State of Alaska Ombudsman

ANNUAL REPORT 2016

ALASKA STATE OMBUDSMAN
240 MAIN STREET, SUITE 202
JUNEAU, ALASKA 99801

INTRODUCTION

The Alaska State Ombudsman is responsible for investigating citizen complaints about state executive branch agencies. The Ombudsman can also review complaints about administrative actions of the court system, legislature, and quasi-governmental organizations.

The Ombudsman's role is to objectively review the administrative actions of state agencies to determine whether they were unlawful, unreasonable, unfair, or based on unacceptable grounds. The Ombudsman is not a citizen or consumer advocate. The role of the Ombudsman is to help ensure that state government is serving Alaskans as efficiently, effectively, and equitably as possible.

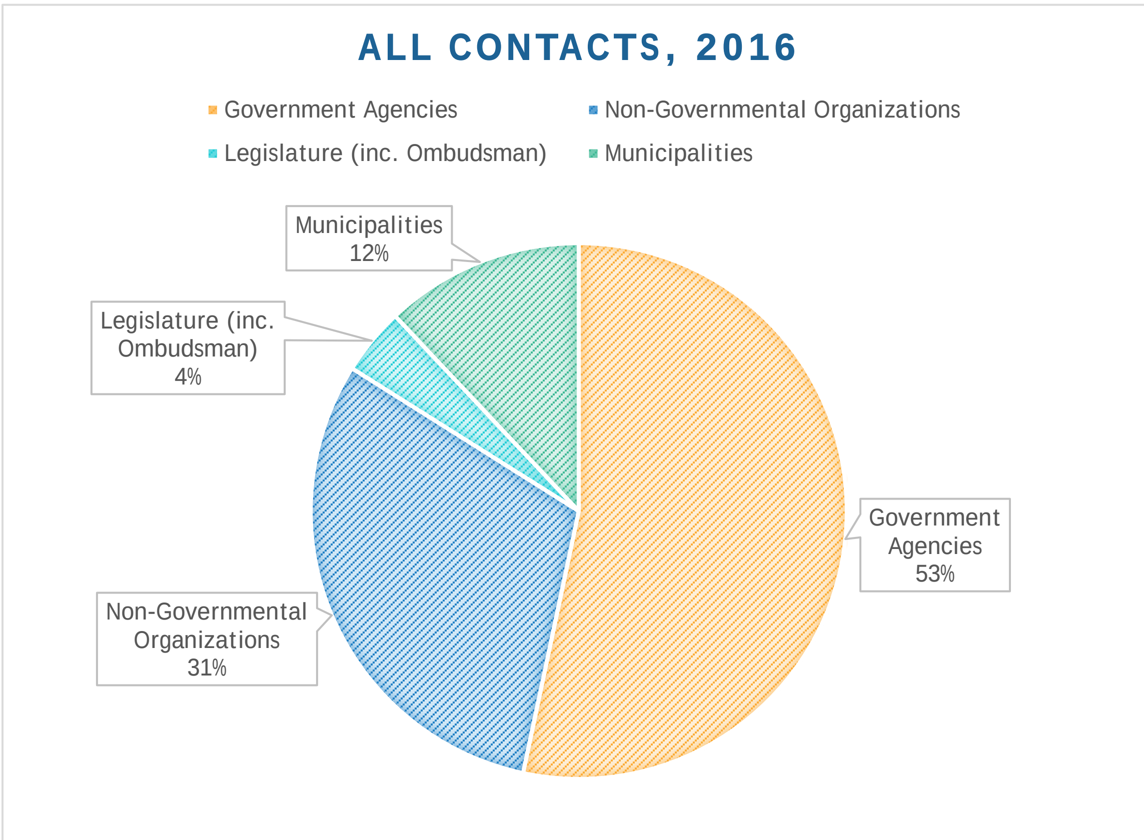
From offices in Juneau and Anchorage, the Ombudsman serves the entire state. Intake and screening of complaints is centralized in Anchorage. There are assistant ombudsman investigators in Anchorage and Juneau. Combined, the investigatory staff have more than 75 years of experience reviewing citizen complaints in Alaska.

> Don't look where you fall, but where you slipped.
>
> – African proverb

The 2016 Annual Report was prepared in part by former Ombudsman Linda Lord-Jenkins and by incoming Ombudsman J. Kate Burkhart.

