ALASKA OMBUDSMAN

Public Report

Ombudsman Investigation 2021-05-0791

Alaska Department of Health, Division of Senior and Disabilities Services

January 11, 2024

Alaska State Ombudsman J. Kate Burkhart provides this public report of the investigation of complaint 2021-05-0791 pursuant to AS 24.55.200. This report has been redacted to remove information made confidential by law and to protect individual privacy. Ombudsman investigations are confidential according to law, although the Ombudsman is permitted to disclose information that is necessary to carry out her statutory duties and to support recommendations (AS 24.55.160(b)).

Introduction

The Ombudsman received a complaint in May 2021 from a complainant who reported that they had called Adult Protective Services (APS) multiple times to report concerns about a neighbor. The complainant reported that the neighbor had physical disabilities, and they were living in a home that was not safe. The complainant reported that the neighbor was not able to meet their basic needs, such as accessing water and maintaining heat in their home. The complainant also reported that the neighbor was an animal hoarder. The neighbor was found in their home, dead, in March 2021. The complainant alleged that APS did not do enough to intervene and protect the vulnerable adult and prevent their death.

Assistant Ombudsman Elizabeth Jenkins investigated this complaint.

Allegations

Based on the facts in the complaint, the Ombudsman investigated two allegations:

Unreasonable: Adult Protective Services (APS) categorized reports of harm alleging significant health and safety risks to a disabled elder as a low priority level for review.[1]

Performed Inefficiently: Adult Protective Services (APS) did not initiate services soon enough to protect a vulnerable adult.[2]

Relevant Statutory, Regulatory, Policy Authority

Adult Protective Services outlines its philosophy as:

> The Adult Protective Services unit provides supportive and protective services to Alaskans within the philosophy of respect for the individual's right to refuse services and to exercise self-determination in the receipt of services. As a result of this philosophy, the program requires that an adult consent to the receipt of services if the adult has the decision making capacity to do so, and that the adult participate in any and all planning and delivery of services. The program also works to help the vulnerable adult whose decision making capacity is impaired to avoid the extreme step of court appointment of a guardian or conservator to make decisions for the adult. APS may utilize surrogate decision makers, provided for by statute, and help make arrangements for substitute or joint decision makers in various areas of daily living to enable the adult to retain as much independence and control over their lives as possible. APS uses a least restrictive approach to providing protective services to vulnerable adults. Requesting the courts for a guardian or conservator is the APS workers' last resort when providing protective services. APS firmly believes in the right of the vulnerable adult to live any lifestyle the adult chooses so as the adult has the mental capacity to do so.[3]

[1] In an ombudsman investigation, "unreasonable" means (A) the agency adopted and followed a procedure in managing a program that was inconsistent with, or failed to achieve, the purposes of the program; (B) the agency adopted and followed a procedure that denied the complainant's valid application for a program benefit; or (C) the agency's action was inconsistent with agency policy and thereby placed the complainant at a disadvantage relative to all others.

[2] In an ombudsman investigation, "Performed inefficiently" means: (A) An administrative act exceeded: (1) a time limit established by law; or (2) a time limit established by custom, good judgment, sound administrative practice, or decent regard for the rights or interests of the person complaining or of the general public.

[3] APS Policy and Procedures Manual (2018) at 4 and 5.

According to the statutory definitions, "decision making capacity" means the ability to understand and appreciate the nature and consequences of a decision and the ability to reach and communicate an informed decision.[4] In this paragraph, "informed decision" includes a decision made by the vulnerable adult that is free from undue influence.[5] State law defines "undue influence" as the use by a person, who stands in a position of trust or confidence, of their role, relationship, or authority to wrongfully exploit the trust, dependency, or fear of a vulnerable adult to gain control over the decision making of the vulnerable adult, including decision making related to finances, property, residence, and health care.[6]

A "vulnerable adult" is a person 18 years of age or older who, because of incapacity, mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, fraud, confinement, or disappearance, is unable to meet the person's own needs or to seek help without assistance.[7] An "incapacitated person" is a person whose ability to receive and evaluate information or to communicate decisions is impaired to the extent that the person lacks the ability to provide or arrange for the essential requirements for the person's physical health or safety without court-ordered assistance.[8] "Self-neglect" is defined as an act or omission by a vulnerable adult that results, or could result, in the deprivation of essential services necessary to maintain minimal mental, emotional, or physical health and safety.[9]

AS 47.24.015(a) requires APS to investigate reports of harm:

> Upon the department's receipt of a report under AS 47.24.010, the department, or its designee, shall promptly initiate an investigation to determine whether the vulnerable adult who is the subject of the report suffers from undue influence, abandonment, exploitation, abuse, neglect, or self-neglect. The department, or its designee, shall conduct a face-to-face interview with the subject of the report unless that person is unconscious or the department, or its designee, has determined that a face-to-face interview could further endanger the vulnerable adult.[10]

[4] *See* AS 47.24.900(5).
[5] *Id.*
[6] *See* AS 47.24.900(20).
[7] *See* AS 47.24.900(21).
[8] *See* AS 47.24.900(11).
[9] *See* AS 47.24.900(17).
[10] AS 47.24.015(a).

APS provides different levels of services to people depending on the facts of the case. "Supportive services" are the range of services delivered by public and private organizations and individuals to help elderly and vulnerable adults with their social, health, educational, recreational, transportation, housing, nutritional, financial, legal, or other needs.[11] "Protective services" are intended to prevent or alleviate harm resulting from undue influence, abandonment, exploitation, abuse, neglect, or self-neglect and that are provided to a vulnerable adult in need of protection.[12] The statute defines "services" to include protective placement, applying for or obtaining public benefits, obtaining health care services and supplies, staying financial transactions, petitioning for a protective order, assisting with personal hygiene, obtaining food and clothing, protection from physical and emotional abuse, obtaining representative payee services, and coordinating protective services.[13]

The roles of APS staff are outlined in the agency's policy and procedures manual. The APS Screener is responsible for "assigning information and referral cases to a worker."[14] The APS Screener's role includes assigning a priority to each report of harm.

