Ombudsman
SASKATCHEWAN

Annual Report 2011

WHAT WE ARE

Fair
Independent
Impartial

WHAT WE DO

Negotiate
Investigate
Mediate

HAS GOVERNMENT BEEN FAIR?

Ombudsman
SASKATCHEWAN

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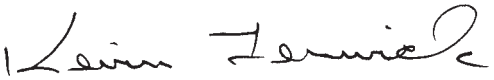
April 2012

The Honourable Dan D'Autremont
Speaker of the Legislative Assembly
Province of Saskatchewan
Legislative Building
Regina, Saskatchewan

Dear Mr. Speaker:

In accordance with section 30 of *The Ombudsman and Children's Advocate Act*, it is my duty and privilege to submit to you the thirty-ninth annual report of Ombudsman Saskatchewan for the year 2011.

Respectfully submitted,



Kevin Fenwick Q.C.
Ombudsman

promoting fairness

Vision, Mission, Values & Goals

Vision

Our vision is that government is always fair.

Mission

Our mission is to promote and protect fairness in the design and delivery of government services.

Values

In pursuit of fairness, we will demonstrate in our work and workplace:

- independence and impartiality
- respectful treatment of others
- competence and consistency
- timely delivery of our services

Goals

Our goals are:

- to provide effective service to individuals, using appropriate methods of service.
- to lead by example, demonstrating fairness in all we do.
- to assess and respond to issues from a system-wide perspective.
- to provide education and training to promote the principles and processes of fairness throughout the province.
- to have a safe, healthy, respectful and supportive work environment.
- to promote, provincially, nationally and internationally, Ombudsman Saskatchewan and the institution of the ombudsman.

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Ombudsman's Observations

Kevin Fenwick Q.C., Saskatchewan Ombudsman

2011 was an interesting and exciting year at Ombudsman Saskatchewan.

Looking back, we see areas of both stability and change. Healthy organizations strike a balance between the need to benefit from the wisdom of experience and the need to embrace the energy of new ideas. We think our work demonstrates that balance. For example, the number of complaints received at the office over the last several years has remained relatively stable. At the same time, reflections on the past year also reveal significant change. We were able to significantly expand our work in the health sector. We continued to receive increasing demands for our "Fine Art of Fairness" training workshops. And we continued to devote more resources to our work on systemic reviews. Several of these topics will be reported on more fully elsewhere in this report.

One of the interesting and somewhat ironic factors in the work of an ombudsman is that the vast majority of citizens who come to us with a complaint have an ongoing relationship with the very agency they are complaining about. Whether they are recipients of health services or social services, policyholders with SGI, or purchasers of utilities from SaskPower, SaskEnergy, or SaskTel, the people who come to us with complaints will most likely continue to deal with those agencies after their complaints have been resolved. It is important, therefore, that we don't just help them fix the problem, but that we also leave the citizen and the government agency with a better problem-solving process. It is our hope that the next time there is a difficult issue between them, they will be better equipped to resolve the problem by communicating with each other.

This means that much of our work is done quietly behind the scenes. It often means that we have to set aside our institutional ego and let others take the credit for solving the problems. We are happy to do so. Indeed, that is part of our philosophy. That philosophy, however, does come with some challenges.

Because we prefer to see the citizen and the government agency take credit for solving their own problems, and because we often do our work quietly and without much fanfare, it is sometimes difficult for us to create a noticeable public profile. In some ways, the better we do our work, the less people know about us. And that is a dilemma because we do want people to know about us. We want all citizens of Saskatchewan to know that if they believe they have been treated unfairly by the provincial government, they can come to us.

We conducted a survey in 2011 to assess the level of current public awareness about our office compared with the results of a similar survey we conducted in 2004. The initial numbers looked reasonably good. About three-quarters of the people surveyed said they had heard of the Ombudsman. But when we dug a bit deeper, we found that accurate awareness of the role of the Ombudsman is much lower. Fewer Saskatchewan residents know with any degree of accuracy what it is that the Ombudsman does and what kinds of complaints they can bring to our office. In some areas, such as complaints about health services, the level of awareness was particularly low. Clearly, we have work to do.

In 2011, Ombudsman Saskatchewan received additional funding to allow us to expand our services in the health sector. We created a health team within our office to complement our

existing staff by recruiting two new Assistant Ombudsman with significant experience in the health field. We have worked hard in the past year with all our staff to raise our level of knowledge about health issues and to raise our profile pertaining to health issues with the public, with Regional Health Authorities and with the Ministry of Health. We have responded in a timely fashion to a significant increase in the number of complaints coming to our office about health services. And we have analyzed where we can be most effective by allocating some of our resources to health-related systemic reviews. We believe that we have a relevant and valuable role within Saskatchewan's model of patient and family-centered care. Our recent invitation from the Minister of Health and the Chair of the Board of the Saskatoon Health Region to examine the treatment of former tenants of St. Mary's Villa in Humboldt demonstrates that we are an important and credible independent voice.

We have seen a significant increase in the number of complaints over the past two years about health issues. We do not believe that this increase is due to the fact that the health system is performing differently than in the past. Instead, we think that this increase is directly attributable to greater awareness about the role that our office plays within the health sector. As we continue to raise our profile with respect to health issues, we should not be surprised to see the number of complaints continue to rise.

In 2011, we also saw decreases in the number of complaints coming to our office about some agencies. Across government we do see a general increase in the commitment to treat citizens fairly. For various reasons, including the work of our office and the delivery of our "Fine Art of Fairness" workshops to public servants, we see public servants paying attention to three aspects of fairness as they make decisions. We expect our public servants to make good decisions, to use transparent and inclusive processes while they make those decisions, and to treat people with respect.

This often means that public servants need to be flexible in the application of policies. They have to realize that one size does not fit all and that sometimes they have to exercise discretion to make sure that citizens are being treated fairly. There are many examples where agencies of government are doing so. In this annual report we recognize several individuals for their excellent efforts in making sure that government services are fair. Many government agencies are encouraging an entire culture of fairness within their organizations. I want to cite one such agency for its high level of service in this regard.

SaskEnergy is a government agency that has incorporated into its organization a culture of fairness, flexibility where necessary, and discretion when appropriate. SaskEnergy also has a very rich internal leadership development program that encourages the acceptance of responsibility for such decisions. One of the demonstrable results of these efforts is that the number of complaints that come to Ombudsman Saskatchewan about SaskEnergy has fallen from more than 90 in 2005 to only 13 in 2011.

> "We expect our public servants to make good decisions, to use transparent and inclusive processes while they make those decisions, and to treat people with respect."

In 2011 Ombudsman Saskatchewan also received an additional budget allocation to assume a role with respect to Saskatchewan's new *Public Interest Disclosure Act*. With the appointment of the Ombudsman in February, 2012 as Acting Public Interest Disclosure Commissioner, our office is now able to review issues brought forward by public servants who believe they have knowledge about wrongdoings as defined in the Act or believe they have been the subject of a reprisal for reporting such a wrongdoing. We have created a distinct identity for the Ombudsman's role as Acting Public Interest Disclosure Commissioner. This includes a separate visual identity, distinct educational materials and a new website. We are now able to respond to allegations of wrongdoing or reprisal.

We have also worked hard in the past year, not just to raise our profile so that citizens know we exist, but to better explain what it is that we do and how we do it. We are in the process of completing a significant project to review and revise our internal policies and procedures and, once completed, they will be accessible to the public. Revising internal policies is a labour-intensive task. We regard the effort as an investment of time that will pay dividends for the public in the form of better service from our office.

In the annual reports for the past two years, I have commented specifically on two issues: the need for better accessibility to, and coordination of, mental health services and the significant problems caused by overcrowding in our provincial correctional centers. We continue to watch developments in both those areas.

In 2011, we monitored complaints that came to our office in an attempt to identify those that had mental health implications. We continue to do so for two reasons. We hope to make our own services more relevant to those

facing mental health challenges. We also hope to better analyze some of the significant mental health challenges faced by the clientele of government agencies - and then recommend solutions to those agencies.

With respect to the continuing problem of overcrowding in correctional facilities, we are very concerned that the current situation could go from bad to worse. Correctional centres in Saskatchewan already house almost twice as many inmates as they were designed for. With the recent passage of the federal omnibus crime bill, Bill C-10, this situation has the potential to deteriorate further. No one can predict with certainty how great the impact will be, but it would be naïve to suggest that the impact will be anything less than significant. Some of the problems are obvious. Double-bunking is already common in cells that were designed for one person and there is the potential that three inmates may be squeezed into cells designed for one. Classrooms have been converted into dormitories. Entire sections of our jails that had been closed due to their age and poor condition, and should have remained so, have been re-opened because there is nowhere else to put the inmates.

The problem of overcrowding is not just about the humane treatment of prisoners. Overcrowding does pose serious health and safety risks for the inmates, but it also poses risks for the corrections workers tasked with supervising them.

Perhaps what is most significant in the long term, however, is that every time a classroom is converted into a dormitory, every time resources must be reallocated away from education and training for prisoners, and every time correctional centres are reduced to just guarding inmates, our jails take a step backward. It is true that jails are intended to be places of security and punishment – the punishment being segregation from society. But jails must also be places of rehabilitation. It has to be a goal of society that when we send someone to jail, that person leaves the jail after serving his or her sentence better equipped to be a contributing member of society. We must allocate resources to training programs. There is a tremendous need for basic programs such as addictions counseling and anger management. However, in order for inmates leaving these facilities to be contributing members of society who are less likely to commit crimes again and go back to jail, we have to give them skills. We have to be able to provide for Grade 12 equivalency. We have to be able to give them meaningful skills in the trades. If a person comes out of jail as a welder or a carpenter, they are much less likely to reoffend. That is a goal that we all seek and from which we all benefit.

"Perhaps what is most significant in the long term, however, is the fact that every time a classroom is converted into a dormitory, every time resources must be reallocated away from education and training for prisoners, and every time correctional centres are reduced to just guarding inmates, our jails take a step backward."

We expect 2012 to be an interesting year. The Ombudsman has new duties as Acting Public Interest Disclosure Commissioner. Our "Fine Art of Fairness" workshops are in great demand, so much so that we have been booked to capacity for 2012 and are already scheduling sessions into 2013. We believe that our increased profile in the health sector will generate more complaints. The more we do the more we will be asked to do.

We continue to strive to provide excellent service to the citizens of Saskatchewan. We want our decisions to be timely, relevant and effective. We have set goals to have 90% of all the complaints received by our office completed within three months and 95% completed within six months. I am very pleased that again in 2011 we exceeded both of those goals. Our intention is to continue to deliver that high level of service in 2012. We will continue to look for the underlying reasons for complaints about government service. We want to address those underlying concerns as we work to resolve the specific problems that are presented. In this way, our work impacts not just the individuals who bring complaints to us, but it also has a positive effect for many others who face similar issues, but who may not have brought their complaints to the Ombudsman.

Internally, we are saying goodbye in 2012 to some of the longest serving members of our staff and welcoming new people into those positions. We will miss the wisdom and experience of those who are departing and we wish them the best in the future. In 2012 we also welcome the energy and the enthusiasm of the new staff who are joining us.

Initiatives

Health Services Program Update

Our enhanced health service program started to take flight in 2011 when the government approved our request for additional resources. We now have three Assistant Ombudsman available to address issues involving the Ministry of Health, the Regional Health Authorities and the Saskatchewan Cancer Agency.

Preparations for this updated service began in 2010, with a series of meetings with all of the regional health authorities, the Saskatchewan Cancer Agency, the health professional regulating bodies, union representatives and health promotion agencies and associations. We talked to these groups about our role and mandate in health and sought feedback about how to improve our services.

After 27 meetings, we heard the following advice:

- We need to do a better job of spreading knowledge about who we are and what we do.
- We need to clarify our role in health as a reviewer of administrative versus clinical decisions.
- We were encouraged to work collaboratively with the health system and its complaint handling services like Quality of Care Coordinators and Client Representatives.
- We need to provide information about the distinction between our office and other oversight bodies like the professional colleges.
- We heard about interest in our fair practices training, fairness lens services and our systemic reviews.
- We were encouraged to focus our efforts on underserved or vulnerable populations and areas where people fall through the gaps.
- Finally, we were asked to think how we could examine broader systemic issues that currently fall outside of our jurisdiction.

This advice was taken to heart and we responded in several ways. Along with a public campaign to raise general awareness, we began a second round of meetings – this time with organizations that assist clients who require health services. We also met with the Quality of Care Coordinators from across the province to talk about the types of issues they might wish to refer to our office.

We worked to improve our print and online materials. These now include a brochure called “Resources for Health Complaints” which clarifies the differences between the services we provide and the services provided by other agencies. Also available is a one-page handout called “Administrative vs. Clinical Decision Making,” which clarifies the types of decisions we can review in the health system. It was developed based on research completed for our *A Matter of Time* systemic review. A special health section has been added to our website and includes a sampling of cases we have managed.

