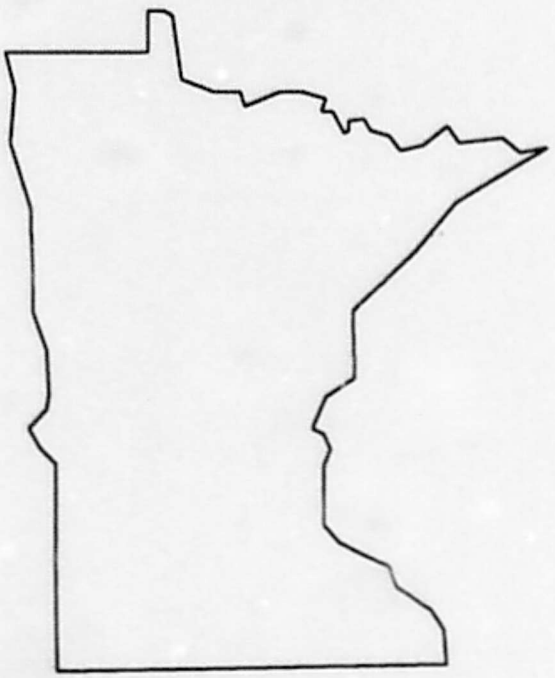
Office of the Ombudsman for Mental Health and Mental Retardation

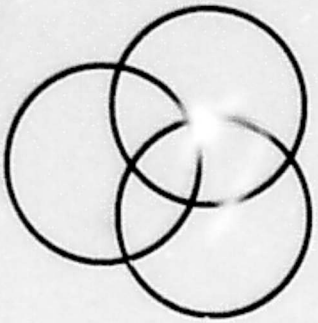
ANNUAL REPORT

TO THE GOVERNOR

1989



Submitted by the Ombudsman
for Mental Health and Mental Retardation,
Pursuant to Minn. Stat. Section 245.95, Subd. 2
January, 1990



Contents

Introduction 3

Organization of the Office 4

Outreach Efforts 5
Facility Visits
Informational Meetings Around the State
Provider Mailings
Quarterly Newsletter
Outreach to Community Groups
Office Brochure

Investigation of Complaints 7
General Complaint Overview: Matters Appropriate for Review
Complaint Statistics
Complaint Examples

Systemic/Focused Issues 12
Survey of Psychotropic Medication Usage in Community Rule 34 Facilities in Minnesota
Accessibility Survey of Community Rule 36 Facilities
Valor Corporation Review
Gerard of Minnesota Review

Legislative Efforts 14

Ombudsman Advisory Committee 15
Overview
Committee Members

Medical Review Subcommittee 16
Overview
Summary of Client Deaths Reported to the Office in 1989
Example of Cases Reviewed by the Medical Review Subcommittee

Summary 21

Appendices 23
Compilation of Statutes
Complaint Review Protocol
Ombudsman Poster

Introduction

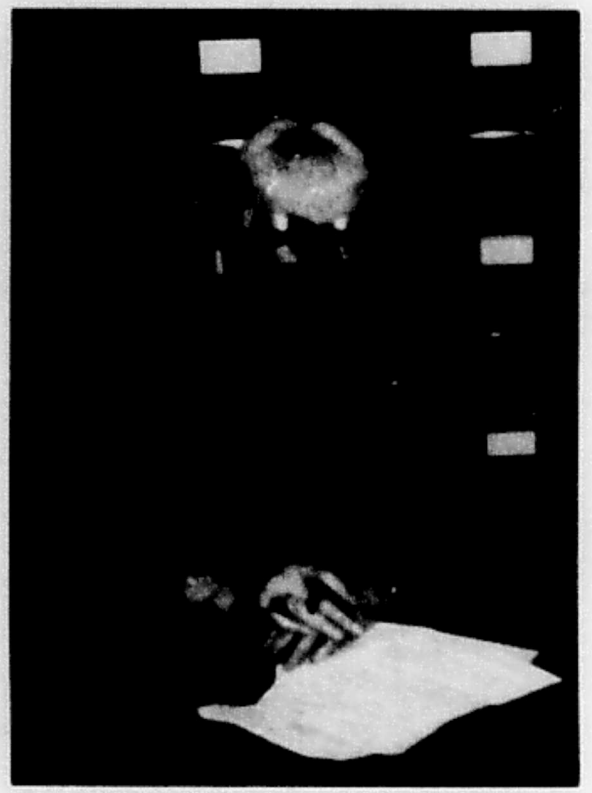
The Office of Ombudsman for Mental Health and Mental Retardation was created by the 1987 Minnesota Legislature. (Minn. Stat. § 245.91 et. seq.). Governor Perpich signed the bill into law on June 2, 1987, with a July 1, 1987 effective date. Shirley Hokanson was appointed Ombudsman on September 1, 1987.

The Ombudsman has been given a broad mandate to "promote the highest attainable standards of treatment, competence, efficiency, and justice for all people receiving care and treatment for mental illness, mental retardation, chemical dependency, or emotional disturbance."

To carry out the statutory mandate, the Ombudsman has been given the power to:

- prescribe the methods by which complaints to the office are made, reviewed, and acted upon;
- mediate or advocate on behalf of clients;
- investigate the quality of services provided to clients;
- determine the extent to which quality assurance mechanisms work to promote the health, safety, and welfare of clients;
- gather information about and analyze the actions of an agency, facility, or program;
- enter and view premises of an agency, facility, or program;
- examine records of an agency, facility, or program on behalf of a client;
- subpoena a person to appear, give testimony, or produce documents relevant to a matter under inquiry;
- attend Department of Human Services Review Board and Special Review Board proceedings.

The following report, submitted pursuant to Minn. Stat. § 245.95, Subd. 2, describes the activities undertaken by the Office of Ombudsman during 1989.

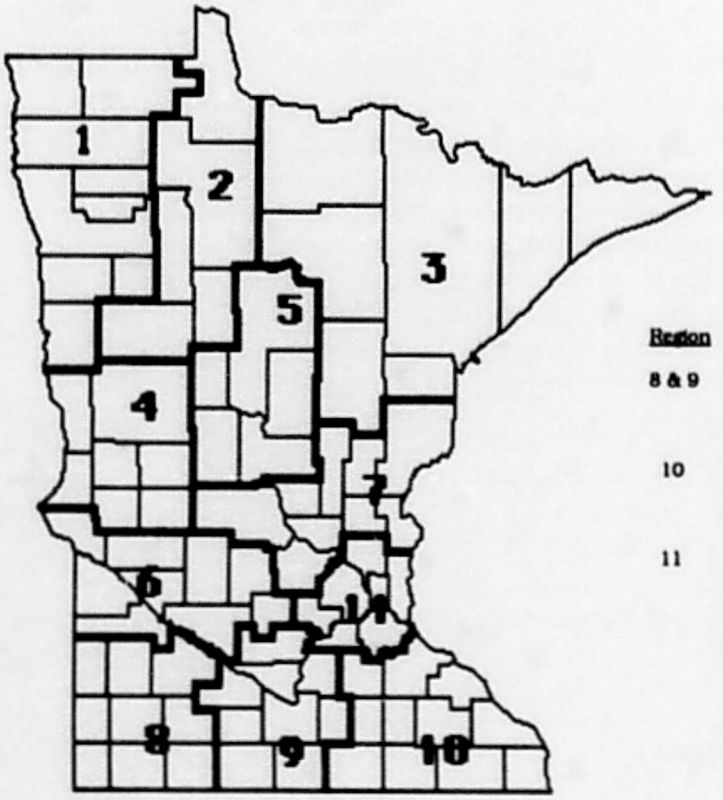


Shirley Hokanson, Ombudsman

Organization of the Office

The Office of Ombudsman for Mental Health and Mental Retardation consists of a central office in St. Paul and regional offices throughout the state. The regional offices, which are each staffed by a regional client advocate, are located in the Regional Treatment Centers in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, Moose Lake, St. Peter, and Willmar. The St. Paul staff consists of the Ombudsman, Deputy Ombudsman, a Director of Planning, a Medical Review Coordinator, a Quality Monitoring Coordinator, two metropolitan client advocates, a student paraprofessional, an office manager, and a secretary. A strong, cohesive relationship exists between the central office staff and the regional client advocates. Common goals and coordinated work encourages and enhances cooperation in resolving both individual and system complaints. The Deputy Ombudsman is responsible for the supervision of the regional client advocates.

The regional client advocates and their respective service areas are delineated below.