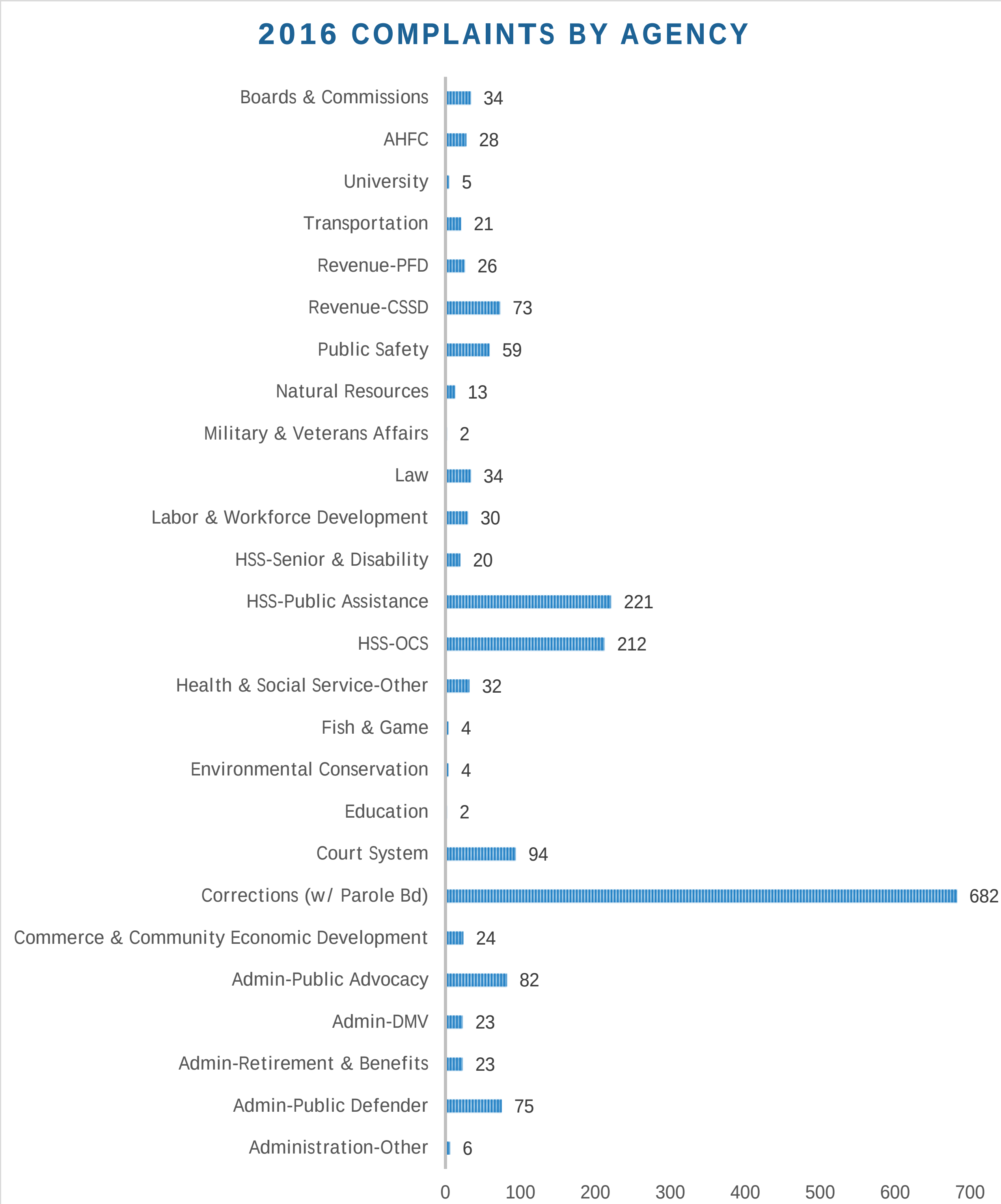
OVERVIEW OF COMPLAINTS

In 2016, the Office of the Ombudsman received 2,664 contacts. People come in or contact the office by phone, email, and mail. Often, they have a question or concern that doesn't rise to the level of a complaint. Many people call about problems with a city department, a legal action, a non-profit, an elected official, or other organization outside of the Ombudsman's jurisdiction. Our staff provide information and referrals to more appropriate sources of assistance in these cases.