The Screener must notify a supervisor when a report is received where the person appears to need immediate medical attention, police protection or welfare check, or if a Priority 1 response is believed to be needed.[15] A classification of Priority 1 includes imminent risk of harm or death and requires a 24-hour response time.[16] These reports include allegations that an adult's living situation is immediately dangerous or unsafe and/or their living conditions pose a serious health or safety hazard.[17]

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[11] *See* AS 47.24.900(18).
[12] *See* AS 47.24.900(15).
[13] *Id.*
[14] *See* APS Policy and Procedures Manual, Responsibilities (2018) at 21.
[15] *See* APS Policy and Procedures Manual, APS Screening (2018) at 23.
[16] *See* APS Policy and Procedures Manual, Screening Priorities Among Screening/Intake for Adult Protective or Supportive Services (2018) at 28.
[17] *See id.*

A classification of Priority II/III is assigned when the adult does not appear to be at imminent risk of harm or death, nor is an urgent response necessary based on information collected at intake.[18] A Priority II/III report requires a response within 5-10 business days.[19]

A Priority IV report is one in which "the vulnerable adult is not in need of protection to alleviate harm resulting from abandonment, exploitation, abuse, neglect, undue influence or self-neglect, but requires assistance with their social, health, educational, recreational, transportation, housing, nutritional, financial, legal, or other needs to prevent or diminish the risks that the adult will suffer harm."[20] Priority IV is considered "preventative" and requires a response within 10 business days.[21]

The APS Policy and Procedures Manual describes how the APS Screener should determine the immediacy of the report allegations:

> i. If emergency services or a welfare check is thought to be needed, the Screener must contact their supervisor to staff the case to approve or deny calling for emergency services.
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> ii. If a Priority One response is needed, the Screener must contact the identified APS supervisor or manager to review the case to approve or deny this response level.
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> 1. Confirmation that the supervisor or manager has received the request is required.
> 2. The screener will request direction from another identified supervisor or manager, if the first supervisor or manager does not respond until the intake is reviewed.
> 3. If screener is directed to process as a P1, the screener will notify the investigations supervisor and assign to the identified staff member as soon as possible.
> 4. If screener is directed to process normally, the screener will proceed normally.
>
> iii. The APS Supervisor or Manager has the discretion to independently evaluate the intake information to determine Priority levels 1, 3 or 4.[22]

[18] *See id.* at 29.
[19] *See id.*
[20] APS Policy and Procedures Manual, APS Screening (2018) at 29.
[21] *Id.*
[22] APS Policy and Procedures Manual, APS Screening (2018) at 26.

APS Screeners are expected to provide a written explanation or additional comments about their screening decision for staff to reference in the database as needed.[23]

The APS Worker is responsible for responding to the case. That response includes giving the reporter and/or alleged victim information and referral to services. The Worker is responsible for responding and closing the case within 10 days of assignment.[24] The Worker must notify a supervisor if additional information is learned that requires further investigation. The APS Worker decides if criminal conduct is suspected and law enforcement should be notified.[25]

APS Workers have 90 calendar days to complete an investigation and submit it for closure.[26] APS Workers must consult with their supervisor when they are unable to complete an investigation within the statutory timeframe.[27] There must be a justification as to why the investigation was not conducted within the given time frame documented in case notes and approved by a supervisor.[28]

APS's procedure for delivering protective services with the adult's consent includes:

- offering actions or services or both, to resolve identified problems;
- locating and coordinating community resources;
- evaluating the effectiveness of provided services;
- pursuing necessary legal intervention;
- providing temporary emergency services (such as protective placement);
- deciding when all necessary protective services have been provided and the adult case warrants case closure.[29]

In non-emergency situations, if it is not clear whether the person has capacity to consent, but the protective service investigation has revealed that the person is a vulnerable adult who needs protective services, the Worker should, before providing services:

[23] *See* APS Policy and Procedures Manual, APS Screening (2018) at 27.
[24] *See id.*
[25] *See* APS Policy and Procedures Manual, APS Investigations (2018) at 33.
[26] *See* APS Policy and Procedures Manual, Conducting the Investigation (2018) at 34.
[27] *See* APS Policy and Procedures Manual, APS Investigations (2018) at 33.
[28] *See id.*
[29] *See* APS Policy and Procedures Manual, Delivery of Protective Services for Vulnerable Adult (2018) at 38.

> 1. determine if the adult has any advance directive in place such as a Power of Attorney, Durable Power of Attorney, etc. that enable others to make some or all decisions for the vulnerable adult; or
>
> 2. where appropriate, help to obtain an evaluation by a psychiatrist, psychologist, physician, or other appropriate mental health professional, who can determine the person's decision making ability.[30]

AS 47.24.017 gives APS authority to provide services without consent in an emergency:

> if the department determines that an emergency situation exists that necessitates provision of protective services to a vulnerable adult, the department may provide the necessary protective services in a manner determined by the department to be the most appropriate in light of the emergency situation, regardless of whether the vulnerable adult or any other person has consented to receipt of the services.[31]

When no one else is available to petition the court for protection of a vulnerable adult, and no less intrusive services will meet the vulnerable adult's needs, the APS Worker should contact the Department of Law for assistance filing a petition for the least restrictive legal intervention possible that will meet the adult's needs. Full guardianship will only be requested when less restrictive alternatives do not appear feasible or adequate.[32] In order to initiate a guardianship for a vulnerable adult, the APS Worker is expected to complete the packet of information required by the Department of Law.[33] This packet includes the "Office of Public Advocacy Referral for Guardianship or Conservatorship" form.[34]

The APS Supervisor is responsible for ensuring workers complete their work in a timely and effective manner and for providing guidance on complex and urgent case issues.[35] The APS Manager is responsible for providing guidance on complex and urgent case issues that cannot be resolved by a supervisor and for addressing larger system and program issues.[36]

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[30] APS Policy and Procedures Manual, Delivery of Protective Services for Vulnerable Adults (2018) 43.
[31] AS 47.24.017(b).
[32] *See* APS Policy and Procedures Manual, Petitioning for Legal Protection for Vulnerable Adults (2018) at 71.
[33] *See* APS Policy and Procedures Manual, Legal Actions to Protect the Vulnerable Adult's Person (2018) at 72.
[34] *See id.*
[35] *See id.*
[36] *See id.*

Investigation

The adult was well-known to APS. They had been the subject of reports of harm since at least 2016. According to their medical records, they were an older adult who experienced chronic health conditions and limited mobility. They used a walker to avoid falls around the house.

The scope of the ombudsman investigation covers APS's actions in 2020 through March 2021. During this time, APS offered the adult "supportive services," but did not provide any "protective services." According to the APS Worker's case notes, they believed that the adult did not meet the statutory definition of a "vulnerable adult" (AS 47.24.900) because they were able to seek help without assistance.

Early 2020 APS Investigation

According to a January 2020 APS Intake Report, the complainant contacted APS to report that a nonprofit animal rescue was paying the adult's electric bill. They reported that the animal rescue organization had also purchased gas for the adult's vehicle — which the adult couldn't drive but was using to keep warm. The complainant reported to APS that they had not seen the adult lately, and they were concerned because they thought the adult may be without heat again.

The APS Screener classified the report as Priority 3, which requires a response within 10 days. This is despite the reporter alleging that the adult's living conditions posed a serious threat to their health and safety — specifically, using a car to stay warm because their home may not have had heat.

