Table of Ombudsman Investigations

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Department /Agency Case Number Public Report Status Subject of Investigation Findings & Disposition	Results & Recommendations
Administration / Division of Senior Services J098-0265 No public report **Complainant alleged** that the Division of Senior Services (DSS) unfairly lacked an effective complaint system for clients of personal care services and that DSS unreasonably failed to provide the complainant with a new care coordinator. Partially Justified & Rectified	**Investigation revealed** that the agency lacked a complaint system for clients whose complaints did not fall under the Medicaid fair hearing process, so this portion of the complaint was found justified. Investigation also revealed that the agency attempted to find another care coordinator for the client but lacked authority to force care coordinators to accept particular clients. This portion of the complaint was found not supported. **The ombudsman recommended** that the agency devise in writing a system for handling complaints from clients. The agency agreed to implement the recommendation.
Administration / Office of the Commissioner A095-3231, J096-0510 Public report **Complainant alleged** that the Commissioner of Administration unfairly cancelled a $10,000 state contract to dispose of infectious medical waste from several prison facilities after another bidder protested the contract award. *See companion case under the Department of Corrections, Division of Administrative Services.* Justified & Rectified	**Investigation revealed** that the commissioner's hearing officer violated the state Procurement Code by not investigating the protest before taking the admittedly "rare" step of overturning the contract award. In addition, the ombudsman found that the hearing officer had incorrectly analyzed the documentary record before ruling against the businessman, basing his decision on the belief that the businessman had knowingly violated the bidding rules. Because the businessman was not notified of the protest, he had no opportunity to correct the hearing officer's mistake. When the businessman learned that his contract had been cancelled, he wrote to the commissioner to dispute the decision, but the letter received no response. **The ombudsman recommended** that the chief hearing officer routinely provide vendors information clarifying the bid protest appeal process and refine a checklist to ensure that vendors receive timely information about protest and appeal procedures. The agency accepted these recommendations.
Administration / General Services A2000-0324 Public report **Complainant alleged** that DGS unfairly assisted another bidder to meet Request for Proposals (RFP) specifications for leased office space in Homer while withholding similar assistance from the complainant. The complainant also alleged that DGS unfairly reneged on a commitment to notify the complainant when the state issued a subsequent RFPs for lease space in Homer; DGS did not respond to the complainant's requests for public information and, by its own inaction, created a situation that led to a lease procurement being handled as an emergency where no emergency originally existed. Partially Justified & Partially Rectified	**Investigation revealed** that the lease procurement required that the agency move in less than six weeks. However, the complainant offered space in a building which had to be moved to the complainant's undeveloped property from across state. DGS staff did not believe the building could be moved and made functional in less than six weeks. Investigation did not establish proof that the public records request had been made. Investigation further revealed that the leasing officer promised the complainant to notify the complainant of future procurements but did not adhere to that promise in a subsequent procurement. The agency argued that the subsequent procurement was an emergency because the landlord gave the agency only two weeks to leave the space. However, the investigation found that the existing office space had health and safety issues known to DGS. Additionally, DGS knew months in advance that the lease was expiring and did not issue the RFP in time to find new office space following normal procurement guidelines. **The ombudsman recommended** that DGS: inform all vendors in Homer of future lease procurements and how to be placed on the state procurement lists; give notice of protest and appeal rights when notifying bidders of bid awards and determinations that proposals are non-responsive; and use Internet technology in the case of true emergency procurements by sending notices to potential bidders via mass e-mails.
Administration / Personnel and Labor Relations A2010-0552 Public report **Complainant alleged** that Division employees did not provide him with a full copy of his personnel file after he was terminated from State of Alaska employment. The complainant wanted copies of any complaints filed against him and copies of any investigative files concerning those complaints. Justified & Rectified	**Investigation revealed**, after a protracted exchange of communications, that the agency was illegally withholding information from the complainant and not telling him which information was withheld and why the information was withheld, as required by the Alaska Public Records Statute. At the ombudsman's urging, the Division released the information, redacted to protect confidentiality and ensure privacy rights of individuals named in the information. **The ombudsman recommended** that DOP&LR should revise its policy regarding employee records to explain which files are personnel records to which the employee or former employee should have access. If there are situations where staff should consult with the Labor Relations section before providing the files, the policy should outline those situations.

	The ombudsman also recommended that all agency responses to staff requests to view their own personnel files should include a list of the types of personnel files that exist and the name of the custodian of the files. The Division agreed to implement both recommendations.
Administration / Personnel J2010-0144 Public report **Complainant alleged** that Division of Personnel's on-line application instructions are unreasonably confusing to prospective applicants and fail to achieve the purposes of the application process. Justified & Rectified	**The ombudsman found** the allegation justified and proposed that Personnel review and revise all future recruitment notices to clarify the appropriate process a prospective applicant should follow when applying for a position by U.S. mail. Because Personnel recognized the need to clearly explain the process for applicants applying by hard copy, and has clarified this information on current job postings on the Workplace Alaska website, this may prevent similar problems from recurring. Therefore, the complaint against Personnel was closed as rectified.
Administration / Public Advocacy A2014-0269 Public report **Complainant alleged** that the public guardian assigned to her brother's case failed to adequately prepare for her brother's passing, failed to notify his family of his death, and was responsible for the diminishment of his estate from extra fees to store his remains. Justified & Rectified	**The ombudsman found** that OPA was appointed guardian of the complainant's brother after he was diagnosed with terminal cancer. Several months later the ward died. **Investigation revealed** that the guardian did no end-of-life planning with the ward, nor did she undertake any efforts to locate the ward's next-of-kin. As a result, the ward's family only learned of his passing months after staff at his assisted living home located his mother and sent her some of his cards and letters with a sticky note letting her know of his passing. Additionally, because no one had authorized burial arrangements, the ward's estate was charged an additional $1000 to store his body for the four months that elapsed between his death and when his family learned of his passing and contacted the funeral home. **The ombudsman recommended** that OPA institute a tracking system to ensure that deceased wards' remains are accounted for in a timely fashion, that OPA conduct training for its workers on searching for wards' relatives and next-of-kin after appointment to a case, and that the agency reimburse the ward's estate for the extra storage fees that were incurred due to the agency's failure to authorize burial arrangements. The agency disputed the ombudsman's findings but did not provide evidence to justify changing or modifying them. Even so, the agency agreed to implement the ombudsman's recommendations.
Administration / Retirement & Benefits A2010-0281 Public report **Complainant alleged** that he had been receiving PERS disability benefits, but the Division of Retirement and Benefits stopped paying benefits only a few months after approving his application for disability. The ombudsman investigated whether the Division of Retirement and Benefits (DRB) had acted unreasonably in this instance. Justified	**Investigation revealed** that the complainant had received PERS non-occupational disability benefits. The Alaska statute providing for those benefits, AS 39.35.400, limits the Division of Retirement and Benefits (DRB) to paying twelve months of disability benefits, and then cuts off further benefits unless the beneficiary has qualified for Social Security disability. (There is an alternate twelve-month review process for PERS members who have not paid into Social Security enough to be eligible for federal disability). Non-occupational disability payments are reinstated if the beneficiary later prevails in a claim for Social Security disability. When DRB approved the complainant for non-occupational disability, he had already been out of work for seven months. He received a lump sum payment and retroactive "appointment date" for his non-occupational disability, dating back to when lost his job. Then he received monthly benefits for five months (including the month his application was approved). After those months, DRB stopped paying him because he had received the equivalent of twelve months of benefits but had not obtained Social Security disability. The complainant's application for Social Security was pending at the time DRB stopped paying him. A month later, he received the Social Security Administration's initial denial of his disability claim, which he could appeal. However, the wait time for a Social Security appeal hearing was one to two years at that point. The complainant could not afford to wait and see if his PERS benefits would be reinstated upon winning a Social Security claim. He cashed out his PERS account for short-term financial

	support and forfeited the possibility of regaining PERS disability benefits; he also forfeited a normal retirement benefit. The ombudsman concluded that the result in the complainant's case was required by existing statute. The ombudsman further concluded that the existing statute is not serving the purpose of the disability benefit program, to the extent that disability benefits should be stable and predictable, rather than subject to long interruptions tied to delays in the federal Social Security process. **The ombudsman recommended:** *The Division of Retirement and Benefits should seek amendment of AS 39.35.400 to either separate PERS non-occupational disability from the Social Security Administration's determinations, or to otherwise mitigate the effects of tying continued PERS benefits to the Social Security disability determinations.* **DRB rejected the recommendation and disagreed with the finding.** DRB responded that it believed that the restrictions on continuing benefits, as set forth in the statute, were reasonable and carried out the purpose of the program, especially because non-occupational disability benefits are expensive. In an effort to address the specific problem in this case, DRB provided numbers showing that the number of PERS disability recipients who lose benefits due to lack of a Social Security disability award is small. Out of 160 beneficiaries approved for non-occupational disability, 2005-2011, seven lost continuing benefits due to failure to obtain Social Security disability. None of the seven have had PERS disability reinstated so far. DRB also indicated that the Social Security Administration has reduced the wait times for its appeals, so that appealed claims are more likely to be resolved sooner, with less hardship to PERS beneficiaries.
Administration / Retirement & Benefits J2007-0436 No report **Complainant alleged** that the state's health insurance administrator, Premera, assured the complainant that the complainant could make partial payments on COBRA premiums, but then the Division of Retirement and Benefits contradicted Premera's earlier representation, and declared complainant's coverage invalid for the previous ten months. Discontinued as Resolved	**Investigation revealed** that Premera accepted complainant's partial premium payments for COBRA coverage for approximately 10 months, and paid numerous medical claims (including some requiring preauthorization by Premera). When Premera discovered that complainant should not have received coverage, the Division of Retirement and Benefits (DRB) stated that Premera should terminate health insurance coverage retroactively for the 10-month period, unless the complainant could make an immediate lump sum payment of all past due premiums, plus the current month. The complainant was unable to meet this demand. In the meantime, Premera began recouping payments from complainant's medical providers. The ombudsman investigator reviewed documentation provided by Premera via DRB. After some discussion, DRB persuaded Premera to absorb the cost of the unpaid 10 months of premiums -- the period during which the complainant relied on Premera's erroneous acceptance of the partial premium payments. The complainant made a lump sum payment for the months *after* Premera and DRB notified the complainant of the coverage error. Premera reinstated the complainant's coverage and reprocessed the medical providers' claims for the disputed months.
Administration / Retirement & Benefits J2008-0359 No report **Complainant alleged** R&B unreasonably and contrary to policy refused the complainant and her gravely ill husband's request to withdraw their deferred compensation funds based on medical hardship. Discontinued as Resolved	**Investigation revealed** that R&B's three-member Hardship Withdrawal Review Committee had returned the complainant's application to the director's office requesting he obtain a notarized power of attorney and additional information from the applicants. After the ombudsman contact the deputy director contacted the complainant telling her what he needed. The complainant faxed the material to R&B later that same day. The agency convened the Hardship Withdrawal Review Committee which quickly reviewed the documents and recommended approval of the complainants' application. R&B signed the approval memo and instructed the state contractor who handles the Deferred Compensation funds and disbursements, to expedite processing and return the check to the complainants the next business day.

Administration / Retirement & Benefits J2007-0117 No report **Complainant alleged** that when he retired Retirement and Benefits denied him military service credit in PERS for his six months in basic training as a National Guard recruit; more recently the agency had granted him PERS credit but only if he paid both principal and interest to buy in (retroactive payment for PERS credit). Discontinued as Resolved	**Investigation revealed** that Retirement and Benefits (R&B) had erroneously denied the complainant service credit when he first applied for it at his retirement. Upon further review, R&B determined that the complainant should receive six months of PERS service credit. The agency further determined that the complainant was *not* required to make retroactive payments to obtain the PERS credit, because under AS 39.35.340, the state does not require retroactive PERS payments from a state employee who serves on active duty and then immediately returns to state employment after military service. **Investigation also revealed** that R&B had treated National Guard veterans inconsistently. In a 1994 Attorney General's opinion, the Department of Law advised the agency that federal law required that National Guard members be granted PERS credit when they took unpaid leave from state employment to complete basic training, i.e. boot camp. The opinion was prompted by a retiree identically situated to this complainant. The agency addressed PERS service credit for one individual in 1994, but apparently did not address any other similarly situated National Guard veterans who had retired from state service. The ombudsman suggested that R&B make an effort to reach other retirees who may be similarly situated to the complainant. As of January 2008, R&B published a notice both online and in the PERS newsletter that alerts retirees to the issue and advises National Guard veterans who are PERS retirees to contact R&B if they did not receive appropriate military service credit.
Administration / Retirement & Benefits J2006-0303, J2007-0238 No report **Complainant alleged** that Retirement & Benefits ceased providing point-of-sale coordination of prescription drug benefits for dually-covered retirees, and that this resulted in inefficient extra paperwork for the retirees. The complainants are married couples who have dual coverage in the state health insurance system – each spouse is covered by first by her own policy as a former state employee and then secondarily as the spouse of another retired state employee. Dual coverage means that the state's health insurance carrier (currently Premera) is ultimately responsible for the usual covered percentage of a prescription drug's cost and for the co-payment, which is covered by the secondary policy. However, the primary and secondary policies are not being coordinated automatically (point of sale coordination). Instead, the spouse pays the co-payment at the pharmacy and then submits a paper claim form to Premera to be reimbursed. The complainants alleged that this was inefficient. Discontinued	**Investigation revealed that**, while automatic coordination of benefits (COB) is possible, it is not without significant cost and risk to the agency. Pharmacy benefits are handled by a third-party contractor (Medco) instead of directly by Premera. The Division of Retirement and Benefits (R&B) said that Medco has the capacity to provide automatic (point of sale) coordination of pharmacy benefits, but only if Retirement and Benefits provides the data to link the spouses, showing which retirees or employees are also "dependents" with secondary coverage from a spouse's policy. R&B lacks the capacity to provide up-to-date lists showing which retirees are linked as dependents of other retirees and thus dually covered. R&B reached that conclusion after R&B audited the lists of dependents and discovered that the state and the previous insurer (Aetna) had paid benefits to numerous dependents who no longer qualified. R&B concluded that it is having difficulty keeping the up-to-date lists of employees' dependents and is therefore reluctant to undertake an additional commitment to provide information. The agency's decision not to incur such costs and risk was reasonable, given the demonstrated commitment to expanding services and resources over time. **Investigation also revealed** that Aetna's apparent coordination of benefits actually resulted from mistakenly allowing a spouse to use the other spouse's insurance card when paying for prescriptions, instead of requiring the spouse to use her own (primary insurance) card.
Alaska Railroad Corp. A1989-0480 Public report **Municipalities objected** to fees the agency imposed for maintaining railroad crossing signals. Partially justified & resolved	**Investigation** revealed that although the railroad's billing method was legal, the municipalities were partially justified in their objections. The size of the increase over the previous five years was not linked to administrative support increases for crossing maintenance. **The ombudsman recommended,** and the railroad agreed, to eliminate the present method of calculating overhead costs, and that the railroad charge only for those supervisory services and employee benefits directly related to signal maintenance. The railroad agreed to restructure the rate after meeting with municipal leaders. The railroad also agreed to set up a formal appeal process to review crossing decisions. The ombudsman also recommended several other changes accepted by the railroad, including discussion with municipalities of criteria to apportion crossing costs based upon the benefits received by all involved parties. The railroad agreed to expand its Community Briefing Council, an advisory group on railroad issues, to include representatives from all Railbelt municipalities.
City & Borough of Juneau / Assessor's Office J098-0002	**Investigation revealed** that the Assessor's Office had made a good faith effort to notify business people of the filing deadline and that the municipal code requires a

Public report **Complainant alleged** that the Assessor's Office, contrary to law, overstepped its authority by charging a $25 penalty for missing the deadline to file a declaration of business property for a small business. The tax obligation to the borough was only $0.37. Justified & Rectified	$25 base penalty for those failing to file on time. Investigation also revealed that the state statute authorizing the borough tax limited any penalty to 20 percent of the taxes due. In this case, that would have been seven cents. **The ombudsman recommended** that the Assessor rescind the $25 penalty and related charges, propose amendments to the municipal code to bring it in line with state statute, and consider a policy suspending enforcement of very small debts. The City accepted these recommendations.
City & Borough of Juneau / Assessor's Office J2003-0020 Public report **Complainant alleged** that CBJ was illegally charging property tax on a building owned by a tribal council and located in a historic Indian village, because the building should be exempt from local taxes pursuant to federal Indian law. Not Supported	**Investigation revealed** that the property had been conveyed to the tribal council by the federal government, pursuant to the Alaska Native Townsite Act of 1926. Although the Townsite Act provided for issuance of restricted, tax-exempt deeds to individual Alaska Natives, the Townsite Act also allowed issuance of standard (taxable) deeds, and, in any case, did not provide for issuance of a restricted deed to a collective entity such as the council. The council's deed was not restricted. Without a specific federal restriction on the land, e.g. reservation status or a restricted deed, available legal precedent indicated that ownership by a Native council did not exempt the building from local property tax.
City & Borough of Juneau / Attorney's Office & Police Dept. J2002-0043, J2002-0044 Public report **Complainant alleged** that Juneau Police unreasonably failed to arrest or cite hunters who fired shotguns toward the complainant's home. Complainant further alleged that the CBJ Attorney's Office unfairly issued a biased report designed to excuse continued hunting in the Mendenhall Wetlands State Game Refuge, and that the CBJ Attorney's Office issued a report that overlooked the hazards posed by shotgun pellets, thereby basing its report on improper grounds. Partially Justified and Partially Resolved	**Investigation showed** that police responded to complaint in a professional and reasonable manner. Investigation also showed that CBJ was not biased, but that its report, prompted by the complainant's concerns, downplayed the danger of shotgun pellets fired from distances of 150 yards or more. Since the safety issue was central to the complainant's concerns, the ombudsman found that the report was based on improper grounds. The ombudsman found the complaint partially justified and partially resolved. The ombudsman made no recommendations.
City & Borough of Juneau / Engineering Department J094-1567 No public report **Complainant alleged** that the City acted unreasonably by failing to maintain properly a spring box system causing ground water to damage the complainant's home. Justified & Partially Rectified	**Investigation revealed** that the spring box, which was built by a previous homeowner and subsequently became part of a larger City reservoir system, had been maintained by the City to provide a water source for neighborhood firefighting. Over the years the system fell into disuse, deteriorated, and eventually clogged up and overflowed. The ombudsman determined that the damage to the complainant's home was caused, at least in part, by the overflowing spring box and that the City had a responsibility to properly decommission the system. During the course of this investigation the City made an unsuccessful attempt to resolve the problem, but then refused to take further action. **The ombudsman recommended** that the City decommission the spring box at their expense and compensate the complainant for expenses incurred in an attempt to identify the source of the overflowing water, protect the property, and replace damaged property. The agency accepted these recommendations with only minor qualifications. This investigation was closed with an overall finding of justified, partially rectified.
City & Borough of Juneau / Harbor Department J2003-0120, J2004-0075 Public report **Complainant alleged** that the harbormaster unfairly removed complainant's two rifles from complainant's boat when the harbormaster impounded the boat for nonpayment of fees. Worse, the Harbors Department delivered the rifles to the Juneau Police Department (JPD) for "safekeeping," but did not inform the complainant that JPD would destroy the rifles after ninety days. JPD then destroyed the rifles before the complainant attempted to reclaim them. *See companion case under CBJ, Juneau Police Department (JPD).* Partially Justified & Rectified	**Investigation revealed** that CBJ Harbors impounded the complainant's boat pursuant to ordinance, and followed the department's standard policy of removing and storing valuable portable goods during the impoundment. The harbormaster explained that guns were stored at the Juneau Police Department (JPD) for security. CBJ Harbors, however, did not send the rifles immediately to JPD. The rifles were still on the harbor premises when the complainant signed a repayment agreement and his boat was released to him, but Harbors staff told the complainant his rifles were at JPD because some of the staff members believed that the rifles had already been delivered to JPD. Harbors then took the rifles to JPD for storage in the JPD gun locker. CBJ Harbors did not inform the complainant of the ninety-day deadline to reclaim the rifles, because all of the Harbors staff were unaware of the deadline. Further, when Harbors delivered the rifles to JPD, Harbors did not provide JPD with a recent address or telephone number for the complainant, which hindered JPD's efforts to notify the complainant of the applicable deadline.

	The ombudsman recommended that CBJ Harbors require staff to know relevant storage deadlines when placing a boat owner's personal property off-site for storage, and that Harbors tell the boat owner about relevant deadlines, as well as telling him where the property is stored. The ombudsman also recommended that, whenever Harbors delivers a boat owner's property to JPD for storage, Harbors should also deliver their best contact information for reaching the owner. CBJ Harbors accepted both recommendations.
City & Borough of Juneau / Police Department J2003-0053 Public report **Complainant alleged** that JPD impounded his car for a $15 ticket and demanded that he pay almost $100 to retrieve the car before complainant had an opportunity to contest the ticket. Complainant then alleged that JPD allowed his impounded car to be destroyed, so that by the time complainant was vindicated in court, he no longer had a car. Complainant also said that he had been told he would be billed several hundred dollars for the cost of dismantling his car. Partially Justified	**Investigation revealed** that JPD initially impounded the complainant's car because he had allegedly left it parked on the street without moving it for several days. The citation ("streets for storage") was based on a CBJ ordinance that had been repealed. The complainant refused to pay the impoundment and storage costs before his court date, because he maintained that he was innocent and should not have to pay. The tow yard used by CBJ destroyed unclaimed cars after 30 days. Because the complainant did not have a trial within 30 days of the impoundment, the tow yard destroyed the car by the court date. The court dismissed the ticket because it relied on a repealed ordinance. **Investigation revealed** that JPD usually considered impoundment fees to be nonrefundable regardless of the outcome of the charges. JPD did explain that it would, on a case-by-case basis, refund the initial impoundment charges if it turned out that JPD had lacked probable cause for the impoundment. However, no one explained this case-by-case refund policy to the complainant when his car was impounded. Instead, complainant was left with the belief that if he paid the impoundment costs, he would never see the money again; the complainant therefore refused to pay prior to his court date. After the court hearing, JPD agreed to cover the initial impoundment costs but refused to cover costs for storage or costs incurred when tow yard destroyed the car. (The value of the car itself was minimal). CBJ, however, absorbed the disposal costs without billing the complainant. **Investigation revealed** that CBJ ordinances regarding vehicle impoundments were confusing and contradictory regarding who should bear the cost if the charges justifying the impoundment if the charges were dismissed or the defendant acquitted.
City & Borough of Juneau / Police Department J2002-0070 No public report **Complainant alleged** that Juneau Police Department (JPD) covered up the actions of a police officer assigned to the public schools who inappropriately un-holstered a weapon in a school hallway. JPD had found the incident did not happen as alleged. Not Supported	**Investigation revealed** that police reported the testimony of a student witness accurately, contrary to the complainant's claim. There was, therefore, no reason to believe that police covered up officer misconduct.
Commerce, Community & Economic Development / Alaska Energy Authority A2012-1355 Public report **Complainant alleged** that AEA improperly administered the Emerging Energy Technology Fund by allowing applicants that did not meet the basic eligibility requirements to proceed past the initial phase of the grant process, by failing to notify interested parties of several agency meetings, by failing to award grants using priorities required by AS 42.45.375(d), and creating a conflict of interest by allowing a contractor to review and make recommendations on a grant awards when its staff were involved in several of the grant proposals. Partially Justified and Fully Rectified	**Investigation revealed** that the agency did in fact allow one applicant that did not meet the eligibility requirements to proceed in the grant process and ultimately awarded that company a sizable grant. The ombudsman also found that the agency's process for notifying the public of two of its meetings was arbitrary, in that the agency failed to utilize its list-serve that had been previously used to distribute notices to interested parties. The ombudsman did not find support for the allegations that AEA failed to use the statutory priorities for awarding grants or that the agency created a conflict of interest. **The ombudsman recommended** that the agency take care to enforce the eligibility requirements and that it provide public notices for its meetings consistently in future grant cycles.
Commerce, Community & Economic Development / Division of Banking & Securities A2006-0620 No public report	**Investigation revealed** that DBS did not have a credible explanation as to why it did not release the results of its investigation to the complainant. The investigation also revealed that DBS's investigation was incomplete because it failed to interview the complainant's spouse, who was a primary witness. Also, the ombudsman concluded

Expanded summary **Complainant alleged** that the Division of Banking and Securities (DBS) refused to disclose the result of its investigation into his complaint against a financial institution. The ombudsman also investigated whether DBS's investigation was performed inefficiently, and whether DBS unfairly sent two conflicting letters about its investigation policies to the complainant. Justified	that the two conflicting letters sent to the complainant should have been reconciled. **The ombudsman recommended** that DBS re-open its investigation and then interview the complainant's spouse. The ombudsman also recommended that DBS work with the Department of Law to determine what type of information can be shared with an individual who files a complaint against a financial institution. The ombudsman further recommended that DBS release the results of its investigation to the complainant if the Department of Law determines that it would not violate any statute or regulation. Finally, the ombudsman recommended that DBS rewrite one of its regulations because it was unintelligible.
Commerce, Community & Economic Development / Corporations, Business and Professional Licensing A2010-1175 No public report **Complainant alleged** that the agency imposed an unreasonable fine and reprimand for an oversight of an obscure administrative regulation. Discontinued	**Investigation revealed** that the complaint was unsupported by the evidence reviewed. The ombudsman investigator reviewed the State Medical Board's summary of board actions from 2001-2011 since 12 AAC 40.930 was adopted to identify other physicians who have been investigated and fined for similar violations. Between 2001 and 2011, the Board cited 18 other actively licensed physicians for violating this regulatory provision. According to the number of licensed physician in Alaska (varying annually between 2,080 and 3,401) this represents approximately 0.061% of the active licensed physician population and is not indicative of a systemic issue. Of all these, the other medical professionals were universally fined $1,000 and given a written reprimand. Therefore, the similarly imposed fine on the complainant was not unreasonable or unfair, as it was similar to that imposed on other physicians.
Commerce, Community & Economic Development / Corporations, Business and Professional Licensing A2009-0919 Public report **Complainant alleged** that the Alaska Medical Board and its executive administrator had violated his due process rights and treated him unfairly. The complainant was seeking reinstatement of his professional license and believed that the Medical Board had improperly received evidence from its executive administrator and taken action without notice to the complainant. Partially Justified & Partially Rectified	**Investigation revealed** that he complainant was seeking reinstatement of his license, and appeared before the Medical Board, which voted to have its staff draft a consent agreement restoring his license. However, the following day, the Medical Board received additional information from its executive director. Then the Medical Board voted a second time and decided against the consent agreement until the complainant satisfied additional prerequisites. The complainant had no notice of the second vote, and did not learn of the change until almost three months later. The ombudsman found that the Board had acted unfairly. Although the Medical Board's actions were probably legal, they represented poor administrative practice. **The ombudsman recommended** that the Medical Board should inform an applicant or licensee when the Board may reconsider previous action that would change the individual's circumstances. The ombudsman also recommended that the Medical Board contact an applicant or licensee whose case may come before the Board at a meeting so that the individual has an opportunity to be present. The director of the Department of Commerce, Community and Economic Development responded on behalf of the Medical Board, and accepted Recommendation 1. The director indicated that the Medical Board would consider Recommendation 2.
Commerce, Community & Economic Development / Division of Community Advocacy A2004-0614 Public report **Complainant alleged** that the Division of Community Advocacy (DCA) unreasonably placed the Lower Kuskokwim Economic Development Council (LKEDC) in the Tier I funding category of the Alaska Regional Development Organization (ARDOR) program without giving it an opportunity to fulfill the Tier II requirements. **Complainant also alleged** that DCA unfairly created a conflict of interest by appointing persons to the ARDOR tier review committee who were also executive directors of agencies applying for ARDOR funding. **Complainant further alleged** that DCA unreasonably required ARDORs to provide costly financial reports and penalized ARDORs that could not provide them. Partially Justified & Not Rectified	**Investigation revealed** that DCA did not give LKEDC an opportunity to fulfill the Tier II requirements before placing it in Tier I. This allegation was found justified. Investigation also revealed that DCA's appointment of ARDOR executive directors to the tier review committee appeared to create a conflict of interest because the executive directors had a personal interest in the funding outcome. DCA resolved this problem by removing the four executive directors from the review committee and replacing them with people unaffiliated with the ARDORs. This allegation was found justified and rectified. The investigation further revealed that requiring ARDORs to provide costly financial reports was unreasonable because DCA did not review them. However, the ombudsman recognized that DCA implemented the requirement in response to legislative directions. Therefore, this allegation was found partially justified. **The ombudsman recommended** that DCA should develop clear and well-written policies and procedures for administering the ARDOR program application process. The ombudsman also recommended that DCA should clearly state in writing the reasons for a denial or a decrease in funding when notifying an ARDOR of their funding level. Finally, the ombudsman recommended that DCA should develop a written appeal process for ARDORs to contest their tier assignments. DCA did not accept any of these recommendations.

Community & Economic Development / **Division of Banking, Securities & Corporations** A097-0341 Public report **Complainant alleged** that the Division of Banking, Securities, and Corporations (DBSC) unreasonably registered a business name for the complainant's business competitor that was deceptively similar to the name of the complainant's business, resulting in loss of customers to the competitor. Justified & Rectified	**Investigation revealed** that DBSC policy guidelines permitted registering business names so similar that potential customers could easily mistake one business name for another. Not long after this complaint was filed, a different business owner appealed to the superior court the same agency's decision regarding a different pair of similar business names. The Department of Law advised the agency to reverse its decision in that dispute and rule that the second name was deceptively similar to the first. The ombudsman found that DBSC's guidelines unreasonably failed to achieve the ostensible purpose of the business name registration program. **The ombudsman recommended** that the agency reverse its decision in the complainant's case also. The agency agreed not to renew the competitor's name registration when it expired, and said it would support legislation to change the standards for registering business names. In a 1999 report to the legislature, DBSC recommended that the legislature eliminate "deceptively similar" from state statutes and replace it with "distinguishable on the record." The 21st Legislature subsequently passed legislation making this change.
Community & Economic Development / **Division of Community & Business Development** J093-0854 Public report **Complainant alleged** that the former Department of Community & Regional Affairs, Division of Rural Development unreasonably failed to monitor adequately federal monies granted to the non-profit Rural Alaska Community Action Program (RurAL CAP) for a mail order artisan's catalog that directly competed with the complainant's private sector business. Complainant also alleged that the agency's support of the non-profit organization unreasonably conflicted with the state's policy of encouraging development of the private sector. Justified & Not Rectified	**Investigation revealed** that the agency had not maintained adequate verifiable data to justify continued funding of the catalog project, but had contracted for a review of the project by the University of Alaska Center for Economic Development. The agency was waiting for the results of that review to decide whether to fund the project for another year. **The ombudsman recommended** that the agency conduct a review of the catalog project to ensure full compliance with federal funding requirements, and that the agency consider bringing its project funding policies into compliance with the recommendations of the Governor's Conference on Small Business. The commissioner rejected these recommendations. This investigation was closed with an overall finding of justified, not rectified.
Community & Economic Development / **Office of Economic Development** A2006-0166, 0195, & 0196 Public report **Complainants** alleged that contrary to law, the Office of Economic Development (OED) discriminated against non-Alaska residents applying for grants from its Salmon Vessel Quality Upgrade Program (SAVQUP). Justified & Rectified	**Investigation revealed** that OED had discriminated against non-Alaska residents in violation of the Privileges and Immunities Clause of the U.S. Constitution. **The ombudsman recommended** that OED should pay out the SAVQUP grant funds to all of the non-Alaska residents who qualified after their scores were re-calculated. The ombudsman also recommended that the 2007 SAVQUP application assessment criteria should be adjusted to eliminate the discriminatory scoring. The ombudsman further recommended that future meetings of the "Fish Cabinet" should be documented in some form, whether it be by a secretary taking notes or a Board secretary taking minutes. OED accepted all three of the ombudsman's recommendations.
Community & Economic Development / **Division of International Trade & Market Development** A098-0143 Public report **Complainant alleged** that a contract between the Division of Trade & Development and the American Business Center (ABC) to represent Alaskan interests on Sakhalin Island in Russia was entered into without competitive solicitation, contrary to law, and had cost overruns in excess of $50,000. The complainant also alleged that ABC was already under contract with the federal government to provide the same services that the division contracted for, and so the division was unreasonably allowing ABC to double-bill for services already covered by federal funds. Not Supported	**Investigation revealed** that the contract was exempt from the state procurement code; therefore, the lack of competitive solicitation was not contrary to law. AS 36.30.850(b)(31) exempts contracts that are to be performed in a foreign country and that require knowledge of local customs, procedures, or laws. The contract with ABC qualified for this exemption. The division was required only to have a reasonable method of selecting the contractor, and it appeared to have acted reasonably when it selected ABC to represent Alaska trade interests. Investigation also revealed that the alleged cost overruns were contract amendments. Although such large amendment amounts would be prohibited by the procurement code, they were permissible in a contract exempt from the procurement code. Investigation further revealed that although ABC is subsidized by the federal government, it is expected to charge user fees to break even. The division's contract payments were legitimate user fees, not double-billing.
Community & Economic Development / **Local Boundary Commission**	In 2007, in order to vote to create a Home Rule Borough, a region had to meet regulatory requirements that included the presence of at least two "communities" in the

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Complainant alleged that the LBC arbitrarily found that Whitestone and the Native Village of Healy Lake are communities satisfying the requirements of AS 29.05.031(a)(1) and 3 AAC 110.045.

