





2020 Annual Report



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**April 2021** 

The Honourable Randy Weekes 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 annual report of Ombudsman Saskatchewan for 2020.

Respectfully submitted,

may mitady

Mary McFadyen Q.C.

**OMBUDSMAN** 

# Vision, Mission, Values and Goals

### **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**



Mary McFadyen, Q.C. Ombudsman

I am pleased to present Ombudsman Saskatchewan's 2020 Annual Report, highlighting our progress and activities during the year.

Under *The Ombudsman Act, 2012*, the Ombudsman's role is to investigate or informally address complaints about matters of government administration, make findings and recommendations, issue reports, and educate the public and public servants about administrative fairness and the role of the Ombudsman. We have jurisdiction to review the administrative decision-making processes of provincial ministries, Crown corporations, most provincial and provincially-funded agencies, boards and commissions, publicly-funded health entities, and municipalities, as well as the conduct of municipal council members under their codes of ethics. To enable us to effectively carry out our work impartially without any threat of improper influence, the Legislative Assembly of Saskatchewan gives us wide powers of investigation and protects our independence and the integrity of our investigation process.

This year was challenging for everyone as we adapted to the COVID-19 pandemic. We are truly grateful that we were able to work remotely when necessary, to help stop the spread of COVID-19. We continued to take and deal with complaints about provincial and municipal government services. Even during a pandemic – especially during a pandemic – Saskatchewan residents need somewhere to turn if they feel they have not been treated fairly when dealing with a government institution.

We received a wide range of complaints and addressed some informally and some formally. Some of our early resolution stories are highlighted in this annual report. Based on the complaints we formally investigated, we made 24 recommendations to provincial and municipal government entities this year. In the following pages, you will find summaries of these investigations and the recommendations we made. Our recommendations are aimed at improving government decision-making processes, which in turn improves and strengthens the administration of government services.

The pandemic affected many government services and likewise, the types of concerns people brought to us also changed. Complaints about the health system increased, but complaints about Social Services, SaskPower and SGI decreased. We have included a "COVID-19" section

this year, as it is interesting to see the types of issues related to the pandemic that were raised in 2020.

We also realized and appreciated that we were not the only ones working remotely this year. We want to acknowledge and thank the many provincial and municipal government employees we reached out to for being responsive to our inquiries, so that we could, in turn, respond to and deal with the complaints made to us. In true Saskatchewan form, everyone is doing the best they can in these challenging circumstances.

In closing, I want to thank everyone at Ombudsman Saskatchewan for being so adaptable and doing such a great job this year. It was important that we did not let anyone slip through the cracks and that we responded to complaints quickly and efficiently. I appreciate this very much and thank all of you. Being the provincial Ombudsman is one of the highlights of my career, and it is all of you who have made this possible.

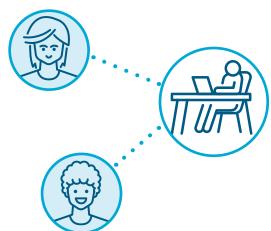


# COVID-19

# **How the Pandemic Affected Complaints**

On March 18, 2020, Saskatchewan declared a state of emergency due to the COVID-19 pandemic and, while many provincial and municipal services continued, changes often needed to be made to the way they were being provided. This affected the number and types of complaints we received.

Of the 3,415 complaints we received in 2020, 2,492 were about organizations within our jurisdiction. Overall, 477 or 14% were related to COVID-19. While we continued to see many of the same types of complaints as usual during the pandemic, others changed based on what was happening in each sector. Here are some of the changes we observed due to the pandemic.