A month later, a community nonprofit employee emailed the APS Worker to express their concern about the adult. The adult was weak and unable to walk in their home, which was full of piled belongings and animal urine and feces, and the roof was caving in. The electricity had been disconnected, but the nonprofit had been working on getting it reconnected. The adult had been living without heat, running water, or electricity for a while. The nonprofit employee wrote that they had been coordinating with another community organization to help with the adult's basic

necessities. However, the nonprofit had exhausted all the community partnerships and would no longer be able to provide the same level of assistance to the adult.

In March 2020, the APS Worker visited the adult's residence in person. This face-to-face meeting was based on the Incident Under Investigation from January 2020. The APS Worker documented the visit in April, a month after the fact.

The APS Worker documented that the adult was living in extremely unsanitary conditions, including huge amounts of animal feces. Local cab companies refused to transport the adult, due to the smell. The APS Worker observed that the electricity in the home was working, and the home was heated. During the visit, the APS Worker asked the adult if they would be interested in moving to an Assisted Living Home. The adult declined because they didn't want to leave their animals.

The adult reported that they had just renewed their Medicaid application, and they were paying their bills. There is no evidence in the administrative record that the APS Worker independently confirmed with the Division of Public Assistance or others that this information was accurate.

The APS Worker closed the investigation and concluded that the adult was not vulnerable because they were used to asking for and receiving help from neighbors and community nonprofits. However, the APS worker substantiated the allegation of "self-neglect." They believed that animal hoarding was preventing the adult from seeking safe and sanitary housing, but the adult was considering selling the property.

Late 2020 APS Investigation

In October 2020, the complainant reported that the adult's roof was caving in and they had no access to a heat source or running water. The complainant explained that the adult was currently squatting on the property, which they had sold. The complainant was worried about the conditions of the adult's home, and that they might freeze as the weather got colder. The home was missing a door, and the entrance was covered in six inches of animal feces. The complainant was worried because the adult did not have local community support.

The APS Screener classified this report as Priority Level 3. Again, APS classified a report of a disabled elder at risk of freezing as a low priority.

The following day, the complainant requested that the Alaska State Troopers (AST) conduct a welfare check on the adult. The Troopers searched the house because the adult's door was open. The adult was not in the home, and the Troopers did not speak to the adult, but they were able to confirm the adult was safe at another location.

The APS Worker called the adult on November 5, 2020. The adult reported that they had access to food and had purchased some new heaters for the home. The adult had recently sold their property. The new owner agreed to let the adult stay on the property, but the adult had remained there longer than expected. Despite recently selling the land, the adult did not have the funds for a new place to live. The adult had been scammed out of the money by a person they met on the internet and was reluctant to move because the animals were still on the property.

The ombudsman investigator asked the APS Worker if they reported the internet scam to law enforcement or encouraged the adult to report it. The APS worker said they did not recall. The Worker's notes indicated that they had encouraged the adult to report the scam to Facebook.

APS initiated an investigation into the report of harm three weeks later. The APS Worker did not visit the adult in person during this investigation. They attributed this to COVID-19 pandemic precautions. APS leadership clarified that the agency did not implement travel restrictions during this time. Workers were encouraged to discuss the need to travel with their supervisors.

The APS Worker relied on phone calls to the adult, AST, and other witnesses to make their determinations. The APS Supervisor approved a "face to face waiver" request for this investigation.

The APS Worker had a conference call with the adult and the real estate agent who helped with the sale of the property. The APS Worker had learned that the real estate agent had been paying the electric bills and helping the adult in other ways, such as assisting with their Permanent Fund Dividend (PFD) application. The adult indicated that they might give their PFD to a family

member. The APS Worker documented that they thought this may be connected to another internet scam.

After this call, the APS Worker noted that they needed to send the adult information and an application for a public housing voucher. The ombudsman investigator asked the APS Worker if they sent the application, since this action was not documented. The APS Worker said they might have emailed it to the real estate agent, presumably for the adult to complete. There is no evidence in the administrative record to confirm that occurred.

The complainant warned the APS Worker that they thought the real estate agent was taking advantage of the adult. The ombudsman investigator asked the APS Worker how they evaluated that allegation. They said they spoke to the real estate agent and decided that they were not taking advantage of the adult, citing the real estate agent's willingness to pay the adult's electric bill and assist with errands.

The APS Worker did not pursue a conservator or limited guardianship for housing for the adult in November 2020. The APS Worker explained to the ombudsman investigator that they discussed the need for money management with the adult, and the adult agreed. The APS Worker said the adult did not want a conservator because they did not want to go to court.

The APS Worker maintained that the adult had decision-making capacity and, therefore, APS did not have the authority to initiate filing for a conservator or guardianship without the adult's consent. The APS Worker decided to identify someone to have power of attorney, which is less restrictive, for the adult. The APS Worker tried to get in contact with the adult's family members. The APS Worker told the ombudsman investigator that they had difficulty getting in touch with the adult's relatives because the adult gave them the wrong phone number. Nearly four months after the investigation was initiated, in March 2021, the adult called the Worker and left them a voicemail that included the family member's correct phone number. The APS Worker was able to talk with the adult's relatives that same day, and they agreed to the power of attorney arrangement.

At this point, the adult began to disconnect further from family and existing community supports. On March 22, 2021, a food delivery service volunteer asked AST to do a welfare check because

the adult had not picked up their food for three days. When the APS Worker spoke with the Trooper before the welfare check, the APS Worker expressed concern that the adult may be at risk for suicide.

The Trooper found the adult at home. The adult told the Trooper they just "didn't feel like picking up the meals from the porch." The Trooper asked the adult to call the APS Worker, and the adult agreed to call after they charged their phone. The responding Trooper did not make a report of harm indicating the adult was in imminent danger or at risk for abuse, neglect, exploitation, or self-neglect. The adult did not call the APS Worker after this.

The adult's family member (who had agreed to serve as power of attorney) called the APS Worker two days later. They reported that the adult was not answering their phone, and the last time they spoke with the adult, the adult told them they had met a new person online. The family member told the APS Worker that the adult may not have paid their phone bill. The APS Worker assured the family member that a Trooper had conducted a welfare check. The family member told the APS Worker they did not believe the adult was going to cooperate with the plan to give them Power of Attorney. The APS Worker agreed.

That same day, the APS Worker contacted their supervisor and the Senior Assistant Attorney General (AAG) about a plan to file for emergency conservatorship and limited guardianship for housing. The APS Worker explained to the ombudsman investigator that it is routine to discuss an investigation with the AAG when something will have to go to court and evidence will be sent over to them. In this instance, the APS Worker wanted to file a petition for an emergency conservator, which could be evaluated by the court within 72 hours, and a limited guardian for housing, allowing for the person appointed by the court to find new housing for the adult.