Complainant alleged that the LBC unfairly failed to provide accessible public notice as required by the formal policies of the State of Alaska and accepted standards of public notice to the populations affected by the proposed borough incorporation, resulting in the populations' inability to participate in the public comment and hearing process.

Complainant alleged that the LBC unreasonably failed to engage in government-to-government consultation with the tribal government of the Native Village of Healy Lake, as required by the State of Alaska policy adopted in the 2001 Millennium Agreement.

Justified & Partially Rectified

proposed Borough area. Regulations define "community" in part as a settlement of at least 25 permanent inhabitants residing in close proximity as a discrete and identifiable social unit that allows frequent personal contact. There is a presumption that a settlement does not constitute a community if public access to or the right to reside at the settlement is restricted.

Investigation revealed that LBC staff reported to the LBC that along with Delta Junction, the Native village of Healy Lake and the religious commune Whitestone met the regulatory requirements to be a community. Multiple public comments stated that Healy Lake and Whitestone were separate and removed—geographically, culturally, economically, and socially—from the residents of each settlement and from the region's population in and around Delta Junction.

The LBC then found that transportation and communication patterns reflected "a population that is interrelated and integrated with respect to social, cultural and economic characteristics and activities" However, the LBC did not specify what those patterns are. Public comment disputed that such patterns existed. The LBC did not respond specifically to these comments or reconcile conflicts between the factual record and their unsupported assertions in making their finding. Failure to specify the reason for its findings is arbitrary by ombudsman standards.

Investigation revealed that the public notice given to residents about LBC proceedings was unfair because:

- LBC notice of hearings was not written in "plain English," which prevented citizens from fully understanding and fully participating in the LBC comment process.
- The LBC did not provide notice of hearings in Russian nor did LBC provide Russian language translators at all LBC hearings on the Charter Commission business. A large portion of the affected population speaks Russian or speaks English as a second language.

Investigation revealed that while the LBC provided public notice to the Mendes Cha-Ag tribe at Healy Lake, it did not deal with the tribe on a government-to-government basis as called for in the 2001 Millennium Agreement. The Millennium Agreement is a statement of intent that the State will coordinate and cooperate with sovereign tribal governments. A guiding principle is that "as a matter of courtesy between governments, the State and the Tribes agree to inform one another, at the earliest opportunity, of matters or proposed actions that may significantly affect the other. Investigation also found that the LBC did not respond to tribal questions and complaints about the lack of state consultation.

The ombudsman recommended that LBC should pend its acceptance of the Petition while it solicits further evidence and public comment and holds at least one additional public hearing on the issue of whether or not the proposed Deltana Borough met the statutory requirement of social, cultural, and economic interrelationship and integration. The LBC should then issue an amended Final Report with the findings and conclusions reached based upon the information received. LBC rejected this recommendation, saying it was unable to recall its petition once the matter had been forwarded to the Division of Elections for a vote. The vote was held and the ballot measures were defeated by voters.

LBC subsequently amended its regulations to extend the deadline for the LBC to reconsider a decision on its own motion. LBC now can order reconsideration of all or part of its decision within 30 days after a written statement of decision is mailed. LBC also amended 3 AAC 110.660 to state that the LBC can relax a procedural requirement with a vote of at least 3 members.

The ombudsman recommended that LBC should adopt written policy and procedure for provision of "plain English" notices in compliance with State policies. The policy should utilize accepted "plain English" standards to ensure that notices are accessible to the greatest number of people. The LBC did not specifically reject this recommendation but voiced concern that accessible notices could not be issued that also complied with regulations requiring the inclusion of statutory and regulatory citations in text.

	The ombudsman recommended that LBC should adopt written policy for providing notice in languages other than English whenever the population affected by the proposed agency action includes a language minority constituting more than 5 percent of the citizens of voting age. Such policy and procedure should include the provision of translation services at all public proceedings. The LBC rejected this recommendation, citing cost considerations and an inability to determine when a language minority exists. **The ombudsman recommended** that LBC should adopt policy for government-to-government consultation with Alaska Native tribes, in conformance with the express policies of the State and DCCED. Such policy should include specific procedures for notifying and consulting with tribal governments by LBC staff and commissioners on issues affecting the tribe related to the agency action being considered. The LBC rejected this recommendation, stating that the Millennium Agreement is not legally binding or enforceable and that LBC promotes reasonable means to encourage public awareness of and participation in its proceedings.
Community & Economic Development / **Division of Occupational Licensing** A095-2677 Public report **Complainant alleged** that the Division of Occupational Licensing (DOL) unreasonably issued a guide-outfitter license to a former law enforcement officer who did not meet the qualifications for a license because of unethical conduct. Not Supported	**Investigation revealed** that the former law enforcement officer earned assistant guide credit at an earlier date despite a Department of Public Safety policy prohibiting such activity. In 1992 the Legislature passed a law prohibiting active law enforcement officers from obtaining credit toward a guide license, but this law could not be applied retroactively to experience gained prior to 1992. The Department of Law advised DOL that it did not have sufficient cause to deny the license. For these reasons, the ombudsman concluded it was not unreasonable for DOL to issue the license. This investigation was closed with an overall finding of not supported.
Community & Economic Development / **Division of Occupational Licensing** A093-0966 No public report **Complainant alleged** that an investigator for the Division of Occupational Licensing (DOL) abused his discretionary authority by failing to conduct a complete investigation into an alleged instance of nursing malpractice. The complainant also alleged the investigator's conclusion was biased. Not Supported	**Investigation revealed** that the DOL investigator arrived at a reasonable conclusion and that the evidence did not support the complainant's other allegation. However, investigation also revealed that agency guidelines on conflict of interest needed updating. **The ombudsman suggested** that DOL review its guidelines on conflict of interest. The agency director agreed to conduct such a review.
Community & Economic Development / **Division of Occupational Licensing** A098-0760 No public report **Complainant alleged** that a Division of Occupational Licensing investigator unfairly and incorrectly identified the complainant as the person who filed a licensing complaint against a physician. The complainant said another person filed the licensing complaint and the complainant was only a witness who had been promised confidentiality by the licensing investigator. Not Supported	**Investigation revealed** that the evidence did not support the complainant's allegation. The licensing investigator opened an investigation based on information gathered during a phone call from the complainant. The investigator never spoke with the person identified in the ombudsman allegation as the "real" complainant, and ombudsman investigators were never able to confirm that person existed. The complainant refused to disclose the name of the "real complainant" to the ombudsman investigator. **Investigation also revealed** the agency had no statutory or regulatory confidentiality requirements, nor were there national standards for promising confidentiality to people who report medical malpractice. The licensing investigator had discretionary authority to reveal to the accused physician the name of the person who filed the complaint because he determined that was critical to proceeding with the investigation. The investigator acknowledged discussing confidentiality with the complainant but denied promising not to disclose the complainant's name. There was no firm evidence to the contrary. **The ombudsman suggested** that the agency develop standard boilerplate text to explain confidentiality rights to complainants and witnesses. The agency did not respond to this suggestion. This investigation was closed with an overall finding of not supported.

Community & Economic Development / Division of Occupational Licensing J2000-0045 No public report **Complainant alleged** that, contrary to law, the Alaska Board of Chiropractic Examiners and the Division of Occupational Licensing denied the complainant's application to renew a chiropractic license by failing to endorse legitimate continuing education credits. The complainant also alleged that, contrary to law, the Board of Chiropractic Examiners made public confidential documents and personal information relating to the complainant. The complainant also alleged that the president of the Board of Chiropractic Examiners arbitrarily and capriciously used his official position to harass the complainant. Not Supported	**Investigation revealed** that the agencies had never denied the complainant's license renewal as alleged, but only requested more information about the complainant's continuing education courses before approving the application. Investigation also revealed that documents released by the Board of Chiropractic Examiners were public records that are accessible to anyone and may be distributed by anyone. Investigation showed that although the board president and the complainant had a personal dispute, the board president did not use his position to harass the complainant.
Community & Economic Development / Division of Occupational Licensing A1999-0018 Public report **Complainant alleged** that the Division of Occupational Licensing (DOL) unreasonably issued a professional license to a chiropractor within months of his being disciplined by a Washington State licensing board for inappropriate sexual contact with a minor. The complainant reported that the chiropractor sexually molested her children during an examination. Justified & Rectified	**Investigation revealed** that the chiropractor was first licensed in Alaska in 1972 but allowed the license to lapse in 1974. He obtained a license in Washington State in the mid-1970s, but Washington revoked his license in 1978 for inappropriate sexual contact with a minor client. The chiropractor asked Alaska to reinstate his license two weeks before the Washington license revocation took effect. At that time state licensing boards did not have an automatic mechanism to exchange information about applicants and licensees. Also, the Alaska reinstatement form did not seek information about past disciplinary actions. Subsequent Alaska renewal forms were revised to ask about disciplinary sanctions in the immediately preceding licensing period. The chiropractor was able to answer this question accurately "no," and the Washington disciplinary action went unnoted by the Alaska licensing board for over 20 years. **The ombudsman recommended** that DOL revise the chiropractic licensing renewal application form to require applicants to answer questions about any licensing actions during the applicant's entire professional history; and that the form should ask if the applicant has reported the adverse action to the Alaska DOL. DOL accepted these recommendations and asked all the professional boards to consider adding the recommended question to their forms. The boards, including the Board of Chiropractic Examiners, all agreed, and DOL revised the forms. DOL also added the recommended questions to the renewal forms for programs the division administers directly without board oversight.
Community & Economic Development / Division of Occupational Licensing J2000-0386 Public report **Complainant alleged** that the Division of Occupational Licensing used a release of information form for complaints to the Medical Board that was unreasonably intrusive, requiring the release of more confidential information about the complainant than was necessary to investigate most complaints. Justified & Rectified	**Investigation revealed** that the agency used the same release of information form for persons complaining about licensees as it did for applicants for medical licenses. This required complainants to release information about their education, litigation history, and criminal history, as well as their medical history. Investigation also showed that California, Washington, and Oregon use release of information forms requiring the release of medical records only. **The ombudsman recommended** that the agency develop a new release form limited to releases of medical, psychiatric, drug, and billing information only. The ombudsman also recommended that the agency send a copy of the new release form to the complainant, along with a letter inviting the complainant to complete the Medical Board complaint process. The agency agreed to carry out the recommendations. This investigation was closed with an overall finding of justified, rectified.
Community & Economic Development / Division of Occupational Licensing A2002-0349 Public report **Complainant alleged** that DOC issued a business license in 1998 authorizing the complainant to engage in the business of animal physical therapy for horses and dogs, and then unfairly issued a cease and desist order in 2002 after the complainant had invested in buildings and equipment to conduct the business. The complainant alleged further that the DOC investigative unit arbitrarily singled out the	**Investigation revealed** that the complainant agreed the business license clerk had referred the complainant to the state veterinary board to learn about the relationship of the proposed business activities to veterinary practice, so it appeared that the agency gave adequate and reasonable notice of the matter. There was no evidence that the clerk was biased. The decision was made on the record, though it is not clear that the complainant could have known both that the application was available for examination after the license was issued and that there was any reason to examine it. The clerk said he stated his decision plainly to the complainant and supported it by reference to the licensing examiner and the veterinary board. His decision that the technical activities required an occupational license was later seconded by the

complainant for investigation while ignoring many other businesses whose services significantly affect the health of animals. The complainant also alleged that the DOC Business License section improperly altered the complainant's license application form by scratching out the description of proposed business activities without notifying the complainant of this alteration. Not Supported	veterinary board and by an outside expert. The application form and instructions clearly advised applicants that anyone whose business activities required an occupational license was required to obtain that license before applying for a business license. As for the allegation that DOC applied standards or principles inconsistently in deciding to restrain the complainant's business activities, the proper forum in which to have pursued this argument was at the scheduled hearing on the first Temporary Cease and Desist Order and, if necessary, in court. The complainant chose on the advice of an attorney not to seek resolution of the complaint in those forums.
Community & Economic Development / Regulatory Commission of Alaska A094-0668 Public report **Complainant alleged** that a member of the former Alaska Public Utilities Commission (APUC) (now known as the Regulatory Commission of Alaska) misused state time and equipment for personal financial benefit; unreasonably failed to attend meetings and hearings; improperly engaged in *ex parte* contacts with parties who had business before the commission; and participated in commission matters in which the commissioner had a conflict of interest. The ombudsman also investigated whether the APUC unreasonably failed to restrict commissioners from initiating employment inquiries with parties to actions before the commission. Partially Justified & Rectified	**Investigation revealed** that the commissioner worked irregular hours, but the evidence did not establish that total hours worked were inadequate. The misuse of time portion of the allegation was found indeterminate. The commissioner's non-work use of the office computer was insignificant. Investigation also revealed that the commissioner missed more tariff action meetings than other commissioners but performed the required review and actions on most matters. However, in one hearing the commissioner failed to hear evidence or review the record before acting, a violation of state law. There was no evidence to support the allegation of improper ex parte contacts. Investigation also revealed that the commissioner sent a resume and inquires about possible employment to two corporations pursuing numerous cases before the commission, but no interviews or job offers resulted. The commission had no regulations forbidding employment negotiations between commissioners and parties, and it was not clear whether the commissioner violated Alaska Bar standards. However, the ombudsman concluded that the commissioner's actions created at least the appearance of impropriety and that commission guidelines on conflict of interest were inadequate. **The ombudsman recommended** that the APUC consider adopting a regulation defining the commission chair's authority, as some of the conflicts evident among commission members arose because it was unclear what authority the chair had over other commissioners (for example, in setting work hours). Since this investigation was concluded the APUC has been replaced by the Regulatory Commission of Alaska (RCA), and AS 42.04.070 defines the chair's authority. The ombudsman also recommended that the APUC consider a policy requiring commissioners to document actual work hours and consider making the commission chair the payroll certifying officer for the commissioners. The ombudsman recommended further that the APUC standardize tariff action meeting procedures and adopt a policy to ensure that commissioners decide only matters in which they have heard evidence or have read the record. The ombudsman also recommended that APUC consider drafting regulations governing ex parte contacts. Finally, the ombudsman recommended that the APUC devise guidelines for commissioners and staff seeking post-commission employment, and consider adopting regulations defining "relationship" and "conflict of interest." The APUC accepted these recommendations. This investigation was closed with an overall finding of partially justified, rectified.
Corrections A2016-0317 Public report **Complainants alleged** that DOC unfairly deemed him ineligible for furlough because of a crime he was charged with as a juvenile. He explained that he had been charged with a sexual offense but that the charge was later dismissed. Justified & Rectified	**Investigation revealed** that the inmate did, in fact, meet the furlough eligibility standards provided in DOC Policy and Procedure 818.02. However, the Department had been operating under an informal, but long-standing, practice of deeming inmates with a history of sexual offenses, whether convicted or not, as ineligible for furlough consideration. **The ombudsman recommended** that DOC revise its policy and explicitly address any eligibility restrictions for those with convictions or charges for sexual offenses. The Department agreed with the recommendation and provided a draft revised policy which was subject to approval. This did not result in the complainant being eligible for furlough but clarified the issue for many inmates who complained about the same issue.
Corrections / Division of Administrative Services A1999-0030, A1999-0032, A1999-0034, A1999-0035, J2000-0048, A2000-0115, J2000-0292 Public report **Complainants alleged** that psychological testing conducted by a	**Investigation revealed** that psychological screening is generally accepted as necessary in recruiting correctional, probation/parole, and police officers. The investigation compared DOC's screening mechanism with standards of the International Association of Chiefs of Police (IACP). DOC's psychological screening met IACP standards with two exceptions. First, DOC did not collect and evaluate follow-up data to determine whether the "suitability" ratings used in screening

Department of Corrections (DOC) contractor during the recruitment process for correctional and probation/ parole officers unfairly resulted in the withdrawal of conditional offers of employment. Complainants also alleged that the testing process was unfair because they were denied access to the results or an explanation of the results; they could not appeal the results or obtain a second opinion from another psychologist; and the interviewing psychologist exhibited bias. Some of the complainants also alleged that DOC unfairly permitted current employees to repeat the tests "until they passed." Partially Justified & Partially Rectified	applicants actually led to those applicants becoming successful corrections officers. Second, DOC did not perform adverse impact analysis to detect any improper patterns of discrimination in the selection process. **Investigation revealed** that the allegations of unfair process were not supported by the evidence. All complainants had signed a waiver explaining that the tests were administered for the benefit of DOC and applicants would not see the results. Investigation also revealed that agencies across the United States were divided about whether to allow an appeal or second opinion after a negative psychological evaluation, but many agencies did not allow an appeal and gave reasonable explanations for this. The ombudsman does not have jurisdiction over private sector contractors and therefore did not investigate the actions of DOC's contract psychologist. However, the ombudsman did review the screening process, which appeared sufficiently standardized in both questions and length to be fair. There was no evidence of a "special" retesting rule for current employees. **The ombudsman recommended** that DOC integrate its hiring and retention standards, incorporating its desired psychological characteristics into the standards. DOC's human resource office began implementing this recommendation before the final investigative report was issued. The ombudsman also recommended that DOC collaborate with its contractor to determine whether the psychological screening "suitability ratings" are validated by post-hiring outcomes and that the department analyze adverse impact data collected by the contract psychologist. DOC accepted the first recommendation. Regarding the adverse impact data, however, DOC indicated that it would review the raw data, but the department considered the sample size too small for meaningful analysis. Finally, the ombudsman recommended that DOC reconsider whether to allow applicants to appeal the psychologist's negative determination. DOC responded that it would not allow a formal appeal, but an informal appeal existed for those with complaints about the screening process.
Corrections / Division of Administrative Services A095-3231, J096-0510 Public report **Complainant alleged** that Department of Corrections (DOC), Division of Administrative Services unfairly rescinded a contract award on the grounds that the complainant submitted a late bid, even though this was due to administrative errors by the contracting agency; also, that contrary to law DOC failed to notify the complainant that the contract had been protested. *See companion case under the Department of Administration, Office of the Commissioner.* Justified & Rectified	**Investigation revealed** that DOC failed to notify the contractor that a protest had been filed, a violation of the state Procurement Code. In addition, DOC had no procedures for handling faxed solicitations for bids and proposals or for handling faxed vendor submissions. **The ombudsman recommended** that DOC purchase the supplies the businessman had purchased at DOC's direction before the agency cancelled the contract. The ombudsman also recommended that DOC develop policies and procedures for using fax machines to issue contract announcements and receive proposals and quotations from vendors. The ombudsman further recommended that the agency provide vendors more complete information on bid protests. DOC agreed to these recommendations. This investigation was closed with an overall finding of justified, rectified.
Corrections / Division of Institutions A2015-0727 Public Report **Complainant alleged** that the Goose Creek Correctional facility would not allow him to have a secured visit with the facility standards officer to ask questions on how to operate the computer legal research program contrary to agency policy and state regulation. He also complained that when he attempted to grieve and appeal the issue following DOC's grievance and appeal process, the standards staff improperly screened his grievances. Justified, Partially Rectified	**Investigation found** both allegations justified. The ombudsman made the following recommendations: **Recommendation 1**: DOC should ensure that both staff and inmates who provide law library assistance to inmates are trained on how to conduct research through the LexisNexis program. **Recommendation 2**: DOC should provide the complainant and all inmates access to a copy of a simple reference guide to assist with legal research. **Recommendation 3**: The facility standards sergeant and superintendent should attend training at the DOC academy with a focus on the due process of grievances, disciplinary procedure, and appeals. DOC's interim commissioner accepted all of the ombudsman's recommendations and DOC held a two-day training for management staff on the due process of grievances, disciplinary procedure, and appeals. After the final report was issued, the facility's superintendent and standards sergeant objected to the ombudsman's findings and requested that she review additional

	evidence. The ombudsman agreed to review this information. After carefully reviewing the additional evidence provided by Goose Creek staff, the ombudsman ultimately concluded that it would not have changed the ombudsman's investigative findings, had it been timely provided by Goose Creek staff in response to the ombudsman's preliminary report. The ombudsman added a fourth recommendation based on the Goose Creek staff's responses to the report and included their written objections in an amended final report: **Recommendation 4**: The superintendent should ensure that segregated inmates are provided secure visits with a trained law librarian, whether this position is filled by another inmate or manned by standards staff. The ombudsman closed this complaint as justified and partially rectified based on DOC's acceptance and implementation of Recommendations 1, 2, and 3. The ombudsman will follow-up with the facility superintendent to verify if he has implemented Recommendation 4.
Corrections / Division of Institutions A2015-0320 Public Report **Complainant alleged** that DOC kept him in solitary confinement, based on a request from the U.S. Marshal Service, for over a year without holding a real hearing on his placement. Justified, Not Rectified	**Investigation revealed** that, although DOC held a classification review hearing monthly as required by departmental policy, the hearing was pro forma. DOC failed to provide the inmate with the U.S. Marshals' request to hold him in solitary, which was the only piece of evidence against him. Additionally, the ombudsman could find no authority in statute, regulation or departmental policy allowing DOC to defer its responsibility to classify an inmate to an outside entity, such as the U.S. Marshal's. **The ombudsman recommended:** ***DOC should immediately provide the Complainant with an administrative segregation review hearing that comports with DOC policy and provides sufficient due process.*** DOC failed to respond to the report and the inmate was subsequently transferred out of DOC custody. The recommendation was effectively mooted by DOC's failure to respond before the inmate was transferred. As such, the ombudsman offered the following alternative recommendation: ***DOC should immediately stop its practice of deferring to U.S. Marshals' requests to house federal inmates in solitary confinement. If DOC is holding federal inmates in solitary confinement pursuant to a U.S. Marshals Service request, DOC should immediately schedule administrative segregation classification hearings for those inmates that comports with the basic tenets of due process.***
Corrections / Division of Institutions A2014-0895, -1059, -1275 Public Report **The Complainant** was one of three inmates at Palmer Correctional Center who complained that their rights to due process of law had been violated in prison disciplinary hearings that all arose from a single alleged incident. The complainants each stated that they had been found guilty of attempt to escape based on the word of an unnamed confidential informant. The complainants asserted that they were denied an opportunity to question the informant and to call witnesses in their favor. The complainants asserted that they could not defend themselves, because they were not told what specific acts they had allegedly committed constituted an offense, or when and where any misconduct had occurred. Justified, Not Rectified	**Investigation revealed** that the complainants were among seven inmates who had each been accused and found guilty at consecutive disciplinary hearings of attempting to escape from Palmer Correctional Center (PCC). The accusations had originated from an anonymous confidential informant. While the informant had stated that the seven inmates were planning to escape, he did not say how he knew this, or what any of the inmates might have actually done to further a conspiracy. There was no evidence that any of the inmates had ever spoken to each other, or anyone, about escaping, or taken any steps that would indicate intent to escape. There was no evidence to contradict inmates' assertions that some of them didn't even know each other. Analysis of the evidence presented at the hearings showed that there was absolutely no credible evidence linking any of the seven accused inmates to any act of possible misconduct. The three inmates who complained had asked to question the confidential informant. These requests were denied. The inmates were not allowed to pose questions to the informant in writing, or to have the informant questioned by the disciplinary committee outside of their presence. Relevant questions to the correctional officer who had supposedly investigated the matter were overruled as irrelevant. One inmate's request to question a witness in his favor was denied either on the grounds that there was no such person in custody or on the grounds that calling the witness would somehow be a threat to security, depending on whether one was listening to the hearing officer on the record or reading her written report. While this inmate had offered information that might have exonerated all of the accused inmates, the facility made no effort to investigate this information.

	Contrary to state law, the disciplinary committee did not make any findings of fact to explain what it believed the inmates did and why it believed they were guilty. While the facility has the burden of proving allegations by a preponderance of the evidence, in this case there was no credible evidence to link any of the inmates to any act of misconduct. Because they did not know what acts they were being accused of, the inmates were not able to defend themselves, nor were they able to prepare effective appeals. Also contrary to state law, the committee did not state orally on the record why it was not calling the informant as a witness, or prepare a written report documenting its reliance on a confidential informant. The inmates' administrative appeals to the facility superintendent and then to the director of institutions were cursorily denied with no indication that they had been given any consideration at all. The Ombudsman found the allegations to be justified. After one inmate appealed to the superior court, the Department attempted to conduct a second disciplinary hearing. When the confidential informant refused to testify or provide any other information, and the security officer who took the original accusation admitted that he did not take any steps to investigate the veracity of the informant, the hearing officer in the second hearing found that inmate not guilty. The Department then, after the Ombudsman's investigation was complete, reversed the findings against the other inmates. The Department did not provide a substantive response to the allegations of its unlawful conduct, except to say that if any inmate was unhappy he could take the matter to court. **The Ombudsman recommended** that, because of the number of other recent valid complaints about disciplinary proceedings at PCC, the Department review all suspect disciplinary proceedings at PCC from the last year, and develop a plan to ensure that future disciplinary actions at PCC would be based on sound evidence and conducted according to law. The Ombudsman stated that this plan should consist of more than mere additional training for hearing officers, and that the department should consider whether administrative hearings should be conducted by persons other than corrections officers. The Department stated that it agreed with these recommendations, but at the same time indicated it was doing nothing more than reversing the guilty findings for the inmates in this case, and giving the hearing officers involved a one-day training session. With no plans in place to monitor future cases, the Ombudsman has no basis to conclude that any substantive change has taken place at PCC. The inmates in this case were punished with, among other penalties, lengthy periods of solitary confinement, based on unlawfully conducted proceedings, with no credible evidence of wrongdoing having been presented, and their appeals had been essentially ignored. The Ombudsman recommended that the Department at least apologize for its unlawful actions and unjustified punishment. The Department rejected this recommendation without comment, except to say that merely reversing the guilty findings against the inmates was sufficient. The Ombudsman observes that the punishment that has already been wrongly inflicted cannot be undone, and notes that it is difficult to regain confidence in the Department when it refuses to acknowledge and be held accountable for its unlawful acts and wrongful infliction of punishment.
Corrections / Division of Institutions A2014-1425 Public Report **Complainant alleged** that the Palmer Correctional Center superintendent unlawfully reversed a disciplinary board's acquittal of the complainant and imposed solitary confinement. Justified, Not Rectified	**Investigation revealed** that the complainant was charged twice for the same short series of events involving a contract employee of the institution, and that the person who had written the charging document was not the person with direct knowledge of the alleged incident, as the law requires. The Disciplinary Board found the complainant guilty of one of the charges and not guilty of the other because the second charge arose from the same incident. The inmate did not appeal the dismissal of the second case, but weeks later, after the appeal period had run, the superintendent on her own motion reversed the not guilty finding and imposed 20 days of punitive segregation, loss of commissary access, and loss of good time on the complainant. This violated regulations which state that only a Disciplinary Board can impose sentences. If an inmate appeals, a superintendent can reduce punishment or reverse a finding of guilt, but not reinstate a charge that has been dismissed or increase punishment. In this instance the case was not even properly before the superintendent, because the inmate had not appealed. The complainant appealed the wrongful reinstatement of the

	accusation up to the director of institutions but the appeal was denied at all levels. The ombudsman found the complainant's allegations ***justified*** and made the following recommendations: ***Recommendation One: The superintendent's decision to reverse the hearing officer's ruling and impose punishment in case 14-009 should be vacated.*** **DOC responded** that it agreed that the case should be vacated, but on the grounds that the inmate had been denied due process by not having his case heard a second time after the superintendent reinstated it. **The ombudsman responded** that a rehearing was not warranted because the hearing officer's final decision was not on appeal and the case was over. The Department had no authority to attempt a rehearing of this matter, and any further proceedings would be unlawful. ***Recommendation Two: The finding of guilt in case 14-008 should be reversed, because the charging document was not written by someone with knowledge of the alleged incident.*** **The Department** concurred with the recommendation and rescinded all findings as well as any classification or disciplinary actions. **The ombudsman** was pleased that the Department accepted the recommendation but concerned that the Department has not stated whether it intends to resurrect the accusation in this case with a properly prepared incident report and a new hearing. The Ombudsman will be monitoring the inmate's disciplinary files to ensure that any further proceedings are conducted in accordance with the law. ***Recommendation Three: The superintendent and the deputy director of institutions should attend the Department of Corrections training class for disciplinary hearing officers.*** **The Department** rejected this recommendation, saying it has redesigned the disciplinary process, retrained all hearing officers, and reemphasized the importance of disciplinary procedures throughout the chain of command from the Division Director to the facility Hearing Officers. **The Ombudsman** requested the Department to elaborate on its "redesign" of the disciplinary process but the department did not respond. The ombudsman noted that the principal legal error was not committed by a hearing officer, but by the PCC superintendent who, on her own motion, unlawfully resurrected a case that had been dismissed by a hearing officer, with a rationale that revealed a serious lack of understanding of the law. The Department also pointed out that the deputy director of institutions has recently retired, to which the ombudsman responded that, as the person responsible for reviewing the legal correctness of hearing officer decisions, any person holding this office, or any designated deputies, should have the most thorough understanding of the applicable law of anybody involved with disciplinary hearings.
Corrections / Division of Institutions A2014-1621 Public Report **Complainant alleged** that his right to due process of law had been violated in a prison disciplinary hearing. The complainant stated that he had been disciplined for heroin that had allegedly been found in his cell while he was in segregation. The complainant alleged that a correctional officer had taken the alleged substance home, kept it overnight, and then brought it back in to the facility the next day before testing it. The complainant stated that the contraband was not his, that he did not know how it came to be in his cell, or who had allegedly found it there. The complainant asserted that there was no way for him to defend himself because he had no information about where the material came from and what the officer had done with it while it was outside of the facility.	**Investigation revealed** that the complainant had been accused and found guilty of committing a Class A or unclassified felony while in prison. The complainant had never been told specifically which Class A or unclassified felony he was alleged to have committed. As a Class C felony, possession of heroin would not support the far more serious disciplinary finding that the complainant had committed an unclassified or Class A felony offense. **Investigation further revealed** that, contrary to well established state and federal law, the disciplinary report had not been written by the person with the most direct knowledge of the alleged incident. The disciplinary report is the charging document in a prison discipline case, and it should have been written by the person who had direct knowledge of where the alleged contraband had come from and why it was believed to have belonged to the inmate. Instead, the report had been written by an officer who had been handed the substance for placement in an evidence locker, but was not present when the material was discovered and had no direct knowledge linking it to the complainant. The agency did not call witnesses at the complainant's disciplinary hearing. The only evidence was the report. Contrary to state law, the disciplinary

