# **Ombudsman Saskatchewan** Annual Report 2016



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April 2017

The Honourable Corey Tochor Speaker of the Legislative Assembly Province of Saskatchewan Room 129, Legislative Building 2405 Legislative Drive Regina, Saskatchewan S4S 0B3

Dear Mr. Speaker:

In accordance with subsection 38(1) of *The Ombudsman Act, 2012*, it is my duty and privilege to submit to you the forty-fourth annual report of Ombudsman Saskatchewan for the year 2016.

Respectfully submitted,

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Mary McFadyen Q.C. OMBUDSMAN

# Vision, Mission, Values and Goals

Ombudsman Saskatchewan also serves as the Office of the Public Interest Disclosure Commissioner. Our vision, mission, values and goals reflect our dual role:

### Vision

Our vision is that government is always accountable, acts with integrity, and treats people fairly.

### **Mission**

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

### Values

We will demonstrate in our work and workplace:

- fairness, integrity and accountability
- independence and impartiality
- confidentiality
- respect
- competence and consistency

# Goals

Our goals are to:

- Provide effective, timely and appropriate service.
- Assess and respond to issues from a system-wide perspective.
- Undertake work that is important to the people of Saskatchewan.
- Demonstrate value to the people of Saskatchewan by making recommendations that are evidence-based, relevant and achievable.
- Be experts on fairness and integrity.
- Educate the public and public servants about fairness and integrity.
- Have a safe, healthy, respectful and supportive work environment.

# **Ombudsman's Message**

Ombudsman Saskatchewan was busy in 2016. We received 4,406 complaints, 3,419 of which were about provincial and municipal government entities and issues within our jurisdiction. This marked an increase of almost 22% over complaints from 2015 and an increase of 48% over 2014.

Some of this increase is due to our new jurisdiction in the municipal sector. 2016 marked the first full year in which we could take complaints about Saskatchewan's 780 cities, towns, villages, resort villages, rural municipalities, northern municipalities, and their council members. We received 506 municipal complaints, which were generally about administrative matters and/or council member conduct. This accounted for 15% of the complaints within our jurisdiction received in 2016. The remaining 85% were about provincial government ministries, agencies, Crown corporations and health entities. In general, the number of complaints we received concerning most provincial entities remained steady, but we did see an increase in complaints about Corrections and Social Services.

We have successfully met the challenge of addressing this influx of complaints. We resolve most complaints informally through appropriate referrals, coaching, facilitated communication, diplomacy and mediation. If a complaint cannot be resolved informally, we can investigate and make recommendations aimed at correcting the issues we uncover. In 2016, we made 25 recommendations to nine government entities. We have summarized these investigations in this annual report.

We are pleased to highlight the work we have completed throughout 2016 in this annual report. We have made some changes to the way we present our case work – demonstrating our achievements in six main categories: Corrections, Social Services, Municipalities, Health, Crown Corporations, and Other Ministries and Entities.

In 2017, we will continue outreach efforts to communities across the province. It is important that all citizens know that Ombudsman Saskatchewan is here to help, free of charge – that there is a place they can turn to if they feel they have not been treated fairly when receiving government services.

Lastly, I also want to acknowledge the staff at Ombudsman Saskatchewan. They are hard-working, and dedicated to fairness and to helping complainants. I am honoured to have the opportunity to work with all of them. It is important to have that kind of commitment to the citizens of Saskatchewan and to promoting and protecting fairness in government services.



Mary McFadyen, Saskatchewan Ombudsman



When individuals believe a provincial or municipal government entity has been unfair to them, they are often able to raise the issue themselves and work out a resolution with the office involved - but sometimes resolutions do not come about so easily. Policies may be applied too rigidly, clear explanations may be lacking, and people on both sides may stop listening to one another.

When people contact us, we listen and try to find out, as soon as possible, whether we can take the complaint. If we can't, we refer the person to the most appropriate place. For example, a person came into our Office whose permit to work in Canada had recently been renewed, but with an error that could cause her to lose her job. Since this was a federal matter, it was not a complaint we could take, but we provided her with assistance to reach someone within the federal government who could help her.

For complaints within our jurisdiction, we often provide initial support. For example, we may refer people back to the government entity to try to work it out with them or to appeal the decision. If they receive a final decision and still think it is unfair, there may be a role for our Office. Whenever possible, we use our early resolution process to resolve problems informally. If that doesn't work or would not be appropriate, we may assess the file for investigation. Following an investigation we will determine whether to make recommendations to the government entity. For an overview of this process, see our flowchart on the next page.

The rest of this section provides complaint examples and statistics for 2016. These are sorted by organization type and demonstrate the kinds of complaints people brought to us and the ways we resolved them.

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

# **Our Complaint Process**



# Corrections

## **Complaints Received**

MINISTRY OF JUSTICE, CORRECTIONS AND POLICING	2016	2015	2014
Pine Grove Correctional Centre	84	53	42
Prince Albert Correctional Centre	156	110	130
Regina Correctional Centre	341	351	236
Saskatoon Correctional Centre	320	256	166
White Birch Female Remand Centre	8	7	11
White Spruce Provincial Training Centre	5	2	n/a
Adult Corrections – Other	10	14	13
Corrections & Policing – Other	8	13	3
TOTAL	932	806	601

Complaints about Corrections have increased by 55% in the last two years. More than 25% of Corrections complaints in 2016 were about medical concerns. Other complaints included security ratings and unit placements, charges and discipline, cell conditions, transfers, staff conduct, funeral passes, telephones, property, and access to programming.

## **Case Examples**

Investigation



### LIVING CONDITIONS Saskatoon Correctional Centre

Living conditions at the Saskatoon Correctional Centre received media attention in the summer of 2015. Inmates wrote an open letter to the media, describing the living conditions as inhumane, and stating that these conditions and the increased violence at the facility were a result of overcrowding. We also received complaints, and decided to investigate. We assessed the physical living conditions, and whether the conditions we observed met reasonable standards.

We focused our investigation on the secured living areas of the main building including the dormitories, gymnasium and the specialized living units (medical, secure, and holding). Overall, we found the cleanliness, maintenance and repair of these areas was lacking, particularly in the specialized living units. The Ministry of Justice, Corrections and Policing has an operating agreement with the Ministry of Central Services under which they share responsibility for repairing, maintaining and cleaning adult correctional facilities. Both ministries are to have clear standards and communication protocols for scheduling maintenance and repairs in secured areas. As for cleaning, Central Services is responsible for cleaning all non-secure areas and the medical unit, and Corrections is responsible for cleaning all the other secure areas. Both ministries are to meet basic cleaning standards. But the agreement only includes specific, detailed cleaning standards for Central Services to meet. There are no specific cleaning standards that Corrections must meet.

We also reviewed accommodations, beds and bed space, and access to toilets and showers. Corrections told us that it has no uniform definition of an individual bed space. It has historically met and continues to meet the demand for bed space by double-bunking inmates or adding beds to the dormitories. We saw inmates using mattresses on the floor in the medical, holding, secure and remand units, and the dormitories. Corrections told us this was temporary. For the most part, inmates in dormitories and living units had access to toilets and showers that are somewhat private and isolated from the common living areas. However, inmates double-bunked in cells, including specialized unit cells with toilets, had no privacy. In some cells, there is minimal space between where inmates sleep or eat and where they use the toilet. Inmates in the specialized living units told us they spend the bulk of their day in these cramped living conditions.