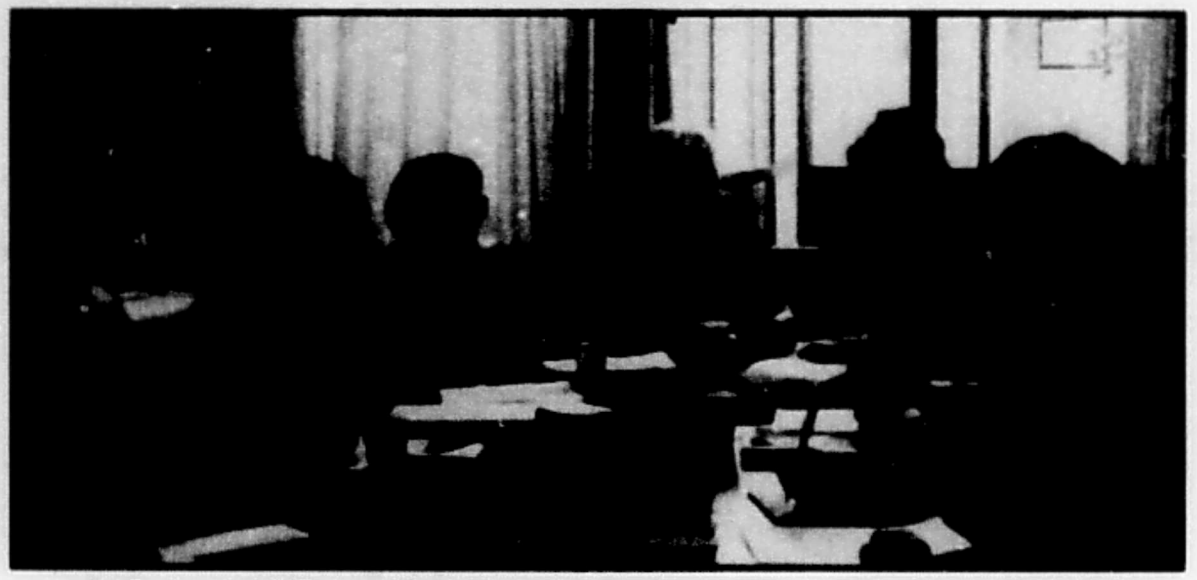


Region	Staff
1 & 4	Jerry Hanson Fergus Falls RTC (218) 739-7364
2 & 5	Cheryl Turcotte Brainerd RTC (218) 828-2366
3	Joyce Hultberg Moose Lake RTC (218) 485-4411 Ext. 302
6	Roger Schwab Willmar RTC (612) 231-5962
7	Jim Tausch Cambridge RTC (612) 689-2121 Ext. 337

Region	Staff (cont.)
8 & 9	Glenda Bode St. Peter RTC (507) 931-7105
10	Kathleen Dohmeier Faribault RTC (507) 332-3380
11	Claudia Hulleman Anoka RTC (612) 422-4269
	Bill Wyss St. Paul Office (612) 297-2762
	Sandra Newbauer St. Paul Office (612) 296-5687

NOTE: *Although the offices of the regional client advocates are located in the regional treatment centers, staff respond to complaints from the communities, as well as from the regional treatment centers.*

Outreach Efforts



Ombudsman Office staff meeting with Faribault RTC staff to discuss the new mandatory reporting law.

Facility Visits

The Ombudsman and her staff continued making visits during 1989 to randomly selected community residential facilities and acute care inpatient facilities. Over 150 facility visits were made during the past year. The purpose of these visits was fourfold:

- to introduce the Office of Ombudsman for Mental Health and Mental Retardation;
- to meet the facility directors and other staff.
- to tour the facility; and
- to meet with the clients who reside in or receive services from the facility.

The facility visits continue to be a valuable outreach tool for the Ombudsman Office.

Informational Meetings Around the State

The Ombudsman and her staff conducted a series of meetings throughout the State, with providers, regional treatment center staff and county social service agencies to discuss the implementation of the 1989 legislation which mandated the reporting of all client deaths and serious injuries to the Ombudsman. In all, 29 meetings were held with over 400 people in attendance. Meetings were held in Bemidji, Brainerd, Cambridge, Crookston, Duluth, Faribault, Fergus Falls, Grand Rapids, Marshall, Moose Lake, Rochester, St. Cloud, St. Paul, St. Peter, Willmar, and Worthington.

Provider Mailings

In late July, the Office of Ombudsman for Mental Health and Mental Retardation sent a mailing to all providers, notifying them of the 1989 legislative amendments

which mandated the reporting of all client deaths and serious injuries to the Ombudsman. A follow-up letter clarifying the reporting requirements was sent out in August. A third mailing consisting of commonly asked questions and answers regarding the new mandatory reporting law will be mailed to all providers in early January, 1990.

Quarterly Newsletter

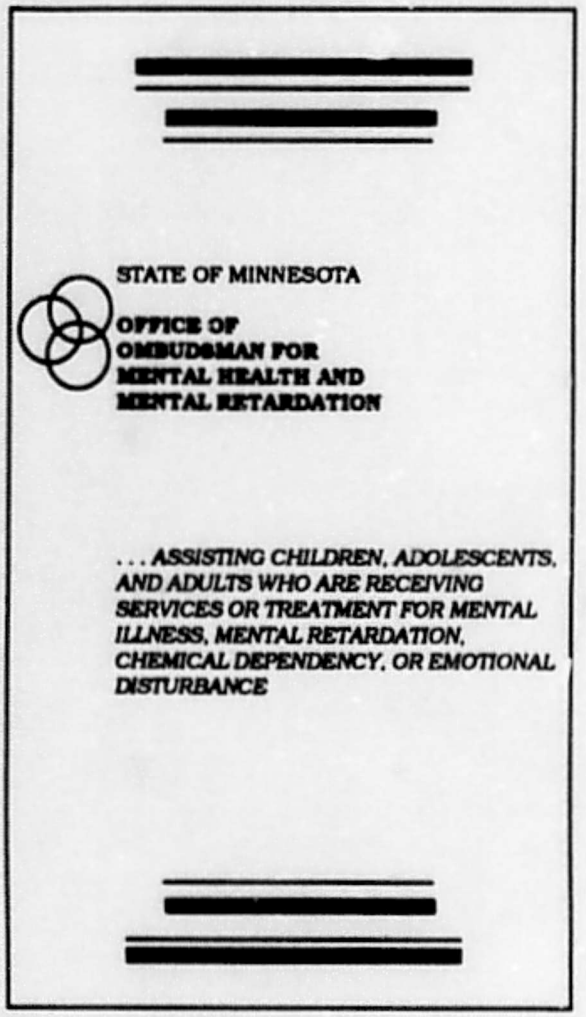
The Office of Ombudsman for Mental Health and Mental Retardation began a quarterly newsletter, *Ombudsman News*, in 1989. The newsletter is mailed to all providers and county social service agencies, legislators, advocates and other interested parties, including other state agencies. The newsletter features activities of the Ombudsman Office including samples of complaints handled, legislative activity affecting the Office, Ombudsman Advisory Committee updates, and a focus on one Ombudsman staff member each edition. The newsletter has been well received and has been an effective outreach tool for the Office.

Outreach to Community Groups

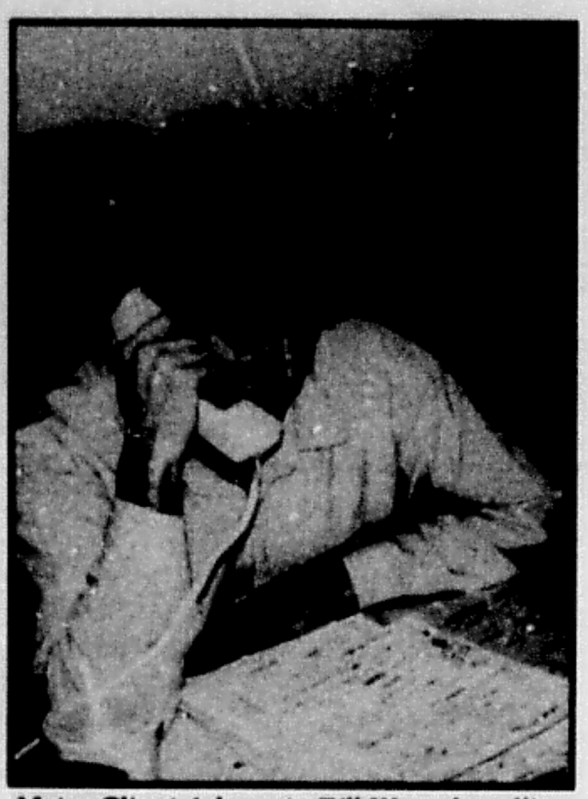
The Ombudsman and her staff made many presentations to advocacy, provider, and human services practitioner groups throughout the past year. These presentations were made to increase the awareness of the Office and the services provided to clients. In many instances, these outreach efforts were followed by requests for Ombudsman assistance in resolving individual client complaints.

Office Brochure

Over 5,000 copies of the Office brochure were distributed by the Ombudsman Office in 1989. Copies of the brochure were mailed to each community residential facility and county social service agency, along with a form on which to request additional copies. Provider and advocacy organizations were also supplied with copies. A copy of the brochure was mailed to each member of the Legislature. Other State agencies requested and received copies of the brochure to distribute to staff and clients.



Office Brochure



Metro Client Advocate Bill Wyss handling client intake call.

Investigation of Complaints

General Complaint Overview: Matters Appropriate for Review

Pursuant to the Ombudman's power to prescribe the methods by which complaints to the Office are made, reviewed, and acted upon, the Ombudsman developed a complaint review protocol in 1988. This protocol was slightly revised in 1989, based upon the experience in using the original protocol. (See Appendix B for full text).