Partially Justified	committee did not make findings of fact to explain what it believed the inmate did and why it believed he was guilty. Even for a Class C felony, the facility would have had to present evidence and make findings of fact before it could find the inmate guilty. **The Ombudsman recommended** that the inmate be immediately released from punitive segregation and that the findings of guilt be vacated. While the agency did not dispute that it had violated the inmate's constitutional rights, it characterized the violations as minor technicalities. The agency stated that it had conducted a new hearing to remedy the errors in the first hearing, but it did not provide documentation.
Corrections / Division of Institutions A2013-0859 Executive Summary **Complainant alleged** that two other inmates assaulted him after a corrections officer (CO) posted a message about him on a dry erase board that was visible to other inmates. He said that immediately after the CO wrote the note, other inmates started asking if he knew about the note, and if he was ratting or snitching on other inmates. Subsequently, two inmates who had read the note on the dry erase board accused him of being a snitch and assaulted him. He claimed the two inmates beat him up because the posted message implied he was giving guards information about others for preferential treatment. Justified & Rectified	**The ombudsman investigated** the Complainant's allegation and added a second allegation on her own motion: ***Allegation 1:*** *Unreasonable: Goose Creek Correctional Center staff publicly posted a note about the Complaint that led other inmates to believe he was giving GCCC guards information about the other inmates. This in turn resulted in the inmate being assaulted.* ***Allegation* 2:** *Unreasonable: Goose Creek Correctional Center staff improperly screened an inmate grievance alleging staff misconduct contrary to Department of Corrections' policy.* **The ombudsman found** both allegations justified. The ombudsman made three recommendations: The first recommendation is confidential under Alaska Statutes. It was accepted with changes proposed by GCCC that complied with the intent of the original recommendation. ***Recommendation* 2:** *The superintendent should issue a written directive to all staff prohibiting the posting of notes about inmates in areas that are visible to the inmate population.* ***Recommendation* 3:** *The superintendent should clarify with the facility standards officer that all inmate grievances alleging misconduct should be handled in accordance with existing DOC Policy 808.03.* The agency accepted the second and third recommendations.
Corrections / Division of Institutions A2013-0210 Public Report **Complainant alleged** that DOC lost his money after he was transported from a municipal jail to Anchorage Correctional Center East. He had filed a lost property report with DOC, which was denied. Partially Justified & Partially Rectified	**Investigation revealed** that the inmate was transported from the municipal jail to ACC by Alaska State Troopers. During transport, the inmate did not have access to his property. AST attested that his money was included with the inmate's property at the time of transfer. DOC, however, failed to inventory the inmate's property upon arrival at ACCE in his presence, as required by DOC policy. While the ombudsman could not say with certainty that the money was lost at ACC, rather than at some point during transit, it was more likely than not that the money disappeared at ACC. DOC reimbursed the complainant for the lost money while the complaint was still pending. Further, while this complaint was pending, the complainant's money was lost a second time during another transport from the municipal jail to ACC. This time the missing money totaled $326.38. The agency promptly reimbursed the complainant for this loss as well. The ombudsman will not release the content of its recommendations because they relate to security at the institution. The agency accepted two of the four recommendations of the ombudsman.
Corrections / Division of Institutions	**Investigation revealed** that the SCCC superintendent removed all food items from the

A2011-0242 **Complainant alleged** that the Department of Corrections (DOC) was not providing adequate food service at Spring Creek Correctional Center (SCCC) on the weekends and holidays. Complainant also alleged that the superintendent at SCCC did not follow DOC policy before removing food items from the commissary for the segregation unit. Partially Justified & Rectified	commissary purchase order for all inmates in administrative segregation. The complainant believed the superintendent failed to follow DOC policy when making this decision. Policy 808.13(A) states the use of the commissary is a privilege and not a right. The superintendent correctly followed department policy when he made his decision. He obtained approval from the director of the Division of Institutions and the Commissioner, which meets the requirements of 22 AAC 05.170. Allegation 1 was found to be not supported. **Investigation also revealed** that SCCC was in violation of DOC policy 805.01 (A) because it exceeded the amount of time between meals and provided only a piece of fruit as a snack on weekends and holidays. Investigation showed all other DOC institutions provided a more substantial snack. The investigation also showed DOC had not followed its policy 805.01(B)(2) requiring a qualified nutritionist to review the master menus and the modified menus for each facility annually. Allegation 2 was found to be justified. **The Ombudsman recommended** that Spring Creek Correctional Center review its institution's meal times to ensure no more than 14 hours elapses between the next meal or snack as required by DOC policy 805.01, and that DOC Division of Institutions have a qualified nutritionist review the master menus at all DOC institutions to ensure adequacy of food services. The nutritionist should review SCCC policy to determine whether serving a single piece of fruit as a snack meets the 14-hour rule.
Corrections / Division of Institutions A2010-0601 Public report **Complainant alleged** that staff at the Mat-Su Pretrial facility withheld her epilepsy medications when she arrived, causing her to suffer a seizure, fall, and gash her head. This complaint is related to A2010-0600 against the Alaska State Troopers. Not Supported	**Investigation revealed** that the Trooper who searched the complainant's vehicle inventoried a variety of medications, over the counter medications, and empty prescription bottles but did not list Keppra, an epilepsy mediation. On the complainant's Criminal Remand Screening form, the MSPT staff noted "Meds to be brought in tonight." Nothing in the DOC records indicated that the staff took custody of any medications arriving with the Complainant. Finally, the Complainant told a treating hospital physician treating her for the laceration that "…she has been on antiepileptic medication but is not currently on anything." The physician gave her a dose of Keppra, a dose of another anti-seizure drug, and a painkiller. He also wrote her a prescription for Keppra with instructions to take it twice daily, and directed a large daily dose of Ibuprofen. The jail nursing staff began providing the medicines to her the next day. There was no proof that the complainant had entered the jail with the medication. DOC policy calls for the medical staff to administer medication only when they can prove an inmate has a medical condition or when proof can be presented in the form of outside medical records. Neither happened in the short time the complainant was remanded. While the ombudsman did not find fault with the agency in this case, the ombudsman did determine that the State of Alaska has no requirement that public employees such as Corrections or AST notify the Division of Motor Vehicles when they learn a person has suffered a seizure while driving. The ombudsman suggested to the three commissioners that they confer and possibly offer information to legislators considering HB 149 which would allow anyone, including physicians, to report drivers with a medical or other condition that could, in their opinion, impair the ability of a driver to safely operate a vehicle. In making this suggestion the ombudsman did *not* suggest the departments lobby for or against this bill, just that they consider this an opportunity to discuss the issue. Alaska also has looming on its horizon an increase in the number of citizens over 65 years of age, a demographic in which chronic medical impairment becomes more common. It would seem in the best interests of the Department of Public Safety and DMV to consider these problems before they become endemic.
Corrections / Division of Institutions J2008-0161 Public report **Complainant alleged** that DOC was not providing appropriate medication for her multiple sclerosis. She stated that since her incarceration she had not received any of the medications usually	**Investigation revealed** that the inmate arrived in DOC custody with a known diagnosis of MS and remained there almost a year before receiving appropriate medication. DOC had the inmate in custody continuously starting July 2007, but the inmate did not receive appropriate medication until July 2008. **Investigation also revealed** that DOC staff did not follow procedures to ensure the pharmacy did not run out of the muscle relaxant and then decided not to obtain an

prescribed to delay the worsening of multiple sclerosis. She also complained that Lemon Creek Correctional Center had run out of the muscle relaxant that LCCC medical staff had been prescribing for her symptoms, and had not refilled it for several days, causing her to suffer muscle spasms and difficulty swallowing. Justified	interim supply of the medication from a private sector pharmacy. As a result, the inmate suffered unnecessarily due to DOC inefficiency. **The ombudsman made the following recommendations:** Recommendation 1: Upon sentencing, DOC should begin necessary medical treatment of chronic conditions immediately, instead of waiting for transfer to another institution. If recommended medical treatment cannot be obtained at the institution where the inmate is located at the time of sentencing, DOC should immediately transfer the inmate to a facility where treatment is available. Recommendation 2: DOC should not delay treatment pending sentencing when the inmate has already been convicted of a felony with a probable multi-year sentence. Proposed Recommendation 3: DOC should treat multiple sclerosis with as much attention as is provided to other chronic conditions such as diabetes. Proposed Recommendation 4: DOC should review its procedures and policies for obtaining prescription medicine for its inmates including but not limited to establishing protocol in policy and procedure for accessing and obtaining medications from a pharmacy in the community or contract pharmacy on an emergency basis or in the case of DOC pharmacy staffing shortages. Recommendation 5: DOC should establish clear policies and procedures to be followed during and after inmate transfers so that medication and treatment plans are followed as closely as possible. **DOC accepted recommendations 1-3** and stated that DOC policy already complied with recommendations 4-5. The ombudsman noted that DOC personnel failed to follow these policies.
Corrections / Division of Institutions A2008-0586 **Complainant alleged** that the Department of Corrections did not hire her due to her age. Discontinued	**Investigation revealed** that the agency neglected to inform the complainant of available appeals and explanations. The ombudsman investigator reviewed the rejection letter and noted that it lacked information concerning an informal appeals process available to a person that was rejected based on the results of a psychological evaluation. The Department of Corrections previously had accepted an ombudsman's recommendation to provide informal appeals in similar cases. While the Division of Personnel and the Department of Corrections would not agree to allow the complainant to appeal the psychological testing results, the agencies ultimately agreed that their rejection form letter needed further clarification concerning the rights of applicants. The complainant was provided with the necessary information for bringing her concerns to the Division of Personnel, and was referred to the Human Rights Commission for further investigation of her age discrimination allegation.
Corrections / Division of Institutions A2007-1411 Public report **Complainant alleged** that the Department of Corrections tested his drug sample at a more stringent standard than the 50 nanograms per milliliter specified in department regulations, leading to a failed drug test and disciplinary action against the inmate. Partially Justified & Rectified	**Investigation revealed** that the complainant had been tested at a more stringent standard, but that the inmate's sample nonetheless showed an illegal drug level in excess of the department standard, making his complaint moot. However, **the ombudsman recommended** that DOC notify its contracting laboratories of the regulatory standards for drug tests at Alaska prisons.
Corrections / Division of Institutions A2007-0557 Public report **Complainant alleged** that Ketchikan Correction Center (KCC) unlawfully removed and disposed of property from his property locker. Not Supported	**Investigation revealed** that the complainant had a woman's ring in his possession at the time he was admitted to the prison. KCC staff inventoried the property according to policy and provided the proper receipts. Later, the personal representatives of the estate of the person who rightfully owned the ring demanded return of the item as part of the owner's estate. The complainant was later convicted of murdering the owner of the jewelry. DOC has no written policy regarding this situation, so the KCC superintendent

	consulted with his superiors and the agency attorney. All agreed the property should be returned to the estate, which the superintendent did. The ombudsman determined that the superintendent acted properly.
Corrections / Division of Institutions A2007-0247 Public report **Complainant**, an inmate at the Anchorage Correctional Annex, alleged that DOC mental health staff had deprived him of the medications he had been taking prior to incarceration for the treatment of his mental illness Not Supported	**Investigation revealed** that DOC had provided the complainant with a wide range of mental health services on a regular, ongoing, and timely basis during the period in question. These services included mental health screenings upon each remand into DOC custody or transfer to a new facility; mental health consultations and/or evaluations on at least 24 different occasions; prescribing and dispensing of psychotropic medications; and case management services. In providing mental health services for the complainant, DOC also requested and reviewed his outside medical records from five different community mental health providers. **Investigation also revealed** that the complainant voluntarily took the psychotropic medications prescribed and dispensed by DOC sporadically or not at all. The ombudsman determined that DOC had met the required standard of care by providing the complainant with essential mental health care.
Corrections / Division of Institutions A2006-0344 Public report **Complainant alleged** that the Department of Corrections medical staff violated policy and procedure by failing to provide him with dentures. Not Supported	**Investigation revealed** that the complainant's lack of teeth did not affect his health and there was not enough time left in his sentence to make serviceable dentures.
Corrections / Division of Institutions A2005-0793 Public report **Complainant alleged** that DOC staff did not attend to complainant's medical needs following a traffic accident in which the complainant was injured; and that DOC transport officers failed to comply with statutes and regulations concerning highway accidents while transporting inmates. Not Supported	**Investigation revealed** that Department of Corrections transport officers questioned inmates about possible injuries and, hearing nothing to cause them to proceed to a hospital, inmates were transported to nearby correctional facility. Upon arrival at the facility, medical staff examined all passengers. The complainant's medical records showed additional examinations several days following the accident. Although this office does not have the expertise to question health care decisions, based on health care notes, it did not appear that the complainant's medical concerns were neglected. **Investigation also revealed** that Department of Corrections staff appeared to take appropriate action after assessing the condition of all passengers and the condition of the vehicle. Reports from passengers did not warrant or require an emergency room visit and the extent of damage to the vehicle did not warrant notice to Department of Public Safety.
Corrections / Division of Institutions J2004-0137 Public report **Complainant alleged** that the KCC superintendent violated state statute by refusing to allow the inmate to place telephone calls to his attorney. **Complainant also alleged** that the superintendent's action caused the inmate to miss a scheduled court hearing. Partially Justified & Partially Rectified	**Investigation revealed** that the inmate had repeatedly violated a no contact order by calling his estranged wife using other inmates' Personal Identification Numbers in violation of DOC policy. The superintendent ordered that the inmate's phone privileges be suspended for more than one month. The superintendent also refused repeated written requests that the inmate be allowed to call his attorney, in violation of AS 33.30.231(a) as well as 22 AAC 05.530 and DOC policy and procedure. Investigation also found that the superintendent took this action without issuing a written individualized determination that the inmate could appeal. This allegation was justified. Investigation found no evidence that the inmate was kept from attending any court hearing because of the restrictions. Investigators were unable to find that any hearing had been scheduled during the period of the restrictions. This allegation was not supported. DOC accepted both findings without objection. **The ombudsman recommended** that DOC should reinforce with all KCC staff the statutes, regulations, policies and procedures regarding inmate access to telephones

	for the purposes of contacting their attorneys. The ombudsman also recommended that DOC administrators issue clear directives and guidelines to superintendents on the use of individualized determinations to ensure that the superintendents articulate in writing the reason for the determination.
Corrections / Division of Institutions A2004-0077, A2004-1270 Public report Inmate **complainants alleged** that the Department of Corrections lost their cash during their transfers from local jails to the state prison system. Partially Justified & Partially Resolved, Rectified.	**Investigation revealed** tracking of cash transfers from local jails was so poor that ombudsman investigator was unable to determine what happened to complainant's money in case 0077. In case 1270, it was clear that DOC had mishandled complainant's cash, but returned it to him during the course of the investigation. **The ombudsman recommended** that DOC change its procedures for transferring cash from local jails to state correctional facilities. The commissioner agreed with the recommendation and a new policy is to go into effect January 31, 2006. That policy requires money to be transferred by check rather than in cash.
Corrections / Division of Institutions A2004-0036 Public report Inmate complainant alleged that DOC lost complainant's dentures when complainant was transferred for medical treatment. DOC refused to reimburse complainant for the loss. Not Supported	**Investigation revealed** no evidence to prove that the complainant had the dentures in his custody when remanded. The complainant had not noted in any property form that he had dentures nor had the dentures been seen or inventoried at any time where they would logically appear.
Corrections / Division of Institutions A2005-0122 Public report **Complainant alleged** that Ketchikan Correctional Center staff assaulted an inmate, which resulted in the inmate's death. Not Supported	**Investigation revealed** that the inmate was not beaten by guards or anyone else. The investigator reviewed a video recording of the inmate's cell during the last three hours of life. The inmate was alone at all times and did not show visible signs of distress. The investigator found no evidence supporting the claim of a violent death. No recommendations necessary.
Corrections / Division of Institutions J092-1773 No public report **Complainant alleged** that Department of Corrections (DOC) staff were arbitrary and inconsistent when evaluating sex offenders for release on furlough and sometimes failed to follow department policy. The ombudsman also investigated whether DOC staff acted capriciously by twice granting and then rescinding one inmate's furlough. Justified & Partially Rectified	**Investigation revealed** that miscommunication and disagreements among staff during a period of changing leadership and budget cuts led to inconsistent application of department policy. Investigation also revealed that DOC's handling of the inmate's furlough application was inconsistent and unfair. **The ombudsman recommended** that the agency develop a furlough tracking system to ensure greater consistency in decision making; that the department analyze data about released offenders to develop ways to improve programming and decision making; that DOC review its furlough policies for consistency; and that the department consider increasing follow-up treatment from one year to the 3-5 years within which, studies show, offenders are most likely to re-offend. DOC accepted these recommendations subject to availability of funds. This investigation was closed with an overall finding of justified, partially rectified.
Corrections / Division of Institutions A093-0035 No public report **Complainant alleged** that contrary to law and Department of Corrections (DOC) policy, Cook Inlet Pre-Trial facility staff failed to give notice of a classification hearing, thereby denying the complainant the right to be heard before he was re-classified to a higher security rating. Not Supported	**Investigation revealed** that the inmate had already attended one hearing, which resulted in the re-classification the inmate objected to. Thus, the complaint as presented was not supported by the evidence. However, the evidence also showed that this institution's procedure for giving notice of classification hearings was out of compliance with DOC regulations and policy. **The ombudsman suggested** that DOC review the institution's practices to ensure compliance with the law and with department policy. This investigation was closed with an overall finding of not supported.
Corrections / Division of Institutions C091-0855, C091-0891, A093-0357 No public report **Complainant alleged** that Department of Corrections (DOC) staff unreasonably harassed the complainant, an attorney, to thwart	**Investigation revealed** that SCCC staff refused to deliver a lengthy legal pleading that the complainant faxed to the inmate client via the prison's attorney fax line, explaining that agency policy limited the number of pages that could be faxed to an inmate. However, no such policy existed. Prison staff did limit access to inmate witnesses in accordance with a court order on who could be interviewed. Prison staff strip-searched a potential inmate witness known to resist strip searches; the court later ruled the

representation of an inmate who acted as co-counsel in the inmate's own defense. Specifically, the complainant alleged that Spring Creek Correctional Center (SCCC) staff violated department policy by restricting communications between the attorney and the inmate client; restricting communications between the attorney and other inmates who were witnesses; strip-searching an inmate after the attorney interviewed him; making decisions based on prejudice; and making improper comments to inmates about the attorney. *See companion case under the Department of Law, Criminal Division.* Partially Justified & Partially Rectified	search was proper. Prison staff admitted making inappropriate statements about the attorney to potential witnesses and to at least one client. **The ombudsman recommended** that DOC review its inmate strip-search policy and consider whether to make exceptions for official visits; that DOC remind staff to apply the policy consistently within each institution and statewide; and that DOC, with help from the Department of Law, implement a policy that details the conditions for visits by attorneys who are visiting an inmate other than their client. The ombudsman also recommended that DOC should caution staff to treat official or personal visitors of violent or notorious inmates appropriately; that DOC staff should not deviate from standard procedure for visiting or other communications with inmates without a documented, justifiable reason; and that the Director of Institutions should approve any change in procedure on a case-by-case basis. Finally, the ombudsman recommended that DOC and Law conduct an internal review of this matter and those outlined in companion cases and consider whether disciplinary action would be appropriate. DOC agreed with these recommendations in principle but contended that current policy and procedures were adequate if followed by staff. The department advised prison superintendents to review department policy on visits and communications by legal counsel.
Corrections / Division of Institutions J2000-0010 Public report **Complainant alleged** that Department of Corrections staff, contrary to law, mishandled cash brought to the Sixth Avenue Correctional Center by the complainant, an inmate. The ombudsman also investigated whether the agency unreasonably failed to safeguard videotape that was evidence in the complaint involving mishandled money. Partially Justified & Rectified	**Investigation revealed** no evidence that the agency mishandled the inmate's cash. This portion of the complaint was not supported. However, investigation also revealed that videotape of the complainant's booking had somehow been damaged and that the agency's procedures for safeguarding this videotaped evidence were poor. This portion of the complaint was justified. **The ombudsman recommended** that whenever the superintendent receives a complaint that touches on property inventory procedures, the superintendent should secure the videotape of the questioned property inventory in a locked cabinet with restricted access. The agency agreed to follow the ombudsman's recommendation.
Corrections / Division of Institutions A2002-0294 Public report **Complainants alleged** that Division of Institutions (DOI) correctional officers unreasonably used excessive force against complainant when trying to obtain an oral DNA sample, causing an injury. Not Supported	**Investigation revealed** that the complainant was restrained and subdued by DOC correctional officer, but investigation revealed no evidence that DOC correctional officers acted in violation of statutes, regulations, policies, procedures or that anyone used excessive, unreasonable or inappropriate force when handling the complainant in an attempt to obtain an oral DNA sample.
Corrections / Division of Institutions J2004-0047 Public report Complainant alleged that DOC neglected to inform complainant that funds in prisoner account would be forfeited if complainant left halfway house unauthorized. Not Supported	Investigation revealed that DOC policy is clear that inmates who escape will forfeit their property and inmate funds. Complainant was notified of that penalty and kept a record of that notification. DOC did not act unfairly.
Corrections / Division of Probation A2004-1138 Public report **Complainant alleged** that DOC unfairly denied the complainant a pre-release furlough to a halfway house in retaliation against the complainant for informing the agency that a correctional officer was having a sexual relationship with another inmate. The ombudsman also investigated whether DOC provided the complainant with a reasonable appeal process. Partially Justified and Rectified	**Investigation revealed** that the complainant had been furloughed after informing on a correctional officer. It was only after the complainant was sent back to prison for violating the conditions of the furlough that DOC rejected a subsequent application for furlough. DOC's denial of furlough for this complainant was reasonable under the circumstances, and the ombudsman found the first allegation not supported. However, investigation turned up a problem with the appeal process in this case. The complainant's appeal was reviewed by the same official who made the initial denial. This is unreasonable under ombudsman standards and a violation of the spirit of DOC's own policies. The ombudsman found the second allegation justified.
Corrections / Office of the Commissioner	**Investigation revealed** the complainant terminated employment with DOC in 1993. In

A098-0777 Public report **Complainant alleged** that the Department of Corrections (DOC) unfairly refused to rehire him as a correctional officer without giving a written reason, thereby depriving him of the information needed to appeal the decision. The complainant also alleged that DOC unreasonably required him to take a psychological examination required by the Alaska Police Standards Council statutes, ignoring a "grandfather" clause in the law that exempted him from the exam. Not Supported	1998 he received notice from the Department of Administration that, under the Injured Worker's Rehire Act, he was entitled to his job if he was deemed physically able to work. Enabling legislation for the Police Standards Council statute's "grandfather clause" specified that current officers, but not former employees, were exempt from the psychological exam. DOC notified the complainant in writing that he would not be rehired based on his unfavorable psychological screening. The complainant also was notified he was eligible to apply for other state positions but did not do so.
Corrections / Office of the Commissioner C090-0049 Public report **The ombudsman investigated** (based on criticism of the department by a coroner's jury) whether the Department of Corrections (DOC) had taken reasonable steps to ensure the safety of incapacitated and suicidal inmates. Indeterminate & Rectified	**Investigation revealed** that while DOC had taken important steps to detect suicidal prisoners and ensure their safety, the department was slow in some instances to revise its institutional suicide prevention policies in light of experience, and it had no unified policy for all of its correctional institutions. In addition, DOC had never systematically compiled and analyzed information about suicide attempts in the state's prison facilities. Investigation also revealed that training of department staff in suicide prevention and response procedures did not meet national best-practice standards in all respects. **The ombudsman recommended** that DOC develop a comprehensive set of policies and procedures for detection of prisoners at risk for suicide and for prevention of self-injurious behavior. The ombudsman also recommended that DOC revise its policy on Special Incident Reporting to ensure that these reports include critical incident analysis to assist in detecting problems and improving procedures. DOC agreed to these recommendations, subject to availability of funds.
Corrections / Office of the Commissioner A2004-0029 No public report **Complainant alleged** that when released from prison, complainant did not receive the $150 in gate money that had been provided to all qualified felons since the Cleary settlement agreement of 1990. In the weeks following complainant's release, complainant requested the gate money several times. Complainant said employees of the Department of Corrections (DOC) said that complainant qualified for gate money, yet complainant never received it. Justified and not rectified	**Investigation revealed** that the complainant was denied a program benefit for which complainant was qualified. Complainant's application for gate money was handled differently than others, in a manner that was inconsistent with agency policy and practice. This placed complainant at a disadvantage relative to all other felons released under the DOC gate money policy in effect through September 30, 2003.
Court System / Superior Court, **First Judicial District, Clerk of Court** J2008-0313 **Complainant alleged** that the Clerk of Court for the First Judicial District would not process the complainant's writ of execution on the PFD office despite it being timely filed for service. Discontinued	**Investigation revealed** that the complainant failed to provide the necessary certified postage to mail the documents to the PFD office. However, the Clerk of Court's office provided wrong information concerning the ability to reprocess her paperwork after she brought the required postage. The ombudsman investigator contacted the court administrator who advised that the complainant could bring her paperwork back to court and it would be processed. The Clerk of Court and court administrator accepted the investigator's suggestion that the instructions booklet for PFD attachment should be clarified further to indicate that the required postage must include the appropriate mailing fees for certified mail return receipt.
Court System / Superior Court, **Third Judicial District, Custody Investigations** A2006-0741 No public report **Complainants alleged** that the court-appointed custody investigator submitted an inaccurate custody report in the emancipation petition of the complainants' teenaged child. The report presented only the child's side, the complainants said, and failed to provide the complainants' perspective. Not Supported	**Investigation revealed** that the complainants repeatedly refused to meet with the custody investigator to talk about the child's emancipation petition. Further, the complainants supported the petition in statements to the court and during the court hearing. Because they did not provide information to the custody investigator and did not challenge the petition in court, the ombudsman found the allegation not supported. No recommendations were warranted.

Court System / Superior Court, First Judicial District, Juneau J099-0107 Public report **Complainant alleged** that juvenile probation officers in the Department of Health and Social Services unreasonably failed to enforce a judgment for restitution against a juvenile delinquent. After review, the ombudsman closed the complaint against Health and Social Services and opened a similar complaint against the Juneau Clerk of Court. The ombudsman investigated whether the Clerk of Court had unreasonably prevented the complainant from filing a petition for a writ of execution against a minor the complainant had a judgment against for restitution. Justified & Rectified	**Investigation revealed** that the Clerk of Court had prevented the complainant from filing the writ, advising the complainant to instead wait until the minor emancipated. Investigation also revealed that Alaska statutes provide for enforcement of judgments for restitution against minors. The Clerk of Court conferred with the court attorney, who advised that victims of juvenile delinquency like the complainant could file for a writ of execution. The Clerk of Court immediately invited the complainant to return to the clerk's office and file. **The ombudsman recommended** that the court system educate court staff statewide of the conditions under which a person can petition for a writ of execution against a minor. The ombudsman also recommended that the court administrator, during the next revision cycle, revise the court's writ of execution form to include a check box for "court ordered restitution against a minor." The court system accepted the recommendations. This investigation was closed with an overall finding of justified, rectified.
Court System / Superior Court, Third Judicial District, Anchorage A095-3863, A095-4448, A096-1483, A096-4578, A096-4579 Public report **Complainants alleged** that the Anchorage trial courts contributed to delay in modification of child support orders by inefficient handling of modifications cases. *See companion cases under the Department of Revenue, Child Support and Enforcement Division, and Department of Law, Civil Division.* Indeterminate & Rectified	**Investigation revealed** delays in dealing with modification-related motions, including delay in recreating paper copies of the original judicial support order from microfilm, and delay in assigning judges to modification cases. However, the Anchorage trial courts rectified or were working to remedy these matters. **The ombudsman suggested** simplification of judicial assignments in modification cases. The Anchorage trial courts accepted and implemented this suggestion before issuance of the final investigative report. The Anchorage trial courts also decided to allow clerks to signature stamp some unopposed motions, thus speeding up the process. The ombudsman also suggested that the court system work with the Department of Law and the Department of Revenue's Child Support Enforcement Division (CSED) to coordinate handling of routine modifications; explore the possibility of creating a convenient database of final support judgments and orders to speed processing when a modification is requested a few years later; and consult with CSED and Law on development of a pro se support modification packet to enable parents to seek judicial modifications on their own. The court system accepted these suggestions. This portion of the investigation was closed with an overall finding of indeterminate, rectified.
Department of Education & Early Development / Child Care Licensing A2002-0300 Public Report **Complainant alleged** that Child Care Licensing acted unfairly by failing to investigate a complaint of misconduct against two of its inspectors filed by the complainant. Justified & Rectified.	**Investigation showed** that agency failed to adequately investigate a complaint against two of its employees and failed to report back to the citizen who complained.
Department of Education & Early Development / Division of Early Development A2002-0168 Public Report **Complainant alleged** that the Division of Early Development (DED) improperly upheld denial of a Child Care Assistance “approved provider” application based on a misleading criminal history report on a resident of the household. Complainant also alleged that DED’s decision unreasonably ran counter to the purpose of the Child Care Assistance program because it resulted in denying benefits to the qualifying family. Not Supported	**Investigation revealed** that DED properly applied 4 AAC 65.185 in this case. This portion of the complaint was found not supported. Investigation also revealed that the Alaska Supreme Court had approved a nearly identical Foster Care licensing regulation, and that the Attorney General’s Office had advised DED the court’s decision applied to the Child Care Assistance regulation as well. This portion of the complaint was also found not supported.
Fish & Game J2009-0217 Public Report	**Investigation revealed** that ADF&G bore some responsibility for the complainants’ decision to begin construction.