Our office hosted a booth at the 2011 Health Quality Summit to promote our role in health care. In 2011, six "Fine Art of Fairness" workshops were provided to approximately 165 staff who work in the health care field. We completed a fairness lens review for one program at the Ministry of Health and we have been approached by other agencies interested in this service.

Finally, we continue to respond to a growing number of callers who raise issues of fairness in our publicly-funded health care system.

As we move into 2012, our aim is for the public and those in the health sector to better understand the Ombudsman's role in health, and for increased fairness in the administration of the health system.

The Public Interest Disclosure Act

On September 1, 2011, *The Public Interest Disclosure Act* (PIDA) came into effect. Under PIDA, Saskatchewan public servants who want to disclose wrongdoings in the workplace may take their concerns to a designated officer within their organization or to the Public Interest Disclosure Commissioner without fear of reprisal. On February 9, 2012, Kevin Fenwick was appointed as the Acting Public Interest Disclosure Commissioner.

The Commissioner has authority over prescribed government institutions, including any ministry or similar agency of executive government and any prescribed board, commission or Crown corporation. The Commissioner can offer advice about, investigate and make recommendations respecting employee disclosures of the wrongdoings of government institutions and reports of reprisals taken against public servants.

PIDA applies to public servants: that is all employees and officers of government institutions. Government institutions include all provincial government ministries, agencies, boards, commissions, and Crown corporations. PIDA does not apply to members of the public, private corporations, officers of the Legislative Assembly, regional health authorities, school divisions, universities, colleges, municipalities and civic governments.

Though PIDA allows for the Ombudsman to be appointed as the Commissioner, the Public Interest Disclosure Commissioner is also an independent officer of the Legislative Assembly and as such will be required to table an annual report. The Commissioner will table his first annual report in April of 2013 for the 2012 reporting year. The Office of the Public Interest Disclosure Commissioner, though connected to Ombudsman Saskatchewan, has dedicated staff and is currently accepting complaints. More information about the Office of the Public Interest Disclosure Commissioner can be found at www.saskpidc.ca.

Our Lean Initiative

In 2011, Ombudsman Saskatchewan undertook a Lean process and examined our case management practices, from the point when a citizen first calls to request our assistance through to the Ombudsman making formal recommendations to a government agency. Each year we receive approximately 3,400 complaints and of those approximately 2,200 are complaints about provincial government agencies within our jurisdiction. We wanted to ensure our services were not only efficient, in that we would resolve each non-investigative file within 90 days of receiving the complaint, but we also wanted to ensure our services are complainant-focussed, transparent, consistent and effective.

We embarked on a seven-day Lean process involving all of our staff, from support staff to the Ombudsman himself. Over those seven days we:

- reviewed current case data and trends.
- reviewed our entire case management process.
- streamlined the case management process and in doing so added consistency throughout the process, and are now better able to meet the needs of our complainants and the government entities we work with.

Over a period of several months we implemented our new case management process and developed policies and procedures which will be placed on our website with full public access in the spring of 2012.

Our Approach: A Focus on Best Practices

As part of our Lean implementation we also developed and articulated the foundation for our practice or what we call our practice orientation. Our foundation describes what we do and how we do it and ensures not only consistency throughout our services, but ensures that our services are transparent for those who call us for assistance and for those government agencies we work with and at times investigate.

Over several years, Ombudsman Saskatchewan has moved away from its traditional oversight role as the "enforcer of rules" to a "promoter of best practices." As a promoter of best practices, we have become more actively involved - or become involved at a much earlier stage - with the systems we oversee. Involvement does not mean alignment, however, and our challenge has been, and will

be, to remain true to our legislative role to provide independent review and work with government in a manner that can both produce individual redress and impact systemic change.

Affecting change for individual citizens, either with the front line decision-maker or with the government agency itself, is achieved through our relationships with government agencies and the general public. The Ombudsman, unlike the courts, cannot impose a decision or order compliance. The Ombudsman's authority is limited to making recommendations and "the power of an Ombudsman comes not from an ability to impose his or her will, but through persuasion and trust in the institution."[1]

Ombudsman Saskatchewan attempts to influence the administrative actions of government officials and agencies through cooperation and consensus building as opposed to coercion through sanctions. We call this approach "cooperative influence." Under this model, we focus our efforts on producing outcomes that flow from open, forthright and transparent communication, persuasion and negotiation.

The central characteristics of the model of cooperative influence are:

- Change is sought through negotiation and consultation.
- The primary methods of influence are consultation and persuasion.
- The nature of the decision is a recommendation which is advisory or facilitative in nature.
- The relationship with and between the parties is collegial (horizontal) rather than hierarchal (vertical).
- The orientation of the model is proactive rather than reactive.

Cooperative influence focuses the work of Ombudsman Saskatchewan on the promotion of fairness and best practices, rather than regulation of the actions of others. This requires, and our own best practices dictate, that Ombudsman staff will, when working both with the individual citizen and provincial government agencies:

- Encourage and provide a high level of communication and feedback with and between the parties.
- Model an open and transparent style of communication.
- Build inclusion within the process.
- Consult with the right people at the right time.
- Share findings with the parties.
- Consult with the parties when developing recommendations.

Legislative and Policy Consultations

Ombudsman Saskatchewan staff worked on a number of legislative and policy consultations in 2011. We participate in these consultations as a means to assist government proactively, attempting to help entrench fairness into the legislation and policies of various areas of government.

We were consulted on *The Correctional Services Act, 2011,* which will be the new legislation governing adult corrections in the province. We were also consulted by The Workers' Compensation Act Committee of Review. Additionally, we provided some comments with respect to proposed changes to regulations for *The Adult Guardianship and Co-decision-making Act*.

In addition to the consultations that we participated in on proposed legislative changes, we have also consulted with some areas of government with respect to policy changes. In particular, we have been working with the Ministry of Corrections, Public Safety and Policing with respect to appeal policies for the Provincial Disaster Assistance Plan. We are also working with the Ministry of Social Services with respect to appeal policies for the child welfare system.

Public Awareness Survey

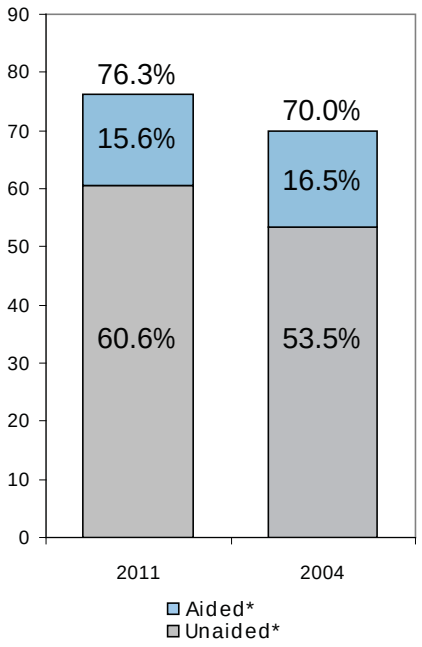
We have long believed that everyone in Saskatchewan should know about our office. This past year, as we strengthened our focus in the health sector, we knew that we also needed to strengthen awareness of this aspect of our work. We had been meeting with health care service providers across the sector and they had been learning more about our office. Now it was time to take the message to the general public.

Our first step was to find out how much the people of Saskatchewan already knew about us and where the gaps were. Building on a general awareness survey that we conducted in 2004, we included questions that would address people's knowledge of our work in health.

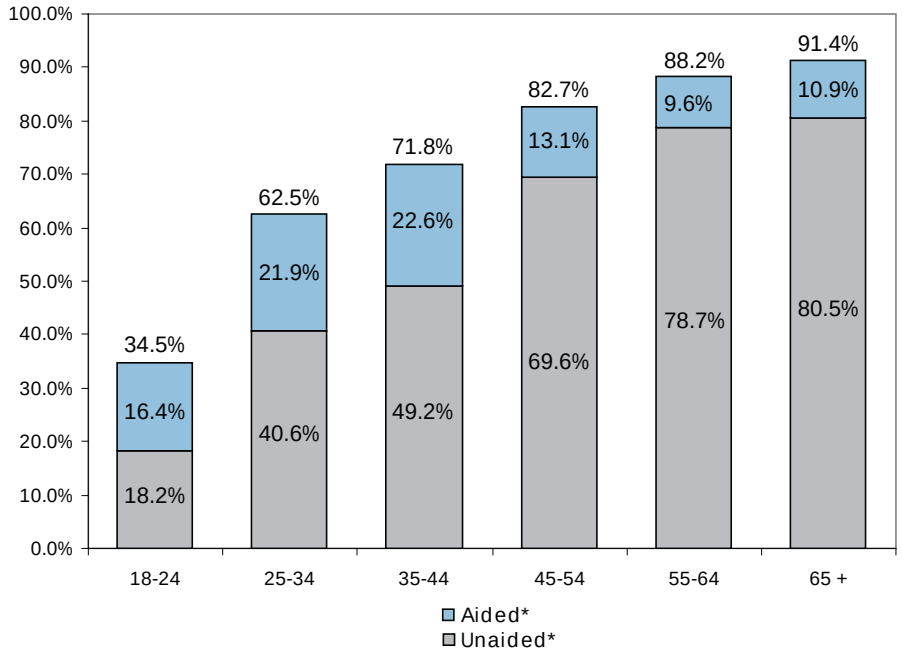
This time, the survey was mainly conducted online compared to 2004 when it was conducted by phone. The exception was in northern Saskatchewan (generally La Ronge and north), where we continued to survey by phone. The survey cost $11,000 and was conducted by Insightrix. It

1. Fenwick, K. (2010). Ombudsman Saskatchewan Annual report., p. 4

General Public Awareness



Public Awareness by Age



Q: Have you heard of the Saskatchewan Ombudsman?

**An unaided response means the respondent said yes; an aided response means the person said yes after hearing a brief description.*

provided valuable information about people's current understanding of our office and their preferences for contacting us and receiving information about us.

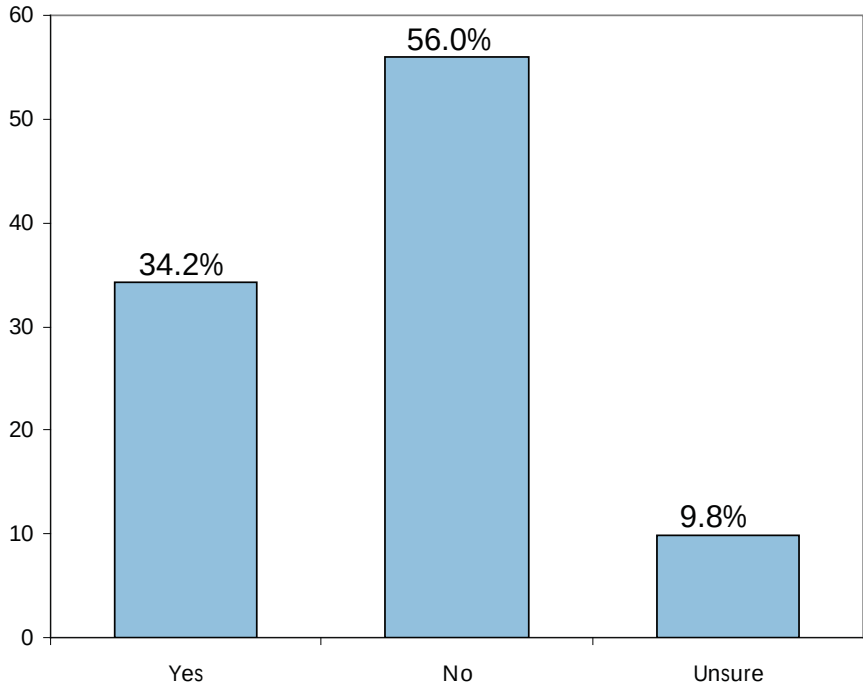
The results were interesting. In general, compared with 2004, about the same or slightly more people said they had heard of our office.

This awareness changes significantly, however, when broken out by age, as demonstrated in the chart, above on the right.

In general, while young adults are still least likely to have heard of our office, results for 18-24 year olds have improved compared with 2004, when unaided awareness was at 8.2%. Although one has to take into account some variance due to this age group being a smaller sample size than the total number surveyed, we believe that part of the reason for this change is the work we have done in high schools and with high school teachers over the last few years. In fact, some respondents said they had heard about the Ombudsman at school.

In addition to general awareness that the Ombudsman exists in Saskatchewan, fewer people knew what we do or what kinds of complaints we take. This was particularly evident when respondents (who had already said they heard of the Ombudsman) were asked: Were you aware the

Awareness of Our Jurisdiction in Health



Q: Were you aware the Saskatchewan Ombudsman can take complaints from people who think they have been treated unfairly by regional health authorities, the Saskatchewan Cancer Agency or the Ministry of Health?

Note: This question was asked only of people who had already said they had heard of the Saskatchewan Ombudsman.

Saskatchewan Ombudsman can take complaints from people who think they have been treated unfairly by regional health authorities, the Saskatchewan Cancer Agency or the Ministry of Health? Only 34.2% – or about a third – said yes. That is not counting the additional respondents who had never heard of the Ombudsman, so of course would not know that we could take health complaints.