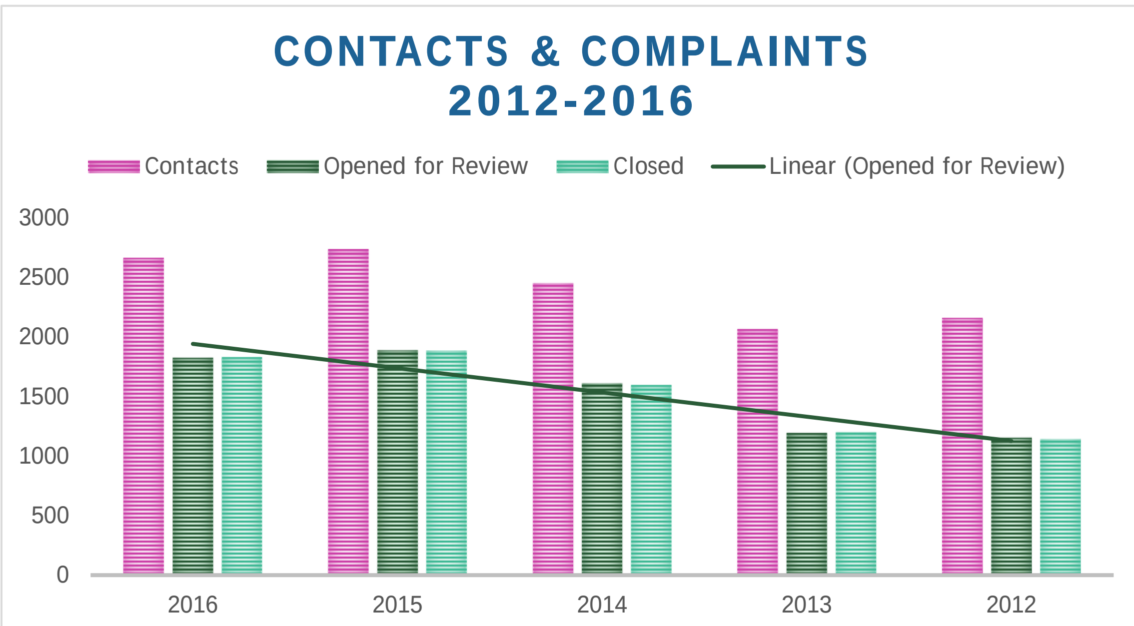
The Ombudsman received 1,883 jurisdictional complaints in 2016. We encourage people to attempt to resolve their complaints directly with the agency, especially if there is a grievance process or complaint resolution center within the agency. If a person hasn't raised their problem with the agency, or attempted to find a solution through a grievance process, we tend to decline to review the complaint until after they have pursued that course of action. This is because internal administrative grievance and appeal processes can often result in a resolution without the need for an investigation. (Exceptions are made if the person experiences a disability and needs assistance to navigate administrative processes, or if there is a significant risk to health or safety.)

In 2016, the majority of the 1,883 jurisdictional complaints received were about the Department of Corrections (682, including 17 related to the Parole Board). The Department of Health and Social Services had the next largest number of complaints (485). There were 209 complaints about the Department of Administration, most of which were about the Office of Public Advocacy (82) and the Public Defender (75). The breakdown of annual complaints reviewed by agency is provided in the chart below.



Not all of these complaints resulted in investigations. In 2016, 52% of total contacts were declined for review, usually because the complainant had not attempted to resolve their problem with the agency first. Whenever a complaint is declined for review or investigation, our staff provides the complainant with information about the relevant agency grievance/complaint resolution process and other resources that may be of assistance. Complainants are encouraged to contact the Office of the Ombudsman if they are not able to resolve their problem through the grievance process to which they were referred.

There has been an increase in contacts since 2012, which has resulted in an increase in complaints opened for review and investigations closed each year. The number of complaints investigated and resolved through informal consultation with complainants and state agencies has remained consistent since 2012 (an average of 441 per year). The number of complex investigations resulting in formal recommendations for corrective action to a state agency has remained consistent since 2013 (an average of 5 per year).



The Office of the Ombudsman investigated 435 complaints in 2016. These investigations resulted in a variety of outcomes for the complainants. In 82% of complaints, the ombudsman investigators identified the root of the problem and found a solution in consultation with the complainant and state agency. In 16% of complaints, the ombudsman investigators determined that either the allegations about the state agency were not justified or that the resolution sought by the complainant was not possible. Just about 1% of complaints resulted in a complex investigation followed by formal recommendations for corrective action by the state agency.

COMPLAINTS ABOUT ADMINISTRATION

The Office of the Ombudsman reviewed 209 complaints about the Department of Administration. The majority of complaints were about the Office of Public Advocacy and Public Defender's Office. The Division of Retirement and Benefits and the Division of Motor Vehicles each accounted for 11% of the total complaints.

PUBLIC DEFENDER & OFFICE OF PUBLIC ADVOCACY COUNSEL

The 99 complaints about attorneys from the Office of Public Advocacy and Public Defender's Office made up 47% of complaints about the Department of Administration. In nearly all of these complaints, the complainant was referred to the director of the agency or a supervisor, and the Alaska Bar Association. This is because the primary allegation made by complainants about their court-appointed counsel was that the attorneys were not zealously representing them — which is an issue of professional conduct most appropriately reviewed by the Alaska Bar Association.

OFFICE OF PUBLIC ADVOCACY GUARDIANS, CONSERVATOR

Complaints about guardians and conservators appointed through the Office of Public Advocacy accounted for 23% of complaints received in 2016 about the Department of Administration. Ombudsman investigators reviewed and assisted in resolving 19 complaints related to guardianships and conservators.