Complainant alleged that ADF&G employees led the complainants to believe that the necessary permits for connecting a private marina to the Chilkat River were forthcoming, which convinced the complainants to spend thousands of dollars constructing a marina and access route prior to final permitting approval. The permits then were denied. The complainants also filed a related complaint against the Department of Natural Resources, which is recorded as J2009-0224. Justified	**The ombudsman recommended** that ADF&G pay one-third of the expenses incurred by the complainants for excavation and construction of the marina, restoration of the riverbank, and filling in the marina. The agency rejected the recommendation. Complainants were referred to Risk Management and their legislators for further assistance, because the ombudsman cannot enforce its recommendations.
Fish & Game / Commercial Fisheries Entry Commission A097-1749 No public report **Complainant alleged** that the Commercial Fisheries Entry Commission (CFEC) unreasonably refused to transfer a fishing permit originally owned by the complainant from one relative of the complainant to another. Not Supported	**Investigation revealed** that the complainant had once owned two limited entry fishing permits. The complainant transferred the first permit to another person two years after it was issued, and the complainant no longer owned the permit. This permit had then been transferred twice more. The current owner did not want to transfer the permit to someone else, and the CFEC lacked authority to require that she do so. The complainant sold the second permit in 1995 to another person, and the CFEC transferred it in accordance with state law. The ombudsman concluded that the CFEC had acted reasonably.
Fish & Game / Division of Administrative Services A2000-0168 Public report **Complainant alleged** that the Department of Fish & Game, Division of Administrative Services, unreasonably cancelled a solicitation for bathymetric surveys, for which her company was the apparent low bidder, after her company had already obligated itself financially to reserve the surveying equipment. The complainant alleged that the agency cancelled the solicitation because it preferred another bidder, and the complainant doubted the agency's explanation that federal funding had not been approved in time to conduct the survey. Not Supported	**Investigation revealed** that the survey project relied on a substantial amount of funding from the U.S. Geological Survey (USGS). Agency documents showed that USGS did not return the cooperative agreement to the state until after the scheduled survey period. Investigation also revealed that the state's Invitation to Bid on the survey warned prospective bidders that funding had not yet been secured for the project and cautioned them against incurring costs until they received a signed contract.
Fish & Game / Division of Wildlife Conservation A2009-1640 Public report **Complainant alleged** that DWC failed to fully disclose documents pursuant to an Alaska Public Records Act request, that DWC failed to timely disclose the documents it did provide to the complainant, and that a DWC employee violated the Executive Branch Ethics act to interfere with the complainant's efforts to establish trails in a state park. Partially Justified & Partially Rectified	After investigation, the ombudsman determined with respect to each allegation that: 1. Although DWC technically complied with the Alaska Public Records Act when fulfilling the complainant's request, the agency should have either provided the additional document the complainant sought or specified a legal basis for withholding the item, 2. That DWC did indeed fail to timely disclose documents to the complainant, and 3. That the complainant's allegation regarding the DWC employee's actions were unsupported by the evidence. The ombudsman recommended that DWC 1. Provide the withheld documents to the complainant, 2. Provide regular training sessions to staff regarding the requirements of the Alaska Public Records Act to ensure that future requests are handled timely, and 3. Consult with its Assistant Attorney General regarding public records requests to ensure that appropriate document disclosure occurs in the future. The agency accepted all of the ombudsman's recommendations and provided steps that the agency will take to fulfill the recommendations. The complaint was closed as partially rectified, however, because the agency had not fully implemented the ombudsman's recommendations.
Governor's Office **Alaska State Commission for Human Rights** A2004-0822	**Investigation revealed** that because of high caseloads, the agency pended the complaints for nearly two years but, once the investigator started her active review she proceeded steadily. Additionally, the case was further delayed when the complainant

No public report **Complainant alleged** that the Alaska State Commission on Human Rights inefficiently took too long to investigate his complaint that a State of Alaska agency (1) discriminated against him; (2) unreasonably failed to interview all witnesses the complainant recommended ASCHR talk to in reviewing his complaint, and violated AS 24.40.25.110 when it (3) denied the complainant's requests for information about ASCHR determinations in complaints about State of Alaska agencies and when it (4) refused to provide statistical information about the agency's findings in discrimination investigations involving the State. Allegation 1: Partially Justified; Allegations 2, 3, 4: Unsupported	added, then amended, a second complaint. After the ASCHR determination was issued, the complainant requested reconsideration on both complaints. His request was granted on one complaint and denied on the other, further delaying final resolution. **Investigation further revealed** that the ASCHR investigators interviewed almost all of the people named by the complainant if they had information pertinent to the complainant's specific allegations. Regarding the complainant's request for information, the ombudsman found that AS 18.80.115 barred ASCHR from releasing information about the identities of employers who allegedly had discriminated. Because the State of Alaska was an employer, that information was protected. **The ombudsman suggested** that the complainant consider contacting his legislator to discuss amending the ASCHR confidentiality provisions as they related to governmental agencies.
Governor's Office **Alaska State Commission for Human Rights** A2004-0821 Public Report Withdrawn **Complainant alleged** that ASCHR did not timely complete investigation of his complaints against a state agency. **Complainant also alleged** that ASCHR violated Alaska Public Records laws by not providing him information he asked to see. **Complainant also alleged** that ASCHR did not investigate his complaint that his supervisor fired a "cracker pistol" at him while he was working. Partially Justified	*Allegation 1: Performed Inefficiently: The Alaska State Commission on Human Rights investigation of the complainants' allegation of discrimination was inefficient.* It took ASCHR two years to commence review of this allegation and five more years to complete the review. This was found to be **justified**. *Allegation 2: Unreasonable: Alaska State Commission on Human Rights investigators did not interview witnesses that the complainant told them would substantiate his claim of discrimination.* Review found that ASCHR interviewed most of the witnesses who were named and many of them did not support complainant's complaint. ASCHR also reviewed work and training records which showed the complainant was not treated differently than others when he had minor problems at work. This allegation was found to be **not supported**. *Allegation 3: Contrary to law: The Alaska State Commission on Human Rights denied the complainant's requests for information, violating the Alaska Public Records Statute AS 40.25.110.* ASCHR has strict confidentiality provisions for releasing the identities of complainants and respondents. ASCHR adhered to those provisions when denying requests to release statistical information about State of Alaska agencies which had been subject to discrimination complaints. This allegation was found to be **not supported**. *Allegation 4: Unreasonable: The Alaska State Commission on Human Rights did not investigate the complainant's allegations that a supervisor fired a "cracker pistol" at the complainant while both were working.* Review of this allegation focused on whether ASCHR investigators ever investigated the complaint, not whether the incident actually occurred. The evidence showed that the incident occurred at the latest in 1995 and the complainant first approached ASCHR about discrimination in 1997. Nothing exists in the record to indicate he discussed the cracker pistol incident in 1997. The first documented mention of the incident was in 2000 when the complainant mentioned the incident in a letter. Under ASCHR statutes and regulations, ASCHR cannot investigate an incident that occurred more than 300 days prior to filing the complaint. Even if the complainant had raised the cracker pistol incident in 1997, the complaint was not timely. The ombudsman finds this allegation to be **not supported.** The overall complaint was found to be **partially justified**. The complaint of inefficiency was rectified by the addition of more staff. ASCHR ultimately resolved the public records request issue by providing a report to the Governor's office which, as representative of the respondent agencies, was authorized to release the information and it did so to the NAACP. The ombudsman shares the complainant's concern that ASCHR cannot release statistical information about the discrimination records of State of Alaska agencies and suggested that the complainant contact his legislators about amending the statute to allow release of statistical information about the discrimination record of State of Alaska governmental agencies.

Health & Social Services / Division of Administrative Services J096-0208, J096-1873 Public report **Complainants alleged** that the Department of Health & Social Services (DHSS) unreasonably conducted inadequate investigations of unrelated ethics violations they reported to the agency. The ombudsman also investigated whether DHSS unreasonably treated differently two persons who came forward with ethics concerns. (One of the complainants was informed of the results of the investigation while the other was not.) The ombudsman also investigated whether the agency's procedures for handling reported violations of the Ethics Act were contrary to law. Partially Justified & Rectified	**Investigation revealed** that the agency investigations into the two alleged ethics violations were adequate. The agency treated one of the complaints as a personnel complaint, which precluded revealing its disposition. The other was treated as a complaint under the Ethics Act, where reporting to the complainant is permissible. The investigation revealed that the agency had reasonable grounds for making this distinction between the two complaints. The investigation also revealed that the agency's procedures for handling ethics complaints were not in accord with the Ethics Act, because they failed to require a sworn and written complaint. **The ombudsman recommended** that the agency adopt written procedures for handling ethics complaints and provide training for its designated ethics supervisor. The agency accepted these recommendations.
Health & Social Services / Child Care Licensing J096-0206 Public report **Complainant alleged** that Child Care Program licensing workers harassed her at her daycare business by inquiring into her medical history of panic attacks in an improper manner, and improperly searched through personal papers at the facility and read a confidential note from a medical provider. Complainant also said it was unreasonable for the Child Care Program not to disclose to the public how it handled complaints about a licensing worker, and not to disclose the names of persons who file complaints against licensed child care centers. Not Supported	**Investigation revealed** that the agency had legal authority to inquire into the complainant's medical history and also that the complainant obtained the medical note to give to the agency and left it out on a counter in public view at a time when she knew the agency would be on site to inspect the facility. Personnel law prohibits disclosing personnel records. The name of a person who complains about a licensed child care center is confidential by law until an investigation is completed, at which time the name becomes public information.
Health and Social Services / Office of Children's Services A2017-0015 Executive Summary **Complainant alleged** that the Office of Children's Services (OCS) had failed to timely initiate an Interstate Compact on the Placement of Children (ICPC) request packet to assess him for placement of his great-granddaughter, who was in state custody. The ombudsman conducted a formal investigation of the following allegations stated in terms to conform to statutory guidelines for investigations by the ombudsman established in AS 24.55.150: Allegation 1: OCS failed to timely explore and consider a relative for placement of a child in state custody. Allegation 2: OCS failed to timely initiate an Interstate Compact on the Placement of Children home study request packet to assess the suitability of a relative who resides out-of-state for placement of a child in state custody. Justified & Not Rectified	**Investigation revealed** that both allegations were justified. The ombudsman made the following recommendations: **The ombudsman recommended**: 1: OCS should improve oversight to ensure caseworkers are timely exploring and considering relatives for placement. 2: OCS should improve oversight to ensure caseworkers are timely completing ICPC request packets and take immediate action to clear up the backlog of cases awaiting ICPC request packets in the Wasilla Office. 3: OCS should improve oversight to ensure that caseworkers are following up on findings and implementing recommendations made by the Quality Assurance Unit in the administrative case review process. 4: OCS should reassign this case to another caseworker and supervisor so that the great-grandfather receives prompt and fair consideration of the ICPC home study and long-term plan for his great-granddaughter. 5: The OCS Quality Assurance Unit should review the caseworker's other cases to determine if she has been meeting the Department's requirements for reasonable or active efforts, as the case demands, and for regular visitation with children. 6: The OCS Quality Assurance Unit should review whether the caseworker has received adequate supervision of her cases by her superiors. 7: OCS should apologize to the great-grandfather for the delay in initiating the ICPC process and for the misrepresentations made by the caseworker to him and the court

	about the progress of the ICPC. OCS did not concur with the findings and agreed only to Recommendation 7.
Health and Social Services / Office of Children's Services A2016-0923 Executive Summary **Complainant alleged** that his caseworker failed to timely initiate a request for a home study under the Interstate Compact on the Placement of Children (ICPC) so that he could be considered for placement with his daughter, who was in OCS custody. He also alleged that his caseworker was non-responsive to his contacts and his concerns that his daughter was unsafe in her foster placement. Justified & Not Rectified	**Investigation revealed** that the complainant's allegations were justified. The OCS caseworker delayed processing the complainant's ICPC request for more than a year, despite numerous contacts from both the complainant and his attorney to get the process moving. Shortly after the father complained to the ombudsman, the daughter was removed from her placement because her foster father was sexually abusing her. Investigation revealed that, in addition to the father's concerns, the caseworker had received reports of concern from the daughter's court appointed special advocate, her teacher, and her counselor but the caseworker failed to take action to investigate the concerns for several months. In addition, the ombudsman found that the caseworker failed to provide case planning services to the father so that he could reunify with his daughter. Lastly, the ombudsman found that OCS failed to respond to the father's grievances in accordance with state regulation and policy. **The ombudsman recommended** that OCS direct its Quality Assurance team to review the caseworker's open cases to see if her other cases are in need of attention and to determine if she has received adequate supervision from her superiors, that OCS review whether its contracted providers of psychological assessments are able to submit reports in a timely fashion, and that OCS should apologize to both the father and the daughter for the serious deficiencies in this case. OCS rejected all of the ombudsman's recommendations except for the recommendation that the agency apologize to the father.
Health and Social Services / Office of Children's Services J2011-0222 Public report **The ombudsman initiated an investigation** of OCS's implementation of its grievance procedures. The ombudsman had received multiple complaints that appeared to indicate that the OCS grievance process was not well understood and not consistently made available to complainants. The ombudsman undertook a review of the OCS grievance process, to determine whether the individual complaints actually reflected a systemic problem. The allegation, stated in terms conforming to AS 24.55.150, was as follows: *UNREASONABLE: In the administration of the Grievance Procedure under 7 AAC 54.205 – 240, the Office of Children's Services has not carried out the grievance process in a fair and efficient manner, has not adequately notified citizens of the process, has not responded consistently to grievances filed by citizens, and has not consistently responded to grievances in a timely or adequate manner.* Justified & Partially Rectified	**The ombudsman surveyed** both users of the OCS grievance process, agency caseworkers, and their supervisors. Alaska Statute (AS) mandates that OCS have a grievance procedure. As of the date of the ombudsman's report, the process is set forth in regulations at 7 AAC 54.205 – 54.240. OCS policy simply restates the regulations. The ombudsman investigator analyzed the statutes and regulations provisions governing the OCS grievance process, and also reviewed grievance regulations from other State of Alaska agencies. **Investigation revealed** that OCS did not provide any formal training regarding the grievance system, and a number of less experienced employees were unaware that the process existed. Despite the fact that OCS deals with many individuals who feel wronged by OCS at some point, grievances were surprisingly uncommon in most offices, indicating that the grievance process has not been serving as an effective dispute resolution method. There was no centralized tracking of grievances, so the children's services managers did not automatically know when a grievance was filed, or whether the grievance had been processed. Investigation revealed that OCS employees generally wanted to understand the grievance process and be able to use it. Almost all of those interviewed stated they wanted training on the topic. Also, when a grievance proceeded through all the steps to a regional panel, the children's services managers perceived the panels as providing a good quality of substantive review. Unfortunately, even the regional children's services managers, all of whom had extensive knowledge and experience with the process, regarded it as confusing and difficult to apply. The ombudsman concluded that the underlying problem is that the existing grievance regulation as a whole is poorly written. The requests for training in part reflected the excessive complexity of the regulations, and widespread confusion over how to apply the regulations arose from the regulatory language itself. **The ombudsman made the following recommendations:** **1**: The Office of Children's Services should repeal the current regulation in its entirety to the extent it applies to OCS and adopt an entirely new regulation providing for a

	grievance process. • The regulation should be as clear, simple, and intuitive as possible. • All grievances should follow a single path in all cases. • The new regulation should be entirely separated from procedures of the Division of Juvenile Justice. **2:** The Office of Children's Services should adopt a uniform agency-wide computerized tracking system to maintain a record of every grievance filed. All grievances should be numbered upon receipt and immediately forwarded to the appropriate Children's Services Manager upon receipt. **3**: The Office of Children's Services should repeal and replace the OCS Policies and Procedures Manual section for grievances. **4:** When OCS adopts the new grievance regulations and policy and procedure, OCS should implement an agency-wide training program on the grievance process. As part of this training, OCS should create and maintain Webinar training on the agency Intranet for employees to refresh their knowledge of the subject. **OCS accepted the recommendations**, with the qualification that OCS would not necessarily rewrite the grievance regulations to provide a single appeal path. OCS stated that it would begin drafting new regulations in July 2012. Also, while the ombudsman's report was pending, OCS began collecting all grievance filings at a central distribution point, so that a grievance coordinator in Juneau records the existence of each grievance before referring it to the supervisor of the regional children's services managers. In the final report, the ombudsman found the allegation justified, and concluded that OCS had partially rectified the problems, based on OCS's agreement to implement the recommendations. The ombudsman considered the complaint only partially rectified because OCS had not yet taken action to implement most of the recommendations.
Health and Social Services / Office of Children's Services A2009-0208 Executive Summary **Complainants alleged** that OCS mishandled the investigation of charges that they had physically and emotionally harmed three young relatives for whom they were providing foster care. Complainants alleged that OCS erroneously found the reports of harm to be substantiated. They also complained that, after OCS removed the children from their home, caseworkers placed the children with another relative who had abused and neglected her own children. The couple alleged that the children's caseworker failed to look into the other relative's background and reports of harm filed against her while the three foster children were in her care. They asserted that the children were not safe in this placement, and were subjected to both verbal and physical abuse by the other relative. They also complained that OCS improperly restricted their visitation with the children and refused to reconsider them as foster or adoptive parents. They further complained that the caseworker was discourteous and failed to respond to their contacts and requests for information. They sought the ombudsman's assistance in removing the OCS substantiated finding of abuse from OCS files and having the foster children returned to their care to foster or adopt. Partially Justified and Rectified	**Investigation revealed** that OCS had failed to conscientiously consider evidence that the second set of foster parents had exposed the children to domestic violence. That allegation was found to be ***partially justified***. However the ombudsman found that OCS had not mishandled investigation of the report of harm charges against the complainants and found that allegation to be ***unsupported***. The ombudsman found ***justified*** the allegation that OCS unfairly required the complainants to have supervised visitation with the children even after the Attorney General reversed the substantiated report of harm. OCS for years also did not change its on-line case management database to reflect that the finding had been reversed. The ombudsman could not determine what happened in the allegation of OCS discourtesy and found that to be ***indeterminate***. The ombudsman recommended that OCS issue a written apology letter to the complainants acknowledging its failure to amend agency records, resulting in an unnecessary requirement for supervised visitation. The ombudsman also recommended that OCS modify or amend its records to reverse the substantiated finding against the complainant, as the Attorney General's office previously indicated would occur. The agency did not dispute the ombudsman's findings and accepted both recommendations. OCS sent the complainants an apology letter acknowledging the agency's errors that lead to unnecessary supervised visitation with the foster children and failure to previously modify the agency's records to reverse a substantiated report of harm against the complainants. The agency's records have since been amended.

Health and Social Services / Office of Children's Services A2008-0409 Public report **Complainant alleged** that: (1) OCS staff in the Mat-Su office unreasonably and intentionally failed to attempt to place foster children in the complainants' home the first 15 months they were licensed foster parents. (2) OCS did not follow its own policy by not referring the complainants to the OCS adoption screening process after they became licensed foster parents and declared their desire to adopt children through OCS. (3) The OCS social worker who prepared the complainant's home study for a private adoption agency knowingly violated OCS policy 3.24.4 which prohibits such arrangements. (4) The social worker's actions in working for OCS while also contracting to work for Catholic Social Services constituted a violation of the Alaska Executive Branch Ethics Act. (5) The Office of Children's Services awarded a grant to a private non-profit social service agency to conduct home studies, while at the same time administering the agency's child placement license. Partially Justified & Rectified	**Investigation revealed:** **Allegation 1:** The complainants had become licensed foster parents with the primary goal of adopting a child through OCS. Investigation revealed that OCS had attempted several times to place children in the complainants' home during the first 15 months they were licensed foster parents. The ombudsman determined that the agency called the complainants' home "land-line" phone but the complainants didn't retrieve the messages until they returned home at night. By then the children had been placed in other foster homes. The complainants also had a narrow set of criteria for the children they would accept in their home which further limited the placement contacts from OCS. Allegation 1 was found to be ***unsupported.*** **Allegation 2:** Investigation showed that OCS was supposed to have notified its office adoption specialist that the complainants were interested in adopting a child through OCS but did not do so. The complainants also alleged the adoption specialist did not contact them after they tried repeatedly to contact the specialist. Allegation 2 was closed as justified. **Allegation 3:** Investigation showed that contrary to OCS policy and procedure the OCS social worker accepted part-time work outside the agency conducting a home study for the complainants who were also licensed OCS foster parents. Allegation 3 was found to be ***justified***. **Allegation 4:** Investigation showed that the social worker had filed an ethics disclosure form seeking permission to work outside the agency doing adoption home studies. The request was granted by the social worker's supervisors. Allegation four was found to be ***unsupported.*** **Allegation 5:** Investigation showed that the contract and grant from OCS and the social services agency was in line with Alaska Statute and procurement guidelines. Allegation 5 was found to be ***unsupported***. The complaint was closed as ***partially justified*** and ***rectified***. Investigation revealed that OCS had in part erred in this case. The ombudsman made the following recommendations, which were accepted by the agency: **Recommendation 1:** OCS should evaluate its policies as they relate to the adoption screening process and review the adoption specialists' practices in each of the five regions to determine whether they are following the intent of the policy. **Recommendation 2:** OCS should consult with Alaska Center for Resource Families (ACRF) and clear up misconceptions about any role ACRF has or does not have in adoption intake and screening for children in OCS custody. **Recommendation 3:** OCS should review the Mat-Su office's foster child placement process to determine whether this process can be administered more efficiently and effectively. **Recommendation 4:** Mat-Su OCS should require licensing staff and social workers to use the OCS ORCA database instead of the Excel spreadsheet to track foster placements for children in custody. **Recommendation 5:** OCS should implement a written standard of review to be used when considering whether they will allow the grantee to hire an applicant as a home study writer.
Health and Social Services / Office of Children's Services A2011-0026 Public report **Complainant alleged** that his daughter was in state custody for more than a year before OCS notified him. He also complained that in the 11 months since notifying him that his daughter was in state custody, OCS had failed to develop a case plan for him and did not appear to be working toward reunification of his daughter with him. Justified & Rectified	**Investigation revealed** that OCS had erred in this case. The ombudsman made the following recommendations, which were accepted by the agency: *Recommendation 1: The Office of Children's Services should conduct additional training for all agency staff regarding the requirements for identifying and locating absent parents of children in state custody. This training should emphasize the importance of initiating timely upfront and ongoing diligent searches for absent parents.* *Recommendation 2: The Office of Children's Services should improve its oversight to ensure workers are conducting timely and thorough diligent searches for absent parents.*

	Recommendation 3: The Office of Children's Services should conduct additional training for all agency staff regarding case planning requirements for parents. The training should emphasize the importance of initiating timely case planning for parents. *Recommendation 4: The Office of Children's Services should improve its oversight to ensure workers are initiating timely case planning for parents.*
Health and Social Services / Office of Children's Services A2010-1326 Public report **Complainant alleged** that the Office of Children's Services (OCS) arbitrarily demanded that he submit his children for forensic examinations and interviews to investigate for sexual abuse. During the course of investigation, the ombudsman added several additional allegations: that the agency relied on another person's criminal history when considering the complainant's case; that the agency relied on incorrect information regarding the mother's sobriety; and that OCS assigned investigation of a protective services report to the worker who filed the report. Justified & Rectified	**Investigation revealed** that the complainant's fiancée's teenage daughter was voluntarily placed out of the home because of the complainant's criminal history. The agency's case records showed that the complainant had a long history with OCS regarding his own children for allegations of neglect but not sexual abuse. Further, the agency was aware of the complainant's criminal background and had never expressed concern about possible sexual abuse. The request to interview and examine the complainant's children appeared related to the fiancée's request to have her daughter move back into the home and not related to any demonstrated safety risk involving the complainant's own children. The ombudsman found this allegation justified. Further the ombudsman found that the agency did not actually rely on the incorrect criminal conviction information contained in its file, but the ombudsman was troubled that the agency had not realized the error. The ombudsman also found justified the allegations that the agency relied on incorrect information regarding the mother's sobriety when deciding to begin a trial home visit and that the agency should not assign protective services reports to the very worker that filed the report for investigation as it appeared to present a conflict of interest. The ombudsman recommended that the agency establish official policy for conducting investigations where a caregiver is a sex offender and that the agency should reevaluate whether the mother was ready to being a trial home visit. Although the agency disputed the findings in this case, it decided to adopt and implement all of the ombudsman's recommendations.
Health and Social Services / Office of Children's Services A2010-1040 Public report **Complainant alleged** that OCS failed to timely refer a parent for random urinalysis to check his sobriety, failed to timely complete paperwork necessary for children in custody to be assessed for Fetal Alcohol Spectrum Disorder (FASD), and failed to follow up on other services for the children. **Complainant also alleged** that OCS failed to maintain minimum contact standards with children or parents, failed to provide guardian ad litem with timely information, and failed to deliver important information to case parties. Partially Justified & Rectified	Investigation revealed that OCS had erred. The ombudsman found all allegations justified but one: that OCS failed to timely refer the parent for substance abuse and mental health assessment. OCS allowed the case to fall through the cracks. The agency failed to meet minimum contact standards with the parents and children, failed to make timely referrals for services, and generally took a hands-off approach to managing the case, which was an ICWA case requiring active efforts by OCS. In spite of OCS's efforts, or lack thereof, the father was successfully reunited with his children after he took complete responsibility for his case plan and followed through on getting services without OCS's assistance. The ombudsman recommended that OCS follow its policy regarding supervisory oversight. While OCS disagreed that its policy required weekly supervisory review as its policy seemed to suggest, it acknowledged that more supervisory oversight was necessary in this case. The agency agreed that supervisory review is critical to case management and agreed to provide a refresher course to supervisors and "specific individualized coaching and mentoring will be provided to supervisors as needed based upon their track record of identifying and addressing priorities appropriately."
Health and Social Services / Office of Children's Services A2009-1454 Public report The complainant, a foster mother, complained that OCS unfairly removed foster children, who had been in her care for years, from her home without considering all relevant factors including holding a team decision meeting which would have included the children's therapist and Guardian ad Litem. During the investigation, the ombudsman added the following allegations: *Unreasonable – The Office of Children's Services failed to notify the complainant of the administrative grievance*	**Investigation showed** that one of the children told her therapist that the foster mother made them sleep in sleeping bags on the floor of their baby sibling's room; had grabbed the children by their earlobes and chins when she was correcting their behavior; and that she "badmouthed" their biological mother to them. The caseworker did not call a team decision meeting to discuss the decision to remove the children with their therapist or Guardian ad Litem, both of whom opposed the move and felt any problems with the foster mother could be corrected. The caseworker also didn't notify the foster mother that she could challenge the removal and admitted that she was unaware of that provision of OCS policy. After the ombudsman notified the foster mother of her right to appeal the removal, she did so; the Child Services Manager reversed the decision and directed the children be returned to the first foster mother's home. However, during this time the biological parents were not informed the children had been returned to the first foster mother as required by statute and OCS policy.

process available to her to contest the non-emergency removal of foster children from her home.
Contrary to Law – OCS failed to provide the parents of children in state custody with advance notice of a non-emergency placement change and their right to request a court review hearing on the decision in accordance with AS 47.10.080.
Unfair – OCS failed to provide the parents of children in state custody with advance written notice of a non-emergency placement as required by policy.
Performed Inefficiently – OCS failed to conduct thorough and timely child protective services and licensing investigations.
Performed Inefficiently and Unreasonably – OCS failed to meet the required minimum contact standards established in policies and procedures for home visits with children in foster care placement.

Investigation showed that one of the children told her therapist that the foster mother made them sleep in sleeping bags on the floor of their baby sibling's room; had grabbed the children by their earlobes and chins when she was correcting their behavior; and that she "badmouthed" their biological mother to them. The caseworker did not call a team decision meeting to discuss the decision to remove the children with their therapist or Guardian ad Litem, both of whom opposed the move and felt any problems with the foster mother could be corrected. The caseworker also didn't notify the foster mother that she could challenge the removal and admitted that she was unaware of that provision of OCS policy.
After the ombudsman notified the foster mother of her right to appeal the removal, she did so; the Child Services Manager reversed the decision and directed the children be returned to the first foster mother's home. However, during this time the biological parents were not informed the children had been returned to the first foster mother as required by statute and OCS policy.
Review also showed that the caseworker did not conduct the required number of home visits with the children in their foster home.

Justified & Partially Rectified

Review also showed that the caseworker did not conduct the required number of home visits with the children in their foster home.
Justified & Partially Rectified

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Recommendation 1: OCS should issue a written directive to all agency staff reminding them of the provisions in Alaska Administrative Code 7AAC 54.228, Foster Parent Grievances, OCS CPS Policy and Procedure 6.1.5, Grievance Procedure, that grant a foster parent the right to contest a decision by the agency to remove a foster child on a non-emergency basis using the foster parent grievance process.
OCS agreed to Recommendation 1, stating that OCS will send an all staff e-mail reminding all agency staff of the provisions of rights to foster parents, as listed in recommendation one.
The Ombudsman responded that a one-time e-mail will be of little use to caseworkers who join OCS after the e-mail is issued. The Ombudsman believes that a director's directive has more power for changing agency action than a single e-mail, especially given the high employee turnover that OCS experiences. This portion of the recommendation is ***partially justified.***

Recommendation 2: OCS should immediately revise Notice of Non-Emergency Placement Change (Form 06-9762) to include a description of the foster parent grievance process.
OCS ***declined*** to revise the form at this time, saying a contractor is analyzing OCS process related to noticing and due process advisement and this review might change how OCS does business, "OCS does not wish to make any changes now that may need to change again soon."
The Ombudsman responded that OCS CPS Policy and Procedure at 3.7, Change or Termination of a Placement/Trial Home Visit/Return Home, *requires* the agency to provide the case parties with advance written notice of the non-emergency change in a child's placement. The Notice of Non-Emergency Placement Change is the standard computer generated form letter used by OCS staff statewide to notify foster parents and case parties of a proposed non-emergency placement change. However, the notice altogether omits information about a foster parent's right to grieve an OCS decision to remove a foster child from a foster home on a non-emergency basis. In failing to provide proper written notice to affected foster parents statewide of their right to contest an agency decision to remove a foster child from their home on a non-emergency basis, OCS is effectively depriving these foster parents of their due process rights. The ombudsman also questions how difficult an undertaking it would be for OCS to add a simple paragraph to an already existing computer-generated form, no matter what other evaluation of the notification process is being undertaken.
This recommendation is ***not rectified.***

Recommendation 3: OCS should conduct training for all agency staff regarding the foster parent grievance process.
OCS ***agreed*** with this recommendation and stated OCS will remind all licensing staff of the grievance procedures for foster parents via an e-mail by October 31, 2011.
The Ombudsman's responded: Again, while the OCS response partially satisfies this recommendation, the ombudsman is concerned that a one-time e-mail will be of little use to incoming caseworkers after the e-mail is issued. The Ombudsman believes that a director's directive coupled with training has more power for changing agency action than a single e-mail, especially given the high employee turnover that OCS experiences. This portion of the recommendation is ***partially rectified.***

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Recommendation 4: OCS should revise OCS CPS Policy and Procedure 3.7, Change or Termination of a Placement/Trial Home Visit/Return Home, to include information regarding a foster parent's right to contest a decision by the agency to remove a foster child on a non-emergency basis using the foster parent grievance process.
OCS ***agreed*** with this recommendation and stated OCS will revise the policy accordingly in the next year.
Ombudsman Response: While the ombudsman is concerned about the length of time it will take to include basic information about a foster parent's appeal rights, the OCS response fulfills the intent of the ombudsman's recommendation. The ombudsman will routinely monitor OCS to ensure the policy is amended. This recommendation will be

considered to be ***rectified.***

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Recommendation 5: OCS should improve its oversight and more effectively monitor the investigation process to ensure workers are conducting timely and thorough investigations.