In selecting matters for review by the Office, the Ombudsman is directed to give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

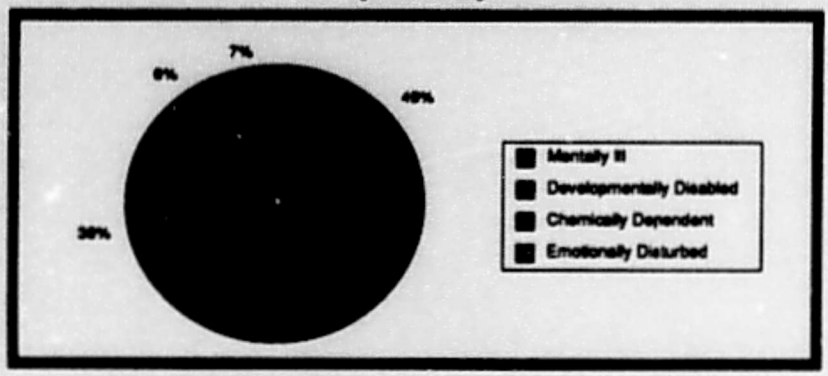
- may be contrary to law or rule;
- may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;
- may be mistaken in law or arbitrary in the ascertainment or facts;
- may be unclear or inadequately explained, when reasons should have been revealed;
- may result in abuse or neglect of a person receiving treatment;
- may disregard the rights of a client or other individual served by an agency or facility;
- may impede or promote independence, community integration, and productivity for clients; or
- may impede or improve the monitoring or evaluation of services provided to clients.

Complaint Statistics

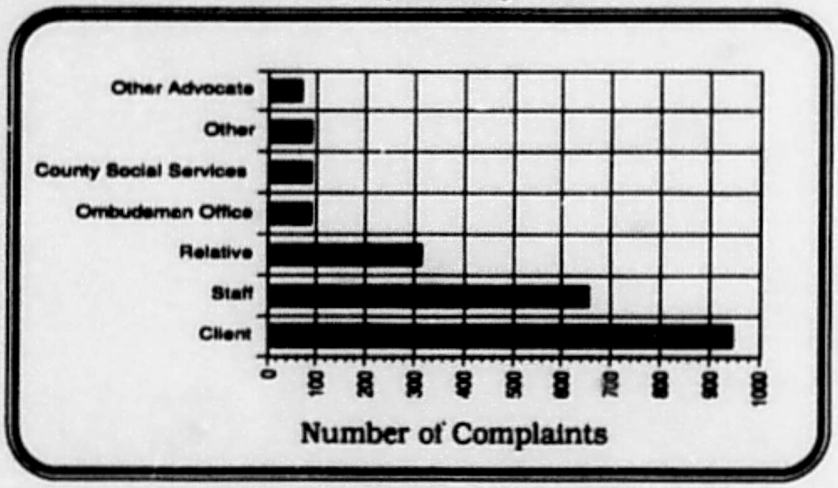
The Office of Ombudsman received over 2,200 complaints during 1989. Most of these complaints were resolved at the local level. Some of the complaints evolved into systemic issues which required a more in-depth review, often resulting in a report or recommendations to the agency, facility, or program affected.

The graphs on the following page detail the nature and substance of the complaints received by the Office during the proceeding year.

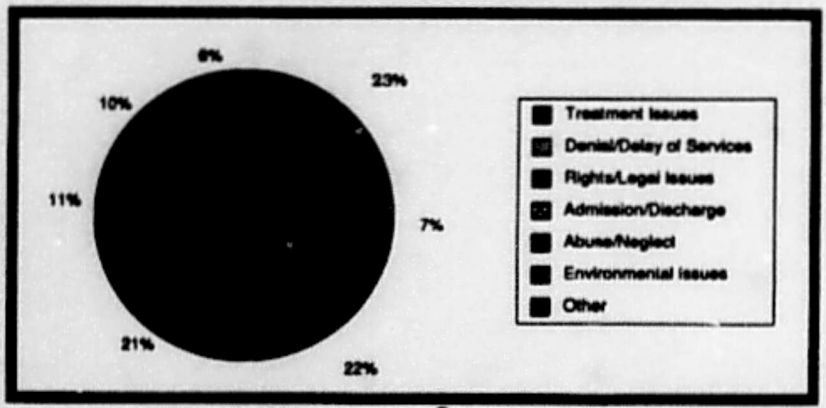
COMPLAINTS BY DISABILITY GROUPS (1989)



SOURCE OF THE COMPLAINTS (1989)



NATURE OF THE COMPLAINTS (1989)



Complaint Examples

A client complained that he had met the provisions of his program that would enable him to get his radio and end his money program. The regional client advocate reviewed the client's program and discovered there were no criteria set forth. The criteria were found in a progress note written two months earlier but was done in such a way as to be confusing and inconsistent. A meeting was held to go over the program. The client was able to get his radio, work out a budget with the staff, and receive a new, written program.

• •

A young woman receiving treatment for chemical dependency was informed she would be discharged for non-compliance with the treatment program. The woman did not want to be discharged and believed that, although she had broken several rules and policies, she was benefiting from the program. The facility's grievance mechanism was implemented and the advocate met with the client, the client's counselor and the facility's Assistant Administrator. The client was allowed to remain in the treatment program and entered into a contract to deal with her behavior in regard to the rules and policies.

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Requests for discharge by an informal client of an RTC were ignored. He also did not receive a medical exam within 48 hours. The regional client advocate intervened and the client's request for discharge was honored.

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A parent who had placed an adolescent child in a treatment facility was being threatened with the adolescent's removal from her home if she signed her child out, and sought treatment elsewhere, without the treatment team's approval. The client advocate investigated, found that the adolescent had been receiving inadequate mental health services and intervened with the county agency on behalf of the adolescent and parent. Eventually, the child was able to return home with arrangements for outpatient services.

• •

A client residing in an apartment and receiving outpatient mental health services, found herself unable to obtain legal representation for a marriage dissolution/child custody matter. The advocate investigated, found that Legal Aid would not provide representation unless she asked for full custody (which the client recognized would not be in her child's best interest), and was able to arrange for private legal representation without cost to the client.

• •

A client scheduled for discharge from an RTC had some temporary medical needs which the proposed community facilities were not certain they could handle. The regional client advocate assisted in identifying needs and resources and in delaying discharge until those necessary services were in place.

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Three persons in a treatment facility who are chemically dependent and hearing impaired met with the regional client advocate and an interpreter to complain that an interpreter was not always assigned to groups. They indicated that when the group leader or other clients had to do the interpreting, it interfered with the group process. The advocate checked out scheduling patterns and contacted the Administration on behalf of the clients.

Scheduling priorities were changed to resolve the problem.

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A resident of an RTC contacted the regional client advocate to express dissatisfaction with the status of his discharge planning. The resident had rejected all previous discharged efforts during his three years at the RTC because he felt the plans were overly restrictive and did not meet his needs. He was able to clearly state what he wanted in a community placement. When the advocate relayed this to the facility and county staff, there was some initial reluctance to incorporate the resident's goals and approaches into the discharge plan. They questioned whether it would be ethical to include what they considered to be unrealistic goals and expectations into the discharge plan. The advocate facilitated a meeting with the agency case manager and facility staff. The resident later joined the meeting. A discharge plan which incorporated the resident's goals and personal needs was developed. Approximately six months later he was discharged to a community placement that was acceptable to both the resident and other involved parties.

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Program staff, in a community chemical dependency facility, contacted the regional client advocate about a client who insisted that someone had forged some checks on his checking account. The advocate met with the client and reviewed the alleged forgeries. The advocate began piecing together the events prior to and after the time the checks were cashed, and then contacted the law enforcement agency in the appropriate city. The advocate took the client to the appropriate law enforcement agency to file a complaint, and to the bank to file an affidavit of forgery.

• •

The staff at a treatment facility wanted a client to go to a halfway house but the client did not want to go. A review of the client's chart revealed that the 90 day report to the court stated the client was no longer in need of commitment. After finding that the attorney of record was no longer the attorney of record, the regional client advocate contacted the court administrator. The administrator checked the file and found that an order had already been filed discharging the client. The order, signed nearly a month earlier, should have been sent to the medical records office but the order had not been received. The advocate requested that medical records contact the court administrator and have a copy of the order faxed up. The order arrived 15 minutes later and the advocate gave a copy to the client and explained she was no longer committed.

• •

A unit for clients with mental illness had an expectation that clients would make their beds each morning and keep their bedroom areas neat. If this is not done the bedroom was locked until supper, with the hope that the client's roommates would apply peer pressure to help solve the problem. The roommates resented being penalized for another client's actions. The regional client advocate wrote to the Administration, outlining the flaws in this practice and the fact that it violated clients' rights. The practice was stopped and problems would now be dealt with through clients' Individual Treatment Plans.

• •

The regional client advocate was contacted by the mother of an adolescent child receiving treatment for emotional disturbance in a residential treatment facility. The mother wanted her daughter to receive treatment out-of-state so that they could be closer together. Facility staff told the

mother that the daughter could not leave the program. The advocate met with the staff and the daughter and informed the daughter of her right to leave treatment upon turning 16. The daughter did choose to leave Minnesota and receive treatment while living near her mother. Mother and daughter are now doing fine.