DIVISION OF MOTOR VEHICLES

The Office of the Ombudsman investigated 9 complaints about the Division of Motor Vehicles in 2016. All were resolved in consultation with the complainant and agency. None resulted in formal findings of agency error or recommendations.

DIVISION OF RETIREMENT & BENEFITS

Of the 23 contacts about the Division of Retirement and Benefits, ombudsman investigators reviewed and resolved 8 complaints. Of these complaints, 3 were about employee or retiree health plan benefits and 5 were about retirement benefits. In only one instance was an error (excessive delay in providing information to the complainant) on the part of the agency found. In that complaint, ombudsman staff worked with the agency to resolve the error within 24 hours.

SELECTED INVESTIGATIONS

Ombudsman investigators conducted 27 in-depth investigations of complaints about the Department of Administration. Examples of closed investigations include:

- A complainant experiencing significant disabilities sought help getting a new Medicaid card and funds from the appointed conservator, who was not responding to communications from the complainant or their care-coordinator. The ombudsman investigator determined that the complainant's emails had been intentionally forwarded to a "spam" folder, which was not regularly checked by the conservator. No reason for ignoring the care coordinator's communications was found. Working with the agency, the investigator ensured a new Medicaid care was issued and that the refusal to release funds was resolved through the agency's grievance procedure.

- A complainant experiencing disabilities was initially referred to the Office of Public Advocacy's grievance procedure to resolve a complaint about accessing their money to buy clothes. However, the complainant returned to the Ombudsman for assistance when they could not navigate the grievance procedure unassisted. The ombudsman investigator worked with a supervisor at the agency to resolve the complaint by having funds released to the complainant.
- A complainant born at home in a rural community in 1931 was not able to get an Alaska ID because they had no birth certificate. The lack of a state identification was a barrier to applying for Medicaid and public assistance, which in turn prevented them from being able to access home and community based services so they could continue to live at home. The ombudsman investigator determined that there were strict statutory requirements for documenting identity to the Division of Motor Vehicles and the Division of Public Assistance. In the meantime, the Division of Motor Vehicles manager reviewed the case, denied the application for an Alaska ID, and then forwarded the matter to the Governor's Office for consideration. The Governor's Office determined that an ID should be issued to the complainant.

COMPLAINTS ABOUT ALASKA HOUSING FINANCE CORP.

There were 34 information and referral calls about Alaska Housing Finance Corporation (AHFC) and 19 jurisdictional complaints. Of these, 7 complaints were reviewed. Only in one instance was an agency error found after investigation.

SELECTED INVESTIGATIONS

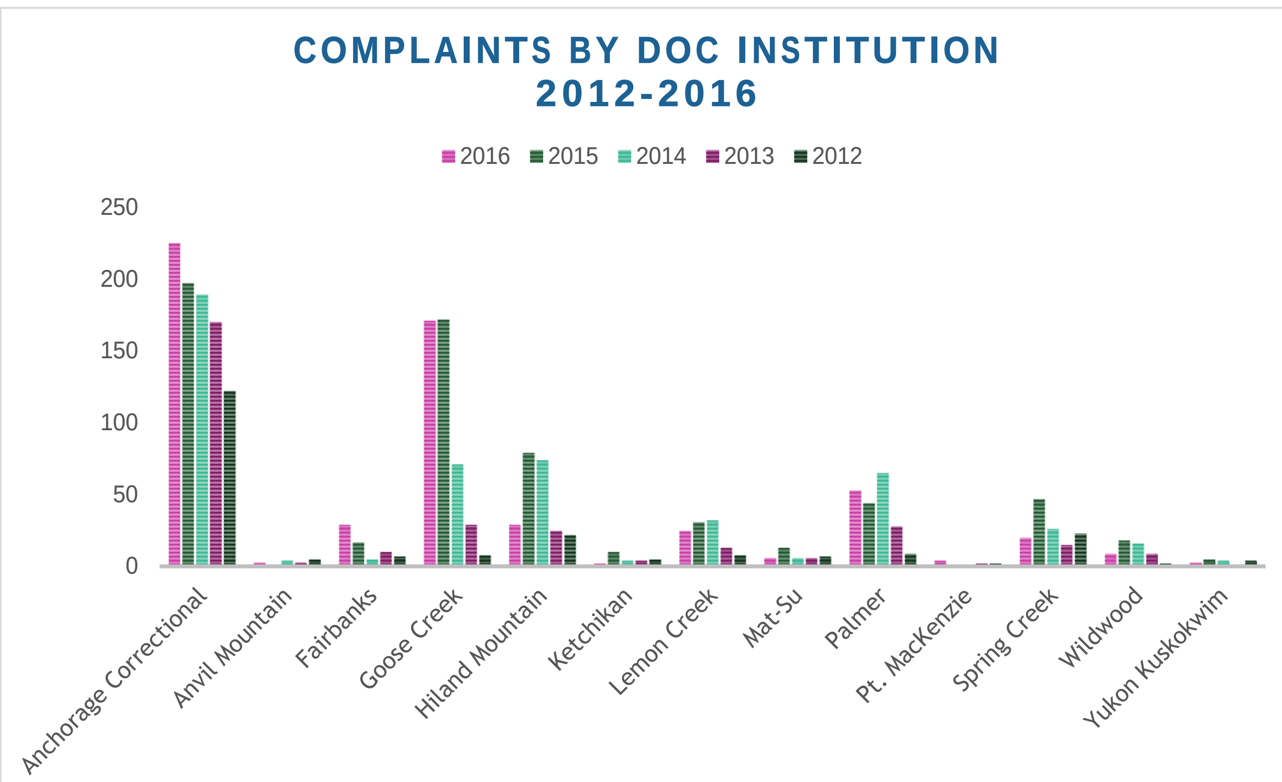
- A complainant alleged that he was improperly denied a housing voucher from a past debt owed by his mother to AHFC. The ombudsman investigator found that the debt was the result of the complainant, who was a landlord at the time, receiving and keeping payments from AHFC subsidizing a tenant's rent even after the tenant had died. While the debt was legitimate, it had accrued many years before and AHFC had made no meaningful attempt to collect on it. The statute of limitations for collecting the debt had passed, and AHFC was prohibited from considering it a "current debt" for the purposes of voucher eligibility. As a result of the investigation, the complainant was determined eligible for a housing voucher.