Before we issued notice of our investigation, Corrections had developed a workplan to address issues in the holding and medical units. During our investigation, it made some progress, which it has told us will continue in 2017, including putting in new flooring, doing repairs, cleaning, and painting. In 2016, it bought better quality temporary beds, so inmates do not have to sleep on mattresses on the floor when the centre's population exceeds capacity. It also added a shower, sink and a urinal to one of the dormitories in the main building.

For the most part, the Saskatoon Correctional Centre has run at or over its operational capacity since it opened 35 years ago. While Corrections does not have control over how many people are remanded, or sentenced to serve time in a provincial correctional centre, it does have control over the operation of these correctional centres. In our opinion, Corrections should establish minimally acceptable standards for inmate accommodations, beds/mattresses, privacy and the use and availability of toilets and showers – and it should ensure these standards are met. In establishing these standards, Corrections should consider the *United Nations Standard Minimum Rules for the Treatment of Prisoners*. Also known as the Nelson Mandela Rules, these are generally accepted practices for the treatment of prisoners and include rules about cleanliness, sleeping accommodations and beds, sanitary conditions, heating, cooling and ventilation, and lighting. We made four recommendations.

### Recommendations

1. The Ministry of Justice, Corrections and Policing, establish and implement reasonable, detailed standards for the physical living conditions at each of its adult secure correctional centres, including cleanliness, maintenance and repair standards.

#### Status: Accepted

 The Ministry of Justice, Corrections and Policing, establish and implement a system of regular inspections to ensure each of its adult secure correctional centres is complying with its standards for physical living conditions.

#### Status: Accepted

3. The Ministry of Justice, Corrections and Policing, in collaboration with the Ministry of Central Services, review and update the Operating Agreement to ensure it clearly and in sufficient detail articulates each party's responsibility to operate, manage, maintain, repair and clean each adult secure provincial correctional centre to the Ministry's standards for physical living conditions at the centre.

#### Status: Accepted

4. The Ministry of Justice, Corrections and Policing should ensure the Ministry's standards for physical living conditions are widely communicated and fully understood by all staff directly responsible for completing work (maintenance, repair, cleaning, etc.) to the standards or for supervising inmates who are responsible for completing the work.

#### Status: Accepted

Corrections has advised us that the operating agreement is currently under review and is being updated. Corrections will work with Central Services to establish and implement reasonable, detailed standards for the physical living conditions at each of the adult secure correctional centres, including cleanliness, maintenance and repair standards. This will be done during the 2017/18 fiscal year. Corrections will also establish and implement a system of regular inspections to assess compliance with the physical living condition standards for each of its adult secure correctional centres. Regular inspections will be implemented in the fiscal year 2018/2019. In the interim, unit supervisors will monitor cleanliness and the need for painting and repairs within their units, and Central Services' maintenance supervisor will tour the correctional centre on a weekly basis looking for any maintenance, infrastructure or repairs issues. Corrections also confirmed that it will implement a communications strategy for staff responsible for maintenance, repair, cleaning, etc. to ensure the operating agreement is being followed and the standards are being met.

### **11 DAYS TOO MANY** Prince Albert Correctional Centre

Luke believed he had served his sentence and was to be released, but staff told him that he was not to be released for 11 more days. He asked if they could confirm this and they told him they did. He did not think this was correct and called us.

We contacted Sentence Management at the Ministry of Justice and officials reviewed Luke's court records. The calculation was complex, but they found that Luke was right. He was released the same day.

Status: Resolved

### DID HE DO IT? Regina Correctional Centre

Some graffiti was found scratched on the outside of the window of several cell doors, including Keith's. He received an institutional charge for the damage to his cell door. He said he did not do it, but was found guilty and was charged \$350 to replace the window. The money was withdrawn from his inmate account, which meant he could not transfer some of it to his Telmate account for making phone calls. He wrote to the Director of the correctional centre to appeal the decision, but the decision did not change, so he called our Office.

We contacted the correctional centre. The paperwork for the decision said that Keith had been inside his cell at the time of the incident. The reasoning behind the decision was that, even if he didn't make the graffiti, he should have reported who did.





Early Resolution

When we reviewed the decision in light of the regulations, we found that the decision should have been based on satisfying, on a balance of probabilities, that Keith committed the offence. If he was inside his cell, he could not have made graffiti on the outside of the door. We raised this point, and the decision was reversed.

Status: Resolved

**Early Resolution** 



### POLICY REVIEW: USE OF PEPPER SPRAY Ministry of Justice, Corrections and Policing

Following an incident where an inmate was pepper sprayed during a cell extraction, we looked at Corrections' policy and local procedural directives for the use of pepper spray in the four adult correctional centres.

Corrections had already started an internal review of its use of force policy, and was receptive to our investigation. Corrections audited the use of pepper spray in the four correctional centres. It also updated and standardized its provincial policy and all local directives concerning the use of force in correctional centres. Our Office provided input into the updated directives and policies.

Inmates can file a complaint with the Director of the correctional centre, if they feel they have been subjected to excessive use of force. We determined that there was not a process in place so that inmates who felt that their complaints about excessive use of force were not properly reviewed by the Director, could have those decisions reviewed by a higher authority. After our intervention, Corrections agreed that inmates would now be able to have such decisions reviewed by the Executive Director of Adult Custody. Corrections has advised us that this option will now be included in all Director's decision letters, so that inmates are aware of this additional review process.

These updated policies and directives should provide for a more consistent approach – for when and how pepper spray should be used, and for the way incidents are documented and reviewed within the Ministry, and give inmates the opportunity to have these decisions reviewed by an authority outside of the correctional centre.

### **TESTING POSITIVE... BUT WHAT DOES IT MEAN?**

Lucas contacted our Office because he disagreed with a discipline charge he had received at a correctional centre. He was part of a group of inmates that had been given a urinalysis test. None of the others tested positive for THC (which would indicate marijuana use), but Lucas did. As a result, he went before a discipline panel, which found him guilty. He was placed in segregation and denied telephone use and his future programming was affected.

Lucas told us that he had recently been admitted to the centre and that he had used marijuana before then, but not since. He had appealed the panel's decision, but his appeal was denied. The denial letter said that THC stays in a person's system for 21 days and the test had been taken after that period had passed.

The letter was in keeping with a policy for urinalysis testing in correctional facilities. The policy provides a schedule that indicates how long different types of intoxicants remain in a person's system. For cannabinoids like THC, the time listed was 21 days. Lucas had been tested 28 days after being admitted.

We contacted the Saskatchewan Disease Control Lab, which told us cannbis could be detected for up to a month after consumption and that this was especially true of chronic use.

We discussed this information with Corrections officials and they agreed to change the policy schedule to indicate that cannabinoids stay in the system for 30 days.



# **Social Services**

## **Complaints Received**

MINISTRY OF SOCIAL SERVICES		2015	2014
Child & Family Services	139	117	83
Housing	59	62	70
Income Assistance & Disability Services Division - Community Living Service Delivery	9	9	5
Income Assistance & Disability Services Division - Saskatchewan Assured Income for Disability	145	126	126
Income Assistance & Disability Services Division - Saskatchewan Assistance Program	385	410	383
Income Assistance & Disability Services Division - Transitional Employment Allowance	104	54	39
Income Assistance & Disability Services Division - Income Supplement Programs - Other	25	26	18
Social Services - Other	3	10	7
TOTAL	869	814	731

### **Case Examples**

**Early Resolution** 



### **TIME TOGETHER**

Income Assistance & Disability Services Division - Saskatchewan Assistance Program

Ken told us that a family member was in hospital and had been given about a week to live. He lived in a different community, but came to the city to be with her. He had no money for a hotel, transportation, or extra food, so he asked his social worker for additional benefits. The same thing had happened a few months earlier with the same family member. That time his request was approved, but this time it was denied.