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The guardian of a client in an adult foster home contacted the regional client advocate expressing dissatisfaction with the client's placement. The client, however, was very satisfied with the placement and did not want to move. After meeting with the county social worker and the client to discuss the complaint, the advocate suggested that the guardian ask to be relieved of her duties. The guardian no longer was living in the same area as the client and was feeling over-burdened by the responsibilities. A family member who lived closer to the client agreed to assume guardianship responsibilities.

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A 14 year-old boy receiving treatment in a private psychiatric hospital contacted the Office. He complained that the attending psychiatrist would not allow him to read the Bible, review his chart, have his own radio, and interact with female patients. The patient requested a new psychiatrist. The client advocate assisted the patient in filing a formal grievance with the hospital. The patient was assigned a new psychiatrist and his restrictions were lifted.

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A young man, committed to a treatment facility as both mentally ill and chemically dependent, was due to transfer to the CD treatment unit. The treatment was denied because no Rule 25 assessment had been made, as required by Consolidated Funding. In reviewing the matter, the regional client advocate discovered a conflict between two counties over financial and case management responsibility. As a result, neither county would do the Rule 25 assessment. The client's immediate concern was the increased length of his stay at the treatment facility. The advocate met with the treatment facility administration and maintained that the client should not suffer due to a bureaucratic mix-up. Administrative authorization for immediate transfer was given. The advocate then provided program staff with references and resources for straightening out the conflict between the counties.

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The Office was contacted by an anonymous staff person employed in a Rule 34 facility. The person reported that no hot water was available for clients, which apparently had been a long standing issue. The client advocate contacted the facility to inquire why no hot water was available for clients. After a plumber's evaluation, the facility agreed to replace its hot water system.

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The Ombudsman Office was contacted on behalf of a client who was receiving services for mental illness at an RTC. The client had been on a locked unit for two years and his condition was not improving. Concerns over the client's treatment plan and the high use of medications were also raised. After much effort by the client advocate, the client was transfered to an RTC that provides services for persons with mental retardation. The client's parents, who reside in Paris, France, kept in regular mail and phone contact with the Ombudsman Office in an effort to monitor the situation. Since being transfered, the client's condition has improved.

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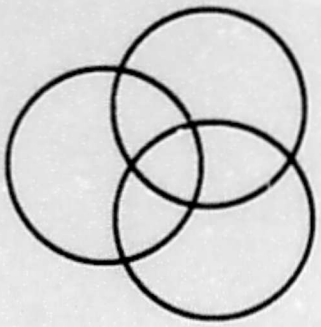


Systemic/Focused Reviews

The Office of the Ombudsman for Mental Health and Mental Retardation has taken an in-depth look at several systemic issues in an effort to improve the quality of services and treatment to persons with mental illness, mental retardation or related condition, chemical dependency, or emotional disturbance. The following are some of the issues that were examined in the past year:

Survey of Psychotropic Medication Usage in Community Rule 34 Facilities in Minnesota

The Office of the Ombudsman completed a survey of psychotropic medications administered to persons with mental retardation or related conditions in community residential settings. The survey was released to the public in August, 1989. The following were among the findings of the survey:

- The overall rate of use of psychotropic medication was 19%.

- The overall rate of use of neuroleptic medication was 12% (compared to approximately 25% in the RTCs).

- Ninety-four percent (94%) of clients on psychotropic medication are being monitored for side effects by use of a standardized format.

- Ninety-four (94%) of clients who are on psychotropic medication have had, or currently have, behavioral programs as part of their treatment regime.

- Twenty-one percent (21%) of the clients who take psychotropic medications are prescribed two or more psychotropic medications.

The Ombudsman Office encouraged the Department of Human Services (DHS) to incorporate the findings of the survey into its overall plan for evaluating psychotropic drug usage in the RTCs and community Rule 34 facilities. The Ombudsman also encouraged the Department of Health to identify problems in psychotropic medication administration through its monitoring effort. The Ombudsman further encouraged providers and advocates to take a proactive rather than reactive stance; rather than focus on the process, the Ombudsman encouraged providers and advocates to examine the benefit to the client and the improvement to his/her quality of life.

Accessibility Survey of Community Rule 36 Facilities

The Office of the Ombudsman for Mental Health and Mental Retardation completed a survey to assess the accessibility of community Rule 36 facilities for persons with mental illness. The survey was released in October, 1989. An earlier telephone survey of all Rule 36 facilities in

Minnesota revealed that only six out of 74 facilities claimed to be wheelchair accessible. The more detailed survey revealed a lack of facilities that could accommodate people with physical disabilities.

The Office encouraged the Department of Human Services (DHS) to assess the need for such facilities and encouraged DHS to provide incentives to providers to develop Rule 36 facilities that are accessible to people with physical disabilities should such a need be found. The Office also encouraged existing facilities to take immediate economical steps to make the facilities as accessible as possible. The Ombudsman noted a lack of awareness of the needs of people with both mental illness and physical disabilities among the general public and policy makers, and encouraged advocacy groups representing these disability groups to work together to instill this awareness.

Valor Corporation Review

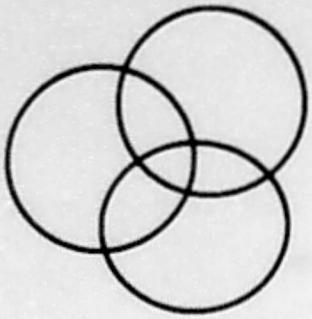
In response to the closure of one Valor facility and complaints from several other Valor facilities, the Ombudsman Office undertook a comprehensive review of the facilities managed by the Valor Corporation. Ombudsman Staff made unannounced visits to 16 Valor managed Rule 34 facilities in January, 1989. A preliminary report was prepared and discussed with Valor Corporation staff. The Office still had some concerns after receiving both written and oral responses from Valor. A second round of more limited unannounced visits was undertaken in April. A full report was prepared and made public in early May. Shortly thereafter Valor agreed to the Department of Human Service's request to enter into a voluntary receivership of the Valor managed facilities. As a result of the efforts of the Ombudsman Office and the Department of Human Services, the clients residing in those facilities are now in a more stable and homelike living arrangement and are hopefully receiving better services.

Gerard of Minnesota Review

In response to concerns raised by Mower and Hennepin County Social Services, the Ombudsman Office undertook a thorough review of services and treatment provided by Gerard of Minnesota in November, 1989. Gerard is a licensed Rule 5 facility which provides treatment to emotionally disturbed children in Austin, Minnesota.

The Office sent a full report of its investigation to Gerard of Minnesota in mid-December. In reaction to the report, Gerard submitted a written response which indicated that many of the practices complained of had been terminated. Gerard accepted and agreed to implement all of the Office's recommendations.

The Office is encouraged by Gerard's willingness to work with the Office to insure the highest attainable standards of treatment for adolescents in their facility. The Office will continue to monitor Gerard to insure that the agreed upon recommendations are satifactorily implemented.



Legislative Efforts

The Office of Ombudsman for Mental Health and Mental Retardation successfully pursued two legislative initiatives in 1989. The Legislature: 1) approved the addition of subpoena power to the list of the Ombudsman's powers; and 2) required the reporting of all client deaths and serious injuries to the Ombudsman. Governor Perpich signed the bill approving these initiatives on June 1, 1989, and the changes became effective on August 1, 1989.

While the Ombudsman expects to use the subpoena power rarely, having the power should facilitate investigations.

Under the mandatory reporting provisions of the new law, all client deaths and serious injuries must be reported to the Ombudsman by the facility or program director within 24 hours after the death or serious injury occurs. Since client deaths and serious injuries are indicators of quality of care, this new requirement will allow the Ombudsman to more closely monitor quality of care in community settings.

The Ombudsman Office also monitored the Regional Treatment Center legislation. As part of that legislation, the Office of the Ombudsman was given a role in the screening process used to discharge persons with mental retardation or related conditions from the RTCs. The Ombudsman also was designated to serve on two DHS task forces examining the screening process for persons receiving services or treatment for mental illness or emotional disturbance.

The Legislature approved the addition of two staff positions in fiscal year 1990 and a third position in fiscal year 1991.

Deputy Ombudsman John Waldron testifying before Senate Finance Committee.

Ombudsman Advisory Committee

Ombudsman Advisory Committee members meeting with interested persons from the St. Peter community to discuss the implementation of the 1989 RTC legislation.

Overview

The Ombudsman Advisory Committee consists of 15 members appointed by the governor to staggered three-year terms. All members of the Committee have a special knowledge of and interest in facilities and programs serving persons with mental illness, mental retardation or related conditions, chemical dependency, or emotional disturbance. The Committee meets on a quarterly basis to advise and assist the Ombudsman.

The Committee's major focus for Fiscal Year 1990 will be to review the planning process for the move to the community that will occur as a result of the 1989 RTC legislation. As part of this review, Committee members visited all of the RTC communities to examine how each is planning for the discharge of clients from the RTC into the community. Committee members met with RTC staff, county officials, regional task force members, and local advocates to discuss the planning process. A report to the Ombudsman is expected in early January, 1990.