> A pessimist sees difficulty in every opportunity;
> an optimist sees opportunity in every difficulty.
> – Winston Churchill

COMPLAINTS ABOUT CORRECTIONS

Historically, complaints about the Department of Corrections (DOC) have been a large portion of complaints received and investigated by the Office of the Ombudsman. The number of contacts about DOC nearly tripled from 327 in 2012 to 810 in 2015, falling to 686 in 2016. However, the percentage of contacts related to jurisdictional complaints (as opposed to non-jurisdictional complaints such as the adequacy of court appointed counsel or sentencing) has remained between 75-84% since 2013. Complaints about inmate health care services (medical care, behavioral health care, and pharmacy) have tripled from 54 complaints in 2012 to 153 complaints in 2016.

Over the past five years, some DOC institutions have had relatively uniform numbers of complaints each year. Anchorage Correctional Complex and Palmer Correctional both experienced a steady increase in complaints since 2012. Anchorage Correctional complaints in 2016 (225) were 84% higher than the number of complaints in 2012. Palmer Correctional complaints in 2016 complaints were more than five times greater than in 2012 (53 versus 9). (Palmer Correctional was closed in 2016.) Fairbanks Correctional had 7 complaints in 2012 and 29 complaints in 2016. Goose Creek Correctional has also experienced a dramatic increase in the number of complaints (due in part to the institution becoming more populated over time).



SELECTED INVESTIGATIONS

The Office of the Ombudsman closed 41 investigations about the Department of Corrections in 2016. Of these, 32% (13) resulted in a finding that the agency's actions were unlawful, unreasonable, or otherwise in error. Examples include:

- A time accounting decision to add time from a previous sentence (previously disposed as "time served") to a complainant's new sentence appeared contrary to the court's intent in sentencing. After documenting the discrepancy between the court's sentencing order and DOC's time accounting decision, the ombudsman investigator informed the Public Defender's Office so that the complainant's attorney could seek clarification from the court — resulting in reduction of the complainant's time to serve by over a month.
- DOC had a long-standing policy deeming any inmate with a "history of sex offenses" — whether convicted or not — as ineligible for furlough. Investigation showed that this *de facto* policy was in fact contrary to DOC Policy 818.02 related to furloughs. The ombudsman investigator recommended that DOC review its policy and revise it to explicitly identify conditions barring eligibility for furlough. DOC agreed, and issued an updated policy on February 24, 2017 that states that "a prisoner who has a current or past conviction or crime involving a sexual offense or arson/burning offense is not eligible for pre-release furlough."
- Due to delays by DOC in sending child support payments from inmates' wages to the Child Support Services Division (CSSD), the complainant (and other inmates in similar situations) was being charged interest for late child support payments. The ombudsman investigator determined the cause of the problem and informed both state agencies of how this administrative action was having serious consequences to inmates, due to no fault of their own. Leadership of DOC and CSSD worked together to find a solution, which included DOC auditing all inmate offender trust accounts and paying CSSD $9,442 to bring accounts current and compensate inmates for interest charged to them for late payments.
- Investigation of a complaint about an improper strip search of a group of inmates found that a) the group strip search occurred, which was contrary to DOC policy and procedure; and b) the complaint about the search made to the facility Prison Rape Elimination Act (PREA) had not been investigated. As a result of the ombudsman investigation, DOC immediately conducted internal investigations of the search and the PREA allegations. The facility superintendent found that the manner in which the search was conducted was contrary to "acceptable correctional practices" and staff involved received additional training on how to properly conduct searches of inmates. The PREA investigation found that, while the search was improper, it did not constitute sexual harassment (as alleged by the complainant).