Ken contacted our Office and said that his worker told him he could only use this benefit once. We contacted the supervisor, who confirmed this and told us Ken had received the maximum amount earlier and could not receive it again. We contacted a senior official to learn more about the intent of the policy related to visiting a family member with a life-threatening illness. The official checked and told us that in a situation like Ken's where the new request was a separate event from a previous request, then the benefit could be issued again. She said she would talk to the manager and supervisor to ensure Ken's request was approved.

### HELP MOVING TO A NEW JOB Income Assistance & Disability Services Division - Transitional Employment Allowance



After Lily was released from a correctional centre, she went on the Transitional Employment Assistance (TEA) Program, then found a job and left the program. She then found a better paying job and started working there, but was fired. She contacted Social Services to see if she could go back on some form of assistance, but was told she could not because she had been fired. About a month later, she found a job in another community, but did not have the money to move there and get started. She called Social Services to see if she could get help with travel expenses, but was told that she could not.

She called us to see if we could help. We contacted Social Services, explained Lily's situation, and were told that there was a benefit that would apply. Lily was then offered a relocation allowance for her travel expenses and a job-start grant to help with clothing required at her new workplace.

Lily told us this would help her to move forward and that she was excited about starting her new job.

Status: Resolved

### I WANT TO STAY OUT OF JAIL Income Assistance & Disability Services Division - Saskatchewan Assistance Program

Lorne was released from a provincial correctional centre under specific conditions, one of which was that he must return to his community and find approved housing by 5:00 p.m. the next day. In order to accomplish this, he was told to contact the Ministry of Social Services for emergency funding. When he was unable to get through to the call centre, he contacted our Office. He said that he had tried all day the day before, but kept receiving the "high call volume" message. He now had a few hours to find a place to live or he would be in violation of his release conditions.

We contacted an official at Social Services to explain Lorne's situation. She arranged for Lorne to receive the benefits he needed so he could secure housing. In addition, she made arrangements for him to begin receiving assistance due to a health condition.



The official told us that Social Services had set up a new process with some correctional centres. Applicable inmates are provided a "soon to be released" application, which is sent to Social Services for assessment so arrangements for housing and other benefits can be made ahead of time. She said that she would check with the centre Lorne was in to see if they could set up the same process there.

Status: Resolved

**Early Resolution** 



### A CHANCE TO HEAR AND BE HEARD Housing Authority

Kyla had a rental disagreement with a local housing authority and was evicted. She was homeless for a time, then began renting from a housing authority in a different community. She then received a letter from the first housing authority that said that she still owed about \$2,500: \$500 in rent and \$2,000 in other fees, including the costs of hearings with the Office of Residential Tenancies (ORT), the cost of having the sheriff remove her belongings, and cleaning costs. The letter offered a payment arrangement and asked her to agree to the terms.

Kyla contacted our Office. She told us that she did not believe she owed any back rent and that the way her property had been disposed of was unfair. She also told us that she had not received the results of the ORT hearings. The ORT told us that this was likely, since they did not have any new contact information for her. We arranged for Kyla to receive copies of the ORT hearing results, and we facilitated a meeting between her and a housing authority official. She and a support person were able to fully explain her situation and the housing authority was able to share its records with her. Even though there were some gaps in their documentation, they were able to pinpoint the time period for the rent they believed Kyla still owed. Now that she understood their reasoning, she agreed that she probably did owe the \$500 rent. For their part, the housing authority staff realized how Kyla had been treated during the eviction process. They apologized to Kyla, wrote off the fees and other costs associated with the eviction, and offered to collect the \$500 rent through a payment plan.

### FIGURING OUT RENT AND FURNITURE Income Assistance & Disability Services Division - Saskatchewan Assistance Program



Kaelyn came to our Office with two concerns about social assistance. First, she had requested a grant for furniture and was denied. She said she had not asked for a furniture grant before and that she had no bed. She said the verification worker came to her apartment, but did not ask very many questions. Second, she said that she had come to our Office in 2015 when she was at risk of being evicted because a previous roommate had moved out without paying his share of the rent. We had contacted Social Services and they had covered the arrears. She was later charged an overpayment which she believed may have been in relation to that– but she wasn't sure.

First, we called Social Services about the furniture grant and were told that the verification worker had reported the suite was furnished, but that Kaelyn had no bed, and that she had been unwilling to answer questions about when she last had a bed or dresser. She told us she had not refused to answer these questions. We put her on the phone with Social Services so she could explain her needs and also hear the explanation for the decision. She was eventually approved for a dresser and bed.

Second, we checked with Social Services and learned that the overpayment was for the rent her roommate had not paid. Her worker reviewed the policy and found that it provided the ability to allow excess shelter for changes in circumstances which are beyond the client's control, for a specific period. As a result, she reversed the overpayment and refunded the amount that had already been collected.

# **Municipalities**

### **Complaints Received**

	2016	2015*	2014
MUNICIPALITIES			
Cities	114	6	n/a
Towns	94	5	n/a
Villages	82	7	n/a
Resort Villages	35	2	n/a
Rural Municipalities	156	10	n/a
Northern Municipalities	18	3	n/a
Other / Not Disclosed	7	0	n/a
TOTAL	506	33	N/A

\*The Ombudsman received jurisdiction to take complaints about municipalities on November 19, 2015.

Since November 19, 2015, the Ombudsman has had jurisdiction over all 780 municipalities in the province. The Ombudsman may investigate complaints about cities, towns, villages, resort villages, rural municipalities and northern municipalities, including their councils, council committees, controlled corporations and other bodies established by a council. The Ombudsman may also investigate complaints about the actions and decisions of council members, including complaints about council members' conflicts of interest or contraventions of a code of ethics. There are approximately 3,700 municipal council members in Saskatchewan. Depending on the type of municipality, municipalities and their council members are subject to *The Cities Act, The Municipalities Act, or The Northern Municipalities Act, 2010*.

Of the 539 complaints we received about municipalities since November 19, 2015, about one third were about the conduct of council members, including conflicts of interest. We completed three conflict of interest investigations in 2016, the results of which were made public in early 2017. We took this opportunity to remind council members of the importance of knowing and following the rules for conflict of interest situations.

Other complaints we received included a wide variety of administrative matters, many of which were addressed using our early resolution processes.

## **Case Examples**

### **CONFLICTS OF INTEREST**

The Ombudsman investigated allegations from two municipalities that council members had conflicts of interest in matters before their councils and did not take the steps required of them to deal with the conflict of interest as set out in *The Municipalities Act*.



One case involved the decision of the Village of Manor to sell to the then-mayor's son public land that had been gifted to the Village and used as a rest stop, picnic site and campground for over 30 years. We found that the Village sold the land without giving public notice, contrary to its own bylaw under which it was required to give public notice before it sold any municipal land, and contrary to *The Municipalities Act*, which also requires public notice to be given before a municipality disposes of land used for park purposes. We also found that the mayor did not declare a conflict of interest and take the steps required to deal with the conflict as required by *The Municipalities Act*. Since the mayor was not re-elected in 2016, we did not recommend that the council take steps to have the mayor disqualified from council. We did recommend, however, that the village pass a bylaw so allegations of conflict of interest can be properly addressed at the local level. A full copy of our public report can be found on our website under Public Reports.

