved issue and were provided an invoice after family was able to provide direction on the burial. Invoice for cremation was received on [early February 2014] and payment was issued the same day.

The ombudsman investigator spoke with the owners and directors of the crematorium who said they sent the following email to Ms. White the day after the Brother died:

> From: **crematorium** <[email address redacted]>
> Date: October, 2013 at 10:01 AM
> Subject: [Name Redacted]
> To: valerie.white@alaska.gov
> Valerie:
>
> You probably received initial notification from . . . Hospice last evening in regards to [the Brother] who passed away at the [Home] on [date redacted]. We were notified by Hospice and brought [the Brother] into our care. **Could you provide us with directions on final disposition or family contact information for [**the Brother] [Emphasis added]
>
> I can be reached at the [crematorium]

The crematorium owners said Ms. White did not respond to this email, and said when they repeatedly contacted her later, she didn't respond or gave them no direction.

However, the information provided to the ombudsman by the owners is contradicted by an undated note from Ms. White to the OPA file. Placement in the file seems to indicate this was written in early October 2013.

> T/C [telephone call] to [crematorium]– indicated OPA could not consent to cremation and we had no information of family contact in our records but that [the Home] may have some. My understanding is that [crematorium] and/or Alzheimer's Resource agency will confirm any next of kin information which may be available.

The crematorium owners said they tried multiple times to contact Ms. White to get her direction on how to dispose of the Brother's remains; they said they didn't hear back from her. They told the ombudsman that they didn't document in their records when they called Ms. White and on some occasions they didn't leave messages for her to return their calls.

The subject of locating the Brother's next of kin is also mentioned in an email dated in October, 2014from the Alzheimer's Resource of Alaska case care coordinator for the Brother, to Valarie White. The messages found in the OPA files stated:

> Hi Valerie,
>
> Our mutual client, [Brother's Name Redacted], passed away last night at his ALH [assisted living home]. Hospice informed me of his death and I was told his death was caused by his terminal cancer. **They are working on contacting his family-although I am unsure if he has any family. If you know of anyone or any contact information of [**the Brother's] **family, please let me know.** I sent a CIR (Critical Incident Report) to SDS [Senior and Disability Services]. [Emphasis added]
>
> Let me know if you have any questions.
>
> Thank you.

Ms. White responded:

> **From:** White, Valerie J (DOA)
> [mailto:valerie.white@alaska.gov]
> **Sent:** Monday, October 07, 2013 11:56 AM
> **To:** [care coordinator's name redacted]
> **Subject:** RE: [Brother's name redacted].
>
> I do not have any family information-does [the Home] have any?

The care coordinator responded quickly:

> **From:** [Name redacted]
> **Sent:** Monday, October 07, 2013 12:29 PM
> **To:** White, Valerie J (DOA)
> **Subject:** RE: [Name redacted].
>
> They have names, but no contact information. **I'll contact the admin- . . . and see if there's anything I can do to assist with this.** [Emphasis added]
>
> Thank you Valerie.

The Brother's body remained in cold storage at the crematorium until early February 2014, when it was cremated.

When the investigator asked Ms. White about the delay in burying the body, she responded:

> When I spoke to [the crematorium] in Oct. I told them we cannot consent to cremation on behalf of a deceased ward. I also indicated that I had no information on next of kin contact. **I assumed, obviously incorrectly, that [the crematorium] would provide our office an invoice for burial and upon receipt I would issue payment.** Since our office didn't receive an invoice- funds for burial were not issued. There was no other communication with the funeral home initiated by our office or the funeral home until early 2014 when family contacted our office. [Emphasis added]

The crematorium owners had a different version when asked. They said Ms. White told them shortly after the Brother's death to bury him and send her an invoice. The owners said they told the OPA guardian that they couldn't just bury him; they would have to go to Superior Court to obtain an order to bury an unclaimed body.

The investigator asked the owners if they or their staff have ever searched to find the next-of-kin for an unclaimed body and then petitioned the court to bury the remains. They said they usually have three or four cases a year that requires them to file such a petition. Alaska Statute addresses this issue in AS 12.65.100 which states:

> **Unclaimed bodies.** When a person dies and no person appears to claim the body for burial, and no provision is made for the body under AS 13.52, the Department of Health and Social Services, upon notification, shall request a court order authorizing the body to be plainly and decently buried or cremated and the remains decently interred. A judicial officer shall issue the requested order upon the sworn testimony or statement of a representative of the Department of Health and Social Services that a person has not appeared to claim the body for burial and provision is not made for the body under AS 13.52.