These results reinforced to us the need to let the public know about the kinds of health concerns they could bring to us. We had already been working with an advertising agency and began refining our public awareness plans.

As we developed our advertising concepts for health, we also considered the preferences people expressed for hearing about our office. In 2004, more people wanted to hear about us via television than any other method of communication. This year, we learned that this preference had shifted and people's top preference was via website. Other media such as flyers, brochures, newspaper and TV still ranked as important. We agreed that our website was a good source of information, but people would still have to know about it or be able to find it, so these secondary preferences would be useful in that regard.

In December, we focus-tested our advertising concepts and found that the focus groups reinforced another important aspect that had previously surfaced in the general survey: even though people may have heard of us, there is a significant gap in understanding what we do. We realized that, if we simply ran health ads, there was a risk that many people would think that is all we do.

The project continued into 2012 as we broadened our advertising concepts to include other areas of our work. More details about the campaign and its results will be reported on in our 2012 annual report. Awareness of our work in health also remains a priority and we have ongoing plans to get that message out.

Complaints from Individuals

When individuals believe a government ministry or agency has been unfair to them, they are often able to raise the issue and work out a resolution with the office involved. Unfortunately, there are also times when resolutions do not come about so easily. Sometimes, for example, policies are applied too rigidly, or clear explanations are lacking, or people on both sides become hardened in their respective positions.

Whatever the case, by the time people contact us, they are often frustrated and in addition to looking for a solution, also want someone to listen. Listening, indeed, is our first step in beginning to understand the situation. From there, we determine whether the issue fits within our mandate and which of our services will be the most useful.

We may provide information and coaching so the person can return to the situation and work it out or pursue an avenue of appeal not yet tried. We may facilitate communication between parties who are no longer talking to each other or who are having trouble understanding each other. We may work with all the parties involved to bring about an agreed-upon resolution. We may conduct an investigation, and may make recommendations to the government ministry or agency.

The solutions that result are often cooperative ones – the result of shared discussions in light of facts, policies, discretionary considerations, fairness principles, best practices and the interests of the parties involved.

In addition to working towards a fair resolution for the individual involved, this kind of process can also bring about lasting change within government offices so that similar situations can be prevented or resolved at an earlier stage.

Another, more proactive version of this process is also available. When government offices are launching a new program or would like to review an existing one, they can request our "fairness lens" service. It provides an opportunity to look at services through a fairness perspective, which includes what is decided, how it is decided and how people are treated while those decisions are being made.

Following is a series of case examples that demonstrate the range of our work on individual files - from consultation and early resolutions through to investigations and recommendations.

Names have been changed to protect the confidentiality of those involved.

Fairness Consultation

Fairness Lens: Best Practices for Appeals

Ministry of Corrections, Public Safety and Policing, Provincial Disaster Assistance Program

In 2011, the Public Disaster Assistance Program (PDAP) saw unprecedented activity, mainly from widespread flooding. Program staff increased from seven people to 100 in order to

cope with the incoming requests from people throughout the province. As one might expect, there were times when applicants disagreed with the responses they received. When this happened, officials and staff at PDAP provided an informal appeals route.

The manager of the program believed appellants would be better served by a more structured appeals process. He contacted our office and asked if we would meet with them to discuss best practices in this area. We did so and appreciated the opportunity to apply our "fairness lens" to this proactive discussion.

Early Resolution

When Was That Exactly?

Ministry of Health

Dexter and Desirée, who were both in their 90s, were returning to Saskatchewan after spending a couple of years in another province. They moved into a supportive housing facility, but soon realized that it did not meet their needs, so moved again a few weeks later to one that did. Since they were about three-quarters of the way through the month, the staff at the new facility suggested that they record Dexter and Desirée as moving in on the first of the following month.

In the meantime, the couple had completed application forms for a Saskatchewan health card. On the forms, they correctly noted their residency date as the day they returned to the province. Saskatchewan Health contacted them and asked for proof of occupancy. Dexter explained that, despite the date on their current rental agreement, they had actually arrived in the province on the date recorded on their forms. After further phone calls, Dexter and Desirée received a request to start over and complete new application forms.

A few months had now gone by and Dexter did not think it was fair that confusion over the move-in date would continue to delay their access to health benefits. He and Desirée had both been born in Saskatchewan and, apart from the last two years, had lived here all their lives. With ongoing medical conditions to address and winter coming on, they wanted to make sure their health benefits were in place and they wanted to be able to get their flu shots. Dexter contacted our office.

After listening to Dexter's account of the events, we contacted Saskatchewan Health to inquire about his situation and ask for expedited service. The manager we spoke with quickly realized that this application could and should be processed without delay. Dexter's and Desirée's health benefits were activated within 24 hours and their new health cards provided shortly thereafter.

From Crowded to Empty

Ministry of Social Services, Income Assistance and Disability Services Division, Transitional Employment Allowance

After living in a small house with sixteen people, Demi and her two children had been granted a housing unit and were making plans to move. Demi was receiving the Transition Employment Allowance, but did not have any furniture and did not have money to buy any.

When she called the Social Services contact centre, she was advised to find used furniture from a community organization. This would have been good advice in a larger centre, but in Demi's small remote community, there were no used furniture donations available. She contacted our office to see if there was anything else she could do.

Based on Demi's situation, we contacted Social Services to see if her current living situation would be considered a health and safety risk. The manager we talked with believed that it would and that this would qualify Demi for a relocation grant. The grant was approved and Demi was able to use it to buy some furniture for her family.

Is Closer to Home Better?

Regional Health Authority

Darla's Aunt Dorie had been living independently in a rural area. After some medical concerns and a confirmed diagnosis of Alzheimer's, Dorie was assessed as needing long term care. She was placed in a local long-term care facility on a respite basis until a permanent placement could be arranged.

In hopes of keeping her nearby, Dorie's family requested a long-term care facility in her home community. Instead, they were advised that a bed was available at another facility and

if they didn't accept, Dorie would be moved to the bottom of the transfer list. Her family accepted.

Following this placement, Dorie made several attempts to wander away from the building. As a result, she was moved to another facility a considerable distance away that had secured units. Darla (who had power of attorney) and other family members did not believe that Dorie's dementia was so advanced that she was a wander risk, but believed that if Dorie were closer to home and family, she would not be inclined to wander. They immediately requested a transfer to her hometown facility.

Health region staff advised Darla that before any transfer could occur, a behavioural assessment would need to be completed. After waiting for several weeks with no test results, Darla called our office.

We listened to Darla and noted that any comments on the clinical assessment would not be within our mandate. The lack of communication from the health region appeared to be a key aspect of this situation and we helped Darla contact a Quality of Care Coordinator for the health region. If, after working with the Coordinator, Darla felt the situation was unfair, she could call us again.

The Quality of Care Coordinator organized a meeting with members of the care team, the family and other stakeholders such as the family physician. They discussed results of the behavioural assessment and the capabilities and limitations of the long term care facilities in ensuring the safety of residents with cognitive impairments. A plan was developed for Dorie to be moved to the facility in her home community to ascertain whether her condition would improve with family in close proximity and for health region staff and family to meet regularly to discuss Dorie's status.

It quickly became evident that this placement was not suitable for Dorie and other residents' safety and she was transferred back to the previous facility. Darla and her family were disappointed with this development but understood why the decision was made.

Visiting Privileges

Ministry of Corrections, Public Safety and Policing, Regina Correctional Centre

Darcy very much wanted his children to be able to visit him while he was in jail. Like other inmates, when he first arrived, Darcy was asked to provide two visiting lists: one of friends and the other of family members.

Darcy had provided his ex-wife's name as his next-of-kin and assumed that she would be granted visiting privileges, even though he did not actually put her on either list. He did not particularly wish to see her, but believed that she would be able to bring their children for visits. He later learned that, for this to happen, he would have had to put her on his friend visiting list because she would not automatically be considered and in fact did not qualify to be added to the family visiting list – plus, the friend visiting list could only be updated every six months.

He did not want to wait so long to see his children, so he asked for an appeal of the decision. When he did not receive a reply after three weeks, he contacted our office.

We checked with the correctional centre and were informed that the response was on its way. The answer was no. Darcy's ex-wife would not be considered family and he could not add her to his friend list until the six months had passed.

While this response was correct according to policy, it meant that Darcy would not be able to see his children for six months because he misunderstood the rules. We contacted the visiting officer, who acknowledged Darcy's predicament and provided another option. Based on the visiting officer's advice, Darcy's ex-wife submitted a guardianship paper, permitting his sister, who was already on his family visiting list, to bring the children with her.

Facilitated Communication

I Still Want to Work

Ministry of Social Services, Income Assistance and Disability Services Division, Saskatchewan Assistance Program

Dallas was over 60 and had worked all his life. He had lived and worked in various parts of Canada and the United States. He moved to Saskatchewan to find work and landed a job. Unfortunately, he was unable to keep it because of a worsening medical condition. This happened with a second job as well.

Dallas was on a waiting list for surgery and did not know whether he would be able to return to the same kinds of work that he used to do. In the meantime, he could not find another job, had used up his savings, and was in danger of being evicted. Dallas attended a work assessment program to see if there was any work that he could do in his condition. There wasn't. He also applied for social assistance and was initially provided benefits of about $125. In addition to being disappointed with the amount, he felt that he had received poor

service and was treated disrespectfully. Based on a suggestion from the Canada Pension Plan office, he contacted us.

Dallas told us that when he was assessed for social assistance, his social worker did not explain which benefits he might be eligible for. He had been asked personal questions about his medical condition and financial situation in a reception area where others could hear, and when he asked to have the discussion in private, this was not granted.

When people contact us, we assess their complaints based on three areas of fairness: What was decided? How was it decided? How were they treated? We saw that Dallas had encountered problems in all three of these areas.

We asked the Income Assistance Area Manager to review Dallas's file. This was done and he was assigned an assistant supervisor as his new worker and was provided basic assistance of food and shelter. We met with Dallas and the new worker, who apologized for the previous difficulties Dallas had encountered and committed to giving him a fresh start.

The new worker reviewed Dallas's application and requested documentation about his pending surgery. Dallas was then provided full assistance benefits and additional benefits based on his medical condition.

The Unit Supervisor also wanted to meet Dallas in person so she could better understand what happened and prevent similar problems in the future. She also invited the worker Dallas had initially dealt with. Dallas asked us to attend this meeting with him. At the meeting, the worker said that he had not intended to be disrespectful and he and the Program Manager both apologized to Dallas. He accepted their apologies and let them know that he appreciated their time and their efforts to make changes.

The Income Assistance Area Manager further reviewed Dallas's file to ensure that he would be referred to any other support programs that might be applicable to him. In addition, all staff would be expected to attend our office's "Fine Art of Fairness" workshop and front line staff would also attend the federal government's customer service workshop.

After his surgery, Dallas contacted our office to say thank you. He told us that he was on the road to recovery and was looking into upgrading his skills so he could find work.

Investigations (No Recommendations)

When Each Day Matters

Regional Health Authority

After numerous delays in getting a diagnosis, Deanna learned she had stage 4 colon cancer in August. She met with her oncologist and her first chemotherapy appointment was set for mid-September. It was determined that she would have the chemo through a port which would be surgically inserted.

There was a delay in getting the referral to the surgeon who would insert the port and without it, Deanna had to miss her first chemo treatment. Her second chemo appointment was set for early October but the port still had not been inserted and Deanna did not want to miss treatment again.

Her daughter Dawn was also concerned and contacted the regional health authority to see if the surgery date could be moved up. It was, but now it coincided with the chemo date, so the chemo treatment was rescheduled for 12 days later. At a stage when every day counts, Deanna and Dawn found this further delay very upsetting.

Dawn called our office and, given their experience so far, was not willing to make further inquiries with the regional health authority. With Deanna's consent, we contacted the Quality of Care Coordinator (QCC) offices for the SCA and the regional health authority.

We let the QCCs know about Dawn's and Deanna's experiences to date and Dawn's reluctance to call them herself. Both said they would follow up immediately and asked if it would be possible to communicate directly with Deanna and Dawn. They agreed. A couple of days later, both QCCs called to advise that through their combined efforts, Deanna would have the port inserted and receive her chemotherapy on the previously scheduled date.

Correcting An Old Mistake

Ministry of Agriculture, Lands Branch

Dennis bought a house, which came with some farmland leased from the provincial government. Several years later, Saskatchewan Crop Insurance Corporation measured his land with a GPS system and he discovered that there were fewer acres than what was stated on his lease agreement. He contacted Lands Branch and provided this new information. Lands Branch conducted a field inspection and adjusted his lease accordingly. He was now paying about $2,000 less each year.

While he appreciated this adjustment, Dennis thought that Lands Branch should reimburse him for the excess charges dating back to the start of his lease. This came to about $25,000. The branch denied his request, noting that there is some onus on the leaseholder to let the Ministry know of any discrepancies. Dennis did not think this was fair because he did not have access to the information that was used to determine the number of acres on his lease. He contacted our office.