The other case involved the RM of Sherwood. At a January 13, 2016 council meeting, the council heard from a delegation and discussed a motion that Sherwood should take steps to recover legal fees that it had reimbursed to several council members for legal fees incurred during the Barclay Inquiry. The legal fees had been reimbursed under a bylaw that was later determined by the courts to be invalid. Two council members who had their legal fees reimbursed were present at the meeting. We found that the two council members had a conflict of interest, because they had a financial interest in not having to pay back the money. We found that by not declaring their conflict of interest and leaving the meeting, but instead staying to listen to the delegation, participating in a discussion about whether the motion to seek reimbursement was properly before council, and then voting to table the motion, they did not comply with the conflict of interest rules in The Municipalities Act. One council member did not run for re-election in 2016. The other council member was still on the council, so we recommended that the council, at its next regular meeting, vote on whether to apply to the court for an order declaring the council member to be disqualified from the council. A full copy of the public reports can be found on our website under public reports.

**Early Resolution** 



### **CHECKING THE PROCESS**

Kegan contacted us with concerns about the way his municipal council was handling a proposed development project. He was against the development and had started a petition. A number of people signed the petition and Kegan took the matter to council. The council then voted not to proceed with the development.

Although Kegan got the end result he wanted, he did not think that the council had handled the process correctly. We looked at the requirements in *The Municipalities Act* and the municipality's bylaws. We also checked the minutes of meetings, which the municipality had published on its website. We found that it had followed the Act and its policies in responding to the petition and that its decisions were clearly documented and accessible on its website.

Status: No Further Action

**Early Resolution** 



### LOST AND FOUND

Kim contacted us about a situation with her municipality. She told us she had an agreement in place for her tax payments, and had then encountered more financial problems. In trying to deal with her finances, she needed to provide a third party with a copy of the agreement. She had lost her copy, so asked the municipality if it could provide one, but was told that its copy was also lost. Later, the municipality sent Kim an enforcement letter, which quoted from the agreement.

She said that she had talked to the municipality and asked how they could quote from a lost agreement. The conversation had not gone well and Kim's relationship with the municipality had deteriorated. We said that we would see if there was a role for our Office.

We inquired with the administrator who confirmed that the agreement had been lost until recently, just before the letter was sent. She provided us with copies of the letter and agreement, so we asked if a copy of the agreement could also be sent to Kim and her spouse. She agreed and mailed it to them.

### WATER DISCONNECT

Leslie contacted us because her water had been cut off. She told us that Social Services had been paying her water bills and she did not know that the bills had been unpaid for two months. She contacted Social Services and a worker sent the municipality an email stating that Social Services would pay the bill. When the water was still not connected, Leslie contacted Social Services a second time and was told that a second email would be sent. When she contacted Social Services again to say that the water had still not been turned back on, she was told that they had done all they could. Leslie was concerned because she had two infants at home and needed water to care for them.

We contacted Social Services to confirm the emails had been sent and we contacted the municipality. The municipality said the emails had not been received, but the collections manager reviewed the file and decided to reconnect the water.



# Health

# **Complaints Received**

HEALTH MINISTRY, AUTHORITIES	2016	2015	2014
AND AGENCIES			
MINISTRY OF HEALTH			
Drug Plan and Extended Benefits	17	12	21
Health - Other	19	23	18
TOTAL - MINISTRY OF HEALTH	36	35	39
SASKATCHEWAN CANCER AGENCY	0	1	0
REGIONAL HEALTH AUTHORITIES			
Athabasca Regional Health Authority	0	0	0
Cypress Regional Health Authority	4	3	2
Five Hills Regional Health Authority	8	13	9
Heartland Regional Health Authority	5	3	1
Keewatin Regional Health Authority	2	0	1
Kelsey Trail Regional Health Authority	7	4	2
Mamawetan Churchill River Regional Health Authority	2	2	2
Prairie North Regional Health Authority	9	8	6
Prince Albert Parkland Regional Health Authority	13	3	11
Regina Qu'Appelle Regional Health Authority	30	23	25
Saskatoon Regional Health Authority	41	42	25
Sun Country Regional Health Authority	3	5	3
Sunrise Regional Health Authority	17	11	13
TOTAL - REGIONAL HEALTH AUTHORITIES	141	117	100
HEALTH ENTITIES			
in the Cypress Health Region	1	2	0
in the Five Hills Health Region	4	5	2
in the Heartland Health Region	5	7	1
in the Kelsey Trail Health Region	2	0	0
in the Prairie North Health Region	3	2	1
in the Prince Albert Health Region	3	4	1
in the Regina Qu'Appelle Health Region	28	42	10
in the Saskatoon Health Region	34	35	18
in the Sun Country Health Region	0	2	2
in the Sunrise Health Region	11	10	5
TOTAL - HEALTH ENTITIES BY REGION	91	109	40
TOTAL	268	262	179

## **Case Examples**

### **COMMUNICATING WITH CARE** Extendicare Sunset, Regina Qu'Appelle Regional Health Authority

A resident of Extendicare Sunset (Sunset) fell while being assisted by a care aide. She cut her leg and was sent by ambulance to the hospital emergency room (ER). She returned to Sunset a few hours later, but her pain worsened. She was taken back to the ER by ambulance. It was then discovered that her other leg was broken. She returned to Sunset again but died shortly after.

After ten months of working with staff from Sunset and the Regina Qu'Appelle Health Authority (RQHA) to address concerns about their mother's care, the family was dissatisfied with the progress and approached the Minister of Health. The Minister of Health requested that the Ombudsman investigate the matter.

We examined whether the care provided met the standards set by the Ministry of Health, the RQHA and Extendicare. We also considered whether Extendicare and the RQHA acted reasonably and followed established rules and policies when it investigated her death, and when it worked with the family to try and address their concerns.

Based on our findings, we made seven recommendations. All were accepted. These recommendations included that the agencies ensure their policies and standards are followed, that unexpected deaths are promptly investigated, and that processes are developed to ensure complete and accurate communication of information as residents are transferred from facility to facility. The full public report of our findings and recommendations was issued in September 2016 and is available on our website.

### UPDATE: TAKING CARE REPORT Ministry of Health, Regina Qu'Appelle Regional Health Authority, Santa Maria Senior Citizens Home

On May 13, 2015, the Ombudsman issued a public report, *Taking Care* – *An Ombudsman Investigation into the Care Provided to Margaret Warholm at the Santa Maria Senior Citizens Home*. The report included recommendations to improve the quality of care provided by Santa Maria, as well as the oversight and direction provided to long-term care facilities by the Health Authority and the Ministry of Health. The Ombudsman initiated this investigation at the request of the Minister of Health. All 19 recommendations were accepted.





As of the fall of 2016, the entities provided final updates to us on their progress implementing the recommendations. We have asked all three agencies to make this information available on their websites.

Santa Maria has reported to us that it has completed implementation of 13 of our 14 recommendations, and continues to work on improving its organizational culture. The RQHA continues to work with the Ministry to complete its work on our recommendation. The Ministry of Health has reported completing implementation of three recommendations and, while having made significant progress, is still working on the following two:

- 13. That the Ministry of Health implement a publicly accessible reporting process that families can use to see whether each long-term care facility is meeting the *Program Guidelines for Special-care Homes.*
- 19. That the Ministry of Health, in consultation with the health regions and other stakeholders:
  - a. Identify the care needs of current and future long-term care residents.
  - b. Identify the factors affecting the quality of long term care delivery.
  - c. Develop and implement a strategy to meet the needs of long-term care residents and to address the factors affecting the quality of long-term care in Saskatchewan; and make the strategy public.