Despite initiating the plan, the APS Worker said they did not send the necessary information or evidence to the AAG. The APS Worker explained that they had a large caseload for the region and did not receive overtime, which can affect how quickly tasks are completed. The ombudsman investigator asked the APS Worker if they had requested overtime for this case. They answered, "I don't know." The ombudsman investigator did not find evidence to suggest that the APS Worker had requested overtime for this case, but did find evidence that the APS Worker received overtime

for another case in December 2020. The APS Worker later clarified that they only requested overtime when they were on "travel status" because that was the directive from their supervisor; overtime would not be approved for paperwork or data entry.

The ombudsman investigator asked the APS Worker if they requested an AST welfare check after March 22, 2021. The APS Worker said that they called the adult a "couple of more times," but it was not uncommon for the adult to not answer the phone. The APS Worker explained that the Trooper who responded to the March 22, 2021, welfare check had a rapport with the adult, and the Trooper spoke with the adult that day. Therefore, the APS Worker did not request an additional welfare check. The APS Worker followed up with the real estate agent on March 24, 2021, and learned that they were no longer paying the adult's electric bill.

On March 31, 2021, the adult was found dead in their home by a community volunteer who had been helping the adult.

The APS worker closed the investigation, with approval from their supervisor, on April 8, 2021. They determined that the adult did not meet the APS definition of "vulnerable" because they were able to seek help without assistance. The ombudsman investigator asked the APS Supervisor if the agency considered the adult to be vulnerable since there were plans in place to petition the court for a limited guardian for housing – a protective service – and APS was no longer seeking the adult's consent. The APS Supervisor responded:

> You get to a point where we can keep allowing this to happen or we can staff it with [the] AG, and should we take next step? There are cases where you start out and it's one way, but by the time you're done, it's different. I think this is staffing with [the] AG to see what [the] AG is thinking.

Cause of Death

According to the State Medical Examiner, the cause of the adult's death was hypothermia. They concluded that dehydration may have contributed to death. The manner of death was classified as an "accident."

The March 31, 2021, AST incident report describes how the Troopers struggled to enter the adult's home after receiving the emergency call that they were dead. The ceiling was collapsing, "preventing the door from opening inward," and "trash" and "debris" were piled upwards of "four feet high." The house did not have any heat and the adult appeared to be lying in a position consistent with someone who was cold.

In November 2020, the adult was reportedly using a space heater to warm their home. The ombudsman investigator asked the responding Trooper if the electricity was working, and the Trooper said, "it didn't appear anything electronic was functioning." The Trooper said they did not see any space heaters at the adult's residence, but added that they were not specifically looking for them either.

In 2020, the Alaska Legislature passed Senate Bill (SB) 241, a declaration of a public health disaster emergency in response to the novel coronavirus pandemic. According to an April 27, 2020, press release, the electric company providing service to the adult wrote that, as a result of SB 241, it would be providing payment relief to customers with financial hardship to avoid residential service disconnection. The ombudsman investigator confirmed that the adult submitted paperwork qualifying for payment relief. The moratorium on disconnections of residential utility service was supposed to end in November 2020, but the electric company extended the moratorium through at least March 2021.

Reviewing the adult's kilowatt hours (kWh) provided by the electric company, the adult's energy usage was 531 kWh on February 4, 2021, through March 4, 2021. On March 4, 2021, through April 4, 2021, it dropped to 231 kWh. A year prior to that, the adult's energy usage for the month of March 2020 was 1604 kWh. A phone call from the adult to the electric company in April 2020 indicates that the adult had lost power before and was physically unable to check the breaker, due to their disabilities.

From the evidence reviewed, the ombudsman investigator cannot definitively conclude how the adult's home became so dangerously cold and uninhabitable that it led to their death. According to weather data, from the last day the adult was contacted by AST until the day the adult was found dead, the low temperatures in the community ranged from -9º to 38º Fahrenheit, with an average

temperature of about 22° during the week. According to evidence from the electrical utility, the adult's use of electricity (their primary heat source) had dropped by over 80% the month they died, compared to the same period the year prior.

Analysis – Allegation 1

Unreasonable: Adult Protective Services (APS) categorized reports of harm alleging significant health and safety risks to a disabled elder as a low priority level for review.

The ombudsman investigator asked the APS Supervisor why the APS report of harm from October 27, 2020, wasn't elevated to a higher priority level when it involved potentially dangerous living conditions: not having a heat source in the home. The reporter expressed that they were concerned the adult might freeze. The APS Supervisor explained that Priority 1, which involves an immediate 24-hour response, is reserved for reports where APS "believes the adult is likely to pass away." They said the season may have factored into the lower priority level since the area is "not especially cold" in October.

According to historical weather data, the low temperature on October 27, 2020, was 25° Fahrenheit. It grew colder over the next few days. Hypothermia, the eventual cause of the adult's death, is most likely to occur in very cold weather, but can occur even at temperatures above 40° Fahrenheit if the person becomes chilled. Older adults with inadequate food, clothing, or heating are most at risk for hypothermia. The Ombudsman finds APS's justification for not screening the report as a Priority 1 — that "October is not especially cold" — specious.

When asked about the allegation that the adult did not have access to water, the APS Supervisor said that dry cabins are common in Alaska, and a person could have water delivered. Therefore, they did not believe this situation warranted a Priority 1 response. However, if the reporter had stated that the adult did not have water for three days and there were no delivery options, then a Priority 1 would be considered. The ombudsman investigator did not get the chance to ask about the earlier January 2020 report, where the reporter alleged the adult did not have access to a heat source in the winter. That event was also labeled Priority 3.

The APS Screener said that they selected Priority 3 for the January 8, 2020, report because the APS worker already had an open case for the adult — from back in October 2019. The APS Screener said that the APS Worker would have received an email notification about the January 2020 report. The administrative record does not show how the APS Worker followed up on the January 2020 report until they visited the adult in person in March 2020.

The ombudsman investigator asked the APS Screener about the October 2020 report. They said that they knew the APS Worker was familiar with this case. They believed the adult had decision-making capacity, and, therefore, the adult could "live however they want." Per APS policy, it is not the APS Screener's role to make that determination. The Ombudsman is concerned that the APS Screener chose priority levels which were influenced by previous investigations, rather than on the allegations made in the report before them.