We investigated the matter and it was our view that the Ministry should not retain funds that it was not entitled to receive. The Ombudsman made a tentative recommendation for repayment of all fees overcharged, with the exception of a four-year period when Dennis might not have been compliant with other aspects of the lease agreement. The tentative recommendation was for repayment of $22,000.

When the Ministry reviewed our information, it suggested a compromise: they would share responsibility for the mistake and offered Dennis half of the recommended amount. After some consideration, Dennis accepted the offer. Based on his acceptance, we withdrew our recommendation and closed the file as resolved.

Accolades

Our thanks - and Accolades - to public servants who showed a dedication to fairness in 2011. Somewhere along the way, we found you making a situation more fair.

Cam Swan
General *Manager, Provincial Disaaster Assistance Program, Ministry of Corrections, Public Safety and Policing*

Thank you for your proactive request of a policy consultation in order to strengthen your appeals process.

Dave Cote
Acting Visiting Officer, Regina Correctional Centre, Ministry of Corrections, Public Safety and Policing

Thank you for finding an alternative that enabled an inmate to receive timely visits from his children.

Doug Kelln and staff
President and CEO, SaskEnergy

Our thanks and congratulations to all of you for a consistent and dramatic drop in complaint numbers over the last few years: from 91 in 2005 to 13 in 2011.

Karen Schmidt
Team Lead, Applications Unit, PHRS Test Team, Ministry of Health

Pat Cambridge
Acting Director, Health Benefits, Ministry of Health

Thank you both for applying discretion over bureaucracy to quickly resolve a health card delay.

Laurie Dean
Supervisor, Centre Region, Saskatchewan Assistance Program, Ministry of Social Services

Thank you for taking the time to meet with a challenging client, for exercising discretion and for going the extra mile in finding solutions.

Maureen Marsh
Client Representative, Regina Qu'Apelle Health Region

Bobbi Lochbaum
Quality Improvement Consultant and Quality of Care Coordinator, Saskatchewan Cancer Agency

Thank you both for your prompt and effective advocacy to get a client's treatment plan back on schedule.

Recommendations

Following are summaries of all the recommendations we made in 2011.

Trying to Succeed

Ministry of Social Services – Income Assistance and Disability Services

Dillon, a 20-year-old social assistance recipient, decided to go back to school and complete his grade 12. He had concerns for his safety in his home community so he moved to a city, where he registered for school and found a place to live. He applied for continued social assistance and began receiving partial benefits while attending school.

His social worker told him that he would have to attend 80% of classes in order to continue receiving benefits. He tried to stay with friends and relatives, but their lifestyles made it difficult for him to get a good night's rest and attend school. He had to move a couple of times and when he did, the worker held his benefits until he had a valid address, making it difficult when he could not pay rent.

By the end of the fall semester, his attendance was quite low and his social worker again held his benefits. She requested a case planning meeting where she reminded him that his attendance would need to improve, but did not offer any assistance in finding another place to live or making plans to improve attendance. He was left on his own to sort out his problems and stay in school. He tried to attend more regularly, but was still not achieving 80% attendance. At the end of January, his benefits were cancelled.

He wanted to appeal the decision and the school guidance counselor went with him to the Social Services office. The receptionist told them that he could not appeal the decision because he did not have an address. The guidance counselor offered the school's address, but they were told that this would not work; it had to be a residential address. He was not allowed to speak with his worker because he was now off benefits and therefore had no worker. The guidance counselor was not familiar with the social assistance policies, so did not insist.

Dillon was frustrated and the guidance counselor referred him to an advocate, but he was too upset to pursue the complaint and returned to his home community. The advocate thought it was a worthwhile concern and brought the issue to our attention, although she was not sure if Dillon would pursue the matter.

Our investigation focused on three issues:

1. **Dillon's urgent need for funding so he could complete school**

   Dillon did return to the city to restart classes. He re-applied for assistance and since he was expected to graduate in June (less than six months later) and get a job, he was eligible for the Transitional Employment Allowance instead of the Social Assistance Program. He also found a new place to live which was a more supportive environment.

2. **The refusal to accept Dillon's appeal**

   The decision not to allow Dillon to appeal because he had no address seemed to be contrary to Social Services' policy. Dillon's social worker told us she did not know about his attempt to submit an appeal and that she would have agreed to see him if she had known he came in. Other officials at the Ministry confirmed that, even without an address, he should still have been able to appeal the decision and speak to a worker.

3. **Policies interpreted and applied to vulnerable students, which impact their success**

   Our investigation found that there is no policy requiring students to attend a certain percentage of classes in order to maintain benefits. Dillon's worker told us that this requirement was part of the plan she had set up with him, that other workers suggested 80% attendance as a good target, and that Dillon had signed his case plan, thereby agreeing to 80% attendance.

   While this may be a reasonable requirement in many cases, it is not policy. The worker did not ask Dillon what level of attendance he thought he could achieve, but took his signature as agreement to 80%. For a vulnerable young adult trying to cope with difficult living arrangements, his level of desperation may easily have outweighed his inclination to challenge her assumptions or explain his situation in greater detail. As a result, the matter was unexplored, he did

not have a stable place to live, he failed to attend enough classes, he lost his benefits and then had no income to pay rent, so lost his ability to find another place to live.

In past cases, we have heard reference to a requirement for 80% attendance, so it was clear that this was not a unique target based on Dillon's needs. There was also no mention of the target in policy, so it was essentially an unwritten rule.

Recommendations

1. That the Ministry ensure its general reception staff have an understanding of the appeal process provided by *The Saskatchewan Assistance Act* and regulations to allow them to provide accurate and factual information to the general public when required.

   Status: Accepted
   The Ministry confirmed that it will also ensure that all Income Assistance Service Delivery (IASD) staff are reminded of the appeal processes available to clients and that there are processes in place that clients can use to arrange for an appeal if they do not have an address.

2. That the Ministry review the current unwritten rule with respect to school attendance for the adult student receiving benefits while attending high school in consultation with the appropriate officials in the Ministry of Education and respective school divisions to determine if school attendance should be a factor in the continuation of income assistance benefits for the adult student attending a high school program.

   Status: Accepted
   The Ministry confirmed that the Saskatchewan Assistance Program manual's guidelines about case planning are flexible enough to ensure appropriate discretion be used on a case-by-case basis.

3. That the Ministry of Social Services ensures that all high schools across the province are aware of the supports available from the income assistance programs for adult students and that this includes information about the available appeal avenues.

   Status: Accepted
   The Ministry sent a letter to senior school board officials to ensure that all high schools across the province would be aware of the supports available from the Income Assistance Programs for adult students, including information about appeal processes.

How Was She to Know?

Office of Residential Tenancies

Denise had a dispute with her landlord, who took the matter to the Office of Residential Tenancies. A hearing took place and Denise was told that she would receive a decision within 45 days. She was eagerly awaiting this information because of the potential impact on her finances and where she would live. It arrived 58 days after the hearing.

Denise disagreed with the decision and believed it contained factual errors. Instructions at the bottom of the decision indicated that:

"Any person who is aggrieved by a decision or order of a hearing officer may appeal the decision or order on a question of law or of jurisdiction to a judge of the Court of Queen's Bench within 30 days after the date of the decision or order."

Based on this information, Denise believed that she should appeal the decision to the Court of Queen's Bench. The court dismissed her appeal because it was not based on a question of law or jurisdiction. She then discovered that the proper avenue of recourse would have been to take the matter back to the Office of Residential Tenancies within 15 days of the decision and request a review. By now, more than 15 days had passed and although Denise tried to convince the Office of Residential Tenancies to consider her information, it would not make an exception to the deadline.

Frustrated, she contacted our office with three complaints:

- that the decision took too long
- that the Office of Residential Tenancies did not specify that she could not take a question of factual error to the Court of Queen's Bench
- that the Office of Residential Tenancies did not inform her of the review process for errors set out in section 76 of *The Residential Tenancies Act*

During the course of our investigation, we turned to *Hearing Back: Piecing together Timeliness in Saskatchewan's Administrative Tribunals*. *Hearing Back* is a report we issued in 2007 that deals with matters of timeliness and best practices for administrative tribunals such as the Office of Residential Tenancies. The report recommends that tribunals establish timelines for decision-making after a hearing and in circumstances where those timelines cannot be met, the tribunal should notify the consumer, providing reasons for the delay and a date when the decision will be ready.

In reviewing Denise's situation, we found that the Office of Residential Tenancies had an unwritten guideline

that hearing officers would complete decisions within 40 days of a hearing. This was a step in the right direction, but it was not part of written policy and there was nothing in the policy to say that the parties should be contacted in the event of a delay and provided with reasons and a new timeline.

We also found that, based on best practices, the Office of Residential Tenancies should have specified where to take a question of factual error and should have informed Denise of the review process available and the 15-day deadline to request a review. The Office acknowledged that there was merit to Denise's complaint and allowed her to apply for a review under section 76 of *The Residential Tenancies Act*, even though the deadline was past.

The Office of Residential Tenancies took steps to remedy this complaint, devised a plan and made changes to the appearance and contents of decisions. These changes would ensure that tenants and landlords would be aware of the appropriate steps for handling concerns on decisions when they disagree on fact, law or jurisdiction. Our office was provided an opportunity to offer feedback on the wording of the new forms and the changes are now in effect.

These voluntary changes addressed almost all of Denise's concerns, leaving us with only one recommendation to make.

Recommendation

1. That the Office of the Residential Tenancies implements Recommendation 13 made in the report *Hearing Back: Piecing Together Timeliness in Saskatchewan's Administration Tribunals.*

Recommendation 13: That government and tribunals work together to implement policy timelines within which hearings must be held and decisions must be made. The timelines must be readily available to consumers. In the event a timeline is breached, the decision-maker must provide the parties with the reason for the breach and a new timeline for rendering the decision.

Status: Accepted

Notice Needed

Office of Residential Tenancies

Doug attended a hearing at the Office of Residential Tenancies and it was decided that the hearing should continue on subsequent dates to allow for the evidence and arguments to be presented. A few weeks later, Doug received a letter banning him from the Office of Residential Tenancies. It said that he could have someone represent him or he could attend by telephone. Doug did not think this was fair and contacted our office.

Our investigation found that, based on Doug's behaviour, the decision itself was not unreasonable, but the Office of Residential Tenancies did not use a fair process. With situations like this in mind, Ombudsman Saskatchewan produced a guide in 2009 titled *Practice Essentials for Administrative Tribunals*, which was shared with tribunals across the province.

As noted in the guide, those who will be directly affected by a decision must be given adequate notice that a decision is going to be made. The notice should include brief information about who is involved, what the issues are, what decisions may be made and what may be the potential consequences or outcomes. Notice has to be provided in sufficient time to allow the affected person to have a reasonable opportunity to respond.

In order that they can prepare a proper reply, persons directly affected by a decision have to be given all the relevant information about the case. This generally means that a decision maker must disclose any relevant information about the case that is in the decision maker's possession.

In this case, Doug did not know that a decision was going to be made and he was not provided with the information that led to the decision. He was not informed of the potential consequences or outcomes nor was he given an opportunity to be heard. He was simply told via a letter that he was not allowed to enter the premises of the Office of Residential Tenancies.

Recommendation

1. That where the Office of Residential Tenancies intends to make a decision adverse in interest to a particular individual, that individual is to be given adequate notice that a decision is going to be made, information as to the issues and consequences and be provided with an opportunity to reply.

Status: Accepted

How is That Search Going?

Public Guardian and Trustee

When Dan passed away, he had some money, but left no will. It was now the job of the Public Trustee's Office to collect a list of beneficiaries and distribute the funds. To ensure a complete and accurate list of beneficiaries, the Public Trustee hired an heir locator.

A few years later, the heir locator contacted Dorothy and she was informed that she was one of the beneficiaries. About five years after that, no funds had been distributed and Dorothy, who was quite elderly, wondered whether she would survive to receive her portion. She contacted our office.

We investigated the matter found that there is no time limit stated in *The Intestate Succession Act, 1996*, and in some cases, the search may take considerable time. The administrator cannot pay out funds to the wrong persons, and will not pay out the funds until the heir locator has exhausted his or her search. Our research found that this practice is similar to other jurisdictions in Canada.

While the work of the heir locator had to follow its due course, we noted that Public Trustee's Office did not require the heir locator to provide regular reports on his progress. As a result, sometimes as much as six months or more passed between reports. Nor did the Public Trustee's Office have a process for reporting back to the known beneficiaries. Without knowledge of the progress being made towards completing the search for other heirs, Dorothy could only wonder how much longer she would have to wait.

We made two recommendations to improve reporting. While this would not necessarily speed up the heir location process, it would make that process more open and accountable.

Dorothy's matter was also concluded at the Public Trustee's Office. During the course of our investigation, the heir locator for Dan's estate completed his search and the Public Trustee's Office made preparations to pay out the funds to the beneficiaries.