OCS ***agreed*** with this recommendation and stated:

> OCS will continue to endeavor to improve this oversight through supervision, supervisory staffing notes and Continuous Quality Improvement focused case reviews.

Ombudsman Response: While the ombudsman is concerned about the lack of details in the OCS response, the OCS response fulfills the intent of the ombudsman's recommendation. The ombudsman will routinely monitor OCS on this issue. This recommendation is ***rectified***.

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Recommendation 6: OCS should consider revising policies and procedures to require that investigations of protective services reports include contacts and interviews with the reporter, all witnesses to the alleged abuse or neglect incident, and age appropriate children living in the home.

OCS ***disagreed*** with this recommendation stating:

> OCS policy for conducting investigations and receiving a Protective Services Report already includes guidance for consulting with the reporter, talking to collaterals that have information about the alleged maltreatment and interviewing alleged victims and non-victims in the home.

Ombudsman Response: The intent of this recommendation was for OCS to provide additional guidance and clarification in policy regarding contacts with collateral sources in the investigation of a Protective Services Report. Current policy does not discuss follow-up contacts and interviews with reporters, if the report was not anonymous. Policy also does not specifically state that all identified witnesses to an alleged abuse or neglect should be interviewed or that other foster children living in the home should be interviewed. Because the ombudsman recommended that OCS *consider* revising policy to provide additional guidance, the recommendation will stand. This recommendation will be closed as ***not rectified***.

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Recommendation 7: OCS should conduct training for all agency staff regarding evaluation of evidence in investigations and evidential requirements for standards of proof.

OCS ***disagreed*** with this recommendation, saying only "Current practice and policy is sufficient."

Ombudsman Response: A basic part of an OCS caseworker's job is obtaining and assessing information to determine if allegations of abuse or neglect are valid. OCS responded, without supporting information, that current practice and policy is sufficient. The ombudsman is surprised that an agency which is empowered to remove children from their homes is unwilling to train its staff on how to critically evaluate evidence used in the removal. This recommendation is ***not rectified.***

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Recommendation 8: OCS should issue a written directive to all agency staff reminding them that ORCA is the agency's system of record and stressing the importance of documenting all case information, activities, and decisions in ORCA in a timely and thorough manner.

OCS agreed with this recommendation and responded that OCS will issue an all staff e-mail reminding them that ORCA is the system of record and that it is important that case information be documented in a timely manner.

Ombudsman Comment: Again, as stated in our comments in Allegations 1 and 3, the OCS response appears to satisfy this recommendation, but the ombudsman is concerned that a one-time e-mail will be of little use to incoming caseworkers after the e-mail is issued. OCS has admitted to an annual employee turnover rate of about 30 percent. The Ombudsman believes that a director's directive has more power for changing agency action than a single e-mail, especially given the high employee turnover that OCS experiences. This portion of the recommendation is ***partially rectified.***

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Recommendation 9: OCS should take steps to ensure that team conferences are held for all non-emergency placement change decisions prior to any change in placement in an effort to increase accountability and promote best interest

	decisions for children. **OCS** ***disagreed*** with this recommendation, saying: Team Decision Making meetings are already held in Fairbanks, Anchorage, and Wasilla. These are the offices that hold the majority of the cases statewide. **Ombudsman Response:** OCS's disagreed with this recommendation because "team conferences are already held in offices that hold TDM's. Yet, this case was a Wasilla Office case and OCS did not convene a team conference or TDM meeting to discuss the underlying issues and explore options to prevent a change in placement prior to the children's removal from the foster home. According to policy, a TDM meeting or team conference should have been held in this case. The Wasilla Office may routinely hold TDMs but they didn't in this case. As a result, the children were placed back in the Foster Mother' home a month later after they needlessly experienced the trauma of an unnecessary change in placement. The recommendation will stand as written and the record will show that OCS rejected this recommendation. This recommendation is ***not rectified.*** *** ***Recommendation 10: OCS should conduct training for all agency staff regarding change of placement decision-making and protocol. This training should stress the importance of placement continuity and sensitivity to the potential harmful effects of placement disruptions.*** **OCS** ***agreed*** to implement this recommendation stating it will work with the Child Welfare Academy to ensure that training regarding the importance of placement continuity is stressed. **Ombudsman Comment**: The Child Welfare Academy provides ongoing training to current and incoming workers. The OCS response appears to satisfy this recommendation. This recommendation is ***rectified.***
Health & Social Services / Office of Children's Services A2010-0265 No public report **Complainant alleged** that the Office of Children's Services changed the permanency-planning goal for the complainant's children from reunification to termination of parental rights and adoption even though the complainant completed the case plan tasks and is in compliance with her case plan. **Complainant also alleged** that OCS was not allowing the complainant adequate visitation with her children. Not Supported	**Investigation revealed** that the complainant repeatedly neglected and put her children at risk by of her drug and alcohol abuse at home and while driving. The complainant was removed from substance abuse treatment programs for non-compliance. The children's father refused to undergo psychological evaluations and was gone for extended periods, leaving his children without a caretaker. Later OCS substantiated that the father had mentally abused the children. Federal law requires that children who have been in out-of-home placement for more than 12 months be placed for termination. These children had been under OCS legal supervision for two years and in physical custody for nearly two more years when termination became the plan. The allegation concerning visitation was discontinued because a superior court judge ruled on the issue.
Health & Social Services / Office of Children's Services A2010-0048 No public report **Complainant alleged** OCS failed to adequately investigate a protective services report alleging he had sexually abused his eldest daughter, and abused his children and a young relative by driving while intoxicated. He further alleged that OCS failed to comply with the Indian Child Welfare Act (ICWA) in the out-of-home placement of his daughters; that OCS had not allowed him and his relatives to have visitation with his daughters; and that OCS had failed to obtain his consent for the medical and dental treatment of his daughters. Not Supported	**Investigation revealed** that OCS collaborated with Alaska State Troopers, the father's Native Tribe, and a Children's Advocacy Center during the investigation. That investigation included forensic interviews of both girls and a forensic exam of the eldest daughter. OCS also interviewed other relevant individuals and reviewed documentation and information it received from collateral sources. OCS sought to interview the complainant regarding the allegation of sexual abuse, but he refused. The ombudsman concluded that OCS responded appropriately and followed Alaska law and division policies and procedures in its investigation of this report. The children's out of home placement had already been reviewed and decided upon in Alaska Superior Court. The ombudsman discontinued review of this allegation. **Investigation revealed** that OCS had not allowed the complainant to have visits and had postponed visits with the relatives based on the recommendation of the children's therapist. OCS was not required to get the father's consent for minor medical and dental treatment of his daughters.
Health & Social Services / Office of Children's Services A2008-0713 No public report **Complainant alleged** that OCS had failed to ensure that its home study provider was fulfilling its contract obligations by providing timely	**Investigation revealed**: OCS acknowledged delays in the home study process and said they were caused by: an increase in the number of home study referrals; delays in the fingerprint clearance process; delays by OCS in making referrals to the contractor; the failure of OCS to adequately track outstanding home study referrals, and high staff turnover at the contract agency.

home study reports. This resulted in substantial permanency delays for children in state custody. Discontinued as Resolved	OCS staff informed the investigator that the agency had implemented several steps to resolve the problems including exploration of electronic submittal of fingerprints to the State and FBI using scanners in OCS field offices. OCS said that within the past year, the contractor had implemented several new changes with the specific goal of reducing home study delays. These included filling staff vacancies within the program; hiring additional contract home study writers; providing additional training to home study writers; streamlining paperwork requirements and revising forms; issuing monthly tracking reports and quarterly progress reports to OCS; and improving communication with its contract home study writers. The information satisfied the ombudsman that the agency is actively addressing the issue of home study delays.
Health & Social Services / Office of Children's Services A2008-0712 No public report **Complainant alleged** that OCS caseworkers were not timely notifying the Social Security Administration that children eligible for SSA benefits had returned to their parental home and that OCS was no longer the child's payee. The allegation was that the practice was contrary to SSA guidelines and resulted in substantial delays in re-directing benefits to payments to parents. The ombudsman reviewed whether OCS Central Office failed to provide sufficient information to employees on how to process SSA benefit paperwork for eligible children in state custody. Finally, the ombudsman reviewed whether OCS policy and procedure failed to provide sufficient information for employees on how to process SSA benefit paperwork for eligible children in state custody. Discontinued as Resolved	**Investigation revealed**: Ombudsman review indicated that OCS policy regarding the handling of Social Security benefits for children in state custody was insufficient. Investigation showed that the OCS practice was to wait six months to notify the SSA that a child had returned to the parental home, and that the agency was no longer responsible for the child's cost of care, and would no longer be serving as representative payee. Ombudsman research showed that these practices were contrary to the SSA guidelines. The ombudsman approached OCS with these concerns and suggestions to discontinue the practice and update policy, which OCS agreed to do.
Health & Social Services / Office of Children's Services J2008-0581 Public report **Complainant alleged** that the Office of Children's Services arbitrarily interviewed his children on school grounds without a school official present. The ombudsman also investigated whether the Office of Children's Services unreasonably failed to conduct interviews of the subjects of child-in-need-of-aid reports in a manner consistent with Alaska Statute (AS) 47.17.027 and, on occasion, in a manner that thwarted the intent of AS 47.17.027. Justified & Rectified	**Investigation revealed** that the caseworker arbitrarily decided that a school official's presence would be detrimental to her investigation, even though AS 47.17.027 creates a presumption in favor of having school officials present, with limited exceptions. The caseworker did so, not because of specific facts and circumstances indicating that an official's presence would actually interfere with these children's responses, but because of her general belief that interviewees are more forthcoming when officials are not present. A survey of 28 OCS caseworkers statewide also revealed widespread ignorance as to the statutory duty of school officials, and in some cases the importance of the statutory requirement. Caseworkers were not sufficiently trained on the statutory requirement, nor did the OCS manual address interviews on school grounds. In the 18 years since the statute was enacted, OCS had not drafted policies to provide caseworkers guidance for determining whether an official's presence would interfere. In some offices, this resulted in wholesale exclusions of school officials from all child protective services interviews taking place on school grounds, violating both the plain language and intent of AS 47.17.027. **The ombudsman recommended** the following: • The agency should re-standardize its form letter to reflect the statutory language of AS 47.17.027; • The agency should adopt a policy to specifically address and guide its caseworkers when conducting interviews on school grounds, including documenting the exclusion of school personnel in the case file; • The agency should include information on the statutory requirement when conducting mandatory reporter training in schools; • The agency should advocate for a change in the law if the agency did not feel the requirement was conducive to collecting accurate information during interviews.

	• The agency should issue a written apology to the complainant's family; The agency agreed to the majority of the recommendations. The agency, however, declined to advocate for a change in the law.
Health & Social Services / Office of Children's Services J2008-0142 No public report **Complainant alleged** OCS cancelled the complainant's foster care license without cause. Discontinued as Resolved	**Investigation revealed**: The complainant was licensed in Alaska as a foster parent for a young relative. The complainant moved to another state in 2007, and her Alaska foster care license was extended temporarily while she attempted to obtain a foster care license from that state. The complainant's Alaska foster care license expired 120 days after she moved out of Alaska before she became licensed in the other state. The Alaska OCS caseworker applied for an audit exception that allowed Alaska OCS to pay for foster care during the month the license was suspended. The complainant returned to Alaska four months after the Alaska foster license expired. In order to compensate the complainant, the caseworker paid a one-time $1100 payment to her mortgage company and submitted another audit exception for the fourth month. The payment came for the OCS special needs fund. In accordance with 7 AAC 53.120, the Office of Children Services did not err in closing the foster license 120 days after the complainant's departure. The complaint's Alaska foster license was later reinstated.
Health & Social Services / Office of Children's Services J2008-0108 Public report **Complainant alleged** that the OCS failed to serve written notice of a CINA hearing on the grandparents of a child who was the subject of the proceeding; that OCS failed to notify the court of a grandparent's request to participate telephonically at a CINA proceeding; and that OCS failed to notify a grandparent of an OCS conference concerning their grandchild, where the grandparent expressed a desire to participate in the placement decision process. *(See related case against the Department of Law, J2008-0229)* Justified & Rectified	**Investigation revealed** that OCS acted contrary to law by failing to serve written notice of a Child in Need of Aid hearing on the grandparents of a child who was the subject of the proceeding. OCS also failed to notify the court of a grandparent's request to participate telephonically at a CINA proceeding, the ombudsman found. **Investigation revealed** that OCS staff did not contemporaneously document telephone contacts with a grandparent as required by OCS policy, and did not notify a grandparent of an OCS conference about the child, when the grandparent had expressed a desire to participate in the placement process. OCS agreed with all the findings. **The ombudsman issued seven recommendations** to OCS and Law as a result of the investigation. Among them were: additional training for OCS staff; better collaboration between OCS and Law; clarification of responsibilities related to notice; and working for changes to the Alaska Rules of Court and Alaska statutes for clear and consistent procedures for the telephonic participation of non-parties in CINA proceedings. The ombudsman also provided the report to the Alaska CINA Court Improvement Committee to consider possible revisions to the Alaska Rules of Court regarding telephonic participation by non-parties or relatives. The ombudsman suggested the committee create a frequently asked questions section for CINA cases on the court's website under the Family Help section, including information on how to request telephonic participation at a hearing. The committee coordinator agreed with this suggestion and is implementing changes to the court's website. Other actions taken in response to the ombudsman report by the committee included the following: in May 2011, the committee addressed several concerns about telephonic issues, including the statewide variance in procedures parties and non-parties are asked to use. The committee is in the process of initiating a survey with judges statewide regarding their telephonic procedures. The committee is also considering publishing and posting online a reference directory for parties and non-parties to call-in for a hearing with a particular judge. The committee will also draft a CINA telephonic hearing guidelines document to provide general information about the process to participants and judges. Once finalized, this information will be posted on the court's website, anticipated completion in the summer of 2012.
Health & Social Services / Office of Children's Services A2006-0451 Public report **The ombudsman investigated** whether the changes that the Office of Children's Services (OCS) made to its food voucher security and	**Investigation revealed** that OCS had taken insufficient measures to ensure the security of the food vouchers or the accuracy of the food voucher logs. **The ombudsman recommended** that OCS should draft policies and procedures to ensure the security and accuracy of its food and transportation vouchers and voucher logs. Specifically, the policies and procedures should require an OCS staff manager to

accounting procedures were reasonable. Justified & Rectified	properly segregate the custody, authorization, and recording of the food vouchers. The policies and procedures should also provide for regular audits of the vouchers. OCS agreed to implement the ombudsman's recommendation and provided the ombudsman copies of the new policy on June 12, 2007.
Health & Social Services / Office of Children's Services A2005-1366 No public report **Complainant alleged** that the Office of Children's Services (OCS) unreasonably removed the complainant's child from her home; that OCS unreasonably removed the complainant's child from her relative placement in another state; that OCS unreasonably contacted the child protection services agency of another state to encourage it to remove the complainant's newborn child from her custody; that OCS unreasonably failed to investigate a relative's home before the complainant's child was placed there; that OCS unreasonably placed the complainant's child in a foster care family that sexually abused her; and that OCS unreasonably failed to seek the complainant's permission when it allowed the foster parents to take the complainant's child out of state on a vacation. Not Supported	**Investigation revealed** that OCS had properly removed the complainant's child from her home based on information from mandatory reporters; that OCS had properly removed the child from her placement in another state. **Investigation also revealed** that OCS had not contacted the child protective services agency of another state to encourage it to remove complainant's child from her custody; the other state acted based on the complainant's words and actions. **Investigation also revealed** that OCS had properly investigated a relative's home before placing the complainant's child there; that OCS did not place the child in a foster home that abused her; and that OCS was not obligated to seek the complainant's permission before allowing the foster parents to take the child out of state on a vacation. This investigation was closed with an overall finding of not supported and no recommendations were made.
Health & Social Services / Office of Children's Services A2003-0289 No public report **The complainants alleged** that the agency had removed their child from home for insufficient reasons. The complainants also alleged that the agency had repeatedly redefined the case plan without adequate explanation. The redefined case plans required additional and costly health care and treatment services, which they said they could not immediately afford. The complainants alleged that the repeated changes hindered their attempts to comply with the case plan and be reunited with their child. Discontinued as Resolved	**Investigation revealed** that OCS had sufficient reasons to remove the child from the complainants' home. During the course of the ombudsman investigation, OCS agreed to soften some of its less pragmatic case plan requirements and assist the complainants by providing referrals and payments to some service providers. In the meantime, the complainants continued to work their case plan diligently, and the family was successfully reunified. OCS closed its case a short time later.
Health & Social Services / Division of Family & Youth Services J099-0212 Public report **Complainant alleged** that the Division of Family & Youth Services (DFYS) unreasonably refused to approve the hiring of the complainant by a licensed care facility because of a minor incident of child abuse from nine years previous. The ombudsman also investigated whether DFYS failed to support with an adequate statement of reasons its disapproval of the complainant's employment by a licensed care facility. Justified & Rectified	**Investigation revealed** that DFYS misapplied its regulations in this instance. The investigation also revealed that the agency failed to retain records of child abuse investigations long enough to effectively administer a portion of its licensing regulations. **The ombudsman recommended** that the agency review its records retention schedule and regulations to make certain that they dovetail; establish appropriate procedures to review employees at childcare facilities; and apologize to the complainant for the way his application was handled. The agency agreed to implement these recommendations. This investigation was closed with an overall finding of justified, rectified.
Health & Social Services / Division of Family & Youth Services A098-0556 Public report **Complainant alleged** that the Division of Family & Youth Services (DFYS) Northern Region staff unreasonably reneged on promises to pay foster parents the full daycare costs for a foster child. The complainant also alleged that DFYS unreasonably treated Northern Region foster parents differently from others in the state by not	**Investigation revealed** that the evidence did not support the allegation that Northern Region staff unreasonably reneged on promises to pay foster parents the full daycare costs for a foster child, because the complainant signed a care plan stating that the foster parents and the agency would share daycare costs. Investigation also revealed that DFYS regulations allow the agency to make daycare payments for foster children in certain circumstances. DFYS central office had routinely approved requests for such subsidies for the two other regions in the state. However, Northern Region management refused to submit requests for foster child daycare subsidies. In light of inconsistent application of agency policy, this allegation was found justified.

allowing them to receive a day care subsidy for foster children. Partially Justified & Rectified	**The ombudsman recommended** that DFYS update its policy manual to say that regulations give the agency discretionary authority to pay daycare costs for foster children. The ombudsman also recommended that DFYS inform all social workers of the availability of daycare payments for foster parents. The agency accepted these recommendations. This investigation was closed with an overall finding of partially justified, rectified.
Health & Social Services / Division of Family & Youth Services A097-2190 Public executive summary issued **Complainants alleged** that the Division of Family & Youth Services (DFYS) unreasonably mishandled investigation into numerous complaints that their adult child had sexually abused their grandchild, and failed to conclude that abuse had occurred. The complainants also alleged that DFYS unreasonably did not move to terminate the parental rights of their adult child during the abuse investigation. Not Supported	**Investigation revealed** insufficient evidence to support these allegations. The allegedly victimized grandchild consistently and convincingly denied that anyone had sexually abused him; medical evidence was conflicting and inconclusive. Further, the parent often asked the grandparents to care for the child, and the grandparents ultimately obtained legal custody and thus were able to protect the child from harm. With the child in a protective environment, there was no need to consider child-in-need-of-aid action or termination of parental rights. This investigation was closed with an overall finding of not supported.
Health & Social Services / Division of Family & Youth Services A097-0982, A097-2162, A098-0245, A097-2187 Public report **Complainants alleged** that the Division of Family & Youth Services (DFYS) performed inefficiently by failing to establish in a timely manner the paternity of children taken into state custody. As a result, children were placed for substantial periods with non-relative foster parents instead of with available blood relatives. Complainants also alleged that DFYS unfairly refused to reimburse for foster care provided during the period that the complainant erroneously believed the child was a grandchild of the caretaker. The ombudsman also investigated whether DFYS acted contrary to law by violating the civil rights of a mentally incapacitated parent. Justified & Rectified	**Investigation revealed** that in one case DFYS and the Department of Revenue's Child Support Enforcement Division (CSED) had filed separate court actions regarding the child, but did not communicate. Neither agency acted to confirm paternity, and the delays lasted a year longer than could reasonably be explained or justified. The child's paternal grandparent was unable to obtain custody of the child during these delays. In the second case, DFYS failed to confirm paternity of the putative father for several months, although the mother's sister maintained that he was not necessarily the father. In the meantime, the putative paternal grandmother cared for the child until a paternity test established the absence of a blood relationship. The child was then removed from the only placement it had until that time. The ombudsman concluded that inefficiency in paternity establishment hindered efforts to make prompt, permanent placements in the children's best interests. It also deprived relatives of the children of their legal right to receive preference over non-relative foster placements. **Investigation also revealed** that DFYS should have reimbursed the putative grandmother who cared for a child at the agency's request, even though she provided the care under the mistaken impression that the child was her grandson. Further, DFYS entered into a "voluntary placement" of the mentally ill parent's child, rather than a court-ordered placement, but DFYS made the placement without the parent's consent or knowledge. Nor did DFYS inform or consult with the parent's guardian (the child's aunt). Thus, the "voluntary placement" was really involuntary, and the agency ignored the parent's rights. **The ombudsman recommended** that DFYS adopt a policy on paternity establishment for children in state care; advocate for a pilot court-based paternity testing program in CINA cases; advocate statutory revisions as necessary to allow DFYS to communicate with CSED regarding pending cases; establish a staff liaison with CSED; develop a policy on working with incapacitated parents; and ensure that all social workers are trained in these issues. DFYS accepted most of the recommendations, but only partially accepted the recommendation of court-based paternity testing. DFYS rejected the recommendation for statutory changes to enable interagency communication, but AS 47.10.093 has since been amended to expressly allow communication between DFYS and CSED on pending cases. DFYS has also changed its policy to avoid "voluntary placements" when a parent may be mentally incompetent to agree to the placement.
Health & Social Services / Division of Family & Youth Services A093-0723 Public report **Complainant alleged** that the Division of Family & Youth Services (DFYS) unreasonably failed to warn a foster parent about a foster child's history of setting fires; unfairly refused to compensate the complainant for property damage resulting from a fire allegedly set by	**Investigation revealed** no information that the foster child had a history of setting fires. By law the state is not liable for the acts of unemancipated minors in its custody, and DFYS regulations allow a maximum $5,000 payment for some losses caused by a foster child. However, agency staff admitted they were unaware of these limitations and had advised the complainant otherwise. **The ombudsman recommended** that DFYS train agency staff in the legal limitations on state liability for property losses to foster parents; that agency staff inform potential

the child; and unreasonably failed to explain the limitations on the state's liability when children in state custody damage property. Partially Justified & Rectified	foster parents of these limitations; that the agency review foster children's written history with foster parents at placement; that the agency increase orientation and training services for foster parents; and that the agency update the Foster Parents Handbook to include topics such as liability for property loss, insurance options, and other financial risks of foster parenting. The agency accepted these recommendations. This investigation was closed with an overall finding of partially justified, rectified.
Health & Social Services / Division of Family & Youth Services J095-1093 Public report **Complainant alleged** that a Fairbanks Youth Center employee entrusted with budgetary and accounting responsibilities committed misconduct by charging over $800 worth of personal items to the Center's charge account at a warehouse discount store and failing to pay for them. The ombudsman also investigated whether the employee had documented leave usage or submitted leave slips as required by department personnel policy. Justified & Rectified	**Investigation revealed** that the Fairbanks Youth Center employee misused a state credit card and failed to pay promptly for personal items. As a result, the Center's charge account was suspended for non-payment. Investigation also revealed that the employee failed to document leave usage and submit leave slips for approximately 150 hours for which the employee was paid. In addition, the employee's supervisors failed to exercise adequate oversight over the employee and failed to take appropriate corrective action when the misconduct was brought to their attention. **The ombudsman recommended** that the director of the Division of Family & Youth Services conduct an internal review of the matter to determine appropriate disciplinary action, and that agency staff receive training in the requirements of the Alaska Executive Branch Ethics Act. The director accepted both of these recommendations. This investigation was closed with an overall finding of justified, rectified.
Health & Social Services / Division of Family & Youth Services A093-6593 Public report **Complainant alleged** that the Division of Family & Youth Services (DFYS) abused its discretion by interviewing the complainant's child based on an insubstantial report of harm and by taking the complainant's child into emergency custody following the interview. Partially Justified & Partially Rectified	**Investigation revealed** that DFYS interviewed the child based on a report of harm that failed to provide details about the alleged harm. Investigation also revealed that DFYS failed to consider collateral information available that contradicted the report of harm. The ombudsman found that DFYS abused its discretion by conducting the interview. The ombudsman found that DFYS failed to retain original notes of the interview, which would have allowed the ombudsman to determine whether the agency abused its discretion by taking the child into emergency custody. Because of the lack of evidence, the ombudsman found this portion of the complaint indeterminate. **The ombudsman recommended** that DFYS caseworkers keep their original notes in the case file, that DFYS study whether it should audiotape or videotape initial interviews with alleged victims of child abuse, and that DFYS continue to improve social workers' skills through comprehensive, consistent, and timely training. DFYS accepted two of the recommendations, but not the recommendation that caseworkers retain their original notes.
Health & Social Services / Division of Family & Youth Services A1999-0019 Public report **Complainant alleged** that DFYS unreasonably did not provide a special-needs adoption subsidy when it placed the complainant's three grandchildren with her. The complainant further alleged that DFYS later granted an adoption subsidy that was far less than subsidies to other families in similar circumstances, and did not make the subsidy retroactive to the date the children were first placed with the complainant, causing an unreasonable financial burden on the complainant. Not Supported	**Investigation revealed** that for adoptive families to receive adoption subsidies, the children must be in pre-adoptive placement; the parental rights of both parents must be terminated; an adoptive home study must have been conducted; and the adoptive parent and the state must sign a subsidy agreement. The children in this case were living with their grandmother a full year before the subsidies were approved. However, the identities of two of the children's fathers were not known and paternal rights of two were not terminated until one month before the subsidy began. Thus, the alleged delay was due to requirements of the law. **Investigation further revealed** that federal and state regulations dictate the amount of subsidy allowed for special needs children. Federal funds paid for this family's subsidies, and federal guidelines do not allow retroactive payments. Further, state regulations establish the maximum allowable amount of subsidy, and this family actually received slightly more than the allowable amount.
Health & Social Services / Division of Health Care Services Background Check Program A2013-0776 Public report **Complainant alleged:** Allegation One: Contrary to Law – The Department of Health and Social Services has failed to establish and maintain a Background Check Program "Centralized Registry," as required by AS 47.05.330, of individuals who have been investigated and found by a state agency to have committed abuse, neglect, or exploitation of a child or vulnerable adult, or medical assistance fraud. Allegation Two: Unreasonable – The Department of Health and Social	**Investigation revealed:** The Ombudsman found all allegations to be justified. *Proposed Recommendation One: DHSS should take immediate action to create the Centralized Registry as required by AS 47.05.330 and 7 AAC 10.955.* *Proposed Recommendation Two: DHSS should immediately stop using AS 47.05.310(c)(1) as a means of barring prospective employees from taking employment where they will have contact with vulnerable children and adults.* *Proposed Recommendation Three: DHSS should conduct a survey of covered entities to see how aware they are of their mandatory reporting duties and, if necessary, implement training for those entities as part of the licensure process.* *Proposed Recommendation Four: The Department of Health and Social Services should notify all those who failed a background check solely because of an OCS-substantiated finding of abuse or neglect that they may reapply for a new background*

Services has failed to consistently apply statutes, regulations, standards, and processes in administering the Department's Background Check Program. Allegation Three: Unfair – The Department of Health and Social Services regards all barrier conditions arising from civil cases as a permanent bar to employment, while conviction of a barrier crime for more serious conduct may prevent employment for only limited periods of time. Allegation Four: Contrary to Law – By regarding probable cause findings in Child In Need Of Aid cases as barrier conditions, DHSS violates 7 AAC 10.955(n) which establishes the correct standard as "preponderance of the evidence." Allegation Five: Unfair – The Office of Children's Services regulations at 7 AAC 54.050 - .060 prohibit the release of child protection case records used by the agency in making a barrier condition determination to an affected individual seeking to review and challenge that decision. Justified, Not Rectified	*check under the current standard. Alternatively, the Department should issue redeterminations for all of the applicants barred under the pre-March 2012 standard.* *Proposed Recommendation Five: The Department of Health and Social Services should notify individuals who were wrongfully denied access to the reconsideration process of their right to reapply for reconsideration under the new standard.* *Proposed Recommendation Six: The Department of Health and Social Services should include a relevancy assessment during the barrier determination review process to ensure that the conduct causing the potential barrier is relevant to the safety of the population that the applicant intends to serve.* *Recommendation Seven: The Department of Health and Social Services has both the statutory authority and an obligation to screen individuals through Adult Protective Services, the Long-Term Care Ombudsman, and the Medicaid Fraud Unit. The Department should begin screening individuals through these agencies to ensure that applicants with adverse findings involving vulnerable adults are prohibited from working, just as it does for those individuals with adverse child protection findings.* *Recommendation Eight: The Office of Children's Services should further modify the Perpetrator Closing Letter to include a more detailed explanation of the potential adverse consequences of being placed on the registry.* *Recommendation Nine: DHSS should consider whether the use of very old CINA findings to permanently bar individuals from employment actually makes sense. The employer reporting provision sets a limit of 10 years; the Ombudsman recommends the Department utilize the same limit when permanently disqualifying individuals from employment for civil misconduct.* *Recommendation 10: DHSS should eliminate the permanent disqualification period for a barrier condition and consider implementing a tiered response system in which the length of the barrier disqualification period varies depending on the nature and severity of the offense.* *Recommendation 11: The Department should reconsider its use of probable cause findings to permanently bar individuals from employment. We suggest that the Department utilize adjudication findings because, at that phase of a CINA case, the judge must find by a preponderance of the evidence that the child is a Child In Need of Aid.* *Recommendation 12: DHSS should amend regulations to provide the release of child protection case records to an individual seeking to challenge an OCS barrier condition determination without a court order.* The Department rejected Recommendations 1, 2, and 11, and agreed in theory with Recommendation 3 but declined to implement it. The Department stated that it would address Recommendations 4 and 5 in the next six months but offered no explanation of how it plans to address the recommendations and the Ombudsman found that the Department recently proposed statutory and regulatory proposals changes that contradicted the Department's response to the ombudsman. The Department agreed to Recommendation 6 but, in fact, the Department's proposed statutory changes would remove the "relevancy analysis" that currently exists in AS 47.05.330(j). The Department responded that Recommendation 7 requires a statutory fix but then proposed legislation that would remove Adult Protective Services and Long Term Care Ombudsman actually received slightly more than the allowable amount.
Health & Social Services / Division of Health Care Services A2004-0633 Public report **Complainant alleged** that the Division of Health Care Services performed inefficiently by failing to provide timely notice and explanation of a Medicare Part B buy-in error to the complainant, a Social Security retiree and Medicare beneficiary. Discontinued as Resolved	**Investigation revealed** that the division had unreasonably delayed in providing notice and explanation of a Medicare Part B buy-in error to 586 former Medicaid recipients affected by the error. This investigation was discontinued as resolved as the agency acknowledged the error during the course of the ombudsman investigation, agreed that notification and explanation was warranted, and took immediate corrective action. Consequently, no recommendations were issued.
Health & Social Services / Division of Health Care Services A2003-0032 Public report	The investigation revealed systemic errors in the agency's Maximum Unit Per 30 Days policy. No recommendations were issued because the DHCS acknowledged the policy deficiencies identified by this investigation and took action to remedy the 'justified' finding during the course of our investigation.