Investigation



### IF DAD CAN'T TELL ME, CAN YOU? Prince Albert Parkland Regional Health Authority

Levi's father was slapped by an employee while living in a long-term care facility. His father could not explain what happened to him, because of his diminished mental capacity. The health region investigated and wrote to Levi to say that it had disciplined the employee, but it would not tell him who the employee was or what the discipline was. It said, while it would make every effort not to have the employee provide direct care to his father, there may be some proximity during daily events.

Levi, who was legally responsible for his father's affairs and health care, wrote back to express his dissatisfaction. He wanted to be sure his father was safe and he requested information about the incident so he could make informed decisions about his father's care. In response, the health region provided him with some information, but would not disclose the name of the employee or any witnesses to the incident. Levi asked the Information and Privacy Commissioner to review the health region's decision. The Commissioner issued a report making three recommendations, including that the health region consider releasing the employee's name to Levi, but the region chose not to. Concerns about how Levi was treated by the health region regarding the incident were raised with our Office.

We investigated how the health region handles cases of resident abuse in long-term care facilities, including what its obligations are under the Program Guidelines for Special-care Homes and its own policies. It is required to provide an environment that is free from abuse, take appropriate action to ensure the safety of residents, and advise the residents' families of any incidents. It is also required to provide full disclosure of any adverse events affecting a resident, including the facts and an overview of the investigative process. Lastly, if criminal activity is suspected, it is to notify the police. While the health region has to balance the rights of residents against the rights of its employees, in our opinion, the health region did not meet its obligations under the Program Guidelines or its own policies in this case. We concluded that the region should have provided Levi with sufficient information so he could make informed decisions about his father's care. The region's interests in properly dealing with its employee should not have outweighed Levi's interest and right to know what happened to his father.

### Recommendation

 The Regional Health Authority should review and update all its relevant policies and procedures to ensure that in cases of resident or patient abuse, that the resident or patient and his or her personal representatives are given full disclosure of the circumstances of the abuse, including the name of the person or people responsible for the abuse, so the resident or patient and his or her personal representatives can make fully informed decisions about his or her care.

Status: Accepted

### **BUT I DIDN'T CALL AN AMBULANCE**

Leona had vehicle troubles, so she pulled over to the side of the road. She called a friend for help and stayed in the vehicle. While she waited, she fell asleep. Shortly afterwards, she was awakened by emergency services staff. She had not called for emergency help but it seemed a concerned motorist passing by had. Leona refused service and the emergency responders left. About a month later, she received a bill from an ambulance service for about \$400. She called them and was told that the bill was for the ambulance being called out. She said she should not have to pay because she didn't ask for their service. She refused to pay and the bill was sent to a collections agency.



**Early Resolution** 

Leona called to see if there was a role for our Office. We contacted the health region, which confirmed that it does not bill people who did not request an ambulance and then refuse service. However, this ambulance was not run by the health region, but by a local community on a contract with the region. The health region contacted them and they agreed to cancel Leona's bill.

Status: Resolved

**Early Resolution** 



### MANAGING PATIENT FLOW

Lana was caregiver for her brother Kirk, so when he became ill, she called an ambulance. It took him to a local emergency room. After assessing Kirk, the doctor wanted to admit him to the hospital, but there were no empty beds, so the ambulance took him to a hospital in another community.

When the ambulance bill came, it was for both trips. Lana was prepared to pay the bill for the first trip, but did not think it fair that she was being asked to pay for the second. She did not have control over which emergency room he had been taken to, nor had she been made aware that if he needed to be admitted, he would need a second ambulance trip, which she would have to pay for. Had she been advised at the start, she might have asked that Kirk be taken directly to the second hospital. When she could not convince the health region to reverse the second charge, she contacted our Office.

We talked with the health region and with several officials at the Ministry of Health, and heard differing viewpoints about whether a patient should pay the ambulance bill in situations like this. We were concerned that while the system is responsible for managing patient flow and bed availability, this second ambulance bill can be seen to shift the cost for some of those decisions on to the patient or family. In the end, the health region decided to cancel the charge for Kirk's second ambulance trip and recognized the need for further discussions on this topic.

# **Crown Corporations**

# **Complaints Received**

CROWN CORPORATIONS	2016	2015	2014
CROWN INVESTMENTS CORPORATION OF SASKATCHEWAN	1	0	0
eHEALTH SASKATCHEWAN	10	14	8
FINANCIAL & CONSUMER AFFAIRS AUTHORITY	5	9	3
GLOBAL TRANSPORTATION HUB AUTHORITY	2	0	0
PHYSICIAN RECRUITMENT AGENCY OF SASKATCHEWAN	0	1	0
SASKATCHEWAN CROP INSURANCE CORPORATION	7	6	10
SASKATCHEWAN GOVERNMENT INSURANCE (SGI)			
Auto Fund	35	43	35
Claims Division - Auto Claims	79	89	80
Claims Division - No Fault Insurance	38	46	38
Claims Division - Other / SGI Canada	23	34	29
Other	25	17	8
TOTAL - SGI	200	229	190
SASKATCHEWAN LIQUOR AND GAMING AUTHORITY	1	1	1
SASKATCHEWAN TRANSPORTATION COMPANY (STC)	1	3	2
SASKENERGY	46	32	42
SASKPOWER	86	81	84
SASKTEL	39	43	51
SASKWATER	1	0	1
WATER SECURITY AGENCY	12	13	15
TOTAL	411	432	407

Investigation



### **FOLLOWING POLICY**

SGI

Kelvin was interviewed by an SGI claims adjuster after being involved in a car accident. Fifteen days later, he received a letter from SGI advising him that he was restricted from attending SGI offices without first scheduling an appointment. SGI told him this was because he had asked the SGI claims adjuster inappropriate questions during the interview. SGI's letter noted that it has a legal requirement and is committed to ensuring that it provides a work environment that is safe and free from harassment. Kelvin believed that SGI's decision was made unfairly. We decided to investigate.

We found that SGI's harassment policy applied to Kelvin's situation – when an employee has a complaint against a customer. In our opinion, SGI's policy provided a reasonable process for ensuring the complaint against Kelvin was dealt with appropriately, including interviewing all parties involved. However, SGI did not follow its policy in Kelvin's case. Instead, SGI made its decision – imposing restrictions on him - without giving him any opportunity to respond to the complaint made against him. This was unreasonable and unfair.

### Recommendations

 SGI should ensure it follows its Harassment Policy to deal with allegations of harassment made by an employee about a customer, including: (a) maintaining appropriate confidentiality, (b) giving the parties notice that a decision is going to be made and a reasonable opportunity to respond to any adverse findings before finalizing the decision, and (c) providing the parties reasons for the final decision.

### Status: Accepted

2. SGI should ensure the consequences it imposes on a customer who has been found to have harassed an employee are effective and appropriate (not more restrictive than necessary to protect SGI's employees), and are periodically reviewed to ensure they continue to be necessary.

### Status: Accepted

3. In the case of the complainant, SGI should remove the requirement that the complainant must schedule an appointment before attending an SGI office.

Status: Accepted

### HOW DID THEY DECIDE THAT? SGI Auto Claim

Lionel had an auto claim with SGI that was being investigated. Partway through this process, he passed away. About a month later, his mother, Karen, received a letter from SGI stating that the claim was denied. Karen contacted our Office because she disagreed with the decision and she did not think that SGI had provided adequate information about the claim.