Committee Members

The Ombudsman Advisory Committee consisted of the following members in 1989:

Louise Brown

Barbara Case

James Dahlquist

Rebecca Fink

Melvin Goldberg, Chair

Dr. Carl Hansen

Katie O'Brien

Genevieve O'Grady

Rodney Otterness

Bette Rosse

Terry Schneider

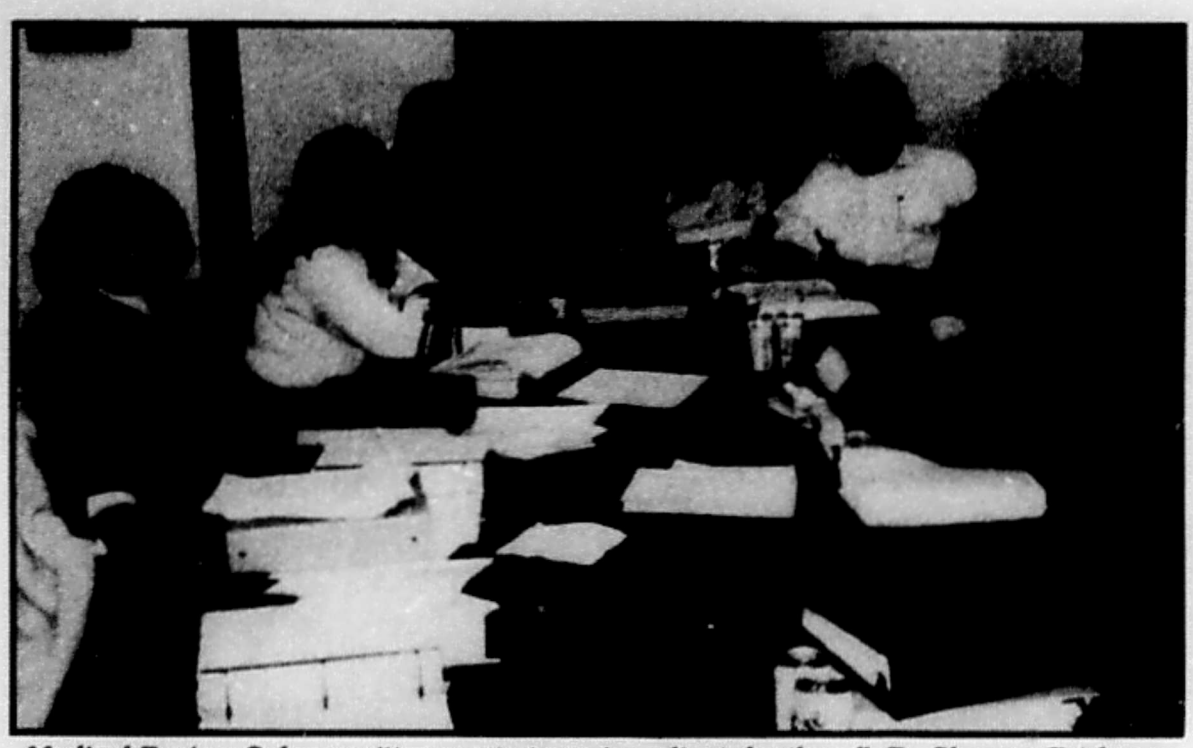
Dorothy Skarnulis

Dr. Lindsay Thomas

James Tweedy

Dr. Ruth Viste

Medical Review Subcommittee (MRS)



Medical Review Subcommittee meets to review client deaths. (L-R: Sharron Erickson, Medical Review Coordinator, and members Dr. Lindsay Thomas, Mel Goldberg, Dr. Ruth Viste, Jim Tweedy, Dr. Carl Hansen, and Becky Fink.)

Overview

The Medical Review Subcommittee (MRS) currently consists of six members of the Ombudsman Advisory Committee. The MRS meets on a regular basis to review the causes and circumstances surrounding the deaths of clients. The MRS makes a preliminary determination as to whether each death is unusual or appears to have resulted from other than natural causes. The MRS then aids the Ombudsman in the review of the deaths. Special attention is given to client deaths by suicide and accident. When appropriate, the MRS makes recommendations to the Ombudsman in an effort to improve the quality of care and prevent deaths under similar circumstances.

Summary of Client Deaths Reported to the Office in 1989

One hundred fifty-five (155) client deaths were reported to the Office of Ombudsman in 1989. Eighty-five (85) of those deaths were of persons with developmental disabilities, 62 were of persons with mental illness, six were of persons with chemical dependency, and two were children with emotional disturbance. Most of the deaths were from natural causes; however 15 suicides and three homicides were reported to the Office.

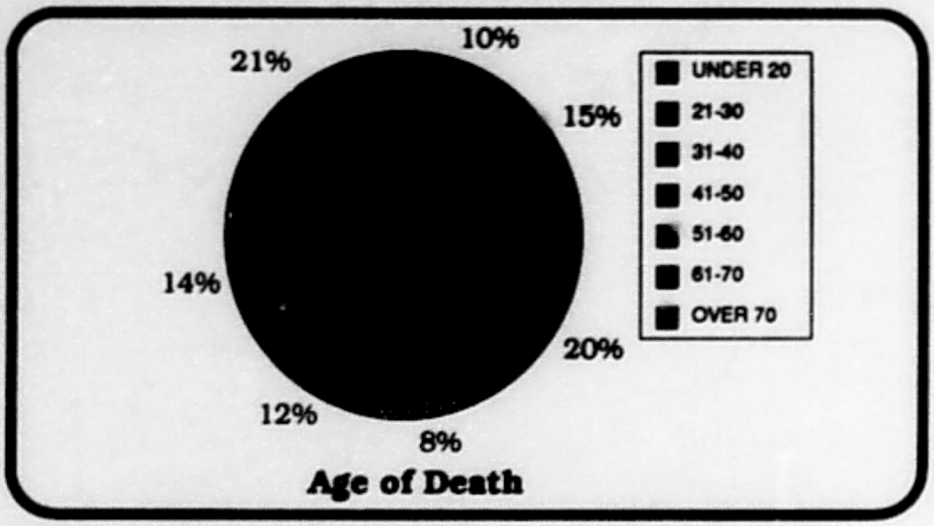
The chart and graphs on the following pages provide a more detailed breakdown of the 155 deaths reported.

CLIENT DEATHS REPORTED TO THE OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION IN 1989

	SEX		AGE							CAUSE OF DEATH				
	M	F	Under 20	21-30	31-40	41-50	51-60	61-70	Over 70	N	S	H	A	U
Developmentally Disabled (95)	46	39	13	12	21	5	12	16	6	75	0	0	6	4
Mentally Ill (62)	41	21	0	8	9	6	6	6	27	38	13	3	3	5
Chemically Dependent (5)	4	2	0	3	1	1	1	0	0	3	0	0	0	3
Emotionally Disturbed (2)	2	0	2	0	0	0	0	0	0	0	2	0	0	0
TOTAL (155)	93	62	15	23	31	12	19	22	33	116	15	3	9	12

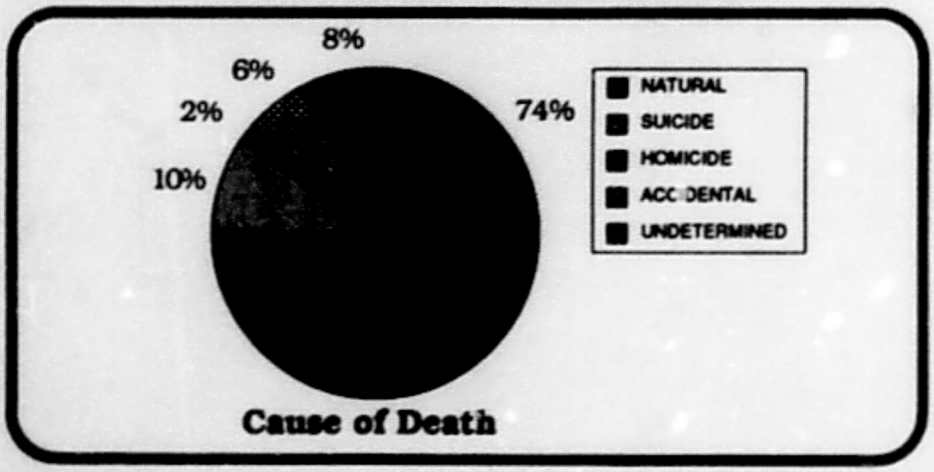
N = Natural
S = Suicide
H = Homicide
A = Accidental
U = Undetermined

CLIENT DEATHS
(1989)