Complainant alleged that the Division of Health Care Services had wrongfully denied his claim for a valid prescription drug refill. Justified & Resolved	
Health & Social Services / Division of Juvenile Justice J2006-0144 Public report **Complainant alleged** that the Division of Juvenile Justice (DJJ) failed to provide him with notice of a court proceeding and failed to serve him with a Petition for Adjudication and a Summons. Justified & Rectified	**Investigation revealed** that DJJ failed to provide complainant, a non-custodial parent, with notice of his child's court proceeding and also failed to serve him with a Petition for Adjudication and a Summons. **The ombudsman recommended** that DJJ conduct training for its staff regarding relevant statutes and delinquency rules. The ombudsman also recommended that DJJ review the relevant statutes and delinquency rules to determine whether any are impractical, superfluous, or redundant. The ombudsman recommended that DJJ administrators then propose amendments as appropriate to the Alaska Legislature. DJJ agreed to the recommendations and held a training session to ensure that DJJ staff was acquainted with statutory requirements related to parent/guardian notice and the service of summons.
Health & Social Services / Division of Juvenile Justice J2005-1194 No public report **Complainant alleged** that the Division of Juvenile Justice (DJJ) administered psychoactive medications to complainant's child without obtaining complainant's consent or even notifying complainant of the use of these medications in a timely fashion. Discontinued as Resolved	**Investigation revealed** that DJJ policy at McLaughlin Youth Center and other juvenile detention centers was to administer psychoactive medications to resident minors without obtaining parental consent or a court order allowing psychoactive medication. The Division agreed to revise its policy to require parental consent to psychoactive medications, unless the Division obtains a court order in lieu of parental consent.
Health & Social Services / Division of Juvenile Justice J2002-0125 Public report **Complainant alleged** that Juvenile Justice staff unreasonably conducted an incomplete investigation into complainant's grievance. Justified & Resolved	**Investigation revealed** that DJJ failed to completely investigate complainant's grievance. DJJ failed to contact complainant to find out where complainant had applied for jobs in youth service work and whether these potential employers had been influenced by alleged rumors spread by a DJJ employee. In other respects the DJJ investigation appeared thorough and reasonable. **The ombudsman recommended** that the agency reopen its investigation into the complainant's grievance and interview potential employers who rejected the complainant for youth service work if the complainant provides a list of such employers and grants permission to contact them about this matter.
Health & Social Services / Division of Medical Assistance A2008-0118 No public report **Complainant alleged** HS&S handled a Medicaid provider audit unfairly and did not allow the complainant due process to contest a negative audit of the complainant. **Complainant also alleged** that Medicaid regulations were not clear, that DHSS was non-responsive in some instances and provided inaccurate information in others. Finally, the **complainant alleged** that DHSS suspended audits and/or reduced overpayment penalties for similarly situated Medicaid providers but not for the complainant, thereby requiring the complainant to pay more than others in the same situation. Discontinued as Resolved	**Investigator reviewed** the complainant's audit and the provider reimbursement regulations that the complainant had allegedly violated. The Medicaid auditors had concluded that the complainant had violated several regulations and received a substantial overpayment from Medicaid. The investigator concluded that the applicable regulations were arguably unclear and requested an explanation from DHSS. DHSS referred the investigator to the assistant attorney general handling the court appeals brought by several other Medicaid providers similarly situated to the complainant. The attorney explained that she was negotiating settlements with those Medicaid providers, and eventually offered the complainant terms similar to the settlements offered to the providers who appealed their audits in court. The ombudsman concluded that the terms were reasonable, in that DHSS waived recoupment of overpayments that were based on the least supportable regulatory interpretations. The complainant accepted the settlement terms, which greatly reduced the complainant's debt.
Health & Social Services / Division of Medical Assistance A097-1406 Public report **Complainant alleged** that the Division of Medical Assistance (DMA) unfairly failed to give timely notice of the complainant's exclusion as a	**Investigation revealed** that although the complainant had provided health care services to hundreds of Medicaid recipients, most of them children, in the two years before the exclusion took effect, the agency failed to give adequate notice of the exclusion and failed to give timely instructions on seeking a waiver. Investigation also revealed that DMA performed inefficiently in responding to the complainant's appeal because it had no policies or procedures for handling exclusion waiver requests.

health care provider from the Medicaid program due to disagreement over federal loan payments, and failed to give timely instructions on how to request that DMA petition for a waiver of the exclusion from the federal government. **Complainant also alleged** that DMA staff performed inefficiently in responding to the complainant's waiver request; that DMA's statement of reasons to the federal Department of Health and Human Services (DHHS) for requesting the waiver unreasonably contained mistakes of fact that ensured the request would be denied; that DMA abused its discretion in evaluating the complainant's waiver request; and that DMA staff failed to comply with state law in responding to the complainant's request for copies of agency records. Partially Justified & Rectified	Likewise, the agency had no procedures for documenting complaints about Medicaid providers or for responding fairly to such complaints. DMA's letter to the federal DHHS contained mistakes that resulted in denial of the complainant's waiver request. When these mistakes were corrected the federal agency immediately reinstated the complainant's eligibility. Investigation also revealed that some agency staff abused their discretionary authority in deciding how to respond to the complainant's waiver request, and that agency staff failed to comply with state law on requests for public records. **The ombudsman recommended** that DMA develop procedures to document and respond to complaints about Medicaid providers; that DMA develop a procedure for waiver requests; that DMA develop procedures to document calls to the client "Hotline" according to defined standards and categories, and develop a way to search the "Hotline" database for complaints; that DMA develop methods to measure health care provider participation and availability of health care services in an area; that DMA develop policies to guide staff in documenting agency business; that DMA develop policies and procedures to handle confidential records; and that DMA develop procedures for checking legal citations in agency correspondence and decision making. **The ombudsman also recommended** that DHSS ensure that complaints about agency staff are not routed to those staff for response; that DMA develop a records retention policy; that DMA develop procedures for filing agency records that would permit cross-referencing of information; that DMA develop policies to review complaint files and other agency files to ensure that unverified complaints about Medicaid health care providers do not unfairly influence agency decisions; that DMA provide training on public records requests to staff; that DMA review all agency records covered by the complainant's public records request and provide the complainant copies of all records not made confidential by law; that DMA ask the Department of Law to review DMA's handling of confidential records. The commissioner agreed to all recommendations.
Health & Social Services / **Division of Mental Health & Developmental Disabilities** A097-1744 No public report **Complainant alleged** that the Division of Mental Health & Developmental Disabilities (DMHDD) unreasonably refused to consider a new application for in-home childcare funding under DMHDD's "difficulty of care" program after DMHDD had denied the complainant's earlier application. Not Supported	**Investigation revealed** that the complainant did not qualify for the program because the funding was reserved for extremely disabled children. However, DMHDD's policies did not explain when or how an applicant could reapply, and the complainant was referred to unwritten "policies" regarding new applications. **The ombudsman suggested** that the division put its policies in writing because unwritten policies create needless confusion and can lead to inconsistency and lack of accountability.
Health & Social Services / Division of Pioneer Homes A2006-0054 Public report **Complainant alleged** that a Pioneers Home administrator was running a private counseling business from his state office on state time. Supported & Partially Rectified	**Investigation revealed** that the employee used state resources to support a private counseling practice. The resources included a state computer, telephone and, on two occasions, a state office. **The ombudsman recommended** that this practice stop immediately, that the employee log all time spent in and out of the workplace during the workday, and that the ombudsman report be forwarded to the department ethics officer for review. The agency accepted most of the recommendations but declined to require the employee to keep accurate attendance records.
Health & Social Services / Division of Public Assistance A2008-0708 No public report **Complainant alleged** that the Public Assistance Heating Assistance Program (HAP) applied the complainant's heating assistance grant money to pay for an outstanding past debt owed by the complainant's boyfriend. This meant that the complainant could not pay for power.	**Investigation revealed** that a private power company had taken the complainant's Heating Assistance grant money to pay for her boyfriend's debt, which was incurred before he and the complainant began living together. After ombudsman contact, HAP instructed the energy vendor to reverse the funds and credit the money to the complainant's account. HAP also conducted additional training of its employees to ensure that household member's names are not included in HAP vendor payments, unless the household member is the applicant's spouse.

Discontinued as Resolved	
Health & Social Services / Division of Public Assistance A095-1800, A095-3788, A095-4004, A095-4559, A095-4005 Public report **Complainants alleged** that the Division of Public Assistance (DPA) unreasonably granted Public Assistance benefits--Aid to Families with Dependent Children (AFDC), Food Stamps, Medicaid--to runaway teenage children without determining whether the runaway teens had other means of support such as living at home with their parents. **The ombudsman also investigated** whether DPA unreasonably granted Public Assistance benefits (AFDC) to an adopted child's biological parent whose parental rights had been terminated. The benefit grant resulted in establishment of a child support order against the adoptive parents to reimburse the state for the Public Assistance. *See companion cases under the Department of Revenue, Child Support Enforcement Division.* Partially Justified & Partially Rectified	**Investigation revealed** that the teenagers were eligible for Food Stamps and Medicaid under federal law and the state agency did not have discretion to refuse benefits based on their status as runaways. Federal law gave states the option of requiring otherwise AFDC-eligible teenage parents to live at home, but the Alaska Legislature expressly rejected this option. One child, an unmarried teenage mother, was therefore eligible for AFDC benefits under the then-existing Alaska statute, regardless of whether the teenager's parents were capable of supporting her at home. Before the final investigative report was issued, the legislature revised the Public Assistance statutes to require teenage parents to live with their own parents or another adult in order to receive AFDC benefits. Since then, AFDC has been replaced by welfare reform statutes that also require teenage parents to live with a parent, guardian, or other qualified adult. Investigation also revealed that the biological parent of an adopted child is no longer a relative of the child for all legal purposes. Since AFDC benefits were only payable to relatives caring for a dependent child, the biological parent of an adopted child did not qualify to receive AFDC. However, the federal Department of Health and Human Services interpreted federal law as requiring the AFDC program to consider a biological parent an eligible "relative" caretaker for the child despite the adoption. The ombudsman's analysis of applicable federal law concluded that the federal agency was mistaken on this point. **The ombudsman recommended** that DPA protest the federal interpretation and, after obtaining clarification of federal law, notify the Child Support Enforcement Division to cease collecting support payments from the adoptive parents and consider refunding prior payments. The agency accepted the first recommendation, and rejected the second. The federal AFDC program was repealed by enactment of the Temporary Assistance for Needy Families block grant program in 1996, which gave states more freedom to define eligibility criteria. The new state law enacted in 1997 did not address the eligibility of biological parents whose parental rights were terminated by an adoption. State regulations still provide that these parents are eligible if they are caring for the child.
Health & Social Services / Division of Public Health / Medical Examiner J2016-0149 Public report **On her own initiative** per AS 24.55.120, the Ombudsman opened an investigation into an allegation that the Department of Health and Social Services, Division of Public Health, State Medical Examiner Office, has conducted medical death investigations without formally adopting implementing regulations as required by Alaska Statute. Justified & Rectified	**Investigation revealed** that in 2016 the Ombudsman's office had received four separate complaints about the Medical Examiner's office. Three of the complaints brought forth by citizens were found to be without merit and declined; and the fourth found to be unsupported after a formal investigated. In the course of reviewing the complaint, the Ombudsman noted the possibility that AS 12.65.020 could be interpreted to require the Department of Health and Social Services to adopt regulations implementing the Medical Examiner's enabling statute, as opposed the Medical Examiner's traditional reliance on written policy and procedure statements. **The ombudsman recommended** that the Medical Examiner adopt regulations to implement that office's statutory authority. The Medical Examiner agreed with the recommendation and advised the ombudsman that the office had initiated a regulations project to adopt a suitable regulation.
Health & Social Services / Division of Public Health / Medical Examiner A2016-0461 Public report **Complainant alleged** that the Medical Examiner should have performed an autopsy on her late husband, a foreign national, immediately upon his death at a remote worksite in southeast Alaska, and that the Medical Examiner did not correctly determine the cause of death. The complainant also alleged that the Medical Examiner took an unreasonable length of time to finalize the autopsy report and return the remains of her husband to his country of origin. Not Supported	**Investigation revealed** that the husband, who was over 50 years of age, died suddenly while working at a remote camp performing strenuous physical labor. Medical Examiner policy is that no autopsy is performed when a male over 50 years of age dies suddenly with no evidence of foul play, because deaths under those circumstances are almost always due to some form of heart disease. The statistical likelihood that heart disease was the cause of death is so high that the time and expense of performing an autopsy is not considered justifiable. This is in accordance with current medical practice nationwide. The Medical Examiner also followed policy later by reversing that determination after receiving reports from another state agency that dehydration was suspected to be a contributing factor in the death. The Medical Examiner performed the autopsy two days after receiving the new information. During the autopsy, the Medical Examiner performed a visual inspection of the decedent's body and had laboratory tests done on samples of his blood and vitreous humor, a clear gel located behind the lens of the eye that can be tested for certain

	elements. The ME found no medical evidence of dehydration. The complainant believed that the ME should have analyzed the blood for triglyceride and cholesterol levels, but the ME explained that those elements begin to breakdown immediately when a person dies, so blood samples drawn after death do not provide meaningful results. The complainant also alleged that the ME misinterpreted the results of the vitreous humor tests. Ombudsman staff are not qualified to second guess the Medical Examiner's medical expertise, but investigators were easily able to find published research supporting the ME's conclusion. The Medical Examiner does not have a policy specifying how long the agency has to complete and issue an autopsy report, but, according to agency staff, the ME makes an effort to send requested reports within five days after a case is closed. Forty-five days passed in this case before the autopsy report was finalized and provided to the widow. According to agency personnel, Medical Examiner staff thoroughly evaluate each case for errors before an autopsy report is finalized. The Medical Examiner's office was experiencing staffing shortages during the summer and fall of 2015. When the Medical Examiner is short-staffed it must prioritize urgent cases, such as autopsies required for criminal investigations. Six weeks to provide the report is not ideal, but considering staffing issues ME faced at the time, and the need to prioritize cases pending litigation, the ombudsman did not find the delay unreasonable. The complainant appeared to misunderstand the Medical Examiner's role in the process for returning the remains of a foreign citizen to his country of origin. Per Alaska Administrative Code at 7.05.470, it is the responsibility of the funeral home to make arrangements with the country of origin to return the remains. Neither Medical Examiner nor any other State of Alaska agency participates directly in making the arrangements. The ME is, however, required to provide a document certifying that the remains are free from contagious disease, on which they made a clerical error regarding the decedent's date of birth. The reason for the confusion is that the decedent had been illegally working in this country using his brother's identification, so when he died his paperwork initially reflected the brother's personal information. The ME did not catch the mistake when reviewing the final paperwork, but provided a corrected copy shortly after the funeral home pointed out the error. The incorrect birthdate on the document may have contributed to the overall delay of returning the decedent's remains to his native country, but it was a clerical error based on the decedent's own deception and its effect on the process was minimal.
Health & Social Services / Division of Public Health F094-0784, F095-0821 No public report **Complainant alleged** that the Coroner's Office unreasonably failed to determine adequately the cause of death of the complainant's child. *See companion case under the Department of Public Safety, Division of Alaska State Troopers.* Not Supported	**Investigation revealed** that, in the absence of specific information that the death was suspicious, the determination that the daughter died a natural death was reasonable.
Health & Social Services / Office of Children's Services A2005-0220 Public report **Complainant alleged** that OCS arbitrarily and unfairly failed to pay him foster care payments due for one month of 2004, when a child in the complainant's care was transitioning from foster care status to adoptive status. Partially Justified and Rectified.	**Investigation revealed** that OCS policy was reasonable. However, the policy was not communicated to the complainant, who was understandably surprised when he did not receive an anticipated foster care payment. **The ombudsman recommended** that OCS pay the complainant for foster care services provided during the first 29 days of the month in question. The ombudsman further recommended that OCS revise the state and federal adoption subsidy agreement forms to expressly state the financial significance of the transition from foster care to pre-adoptive care and to inform the prospective parents of when that transition will occur. OCS concurred with the findings and recommendations. OCS also agreed to ensure that policy and procedure clearly reflect the expectation that prospective adoptive parents are informed of the effective date of that transition.
Labor & Workforce Development / Labor Standards & Safety (Wage and Hour Administration)	**Investigation revealed** that Wage and Hour did not have written policies as to when business could perform self-audits or purchase media merchandise, such as t-shirts

A2007-1325 No public report **Complainant alleged** that Wage and Hour was unreasonably requiring businesses to perform self-audits. Complainant also alleged that Wage and Hour was unreasonably allowing businesses to purchase media merchandise instead of paying penalties. Discontinued as Resolved	and water bottles, that support the mission of the agency. This investigation was discontinued as resolved because Wage and Hour drafted two new policies. The first policy stated that self-audits could only be presented as an option for businesses, and not as a mandatory requirement. The second policy stated that media merchandise could only be purchased as part of a settlement agreement. As a result, the ombudsman made no recommendations in this case.
Labor & Workforce Development / Employment Security A2011-0480 Public report **Complainant alleged** that division had withheld unemployment insurance benefits (UIB) to repay a penalty obligation in violation of federal law. Justified & Rectified	**Investigation revealed** that federal law allows the division to withhold UIB payments to recoup previously overpaid benefits, but not to repay penalty obligations. After investigation, the ombudsman determined that the division had programmed its computers to withhold benefits even to recover penalties even after all overpayments had been recovered, and that the action violated principles of equitable estoppel under Alaska law. The ombudsman also questioned whether the division's actions violated federal law for states receiving federal funding for UIB. The division stated that it had sought the opinion of an assistant attorney general to determine that it had not violated principles of equitable estoppel, and that it had consulted with the U.S. Department of Labor and determined that it was not in violation of federal law. The ombudsman followed up and determined that after the ombudsman's investigation an assistant attorney general had advised the division that, in her opinion, the division's actions had not violated state equitable principles. However, the U.S. Department of Labor had no record of contact from the division and had not made any determination of the legality of the division's practices. At the ombudsman's request, the USDOL reviewed the division's practices and determined that they violated federal law. The federal agency assigned staff to monitor the division, and reported that the division was taking immediate steps to comply with federal law. Because the federal agency committed to monitor the division and ensure no further violations, the ombudsman closed the complaint as rectified.
Labor & Workforce Development / Employment Security A092-1269 Public report **Complainant alleged** that the Division of Employment Security unreasonably reduced the complainant's unemployment benefits due to alleged termination for "misconduct" on the job. The complainant appealed the decision to the commissioner, who denied the appeal. The complainant alleged numerous violations of due process by the department in its handling of the appeal, including violation of the Alaska Whistleblower Act. Not Supported	**Investigation revealed** that the Division of Employment Security staff and the commissioner acted reasonably and in compliance with state law, and that the complainant's allegations either lacked merit or were not supported by the evidence. This investigation was closed with an overall finding of not supported.
Labor & Workforce Development / Employment and Training Services A2015-1199, A2015-1374 Public report **Complaint:** The complainants, individual employers who had gone out of business in the 1980's, complained about the Department of Labor Employment Security Tax Section's rejuvenated collection efforts on the 30-year-old accounts. The Employment Security Tax section in the fall of 2014 began collecting delinquent unemployment insurance (UI) tax accounts dating from the 1980's and 1990's, many of which had lay dormant for many years, and at least one of which was labeled "uncollectible." Labor had not contacted one of the complainants regarding the delinquent taxes for 19 years; for the other employer, it had been 27 years. Both felt that the collection actions, which included attaching funds from the complainants' Alaska bank accounts and Permanent Fund Dividends, were unfair – or even illegal – after so many years.	**Investigation revealed** that the Employment Security Tax (EST) section was attempting to collect on hundreds of old accounts by sending out statements showing the alleged principle due, plus interest at the statutory rate of 12 percent interest per year. Although UI tax collection is subject to a five-year statute of limitations under AS 23.20.270, the agency relied on the Department of Law's advice that the statute of limitations would not run as long as the agency had served the employer with a Notice of Assessment within five years of the unpaid tax return(s). In the two cases investigated by the ombudsman, there were timely recorded tax liens, but no documentation of service of a Notice of Assessment, as the paper tax files from the 1980's were mostly missing or destroyed. The EST claimed that historical agency practice in the 1980's included serving a Notice of Assessment at the same time that EST recorded a tax lien. The ombudsman suggested that EST contact the Department of Law and find out whether historical practice provided enough proof of service to avoid the statute of limitations. EST responded that it had been advised by an Assistant Attorney General that its collections were legal, i.e. not barred by a statute of limitations. **Investigation also found** that EST's statements mailed to debtors were inaccurate. Although the agency claimed that it was required to collect statutory interest and

Justified & Rectified	penalties, a data migration in the 2000's resulted in deletion of all interest and penalties information from before 1999. The effect of this subtraction varied depending on the age of the account. Also, the initial statements mailed to debtors attributed all of the unpaid taxes to the fourth quarter of 1998, despite the fact that the complainants had filed their last UI tax returns in the 1980's. However, the statements sent to the debtors included interest assessed at 12 percent per year since 1998, so that by 2015 the agency was assessing 17 years' worth of interest for years in which EST had taken no action whatsoever to collect the outstanding tax debt. The ombudsman found the allegations supported by a preponderance of the evidence. The Department accepted the ombudsman's recommendation that EST should write off as uncollectible the accrued interest on all pre-1999 tax delinquencies. The ombudsman did not recommend writing off the principle in unpaid UI taxes, but did recommend that EST should not collect interest for decades in which the agency did not even send out a letter or garnish a PFD. The Department of Labor and Workforce Development accepted the findings and recommendation.
Labor & Workforce Development / Labor Safety and Standards, Wage & Hour Section J2002-0137 Public report **Complainant alleged** that his company was unfairly singled out for investigation by wage and hour investigators during work on a public construction contract. The complainant alleged that the investigators "fished" for complaints and then initiated an investigation that went beyond the scope of actual employee complaints; improperly ordered the Department of Transportation to freeze all contract payments for several months; took an inordinate time to complete the investigation; and provided inaccurate information in response to inquiries by complainant's employees. Complainant also alleged that the department violated his and his employees' privacy by releasing the entire payroll audit to all employees, rather than providing each employee only with information about his or her own wages. Not supported in part, indeterminate in part	**Investigation revealed** that DOL has statutory authority to investigate a public contractor for suspected wage and hour violations even without formal employee complaints. In this case, DOL had probable cause to investigate, due to several employee reports that the complainant's company had failed to make payroll. DOL also has explicit statutory authority to freeze part or all of the contract payments as "necessary" to secure unpaid wages. DOL's unwritten policy has been to freeze all contract payments if it suspects that the total back wages will equal or exceed available contract funds. DOL acted in accord with its statutes and past policy. Most of complainant's allegations were thus unsupported. **Investigation revealed** that DOL withheld the contract funds for four months. Because the contract was the complainant's only significant source of income during this period, the complainant continued to be unable to make current payroll, let alone pay back wages. After DOL released the funds, it was another month before the Department of Transportation disbursed them – a total delay of five months before the withheld funds were disbursed to become paychecks. It is unclear whether the department's actions in this case actually improved the employees' situation, or whether the complainant would have actually paid the back wages more rapidly if the contract funds had not been frozen. The allegation regarding unreasonable delay was found indeterminate because it is not clear whether DOL's decisions served or thwarted the program purpose of protecting employees. **Investigation revealed** that the wage claim information was arguably a public record. In any case, its release to all affected employees did not violate any statutory confidentiality requirement or constitutional privacy interest. This allegation was unsupported. Because the allegations in this case were found to be either unsupported or indeterminate, the ombudsman did not make recommendations.
Labor & Workforce Development / Vocational Rehabilitation A093-7863 Public report **Complainant alleged** that officials at the Division of Vocational Rehabilitation unfairly threatened the complainant's employer, a non-profit service organization, that the agency would cease doing business with the organization unless the complainant was terminated. Not Supported	**Investigation revealed** that there was insufficient evidence to support the allegation. The complainant named witnesses to the alleged threat who did not confirm the story. This investigation was closed with an overall finding of not supported.
Labor & Workforce Development / Vocational Rehabilitation J2004-0075, J2002-0079 Public report	**Investigation revealed** that CSSD contacted DVR regarding the consumer's ability to earn income while receiving DVR services. DVR replied in writing that the consumer could "work part-time" while attending classes for retraining. CSSD assumed that this

The ombudsman investigated whether DVR performed inefficiently by failing to follow up with the Child Support Services Division (CSSD) after CSSD misinterpreted DVR's assessment of a DVR's consumer's ability to work. CSSD had refused to ask a court to lower the consumer child support obligation, because CSSD assumed that the consumer could work as many hours as she had prior to entering a retraining program. *See companion case investigating parallel complaint against Department of Revenue, Child Support Services Division, J2002-0079.* Partially Justified & Rectified	meant that the consumer should be able to work at least 20 hours per week, and based the child support payment on this assumption. In fact, DVR did not believe that the consumer should work more than approximately 10 hours per week while attending classes. After the ombudsman contacted DVR and informed the consumer's DVR counselor that CSSD had misinterpreted DVR's reference to "part time work," the DVR staff left one voice mail message with CSSD, but did not follow up. No one at DVR actually spoke to a CSSD worker until the ombudsman intervened and arranged a teleconference for CSSD and DVR staff. During the months of delay, the consumer was charged child support at the higher rate. Then, after the teleconference, CSSD moved to reduce the consumer's child support obligation. **The ombudsman recommended** that DVR make it standard practice to have a DVR counselor personally speak with the relevant CSSD staff whenever a DVR consumer's ability to earn income is an issue for CSSD. The ombudsman also recommended that DVR sponsor a presentation by CSSD to educate DVR staff on CSSD's procedures, especially CSSD's child support modification process. DVR accepted the recommendations.
Law / Civil Division J2008-0229 Public report **Complainant alleged** that Law failed to serve written notice of a CINA hearing on the child's grandparents; that Law failed to notify the court of a grandparent's request to participate telephonically at a CINA proceeding; that Law failed to timely serve a grandparent with a copy of a court motion requesting that the court re-open a closed CINA proceeding; and that an AAG from Law committed perjury during a CINA hearing when she testified that paternity of the minor child had not yet been determined. *(See related complaint against OCS, J2008-0108.)* Partially Justified & Partially Rectified	**Investigation revealed** that the Department of Law erred when it failed to notify the court of a grandparent's request to participate telephonically at a CINA proceeding. The ombudsman found several other allegations against Law not supported or indeterminate. **The ombudsman issued seven recommendations** to OCS and Law as a result of the investigation. Among them were: additional training for OCS staff; better collaboration between OCS and Law; clarification of responsibilities related to notice; and working for changes to the Alaska Rules of Court and Alaska statutes for clear and consistent procedures for the telephonic participation of non-parties in CINA proceedings. The ombudsman also provided the report to the Alaska CINA Court Improvement Committee to consider possible revisions to the Alaska Rules of Court regarding telephonic participation by non-parties or relatives. The ombudsman suggested the committee create a frequently asked questions section for CINA cases on the court's website under the Family Help section, including information on how to request telephonic participation at a hearing. The committee coordinator agreed with this suggestion and is implementing changes to the court's website. Other actions taken in response to the ombudsman report by the committee included the following: in May 2011, the committee addressed several concerns about telephonic issues, including the statewide variance in procedures parties and non-parties are asked to use. The committee is in the process of initiating a survey with judges statewide regarding their telephonic procedures. The committee is also considering publishing and posting online a reference directory for parties and non-parties to call-in for a hearing with a particular judge. The committee will also draft a CINA telephonic hearing guidelines document to provide general information about the process to participants and judges. Once finalized, this information will be posted on the court's website, anticipated completion in the summer of 2012.
Law / Civil Division A095-3863, A095-4448, A096-1483, A096-4578, A096-4579 Public report **Complainants alleged** that the Department of Law contributed to the delay in modification of child support orders by its inefficient handling of modification cases. *See companion cases under the Department of Revenue, Child Support Enforcement Division; and the Court System, Superior Court, Third Judicial District Anchorage.* Justified & Rectified	**Investigation revealed** wide variation in how quickly Law responded to requests from the Department of Revenue's Child Support Enforcement Division (CSED) to draft and file modification pleadings. A survey of cases entering the Department of Law within one month revealed that 31% of the cases had had no action taken six months later. **The ombudsman recommended** that the Department of Law reconsider how it prioritizes of modification cases; work with CSED to improve case tracking; and take other cooperative actions discussed in the recommendations to CSED. The department accepted all of the recommendations.
Law / Civil Division A096-3444, A097-2272 Public report **The ombudsman investigated** whether the Department of Law inefficiently failed to act on a child support case for more than four	**Investigation revealed** that the case file was misplaced at Law for two years and then not acted upon meaningfully for another two years. Investigation also revealed that more than 40 "employer non-compliance" cases had been referred to Law during this time with no action taken. Attorneys did not know that one employer was not paying in several cases because the cases were grouped by non-custodial parents' names and no review was done on the employer.