Ms. White said she mistakenly assumed the crematorium would coordinate with the assisted living home to locate the Brother's family for direction on how to dispose of his remains. Emails from the crematorium found in the OPA file do not indicate that the owners committed to help find the Brother's next of kin or even suggest they would try to help find the Brother's next of kin.

However, the Alzheimer's group care coordinator emailed Ms. White in early October, 2013, that she would contact the assisted living home administration to see if they had next-of-kin information for their former resident. No further interaction between CSA and OPA is documented in the files obtained by the ombudsman. The care coordinator told the ombudsman that she was unable to get any information on the family and the assisted living home also had no information.

At some point in January 2014, the assisted living home returned a bundle of cards and letters found in the Brother's property to his family out of state. According to the family, Home staff said they conducted an Internet search and found the Brother's mother's address. Management and staff at the Home has since changed and the ombudsman could not confirm how Home staff found the Brother's family.

The complainant told the ombudsman that a "sticky note" expressing condolences to the family was affixed to the cards and letters by someone at the Home. Although the family knew the Brother was living at the assisted living home, this note was the first time the family was made aware that he had been ill or had died, according to the complainant. She said that after receiving the cards, a family member called the Home and was told that no one there knew where the Brother's body was. They somehow connected with the crematorium and learned the Brother's body had been in cold storage awaiting burial since his death four months prior.

The Brother's was cremated in February 2014 after his family provided authorization. The crematorium sent an invoice to OPA and Ms. White authorized payment the day the invoice was received. The cremation cost $1295. Storage for the body was billed at $1,000 for 120 days.

STANDARDS

OPA Policy 6.1 states:

> It is the policy of the Public Guardian section of OPA that **a Public Guardian shall prepare for the possible death of a client by ascertaining whether the client has executed a will, determining any beliefs or attitudes of the client regarding burial and funeral arrangements, by endeavoring to maintain contact information for known relatives,** and by establishing a burial fund and/or prepaid burial contract if appropriate. [Emphasis added]

OPA's authority to authorize burial of remains is defined by **Alaska Statute 13.26.120(b),** which provides:

> . . . if a deceased ward does not have a living family member or if an individual interested in the ward is not available, **the guardian of a ward who dies may arrange for the body of the ward to be transported to a funeral home and may make funeral and burial arrangements for the deceased ward**. [Emphasis added]

OPA Policy and Procedure 6.3 provides:

> It shall be the policy of OPA when a client death occurs **to promptly take action to ensure that (1) the appropriate funeral and burial arrangements for that client are made; (2) all client assets are promptly distributed to persons entitled to these assets in a manner that conforms to Alaska law; (3) notification is promptly given to all entities that need to know of the client's death**; and **(4) required reports are filed with the court.** [Emphasis added]

OPA Policy 6.3 states:

> The Alaska Probate Rules **require a guardian to file a final report within 90 days of a client's death**. In some cases it will not be possible to comply with this deadline and the guardian/conservator shall alert their legal advisor so a motion to extend the deadline can be filed with the court. It is important that the final report be filed as soon as possible so the court case can be closed. It is also important that a final report be filed as soon as possible because the Alaska Supreme Court has ruled that the statute of limitations for filing a suit against an Alaska conservator does not begin to run until the conservator has filed a final report with the court. [Emphasis added]

According to a review of Alaska Court System on-line court docketing system CourtView, the Brother's OPA guardianship report was filed in May 2014, and his guardianship case was closed in late May 2014, 236 days after his death, in violation of OPA and court rules.

One final note: Two documents in the case file listed two very different Social Security numbers for the Brother. The number on the OPA case opening sheet had the three-digit 574 "area number" which was assigned to Social Security accounts opened in Alaska. The Social Security number in the file matched the number on the Brother's death certificate. The other area number, 070, was cited on an email from Ms. White to another OPA employee. The 070 area number was usually assigned to Social Security cards issued in New York.

ANALYSIS AND FINDINGS

OPA Policy 601 directs that Public Guardians prepare for the possible death of a client by determining whether the client has executed a will, determining the client's beliefs or attitudes regarding burial and funeral arrangements, obtaining information about the client's known relatives, and establishing a burial fund and/or prepaid burial contract if possible.

Ms. White, as the Brother's court-appointed legal guardian, had statutory authority under AS 13.26.120(b) to make burial arrangements for him *if there was no family to make funeral decisions.* The statute is permissive, not mandatory, that the guardian make the decision. Alaska Statute doesn't speak to cremation arrangements.