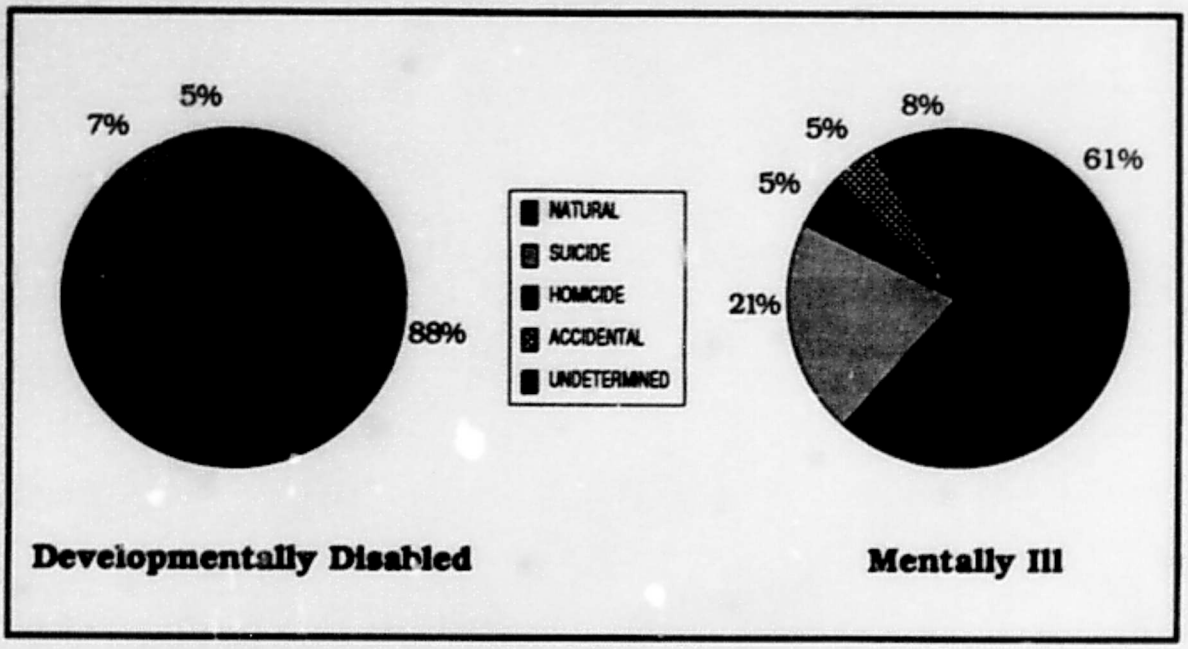
Age of Death

Client Deaths by Disability

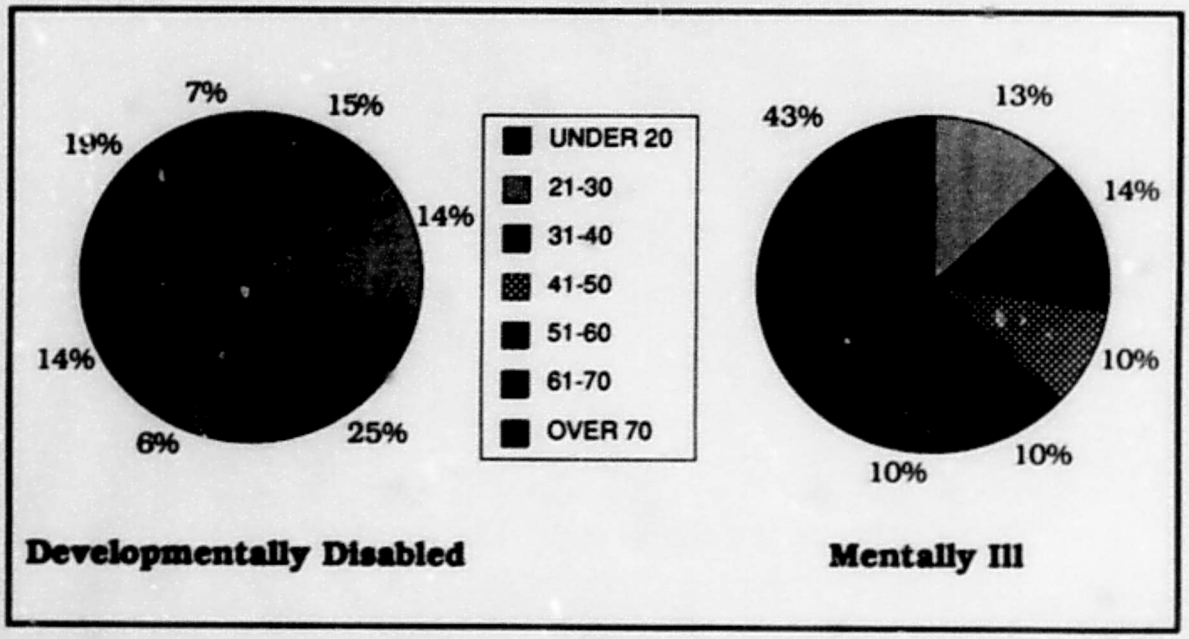


Cause of Death

CLIENT DEATHS BY CAUSE
(1989)



CLIENT DEATHS BY AGE
(1989)



Examples of Cases Reviewed by the Medical Review Subcommittee (MRS)

An adolescent with developmental disabilities participated in a swimming outing planned by the community facility. He was a non-swimmer as was one other person in the group of six clients. The clients were accompanied by two staff members. One staff member left the group and during his absence, the client, who was not wearing a life preserver, accidentally drowned. His body was found in 10 feet of water. Since the beach was non-public and no lifeguard was present, getting emergency support to the area was difficult. During the course of the review by the MRS, it was discovered that while there was a swimming policy, it was not adhered to by the staff. The MRS recommended that life vests be mandatory for all non-swimmers and poor swimmers, that non-public beaches not be used for swimming events, and that part of the client vulnerability assessment include an assessment of swimming capabilities. This spring, the Office will be sending the American Red Cross Safety Tips for Swimming to all community facilities to remind them about safe swimming precautions.

• •

A two-year old with a developmental disability and several medical problems was placed in an adult bed with side rails (much like you would see in a hospital). Her own crib was being used by another child for the night. Sometime during the night, she managed to move and her head became lodged between the railing and the mattress. This movement was unexpected for her in her medical condition. The MRS review was thorough and identified a number of systems as well as individual issues. The Ombudsman responded to the MRS recommendation that the Ombudsman write to all 87 Minnesota county social service agencies describing the circumstances surrounding this accidental death, and warning about the danger of placing small children in adult sized hospital beds.

• •

A young woman with a major psychiatric diagnosis committed suicide shortly after a bifurcated trial during which she was found to be mentally ill and dangerous and not guilty of criminal charges because of her mental illness. The MRS review in this case was long and thorough. While problems were identified in many areas, the major recommendation was that a letter be sent to all public defenders and all county attorneys describing the circumstances leading up to this client's suicide, including the trial. The MRS had reason to believe that if the trial had been handled differently, and if the response of clinical persons had been more immediate, the suicide might have been prevented. Recipients of the letter were urged to contact the State Public Defenders Office, the Attorney Generals Office, and/or the Ramsey County Attorney's Office if they were unfamiliar with the needs of clients who were mentally ill and dangerous.

• •

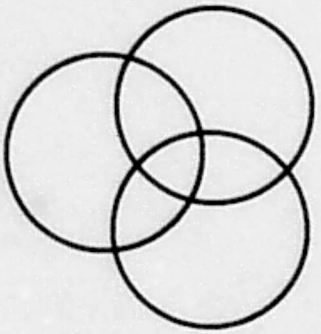
A woman with a developmental disability was living in the community. While riding her bicycle, she was struck by a truck and killed. The MRS review found that the client had prior training in bicycle safety, was wearing reflective clothing and had observed the facility rule about signing out when leaving. In fact, this facility had done everything it could to provide the necessary safety for this client. The only MRS recommendation was that a letter be written to the facility advising them that the case was closed and that the MRS had concluded that there were no quality of care compromises.

Over 2,200 complaints were handled by the Office during the past year. Some of these complaints evolved into systemic issues which required a more in-depth review, often resulting in a report and recommendations.

The Office undertook several studies and comprehensive investigations during the year.

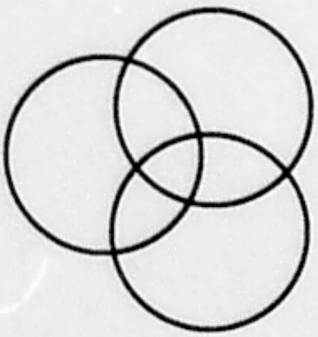
The Office has worked actively with the Medical Review Subcommittee to review client deaths, in an effort to prevent recurrence of similar deaths.

With accelerating efforts to discharge clients from the RTCs, the Ombudsman Office expects even greater focus on community settings and programs in the years to come.



Summary

The past year has been a busy, active time for the Office of the Ombudsman for Mental Health and Mental Retardation. Protocols have been developed to organize the internal procedures and policies of the Office. Regional meetings were held with community providers, RTC staff, and social service agencies to discuss implementation of the 1989 legislation which mandated the reporting of all client deaths and serious injuries to the Ombudsman. The Office brochure was distributed to facilities, counties, advocacy organizations, and other interested persons. A quarterly agency newsletter, *Ombudsman News*, was started in 1989.



Appendices

Appendix A: Compilation of Statutes Affecting Office of Ombudsman
Ombudsman Act (Minn. Stat.§ 245.91 et. seq.) 25
Screening Team 29
Maltreatment of Minors Act (Minn. Stat. § 626.556, Subds. 9 and 10 (b),(e)) 32
Vulnerable Adults Act (Minn. Stat. § 626.557, Subd. 9) 34

Appendix B: Complaint Review Protocol.....35

Appendix C: Ombudsman Poster 37

Appendix A

COMPILATION OF STATUTES AFFECTING OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION

I. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION: MINN. STAT. § 245.91-.97

245.91 DEFINITIONS.

Subdivision 1. **Applicability**. For the purposes of sections 245.91 to 245.97, the following terms have the meanings given them.