We conducted an investigation that looked at two issues: whether the investigation was fair and reasonable, and whether the denial letter was fair and appropriate.

An investigator in SGI's Special Investigations Unit (SIU) had collected information about the claim, including from the police. When the SIU's work was nearing completion, the police charged Lionel with a criminal offence in relation to the claim. At that point, the SIU paused its investigation to await the outcome of the charges. A few months later, Lionel passed away. After that, the police dropped the charges. The SIU then finalized its investigation and issued a report. SGI used the SIU's report to make a decision about Lionel's claim. SGI determined that Lionel had made a false declaration and therefore the claim was denied.

We found that it was reasonable for SGI to wait for criminal proceedings to conclude because the criminal standard of proof is higher than the civil standard of proof. If a conviction had resulted, it would have been good evidence on which SGI could base a decision to deny the claim. Once the charges were dropped, it was reasonable for SGI to use relevant information gathered in the criminal investigation to support the SIU investigation and therefore to use it, in part, to form the basis of its decision to deny the claim. Though it is not certain whether a court case would have resulted in a conviction, we found that SGI's investigation was fair and reasonable.

The denial letter Karen received begins, "Dear Executor" and continues, "As discussed with you by the adjustor..." We found no record of SGI having a discussion with Karen before sending the letter, and the decision to deny the claim was made after Lionel passed away, so this discussion could not have been with him. We found SGI's statement to be inaccurate, and likely the result of relying on a form letter that had not been edited to match the circumstances.



The letter refers to the clause of *The Automobile Accident Insurance Act* that the denial was based on. However, it does not summarize the evidence relied upon, nor does it adequately explain SGI's reasons for denying the claim. It also does not explain the estate's rights to have the decision reviewed or to appeal. Based on this lack of meaningful reasons, we found the letter to be unfair.

Also, the letter was sent shortly after Lionel's death and was addressed to the estate's representative. Even if SGI did not know that Karen was the executor, this role is very often filled by a close family member. Had the letter been more appropriately written, it would not only have answered Karen's questions, but would have been more respectful.

### Recommendation

 SGI denial letters to claimants should, at a minimum, include: (a) a description of the evidence that SGI is relying on; (b) a description of the relevant statutory, regulatory and policy rules SGI considered when assessing the claim; (c) SGI's assessment of the application of the rules to the evidence; and (d) information about the opportunities for claimants to appeal the decision or have it reviewed.

Status: Accepted

Investigation



### **PROCESS FOR REVIEWING DRAINAGE COMPLAINTS** Water Security Agency

A farm couple contacted us about the way the Water Security Agency (WSA) dealt with their complaint about their neighbour's drainage ditches, which they believed were causing their home quarter to flood. They believed the WSA's process took too long, and that it was unresponsive and unfair to them. When the WSA eventually ordered the neighbour to fix the ditches, they believed the order was too difficult to enforce.

The Water Security Agency Act provides a two-stage process for drainage complaints. First, the couple had to submit a written request for assistance. After the WSA conducts a preliminary investigation based on the request, it is to either issue written recommendations for resolving the complaint or dismiss it. The WSA inspected the ditches within 18 days of the couple filing their request, confirming the ditches were illegal. However, it took the WSA almost 13 months to provide its preliminary findings and recommendations. Instead of ordering the neighbour to correct the illegal ditches, the WSA recommended that he take steps to correct them. The neighbour ignored the recommendations, so the couple had to move to the second, formal complaint stage. It took the WSA 6 months to start its formal investigation and over 13 months to order the neighbour to correct the ditches. It then extended the original six-month period for the neighbour to comply with the order for an additional two and half months – without giving the farm couple an opportunity to submit information to show that the extension was not reasonable.

The purpose of the informal request for assistance process is to encourage efficient, early resolution of drainage issues. Even though the WSA's staff were responding to an increase in complaints at the time, we found that the WSA had no policies or procedures to ensure it was able to manage the requests in a timely manner. Equally, we found that the WSA had no administrative processes or policies in place to ensure that the formal investigative process was efficient or effective.

The practical effect of extending the time the neighbour had to comply with the order was that the farm couple's land continued to have flooding. We found that it was unfair for the WSA to grant the extension to the neighbour without first giving the farm couple notice that it was considering the extension, and giving them an opportunity to present their views about it.

Lastly, we found that the WSA proceeded through the informal and formal complaint stages without considering whether it was appropriate for it to simply order the neighbour to bring the ditches into compliance, which it has the power to do. *The Water Security Agency Act* requires anyone constructing certain drainage works to get the WSA's prior written approval. If they don't, the WSA can order the works to be altered or removed. Even though the WSA determined the neighbour's ditches had not been properly approved just 18 days into the informal request for assistance process, it did not consider making an order until the end of the formal process some 26 months later.

Based on our findings in this case, we made six recommendations – five aimed at improving the WSA's processes and one aimed at improving fairness for the farm family who made the complaint. For a more detailed account of this case, see the recommendation report, which was published on our website in 2016. **Early Resolution** 



### **WHO CAN ACCESS A DEATH CERTIFICATE?** eHealth Saskatchewan

Kent had three sisters who passed away within a few weeks of each other, leaving him as the last surviving family member. He obtained death certificates for two of his sisters, but was having difficulty getting a death certificate for his sister Lauren. Lauren had lived in Saskatchewan and had died without a will. Kent requested her death certificate, provided additional documentation, and was told that his request was being reviewed. When he did not hear back from eHealth, he called our Office.

After he contacted us, eHealth told him that his request had been refused. We looked at *The Vital Statistics Act, 2009* and *The Vital Statistics Regulations, 2010*. They were very specific about who could be provided a death certificate (spouses, parents and adult children, for example) and did not allow for discretionary decisions. As a result, even though Kent was Lauren's brother and last surviving relative, this alone did not qualify him to obtain her death certificate. Kent was eventually able to obtain it by going through the courts.

Meanwhile, eHealth told us that amendments to the Act were in process that could make it possible for a death certificate to be provided in exceptional cases like Kent's.

# **Other Ministries and Entities**

# **Complaints Received**

MINISTRIES	2016	2015	2014
ADVANCED EDUCATION	8	12	9
AGRICULTURE	14	6	1
CENTRAL SERVICES	1	2	2
ECONOMY	12	4	14
EDUCATION	5	5	5
ENVIRONMENT	14	12	4
EXECUTIVE COUNCIL	1	0	0
FINANCE	4	4	5
GOVERNMENT RELATIONS			
Public Safety	3	1	10
Government Relations - Other	1	4	1
TOTAL - GOVERNMENT RELATIONS	4	5	11
HIGHWAYS AND INFRASTRUCTURE	16	8	18
JUSTICE (OTHER THAN CORRECTIONS)			
Court Services	18	20	13
Maintenance Enforcement Branch	34	41	34
Public Guardian and Trustee	19	11	12
Office of the Public Registry Administration	3	3	1
Office of Residential Tenancies / Provincial Mediation Board	58	50	47
Justice - Other	21	19	17
TOTAL - JUSTICE (OTHER THAN CORRECTIONS)	153	144	124
LABOUR RELATIONS AND WORKPLACE SAFETY	15	28	26
PARKS, CULTURE AND SPORT	2	3	1