Recommendations

1. That the Public Trustee develop and implement policy that outlines the contractual obligations of the heir locator and the responsibilities of the Public Trustee and includes the reporting obligations of the heir locator to the Ministry and the Ministry to the heir locator in instances where the Public Trustee engages an heir locator to locate beneficiaries of an estate.

   Status: Accepted

2. That the Public Trustee develop and implement policy that outlines the reporting obligations of the Public Trustee to beneficiaries in instances where the Public Trustee has engaged an heir locator to locate beneficiaries of an estate.

   Status: Accepted

Who Decided? What Was Provided?

Workers' Compensation Board (WCB)

Dylan was seriously injured in a work accident. After a few years of medical treatment, he was able to return to similar work. Eventually, this became too difficult, so he retrained and took a more sedentary job. After working full-time for many years, Dylan developed problems with basic mobility, as well as a neck condition.

Based on these changes, he applied to the WCB for benefits. He was approved for benefits relating to his other problems, but not for the neck condition. He did not think this was fair and contacted our office.

Our investigation found that the Medical Review Panel for the WCB had looked at the request and examined Dylan. The Panel had concluded that the neck condition was a result of the original injury. The WCB had then requested clarification from the Panel, which was provided.

Normally, the WCB is required to accept the conclusions of the Medical Review Panel. In this case, however, the WCB found that the panel had exceeded its mandate by concluding that the neck condition was caused by the accident. Only the Board could make the final decision whether a given condition was caused by a work accident.

While the Board was correct to make this distinction, it appeared not to take the next logical step and make a determination whether the neck injury was indeed caused by the accident. We made our first recommendation on that basis and the Board assured us that it did indeed consider the matter. Our other recommendations asked the Board to communicate its

reasons and other relevant information to Dylan.

Recommendations

1. That the Workers' Compensation Board treat the conclusion of the Medical Review Panel (that Dylan's neck condition is the result of his original injury) as some evidence that the injury complained of by Dylan may have been work-related and determine whether or not his neck condition is the result of his original injury.

   Status: Accepted

2. That the Workers' Compensation Board provide Dylan with the reasons for its decision that his neck condition is not a condition that arose of his original work accident.

   Status: Accepted

3. That the Workers' Compensation Board provide the response it received from the Medical Review Panel in response to the Board's request for clarification of the Medical Review Panel's decision.

   Status: Accepted

4. That the Workers' Compensation Board provide the response from the Medical Review Panel to Dylan's advocate.

   Status: Accepted

If Not, Why Not?

Workers' Compensation Board (WCB)

Danton's legs were injured by application of a chemical at work. Initially, he suffered one condition. Later, he was diagnosed with another leg condition that caused him to limp and resulted in further difficulties. He and his doctor believed that these problems were all the result of the chemical injury, but when he applied for benefits from WCB, he was only approved for benefits based on the initial condition.

He did not understand why the WCB made this decision and did not think it was fair, so he contacted our office. We investigated his complaint and found that, while the WCB's decision was not necessarily unfair, it could have done a better job of explaining its reasons to Danton.

Recommendation

1. That the Workers' Compensation Board provide Danton with reasons as to why it does not accept the conditions as resulting from his work accident.

   Status: Accepted

When Exceptions Make Sense

Ministry of Social Services, Income Assistance and Disability Services

Chloe needed to move to a new apartment. She has disabilities and allergies, which made her search more difficult. After a long search she finally found one that was available, reasonably safe, within her price range and able to accommodate her needs. When it came time to pay the damage deposit, the landlord wanted cash. As a Social Services recipient, the process for Chloe would normally be to ask the Ministry of Social Services to issue a letter of guarantee instead, but she knew the landlord would not accept this and she needed an appropriate place to live. She paid cash.

Chloe then went back to her social worker, explained the situation and asked for reimbursement. Based on policy, the social worker said no. To Chloe, this was a lot of money and going without it would be difficult. Chloe appealed at the regional level, and then to the Saskatchewan Social Services Appeal Board (SSAB). The response did not change, so she contacted our office.

In 2010, we made four recommendations on this file: one to the SSAB and three to the Ministry. The SSAB accepted our recommendation and we reported the results in our annual and quarterly reporting for 2010 (Annual Report 2010, pages 18-19). The Ministry, however, did not accept our recommendations and the Ombudsman used the option available in Section 24 of our legislation to provide a report to the Minister. The Minister accepted two of the three recommendations, as described below.

Recommendations

1. That the Ministry of Social Services pay to Chloe the sum of $700.00.

   Status: Accepted

2. That the Ministry of Social Services await a decision of the Office of Residential Tenancies before determining that the security deposit is an overpayment.

   Status: Accepted
   Because the Ministry agreed that this would not be an overpayment, there was no need to await a decision from the Office of Residential Tenancies.

3. That the Ministry of Social Services, in cases where the security deposit exceeds the basic shelter allowance, pay a security deposit to a maximum equivalent of all sources of Social Services funding for which a recipient is entitled towards shelter costs.

   Status: Not Accepted
   The Minister was not prepared to accept this recommendation because she saw it as requiring further research and consultation. If that later occurs and the policy changes in accordance with this recommendation, we will change the status to "accepted."

Questions from Grieving Parents

Ministry of Justice and Attorney General – Saskatchewan Coroner's Service (SCS)

Danielle and Don's daughter was under 18 when she died in a motor vehicle accident (MVA). After the accident, they learned from the community coroner that, because their daughter had been the driver of one of the vehicles involved in the accident, a complete post-mortem, also known as an autopsy, would be required. As parents, they did not want the autopsy to be performed and did not consent to it, but would have consented to an external examination and toxicology tests. They were told that it was policy that complete post-mortems are required on all drivers who die in a MVA. Danielle and Don believed that they were also not informed of any appeal process to have this decision reviewed.

The parents also questioned why they were not allowed access to their daughter's body before the autopsy, why it took several days to complete the autopsy and why they were not informed that the body had been released to the funeral director until after she was returned to their home community. They felt that their wishes as parents had not been considered, and that the delayed access had made their final goodbyes more difficult.

Danielle and Don also learned that they would be permitted to see the community coroner's report and when it came out they noticed several errors. They were concerned that these errors might affect the outcome of a related court case and asked to have them corrected. They still wanted to know why the autopsy had been done and whether it was really necessary. They wrote to the Chief Coroner about these concerns, but were not satisfied with the response. Still grieving, and with many questions, they contacted our office.

Our investigation encompassed several areas, including the contents and application of policy, the role of the parents, the appeal process, the alleged delays, access to the body, the coroner's investigation, the report, communication and transparency.

Ordering of the Post-Mortem Examination

The Coroner's Act allows the Coroner to "order" a post-mortem and the regulations allow for two types of exams: a complete post-mortem (or autopsy) and a less intrusive external examination. In this case, it was well within the community coroner's legislative authority to order a complete post-mortem. In addition, Saskatchewan Coroner's Service (SCS) policies direct, without exception, that the all MVA driver fatalities undergo a complete post-mortem examination. The policy is based on the need to document, retain and preserve evidence, with respect to the manner and cause of death, should the matter proceed to criminal or civil court or for other civil purposes.

Our review did not question the Coroner's authority under the Act to the order a post-mortem examination. We did, however, question the strict application of the SCS policy requiring that all MVA driver fatalities receive a complete post-mortem examination - both in the general sense and, more specifically, in this case.

Our office understood the need for post-mortem examinations, particularly in matters proceeding through the criminal or civil courts; the time limitations community coroners are under to make these decisions; and the serious repercussions of making the wrong decision. We questioned, however, the value of such an intrusive procedure in all but only the necessary cases if other less intrusive means of inquiry are available and would serve the same purpose and meet the same need. In this case it would appear that the less intrusive option could have yielded the same information.

We found that the SCS policy restricts the ability of community coroners to use their discretion in choosing the type of examination ordered in MVA driver fatality cases. It is the Ombudsman's position that "policy should never be rigidly applied or interpreted, and decisions must still be made based on the individual circumstances of each situation." The SCS policy requiring all MVA driver fatalities

to undergo complete post mortems unduly limits the community coroners' discretion and therefore their ability to make the necessary administrative decisions based on the specific case circumstances.

A great deal of information gathered by the coroner can provide data that may help prevent future accidents. When we reviewed the information in this case and required for these purposes, however, we found that it can all be gathered by means other than a complete post-mortem.

Involvement of the Deceased Person's Parents

Parents are accustomed to being asked for their consent for their children's medical and dental procedures, so learning that they have no say in the kind of examination to be performed on a deceased child can be disconcerting. Don and Danielle believed that they should have been asked for their consent in this situation as well. On the other hand, there is an obligation on the part of government to determine the cause and manner of death in order to prevent future deaths and to assign responsibility for the accident. A policy that provides room for discretion and affords parents a role in the decision-making process would help to balance these two important aspects.

Appeal Limitations

Parents or family members who disagree with a community coroner's decision can contact the Chief Coroner, who will review the case and make a final determination. If families still disagree, they can apply for a review to the Court of Queen's Bench. This step is very technical, however, and is limited to a judicial review of the administrative decision of the Chief Coroner. The community coroner had provided Don and Danielle with a pamphlet, but it did not describe these appeal routes.

Timing of the Post-Mortem

We reviewed the time taken to conduct the autopsy and release the body and found that this was reasonable. In our opinion, information to the contrary that had been given to Don and Danielle was not accurate.

Access to the Body

The parents also believed that they were denied access to their daughter's body because of the post-mortem exam. This does not appear to be the case and we found that this concern could have been better addressed with better communication.

The Coroner's Investigation and Report

Danielle and Don noted several errors in the Final Coroner's Report and Final Autopsy Report and were concerned that these errors would impact any future court proceedings. We found the errors to be minor and that the report itself was not part of the subsequent court proceedings.

Danielle believed that the community coroner's investigation was incomplete and biased. She thought it would be more like a police investigation and assign blame. The report indicated that the manner of death was accidental, which she believed meant that nobody was at fault. It meant that the cause of death was an accident, rather than a homicide or suicide, for example. The report did not determine fault and would actually have been biased if it did.

The Importance of Communication

Most people learn about what a coroner does from TV or the Internet. Much of this information is incorrect. Other families, like this one, who encounter the coroner in very difficult circumstances, need more clear and detailed information. In this case the family was provided a single pamphlet on the night their daughter died. The pamphlet, though helpful, does not adequately explain the coroner's process prior to autopsy, the need for and purpose of a post-mortem and any available appeal routes. Accessible, clear and concise information is needed to help families make decisions.

The Coroner's Files

In reviewing the community coroner's files, we found that much of the work was hand-written. The electronic templates available for reporting were not compatible with the community coroner's computer and the Office of the Chief Coroner did not provide laptop computers to its community coroners. This paper-based system extends to the Office of the Chief Coroner and hampers the office's ability to gather and analyze information – information that can and should be used to prevent future deaths.

Recommendations

1. The Ministry of Justice and Attorney General and the Office of the Chief Coroner, in conjunction with policing agencies and other affected stakeholders, undertake a comprehensive review of the current SCS policies requiring that all MVA fatalities undergo a complete post-mortem examination. They should determine if and under what circumstances such examinations are required and develop criteria that would specify the circumstances under which an MVA fatality would undergo a post-mortem examination and of those, which cases require a complete post-mortem and which cases require an external post-mortem examination.

   Status: Accepted

2. The Ministry of Justice and Attorney General and the Office of the Chief Coroner consider the issues of parental involvement when a post-mortem examination (either external or complete) of a deceased minor child is contemplated or ordered by a community coroner. The Ministry and the Office of the Chief Coroner should consider the nature of parental involvement from both a legal and a best practices perspective and develop program policies and practice guidelines that speak to the issue of parental involvement.

   Status: Accepted

3. The Ministry of Justice and Attorney General and the Office of the Chief Coroner develop and implement a review process consistent with the principles of procedural fairness and best practices. The process would look at decisions of the community coroner reviewable by the Chief Coroner, identify what administrative decisions are reviewable, what the appeal process entails, the scope of the review and the timeline for review. This process should then be articulated in Office of the Chief Coroner's policy and produced in information material available to the public both in print and electronically.

   Status: Accepted

4. The Office of the Chief Coroner develop program policies and best practice guidelines that assist the community coroners in determining when a complete post mortem examination would and should be ordered and in what circumstances an external post-mortem examination would and should be ordered.

   Status: Accepted

5. The Office of the Chief Coroner review and if necessary develop information materials directed to family members including parents and guardians of deceased children who may be subject to a post-mortem examination. This material should be made public and easily available.

   Status: Partially Accepted
   The Chief Coroner says that the information provided to parents in the pamphlet "Saskatchewan Office of the Chief Coroner, The Coroner's Investigation" is adequate, that he remains committed to regular reviews of the pamphlet and if additional information is required, changes will be made.

6. The Office of the Chief Coroner acquire and adopt data and case management capability that would allow for greater oversight, support and communication between the Office of the Chief Coroner and community coroners.

   Status: Accepted

7. The Office of the Chief Coroner produce an annual report that provides information concerning their activities and data about the number, type of deaths and findings and recommendations in relation to investigations and inquests.