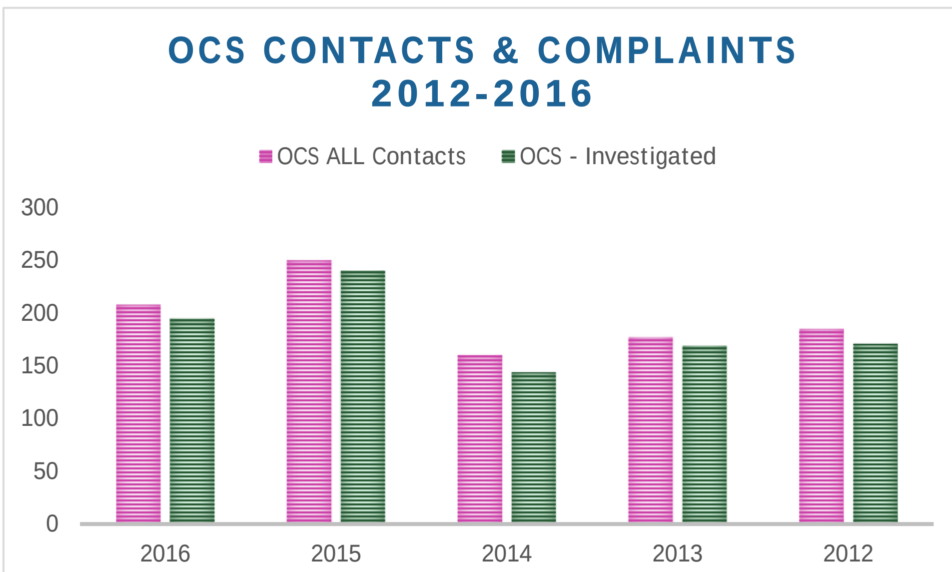
> Don't find fault. Find a remedy.
>
> – Henry Ford

COMPLAINTS ABOUT HEALTH AND SOCIAL SERVICES

Complaints about the Department of Health and Social Services (DHSS) also make up a significant portion of the total contacts received by the Office of the Ombudsman. In 2016, there were 485 complaints about DHSS. There were 221 complaints about the Division of Public Assistance, 212 about the Office of Children's Services, 20 about the Division of Senior and Disability Services, and 32 about other DHSS programs. The majority of these complaints were declined for investigation.

OFFICE OF CHILDREN'S SERVICES

Of the contacts received about OCS each year since 2012, 90% or more were related to jurisdictional matters and were opened for further review and investigation. However, preliminary review of the facts alleged resulted in the complainant being redirected to OCS's grievance process or other resources in about 65% of complaints. The remaining 35% of complaints were more fully investigated and resolved through informal consultation with the agency and complainant, or a formal investigation and recommendations for improvement.