years after receiving the case for review. The non-custodial parent had notified the Department of Revenue's Child Support Enforcement Division (CSED) and Law that her employer was withholding funds from her wages for child support but was not forwarding the money to CSED. *See companion case under the Department of Revenue, Child Support Enforcement Division.* Justified & Partially Rectified	**The ombudsman recommended** that Law immediately complete work on the complainant's case and those cases involving the same employer; coordinate efforts to ensure that when cases for the same non-custodial parent, custodial parent, or employer with similar issues, are referred to Law, they are assigned to the same attorney; that Law should seek to amend state law so that direct monetary judgments obtained illegally are paid to custodial families rather than as a penalty to the state unless the debt is owed to the state. The department accepted these recommendations.
Law / Collections & Support A2005-1495 No report **Complainant alleged** that Collections & Support made an error in computing the amount of a criminal fine owed. Discontinued as Resolved	**Investigation revealed** that the Court ordered the complainant to pay $10,000 with $5,000 suspended. Collections & Support made an error and began garnishing complainant's permanent fund dividends up to the full amount of $10,000. This investigation was discontinued because Collections & Support acknowledged the error and refunded complainant the amount over $5,000 that had been garnished. As a result, the ombudsman made no recommendations in this case.
Law / Collections & Support A2005-0237 Public report **Complainant alleged** Collections & Support did not give proper credit for payment made toward restitution. Cash handling procedures for restitution payments were at question. Justified & Rectified	**Investigation revealed** that agency issued complainant a receipt for an amount of cash paid for restitution. Agency staff said the receipt was issued in error, but investigator checked collateral contacts and the weight of evidence led the ombudsman to determine that the agency erred. Complainant was compensated by the Division of Risk Management, resolving the complainant's specific issue. Although Collections & Support did not accept the ombudsman's findings, the agency began revamping its system for receipt of cash payments, which should prevent errors of this kind in the future.
Law / Criminal Division C091-0855, C091-0891, A093-0357 No public report **Complainant alleged** that Department of Law staff harassed the complainant, an attorney, in an attempt to thwart representation of an inmate client. *See companion cases under the Department of Corrections, Division of Institutions.* Not Supported	**Investigation revealed** that the judge in the case had ruled on much of what the complainant alleged. The assistant attorney general (AAG) representing the Department of Corrections (DOC) in its dealings with the complainant wrote two letters objecting to the complainant's actions concerning inmate interviews. However, the AAG assisted the complainant in other ways, including directing DOC to give a lengthy fax to the inmate-client. The ombudsman suggested that Law conduct its own review of the matter, and the department agreed to do so. This investigation was closed with an overall finding of not supported.
Law / Special Prosecutor A2008-0041 Public report **Complainant alleged** that the Attorney General's office did not prosecute a hunter involved in the illegal taking of a moose because of a personal friendship with the hunter. Not Supported	**Investigation revealed** that the decision to dismiss charges was supported by the Attorney General's Office and Alaska Wildlife Trooper management after evaluation of the evidence. The ombudsman found no evidentiary support for the complainant's allegation that the decision to dismiss charges by the special prosecutor was motivated by a friendship between the District Attorney's office and one of the criminal defendants. The special prosecutor articulated a reasonable basis for his decision, and the complainant offered no specific and credible evidence that the special prosecutor had engaged in professional misconduct in dismissal of the criminal cases. Despite an unsupported finding, the ombudsman suggested that the Board of Game should consider meeting with the Alaska Wildlife Troopers and Department of Law to revisit and clarify the intent of the same-day airborne regulation. During the ombudsman investigator's interviews with Fish and Game staff, Board of Game members, the Alaska Wildlife Troopers and the Department of Law, it was clear that the issue of enforcement of 5 AAC 92.085, the "same day airborne" regulation is an ongoing concern for both the Department of Fish and Game and the Alaska Wildlife Troopers.
Military & Veterans Affairs / Army National Guard J2008-0109 No report Complainant alleged that the Alaska Army National Guard incorrectly billed him for servicemen's life insurance premiums and asserted that he was required to file paperwork to cancel the insurance after discharge.	**Investigation revealed** that Alaska Army National Guard supervisory personnel failed to provide the complainant with a necessary form during the discharge process, and as a result the complainant was erroneously billed for premiums incurred after he had been discharged. As a result, the complainant's account was sent to Federal collections and monies were inappropriately held from his federal stimulus check to satisfy the debt. The complaint was ultimately resolved after contacting the federal Defense Finance and Accounting Service, the agency responsible for collecting on the debt. The complainant received a refund check reimbursing him for the monies

Discontinued	inappropriately withheld. According to the Director for DFAS, this was a common complaint received by his agency from servicemen across the United States. The Director attributed the error to lack of training by military supervisory staff concerning the necessary paperwork to be filed during the discharge process.
Natural Resources J2009-0224 Public report **Complainants alleged** that DNR: (1) led the complainants to believe that the necessary permits for connecting a private marina to the Chilkat River were forthcoming, which convinced the complainants to spend thousands of dollars constructing the marina and access route prior to final permitting approval. (2) required the complainants to pay for the costs of repair to the riverbank adjacent to their property that was breached naturally by rising water in the river. (3) failed to timely notify the complaints of its position opposing a permit allowing the Complainants to connect a private marina to the Chilkat River for commercial use operations. (4) failed to adequately explain to the complainants the agency's reasons for opposing the connection of a private marina to the Chilkat River for commercial use operations. This complaint is related to J2009-0217 against the Department of Fish & Game. Partially justified	**Investigation** found Allegations 1, 3, 4 justified, and Allegation 2 unsupported. **The ombudsman recommended**: (1) that the department pay one-third of the expenses incurred by the complainants for excavation and construction of the marina, restoration of the riverbank, and filling in the marina; (2) that the department should provide additional training to its staff concerning statewide policy permitting restrictions, especially when more than one division or department is involved in a project, to ensure consistent information in turn is provided to the public. The agency rejected the first recommendation, but accepted the second recommendation. Complainants were referred to Risk Management and their legislators for further assistance, as the ombudsman cannot enforce recommendations.
Natural Resources / Commissioner's Office/ Designated Ethics Supervisor A2006-0546, A2006-0583, J2006-0165 Public report **Complainant alleged** that the Ethics Supervisor for DNR performed inefficiently in investigating potential violations of the Executive Branch Ethics Act; and that the Ethics Supervisor's determination regarding a potential violation of the Executive Branch Ethics Act was arbitrary. Justified & Rectified	**Investigation revealed** that the Designated Ethics Supervisor for DNR took six weeks in one case and more than three months in another to evaluate reports of potential violations of the Executive Branch Ethics Act that called for simple investigations. Investigation also revealed that the DES based his conclusions on undocumented communications with department staff and failed to consider all available relevant information in reaching those conclusions. **The ombudsman recommended** that the Department of Natural Resources (1) develop comprehensive department policies and procedures for ethics for the Designated Ethics Supervisor and all DNR staff; (2) review with the Division of Personnel the actions of the Division of Parks and Outdoor Recreation described in the investigative report to determine whether the supervisor needed special training in the Ethics Act; (3) provide initial training on this topic for new department employees; and (4) provide department employees periodic refresher training in provisions of the EBEA as they apply to department business. These recommendations were accepted.
Natural Resources / Division of Agriculture A098-0738 Public report **Complainant alleged** that Division of Agriculture staff unfairly did not provide the public sufficient notice of its intent to auction three agricultural parcels at Point MacKenzie and did not provide sufficient information about the parcels to allow potential buyers to make knowledgeable bids on the land. The complainant contended that notices in the legal notice section of the paper were insufficient and Agriculture should instead have placed display ads in areas of the paper dealing with agricultural parcels. Further, the complainant alleged that the division failed to notify the complainant of impending land sales as requested.	**Investigation revealed** that Agriculture complied with state statute and advertised the sales in five general circulation newspapers throughout the state. Notice of the impending sales also was posted on the State of Alaska Internet home page site for the Division of Agriculture for 20 days prior to the auction. However, the auction was not posted on the Division of Lands home page. Informational packets were mailed to more than 250 people who sought information in response to Agriculture's notices. The complainant's request for information allegedly was verbal, but there was no way to prove that it had been received by Agriculture, and the agency had no record of this request. The ombudsman suggested that Agriculture consider placing legal advertisements for land sales in the real estate sections of publications. This investigation was closed with an overall finding of not supported

Not Supported	
Natural Resources / Division of Mining, Land, & Water A2004-1331 Public report **Complainant alleged** DNR denied complainant's application for a shore fishery permit lease despite complainant's extensive documentation. The lease was given to another person. Not Supported	**Investigation revealed** that DNR had a reasonable basis for its decision. DNR calculated that the successful applicant had between 37 and 41 years of fishing experience at the site in question. The complainant had about 5 years. Looking at the successful application in the worst light possible, it is still likely that the successful applicant fished the site in question at least twice as long as the complainant. Under AS 38.05.082, this is sufficient reason to award the lease as DNR did. No recommendations were warranted.
Natural Resources / Division of Mining, Land, & Water J099-0291 Public report **Complainant alleged** that the Division of Lands unreasonably took back a parcel of land it was selling to the complainant without proper notification regarding a small amount of the selling price that remained unpaid. Not Supported	**Investigation revealed** that the Division of Lands provided the complainant with sufficient legal notice before terminating the purchase agreement. However, because it was apparent that the complainant had intended to complete the purchase, the agency offered to rescind the termination if the complainant would pay the remaining debt. The complainant did so immediately. This investigation was closed with an overall finding of not supported.
Natural Resources / Division of Mining, Land, & Water A095-2803 Public report **Complainant alleged** that the Department of Natural Resources (DNR) unreasonably failed to compute loan repayment interest to veterans in accordance with the intent of the Veterans Loan Program statute, and thus significantly overcharged veterans who obtained land during one land lottery disposal in 1983. Justified & Rectified	**Investigation revealed** that DNR misinterpreted the legislative intent language supporting the retroactive Veterans Loan Discount Program, resulting in 36 veterans repaying $245,000 more than they should have been required to pay. **The ombudsman recommended** that DNR review the loans of the 36 eligible Lottery #12 veterans to determine the estimated total fiscal impact of re-amortizing the loans and refunding or crediting the appropriate amount of overpayment to those who were eligible. The ombudsman recommended further that DNR should present these figures to the Legislature for consideration of whether to appropriate the amount necessary to reimburse the veterans for the overpayment. DNR accepted the recommendations, and the Legislature approved refunds to the veterans for the overpayments.
Natural Resources / Division of Support Services A092-2648 No public report **Complainant alleged** that the Department of Natural Resources (DNR), contrary to law, denied him a copy of a public record. The complainant also alleged that DNR capriciously denied his request for a copy of a geographic database while granting a request for data from the same database to another party. Partially Justified & Rectified	**Investigation revealed** that the agency was not required under the law to release "electronic services or products" (ESP) and that the agency had correctly classified the database in question as an ESP. This allegation was found not supported. Investigation also revealed that the agency had released portions of the database requested by the complainant to another party and thus had surrendered its authority to restrict those portions from release to the complainant. The ombudsman found this allegation justified. **The ombudsman recommended** that DNR supply the complainant with the same data it supplied to the other party. The agency agreed to this recommendation. This investigation was closed with an overall finding of partially justified, rectified.
Public Safety A2015-1375 Public report **Complainant alleged** that DPS refused to remove the complainant from the state's sex offender registry. The complainant asserted that he was no longer required to register after the Alaska Supreme Court held that the sex offender registration requirements were unconstitutional as applied to those whose offensive conduct occurred prior to the effective date of the sex offender registration law. Justified & Rectified	**Investigation revealed** that the complainant's assertion appeared to be correct and recommended that the department immediately remove the complainant's name from the sex offender registry. During the investigation, the ombudsman investigator also discovered that the Department had failed to create a form, required by regulation, for offenders to request a review or correction of the information contained in the registry about them. The Ombudsman also recommended that the department create the required form. The department refused to remove the complainant's name from the registry and asserted, without support, that he continued to be required to register. However, the department did accept and implement the recommendation to create the required form. Several months after the Ombudsman closed the complaint, the complainant filed a complaint with the Office of Professional Standards (OPS) within the Department of Public Safety. The OPS investigator contacted the ombudsman investigator for information on the complaint and, after reviewing the court records and the ombudsman's report, OPS recommended that DPS remove the complainant's name from the registry. The DPS Commissioner agreed and the complainant's entry was finally removed from the state's sex offender registry.

	The Ombudsman reviewed the complainant's case again and was struck by the fact that, in an underlying civil case the complainant had brought challenging his duty to register, he had lost on procedural grounds and had been ordered to pay several hundred dollars in attorney's fees to the state. This seemed unfair considering that the complainant had been correct about the substantive matter at issue. The Ombudsman wrote to the DPS Commissioner and asked him to refund the complainant's money but he declined, based on the fact that a court had ordered the award of attorney's fees.
Public Safety / Council on Domestic Violence & Sexual Assault J2003-0087 Public report **Complainant alleged** that the CDVSA was required to distribute ten percent of the VOCA funds to serve "underserved" victims, i.e. victims of violent crimes other than domestic violence and sexual assault. Complainant alleged that the grant process was biased in favor in programs serving victims of DV and sexual assault, and that programs serving other crime victims did not receive their federally mandated share of funding. Complainant also alleged unfairness in the scoring of the grant applications and alleged that a Council member had a conflict of interest. Partially Justified	**Investigation revealed** that the CDVSA distributed VOCA funds to Victims for Justice, which advocates for victims of all types of crimes. Also, the women's shelters that provide services primarily to victims of domestic violence and sexual assault also provided services to other types of crime victims. But although some funds were used to serve victims of crimes other than domestic violence or sexual assault, the CDVSA did not ensure that "some" would actually mean ten percent of the VOCA funding. **Investigation revealed** that the CDVSA allowed the applicant to submit the application cover sheet late (the applicant submitted the rest of the application timely, but the application was technically incomplete), but the CDVSA then left it to each Council member to decide what effect the late cover sheet would have on his or her scoring of the application. This led to inconsistent treatment of the application. The allegation that the grant application format was unfair to the applicant was found unsupported, as was the allegation that a Council member with a conflict of interest voted on the application. **The ombudsman recommended** that the CDVSA revise the grant process to (1) increase the pool of applicants that specifically provided victim services to all types of crime victims; and (2) ensure that the proper percentage of VOCA funds were in fact used to provide services to "other" crime victims. Finally the ombudsman recommended that the CDVSA standardize its technically incomplete grant applications. The CDVSA indicated that it was already revising its procedures for addressing incomplete applications. The CDVSA disagreed that there were any problems with its distribution of VOCA funding, based on the fact the federal Office for Victims of Crime had not taken action against the CDVSA.
Public Safety / Council on Domestic Violence & Sexual Assault F093-0945, F093-0944, F094-0884 No public report **Complainants alleged** that the Council on Domestic Violence and Sexual Assault unreasonably funded community shelters without adequate oversight. Partially Justified & Partially Rectified	**Investigation revealed** that a review by Council staff of concerns surrounding a Fairbanks shelter was perceived as biased by participants. Investigation also revealed that the Council's complaint procedure was haphazard and unorganized. **The ombudsman recommended** that the Council require its grantees to maintain a file of client grievances and that a summary of staff and client grievances be included in the Council's quarterly report forms. The ombudsman also recommended that shelter clients be informed that the Council is both a funding source and a grant-monitoring agency. The ombudsman also recommended that the Council develop its own complaint process and require impartial investigation of complaints by staff; that the Council executive staff provide council members with more detailed information about the financial records of the grantees; and that Council members evaluate the roles of the Council members and executive staff. The ombudsman also recommended that Council members work with staff to improve on-site evaluation reports. The Council accepted all of the recommendations.
Public Safety / Division of Administrative Services A099-0131 Public report **Complainant alleged** that the Department of Public Safety (DPS) posted on its Alaska Public Safety Information Network (APSIN) incorrect information that the complainant had the HIV-AIDS virus. An Anchorage police officer arresting the complainant informed the complainant's spouse that APSIN stated the complainant had the virus. The complainant does not have HIV-AIDS. Justified & Rectified	**Investigation revealed** that the APSIN system contained information that the complainant had the AIDS virus. DPS obtains APSIN information from all police agencies in the state, but only a person employed by a criminal justice agency can enter information into or obtain information from the system. Federal guidelines governing computerized criminal information generally prohibit including medical information unless it serves a legitimate law enforcement purpose. The complainant's APSIN log showed inquiries on 111 different dates from 15 different police agencies throughout the state. DPS had no way to know who entered the incorrect information or when. State law directs that people who have authorized access to APSIN information may not disclose it to those who do not, even if they are relatives of the subject.

	The ombudsman recommended that DPS ask the attorney general to determine if including medical information on APSIN serves a legitimate criminal justice purpose (for example, forewarning police officers that a subject may be mentally ill and incapable of responding appropriately to an officer). DPS complied with the recommendation and Law determined that the medical information had a legitimate law enforcement purpose. The ombudsman also recommended that DPS issue a memo to all police agencies reminding them of their statutory obligation to keep APSIN information confidential except as outlined in statute; and that DPS should ask the Anchorage Police Department (APD) to conduct an internal review of the release of the complainant's information. DPS issued the memo to all state police agencies and asked the APD to review the matter.
Public Safety / Division of Alaska State Troopers A2010-0600 Public report **Complainant alleged** that Alaska State Troopers "profiled her" as a drunk when they charged her with Driving Under the Influence after she left the road and crashed into a boulder. The complainant contended the trooper failed to recognize she had suffered a seizure and arrested her rather than treat her medical emergency. Not Supported	**Investigation revealed** that the complainant informed the trooper that she had epilepsy but didn't tell him she had suffered a seizure. She further told the trooper that she had ingested an antibiotic and some Benadryl that morning and that she was sure she dozed off while driving. The trooper found a sleep aid and an anti-anxiety drug but not the drug that the complainant said she took for epilepsy. She also failed a field sobriety test. While the ombudsman did not find fault with the agency in this case, the ombudsman did determine that the State of Alaska has no requirement that public employees such as AST or Corrections notify the Division of Motor Vehicles when they learn a person has suffered a seizure while driving. The ombudsman suggested to the three commissioners that they confer and possibly offer information to legislators considering HB 149 which would allow anyone, including physicians, to report drivers with a medical or other condition that could, in their opinion, impair the ability of a driver to safely operate a vehicle. Such reports would be confidential and exempt from disclosure, and those who submit reports in good faith would not be liable for civil damages for doing so. In making this suggestion the ombudsman did not suggest the departments lobby, just that they consider this an opportunity to discuss the issue. Alaska also has looming on its horizon an increase in the number of citizens over 65 years of age, a demographic in which chronic medical impairment becomes more common. It would seem in the best interests of the Department of Public Safety and DMV to ensure that the system for reporting and screening problem drivers is reasonably accurate and effective.
Public Safety / Division of Alaska State Troopers A2010-0228 Public report **Complainant alleged** that a trooper humiliated the complainant and failed to follow standard procedures when he performed a "high risk" traffic stop on the complainant's car, ordered the complainant out of the vehicle at gunpoint, and restrained her with handcuffs. **Complainant also alleged** that trooper supervisors were condescending toward her when she complained about the stop, and failed to apologize for causing her emotional harm. Partially Justified	**Investigation revealed** that the trooper had received a police dispatch report of a shooting from which a car resembling the complainant's car had fled with a male and female in it shortly before the trooper stopped the complainant's car a hundred yards from the crime scene. Within three minutes of stopping the complainant's vehicle the trooper concluded that the complainant and her husband were not the suspects and let them go on their way. Recordings of the complainant's conversations with trooper supervisors revealed that they had attempted to explain the situation to the complainant and apologized that the stop had caused the complainant emotional distress. The trooper captain later wrote a letter to the complainant containing further explanation and apologies. Investigation also disclosed that the trooper failed to activate his recorder during the traffic stop, contrary to agency policy and procedures, and failed to announce the reason for the stop at the outset as the Alaska public safety academy trains officers to do. **The ombudsman recommended** that the agency add a component to its training program instructing officer trainees on the impact their actions can have on the general public and how to defuse negative public perceptions of law enforcement procedures. Between the filing of this complaint and completion of the ombudsman investigation the agency created its Office of Professional Standards to handle citizen complaints.
Public Safety / Division of Alaska State Troopers	**Investigation revealed** that troopers confiscated $4000 during a raid on the house in

J2005-0327 Public report **The complainant alleged** that the Alaska State Troopers deposited the complainant's confiscated money into the state general fund and disallowed the complainant's legitimate claim to the money. Justified & Rectified	which the complainant lived. The complainant was never charged and a letter that troopers sent to the complainant saying the money could be claimed was returned to AST as unclaimed. The complainant later learned that the money was no longer being held as evidence, had been presumed abandoned, and deposited into the state's general fund. The complainant said that AST evidence section staff told her she could no longer claim the money. The ombudsman found that AST misinterpreted or misapplied AS 12.36 and AS 34.45, which require abandoned funds to be delivered to the Department of Revenue Unclaimed Property Fund. Consequently, the ombudsman found the allegation justified. AST agreed with the findings. During the investigation, the investigator contacted the state's Unclaimed Property Fund, which reimbursed the complainant.
Public Safety / Division of Alaska State Troopers F094-0784, F095-0821 No public report **Complainant alleged** that the state troopers failed to sufficiently investigate the death of the complainant's daughter. *See companion case under the Department of Health and Social Services, Division of Public Health.* Not Supported	**Investigation revealed** that the troopers conducted an adequate investigation and had no credible information to prompt further inquiry.
Public Safety / Division of Alaska State Troopers A2003-0255 Public report **Complainant alleged** that two troopers with Alaska Division of State Troopers used excessive force to detain and arrest him during their investigation of a hit and run accident. The complainant alleged that troopers beat, pepper sprayed and 'Tasered' him when he attempted to tell them who had driven a vehicle involved in an accident. Not Supported	**Investigation revealed** that the complainant did not cooperate with troopers who sought to interview him about the accident. A tape recording of the investigation and encounter revealed that the complainant refused to cooperate and fought with officers who tried to handcuff him. The level of force used by the troopers was determined to reasonable and necessary to overcome the complainant's resistance, gain control of the situation, maintain officer safety, and arrest the complainant. The ombudsman also found the use of force in this incident was consistent with Alaska Statute and AST Safety Operating Procedures and with national standards.
Revenue / Alaska Housing Finance Corporation A097-1337 Public report **Complainant alleged** that Alaska Housing Finance Corporation, Public Housing Division (PHD) staff unreasonably did not warn the complainant, a landlord, that a person renting the complainant's property under Section 8 housing assistance had a history of destructive behavior in rental units. The complainant alleged the renter did $7,200 worth of damage to the property. Not Supported	**Investigation revealed** that the destructive tenant moved into the landlord's rental unit and signed a lease before officially moving out of another house. PHD staff did not conduct a move-out inspection of the damaged unit until after the agency was notified that the tenant had moved, which was also after the tenant had moved into the complainant's rental unit. Federal Housing and Urban Development and PHD regulations state that landlords are responsible for screening their tenants, and the complainant signed PHD paperwork attesting to that fact.
Revenue / Alaska Housing Finance Corporation A098-0610, A098-0622 Public report **Complainants alleged** that Alaska Housing Finance Corporation, Public Housing Division (PHD) staff agreed to allow a parent's adult child with a PHD subsidy to live in a house owned by the parent, but then unreasonably reneged on that agreement. The parent had purchased the house specifically so the adult child could live there. Not Supported	**Investigation revealed** that PHD eligibility policies are mandated by federal Housing and Urban Development agency (HUD) regulations. A HUD regulation adopted in May 1998 prohibited Section 8 participants from renting from close relatives. AHFC adopted an identical regulation in July 1998, after the adult child's original lease was signed. PHD "grandfathered" the existing rental agreement but could not approve a new one for a different residence when there were alternative rental units in the area. Investigation also revealed that PHD staff did not know the adult child intended to rent again from her parent when she asked if eligibility for the subsidy would transfer to a different area. This investigation was closed with an overall finding of not supported.
Revenue / Alaska Housing Finance Corporation A096-1080 Public report **Complainant alleged** that Alaska Housing Finance Corporation (AHFC) unreasonably audited the complainant at a time and in such a	**Investigation revealed** that the grantee's contract allowed AHFC to access grantee records at any reasonable time during working hours, but the complainant refused access to records for several weeks in violation of the contract. The audit came in response to legislative direction and concern about the grantee running out of program funds. Investigation also revealed that the grantee incorporated her business using the name of the program AHFC was administering without agency knowledge or

manner as to guarantee the grantee would fail the audit, thus giving AHFC cause to terminate the grantee's contract. The complainant alleged that AHFC unfairly and without good cause suspended, then terminated, the grantee's agreement with AHFC; and that AHFC's action against the grantee was personally ordered by the AHFC director, who also ruled on the grantee's final appeal of agency action, thus denying the complainant a fair review of the appeal. Not Supported	permission. The grantee, with assistance from an AHFC employee who subsequently left the agency, sought and received a federal grant that duplicated the AHFC program. The former AHFC employee lacked authority to give the grantee permission to take the grant. No evidence was found to suggest the AHFC director personally directed the audit action. The ombudsman suggested that AHFC work with the Department of Law to introduce legislation to give statutory protection to state program names. AHFC agreed with that suggestion.
Revenue / Alaska Housing Finance Corporation A097-0799 No public report **Complainant alleged** that the Alaska Housing Finance Corporation (AHFC) unreasonably did not require all bidders for grants from the Weatherization Assistance Program to follow the same grant application format rules, thereby harming the complainant, whose bid was unsuccessful. Not Supported	**Investigation revealed** that each of the applicants used forms provided by AHFC but completed the remainder of the application in different ways. All of the applications met threshold requirements and contained the information necessary to evaluate the bids. Because no points were awarded or subtracted for application format, the agency's decision making appeared to be reasonable and in compliance with Alaska law.
Revenue / Alaska Housing Finance Corporation A095-0217 Summary No public report **Complainant alleged** that the Alaska Housing Finance Corporation (AHFC) Emergency Efficiency Interest Rate Reduction program staff did not tell the complainant about all of the requirements of a loan program, then unfairly denied the complainant an interest rate reduction to which the complainant was entitled. Not Supported	**Investigation revealed** that the complainant's bank did not submit the complainant's program application to AHFC in a timely manner. AHFC rules require that the application be submitted prior to closing the mortgage. The complainant's application was not submitted until months later because the bank had not forwarded it. The error was the bank's, not AHFC's. (The bank eventually "bought down" the complainant's interest rate.)
Revenue / Child Support Services Division A2008-1274 Public report **The complainant alleged** that CSSD collected child support payments from the complainant under an invalid support order, resulting in overpayment of her account. The complainant sought to have CSSD repay her the money it purportedly collected in error. The complainant also alleged that CSSD modified the complainant's support order "on its own motion." Not Supported	**Investigation revealed** that the child support order in question was issued by the court in 1997. The court vacated the order in 2007 and replaced it with a new child support order that covered the same timeframe as the previous order but significantly lowered the monthly child support obligation. This resulted in an overpayment to the obligee in this case. **The investigation revealed** that the 1997 child support order was a valid order for the period it was in effect and the enforcement actions taken by CSSD to collect and distribute payments while the order was in effect were appropriate and in accordance with the law. Further, CSSD policy provides that the agency will not assist obligors in recovering overpayments if the overpayment was not a result of state error. CSSD policy clearly states that overpayment caused by court action is not considered state error. The ombudsman found that the CSSD policy was reasonable. **The investigation further revealed** that in 1996 CSSD did in fact review and modify the original support order during a period when the obligee and children were receiving public assistance benefits. Federal and state laws require public assistance applicants to assign any rights a family member may have to child support to the state as a condition of eligibility. The "assignment of rights" includes the right of the state to seek review and modification of the existing support order. Alaska Statute and Alaska Administrative Code provide that that CSSD may initiate a review of a support order at its own discretion if support has been assigned to the state. Thus, the actions taken by CSSD to review and modify the original support order while the complainant's children were receiving public assistance benefits were appropriate and in accordance with law.
Revenue / Child Support Services Division A2008-0826 No public report **Complainant alleged** that Child Support Services Division workers	**Investigation revealed** that the complainant's administrative paperwork stated that support arrearages would continue to accrue even if CSSD stopped collecting, thus the parents remained responsible to pay the past due amount. However, CSSD waived all interest on the past due amount and changed the language of its form letters to clarify that support continues to accrue for children in state custody until age 19. CSSD also

inefficiently told him that he didn't need to pay support for his son's care while the son, who had reached the age of majority, was in state custody. He said CSSD then notified him eight months later that he had to pay ongoing support as well as the past support and interest on the arrearage. Discontinued as Partially Rectified	offered to work with the complainant to develop a payment plan so they wouldn't have to pay the full arrearage amount at one time.
Revenue / Child Support Services Division A2005-0885 Public report Complainant, a non-custodial parent, alleged that she had been overcharged support. CSSD records showed that CSSD had collected an excess of $1,037, but CSSD initially failed to refund the overpayment. Justified & Rectified	**Investigation revealed** that CSSD garnished the non-custodial parent's paychecks. The custodial parent was receiving public assistance, so CSSD should have retained the garnishments to reimburse the state for public assistance ("state debt"); instead, CSSD disbursed the support to the custodial parent. CSSD indicated this was due to a computer error. In the meantime, CSSD records showed the "state debt" as unpaid, so CSSD also garnished the non-custodial parent's income tax refund. At that point, CSSD had double-billed the non-custodial parent, resulting in an overpayment of $1,037. **The ombudsman recommended** that CSSD refund the non-custodial parent's $1,037, because the overpayment was due to CSSD error. CSSD could then seek to satisfy the "state debt" by collecting the erroneously disbursed money from the custodial parent. CSSD refunded the overpayment, with interest, to the non-custodial parent.
Revenue / Child Support Services Division A2003-0425 No public report **Complainant alleged** numerous errors in CSSD's calculation of his arrearage. Complainant was the obligor (non-custodial parent) on an Alaska child support order, and a resident of Oklahoma. He said that Oklahoma calculated his arrearage as less than $30,000, while Alaska CSSD insisted that he owed more than $50,000. Discontinued	**Investigation revealed** that, because Alaska had issued the controlling child support order, Alaska's calculation of arrears was binding. Oklahoma's tracking of arrears showed only principal, not interest, and thus grossly understated the debt. CSSD had completed a manual audit in 2003, but apparently had not sent the audit to the complainant. The ombudsman arranged to have that audit forwarded to the complainant, and also had CSSD mark this case as one in which the complainant should receive written statements from Alaska (instead of just the web-based KIDS Online tracking). Other issues (wage withholding orders, passport denial, etc.) represented past errors by CSSD that CSSD had corrected, and there was no feasible recommendation that would reduce the likelihood of future errors on these issues. The case presented a systemic issue regarding the interest rate on the non-custodial parent's arrears. When Alaska arrears were reduced to an administrative judgment in Oklahoma, Oklahoma imposed its own statutory interest rate prospectively, despite not having modified the Alaska support order. Under the Uniform Interstate Family Support Act (UIFSA) of 1996, in effect in both Alaska and Oklahoma at the time, this change in the interest rate matched common practice. The 2001 amendments to UIFSA clarified that the state issuing the controlling order (Alaska) also controlled the interest rate. The ombudsman investigator closed the case with a suggestion to CSSD that CSSD seek legislation adopting the 2001 UIFSA.
Revenue / Child Support Services Division A2002-0182 No public report **Complainant alleged** that the agency had failed to respond to numerous requests to perform an account audit. The complainant also alleged that the accounting on the case was erroneous. Discontinued as Resolved	**Investigation resulted** in the agency conducting an account audit. **The investigation revealed** the agency had erred in its accounting by failing to properly credit the complainant for medical support provided in the amount of approximately $4,000. The agency adjusted the account and credited the complainant for this amount.
Revenue / Child Support Enforcement Division J1999-0152 Public report **Complainant alleged** that the Child Support Enforcement Division (CSED) acted contrary to law when it diverted past due child support	**Investigation revealed** that the complainant's allegations were not supported by the evidence. The complainant's teenage daughter decided to attend a residential Job Corps program and applied for Public Assistance to pay for daycare for her infant. Benefits were paid directly to Job Corps in accordance with state law, which prohibits payment of cash benefits directly to a teenage parent. However, to obtain Public Assistance benefits, the teenager was required to assign to the state her rights to

to repay the state for Public Assistance benefits received by the complainant's child, a teenage mother. The complainant also alleged that CSED acted contrary to law by misapplying 42 U.S.C. 666(a) (18), which addresses parents' potential support obligations toward their teenager's own child. The complainant further alleged that CSED unreasonably collected on a Public Assistance debt when the teen parent did not receive a cash grant. Not Supported	present and past due child support, both for herself and for her infant. As a result, past due child support owed by the teenager's father (the complainant's ex-husband) was assigned to the Division of Public Assistance. CSED properly collected the teenager's father's federal income tax refund and applied it to the Public Assistance debt. CSED also acted in accordance with law when it sent past due support payments and the federal income tax refund to Public Assistance instead of to the complainant while the teenager had an open Public Assistance case. Technically, the complainant was also liable for child support while her teenage daughter lived away from home. However, given the small amount of the Public Assistance debt, CSED said it would not seek a support order against the complainant. 42 U.S.C. 666(a) (18), the "grandparent law," concerns enforcement where both parents of an infant are themselves minors. It provides that a teenage, non-custodial parent's support obligations should be enforced against the teenager's own parents. In this case the father of the teenager's child was not a minor, so 42 U.S.C. 666(a) (18) did not apply.
Revenue / Child Support Enforcement Division A096-3444, A097-2272 Public report **Complainant alleged** that the Child Support Enforcement Division (CSED) did not require an employer to send to CSED support payments withheld from the complainant's wages. The complainant alleged that she notified CSED repeatedly that the employer was not forwarding the withheld payments, but the agency did nothing. The complainant alleged further that CSED established an unreasonably high amount of withholding from the complainant's income even after she had regained custody of the child. *See companion cases under the Department of Law, Civil Division.* Justified & Partially Rectified	**Investigation revealed** that the complainant provided proof to CSED that the employer had withheld support payments but had not sent the funds to CSED. Further, the complainant contacted the agency on numerous occasions to seek help, but was told that the case had been sent to the Department of Law for action. CSED caseworkers never contacted Law to determine the status of the case as required by CSED policy. CSED also did not respond to two other non-custodial parents employed by the same business who reported their wages were being withheld but not sent to CSED. Investigation also revealed that CSED doubled the amount of support owed by the complainant after the child returned to the complainant's home, and did not respond to calls objecting that the amount was harming the complainant's ability to provide for the child. CSED responded to other complaints about employer non-compliance by "sweeping" the complaining non-custodial parent's bank account, but took no action against the employer. **The ombudsman recommended** that CSED direct staff who encounter instances of employer non-compliance to review databanks for all cases involving the employer for patterns of non-compliance and to supply the information to Law when cases are referred for attorney action. The ombudsman also recommended that CSED workers who refer cases to Law regularly track progress on those cases; that CSED staff be trained on the proper advice to give non-custodial parents who experience problems with their employers not following withholding orders; that CSED adopt a policy on how to deal with wage withholding when employers declare bankruptcy; that CSED immediately audit the complainant's payment history and make any necessary adjustments. The ombudsman also recommended that CSED work with Law to amend state law so that direct monetary judgments obtained in violation of statute are paid to custodial families rather than as a penalty to the state unless the debt is owed to the state. CSED rejected several of these recommendations but adopted others. Later the agency implemented some of the ombudsman recommendations it had rejected. CSED audited the complainant's account and stopped all collection from the complainant.
Revenue / Child Support Enforcement Division J097-0317 Public report **Complainant alleged** that the Child Support Enforcement Division (CSED) was inefficient by reporting to consumer reporting agencies a debt it should have known was erroneous. The complainant also alleged that CSED unreasonably refused to correct the inaccurate report made to the consumer reporting agencies. The ombudsman also investigated whether CSED unfairly and contrary to law reported the complainant to consumer reporting agencies without providing advance notice of the proposed release of information and of procedures for contesting the accuracy of the information. Partially Justified & Partially Rectified	**Investigation revealed** that CSED performed inefficiently by granting a visitation credit to the complainant without confirming the visitation with the custodial parent, by failing to place a stop code in its computer system to prevent the complainant from being reported to consumer reporting agencies while the complainant's account was being adjusted, and by taking too long to adjust the account. Investigation also revealed that CSED corrected the erroneous credit report within a month of receiving a complaint about it, and this portion of the complaint was found not supported. Investigation also revealed that CSED procedures violated state and federal regulations on notifying debtors before reporting them to consumer reporting agencies. **The ombudsman recommended** that CSED change its procedures to require notice each time a complainant went from paid up status to a debt of more than $1,000. CSED offered to provide such notice, but no more than once per year. This investigation was closed with an overall finding of partially justified, partially rectified.