   Status: Accepted

8. The Office of the Chief Coroner provides opportunities for community coroners who have limited experience to follow or be mentored by more experienced and or skilled coroners.

   Status: Accepted

Towards a Better Understanding

Ministry of Social Services, Income Assistance and Disability Services; Saskatchewan Social Services Appeal Board

Doris was a mother of three children who was living with and caring for an elderly father. A Canadian citizen, she had emigrated from a country where English was not her first language. Doris had a limited understanding of English. Though she could carry on a conversation she had a limited ability to read or write English. Doris was not employed outside the home and received limited support from family. Her father, a senior, was ill and did not have the additional income to support Doris and her three children, so she applied for social assistance with the help of her teenage son as a translator, and was placed on assistance.

While Doris and her children were on assistance, her sister had given them money to visit her ailing mother back in her country of origin. Doris did not understand she had to tell her social worker and cancel her social assistance benefits when out of the country. When their social worker learned of the trip, Doris was charged with an overpayment for the social assistance benefits she had received while she was out of country. The money from her sister was determined to be a gift and after subtracting the $200 allowable gift deduction, the rest was considered money she had available to support her family and calculated as support for a specified number of months in accordance with the applicable policy. She was now not on assistance, with no income and with a large debt to Social Services to be repaid.

When Doris reapplied for assistance at the end of the calculated time period, Social Services reviewed her financial assets and discovered that

Doris's name was on some joint bank accounts with her father. When Social Services confronted Doris about the accounts, she told them she did not know about the accounts and this was the first time she had heard of them.

She was again refused assistance and all the assistance she had been paid since her original application was now deemed to be an overpayment. She and her three children then had to live off of her father's senior income, the Child Tax Benefit and a rental supplement for all their needs.

Her father, who also had a limited ability to communicate in English, met with the Ministry to explain why Doris's name was on the accounts. He explained that the money was to be an inheritance to be left to his entire family should he die. His understanding was that this action replaced the necessity of having a will. He told Social Services she did not know about the accounts. In order to try and resolve the situation, Doris had to show that her name was removed from the accounts. When her father understood the impact, he removed her name from the accounts and verification was provided to Social Services. Social Services placed Doris and her children back on assistance but the overpayment for all previous assistance was still to be paid. Doris tried to discuss the situation further with Social Services, but English was not her first language and she had trouble communicating. Social Services would not change the decision, so she appealed to the regional committee and then the Appeal Board, but was denied. At the appeals she was not provided an interpreter to ensure she clearly understood the process, the questions asked and the policies that were being discussed. The advocate who presented her case was not fluent or knowledgeable in Doris's first language so could not ensure Doris clearly understood the information. After the appeal, Doris obtained an adult friend as an interpreter and contacted our office.

Our investigation found that Social Services was following policy when it assessed Doris an overpayment for the assistance money received while she was out of the country and when they considered the funds from her sister as available money to support her family.

We found, however, that Social Services could not demonstrate that Doris actually knew about the joint accounts or that she had accessed them. In reality, the money in the accounts had not been available to her.

We found that, in both instances, the situation was made more difficult because of a language barrier. It was not appropriate for the Ministry and Appeal Board to assume that Doris understood all the rules when she had difficulty communicating in English, nor was it appropriate to rely on a minor to interpret the obligations under the social assistance policy and program. Doris needed to understand the reasons for the decisions and she needed to be able to communicate clearly in return. She needed the services of an interpreter and translator in her first language, but she could not afford to pay for this.

Recommendations

To the Ministry of Social Services

1. That the Ministry of Social Services provide interpreter services at no cost to income assistance applicants and or recipients where:

   a. it appears to ministry staff that the applicant is unable to reasonably appreciate and understand their obligations with respect to receiving social assistance, or

   b. the applicant or recipient has declared that language will serve as a barrier to their ability to appreciate and understand their obligations required to receive social assistance and that assertion appears to be reasonable.

   Status: Accepted

2. That the Ministry remove the overpayment assessed to Doris based on the decision that she had access to funds in any account held jointly with her father.

   Status: Accepted

To the Social Services Appeal Board

1. That the Social Services Appeal Board consult with the Ministry of Social Services to develop and implement a plan of action that will allow the appropriate appeal panels, both at the regional appeal committee level and at the board level, at their discretion or upon request of a respondent, to provide interpreter services at no

cost to an income assistance applicant and or recipient where:

a. the applicant is unable to reasonably appreciate and understand the hearing process and requires the assistance of an interpreter to adequately make presentation to the appeal panel and to actively participate in the appeal hearing, or

b. the applicant or recipient has declared that language will serve as a barrier to adequately make presentation to the appeal panel and to actively participate in the appeal hearing.

Status: Accepted

Recommendation Update: Ease the Pain

Workers' Compensation Board (WCB)

In our Annual Report 2008, we reported on a complaint from "August" who wanted the WCB to cover the use of prescribed medical marijuana or Marinol (a synthetic form of marijuana) for the pain he was experiencing. The recommendation we made on this case was not accepted by the WCB, but the Board did indicate that it was prepared to study the issue. A study has now been completed and shared with our office. Following is a reprint of the original case story with the addition of the study results.

August injured his back more than 20 years ago and has had numerous surgeries on his spine. He receives full compensation from WCB and is considered unemployable. Over the years, his doctors have prescribed various ways to manage the pain, including very potent pain relievers with limited success. Eventually, a neurosurgeon recommended marijuana, which August began using in 1998.

In 2003, August applied to Health Canada for approval to use marijuana for medical purposes. His application included medical declarations from two neurologists that the marijuana was meant to help him deal with the pain from his surgeries, that other conventional treatments were not appropriate, and that the benefits would outweigh the risks. The application was approved.

In addition to the medical marijuana, August was also prescribed Marinol which is a synthetic form of marijuana. For about two and a half years, the WCB covered August's use of Marinol. They then decided to cease coverage retroactively, leaving him with an unpaid pharmaceutical bill of $2,000. Later, they reviewed this decision and decided to pay the bill and continue coverage for a short time so he and his doctor could find alternate treatment.

During this time, August made repeated requests and filed a number of appeals about the WCB's decisions to deny coverage for his medical marijuana and his prescription for Marinol. His doctor affirmed that the Marinol helped August manage his pain and control the nausea he experienced when taking certain other pain medications. The WCB, when making its decisions, referred to the "indications" listing in the Saskatchewan Health Drug Formulary Plan or the Compendium of Pharmaceuticals and Specialties. Based on this information, the WCB said that Marinol was really only indicated for severe nausea and vomiting associated with cancer chemotherapy and for Aids-related anorexia. It was not indicated for other types of pain management or nausea control.

August contacted us and we investigated. We reviewed the WCB's policy on reimbursement for medications. It states that approval be based on the following criteria:

- it is prescribed by the treating physician
- it is appropriate and needed to treat the compensable injury and/or
- the use of the medication corresponds to the indications listing in the Saskatchewan Health Drug Formulary Plan or the Compendium of Pharmaceuticals and Specialties, or
- it is approved by the WCB Medical Consultant.

While we could understand that WCB's usual preference is to follow the Formulary Plan or Compendium, we also saw some room in their policy to weigh the options and approve coverage for August's use of Marinol. We were aware that the College of Physicians and Surgeons supports evidence-based medicine and was not certain of the safety and efficacy of the use of medical marijuana. However, they still permit licenced physicians to prescribe Marinol and medical marijuana, the latter with Health Canada approval. Two specialists, as well as August's family doctor, supported his use of Marinol and confirmed that it was successfully treating his pain.

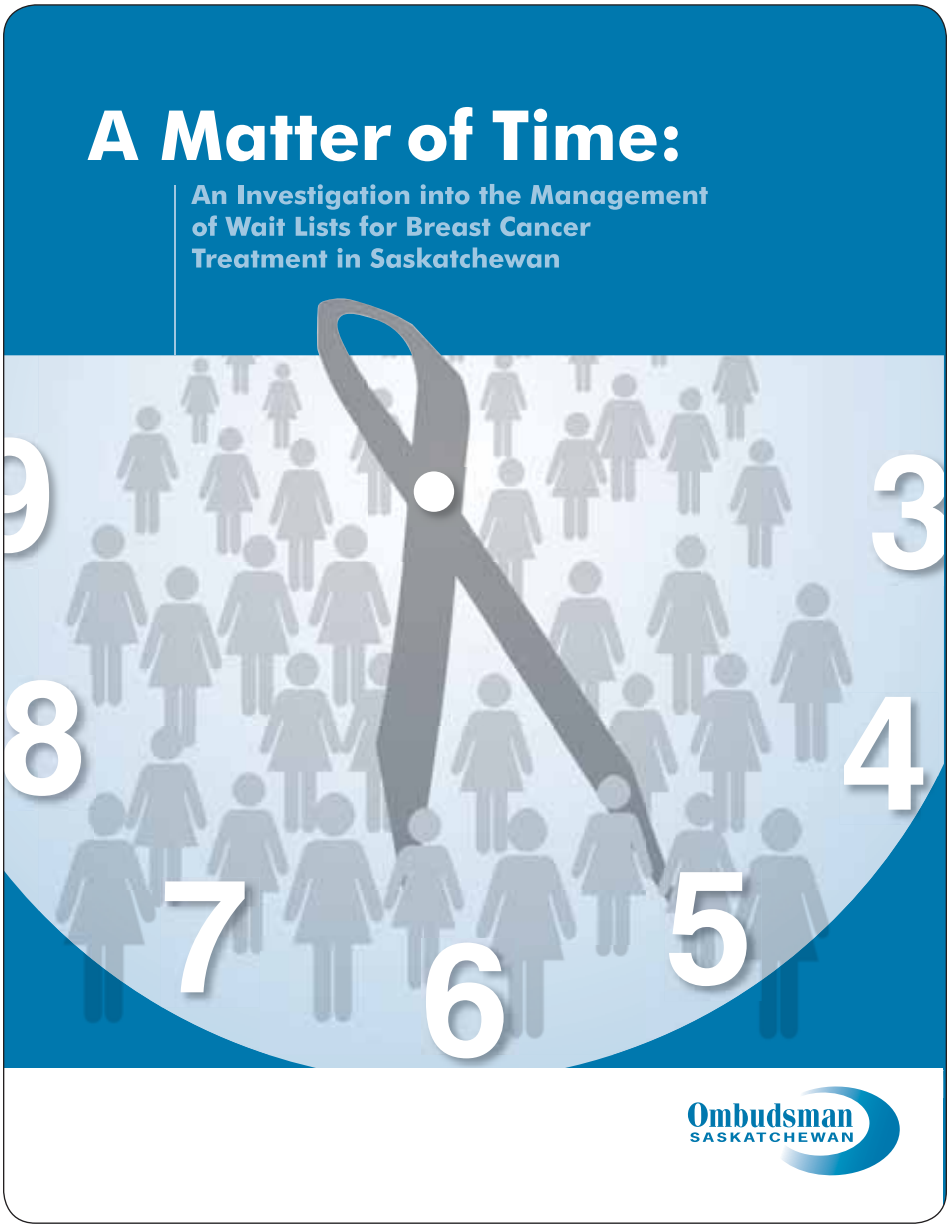
As a result of our findings, we recommended that the WCB approve payment to August for his use of Marinol. WCB did not accept our recommendation and continued to be of the view that its use for the condition August suffered was not in keeping with the College's position supporting evidence-based medicine. In particular, they told us that they do not approve any medications that are not in the formulary. While they did not accept our recommendation, they were prepared to seek other evidence on the treatment. We were

unable to find a remedy for August but we were hopeful that the Board was prepared to study the issue, which leaves the door open to reconsidering our recommendation.

We followed up with the WCB and learned that the Board had conducted its study with a group of 20 patients, performed a literature review and consulted with other jurisdictions. Based on this research, the WCB decided to continue its practice of not covering use of medical marijuana or Marinol for alleviation of chronic pain.

Our office thanks the WCB for reviewing this matter. Given the small sample size, we are not satisfied that the WCB's study is scientifically valid, and we agree with the need to supplement these results with other research. From the perspective of general approach and practices, we understand WCB's rationale for this decision. It is still our view, however, that WCB's existing policy provides room for the Board to weigh the options and approve coverage in special situations, particularly in a case such as August's where two specialists prescribed the treatment.

Systemic Reviews



Systemic reviews look at broad issues affecting a group of citizens or the community at large. These issues come to our attention in different ways. Sometimes several people come to us with the same complaint, and sometimes one person brings a complaint with provincial implications. Systemic investigations can take several months to complete and require dedicated resources. Though equally as important as our investigations into individual cases, systemic reviews tackle the comprehensive policy or structural concerns raised to us about government services. The goal of systemic reviews is to effect change that will provide a collective benefit to those most affected.