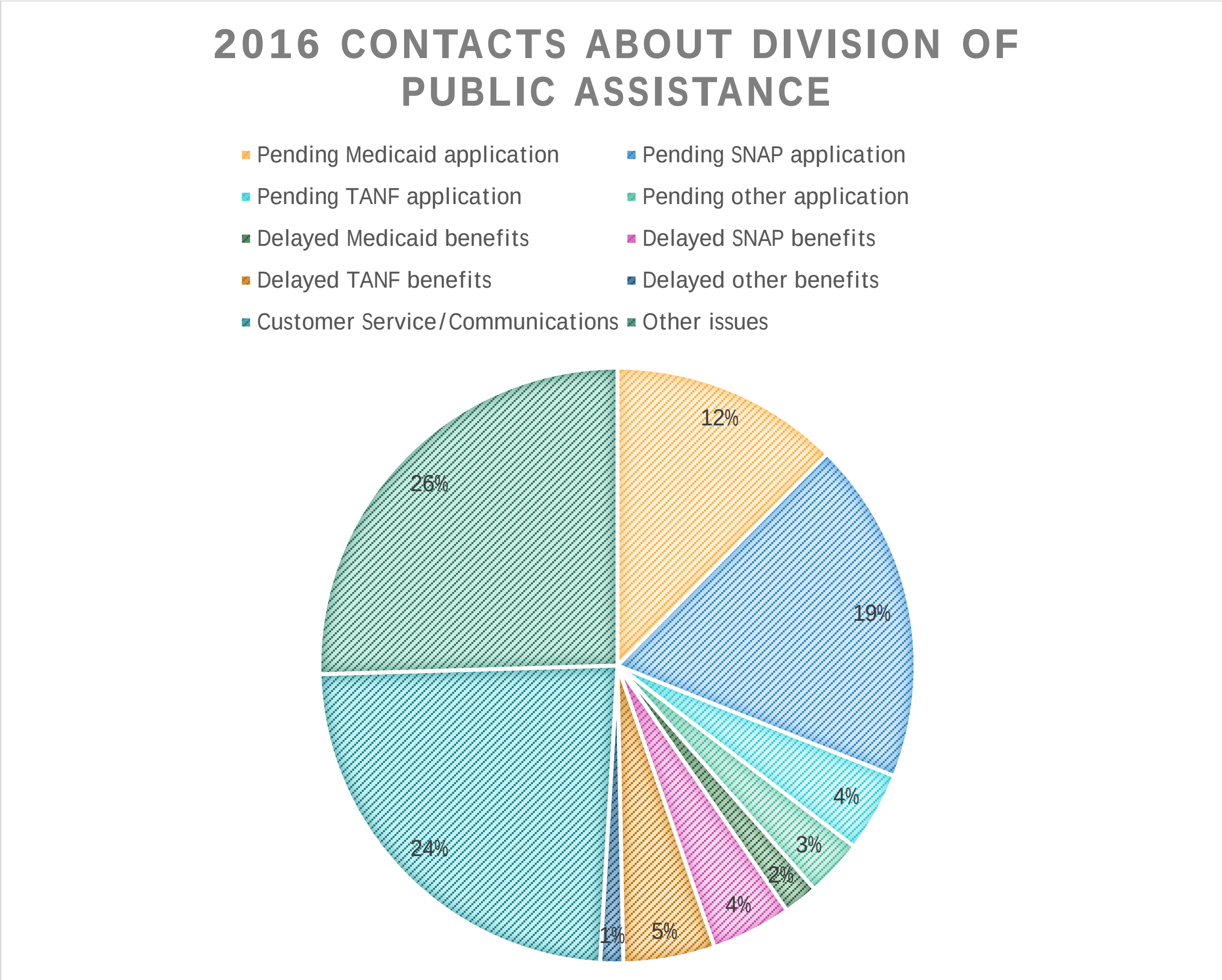


DIVISION OF PUBLIC ASSISTANCE

There were 225 contacts related to the Division of Public Assistance in 2016, most of which were declined:

- 11 Information and referral
- 146 Declined
- 68 Assistance provided

There were no formal investigations of complaints about the Division of Public Assistance in 2016. Of the complaints resolved through brief assistance, the majority (46%) involved complaints about delays in processing applications for food stamps (SNAP), Medicaid, Temporary Assistance for Needy Families (TANF), or Interim Assistance.



People who called the Ombudsman because they could not reach a person or get a call back from the Division of Public Assistance made up 24% of all the calls about the Division of Public Assistance. In all of these cases, ombudsman intake staff provided contact information for the regional supervisor and/or relevant hotlines to help the person resolve their problem. Of these, only 8 people (20%) returned to the Ombudsman because they had been unsuccessful in resolving their problem directly with the Division of Public Assistance. Complaints that were declined as premature or otherwise not ripe for investigation show that the deployment of ARIES (Alaska's Resource for Integrated Eligibility Services information system) and issues of staffing and backlog continued to affect the agency and the public in 2016.

SELECTED INVESTIGATIONS

Ombudsman investigators conducted 20 in-depth investigations of complaints about DHSS. Of these, 12 investigations involved the Office of Children's Services, 3 involved the Division of Public Health, and 3 involved Alaska Psychiatric Institute. Examples of closed investigations include:

- The Ombudsman initiated an investigation into the management of the background check program used by DHSS to screen private sector employees in a variety of organizations serving children, elders, and other vulnerable populations. Investigation revealed that DHSS had not created a centralized registry of people found to have committed abuse, neglect, exploitation, or Medicaid fraud — despite being required by statute. It was also found that DHSS had not been applying the laws, regulations, and standards consistently in the background check program. For example, DHSS used a standard related to finding someone had committed child abuse or neglect that arguably denied the individual due process. The investigation also found that OCS regulations related to release of closed child protection cases prevented people from gathering the information they needed to effectively challenge or appeal a barrier determination. The Ombudsman made twelve recommendations to bring the background check program into compliance with existing law, establish processes that consistently applied the rules and standards to everyone, and urging reconsideration of certain policies related to barriers to employment. In response, DHSS developed new regulations for the background check program in 2016; those regulations were adopted in June, 2017. *(The Ombudsman is reviewing whether the new regulations address the issues identified in the investigation.)*