OPA policy also directs that the Public Guardian should not exercise responsibility for funeral and burial arrangements *until family or friends have been contacted and it is clear that the family or friends cannot or will not make these arrangements.* This means that someone has to look for the family or friends *or* make the decision they cannot be found.

The Brother's OPA guardian knew for five months his death was imminent, yet took no steps to determine his burial preferences or to locate his next of kin to approve burial arrangements when the time came. Then the Brother died and his remains were kept in the crematorium's cold storage for more than four months because no one knew his burial wishes, no one knew where his family was, and no one had taken steps to handle burial arrangements.

The guardian told ombudsman investigators she believed mistakenly that the Brother's care coordinator was working with his assisted living home and the crematorium to locate his family who in turn could make the requisite arrangements.

There seems to be no good explanation for why the OPA guardian did not make plans for the Brother's inevitable death in advance of his death as OPA policy requires. OPA knew the Brother's diagnosis was terminal when OPA was appointed guardian; that's why the hospital moved to have a guardian appointed for him. But he lived four months and six days after OPA was appointed. That was plenty of time to search for his family or determine, prior to his death, that the family couldn't been found and act accordingly when the time came.

Prior planning for the Brother's inevitable death – as required by OPA policy would have reduced the heartache his family endured upon learning that their son and brother had been gravely ill for four months without hearing from his family and that his body remained in storage for four additional months.

OPA contends that the OPA guardian's hands were tied because family notification "was not possible." This explanation does not seem adequate. Emails between OPA and others state that

two of the agencies officially involved in the Brother's life knew the names and general location of his next of kin. The more plausible explanation is that nobody actually looked for the Brother's survivors until his assisted living home found the cards and letters in his belongings, then searched the Internet and found his mother four months after his death.

The ombudsman doesn't know why Ms. White was unable to do the same. Ombudsman review suggests that she didn't try. According to her October 8, 2013, note to the Brother's OPA file she suggested that the crematorium or someone else contact the Home to get family contact information. Then the matter was dropped.

She told the ombudsman she was waiting for a burial or cremation invoice that would have indicated the Brother's body had been buried. That information never came and she never asked about it.

When no burial/cremation invoice was forthcoming within a reasonable time Ms. White should have followed up to ensure that someone had located and notified the Brother's family about his passing or that the family could not be located after a diligent search. If the latter was the case she should have taken steps to have the Brother's body buried or cremated.

It is equally unclear why, even if Ms. White believed that the crematorium and/or the Alzheimer's association would coordinate with the assisted living home to find the Brother's relatives after his death, she did not contact them after she did not receive an invoice for burial/cremation. Forty days might be considered a reasonable delay to some but keeping a body in cold storage for 124 days is simply unreasonable. A simple phone call or email to the assisted living home, the crematorium, or the Alzheimer's association in late October 2013 would have made it clear to Ms. White that no one was searching for the Brother's survivors and she needed to make burial arrangements. It was the guardian's job to make that contact.

It may have been a reasonable decision – for a short time – for Ms. White to rely on others to locate her ward's family. OPA guardians carry large caseloads and are generally extremely busy. However, when no family was located and the ward's remains weren't buried in a reasonable amount of time, it was Ms. White's statutory responsibility to follow-up on the case to make sure that family had been located and arrangements made and, if not, to make burial arrangements herself.

The family finally learned of their son and brother's illness and death from words hastily scribbled on a "sticky note" by the assisted living home staff. This appeared to be more an act of the Home returning a loved one's belongings to the family than official notice of his death. However hastily scribbled the sticky note message was, the Brother's family should take some comfort that the assisted living home staff took the time to return the cards. But for those cards and that note the family still might not know of his death.

After receiving the package and the "sticky note" of condolences, the family contacted the crematorium and flew to Anchorage to make burial arrangements for him. They remain justifiably angry that it took more than 120 days for anyone to contact them, especially, they say, because the Brother had had a court-appointed Public Guardian.

Ms. White's incorrect assumption that someone else was doing her job prolonged the time that the Brother's remains went unclaimed. The guardian's actions were unreasonably inefficient.

The ombudsman investigated the following allegations:

Performed Inefficiently: An OPA guardian failed to plan for her ward's death, which was expected from the time that OPA was appointed guardian.

Unreasonable: An OPA guardian failed to notify the next of kin of a deceased OPA ward and failed to authorize his burial within a reasonable amount of time.