A Matter of Time: An Investigation Into the Management of Waiting Lists for Breast Cancer Treatment in Saskatchewan

Saskatchewan Cancer Agency

In May of 2009 we received a complaint from an individual diagnosed with breast cancer. She was concerned about the availability and accessibility of oncology treatment at the Saskatchewan Cancer Agency (SCA). She was not concerned with the clinical care she received, but with what she perceived to be barriers in accessing timely care, specifically chemotherapy, and with her experience and treatment as she was waiting for care.

Waiting for care is not an easy thing for anyone and yet, wait lists are a current reality within our publicly funded health care system. People want to feel confident that health care services will be available to them if and when they are needed and, "within a time frame that does not significantly compromise their health or well-being."[1] Stories of individuals waiting too long for health care may also erode public confidence in the system. How wait-lists are administered and how individuals are treated while waiting for care are as critical to the individual as the actual clinical services received.

Given the complaint that came forward and the harsh reality that breast cancer is the most frequently diagnosed cancer among Canadian and Saskatchewan women,[2] We limited our review to the SCA's administration of wait lists for those individuals who had been diagnosed with early stage breast cancer and who required adjuvant chemotherapy following surgery. In order to facilitate this review, we developed an evaluative framework based on the principles of care found in Dagnone's *For Patients' Sake* review (2009); also referred to as the *Patients First Review*.

Once the individual case was completed and resolved in 2010, we shifted our focus to a comprehensive systemic review. That review was completed and provided to the SCA and the Ministry of Health in March of 2011. Ombudsman Saskatchewan learned that the SCA had already made concerted efforts to change its internal processes and procedures, in response to the complaint noted above and while our review was ongoing. A number of these changes coincided with our final report recommendations.

Recommendations

Our recommendations were largely accepted by the SCA, and they had already begun the work of implementing many of the recommendations prior to receiving our report. Key recommendations include that the SCA:

- Appoint a senior staff member responsible for overseeing the entire wait list for the province.
- Consider introducing complete and comprehensive electronic medical records to form the basis for the provincial patient wait list.
- Provide all referring community doctors sufficient information to allow the referring doctors and their patients to make informed decisions about alternative care plans at other cancer centres, including agencies outside the province.
- When requested, provide estimates to patients of when they will be seen by a medical oncologist.
- Ensure navigational assistance is in place to assist patients who are waiting for a first appointment with an oncologist.
- Develop and introduce a patient charter based on the principles of Patient and Family Centred Care.

To date, the one recommendation that has not been accepted by the SCA is the recommendation that the SCA merge its two wait lists, one in each Cancer Referral Centre located in Regina and Saskatoon, into one provincial list that is centrally managed and supported. The SCA is continuing to examine this recommendation. For the last few years, the SCA has been monitoring both lists provincially in an attempt to ensure that all patients are seen in a timely manner, regardless of geographical location. The SCA is unsure to date, however, whether merging the lists is the best way to proceed, and it cites patient preference to go to the geographically closest centre, as part of its reasoning.

1. B. Postl (2007). Wait Times: A Medical Liability Perspective. Ottawa: Health Canada at 18. Website: http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2006-wait-attente/index-eng.php. Citing Health Council of Canada. Ten Steps to a Common Framework for Reporting on Wait Times. June 24, 2005.
2. According to the Canadian Cancer Society, breast cancer is the most commonly diagnosed cancer, excluding non-melanoma skin cancer, among women: Canadian Cancer Society website, http://www.cancer.ca/Saskatchewan/About%20cancer/Cancer%20statistics/Stats%20at%20a%20glance/Breast%20cancer.aspx?sc_lang=en&r=1.

Workshops and Presentations

Fairness ... It's a Conversation Worth Having

Ombudsman Saskatchewan's fair practices training program "The Fine Art of Fairness" continues to evolve and gain momentum. 2011 has been an exciting, busy and rewarding year as we continue to engage the public service in dialogues about the concept of fairness. We've met with all spectrums of the public service: from front line service delivery staff to deputy ministers. Each time we come together for a workshop, we are reminded of the seemingly complicated nature of this subject matter. Yet, once we deconstruct fairness and talk about its component parts, it is not such a scary or confusing concept after all.

Our workshop provides the framework for a conversation about fairness. It allows civil servants to visit the concept and relate it directly to their work. Some of it is technical; some of it is common sense. We often say it is about evolution, not revolution. We are not forcing fairness on the public service, but rather inviting them into the dialogue and (we hope) planting seeds along the way.

Our workshop defines fairness for administrative decision-makers and encourages them to see that acting fairly is not just about good feelings: the payoff is tangible and meaningful. Fair practices assist in good decision-making, help avoid or reduce conflict, improve service, help maintain public confidence in government programs and services, and provide job satisfaction. And for all these reasons, it's a conversation worth having.

"Fine Art of Fairness" Workshops Conducted in 2011

- Saskatchewan Administrative Tribunals (administrative tribunal training)
- Open Workshop for government employees, Regina (two workshops)
- Open Workshop for health employees, Regina (two workshops)
- Cypress Health Region
- Mamaweton Churchill River Health Region
- Ministry of Social Services, Prince Albert (two workshops)
- Call Centre, Ministry of Social Services, Regina (three workshops)
- Ministry of Social Services, Saskatoon (two workshops)
- Jubilee Residences (affiliates of the Saskatoon Regional Health Authority)
- Forum of Canadian Ombudsman, spring conference, Vancouver
- Workshop for government employees in Creighton & Sandy Bay

In May 2011, we were invited to continue the conversation with our colleagues at the Forum of Canadian Ombudsman where we offered them a sample of the workshop, as well as a conference session on the cooperative model of influence.

"The "Fine Art of Fairness" was the best training of any kind I attended in 2011 and possibly the best in my healthcare career. I still refer to my workshop binder when evaluating various situations.... I came away realizing that achieving fairness and understanding is a process and the fairness triangle is a great framework."

Tim Kasprick CHIM
Privacy and Access Consultant
Sunrise Health Region

"I learned some interesting info and approaches to help me in my position. It is great to know I can refer people to the Ombudsman for administrative government concerns."

Leanne Keen
Quality Care Coordinator
Five Hills Health Region

"I will be recommending this seminar to everyone."

Niki Rodine
Clinical Improvement Facilitator / Registered Nurse
Sun Country Health Region

Presentations

Throughout government, our communities, in educational settings and various other venues, we have enjoyed the opportunity to meet with people and discuss the work of our office.

Sometimes this can be as informal as a discussion at a staff meeting or as formal as a conference presentation. It may focus on such topics as the kinds of concerns that people can bring to us, how we address these concerns, or how we interact with government and the public.

Community Organizations

- Regina and Regional Intersectoral Committee (service fair, networking lunch)
- BRIDGE (Building Relationships around Injection Drug users for Greater Engagement)
- Saskatoon Open Door Society (two presentations)
- Victims Services Board, La Ronge
- Schizophrenia Society (booth at event)
- All Nations Hope AIDS Network
- Saskatchewan Abilities Council
- Self Help and Recreation Education (SHARE)
- Alzheimer Society of Saskatchewan

Teachers and Students

- Saskatchewan Teachers' Institute on Parliamentary Democracy, hosted by the Speaker of the Legislative Assembly
- Law 30 Class, Notre Dame College
- Carpenter High School, Meadow Lake
- Teachers' Conference, Saskatchewan Council of Social Sciences (booth and presentation)
- North West Regional College
- Saskatchewan Home Exconomic Teachers Association (SHETA) / Association of Saskatchewan Home Economists (ASHE) Conference (booth)
- Provincial Student Leadership Conference (booth and presentations)

Provincial Government and Health

- Orientation, Legislative Interns
- Regina Correctional Centre (three presentations to new recruits and one to the Remand Unit)
- Corrections Workers, Saskatoon Correctional Centre
- Social Services Management Forum
- 2011 Innovators Conference: Moving Patient and Family Centred Care Forward. Saskatchewan Union of Nurses (booth)
- Saskatchewan Registered Nurses Association staff
- Ministry of Health, Residential Coordinators from Regional Health Authorities
- Sunrise Health Region (2)
- Health Privacy Officers
- Joint Communications Committee, Ministry of Health, regional health authorities, Saskatchewan Cancer Agency and Health Quality Council
- Network or Inter-Professional Regulatory Associations (NIRO)

Other

- Presentation on the Cooperative Model of Influence, Forum of Canadian Ombudsman conference, Vancouver
- SGEU (Ombudsman and Public Interest Disclosure overview)
- Sierra Leone Public Service Commission (visiting Regina)
- Johnson Shoyama School of Public Policy, joint presentation / seminar: "The Role of Independent Legislative Officers and their Relationship with the Public"

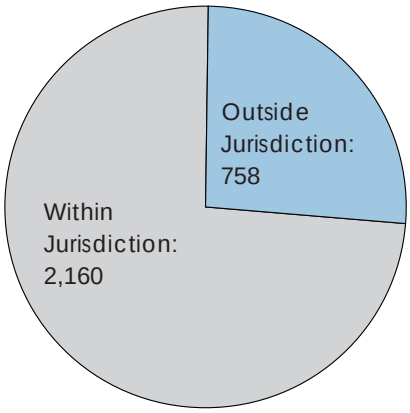
Statistics

Tracking Files and Progress

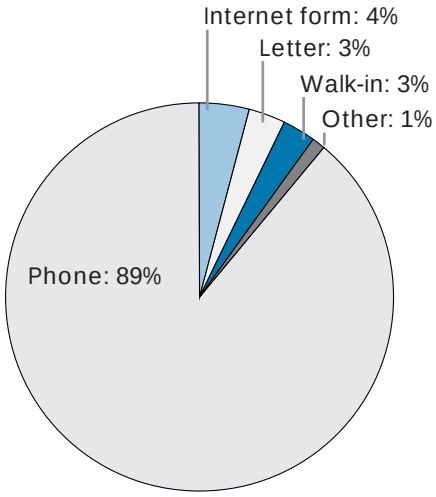
Receiving Files

Each day, we hear from people who are concerned about the impact a government service is having on their lives. Most queries fit within our jurisdiction, but a significant minority do not. In those instances, we take the time to redirect the person, as best we can, to the most appropriate office or service.

Overall, in 2011, we received 2,160 complaints within jurisdiction and 758 that were not.



How do people reach us? The vast majority contact us by phone, but there are several other methods of contact available, including mail, fax, walk-ins and a secure online form.



Time to Process Files

The time it takes to complete and close a file varies, depending on the circumstances and the amount of work required. Many can be closed within a few days, while others may take several months. Overall, our goal is to complete most of our files within three to six months.

Files Closed Within 90 Days
Target: 90%
Actual: 95%

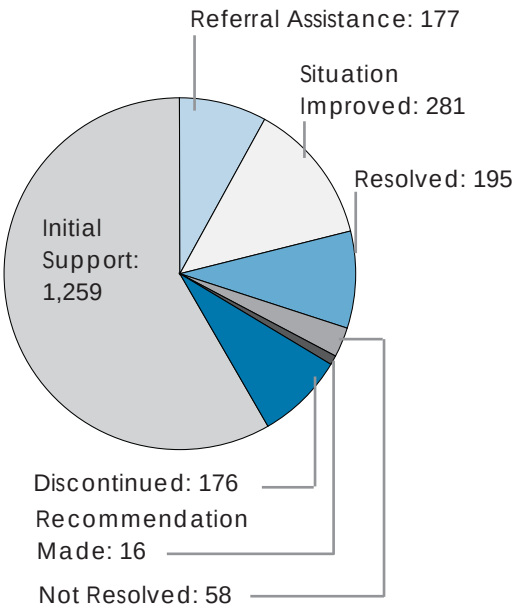
Files Closed Within 180 Days
Target: 95%
Actual 97%

Also worth noting is that, although it was not a specific target, we closed 86% of complaint files within 30 days.

Tracking Outcomes

Since each file is unique, service methods and outcomes may vary greatly. In some instances, we will coach the person to try an avenue of appeal that is available. In other instances, we may progress to a more formal investigation, complete with recommendations. Sometimes our role will be that of facilitator, to bring the individual and the government office together to work out a resolution.

While each situation is unique, we can group our file outcomes for 2011 as follows:



We do not formally notify the applicable government office each time we receive a complaint. In many instances, the matter can be resolved quickly and informally, but in cases where we determine that a formal investigation is the most appropriate route, the Ombudsman sends a notice letter to the Deputy Minister or CEO of the ministry or agency. As the investigation wraps up, the Ombudsman provides a second letter, outlining our findings and, when applicable, any tentative recommendations he is considering. This provides the ministry or agency an opportunity to respond before recommendations are finalized.

While ministries and agencies are not required to follow our recommendations, most do. This year, of the 16 files that resulted in recommendations, 26 recommendations were made, 24 were accepted, one was not accepted and one was partially accepted.

Glossary

Following are definitions of the terms used in the statistical charts on pages 32-41.

Complaints Received

The number of complaints received are counted from January 1 to December 31 of a given year. These complaints are considered within jurisdiction, although a very small number of them may later be determined not to be.

Complaints Closed

The complaints closed are counted from January 1 to December 31 of a given year. When we review each situation brought to our attention, we find that some contain multiple complaints. Since each complaint may have a different end result, each is closed separately and assigned an appropriate status.