Finding

The Ombudsman believes having access to the basic needs for life, such as water and a reliable heat source, warrants a high priority level for review, especially for a medically vulnerable adult. The adult was living in a home that posed serious health and safety risks. The administrative record did not include a written explanation or additional comments about why a lower priority level was selected, which is required by APS policy. Based on the preponderance of the evidence, the Ombudsman finds the allegation ***justified.***

Analysis – Allegation 2

Performed Inefficiently: Adult Protective Services (APS) did not initiate services soon enough to protect a vulnerable adult.

The ombudsman investigator asked the APS Supervisor and Worker why the investigation was not completed within 90 days, as required by APS policies and procedures. The APS Supervisor said, "I don't have a good explanation. This one didn't fall within 90 days. It looks to me, 120 days." The APS Worker said that the inability to travel, due to the COVID-19 pandemic, affected the

length of time it took them to complete some investigations. They kept investigations open to be able to visit in-person, not realizing how long they would be grounded from travel. The APS Worker said they did not know if they included the adult's "case number" for travel requests made during late 2020 and 2021.

The administrative record shows that the APS Worker traveled to visit the adult in person in March 2020, before the COVID-19 pandemic became a major health concern. The agency has stated it did not strictly enforce travel restrictions during this time. In April 2021, an APS protective services manager told Ombudsman Burkhart that APS was "cautiously returning to conducting face to face visits" and later clarified that in-person visits were conducted, as needed, with approval from a supervisor. The APS Worker traveled in September 2020 and April 2021 for other cases, but not to see this adult. Despite not visiting the adult in person in late 2020 and 2021, the APS Worker had enough collateral evidence to make determinations about the adult and provide the appropriate services based on the latest investigation.

The APS Worker did not notify law enforcement of the internet scam that the adult fell victim to. According to APS policy, it is up to the APS Worker to "decide if criminal conduct is suspected and requires law enforcement notification."

APS decided to pursue an emergency conservatorship with limited guardianship for housing, but that plan was never implemented. According to APS policy, the APS Supervisor was responsible for ensuring that the APS Worker completed their work fully and in a timely manner. The evidence shows that did not occur, and the administrative record does not reflect what supervision the APS Supervisor provided to the APS Worker to help them conclude their work correctly and on time.

The Ombudsman recognizes that APS has a duty to respect the rights of the individual, and this was a challenging case. However, APS should have been prepared to quickly pivot as the situation worsened. Based on the preponderance of the evidence, the Ombudsman finds the allegation ***justified.***

Recommendations

Recommendation 1: Adult Protective Services should train screeners so they are able to make well-informed, documented, and unbiased screening decisions.

The Ombudsman invited APS leadership to a consultation meeting on June 20, 2023. APS explained that the agency is now screening reports of harm differently to improve the process. APS converted one of its investigation positions to a "screener/investigator" in February 2023. APS is implementing a two-screener system. The first APS Screener assesses the report of harm from central intake and makes additional follow up contact, as needed. As of October 2023, the second APS Screener will be using the Evident Change Structured Decision Making tool to make further determinations about how to proceed. According to Evident Change, "this evidence and research-based system identifies the key points in the life of an adult protective services (APS) case and uses structured assessments to improve the consistency and validity of each decision."

APS explained that APS Workers will fill out a Safety Assessment when a face-to-face visit is conducted. They will also complete a Strengths and Needs Assessment. This can be shared with the adult so they are included and familiar with their safety plan. Managers must review and approve these steps along the way. The APS Manager said this tool was designed to incorporate the requirements from state law and give more "definition and structure" to how decisions are reached by screeners, workers, and managers.

The Ombudsman appreciates that APS has taken actions to improve its screening process and incorporate a system with more checks and balances. However, the Ombudsman notes that there are still issues with how reports are screened. The ombudsman investigator interviewed the APS Screener in August 2023. Although APS formally implemented the screening changes in October 2023, the Ombudsman believes a continued effort is needed so APS can fulfill its goals. The Ombudsman recommends that APS provide additional training to screeners and screener/investigators to ensure they can think critically about priority levels and document their analysis accordingly.

The Ombudsman recommends that APS Screeners receive robust initial and ongoing training that includes:

- APS policies and procedures;
- APS Priority levels and how to apply them;
- Documentation requirements and expectations;
- Basic interviewing techniques to better gather information from reporters;
- Critical thinking skills and how to apply them in APS practice;
- The aging process;
- Maltreatment of elders and disabled adults;
- Self-neglect; and
- Financial exploitation.

Agency Response to Recommendation 1

The Division of Senior and Disabilities Services (SDS) accepted this recommendation and provided the following response:

> As of 2023, APS screeners receive onboarding training through the National Adult Protective Services Training Center. Additionally, APS intends to initiate a training program that would offer all APS workers quarterly training on issues related to maltreatment, critical thinking around investigating reports of harm, exploitation of vulnerable adults, and new financial scams. Lastly, APS will also incorporate all training recommended by the Ombudsman's office. APS will add a unit on chronic physical diseases that may impair cognition.
>
> Nevertheless, the following would be needed to complete this recommendation: APS currently has grant funding for the creation of a curriculum for ongoing training for existing staff and onboarding training for new staff. APS is hiring a non-permanent health program manager II (HPM 2) to help create the training curriculum with grant funding through the Administration for Community Living (ACL). Addition of the non-permanent position will establish the role and, if budget constraints allow, facilitate its eventual development into a permanent position. However, after the training curriculum is created, APS would need a staff member whose role it is to train, monitor, and evaluate the training outcomes.[37]

[37] Letter from Anthony Newman, SDS Division Director, to Kate Burkhart, Ombudsman (November 9, 2023).

Recommendation 2: Adult Protective Services should establish regional Multidisciplinary Teams.

The Ombudsman recommends that APS develop and implement Multidisciplinary Teams (MDT), groups of professional experts who are committed to achieving a common goal, to support the mission of the agency. This formal partnership can be facilitated by APS and include law enforcement, tribal governments, district attorneys, mental health professionals, and other community resources to respond to cases of elder abuse and neglect.[38]

The National Voluntary Consensus Guidelines for State Adult Protective Services Systems states that adult protection programs are encouraged to use MDTs to support decision making during the initial assessment.[39] Formal MDTs "that convene to review complex cases have been shown to increase effectiveness, satisfaction of workers, and rates of prosecution" and are "associated with a reduction in future mistreatment risk."[40] Teams can have a broad or specialized focus, such as a regional MDT or a hoarding task force.[41]

Some states have mandated MDTs by law, and about half of states have formal agreements to facilitate interagency cooperation.[42] Alaska has not mandated MDTs.[43] However, AS 47.24.050 would allow APS to implement MDTs to improve services to vulnerable adults because it allows for "investigation reports" to be used by "appropriate agencies or individuals inside and outside