#### **Corrections**

Complaints about the Ministry of Corrections and Policing increased from 579 in 2019 to 619 in 2020. About 100 of these were related to COVID-19, one third of which came in during the first three weeks after Saskatchewan declared a state of emergency. Several of these initial concerns were about whether appropriate safety protocols were being implemented and whether inmates were being given enough information about what was happening and how they could protect themselves. We contacted Corrections officials to address these concerns and to ask about the steps they were taking. In the seven months from mid-April to mid-November, we received about 35 more COVID-related correctional complaints. Then, when outbreaks were declared in correctional centres in November and December, concerns rose again. We received about 30 more COVID-related complaints during the last six weeks of 2020. We continued to take individual complaints from inmates and to follow up with Corrections. Many of the concerns we heard were about whether inmates were being adequately protected from the virus, but we also received some complaints that the safety measures limited inmates' access to exercise and programming.

#### **Social Services**

We received 554 complaints about the Ministry of Social Services in 2020, down 37% from 884 in 2019. Complaints were tracking similar to 2019 in January and February but dropped in March when the pandemic started. Over 80 complaints were related to COVID-19. About half of the COVID-19 complaints were from people whose provincial income support benefits were scaled back or cancelled because they received the federal Canadian Emergency Response Benefit (CERB). We have given notice to the Ministry and are currently investigating this issue. The remainder of the complaints included concerns about a variety of issues, some of which are summarized in the Social Services section of this report.

#### Health

Complaints about the Ministry of Health went up from 21 in 2019 to 65 in 2020. About half of these were related to public health measures taken in response to the pandemic. For the most part, these were referred to the Ministry.

Complaints about the Saskatchewan Health Authority (SHA) rose slightly from 141 in 2019 to 156 in 2020. About a third of these were related to COVID-19. These complaints spanned a broad range of topics, from delayed procedures to long-term care.

We also received complaints about SHA affiliates and other health care organizations. These complaints went up from 16 to 26, with about a third related to COVID-19.

During 2020, we received 51 complaints about long-term care facilities (nursing homes). This included complaints about facilities operated by the SHA, and both non-profit and for-profit operators. Several of these were from people who were unable to see their family members in care due to visitation restrictions. Some contacted us because they felt their family member's care home was not taking enough precautions, while others felt the precautions being taken were too strict.

Several long-term care homes experienced outbreaks. The deadliest outbreak was at Extendicare Parkside in Regina, which the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health asked the Ombudsman to investigate. We accepted the Minister's request and decided to review, not only the actions of Extendicare Parkside, but also the oversight and support provided to it by the SHA and the Ministry of Health.

#### **Municipalities**

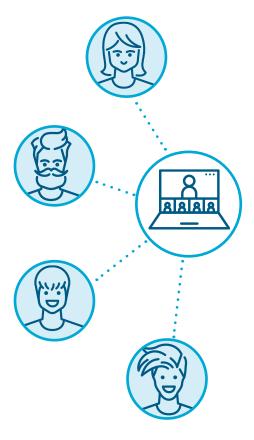
Of the 459 complaints we received about municipalities in 2020, about 20 were related to the pandemic. The most common type of complaint was from people who were having trouble getting public documents or participating in public meetings while their local council and administration were transitioning to online access.

#### **Outreach During a Pandemic**

Our mandate includes providing public education about our work. Normally, we would have numerous interactions with the public at event booths and by doing presentations. We would usually travel to a couple of Saskatchewan communities to take complaints in person throughout the year, which helps to increase local awareness about our Office. We would also typically offer "Fine Art of Fairness" workshops to public sector employees to help them understand the components and dynamics of fair decision making. All these activities stopped on March 18, 2020.

Even though we were unable to connect in person, we continued to reach out virtually. We posted information on our website and continued to interact via telephone and email. We ran some targeted advertising in local newspapers to let people know that they could still contact us with their concerns and to remind them of the kinds of complaints they can bring to us.

In August, we resumed giving presentations, this time in an online format. Saskatchewan correctional centres invited us to resume providing orientation sessions about our Office to new corrections workers. We also participated in a virtual training session hosted by Municipalities of Saskatchewan for newly-elected council members, plus presentations for community groups, a University of Regina social work class, and newly-elected Members of the Legislative Assembly of Saskatchewan.