Revenue / Child Support Enforcement Division A095-3863, A095-4448, A096-1483, A096-4578, A096-4579 Public report **Complainants alleged** that the Child Support Enforcement Division (CSED) unreasonably delayed modification of child support orders. *See companion cases under Department of Law, Civil Division, and the Court System, Superior Court, Third Judicial District Anchorage.* Justified & Partially Rectified	**Investigation revealed** that during 1996 CSED eliminated its backlog of administrative modifications. Therefore, the ombudsman discontinued several complaints involving administrative modifications. But investigation also revealed gross delays in "judicial modifications"--cases that required CSED to send motions to the Department of Law for submission to the Superior Court. The three specific complaints investigated demonstrated disturbing time lags between the original modification requests and the modifications: over four years; two years and four months; and three years and ten months. A survey of CSED's judicial modification caseload revealed large numbers of backlogged modifications despite federal regulations calling for support modifications to be completed within six months. **The ombudsman recommended** that CSED take steps to complete modification proceedings within six months, the federal regulatory standard. Recommended steps included setting standard time limits for non-custodial parents to return income information, followed by prompt court-ordered sanctions for non-custodial parents who fail to cooperate; tracking cases to determine which ones have exceeded the six month timeframe; adopting time limits for various steps of the modification process to ensure that cases move through the process within six months; providing ongoing education for all case workers dealing with interstate support cases; prioritizing opening and logging of incoming mail; ensuring faster transfer of files from CSED to Law; developing a case management system jointly with Law; and working with Law and the court system to implement a support orders database, better overall procedures for judicial modifications, and a pro se modification packet. The agency accepted some of these recommendations..
Revenue / Child Support Enforcement Division A095-1800, A095-3788, A095-4004, A095-4559, A095-4005 Public report **Complainants alleged** that the Child Support Enforcement Division (CSED) unreasonably required parents of a child not living with a parent or guardian to pay post-majority support. Complainant also alleged that CSED unreasonably failed to take into account the parent's need to support several children at home when CSED calculated the parent's support obligation for one minor child living away from home and receiving Public Assistance benefits. *See companion cases under the Department of Health & Social Services, Division of Public Assistance.* Not Supported	**Investigation revealed** that CSED took a "blanket approach" to collecting post-majority support. This was contrary to AS 25.27.061, which limited post-majority support to cases where a child over 18 is unmarried, is enrolled in an educational institution, and is living as a dependent with a parent, a guardian, or a designee of the parent or guardian. In the complainant's case, CSED rectified the error by ceasing to collect post-majority support. Investigation also revealed that Alaska Rule of Civil Procedure 90.3, which CSED uses to calculate support awards, does not consider other children living at home when calculating support for the child living away from home. However, Rule 90.3 does allow CSED to depart from the rule in unusual circumstances. This case qualified as an unusual circumstance, and CSED ideally should have adjusted the support amount to reflect the parent's support obligation to the siblings of the child living away from home. But the complainant did not appeal for reconsideration based on "unusual circumstances." Because the complainant did not pursue the appeal, the ombudsman concluded that CSED acted fairly in not adjusting the support obligation. **The ombudsman recommended** that CSED adopt a policy implementing the statute on post-majority support and rewrite its "Age of Majority" notice to parents to explain the statutory limits on post-majority support; and that CSED review its caseload to identify and remedy cases where parents were paying post-majority support not required by law. The agency proposed a solution of using the message line on its checks and billing statements to inform parties of the statutory requirements, so non-custodial parents who should not actually be paying support would know to seek reduction of support payments. The agency accepted and implemented these recommendations. CSED no longer collects post-majority support unless the child meets the statutory criteria. The ombudsman also recommended that CSED consider asking the Alaska Supreme Court to revise Rule 90.3 to take into account situations such as the complainant's dual obligation to children at home and to the child living away from home. The agency accepted this recommendation, and Rule 90.3(i) has been changed.
Revenue / Child Support Enforcement Division J093-1084 No public report **Complainant alleged** that the then-director of the Child Support Enforcement Division (CSED) improperly conducted personal real estate business and other personal business in the CSED office on state time and using state equipment. The complainant also alleged that the director violated the state procurement code by awarding a	**Investigation revealed** that the agency director sold real estate using a CSED facsimile machine and during CSED work time. This allegation was found to be justified. Investigation also revealed that the recipient of the contract was not a friend of the commissioner but did receive a contract in a solicitation that did not comply with the state Procurement Code. The director changed the scope of work on the contract and did not seek bids from three bidders as required by state law. **The ombudsman recommended** that the Departments of Revenue and Law develop a policy requiring all new agency supervisors to receive training in the Alaska Executive

professional services contract to a friend of the commissioner. Partially Justified & Rectified	Branch Ethics Act. The ombudsman recommended further that subordinates should not be required to train their supervisors in the requirements of the Ethics Act; that the Department of Revenue should issue a written policy to all new staff setting out rules on personal use of state equipment; that Revenue should incorporate into training sessions material on the Ethics Act and ethical conduct in general. In addition, the ombudsman recommended that the Department of Revenue determine if the director owed any financial reimbursement to the agency; that Revenue consult with the Department of Administration to institute training sessions for all new division directors in the procurement process; and that CSED institute training for staff who serve as "backup' procurement officers during vacations. The agency accepted these recommendations. The ombudsman also recommended that if Revenue permits a division director to be personally involved in a procurement solicitation, the department should assign a higher-ranking official to review the procurement prior to selection of the successful bidder. The department rejected this recommendation.
Revenue / Child Support Enforcement Division A095-3425 No public report **Complainant alleged** that, contrary to law, the Child Support Enforcement Division (CSED) disclosed the complainant's address to the child's father, a prison inmate. State law restricts the release of client addresses by CSED. Justified & Partially Rectified	**Investigation revealed** that CSED had sent the father a copy of the case closure letter without blacking out the complainant's address. As a result, the father began to telephone and write her. Investigation revealed that CSED had no written procedures regarding case closure notices and that its release of address information, although inadvertent, violated the law. Although no remedy could undo the effect this error had on the complainant, during the course of the investigation CSED revised its desk manual to include a warning against sending copies of closing letters to the opposite party to avoid similar problems in the future.
Revenue / Child Support Services Division J2002-0079 Public report **Complainant alleged** that CSSD failed to initiate a downward modification of complainant's child support obligation, despite evidence that the complainant was disabled and thus unable to generate income at her prior level. See companion case under Department of Labor and Workforce Development, Division of Vocational Rehabilitation (DVR). See companion case under Department of Labor and Workforce Development, Division of Vocational Rehabilitation (DVR). Partially Justified & Rectified	**Investigation revealed** that complainant told CSSD of her change in income, and then provided authorization for CSSD to contact her vocational rehabilitation counselor for confirmation. CSSD did contact the counselor, but when the counselor's assistant responded that the complainant could work "part time," CSSD assumed without checking that this meant that the complainant should work at least 20 hours per week. After the ombudsman advised CSSD that, in fact, the DVR counselor considered the complainant unable to work that many hours, CSSD staff left one phone message for the DVR counselor, but did not make any further effort up when DVR did not return the call. After further ombudsman intervention, CSSD spoke with DVR again, and then processed a modification of support, but during the several months of delay, the complainant accrued support debt at a rate considerably greater than actual income or ability warranted. **The ombudsman recommended** that in cases where the obligor is receiving DVR services, CSSD request the obligor to provide an authorization, then contact the obligor's DVR counselor regarding any questions of the obligor's employability and insist on actually speaking with the counselor directly. The ombudsman also recommended that CSSD provide a presentation to DVR staff explaining CSSD's role and how it potentially impacts DVR consumers, so that DVR staff could respond more effectively to future CSSD inquiries. CSSD accepted the recommendations.
Revenue / Child Support Services Division J2002-0150 Public report **Complainant alleged** that CSED failed to provide adequate notice that he would be charged child support to reimburse the state for public assistance provided to his child and the custodial parent, and that CSED refused to credit him for direct support payments he made to the custodial parent. Justified & Rectified	**Investigation revealed** that when CSED serves a new support order, it does so via restricted delivery mail, and this increases the chance that the obligor will receive actual notice of the liability. In this case, the initial notice of liability was not a support order, but a notice of public assistance debt, which is not required to be served via restricted delivery. Because CSED refused to credit direct payments to the custodial parent made after CSED mailed the public assistance notice, the notice affected the obligor's liability just as much as a support order, without equivalent procedural protection. **The ombudsman recommended** that in cases where a support order had not yet been served that CSED provide restricted delivery mailing for the notice of liability for public assistance payments. This would guarantee that the first of support liability – whether the public assistance notice or the support order – would be served via restricted delivery. CSED did not change its method of mailing the notice of public assistance debt. However, CSED changed its treatment of direct payments, and began allowing credit for direct payments made prior to entry of a support order, regardless of the mailing of the notice of public assistance. Because the notice of public assistance no longer had such a dramatic effect on the obligor's liability, the method of serving it

	became less important. CSED's response addressed the concerns raised in the investigation.
Revenue / Child Support Services Division J2003-0021 No public report **Complainant alleged** that, in both her child support cases, the Child Support Enforcement Division (CSED) misapplied payments to the state-owned arrears. The complainant contended that the misapplied payments should have been paid to her for ongoing support or custodial-owed arrears. Partially Justified	**Investigation revealed** that, in one of the cases, CSED had erred when it misapplied payments toward the state-owned arrears instead of the custodial-owed arrears in the amount of $396. In response, CSED acknowledged the error, properly adjusted the child support account, and refunded the $396 to the complainant. In the other cases, investigation revealed that the child support payments were distributed appropriately between the various accounting sub-debts. This investigation was closed with a finding of "partially justified." During the investigation, CSED took action to rectify the "partially justified" finding. Consequently, no recommendations were issued.
Revenue / Child Support Services Division J2003-0094 Public report **Complainant alleged** that the Child Support Enforcement Division (CSED) unfairly failed to pursue allegations of welfare fraud against the complainant's former spouse and credit the complainant's child support account for periods that fraudulent welfare benefits were received. In addition, complainant alleged that CSED failed to credit the complainant's account for payments made directly to the custodial parent and for contributions the complainant made to the children in lieu of child support. Not Supported	**Investigation revealed** that the complainant had not provided substantive proof of the alleged welfare fraud to CSED or to the Alaska Division of Public Assistance Fraud Control Unit, so this portion of the complaint was found not supported. Investigation also revealed that the complainant had not provided substantive proof of direct payments made to the custodial parent and contributions made in lieu of child support that would warrant a credit to the complainant's child support account. This portion of the complaint was found not supported. This investigation was closed with an overall finding of unsupported. Because this allegation was found to be unsupported, no recommendations are warranted in this case.
Revenue / Child Support Services Division J2003-0031 Public report **Complainant**, a custodial parent, **alleged** that CSSD had failed to enforce all of the terms of another state's child support order, resulting in the complainant being underpaid. After CSSD petitioned the Alaska court to modify the support order, the complainant alleged errors in CSSD's calculations during and after the modification. CSSD audited the complainant's account, and concluded that the complainant had actually been overpaid support because she had kept some child support payments while receiving Alaska Temporary Assistance Program (ATAP) benefits several years before the date of the audit. (ATAP clients are required to assign their child support rights to the state while receiving ATAP). Then CSSD "suspended" the complainant's ongoing child support until CSSD had recovered the amount of the alleged overpayment from incoming payments; the complainant's child received no support for three months, and reduced support in a fourth month. The ombudsman investigated whether CSSD's audit was accurate, and whether CSSD's method of recovering the overpayment was reasonable. Partially Justified	**Investigation revealed** that the other state's child support order contained a "minimum" set amount per month, plus a "balloon" payment to be calculated each year based on the non-custodial parent's tax returns, if his income exceeded the level used to set the minimum monthly payment. CSSD enforced only the set amount, and ignored the "balloon" payment provision. Although the "balloon" payment provision was not enforceable under Alaska law, CSSD was still obliged to collect the amount that the other state calculated was due. However, because the other state did not award any balloon payment amounts, CSSD did not actually err by failing to collect more than the set monthly amount in the order. The amount collected each month under the other state's order was probably less than would have been calculated under Alaska law. Because the child and both parents had moved to Alaska, CSSD could petition to modify the other state's support order in an Alaska court, resetting the monthly support to match Alaska's rules. CSSD delayed for almost three years before asking a court to modify the support order. The ombudsman concluded that CSSD delayed unnecessarily, but that the complainant's failure to formally request a modification contributed to the delay, so this complaint against CSSD was only partially justified. As for the CSSD audit, **investigation revealed** that the audit was inaccurate regarding three months of alleged overpayments. CSSD refunded $1125 to the complainant, out of money "recovered" by CSSD during the suspension of ongoing support. Other alleged overpayments were accurate, but some of the payments occurred in large part because CSSD erroneously distributed support checks to the complainant while she was on public assistance. CSSD and the Division of Public Assistance had failed to "interface" in 2000-2001, and an unknown number of accounts suffered similar errors. **Investigation revealed** that CSSD lacked a reasonable process to allow a custodial parent to dispute an alleged overpayment. Finally, CSSD's suspension of all ongoing support to the child in order to recover the overpayment (money owed to the state) was both unreasonable and appeared to violate federal policy for state child support agencies. **The ombudsman made 10 recommendations** to CSSD. CSSD accepted some of the recommendations

Revenue / Permanent Fund Dividend Division A2008-1817 No public report **Complainant alleged** that PFD failed to release her children's 2008 year dividends to her despite a court order to do so. The complainant explained that she and her husband were estranged in part due to domestic violence. The complainant, who had physical custody of the couple's children, sought and obtained a long-term protective order against her estranged husband. In the interim, both parents had filed competing applications for the children's 2008 dividends. In the protective order, the court awarded the children's 2008 year dividends to the complainant. The complainant provided a copy of the protective order to the agency, but the PFD technician working the applications advised her that the protective order was not sufficient authorization to release the dividends to her. Discontinued as Resolved	PFD acknowledged the PFD technician had erred in interpreting the order. A PFD manager determined that the protective order was sufficient and the agency subsequently released the children's 2008 dividends to the complainant.
Revenue / Permanent Fund Dividend Division A2004-1010 Public report The complainant alleged that the Division of Permanent Fund Dividend (PFD) arbitrarily denied the complainant's and the complainant's spouse's applications for the 2003 Permanent Fund Dividend. Not Supported	**Investigation revealed** that the complainants' applications for a 2003 PFD were handled in accordance with Alaska law and in full consideration of information they provided to support their appeal.
Revenue / Tax Division A2009-0390 Public report **Complainant alleged** that the agency failed to respond to a public records request. Justified & Rectified	**Investigation revealed** that the complainant's request was received by the agency, but was not recognized as a public records request. The agency failed to respond after several months and multiple requests from the complainant. AS. 40.25 & 2AAC 96.100-900 provide for prompt production of materials prepared by a public agency for routine public distribution when requested by a member of the public. Immediately after notification by the ombudsman of non-compliance with the statute, the agency provided the complainant with the requested information. **The ombudsman recommended** training for department employees handling public records requests and the agency agreed and provided the training.
Transportation & Public Facilities / Administration A2009-1571 Public report **Complainant alleged** that Department of Transportation unreasonably rescinded a job offer to the complainant, who quit another job in reliance on the offer. **Complainant also alleged** that DOT failed to provide the complainant with a clear explanation of the reasons DOT rescinded an employment offer, failed to rank and score applicants for a position prior to extending a job offer as required by 2 AAC 07.106, and failed to retain recruitment documentation as required by 2 AAC 07.113. Justified & Partially Rectified	**Investigation found** all allegations against DOT justified and proposed three recommendations to DOT: (1) DOT should provide the complainant with a written apology for DOT's mishandling of the complainant's employment application and subsequent job offer without Personnel approval. The letter should clearly acknowledge the errors made in the recruitment and hiring process; (2) DOT should consider paying the complainant a reasonable sum of money to compensate her for her financial loss; (3) Recommendation 3 was redacted in accordance with Alaska confidentiality statutes. At the conclusion of an investigation, the ombudsman often requests a state agency report back to her on its progress in implementing any recommendations she has made and the agency has accepted. After multiple contacts by the ombudsman, DOT ultimately issued an apology letter to the complainant, five months after the agency had accepted the ombudsman's recommendation to do so. DOT ultimately disagreed with ombudsman Recommendation 2 despite previously accepting this recommendation after consultation with the Department of Law. DOT determined it was inappropriate to spend public funds by making a payment to the complainant to compensate her for her financial loss.
Transportation & Public Facilities / Division of Measurement Standards & Commercial Vehicle Enforcement A093-1469 Public report	**Investigation revealed** that DPS had only five inspectors to inspect the state's 30,000 commercial vehicles. State law required semi-annual inspections. Federal law required annual inspections. **The ombudsman recommended** that the DPS inspection unit implement AS

Complainant alleged that the commercial vehicle inspection program formerly with the Department of Public Safety (DPS), Division of Alaska State Troopers (AST) did not comply with state law or Federal Highway Administration commercial motor vehicle inspection requirements because DPS inspectors could not possibly inspect all the state's commercial vehicles with existing manpower. Justified & Rectified	28.32.030, which authorizes licensing and certification of private Commercial Motor Vehicle (CMV) inspection stations. The agency rejected this recommendation. However, the Department of Transportation and Public Facilities (DOT/PF) became the lead agency for commercial vehicle enforcement in 1997 and has since expanded the inspection program throughout the state. The ombudsman further recommended that DPS should review program regulations to ensure they are current and do not conflict with other federal and state statutory or regulatory provisions. The ombudsman also recommended that the Division of Motor Vehicles should begin enforcing the inspection requirements and denying registration to CMV operators who do not prove they have passed the inspection; and that the Alaska State Troopers review AS 28.32.020 to determine if the state's semi-annual inspection requirement should be amended to comply with the federal annual inspection requirement. These recommendations were accepted. The ombudsman recommended that AST ask the Department of Law to issue a legal opinion on whether inspectors have legal authority to inspect "owner-deadlined" vehicles on private property. DPS rejected this recommendation but DOT/PF began conducting compliance reviews in 2001.This investigation was closed with an overall finding of justified, rectified.
Transportation & Public Facilities / **Division of Statewide Design & Engineering Services** A099-0027 Public report **Complainant alleged** that the Department of Transportation & Public Facilities (DOT/PF) unreasonably failed to notify all affected property owners of the opportunity to comment on the proposed siting and construction of a bridge planned for Aleknagik. Not Supported	**Investigation revealed** that DOT/PF exceeded the legal requirements for notice on the bridge project by publishing large notices in Alaska newspapers. Investigation also revealed that the complainant learned of the proposed project before the comment deadline and that DOT/PF extended the comment period for anyone who requested more time. This investigation was closed with an overall finding of not supported.
Transportation & Public Facilities / Northern Region F093-1817 Public report **Complainant alleged** that the Department of Transportation & Public Facilities (DOT/PF) statewide office of Disadvantaged Business Enterprise/External Equal Employment Opportunity (DBE/ExEEO) mistakenly set the DBE subcontracting utilization goal for an airport lighting repair contract too high, that the agency unreasonably refused to reduce the DBE goal when the complainant pointed out mistakes in the calculations, and that the DBE goal for the project unreasonably encouraged illegal collusion among bidders. Partially Justified & Rectified	**Investigation revealed** that the DBE/ExEEO Officer and DOT/PF Northern Region contracting staff unreasonably failed to correct significant errors in DBE data and calculations when the complainant pointed them out. The allegation concerning potential collusion was not supported by the evidence. **The ombudsman recommended** that DOT/PF review its policies and procedures to determine whether they adequately explained the proper procedure for determining DBE goals, and that the department review its procedures for responding to inquiries or complaints from potential bidders pointing out errors in project bidding documents. The agency accepted these recommendations. This investigation was closed with an overall finding of partially justified, rectified.
University of Alaska, Anchorage (UAA) Administrative Services, Human Resources Section A2002-0049 Public report **Complainant alleged** that UAA unethically changed the minimum requirements for a job during the recruitment, after advertising the position using the original requirements. The ombudsman also investigated whether UAA provided an adequate and timely explanation in response to the complainant's inquiries, and whether UAA implemented a fair, effective remedy for the initial error in the recruitment process. Justified & Partially Rectified	**Investigation revealed** a University of Alaska regulation specifically prohibits changing the job requirements after the recruitment has begun. UAA violated this regulation. Investigation also revealed that when UAA changed the job requirements, the complainant telephoned, then wrote, requesting an explanation of how the change would affect his application. UAA did not provide a clear explanation to the complainant in response to his inquiries. He eventually received a short letter stating that he had been eliminated from consideration, with no indication of how or if his elimination related to the change in the job requirements. After UAA realized that the change in the job requirements violated a university regulation, UAA reconsidered the applications of candidates who had been disqualified by the changed requirements. However, UAA did not inform these applicants of this remedy until about two months later, after the position had been filled. **The ombudsman recommended** that UAA conduct training for its human resources staff to increase awareness of the existing regulations. Also, the ombudsman recommended that UAA consult with the university's statewide human resources staff and with university counsel to determine if the hiring regulations need revision. The ombudsman also made several recommendations directed at UAA's procedures. UAA accepted some of the recommendations.

University of Alaska / Anchorage Campus / Enrollment Services, Housing A2000-0079 Public report **Complainant alleged** that the university acted inefficiently by not responding in a timely manner to the complainant's petition for an emergency tuition and housing refund after mental problems forced the complainant to drop out of school. **Complainant further alleged** that the University acted unreasonably by ultimately denying the tuition and housing refund. Partially Justified & Rectified	**Investigation revealed** that the tuition refund committee did not respond to the complainant's petition within its four-to-six week timeframe. UAA's response was not sent to the complainant until 20 weeks after the petition was filed. Investigation further revealed that the refund committee did not review the full petition form, which indicated that the complainant had become mentally disabled and therefore fit the criteria for receiving a tuition refund. Investigation also revealed that the complainant's parent co-signed the university housing contract and was aware that the complainant had left school but didn't inform the UAA housing office. The ombudsman found that the parent bore joint responsibility for the housing costs and therefore the allegation against the housing division was found unsupported. The ombudsman recommended that UAA reconsider the complainant's petition taking into account the complainant's mental disability; amend the petition for refund form to include a medical information waiver; better define the term 'disability' in the petition for refund policy and literature; conduct mandatory in-service training on the requirements regarding mental disabilities; review its petition refund process and determine if any changes are needed; and establish an appeal process for the tuition refund requests. UAA accepted and acted upon all recommendations.
University of Alaska / Anchorage Campus A098-0576 Public report **Complainant alleged** that the University of Alaska Anchorage (UAA) unfairly charged an excessive cancellation fee of $250 plus forfeiture of a $100 security deposit when the complainant, a student, gave UAA notice that he would not be occupying a dormitory room reserved for the 1998 spring semester. Not Supported	**Investigation revealed** that the allegations were not supported by the evidence. UAA is allowed by state law to set the terms and conditions for renting residence hall space. The penalties for cancellation were stated clearly in the contract, and the complainant initialed sections in the contract that specifically stated the penalties for cancellation.
University of Alaska / Anchorage Campus A092-7733 No public report **Complainant alleged** that the University of Alaska Anchorage prepared a bid document for telephone equipment that unfairly lacked adequate specifications to allow alternative products, thus placing some vendors at an unfair disadvantage. Not Supported	**Investigation revealed** that the complainant did not respond timely to advertisements of the bid, did not attend a pre-bid conference, did not submit questions before the deadline, did not submit alternative equipment for consideration, and did not bid. The ombudsman found that the complainant's problems with the bid were due to factors within the complainant's control.
University of Alaska / Fairbanks Campus / Cooperative Extension Service A2003-0019 Public report **Complainant alleged** that CES unreasonably denied his public records request for data from the quarterly Alaska food cost survey, unfairly delayed responding to his appeal, changed its basis for denying the request in a second decision four months after the first denial, and failed to follow its own appeal regulations. **Complainant also alleged** that university staff treated him dismissively, and unfairly held him to stricter procedural standards than they observed themselves. Justified & Partially Rectified	**Investigation revealed** that university staff failed to inform the complainant of his rights under state law and university regulation, failed to respond to his requests for clarification of the appeal process university staff were following, and failed to disclose to him the full record of arguments against granting his request and appeal. **Investigation also revealed** that CES responded to the complainant's public records request in a manner that did not comply with state law, Regents' policy, and university regulation. **The ombudsman recommended** (1) that the Regents amend Regents' Policy to require that notice of the formal appeals process be given to those whose public records requests are denied, and to provide specific guidelines to university staff for fair and proper handling of appeals; (2) that the university ensure that all unit directors understand Regents' Policy on public records requests and that they disclose the appeal procedure to anyone whose request is denied; (3) that the university should instruct all administrators to mail or hand-deliver their decisions, together with notice of the appeal procedure; (4) that CES should develop written policy guidelines for stewardship of data gathered in pricing surveys and other CES public service studies; and (5) that UA correct an erroneous statute citation in Regents Policy 05.08.02. The university accepted recommendations 1-3 and 5, and rejected recommendation 4.
University of Alaska / Southeast Campus J096-0863 Public report	**Investigation revealed** that the complainant received full credit for prerequisite courses but failed to satisfy one of the other requirements for admission to the BLA program: passing the Writing Proficiency Review by submitting a portfolio of several

Complainant alleged that staff at the University of Alaska Southeast (UAS) Juneau campus unfairly failed to give full credit for prerequisite courses taken at the UAS Sitka campus, and that UAS faculty unreasonably failed to observe consistent standards in evaluating the student's writing assignments. The complainant said denial of admission to the Bachelor of Liberal Arts (BLA) degree program at the Juneau campus by UAS faculty caused the complainant unnecessary additional expense. Partially Justified	papers in accordance with specific instructions. This requirement was dictated by accreditation standards, was advertised in the UAS catalog, and was applied equally to all BLA program applicants. However, investigation also revealed that the student's writing was evaluated more rigorously for the Writing Proficiency Review than it had been for regular class writing assignments in several academic disciplines at both the Sitka and Juneau campuses. Soon after this complaint was filed, UAS moved in several areas to remedy potential systemic problems highlighted by this student's experience, reviewing intercampus consistency in matters of grading policy, student placement in writing courses, content and methodology of writing courses, interdisciplinary coordination of writing assignments and evaluation standards, and student advising. The ombudsman did not make formal recommendations for further university action.
University of Alaska / Southeast Campus J2003-0055 Public report **Complainant alleged** that the Housing Office unfairly banned him from advertising his rental apartment on the Housing Office bulletin board, based on an inaccurate letter written by a disgruntled former tenant. Justified and Rectified	**Investigation revealed** that UAS received a letter from a former tenant who had rented an apartment from the complainant, charging that both the apartment and complainant's conduct as a landlord were substandard. UAS had an unwritten policy that, upon receipt of any written complaint by a tenant, it would prohibit the landlord from advertising on the Housing Office bulletin board. UAS required that the complaint be in writing, but UAS made no other effort to verify the truth of the tenant complaint, nor did UAS ask for the landlord's side of the story before acting. UAS agreed that its policy was inadequate, and decided that it would no longer process tenant or landlord complaints. UAS decided to provide the bulletin board service without attempting to screen the postings, and to warn both landlords and students that UAS does not screen either tenants or rentals. UAS then applied the new policy to the complainant by reinstating his ability to advertise through the Housing Office.

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