[38] *See* "Member roles and contributions," Department of Justice, Elder Justice Initiative, (https://www.justice.gov/elderjustice/file/938801/download, last visited August 25, 2023). *See* also "2022 Statutory Review of Elder Abuse Multidisciplinary Teams and/or Information Sharing" Department of Justice, (https://www.justice.gov/elderjustice/file/960791/download, last visited August 25, 2023).
[39] *See* "National Voluntary Consensus Guidelines for State Adult Protective Services Systems," Administration for Community Living, at 15 (https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf, last visited August 28, 2023).
[40] *Id. citing* "Holding abusers accountable: an elder abuse forensic center increases criminal prosecution of financial exploitation," Ardia Navarro, Zachery Gassoumis, Kathleen Wilbur, *Gerontologist,* April 2013 (available online at https://pubmed.ncbi.nlm.nih.gov/22589024/, last visited August 28, 2023).
[41] *See* MDT Project: Draft List of MDTs, University of Southern California, (https://eldermistreatment.usc.edu/elder-abuse-mdt-project/mdt_list/, last visited August 28, 2023).
[42] *See* 2022 Statutory Review of Elder Abuse Multidisciplinary Teams and/or Information Sharing, United States Department of Justice, https://www.justice.gov/elderjustice/file/960791/download, last visited August 28, 2023).
[43] *See* AS 47.24.050(a).

the state, in connection with investigations or judicial proceedings involving the undue influence, abandonment, exploitation, abuse, neglect, or self-neglect of a vulnerable adult."[44]

The United States Department of Justice has created a toolkit to facilitate the development of elder abuse case review MDTs, which could provide a helpful blueprint to APS for the creation of MDTs.[45] Evidence from this ombudsman investigation has shown that APS staff and the vulnerable adults involved in complex cases, particularly involving self-neglect, would benefit from an earlier coordinated effort by a variety of experts to assist APS with achieving its mission.

Agency Response to Recommendation 2

The Division accepted this recommendation and provided the following response:

> APS was awarded a grant from Administration for Community Living (ACL) to help develop an MDT for Alaska. The APS manager and SDS Policy Unit staff are working together to create and develop the MDT. The estimated date of completion is unknown due to staff turnover, vacancies, training, and high-priority needs.[46]

Recommendation 3: Adult Protective Services should add an Administrative Assistant 2 position.

SDS shared with the Ombudsman that the agency agrees with the value of regional MDTs and will continue to invite stakeholders to share their observations and concerns in an informal manner.[47] However, there would need to be up to six regional MDTs to address the needs of local vulnerable adults.[48] SDS explained that, to formally develop regional MDTs, the APS Manager needs to devote more time to focus on the creation of the MDT and the formation of community partnerships.[49] Adding an Administrative Assistant position to the APS team would support these efforts.[50]

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[44] *See id.*
[45] MDT Guide and Toolkit, United States Department of Justice, (https://www.justice.gov/elderjustice/mdt-toolkit, last visited August 28, 2023).
[46] *S*upra n. 38.
[47] *See id.*
[48] *See id.*
[49] *See id.*
[50] *See id.*

A review of class specifications shows that an Administrative Assistant 2 position is best suited to perform the duties needed to support implementation of Recommendation 2. The position could cost up to $80,000/year, factoring in merit increases, etc. The Ombudsman recommends the Division seek an increment in the SFY25 budget to fully fund the position for five years.

Agency Response to Recommendation 3

The Division accepted this recommendation.[51]

Recommendation 4: Adult Protective Services should identify and implement a reasonable limit on the number of cases assigned to each APS Worker in order to ensure delivery of comprehensive services.

In 2022, APS management estimated that the APS Worker carried a caseload of between 50-70 cases. That is a slightly larger caseload than the cases reported by the majority of other states, where cases range from 26-50 per worker.[52]

The National Voluntary Consensus Guidelines for State Adult Protective Services Systems suggests a limit on the number of cases assigned to each APS worker.[53] Failure to limit the number of cases assigned to each worker may result in serious risks to the APS system's efficiency and efficacy.[54] This is borne out by the evidence in this investigation. The National Adult Protective Services Association (NAPSA) does not specify a recommended ratio for states to adopt.[55]

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[51] *See supra* n. 38.
[52] *See* "National Voluntary Consensus Guidelines for State Adult Protective Services Systems," Administration for Community Living, (https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf,) last visited August 28, 2023). *See* also a survey conducted by the National Voluntary Consensus Guidelines for State Adult Protective Services Systems that indicated APS worker caseloads vary from 0 to 25 per worker (13 states) to 100+ per worker (four states; NAPSA & NASUAD, 2012). In the majority of states (21), the caseload per worker was 26–50.
[53] *See id.*
[54] *See id.*
[55] *See id.*

The Ombudsman understands that APS has implemented some structural changes to how regional cases are managed since this investigation began.[56] However, the Ombudsman recommends that SDS take the additional step of determining a reasonable caseload for Alaska's APS workers. In developing the caseload limit, consideration should be given to historical trends, differences in geographical areas, differences in time required to manage cases at various phases, acuity of need presented by different types of cases, and differences in the complexity of allegations.[57]

Agency Response to Recommendation 4

The Division partially accepted this recommendation, but responded that "several factors" made it difficult to implement at this time:

> APS has 11 permanent investigators for the state of Alaska. We receive around 7,000 reports of harm a year, resulting in roughly 2,000 Investigations and 1,900 Information and Referral (I/R) cases a year.
>
> Since 2020, APS has had a 50% turnover rate yearly, leading to staff shortages. Currently three positions in the unit are vacant. Given these challenges, limiting the number of case assignments to workers would not be feasible. We are unsure when we will be fully staffed and when we will see a stabilization in staffing. Our priority now is to attempt to ensure vulnerable adults in the community are safe and that cases are initiated in a timely manner. We are doing this by having screeners perform some I/R, having supervisors complete some of the cases on the caseload where staff have left the position, offering overtime, allow protected time for staff to get caught up on documentation, minimize meetings, and adjust regions.
>
> Another factor that would make it harder for APS to limit cases to APS workers is that APS petitions for guardianship and conservatorship. In the Anchorage region, court hearings on cases can sometimes take up to four to six months. Therefore, APS must monitor the case until the hearing is held, which is past the 90-day case closure mark. …
>
> The Division's priority for APS is filling the positions that are currently vacant. Once this occurs, and staffing patterns are stabilized, we will be able to determine the staffing levels that are needed to realize this recommendation. Additional APS workers would still likely be needed to provide case management and follow-up

[56] *See* in-person ombudsman office consultation meeting with APS leadership (June 20, 2023).