# **Complaints**

#### Introduction

It is important to know that provincial, health, and municipal entities in Saskatchewan have a duty to deliver services fairly. It is also important to know that we are available when people run into a problem with one of these services. We are impartial and independent from government. We can help to informally resolve problems or investigate when appropriate.

What sort of problem? One that fits all three of these:

- It is administrative. That is, it happened when a provincial or municipal government organization was carrying out a program or service. For example:
  - · a decision that seems unfair
  - · a gap in services or programs
  - · a delay in service
- 2. It affects you personally.
- 3. You have not been able to resolve it with the government organization.

We also take complaints about municipal council members contravening their code of ethics (including conflicts of interest). In these cases, we usually only get involved after the municipality has had an opportunity to address the complaint first.

People who are not sure whether we can take their complaint should contact us. We can let them know whether we can get involved and if not, provide an appropriate referral.

Note: Case examples have been written to protect the identities of the complainants by giving them different names and removing identifying information that is not relevant to the description of the complaint.

# **Corrections**

# **Complaints Received**

MINISTRY OF CORRECTIONS AND DOLLOWS	2020	2018	2018
MINISTRY OF CORRECTIONS AND POLICING			
Pine Grove Correctional Centre	87	51	81
Prince Albert Correctional Centre	89	90	87
Regina Correctional Centre	189	172	227
Saskatoon Correctional Centre	220	241	327
Saskatchewan Hospital North Battleford (Corrections)	13	4	
White Birch Female Remand Centre	2	0	6
Whitespruce Provincial Training Centre	3	2	9
Appeal Adjudicators	0	0	2
Adult Corrections - Other	8	14	26
Corrections & Policing - Other	8	5	2
TOTAL	619	579	767

# **Case Examples**



#### **HE WANTED TO CALL WITNESSES**

Russ contacted us because he felt he was unfairly charged with breaking the TV in his cell and had to pay restitution.

Corrections had removed Russ from his cell for being belligerent. The next day, when another inmate was put in the cell, the TV was discovered to be smashed. Russ was charged with damaging property. When his case went before a discipline panel, he pleaded not guilty. He agreed to waive his right to a lawyer but asked that the corrections officers who removed him from his cell be called as witnesses so they could give evidence that the TV was not broken when they took him out of the cell. This was not granted. Given the other circumstances, the panel decided that he was guilty.

Several months later, when he started to work in the laundry, the cost of the TV was deducted from his pay as restitution. He said he did not realize this would happen and wanted to appeal the panel decision. Since he was far past the five-day deadline, his appeal was denied, but he was informed that he could contact our Office.

We reviewed his case and pointed out that Russ's request for witnesses during the hearing had been denied. In a 2019 investigation report on Corrections discipline panels, we found that inmates were often not permitted to call staff or other inmates as witnesses. To address this issue, one of our recommendations was:

That the Ministry of Corrections and Policing develop guidelines to ensure discipline panel chairpersons effectively exercise the discretion to allow inmates to call witnesses – whether staff members or other inmates – so that inmates have an opportunity to fully present relevant information to a defence of the charge.

Corrections acknowledged that Russ had not been permitted to call the officers who removed him from his cell as witnesses about the state of the TV at that time, and as a result of this error, he had not received a full and fair hearing. The decision was revoked.

Status: Resolved

#### PEPPER SPRAY USE, DECONTAMINATION, AND DOCUMENTATION

Regan was pepper-sprayed while he was an inmate at the Regina Correctional Centre (RCC). He did not think the use of pepper spray was justified, or that he was properly decontaminated afterwards.