AS 24.55.150 authorizes the Ombudsman to investigate administrative acts that the Ombudsman has reason to believe might be contrary to law; unreasonable, unfair, oppressive, arbitrary, capricious, an abuse of discretion, or unnecessarily discriminatory, even though in accordance with law; based on a mistake of fact; based on improper or irrelevant grounds; unsupported by an adequate statement of reasons; performed in an inefficient or discourteous manner; or otherwise erroneous.

Under 21 AAC 20.210 the ombudsman evaluates evidence relating to a complaint against a state agency to determine whether criticism of the agency's actions is valid, and then makes a finding that the complaint is *justified*, *partially justified*, *not supported*, or *indeterminate*. A complaint is *justified* "if, on the basis of the evidence obtained during investigation, the ombudsman determines that the complainant's criticism of the administrative act is valid." Conversely, a complaint is *not supported* if the evidence shows that the administrative act was appropriate. If the ombudsman finds both that a complaint is *justified* and that the complainant's action or inaction materially affected the agency's action, the complaint may be found *partially justified*. A complaint is *indeterminate* if the evidence is insufficient "to determine conclusively" whether criticism of the administrative act is valid.

The standard used to evaluate all Ombudsman complaints is **preponderance of the evidence.** If the preponderance of the evidence indicates it is more likely than not that the administrative act took place and the complainant's criticism of it is valid, the allegation should be found justified.

The Ombudsman may investigate to find an appropriate remedy.

The Office of the Ombudsman's Policies and Procedures Manual's definition of "**performed inefficiently**" means that the agency:

> (A) exceeded a time limit established by law or by custom, good judgment, sound administrative practice, or decent regard for the rights or interests of the complainant or of the general public; or
>
> (B) mishandled the decision-making process or the process of implementing an act or service through delay, "red tape," or by requiring an unreasonable and unnecessary amount of clarification from the complainant.

According to the Office of the Ombudsman's Policies and Procedures Manual at 4040(2) an administrative act is "**unreasonable**" if:

> (A) the agency adopted and followed a procedure in managing a program that was inconsistent with, or failed to achieve, the purposes of the program,
>
> (B) the agency adopted and followed a procedure that defeated the complainant's valid application for a right or program benefit, or
>
> (C) the agency's act was inconsistent with agency policy and thereby placed the complainant at a disadvantage relative to all others.

For more than four months after OPA was appointed as the Brother's guardian, no one looked to find his relatives although their names and general locations were known at the assisted living home he lived in for 15 years prior to his death. The guardian depended on others to do her job which was to find his family and to determine his wishes on a final resting place.

For more than four months after learning of the Brother's passing, OPA staff took no action to either locate his relatives or make burial arrangements, as authorized by statute and directed by OPA policy. Ms. White's inaction caused the Brother's family emotional suffering once they learned of his illness and passing, months after the fact. It also resulted in a negative impact to the Brother's estate because the fees incurred while storing his body in the mortuary before interment had to be paid from the meager estate.

Based on Ms. White's failure to follow established OPA policy and procedure, and Alaska Statute, the Ombudsman proposed to find both of these allegations to be ***justified***.

RECOMMENDATIONS

The complainant's Brother wasn't a John Doe; he should not have been treated like one.

The ombudsman believes that the responsibility for finding the family and/or making burial arrangements for the Brother belonged to his OPA guardian. Had OPA followed policy and conducted its own search for the Brother's relatives instead of relying on others and apparently forgetting about the body in the morgue, this issue would not have cropped up.

And, had there been a system in place requiring OPA to follow the process of finding a resting place for the Brother, his remains likely would not have been stored for 120 days.

When asked if OPA uses a system to track the benchmarks in a guardianship case, Ms. White said that the agency does not have a tracking system, but since this case, she has implemented a process for her own caseload so this situation would not happen again. That is to her credit but she is not the only busy OPA public guardian with multiple deadlines. Therefore, the ombudsman recommends the following:

> ***Recommendation 1: The Office of Public Advocacy should develop a system that allows OPA to track deceased wards' remains until burial or cremation is completed.***

At the very least, OPA could utilize the calendaring feature available in Microsoft Outlook to track its wards after death. OPA also could consider a low-tech checklist that is maintained with the ward's file to ensure the procedures outlined in OPA Policy 6.3 are followed. The ombudsman believes all guardians need to address this issue and would benefit from using a tracking system, therefore recommends OPA create a consistent tracking system for all OPA employees.