BOARDS	2016	2015	2014
AGRICULTURAL IMPLEMENTS BOARD	1	0	0
FARMLAND SECURITY BOARD	0	1	1
HIGHWAY TRAFFIC BOARD	5	9	3
LABOUR RELATIONS BOARD	0	1	2
LANDS APPEAL BOARD	0	0	2
SASKATCHEWAN MUNICIPAL BOARD	1	1	0
SASKATCHEWAN PENSION PLAN BOARD OF TRUSTEES	0	0	1
SASKATCHEWAN SOCIAL SERVICES APPEAL BOARD	3	8	6
SOCIAL SERVICES REGIONAL APPEAL COMMITTEES	0	1	2
SURFACE RIGHTS ARBITRATION BOARD	0	1	(
WORKERS' COMPENSATION BOARD	88	126	98
COMMISSIONS			
APPRENTICESHIP AND TRADES CERTIFICATION COMMISSION	2	0	4
AUTOMOBILE INJURY APPEAL COMMISSION	4	1	3
PUBLIC SERVICE COMMISSION	3	1	1
SASKATCHEWAN HUMAN RIGHTS COMMISSION	8	19	14
SASKATCHEWAN LEGAL AID COMMISSION	44	42	2
SASKATCHEWAN PUBLIC COMPLAINTS COMMISSION	11	11	3
TEACHERS' SUPERANNUATION COMMISSION	0	1	1
AGENCIES AND OTHER ORGANIZATIONS			
CONEXUS ARTS CENTRE	0	0	1
EMPLOYMENT ACT ADJUDICATORS	0	2	(
SASKATCHEWAN ASSESSMENT MANAGEMENT AGENCY (SAMA)	4	1	1
SASKATCHEWAN POLYTECHNIC	8	6	(
TECHNICAL SAFETY AUTHORITY OF SASKATCHEWAN	2	1	(
TOTAL: OTHER MINISTRIES AND ENTITIES	433	466	394

## **Case Examples**

### **THE RULES ABOUT RESTRICTIONS** Ministry of Central Services

We received a complaint from an individual who had been given restrictions about entering a particular government building. While we did not investigate that decision, we did investigate the process Central Services uses to prohibit and restrict individuals from public buildings.



We found that the policy needed more details about how to administer this process fairly.

### Recommendation

- 1. We recommend that the Ministry of Central Services rewrite its Notice Prohibiting Entry policy to ensure that:
  - Individuals are given reasonable notice that the Ministry is considering prohibiting or restricting them from a public building, a reasonable opportunity to respond to the information being relied on to make the decision, and an opportunity to correct their behaviour.
  - Any prohibition or restriction of an individual is reasonable in the circumstances of each case, is for a reasonable period, and is subject to review periodically and being lifted early in appropriate circumstances.
  - Each written notice of prohibition or restriction is clearly worded to address the specific circumstances, includes meaningful reasons for the decision to prohibit or restrict them, and explains the individual's opportunities to have the decision reviewed.

Status: Accepted

Investigation



### **COMPARING RULES** Ministry of Government Relations

About two years after Lyle had retired from a senior position at the Ministry, he bid on a request for proposal (RFP). It stated that submissions from current or former officials who had resigned or retired less than five years earlier would not be considered. Based on this rule, Lyle's proposal was screened out. Lyle contacted our Office to complain about this process.

We reviewed several other government policies and legislation related to avoiding conflicts of interest during a procurement process. We found that it was appropriate to exclude current employees from competing for ministry contracts in order to avoid the appearance of conflict of interest. However, other government policies and legislation only set a 12-month waiting period for those who had recently retired or resigned. We found that the Ministry's five-year restriction was not in keeping with government procurement standards.

### Recommendation

1. The Ministry should develop and implement a policy that specifically addresses the rationale for excluding former employees from submitting tenders, proposals or quotations in response to all competitive procurement processes used by the Ministry, including establishing a reasonable time period after their employment ceases during which they would be ineligible to submit tenders, proposals or quotations, and a process to justify and document deviations from this standard in exceptional circumstances.

Status: Accepted

Investigation



### **WEIGHING THE EVIDENCE** Workers' Compensation Board

Louise did not think it was fair that the Workers' Compensation Board (WCB) Appeal Tribunal denied her claim for benefits. She had felt a "pop" followed by severe pain while at work. She finished her shift that day, doing only light tasks. The next day, still in pain, she reported the incident to her employer, who told her to take it easy and do only light tasks. She finished her shift then rested over the weekend, hoping she would get better. She again worked light duties on the next Monday, but by the end of her shift, her pain was still severe, so she went to the emergency room. She was diagnosed and went on sick leave. Her employer then reported her injury to the WCB.

The WCB's Operations division and then its Appeals Department denied her claim because the type of injury she had was not usually associated with feeling a "pop", so she could not have gotten the injury at work. She appealed to the WCB Appeal Tribunal. The Tribunal also rejected her claim. Its decision stated that there was no evidence that her disablement from work was a direct result of her work activity that day, in part because she continued to work and significantly delayed seeking medical treatment.

We found that it was unfair for the Tribunal to deny Louise's appeal. There was evidence explaining why she did not seek medical attention immediately. Further, since this issue was never raised by the previous decision-makers, Louise did not have a reasonable opportunity to prepare to speak to it with the Tribunal. Further, the Tribunal's decision implied that she must have injured herself on another occasion, but there was no evidence before the Tribunal to reasonably support this finding. Lastly, while we acknowledged that the Tribunal has the authority to give whatever weight it chooses to the evidence before it, it was not fair that it did not explain why it rejected the opinion evidence of Louise's physician, her physiotherapist, and the Tribunal's own medical consultant who stated, absent good evidence to the contrary, the way she described hurting herself at work probably caused her injuries.

### Recommendation

1. The Workers' Compensation Board Tribunal reconsider its decision in the complainant's case, including gathering and assessing all available evidence from the complainant and any other witnesses about the events that happened to her after she was injured at work and before she sought medical attention for her injuries, and consider whether to rescind, alter, or amend its decision that the complainant does not have a compensable injury claim.

### Status: Accepted

The WCB Tribunal reconsidered its decision and found that Louise had a compensable injury. Louise was paid the benefits to which she was entitled.



### **Receiving Complaints**

Most complaints we receive fit within our jurisdiction, but a significant number do not. In those instances, we take the time to redirect the person to the most appropriate office or service.

In 2016, we received 4,406 complaints: 3,419 that were within jurisdiction and 987 that were not.



### **COMPLAINTS BY REGION**



This map provides an overview of the complaints we received within our jurisdiction, separated into five regions, plus Regina and Saskatoon. Complaints received from inmates in correctional centres have been counted separately since they do not necessarily represent the home communities of those complainants.

### **Regions & Larger Cities**

North	172
West Central	370
East Central	399
Southwest	98
Southeast	386
Regina	427
Saskatoon	512

### **Other Complaints**

Correctional Centres	916
Out of Province	58
Unknown	81

### **TOTAL Complaints**

TOTAL	3,419



### **COMPLAINTS RECEIVED OUTSIDE JURISDICTION**

ТОРІС	COMPLAINTS RECEIVED
Consumer (including landlord/tenant)	326
Courts/Legal	75
Education	13
Federal Government	173
First Nations Government	25
Health Entities Outside Our Jurisdiction	35
Police Complaint	66
Private Matter	74
Professional	41
Other	159
TOTALS	987

### **Closing Complaints**

Each complaint is unique and there are many possible outcomes. However, we have grouped outcomes into the four categories defined below. Please note that some complaints contain multiple issues, which may have had different outcomes.