After weeks of being disruptive, including smearing feces in his cell, throwing urine at other inmates and repeatedly flooding his cell by blocking the toilet, Regan was seen in his cell shredding his security smock. Two officers told him to stop and to pass the pieces of the smock through the food slot. He started to comply, but then stopped. One officer entered the cell, reportedly to retrieve the smock pieces and to search his cell, while the other officer stood in the doorway. He was pepper-sprayed without warning and then left in his cell for 33 minutes. He was not provided fresh air or a proper source of running water to effectively flush his eyes. After finally being taken for a shower, he was given a fresh security smock, but put back in his still-contaminated cell. He was later given supplies to clean his cell himself.

Corrections rejected his formal complaint about the officers, saying the use of pepper spray was appropriate because he had refused to hand over all of the pieces of the smock, and the officers thought he might have had a sharpened object in his cell that he was using to shred the smock. Regan contacted our Office.

We looked at whether Corrections' use of pepper spray complied with The Corrections Act, 2012 and relevant Corrections' policies, including



whether Regan was properly decontaminated, and if the use of force was properly documented.

Corrections may use a reasonable degree and means of force to prevent injury or death to a person, prevent property damage, prevent an inmate from escaping, or maintain custody and control of an inmate. The use of force is an extraordinary measure and is only to be used lawfully, with discretion, care and judgement. Corrections may only use as much force as is believed in good faith and on reasonable grounds to be necessary to carry out its legal duties. Specifically, force is not to be used as punishment or discipline. Pepper spray may be used in an emergency where immediate and decisive action is necessary to, for example, subdue an unmanageable or combative inmate, prevent suicides or other self-destructive behaviour, protect staff from immediate or imminent harm, or to respond to any other serious threat.

We found that retrieving the smock pieces could not reasonably be seen as an emergency, and since Regan was locked in his cell and was not being physically aggressive, the officers were not in any imminent harm. Instead, we found ample evidence that the complainant's behaviour had been consistently disruptive, destructive and often disgusting, so it was understandable that staff were very frustrated with him. Given the officers did not warn him he would be pepper sprayed if he did not comply with their directions, we believed pepper spray was used out of frustration from having to constantly deal with the complainant's negative, exasperating behaviour. Therefore, the use of force did not comply with *The Corrections Act, 2012* or Corrections' policies.

Further, we found Corrections failed to comply with its own decontamination procedures, in that it did not, as soon as was reasonable, remove Regan from the contaminated cell, ensure he could flush his eyes and wash himself, give him access to fresh air and a change of clothes, or offer him medical attention. It also failed to properly decontaminate his cell before returning him to it, as was required.

After staff use pepper spray, they must document the incident and provide reasons why it was required. Each staff member involved in, or who witnesses the incident, must complete a detailed report. Based on these reports, a comprehensive report and any relevant video footage are submitted to the facility director. In this case, the officers initially reported only that pepper spray was used because Regan refused a direct order to hand over the pieces of the smock. However, after Regan

appealed to the director, one of the officer's supervisors coached him to add further justification to the report before it was submitted to the director. We therefore found that the justification for using pepper spray on Regan was not properly documented. We also found the decontamination checklist was not completed accurately. One of the officers checked "yes" to indicate he complied with all but one of the steps in the contamination procedure, but video footage did not support what he reported.

Lastly, the response to Regan's complaint to the director did not explain his right to appeal the decision to the head of Corrections. Instead, it advised he could 'appeal' to the Ombudsman's Office. The Ombudsman is not an appeal body. Once all appeals have been exhausted, however, we may review a complaint to ensure whether decisions were made fairly and according to law, with proper reasons provided to the complainant.

We made the following recommendations:

The Ministry of Corrections and Policing ensure that when a director
of a correctional centre makes a decision on an inmate complaint,
the decision letter clearly informs the inmate of the right to appeal
the decision, sets out who the appeal should be addressed to, and
the timelines for appealing.

Status: Accepted

2. The Ministry of Corrections and Policing ensure that when an organic or chemical agent, or spray irritant is used, the corrections officer using it clearly and fully describes the reasons for the use in writing as soon as possible after the use, including any attempts to de-escalate the situation before using the agent, and that any amendments made to the report after the initial report are fully explained and dated.