*

Ms. White should have attempted to locate the Brother's family prior to his death. OPA policy requires that. OPA was the guardian, not the assisted living home and not the crematorium. The guardian knew that the Brother had a terminal illness. Several months elapsed between OPA's appointment as guardian and his death. Had the guardian made efforts to find his survivors or even to learn of his burial preferences immediately after OPA was appointed guardian, this sorry situation could have been avoided. Therefore the ombudsman recommends the following:

Recommendation 2: OPA should develop a component of case supervision that requires its Public Guardians to conduct a comprehensive search for the relatives of their wards immediately after guardianship is established.

*

The ombudsman recognizes that searching for relatives of those with dementia or other mental problems is difficult. Therefore the ombudsman recommends the following:

Recommendation 3: OPA should develop and conduct trainings for its guardians and other staff on finding next of kin for wards of the agency.

*

Once the Brother died, by statute Ms. White immediately could have made burial arrangements for him if there were truly no family members or friends available to do so. Based on the evidence gathered, it appears that Ms. White assumed that the crematorium or the Alzheimer's group would be working with the Home to locate relatives in order to make burial or cremation arrangements. That may have been reasonable for a short time under the circumstances but when no burial/cremation invoice was forthcoming, the guardian should have followed up to ensure that burial/cremation arrangements had, in fact, been made and her ward taken to his final resting place.

Frankly, the ombudsman finds it disturbing that the guardian was waiting for an invoice to determine that her ward had been buried instead of actively seeking some affirmative notice that the burial or cremation had occurred.

Because of OPA's mistaken assumptions, the Brother's meager estate dwindled to nearly nothing. The ombudsman therefore recommends the following:

Recommendation 4: OPA should reimburse the ward's estate for the storage fees incurred to store his remains.

On December 29, 2014, OPA Director Rick Allen provided the following response to the preliminary report:

> Dear Ms. Lord-Jenkins,
>
> I am writing in response to your preliminary finding in the above-referenced complaint dated November 10, 2014. While I am not opposed to your ultimate recommendations, I believe that the findings discussed in the report miss pertinent information that was provided to the Ombudsman and hold the public guardian staff to unrealistic expectations.
>
> It is truly unfortunate that [the Brother's] family learned of his passing in the manner that they did. However, your report makes no mention of the fact that none of the agencies who were contacted by the Ombudsman's office in the course of its investigation had any contact with his family between the time he went into the hospital in September 2012 and their ultimate notification of his death in late January 2014 and instead places the blame for the lack of communication solely on the Public Guardian's office.
>
> [The Brother] lived at [the Home] for a number of years prior to his death. It was his home. If his family had tried contacting [the Home] at any time after his hospitalization and prior to his death, [the Home] staff would have been able to connect

them. If his family had contacted Adult Protective Services or the police, they would have eventually been connected with him. If his family had reached out to the hospitals, they would have found him. The information the public guardian was provided at the time of its appointment was that the family had not been in contact with [the Brother] for a significant amount of time. Unfortunately, this is not unusual with many wards. However, [the Brother] was not like many other wards of the public guardian who are in and out of housing, the hospital, and jail that family members lose contact because they cannot keep up. He was stable and in the same home for the last many years of his life, his family had even visited with him there several years ago. The family chose to not reach out to their son/brother for at least fifteen months and that fact should at least be acknowledged. In fact, had his family played a more active role in his life it is unlikely he would have become a ward of the state in the first place.

Additionally, the report appears to place all the blame for the lack of a timely disposal of his remains on the public guardian. However, this ignores the realities of what happens when a ward/protected person dies. A guardian/conservator's authority ends on death. AS 13.26.120. It is only when there is no one else to make arrangements or when that other person needs financial assistance that a guardian becomes involved. Id., AS 13.26.285(e). In this case, while the guardian did not respond to the e-mail that was sent to her from the [crematorium], she did speak with an employee and explained she was unable to consent to cremation. After initial contact, it is not unusual for the public guardian to not receive follow-up from the provider or family regarding the disposal of a former client's remains. What is highly unusual is that a funeral provider would allow a body to remain in such an undetermined status for such a lengthy period of time without further contact to this office. Although the funeral providers claim they reached out, they also admitted they did not leave messages (p.5). Therefore, the Public Guardian had no actual knowledge that [the Brother's] remains were awaiting disposal.