- OCS failed to provide notice to paternal grandparents of a child when custody was taken, and later failed to provide notice of hearings or team decision making meetings related to the child — despite the agency's awareness that the paternal grandparents had visited the child and were interested in being involved. The allegations in this complaint were similar to those of complaints investigated in the past. The Ombudsman had made a series of recommendations related to improving notice and contact with grandparents in 2015. These recommendations were reiterated to the agency in this case.
- A complaint about the Medical Examiner's decision not to conduct an autopsy on a foreign national who died while working in a remote camp in Alaska was thoroughly investigated. The investigation found that the Medical Examiner had followed a policy that autopsies are not conducted on individuals over the age of 50 without evidence of suspicious circumstances or "foul play." The Medical Examiner had conducted appropriate lab tests and prepared a report. There was a delay in providing the report to the family, due to staffing shortages at that time. The investigator found that, given the limited resources and prioritization of criminal investigations, the delay was not unreasonable. The investigator found that the delay in providing the documentation needed to repatriate the decedent was due to their working in the United States using someone else's identification, so the initial documentation prepared based on that identification was incorrect. The investigator found that the delay in this paperwork was not attributable to the Medical Examiner's Office.
- OCS failed to provide visitation to a grandparent seeking time with a grandchild in custody. OCS also failed to provide notice to the grandparent that the request to have the child placed in their home was denied. The investigation resulted in a visitation schedule being established for the grandparent, and the required notice being provided.

COMPLAINTS ABOUT PUBLIC SAFETY

Department of Public Safety complaints made up 3% of total complaints in 2016. Of the 60 jurisdictional complaints received, 70% were declined as being premature or otherwise not ripe for review. Ombudsman investigators reviewed 18 complaints, resolving all but one in consultation with the agency and the complainant. One complaint resulted in a formal investigation with report and recommendations.

SELECTED INVESTIGATIONS

- A complainant disputed that he was required to register as a sex offender. Investigation showed that they were, in fact, not required to register according to the decision of the Alaska Supreme Court in *Doe v. State of* Alaska (Alaska, 2008). The Ombudsman recommended that the complainant be removed from the registry, but the Department of Public Safety refused to do so. (That recommendation was implemented later, subsequent to an internal Office of Professional Standards investigation and recommendation.) The Ombudsman also recommended that the agency create a form for requesting review or correction of information in the registry, as required by regulation. The Department of Safety implemented this recommendation.

COMPLAINTS ABOUT REVENUE

There were 99 complaints about the Department of Revenue in 2016. Ombudsman investigators reviewed 23 complaints — 19 about child support issues and 4 about Permanent Fund Dividends. All 23 were resolved in consultation with the agency and the complainant.

SELECTED INVESTIGATIONS

- A complainant argued that he only owed child support through the date their child graduated high school, and not for that entire month. After review of the court's child support order, relevant law and regulation, and legal advice provided to the Child Support Services Division, it was determined that the agency's policy is that the child support obligation accrues on the first of each month and is not pro-rated for the days after the child's graduation (or emancipation). The ombudsman investigator determined that the policy complied with the law, and the agency's handling of the complainant's child support case was reasonable.
- A complainant alleged that their child support order should be modified based on their disability. The ombudsman investigator determined that, while the complainant had been determined disabled and was receiving Social Security Disability benefits, the child support arrearage that accrued while the disability claim was pending could not legally be retroactively modified. The ombudsman investigator did inform the complainant that, if their child was qualified for monthly benefit based on the parent's disability, the Child Support Services Division would be required to credit those funds against the arrearage. The complainant successfully pursued that remedy, and more than $10,000 in benefits paid to their child was credited to the arrearage.

> A problem is your chance to do your best.
>
> – Duke Ellington

CONCLUSION

The vast majority of calls and complaints received by the Office of the Ombudsman are from Alaskans who are, for a variety of reasons, dependent on government services and programs for basic needs and liberties. Many complainants experience disabilities, which may or may not contribute to the problem(s) they are experiencing. Many of the complaints presented are about issues of health, safety, liberty, and family. These are complaints about critical services provided by essential state programs, which affects how the Ombudsman reviews and responds to complaints.

The Office of the Ombudsman encourages Alaskans to try and resolve their problems with state agencies first, before our investigators get involved. This is why such a large proportion of complaints we receive are redirected back to the agency. We also encourage state agencies to make complaint resolution and grievance procedures accessible, understandable, and fair. It is usually a better outcome for the citizen and the state agency when they can come to a resolution together (or with support from the Ombudsman).