Closed Account Statuses

Initial Support
Our office provided initial support for these complaints. For example, we may have linked the complainant to a more appropriate step - perhaps an appeal process not yet tried, an advocacy service, or an internal complaints process.

At this stage, we also encourage people to bring their complaint back to our office if they still feel there is an unfairness after they have tried all the appeal routes available.

Referral Assistance
After beginning a negotiation, mediation or investigation process, we have referred the complainant to an appeal route they have not yet tried or a more appropriate remedy.

Situation Improved
The complainant may not consider the complaint to be completely resolved, but the situation has improved - perhaps for them and perhaps also for others who may encounter a similar situation.

Resolved
The complaint has been completely or largely resolved. This may mean that the complainant feels the complaint has largely been resolved, or that we have determined the complaint to be largely resolved.

Not Resolved
The complaint has not been resolved. For example, the complainant's situation is not significantly better and they remain dissatisfied with the government's decision or action, or there was no appropriate remedy available.

Recommendation Made
Our office has made one or more recommendations. This includes recommendations that are accepted and rejected.

Discontinued
Our office or the complainant has chosen to withdraw or discontinue the complaint. This includes situations where we find, after some involvement, that the complaint is outside our jurisdiction.

Complaints Received		Ministries
2011	2010	
15	**8**	**Advanced Education, Employment and Immigration**
4	**12**	**Agriculture**
		Corrections, Public Safety and Policing
14	31	Adult Corrections - Pine Grove Correctional Centre
74	77	Adult Corrections - Prince Albert Correctional Centre
220	170	Adult Corrections - Regina Correctional Centre
190	176	Adult Corrections - Saskatoon Correctional Centre
19	16	Adult Corrections - Other
13	5	Protection and Emergency Services
8	9	Corrections and Public Safety - Other
538	**484**	**Totals - Corrections, Public Safety and Policing**
2	**1**	**Education**
2	**0**	**Energy and Resources**
15	**12**	**Environment**
2	**5**	**Finance**
0	**2**	**First Nations and Métis Relations**
2	**1**	**Government Services**
		Health
18	8	Drug Plan & Extended Benefits
58	47	Health - Other
76	**55**	**Totals - Health**
11	**9**	**Highways and Infrastructure**

Complaints Closed in 2011

Initial Support	Referral Assistance	Situation Improved	Resolved	Not Resolved	Recommendation Made	Discontinued
8	**3**	**0**	**1**	**0**	**0**	**0**
3	**0**	**0**	**1**	**1**	**0**	**0**
9	2	1	0	0	0	2
45	3	10	7	2	0	8
99	13	31	47	6	0	18
110	11	19	21	1	0	14
14	0	2	1	0	0	2
3	2	2	0	0	0	1
7	0	0	0	0	0	0
287	**31**	**65**	**76**	**9**	**0**	**45**
1	**0**	**0**	**1**	**0**	**0**	**0**
1	**0**	**0**	**0**	**0**	**0**	**0**
5	**6**	**2**	**0**	**1**	**0**	**3**
2	**0**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**0**	**0**
2	**0**	**0**	**0**	**0**	**0**	**0**
7	3	2	2	0	0	1
28	1	7	9	7	0	8
35	**4**	**9**	**11**	**7**	**0**	**9**
5	**0**	**0**	**1**	**3**	**0**	**1**

Complaints Received		Ministries
2011	2010	
		Justice and Attorney General
4	8	Court Services
23	32	Maintenance Enforcement Branch
13	18	Public Trustee
32	35	Office of Residential Tenancies / Provincial Mediation Board
15	12	Justice - Other
87	**105**	**Totals - Justice and Attorney General**
27	**18**	**Labour Relations and Workplace Safety**
3	**1**	**Municipal Affairs**
		Social Services
83	92	Child and Family Services
18	17	Housing - General
7	13	Housing - Regina
8	5	Housing - Saskatoon
26	27	Housing - Other Locations
6	6	Income Assistance and Disability Services Division - Community Living Service Delivery
32	21	Income Assistance and Disability Services Division - Income Supplement Programs - Other
3	4	Income Assistance and Disability Services Division - SAID
499	506	Income Assistance and Disability Services Division - Social Assistance Program
51	44	Income Assistance and Disability Services Division - Transitional Employment Allowance
11	11	Social Services - Other
744	**746**	**Social Services - Totals**
7	**8**	**Tourism, Parks, Culture and Sport**

Complaints Closed in 2011

Initial Support	Referral Assistance	Situation Improved	Resolved	Not Resolved	Recommendation Made	Discontinued
2	0	0	1	0	0	1
14	2	7	0	0	0	0
7	2	4	0	0	1	1
22	1	8	2	4	2	1
14	0	1	0	0	5	0
59	**5**	**20**	**3**	**4**	**8**	**3**
15	**2**	**4**	**1**	**0**	**0**	**1**
3	**0**	**0**	**0**	**0**	**0**	**0**
74	1	3	0	1	0	5
8	4	4	0	0	0	1
3	1	3	0	0	0	3
1	2	3	0	0	0	0
16	3	5	1	0	0	1
3	0	3	0	0	0	0
9	1	9	8	0	0	4
2	0	0	0	0	0	0
290	58	75	51	2	5	25
26	5	15	5	1	0	2
10	1	0	0	1	0	0
442	**76**	**120**	**65**	**5**	**5**	**41**
2	**2**	**0**	**0**	**0**	**0**	**2**

Complaints Received		Boards
2011	2010	
8	**1**	**Highway Traffic Board**
0	**3**	**Labour Relations Board**
1	**2**	**Regional Appeal Committee**
		Regional Health Authorities
22	29	Regina Qu'Appelle Regional Health Authority
20	19	Saskatoon Regional Health Authority
39	36	Other Regional Health Authorities
81	**84**	**Totals - Regional Health Authorities**
0	**1**	**Saskatchewan Arts Board**
0	**1**	**Saskatchewan Pension Plan**
3	**6**	**Saskatchewan Social Services Appeal Board**
1	**0**	**Surface Rights Arbitration Board**
117	**112**	**Workers' Compensation Board**

Complaints Closed in 2011

Initial Support	Referral Assistance	Situation Improved	Resolved	Not Resolved	Recommendation Made	Discontinued
1	**4**	**0**	**1**	**2**	**0**	**1**
1	**0**	**0**	**0**	**0**	**0**	**1**
0	**0**	**0**	**0**	**2**	**0**	**3**
14	3	2	1	3	0	5
10	2	3	3	3	0	2
28	2	4	2	0	0	3
52	**7**	**9**	**6**	**6**	**0**	**10**
0	**0**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**1**	**0**
0	**0**	**0**	**0**	**0**	**0**	**1**
91	**4**	**1**	**3**	**1**	**2**	**5**

Complaints Received		Crown Corporations
2011	2010	
0	**1**	**Agriculture Credit Corporation of Saskatchewan**
1	**0**	**Crown Investments Corporation of Saskatchewan**
12	**7**	**Information Services Corporation of Saskatchewan**
9	**9**	**Saskatchewan Crop Insurance Corporation (SCIC)**
0	**3**	**Saskatchewan Gaming Corporation**
		Saskatchewan Government Insurance (SGI)
36	51	Auto Fund
79	85	Claims Division - Auto Claims
42	47	Claims Division - No Fault Insurance
21	34	Claims Division - Other / SGI Canada
12	8	SGI - Other
190	**225**	**Totals - SGI**
3	**4**	**Saskatchewan Liquor and Gaming Authority**
4	**0**	**Saskatchewan Municipal Board**
1	**0**	**Saskatchewan Research Council**
2	**1**	**Saskatchewan Transportation Company**
11	**4**	**Saskatchewan Watershed Authority**
13	**35**	**SaskEnergy**
50	**66**	**SaskPower**
54	**42**	**SaskTel**
3	**0***	**SaskWater**

* Correction: Following production of the *Annual Report 2010*, it came to our attention that the single complaint for SaskWater was listed in error.

Complaints Closed in 2011

Initial Support	Referral Assistance	Situation Improved	Resolved	Not Resolved	Recommendation Made	Discontinued
0	**0**	**0**	**0**	**0**	**0**	**0**
1	**0**	**0**	**0**	**0**	**0**	**0**
7	**0**	**3**	**2**	**0**	**0**	**2**
3	**1**	**0**	**0**	**0**	**0**	**2**
0	**0**	**0**	**0**	**0**	**0**	**0**
23	1	5	5	1	0	1
53	8	8	2	7	0	11
29	3	4	0	0	0	5
12	1	3	1	1	0	2
6	1	0	1	0	0	0
123	**14**	**20**	**9**	**9**	**0**	**19**
2	**1**	**0**	**0**	**0**	**0**	**1**
0	**0**	**1**	**0**	**0**	**0**	**1**
0	**1**	**0**	**0**	**0**	**0**	**0**
1	**0**	**1**	**0**	**0**	**0**	**0**
5	**1**	**1**	**1**	**0**	**0**	**1**
7	**1**	**1**	**0**	**0**	**0**	**2**
32	**5**	**6**	**6**	**1**	**0**	**2**
22	**4**	**16**	**4**	**5**	**0**	**9**
2	**0**	**0**	**0**	**0**	**0**	**1**

Complaints Received		Commissions
2011	2010	
4	2	**Apprenticeship and Trades Certification Commission**
1	0	**Automobile Injury Appeal Commission**
3	0	**Public Service Commission**
4	0	**Saskatchewan Financial Services Commission**
6	9	**Saskatchewan Human Rights Commission**
37	35	**Saskatchewan Legal Aid Commission**
2	4	**Saskatchewan Public Complaints Commission**
1	0	**Saskatchewan Teachers' Superannuation Commission**

Complaints Received		Agencies and Other Organizations
2011	2010	
1	0	**Saskatchewan Assessment Management Agency**
2	2	**Saskatchewan Cancer Agency**
0	3	**Saskatchewan Institution of Applied Science and Technology (SIAST)**

Complaints Received		Totals - All Categories
2011	2010	
2,160	2,129*	

* Correction: The *Annual Report 2010* listed a total of 2,130 complaints, but this has been corrected to 2,129.

Complaints Closed in 2011

Initial Support	Referral Assistance	Situation Improved	Resolved	Not Resolved	Recommendation Made	Discontinued
0	1	1	1	0	0	0
0	0	0	0	0	0	2
3	0	0	0	0	0	0
0	0	0	1	0	0	2
4	1	0	0	0	0	0
31	2	1	1	0	0	3
1	0	0	0	2	0	1
0	0	0	0	0	0	1

Complaints Closed in 2011

Initial Support	Referral Assistance	Situation Improved	Resolved	Not Resolved	Recommendation Made	Discontinued
0	0	0	0	0	0	0
0	0	0	0	0	0	1
0	1	0	0	0	0	0

Complaints Closed in 2011

Initial Support	Referral Assistance	Situation Improved	Resolved	Not Resolved	Recommendation Made	Discontinued
1,259	177	281	195	58	16	176

Budget

		2009 - 2010	2010 - 2011	2011 - 2012*
Budgetary Expenditures				
	Personal Services	$1,562,600	$1,630,300	$2,120,000
	Contractual Services	$289,500	$282,500	$490,000
	Advertising, Printing & Publishing	$28,400	$23,400	$37,100
	Travel & Business	$38,000	$39,200	$66,400
	Supplies & Services	$8,000	$10,400	$18,100
	Capital Assets	$24,000	$34,500	$45,400
	Budgetary Total	**$1,950,500**	**$2,020,300**	**$2,777,000**
Statutory Expenditures				
	Personal Services	$194,550	$203,000	$202,000
	Statutory Total	**$194,550**	**$203,000**	**$202,000**
Total (Budgetary and Statutory)		**$2,145,050**	**$2,223,300**	**$2,979,000**

*Due to the timing of this report, the 2011 - 2012 numbers reflect the budgeted amount rather than the actual.

Staff

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Ombudsman

Gordon Mayer
General Counsel

Janet Mirwaldt
Deputy Ombudsman

Brian Calder
Assistant Ombudsman

Sherry Davis
Assistant Ombudsman

Jaime Carlson
Assistant Ombudsman

Kelly Chessie
Assistant Ombudsman

Arlene Harris
Assistant Ombudsman

Aaron Orban
Assistant Ombudsman

Carol Spencer
Complaints Analyst

Leila Dueck
Director of Communications

Debra Zick
Executive Administrative Assistant

Azteca Landry
Administrative Assistant
(permanent part-time)

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Connie Braun
Assistant Ombudsman

Jeff Cain
Assistant Ombudsman

Sherry Pelletier
Assistant Ombudsman

Karen Topolinski
Assistant Ombudsman

Rob Walton
Assistant Ombudsman

Barbara Schindel
Complaints Analyst

Diane Totland
Complaints Analyst

Kathy Upton
Complaints Analyst (term)

Lynne Fraser
Manager of Administration

Michelle Baran
Administrative Assistant

Ryan Kennedy
Administrative Assistant (permanent part-time)

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