#### **Initial Support**

We provided basic support, such as a referral to an appeal process, an advocacy service, or an internal complaints process. At this stage, we encourage people to call us back if their attempts to resolve the matter do not work out.

#### Resolved

The complaint has been resolved in some manner. For example, an appropriate remedy may have been reached or a better explanation provided for a decision.

#### **Recommendations Made**

We made one or more recommendations related to this complaint.

### **No Further Action**

No further action was required on the file. For example; there may have been no reason to request the government entity to act, there was no appropriate remedy available, or the complainant discontinued contact with our Office.

### **TIME TO PROCESS CASES**

The time it takes to complete and close a case 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 cases within six months.

ТОРІС	TARGET	ACTUAL
Files Closed Within 90 Days	90%	93%
Files Closed Within 180 Days	95%	97%

# Public Education and Outreach

**Decision Writing** 

### Reasons for reasons

- Why reasons are importan
  - Legal considerations
  - Shows the decision-maker has co evidence and positions of the par

Connects the dots

- Helps avoid c

In addition to taking complaints, outreach is an important part of our role. The public needs to know about our Office and the kind of complaints they can bring to us. Likewise, decision-makers at entities that we can take complaints about may want to know how we decide what is fair and what to expect if someone makes a complaint.

In 2016, we continued with proven methods of outreach, such as presentations to various groups and our "Fine Art of Fairness" workshops for government entities. Also continued from 2015 was our return to conducting mobile intake sessions. These sessions are opportunities for people from communities outside Regina and Saskatoon to meet some of us and to bring complaints to our staff in person.

An important component of our outreach in 2016 was meeting with municipalities. This was our first full year taking complaints about Saskatchewan's 780 municipalities and we wanted to introduce ourselves and our role to as many of them as we could. We accepted speaking invitations from a wide variety of municipal groups, from SUMA and SARM conventions, to the Saskatchewan Association of City Clerks' Spring Convention in Estevan, to the New North Administrators' Conference in Prince Albert, and more. We would like to express our thanks to these groups for providing opportunities for us to meet them and answer their questions.

While we reached many municipal representatives in person, we also reached out in other ways, including emails, website updates and – a first for our Office – webinars. The webinars, titled "What to Expect When the Ombudsman Calls," were an hour in length and we estimate that they reached about 150 municipal staff and council members across the province in 2016. This practice is continuing into 2017.

### **"FINE ART OF FAIRNESS" WORKSHOPS**

Open to All Provincial and Municipal Entities Regina (2)

By Request Financial and Consumer Affairs (3) Ministry of Education Ministry of Health, Community Care Branch, Health (2 half days) Ministry of Social Services Workers Compensation Board (3)

### PRESENTATIONS ("OMBUDSMAN 101" AND MORE ...)

Canadian Federation of University Women - Saskatoon Canadian Bar Association - Public Sector & Municipal Law Section CBA Administrative Law Spring Seminar - panel City of Estevan **Disability Income Support Coalition (DISC)** International Ombudsman Association Luther College High School Long-term and Continuing Care Regional Directors Ministry of Justice, Financial Council members New North Administrators Conference The Osgoode / FCO Certificate: Essentials For Ombuds (2) The Osgoode / FCO Certificate: Essentials For Ombuds (French) Prince Albert Parkland Regional Health Authority Public Service Commission PIDA Milestone Event Regina District Association of Rural Municipalities **RM Division 4 Administrators Conference** SARM Convention - presentation Saskatchewan Association of City Clerks Spring Convention Saskatoon Food Bank Learning Centre Saskatchewan Legislative Interns SUMA Convention SUMA Village Sector Meeting

### **ORIENTATION FOR NEW CORRECTIONS WORKERS**

Pine Grove Correctional Centre Prince Albert Correctional Centre (2) Prince Albert Orientation, combined centres (2) Regina Correctional Centre (2) Saskatoon Correctional Centre (2)

### **BOOTHS AND EVENTS**

U of R Career Days (2) Saskatoon Council on Aging – Spotlight on Seniors Saskatchewan Student Leadership Conference

### WEBINARS

"What to Expect When the Ombudsman Calls" - for municipalities (3)

MOBILE INTAKE Moose Jaw North Battleford "This training will make you think about why you are making the decisions that you have, and explore how you made them, and whether they are fair."

> - Pat Wilson Supervisor Income Assistance Moose Jaw Ministry of Social Services





# Staff and Budget

### Staff

### **Regina Office**

Rahil Ahmad Assistant Ombudsman

Jaime Carlson Assistant Ombudsman

Kelly Chessie Assistant Ombudsman

**Sherry Davis** Assistant Ombudsman

Paul Dawson Assistant Ombudsman

Leila Dueck Director of Communications

**Stacey Giroux** Executive Administrative Assistant

Jennifer Hall Assistant Ombudsman

**Doug Jameson** Assistant Ombudsman

Pat Lyon Assistant Ombudsman

Janet Mirwaldt Deputy Ombudsman

Shyla Prettyshield Complaints Analyst

Will Sutherland Assistant Ombudsman

Greg Sykes General Counsel

Harry Walker Complaints Analyst

**Beverley Yuen** Executive Administrative Assistant

### **Saskatoon Office**

**Christy Bell** Assistant Ombudsman

Jeff Cain Assistant Ombudsman

**Renée Gavigan** Deputy Ombudsman

Adrienne Jacques Complaints Analyst

**Ryan Kennedy** Administrative Assistant

Sherry Pelletier Assistant Ombudsman

**Shelley Rissling** Administrative Assistant

Andrea Smandych Manager of Administration

Lindsay Schmidt Assistant Ombudsman

Niki Smith Complaints Analyst

Kathy Upton Complaints Analyst

**Rob Walton** Assistant Ombudsman

# **Budget**

	2014–2015 AUDITED FINANCIAL STATEMENT (RESTATED)*	2015-2016 AUDITED FINANCIAL STATEMENT*	2016-2017 BUDGET**
REVENUE			
General Revenue Fund Appropriation	\$3,209,314	\$3,151,907	\$3,914,000
Miscellaneous	(\$2)	-	-
TOTAL REVENUE	\$3,209,312	\$3,151,907	\$3,914,000
EXPENSES			
Salaries & Benefits	\$2,514,749	\$2,437,205	\$3,041,000
Office Space & Equipment Rental	\$312,826	\$310,243	\$294,400
Communication	\$54,142	\$51,529	\$55,400
Miscellaneous Services	\$79,281	\$98,012	\$90,200
Office Supplies & Expenses	\$29,500	\$39,888	\$34,500
Advertising, Promotion & Events	\$54,171	\$58,608	\$113,100
Travel	\$63,268	\$52,324	\$54,000
Amortization	\$65,356	\$73,779	
Dues & Fees	\$82,374	\$23,565	\$74,300
Repairs & Maintenance	\$16,532	\$37,289	\$157,100
Capital Asset Acquisitions	-	-	
Loss on Disposal of Capital Assets	\$2,762	-	
TOTAL EXPENSES	\$3,274,961	\$3,182,442	\$3,914,000
ANNUAL (DEFICIT) SURPLUS	(\$65,649)	(\$30,535)	

\*These columns are based on our audited financial statements, which follow our fiscal year (April - March) and our annual report follows the calendar year. The audited financial statements are available on our website at www. ombudsman.sk.ca.

\*\*Due to the timing of this report, 2016–17 numbers reflect the budgeted amount rather than the actual.