Status: Accepted

3. The Ministry of Corrections and Policing ensure that decontamination procedures are clearly set out in policy, and that they are followed in every instance after the use of a chemical or organic agent or spray irritant, and that each step and the time it took to complete each step is properly documented.

Status: Accepted

4. The Ministry of Corrections and Policing ensure its policy clearly sets out that inmates exposed to chemical or organic agents or spray irritants are removed from the contaminated area as soon as it is safe to do so, permitted to shower and to change clothes, referred for medical assessment immediately, and continually observed until they are medically cleared.

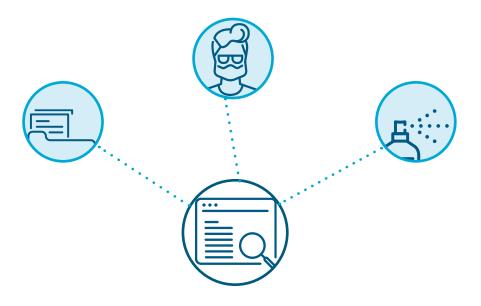
Status: Accepted

5. The Ministry of Corrections and Policing ensure its policy clearly sets out if an inmate specifically refuses medical treatment, then the name of the corrections officer who offered medical treatment and the time of the offer, is accurately documented.

Status: Accepted

6. The Ministry of Corrections and Policing ensure its policy clearly sets out that a contaminated area (cell) and all clothing and bedding be properly decontaminated by Corrections (not the inmate) before the inmate is returned to the area (cell).

Status: Accepted



# **Social Services**

### **Complaints Received**

MINISTRY OF SOCIAL SERVICES	2020	2019	2018
Child & Family Service Delivery	90	132	149
Housing Programs and Finance	60	66	81
Community Living Service Delivery	6	11	8
Income Assistance Services Delivery - Saskatchewan Assured Income for Disability	157	183	162
Income Assistance Services Delivery - Saskatchewan Assistance Program	99	279	341
Income Assistance Services Delivery - Saskatchewan Income Support	92	75	
Income Assistance Services Delivery - Transitional Employment Allowance	28	93	91
Income Assistance Services Delivery - Income Supplement Programs - Other	12	34	38
Social Services - Other	10	11	4
TOTAL	554	884	874

### **Case Examples**

#### **DIETARY FUNDING DURING THE PANDEMIC**

Regis was on the Saskatchewan Assured Income for Disabilities (SAID) program. He contacted us because he felt he was unfairly asked to get a doctor's note.

Regis told us that in order to continue receiving \$27/month in special dietary benefits, he had to submit a doctor's note to Social Services every three years to prove he still has diabetes. In May 2020, he got a letter from his worker, reminding him that it was time to provide the doctor's note again. Regis said his doctor always wants to see people in person, but the office was closed due to the pandemic and his doctor wasn't taking appointments. Regis didn't understand why he had to get a doctor's note during a pandemic to prove that he still has a chronic condition (diabetes).

Regis also said he had several medical conditions and was afraid to go out for groceries in case he caught COVID-19, so he was now also paying to have his groceries delivered. This made the extra \$27/ month more important than ever.



Regis said he had left messages for his income assistance worker, but hadn't heard anything and didn't know how to reach her supervisor. We contacted Social Services to find out more about Regis's situation. Social Services told us it was continuing to send letters to clients to remind them of doctor's note requirements, but that it was also giving them extra time. The person we spoke with said she would ask Regis's worker to contact him.

When we called back to see how Regis was doing, he had already received a call from his worker, who explained that his special dietary benefits were not being cut off and encouraged him to try to get a phone or virtual appointment with his doctor. He told us he was happy with this outcome.