Subd. 2. **Agency**. "Agency" means the divisions, officials, or employees of the state departments of human services and health, and of designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 3. **Client**. "Client" means a person served by an agency, facility, or program, who is receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 4. **Facility or program**. "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, that is required to be licensed by the commissioner of human services, and an acute care inpatient facility that provides services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 5. **Regional center.** "Regional center" means a regional center as defined in section 253B.02, subdivision 18.

Subd. 6. **Serious injury**. "Serious injury" means:

(1) fractures;
(2) dislocations;
(3) evidence of internal injuries;
(4) head injuries with loss of consciousness;
(5) lacerations involving injuries to tendons or organs, and those for which complications are present;
(6) extensive second degree or third degree burns, and other burns for which complications are present;
(7) extensive second degree or third degree frost bite, and others for which complications are present;
(8) irreversible mobility or avulsion of teeth;
(9) injuries to the eyeball;
(10) ingestion of foreign substances and objects that are harmful;
(11) near drowning;
(12) heat exhaustion or sunstroke; and
(13) all other injuries considered serious by a physician.

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information about decisions, acts, and other matters of an agency, facility, or program. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

245.93 ORGANIZATION OF OFFICE OF OMBUDSMAN.

Subdivision 1. **Staff.** The ombudsman may appoint a deputy and a confidential secretary in the unclassified service and may appoint other employees as authorized by the legislature. The ombudsman and the full-time staff are members of the Minnesota state retirement association.

Subd. 2. **Advocacy.** The function of mental health and mental retardation client advocacy in the department of human services is transferred to the office of ombudsman according to section 15.039. The ombudsman shall maintain at least one client advocate in each regional center.

Subd. 3. **Delegation.** The ombudsman may delegate to members of the staff any authority or duties of the office except the duty of formally making recommendations to an agency or facility or reports to the governor or the legislature.

245.94 POWERS OF OMBUDSMAN; REVIEWS AND EVALUATIONS; RECOMMENDATIONS.

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility, or program if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition.

(f) The ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(g) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(h) The ombudsman may attend department of human services review board and special review board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the department of human services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(i) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 12 and 13, regarding services provided to clients with mental retardation or a related condition.

(j) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(k) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Subd. 2. **Matters appropriate for review.** (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

(1) may be contrary to law or rule;

(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

(3) may be mistaken in law or arbitrary in the ascertainment of facts;

(4) may be unclear or inadequately explained, when reasons should have been revealed;

(5) may result in abuse or neglect of a person receiving treatment;

(6) may disregard the rights of a client or other individual served by an agency or facility;

(7) may impede or promote independence, community integration, and productivity for clients; or

(8) may impede or improve the monitoring or evaluation of services provided to clients.

(b) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

Subd. 2a. **Mandatory Reporting.** Within 24 hours after a client suffers death or serious injury, the facility or program director shall notify the ombudsman of the death or serious injury.

Subd. 3. **Complaints.** The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the

ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in section 626.557, subdivision 17, paragraph (c), against a client or other person, who in good faith makes a complaint or assists in an investigation.

Subd. 4. **Recommendations to agency.** (a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

(1) consider the matter further;
(2) modify or cancel its actions;
(3) alter a rule, order, or internal policy;
(4) explain more fully the action in question; or
(5) take other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

245.95 RECOMMENDATIONS AND REPORTS TO GOVERNOR.

Subdivision 1. **Specific reports.** The ombudsman may send conclusions and suggestions concerning any matter reviewed to the governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, program, or any person, the ombudsman shall consult with the governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the governor that is adverse to an agency, facility, program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation.

Subd. 2. **General reports.** In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall at the end of each year report to the governor concerning the exercise of the ombudsman's functions during the preceding year.

245.96 CIVIL ACTIONS.

The ombudsman and his designees are not civilly liable for any action taken under sections 245.91 to 245.97 if the action was taken in good faith, was within the scope of the ombudsman's authority, and did not constitute willful or reckless misconduct.

245.97 OMBUDSMAN COMMITTEE.

Subdivision 1. **Membership.** The ombudsman committee consists of 15 members appointed by the governor to three-year terms. Members shall be appointed on the basis of their knowledge of and interest in the health and human services system subject to the ombudsman's authority. In making the appointments, the governor shall try to ensure that the overall membership of the committee adequately reflects the agencies, facilities, and programs within the ombudsman's authority and that members include consumer

representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individuals served by an agency, facility, or program; human services and health care professionals including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

Subd. 2. **Compensation; chair.** Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The governor shall designate one member of the committee to serve as its chair at the pleasure of the governor.

Subd. 3. **Meetings.** The committee shall meet at least four times a year at the request of its chair or the ombudsman.

Subd. 4. **Duties.** The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

Subd. 5. **Medical review subcommittee.** At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the governor to serve as a medical review subcommittee. Terms of service, vacancies, and compensation are governed by subdivision 2. The governor shall designate one of the members to serve as chair of the subcommittee. The medical review subcommittee may:

(1) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes; and

(5) submit a report regarding the death of a client to the committee, the ombudsman, the client's next-of-kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility.

Subd. 6. **Terms, compensation, removal and expiration.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. The ombudsman committee and the medical review subcommittee expire on June 30, 1993.

II. CASE MANAGEMENT OF PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS: MINN. STAT. § 256B.092, SUBD. 7

Subd. 7. **Screening teams established.** (a) Each county agency shall establish a screening team which, under the direction of the county case manager, shall make an evaluation of need for home and community-based services of persons who are entitled to the level of care provided by an intermediate care facility for persons with mental retardation or related conditions or for whom there is a reasonable indication that they might require the level of care provided by an intermediate care facility. The screening team shall make an evaluation of need within 15 working days of the date that the

assessment is completed or within 60 working days of a request for service by a person with mental retardation or related conditions, whichever is the earlier, and within five working days of an emergency admission of an individual to an intermediate care facility for persons with mental retardation or related conditions. The screening test shall consist of the case manager, the client, a parent or guardian, a qualified mental retardation professional, as defined in the Code of Federal Regulations, title 42, section 442.401, as amended through December 31, 1987. For individuals determined to have overriding health care needs, a registered nurse must be designated as either the case manager or the qualified mental retardation professional. The case manager shall consult with the client's physician, other health professionals or other persons as necessary to make this evaluation. The case manager, with the concurrence of the client or the client's legal representative, may invite other persons to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case.

(b) In addition to the requirements of paragraph (a), the following conditions apply to the discharge of persons with mental retardation or a related condition from a regional treatment center:

(1) For a person under public guardianship, at least two weeks prior to each screening team meeting the case manager must notify in writing parents, near relatives, and the ombudsman established under section 245.92 or a designee, and invite them to attend. The notice to parents and near relatives must include: (i) notice of the provisions of section 252A.03, subdivision 4, regarding assistance to persons interested in assuming private guardianship; (ii) notice of the rights of parents and near relatives to object to a proposed discharge by requesting a review as provided in clause (7); and (iii) information about advocacy services available to assist parents and near relatives of Persons with mental retardation or related conditions. In the case of an emergency screening meeting, the notice must be provided as far in advance as practicable.

(2) Prior to the discharge, a screening must be conducted under subdivision 8 and a plan developed under subdivision 1a. For a person under public guardianship, the county shall encourage parents and near relatives to participate in the screening team meeting. The screening team shall consider the opinions of parents and near relatives in making its recommendations. The screening team shall determine that the services outlined in the plan are available in the community before recommending a discharge. The case manager shall provide a copy of the plan to the person, legal representative, parents, near relatives, the ombudsman established under section 245.92, and the protection and advocacy system established under United States Code, title 42, section 6042, at least 30 days prior to the date the proposed discharge is to occur. The information provided to parents and near relatives must include notice of the rights of parents and near relatives to object to a proposed discharge by requesting a review as provided in clause (7). If a discharge occurs, the case manager and a staff person from the regional treatment center from which the person was discharged must conduct a monitoring visit as required in Minnesota Rules, part 9525.0115, within 90 days of discharge and provide an evaluation within 15 days of the visit to the person, legal representative, parents, near relatives, ombudsman, and the protect and advocacy system established under United States Code, title 42, section 6042.

(3) In order for a discharge or transfer from a regional treatment center to be approved, the concurrence of a majority of the screening team members is required. The screening

team shall determine that the services outlined in the discharge plan are available and accessible in the community before the person is discharged. The recommendation of the screening team cannot be changed except by subsequent action of the team and is binding on the county and on the commissioner. If the commissioner or the county determines that the decision of the screening team is not in the best interests of the person, the commissioner or the county may seek judicial review of the screening team recommendation. A person or legal representative may appeal under section 256.045, subdivision 3 or 4a.

(4) For Persons who have overriding health care needs or behaviors that cause injury to self or others, or cause damage to property that is an immediate threat to the physical safety of the person or others, the following additional conditions must be met:

(i) For a person with overriding health care needs, either a registered nurse or a licensed physician shall review the proposed community services to assure that the medical needs of the person have been planned for adequately. For purposes of this paragraph, "overriding health care needs" means a medical condition that requires daily clinical monitoring by a licensed registered nurse.