While I believe the public guardians should strive for perfection, the Ombudsman's report displays little understanding or acknowledgement that perfection is ultimately unattainable. Instead, it demands near omniscience from public servants who are unarguably overburdened. In fact, Alaska public guardians have the largest caseloads of any public guardian office in the nation. OPA public guardians consistently carry caseloads two to three times the nationally recommended maximum. OPA has requested more resources for this purpose for many years to no avail.

Therefore, I must respectfully object to your findings as I do not believe they account for the full context of [the Brother's] situation. However, as I also said, I do believe we should strive for improvement and am not opposed to your ultimate recommendations.

Regarding recommendation 1: Public Guardian Supervisor Beth Russo will implement a tracking system to follow deceased wards' remains until burial or cremation is completed.

Regarding recommendation 2 and 3: To the extent possible, OPA will ensure that next of kin information is contained in the ward's file upon appointment.

Regarding Recommendation 4: OPA is prepared to reimburse [the Brother's] estate $1000.00 for storage fees incurred.

I have had extensive conversations with the public guardian staff regarding this matter and the need to improve in future. I am confident that positive systemic changes will result from this unfortunate incident.

Sincerely,

Richard K. Allen
Director- Office of Public Advocacy

OMBUDSMAN COMMENT

At the outset, the ombudsman would like to thank OPA for accepting the recommendations proposed in the ombudsman's preliminary report. We very much appreciate that OPA is willing to reimburse the Brother's estate and implement steps that will hopefully prevent another family from learning of their loved one's death months after the fact. We also know that, in the vast majority of their cases, OPA guardians do an excellent job making sure that some of the most vulnerable members of our society are housed, fed, and safe even while they work overwhelming caseloads. Their work is hard and should not be overlooked or minimized.

We can also acknowledge that, had the Brother's family been more involved, it is possible that they would have learned of his death earlier or prevented him from becoming a ward of the state in the first place. Director Allen also makes much of the fact that the Brother's family had not contacted him in quite some time. That very well may be true. There may have been reasons beyond the family's control to account for that. However, it may also have been true that, had OPA located and contacted the Brother's family prior to his death, the family may have been able to rekindle a relationship while the Brother was still alive.

However, that is somewhat irrelevant to the case at hand, as the Brother *was* a ward of the state and, as such, OPA was tasked with ensuring his care.

And, as Director Allen points out in his response, the Brother was not the standard OPA ward – he was not "in and out of housing, the hospital, and jail" like a lot of other OPA wards. So, as far as OPA cases go, this appears to have been a relatively simple one. The Brother had stable housing and supports. His OPA guardian was not required to do much in the way of triage on this case, as is probably required when the ward is not in such a stable situation. Therefore, it is all the more troubling that OPA did not take the time to complete the end-of-life planning that OPA policy requires.

OPA knew, from the moment that it was appointed as guardian, that the Brother was terminal. That was the reason OPA was appointed guardian. And, as Director Allen also pointed out in his response, OPA's duties end at death *unless next of kin cannot be found to handle burial arrangements*. As such, it was all the more important to ensure that any end-of-life planning was accomplished while the ward was still alive to explain what his last wishes were. Instead, his family was left to guess four months after the fact.

In his response, Director Allen says that the guardian had no actual knowledge that the Brother's remains were awaiting disposal – but she was required to file a final report to the court within 90 days of the Brother's death according to the Probate Rules and OPA policy. Had Ms. White done

that in a timely fashion, she at least would have been alerted to the fact that an invoice from the crematorium had not arrived and a little digging to find out why would have exposed the fact that his remains were still unclaimed. But, unfortunately, Ms. White didn't file the final guardianship report until almost seven months after the Brother died and several months after his family found out about his passing from his assisted living home.

Director Allen writes that the ombudsman report fails to acknowledge that "perfection is ultimately unattainable" and "demands near omniscience" from OPA's public guardians. We certainly agree and acknowledge that public guardians, like any state employee, are human and that, considering the staggering caseloads they carry, mistakes can and will happen. In this case, however, omniscience was hardly necessary – OPA knew that the Brother was going to die from the moment that it was assigned as guardian. No superhuman skills were required to understand that planning for his inevitable death should have been part of the case plan. That requirement, after all, is part of OPA policies and procedures. Especially considering that the guardian, in this case, did not have to run triage for the Brother unlike the majority of OPA guardian cases – he was in stable housing and had a good system of supports.

FINDING OF RECORD AND CLOSURE

While Director Allen disputes our findings, we find nothing in his response that would warrant changing or modifying the findings. As such, the allegations will remain ***justified***. In light of OPA's acceptance of the recommendations, however, we will be closing this complaint as ***rectified***.

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