[57] *See* "National Voluntary Consensus Guidelines for State Adult Protective Services Systems," Administration for Community Living, (https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf,) last visited August 28, 2023).

services to adults when APS is awaiting the start of Medicaid services or the resolution of a court case. When APS is adequately staffed, it is possible to look at each investigator's assignment from a percentage of the workload (as opposed to a numerical number of cases) and balance the workload so that active cases do not overload any single investigator or supervisor.[58]

Recommendation 5: Adult Protective Services should update its policy and procedures manual to include more guidance on reporting criminal activity to law enforcement.

The APS Policy and Procedures Manual does not provide specific guidance to APS Workers about what to do if they suspect an adult is the victim of criminal activity during an APS investigation. In this case, the APS Worker referred the elder who was a victim of a "sweetheart scam" to Facebook, rather than making a report to law enforcement. APS staff need more clarity on how and when to respond to these situations as they arise.

The Ombudsman recommends that APS update the section of the policy and procedures manual, "APS Investigation,"[59] to include:

- step-by-step instructions for documenting when a crime has been or may have been committed against a vulnerable adult;
- timelines and instructions for notifying law enforcement, the Office of Elder Fraud and Assistance, and/or the Medicaid Fraud Control Unit;
- whether and how to share evidence with law enforcement agencies; and
- documenting any outcomes from the report(s).

This section should also include instructions for how the worker can pursue a protective order on behalf of the vulnerable adult if they believe it is necessary to protect the person from further exploitation or harm.

[58] *Supra* n. 38.
[59] This section currently appears on pages 32-33 of the APS Policy and Procedures Manual 2018.

Agency Response to Recommendation 5

The Division accepted this recommendation:

> Currently, APS is working with the SDS Policy Unit on regulations for APS. The APS policy and procedural manual will be updated to coincide with the regulations as well as the recommendations from the Ombudsman.[60]

Recommendation 6: Adult Protective Services should add a Protective Services Manager 2 position.

Based on the evidence reviewed, the Ombudsman believes that this investigation warranted more oversight from APS supervisors and managers. APS leadership shared that the agency is working on writing a database query that would flag cases that are not closed within the 90-day timeframe for management to review.[61] Additionally, the agency is creating a "supervisory checklist" to ensure a standardized approach to supervision.

The Ombudsman supports and encourages these efforts. The Ombudsman believes that APS will need additional supervisory staff to successfully implement this quality assurance strategy. The Ombudsman recommends the creation of an additional Protective Services Manager 2 (class code: PF0206) position. This position could focus on a variety of APS initiatives, such as overall program evaluation, staff training, and interpretation of policy and goals.[62]

A review of class specifications shows that a Protective Services Manager 2 position could cost up to $140,000/year, factoring in merit increases, etc. The Ombudsman recommends the Division seek an increment in the SFY25 budget to fully fund the position for five years.

[60] *Supra* n. 38.
[61] *See* in-person ombudsman office consultation meeting with APS leadership (June 20, 2023).
[62] *See* Protective Services Manager 2, Workplace Alaska, (https://www.governmentjobs.com/careers/alaska/classspecs/892149?keywords=Protective%20Services%20Manager%201&pagetype=classSpecifications, last visited August 28, 2023).

Agency Response to Recommendation 6

The Division partially accepted this recommendation, and responded that adding the position would support the Ombudsman's other recommendations:

> The addition of a protective services manager position would allow the APS unit manager and APS supervisors the necessary time to approve assessments, case closures and redistribute the workload. Currently, due to a shortage and turnover in investigation staff and the lack of this position, supervisors are carrying a caseload and training new staff as well as their other duties. There is almost no opportunity for the timely or thorough review of assessments or case closures. …
>
> The Division is evaluating the possibility of reclassifying an existing position and possibly absorbing the cost for one of these to be rededicated as a new protective services manager 2 position. If no existing positions can be identified within the Division currently to fill this need, we would seek additional resources.[63]

The Ombudsman cautions the Division against redirecting existing staff and resources when the evidence from this investigation showed that APS needs additional resources to supervise and support its staff to perform their duties efficiently and effectively.

Recommendation 7: Adult Protective Services should work with stakeholders and service recipients to ensure that the agency's vision and policies for performing its mission align with community expectations and values.

This investigation highlights the disconnect between community expectations and the agency's perspective on when and how to support vulnerable elders. The Guiding Principles set out in the APS Policy and Procedures Manual state the agency's policy: "Freedom is more important than safety. The person can choose to live in harm or even self-destructively provided that he or she has the decision-making capacity to choose, does not harm others, and commits no crime."[64]

Personal independence and freedom from unnecessary and unwarranted government intrusion are values held by Alaskans. Certainly, state government agencies should not limit or infringe on the

[63] *Supra* n. 38.
[64] APS Policy and Procedures Manual (2018) at 6.

rights of individuals unless absolutely necessary to protect them from harming themselves or others. However, as the population ages[65] and incidence of severe self-neglect continue to present difficult cases for APS, it may be time to revisit when and how the State protects vulnerable elders from dying the way this adult did.

APS currently treats issues of self-neglect and hoarding as a choice made by the elder, rather than signs of mental health disorder or incapacity. Engaging with stakeholders, mental health professionals, caregivers, and older Alaskans provides an opportunity to explore whether that framework aligns with the science, evidence, and community values of caring for vulnerable elders.

This adult engaged in hoarding, which is a recognized psychiatric disorder – a form of obsessive compulsive disorder and obsessive compulsive personality disorder.[66] The adult also engaged in animal hoarding, which is defined by the collecting of such a large number of animals that overwhelms the person's ability to provide care, leading to a deterioration of minimal standards of sanitation, the condition of the animals, and the environment – and negative effects on the person's own health and well-being.[67] Hoarding can cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[68] Hoarding is estimated to be a comorbid condition with mental illness in 56-85% of cases.[69] Notably, "given the high prevalence of executive impairment, it is not acceptable to withhold treatment out of a purported respect for the person's autonomy without conducting a capacity assessment."[70]

Some of the behaviors that contributed to the adult's death were probably a form of Diogenes Syndrome.[71] Unlike hoarding, Diogenes Syndrome is not recognized in the *Diagnostic and*

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[65] *See* Alaska Commission on Aging Senior Snapshot 2022, stating that Alaska's population over the age of 60 increased 68% between 2010 and 2022 (https://health.alaska.gov/acoa/Documents/ACoA_seniorsnapshot_2022.pdf, last visited October 3, 2023).
[66] *See Diagnostic and Statistical Manual of Mental Disorders* DSM-5 300.3.
[67] Patronek G. J. *Hoarding of animals: an under-recognized public health problem in a difficult-to-study population,* Public Health Reports (Jan.-Feb. 1999).
[68] *See* Gleason A, et al. *Managing hoarding and squalor.* Australian Prescriber (June 2021).
[69] *Id.*
[70] *Id. citing* Sutherland A. and Macfarlane, S. *Domestic squalor: Who should take responsibility?* Australian & New Zealand Journal of Psychiatry (2014).
[71] Diogenes Syndrome, or "severe domestic squalor," is a form of severe self-neglect. The person neglects their hygiene, home, and health. It is characterized by social withdrawal, hoarding, and lack of concern or awareness of the