(ii) For a person with behaviors that cause injury to self or others, or cause damage to property that is an immediate threat to the physical safety of the person or others, a qualified mental retardation professional, as defined in paragraph (a), shall review the proposed community services to assure that the behavioral needs of the person have been planned for adequately. The qualified mental retardation professional must have at least one year of experience in the areas of assessment, planning, implementation, and monitoring of individual habilitation plans that have used behavior intervention techniques.

(5) No person with mental retardation or a related condition may be discharged from a regional treatment center before an appropriate community placement is available to receive the person.

(6) A resident of a regional treatment center may not be discharged to a community intermediate care facility with a licensed capacity of more than 15 beds. Effective July 1, 1993, a resident of a regional treatment center may not be discharged to a community intermediate care facility with a licensed capacity of more than ten beds.

(7) If the person, legal representative, parent, or near relative of the person proposed to be discharged from a regional treatment center objects to the proposed discharge, the individual who objects to the discharge may request a review under section 256.045, subdivision 4a, and may request reimbursement as allowed under section 256.045. The person must not be transferred from a regional treatment center While the review or appeal is pending. Within 30 days of the request for a review, the local agency shall conduct a conciliation conference and inform the individual who requested the review in writing of the action the local agency plans to take. The conciliation conference must be conducted in a manner consistent with section 256.045 subdivision 4a. A person, legal representative, parent, or near relative of the person proposed to be discharged who is not satisfied with the results of the conciliation conference may submit to the commissioner a written request for a hearing before a state human services referee under section 256.045, subdivision 4a. The person, legal representative, parent, or near relative of the person proposed to be discharged may appeal the order to the district court of the county responsible for furnishing assistance by serving a written copy of a notice of appeal on the commissioner and any adverse party of record within 30 days after the day the commissioner issued the order and by filing the original notice and proof of service with

the court administrator of the district court. Judicial review must proceed under section 256.045, subdivisions 7 to 10. For a person under public guardianship, the ombudsman established under section 245.92 may object to a proposed discharge by requesting a review or hearing or by appealing to district court as provided in this clause. The person must not be transferred from a regional treatment center while a conciliation conference or appeal of the discharge is pending.

III. REPORTING OF MALTREATMENT OF MINORS: MINN. STAT. § 626.556, SUBDS. 9-10

Subd. 9. **Mandatory reporting to a medical examiner or coroner.** When a person required to report under the provisions of subdivision 3 knows or has reason to believe a child has died as a result of neglect or physical or sexual abuse, the person shall report that information to the appropriate medical examiner or coroner instead of the local welfare agency, police department, or county sheriff. Medical examiners or coroners shall notify the local welfare agency or police department or county sheriff in instances in which they believe that the child has died as a result of neglect or physical or sexual abuse. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff and the local welfare agency. If the child was receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance from an agency, facility, or program as defined in section 245.91, the medical examiner or coroner shall also notify and report findings to the ombudsman established under sections 245.91 to 245.97.

Subd. 10. **Duties of local welfare agency and local law enforcement agency upon receipt of a report.** (a) If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, the local welfare agency shall immediately conduct an assessment and offer protective social services for purposes of preventing further abuses, safeguarding and enhancing the welfare of the abused or neglected minor, and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse or physical abuse, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245. 91, has been the subject of physical abuse or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97.

(c) Authority of the local welfare agency responsible for assessing the child abuse report and of the local law enforcement agency for investigating the alleged abuse includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with

the alleged perpetrator. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found and may take place outside the presence of the perpetrator or parent, legal custodian, guardian, or school official. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule 49.02 of the Minnesota rules of procedure for juvenile courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a pan of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare or local law enforcement agency determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the county welfare board or the chair's designee. The notification shall be private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded. Until that time, the local welfare or law enforcement agency shall be solely responsible for any disclosures regarding the nature of the assessment or investigation. Except where the alleged perpetrator is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

(e) Where the perpetrator or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the perpetrator or any person responsible for the child's care at reasonable places and times as specified by court order.

(f) Before making an order under paragraph (d), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(g) The commissioner, the ombudsman for mental health and mental retardation, the local welfare agencies responsible for investigating reports, and the local law enforcement agencies have the right to enter facilities as defined in subdivision and to inspect and copy the facility's records, including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

IV REPORTING OF MALTREATMENT OF VULNERABLE ADULTS: MINN. STAT. § 626.557, SUBD. 9

Subd. 9. **Mandatory reporting to a medical examiner or corner.** A person required to report under the provisions of subdivision 3 who has reasonable cause to believe that a vulnerable adult has died as a direct or indirect result of abuse or neglect shall report that information to the appropriate medical examiner or coroner in addition to the local welfare agency, police department, or county sheriff or appropriate licensing agency or agencies. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff, the local welfare agency, and if applicable, each licensing agency. A person or agency that receives a report under this subdivision concerning a vulnerable adult who was receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance from an agency, facility, or program as defined in section 245.91, shall also report the information and findings to the ombudsman established under sections 245.91 to 245.97.

Appendix B

Process for Handling Complaints Brought to the Office of the Ombudsman

Complaint Intake

1. A complaint may be received from any source concerning an action of an agency, facility, or program. A complaint may be made by telephone, letter, or direct contact with the regional staff or central office staff. The source is strongly encouraged to make the complaint to the regional staff office.

2. The regional staff shall determine if the complaint is an appropriate matter for review. In selecting matters for review, the regional staff shall give particular attention to unusual deaths or injuries of clients, or actions of an agency or facility or program that:

a) may be contrary to law or rule;

b) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program.

c) may be mistaken in law or arbitrary in the ascertainment of facts;

d) may be unclear or inadequately explained, when reasons should have been revealed;

e) may result in abuse or neglect of a person receiving treatment;

f) may disregard the rights of a client or other individual served by an agency, facility, or program;

g) may impede or promote independence, community integration and productivity for clients; or

h) may impede or improve the monitoring or evaluation of services provided to clients.

Action on Complaint at Regional Level

1. If the regional staff determines that the complaint is not an appropriate matter for review, the regional staff shall so inform the source. If possible, the regional staff should refer the source to an appropriate agency or other resource.

2. If the regional staff determines that the complaint is an appropriate matter for review, and the review does not duplicate other investigations or regulatory efforts, the regional staff shall consult with the source, consult with the client (when appropriate), and consult with other persons (as necessary) to obtain information pertinent to the complaint. The regional staff shall then proceed to:

a. notify the agency, facility or program named in the complaint and mediate or advocate on behalf of the client;

b. refer complaint regarding the agency, facility, or program to a more appropriate resource for action;

c. continue to monitor for a reasonable length of time; or

d. notify appropriate parties once all action has been completed.

3. The regional staff may, at any time, refer a complaint directly to the Ombudsman for advice, counsel, or further review and action.

Action by Ombudsman on Complaint

1. Following the receipt and review of a complaint from regional staff, the Ombudsman shall notify the source as to the merit of the complaint and may notify the agency, facility, or program, and any other appropriate parties.

2. After reviewing a complaint, the Ombudsman may request a response from the agency, facility or program.

3. After considering the response of an agency, facility, or program and any other pertinent material, the Ombudsman may recommend that the agency, facility, or program do the following:

a) consider the matter further;

b) modify or cancel its actions;

c) alter a rule, order, or internal policy;

d) explain more fully the action in question; or

e) take other action.

4. The agency, facility, or program shall be notified in writing of the Ombudsman's recommendations and, at the Ombudsman's request, shall within a reasonable time inform the Ombudsman of the action taken on the recommendations.

5. If the actions or response from an agency, facility, or program to the Ombudsman's recommendations resolve the complaint in a manner that promotes the highest attainable standards of treatment, competence, efficiency and justice for people receiving care or treatment for mental illness, mental retardation or related condition, chemical dependency, or emotional disturbance, the Ombudsman shall consider the matter closed and shall so inform the agency, facility, or program.

6. If it is determined that the complaint needs further action, the Ombudsman may send conclusions and recommendations to the Governor as follows:

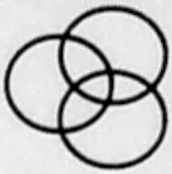
a) If the conclusions or recommendations to the Governor are adverse, the Ombudsman shall notify the agency, facility, or program in writing;

b) The agency, facility, or program shall be given an opportunity to provide any statement of reasonable length in defense or mitigation of the Ombudsman's conclusions or recommendations;

c) The Ombudsman's conclusions or recommendations and the statement by the agency, facility, or program shall be sent to the Governor;

d) Before making public conclusions or recommendations that expressly or implicitly criticize an agency, facility, or program, the Ombudsman shall consult with the Governor and the agency, facility, or program concerning the conclusions or recommendations.

Appendix C
Ombudsman Poster



STATE OF MINNESOTA
OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION

Do You Have A Complaint?

If you do, the Ombudsman for Mental Health and Mental Retardation will assist you.

CONTACT:

OR

CALL: 296-3848 IN METRO AREA OR 1-800-657-3506

OR

WRITE:
OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH
AND MENTAL RETARDATION
SUITE 202, METRO SQUARE BUILDING
ST. PAUL, MINNESOTA 55101

Minnesota Statute § 245.92 states that the Ombudsman for Mental Health and Mental Retardation "shall promote the highest attainable standards of treatment, competence, efficiency, and justice for people receiving care or treatment for mental illness, mental retardation, chemical dependency, or emotional disturbance."

Department of Administration

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