Status: Resolved



#### A LITTLE MORE TIME TO STAY SAFE

Roxy called us because she disagreed with Social Services' decision to get her to stay at a shelter while waiting to move in with her sister. She said that her sister's roommate was moving out and Roxy could move into her sister's place in a few days. Roxy told us about her disabilities and said she has a chronic condition that makes her susceptible to infections. She is a recipient of the Saskatchewan Assured Income for Disabilities (SAID) program. While temporarily placed in a hotel, she was supposed to move to a shelter as soon as possible. She told us that, with her underlying health conditions, she was concerned about the risk of getting COVID-19 from a shelter.

We contacted Social Services to find out more about Roxy's situation. We were told that the SAID program does not normally pay for hotels and Roxy had previously tried to extend hotel stays. Social Services had already extended her hotel stay a couple of days and staff were calling shelters daily to try to find her a spot. They said she had not told them about the plan to move in with her sister and that she had tried living with her sister before but had been kicked out.

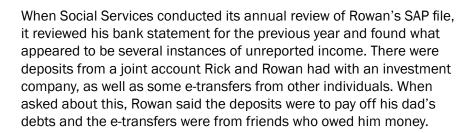
We reviewed Roxy's health risks with Social Services, which would make her particularly vulnerable to COVID-19. While we understood that, under normal circumstances, there would be no option for her but to go to the shelter, we discussed the challenges involved with ensuring physical distancing at a shelter. Given that she would be able to move to her sister's place in a few days, we asked whether it would be appropriate to allow her to stay on at the hotel until then to avoid

exposure at the shelter. While Social Services was not convinced Roxy's living arrangements would work out, they agreed that it would be safer to let her stay where she was until her move date – but if her plans fell through and she had nowhere to go after that, then she would have to stay at the shelter.

Status: Resolved

#### IT'S COMPLICATED

Rick contacted us about his son, Rowan, who had been cut off Saskatchewan Assistance Program (SAP) benefits and was told he had to pay back over \$10,000. Rick felt Social Services improperly assessed Rowan's financial information and that its processes were unfair.



Social Services put Rowan's benefits on hold and asked him to provide two more months of the most recent bank statements. It found more deposits.

Social Services concluded that Rowan ought to have been reporting these funds as income. It wrote to him, saying that he had been overpaid more than \$10,000 in assistance and he would have to pay it back – so \$25/month would be taken from his SAP cheques. He signed an agreement to this effect. Three weeks after the first letter, a new letter arrived from Social Services saying he was cut off SAP and his file closure was backdated two months. Rowan decided to appeal the decision. After this, he received a third letter stating that since he had received more than \$32,000 of unreported income, he would be expected to use it to support himself and would not be eligible for SAP for the next 23 months.

During this period, Rick wrote to Social Services several times, asking for more information about its decisions because he felt information was not properly explained in the letters Rowan received about the matter.



When the appeal went before the regional appeal committee, Rick explained that he had some debts he didn't want his spouse to know about, so he had money deposited into Rowan's account and then got Rowan to give it to him in cash so he could pay his debts. The appeal committee accepted Rick's explanation – that the Ministry did not fully investigate the source of the deposits – and Rowan won the appeal.

Social Services then appealed to the Social Services Appeal Board, which overturned the decision.

Rick felt the process had been unfair because he had to ask Social Services more than once to include copies of relevant information in the appeal packages. He didn't think they understood what the deposits were really for and admitted it was complicated because he had used Rowan's account to hide transactions. Additionally, there were deposits from individuals that owed Rowan money. He also said that Rowan was never told what sort of financial activity he was supposed to report to Social Services.

When Rick complained to our Office, we reviewed his information and contacted Social Services. After further review, Social Services suggested meeting with Rick and Rowan to go over the deposits together and map out what happened to each one. After these meetings, Social Services calculated that Rowan had only been overpaid about \$1,000 and that he could continue receiving assistance while paying back \$25/month.