Statistical Manual of Mental Disorders. It is not diagnosed primarily as a mental illness, but Diogenes Syndrome is "highly comorbid with various psychiatric and somatic disorders" including dementia, depression, serious mental illness, and other medical issues that can impair decision-making ability.[72]

In many Alaskan communities and cultures, caring for elders while promoting independence is a central value. The Alaska Commission on Aging's mission is "to ensure the dignity and independence of all older Alaskans." The proposed Alaska State Plan for Senior Services FFY2024-2027 is based on the vision of "strong partnerships to provide high-quality, culturally sensitive, accessible services for Alaskans age 60 and above to live healthy, independent, meaningful lives in the place and manner of their choosing."[73] Alaska Native cultures include the value of "respect for elders" in a variety of ways.[74] In Hmong culture, "elder people are highly respected, and it's expected they will be taken care of by the younger generation."[75] Similarly, "Filipinos place a strong cultural value on respect for age and for the elderly."[76] Asian cultures emphasize intergenerational relationships and care for elders.[77] Research shows that "members of Hispanic groups are more likely . . . to recognize both parental and filial obligations" to elders.[78]

This investigation showed that individuals and organizations in the community all tried to help the adult and mitigate the risk of harm their behaviors presented. When they were unsuccessful, they contacted APS to help the adult. APS relied on their policy, which prioritizes independence over

severity of the person's living condition. There is insufficient research to show the cause of the behaviors. *See* Proctor C, Rahman S., "Diogenes Syndrome: Identification and Distinction from Hoarding Disorder." *Case Reports in Psychiatry* (November 25, 2021).

[72] Alaska Commission on Aging website, https://health.alaska.gov/acoa/Pages/default.aspx (last visited October 3, 2023).

[73] Proposed Alaska State Plan for Senior Services FFY 2024 - FFY 2027, Alaska Commission on Aging (June 26, 2023).

[74] *See Athabascan Cultural Values*, Alaska Native Knowledge Network, University of Alaska Fairbanks (http://www.ankn.uaf.edu/ancr/values/athabascan.html, last visited October 3, 2023); *Southeast Traditional Tribal Values,* Central Council Tlingit & Haida Indian Tribes of Alaska (https://www.ccthita.org/about/values/index.html, last visited October 3, 2023); *Iñupiaq Cultural Values*, Alaska Native Knowledge Network, University of Alaska Fairbanks (http://www.ankn.uaf.edu/ANCR/Values/Inupiaq.html, last visited October 3, 2023).

[75] Owens, C.W., *Hmong Cultural Profile*, EthnoMed, Harborview Medical center, University of Washington (May 1, 2007) (https://ethnomed.org/culture/hmong/#, last visited October 3, 2023).

[76] Asian & Pacific Islander Older Adults Task Force, MENTORS Project.

[77] *See* Miyawaki, C. *A Review of Ethnicity, Culture, and Acculturation Among Asian Caregivers of Older Adults (2000-2012)*, Sage Open (Feb. 2015).

[78] Landale N.S. et al., *Hispanic Families in the United States: Family Structure and Process in an Era of Family Change*, National Academies Press (2006).

health and well-being, and an unsupported decision that the adult had "decision-making capacity" when determining whether and when to intervene to protect the adult from harm. This highlights a possible misalignment of community and agency values. Engaging in a robust and inclusive conversation with stakeholders will help APS determine whether its policy needs to be revisited, and if so, how to establish a framework for services that reflects the values and expectations of Alaskans.

Agency Response to Recommendation 7

The Division accepted this recommendation and provided the following response:

> Significant stakeholder engagement was conducted in 2022 as part of the effort to draft new APS regulations, including:
>
> • Display ads in Anchorage, Juneau, and Fairbanks newspapers, with overview of APS, request for input with link to email address and on-line survey regarding regulations project
>
> • Live training and input session for mandatory reporters with link to on-line survey
>
> • Live training and input session for general public with link to on-line survey and email address
>
> • Direct-appeal emails from the APS unit manager to stakeholder agencies requesting input with link to on-line survey.[79]

However, the Division explained that APS would need adequate staffing to oversee the quality of APS work to fully implement this recommendation.[80]

Recommendation 8: APS should add a Quality Assurance Manager position.

SDS shared with the Ombudsman that the addition of a Quality Assurance position could assume staff management roles and create more opportunity for the APS Manager to work with community stakeholders and service recipients to ensure core values align with the community's expectations.[81] The APS Manager would be able to attend and engage in more stakeholder events

[79] *Supra* n. 38.
[80] *See id.*
[81] *See supra* n. 38.

and deeply understand the needs of the community and how APS could better address the community's concerns and priorities.[82] The Ombudsman is persuaded that the addition of a Quality Assurance Manager position could strengthen APS's responsiveness to the needs of vulnerable Alaskans.

A review of class specifications shows that a Quality Assurance Manager position could cost up to $105,000 annually, factoring in merit increases, etc. The Ombudsman recommends the Division seek an increment in the SFY25 budget to fully fund the position for five years.

Agency Response to Recommendation 8

The Division accepted this recommendation.[83]

[82] *See id.*
[83] *See id.*

Conclusion

The Ombudsman's recommendations are designed to strengthen APS's ability to provide services to vulnerable adults confidently and lawfully. The largest number of reports received by APS involve self-neglect, followed by financial exploitation.[84] The adult in this investigation experienced both, to such a degree that they died alone, in squalor, of hypothermia. APS was unable to find a meaningful solution to address either issue. APS maintained that the adult had "decision-making capacity," but was unable to provide documentation or a full explanation of how they decided this. The adult was living in a home that was extremely unsafe, and their ability to seek help without assistance had clearly diminished over the course of APS's contacts with them.

APS made good faith efforts to help the adult, but the evidence showed that their situation warranted more action by the APS Worker and more supervision by the agency to achieve a timely and protective response. The Division agreed:

> "[the APS] worker and supervisor did not fully consider the adult's advanced chronic medical diagnosis and the adult's inability to recognize [their] vulnerability or to follow through to meet [the adult's] basic needs. This case demonstrates the need for adequate staffing to ensure that APS has adequate oversight and 'fail safe' policies and procedures and is able to develop and implement quality assurance protocol, from screening and investigation to [the] case closure process."

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[84] *See* APS Policy and Procedures Manual (2018) at 7.