Status: Resolved



#### A MORE SUITABLE SUITE

Ruth and Roger contacted us because they felt their local Housing Authority was not being cooperative about their request to move.

They explained that they had been renting from the Authority and that they both have several chronic health issues, which were getting worse because their suite was hot and noisy, and they were troubled by smells from other suites, such as smoke, garbage and mould. They told us they found it hard to sleep at night, and that they had doctors' notes supporting their need to move.

In the 12 years they had been renting from the Authority, they had experienced similar problems in other suites and had moved three other times. They told us that the reason the other moves had not been successful was because they were not given all the relevant information about the suites before moving in. Now they were seeking a fourth

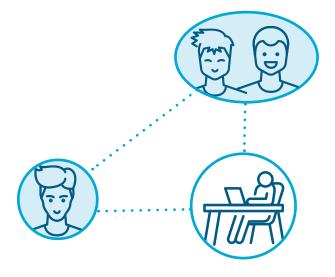
move and they felt the manager was blocking their attempts. They had inquired about a building they thought would be good for them, but he told them it was too close to a busy road and would be too noisy for them. He did offer them a suite, but they found it to be too smoky, with large, noisy exhaust fans, so they didn't accept it. Finally, he had shown them a suite that they thought would suit their needs very well, but he did not offer it to them, initially because it was tied up in a dispute and later, because one of the neighbouring tenants was a smoker.

Roger and Ruth felt that the manager was treating them unfairly and was not letting them decide what they could and could not put up with.

A few weeks later, a new manager started. He wrote Roger and Ruth to say that they would be offered the suite they wanted, but only if they signed an affidavit promising that this was their final move with the Authority. They found the letter heavy-handed and wondered if the Authority could force them to take this step.

We decided to facilitate communication between the parties. We contacted the new manager and suggested a conversation with Roger and Ruth to hear them out and to also present the Authority's view. He agreed and invited them to a phone meeting. They felt he treated them with respect, and they were able to agree on several points, which were written into a letter of understanding. For example, the letter described how complaints would be dealt with after the move and noted that if things didn't work out in the new suite, Roger and Ruth would accept that the Housing Authority did not have rental properties that could meet all their health needs, so they would look elsewhere.





# **Municipalities**

# **Complaints Received**

AND DATE OF THE O	2020	2019	2018
MUNICIPALITIES			
Cities	127	87	114
Towns	103	65	85
Villages	58	62	54
Resort Villages	13	18	24
Rural Municipalities	126	128	145
Northern Municipalities	24	35	21
Other / Not Disclosed	8	8	9
TOTAL	459	403	452

### Introduction

In 2020, we continued to reach out to municipalities to help them understand the role of the Ombudsman and how to fairly deal with complaints about council member conduct. Like *The Northern Municipalities Act, 2010*, changes made to *The Cities Act* and *The Municipalities Act* on July 2, 2020, now allow a council to declare a council member's seat vacant if it determines the council member failed to deal with a conflict of interest properly. It is therefore very important, when making this determination, that councils use a process that is procedurally fair to both the person complaining and the council member complained about.

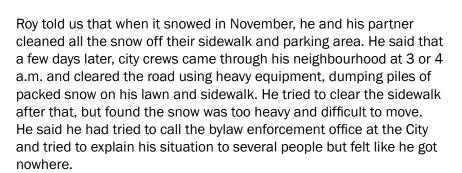
Through our work this past year, we have helped and encouraged municipalities to carry out their duties fairly, for example, to develop fair processes for dealing with people who behave unreasonably with municipal staff and officials, and to charge reasonable fees for copies of municipal documents.

# **Case Examples**

Following are brief summaries of several municipal complaint files. They range from an early resolution file, where we referred the complainant back to a municipal complaint process, through to several investigation summaries, some of which were previously published in greater detail on our website.

#### THE VALUE OF GOOD COMPLAINING

Roy called us because he received a bylaw enforcement notice from the City of Saskatoon, telling him he needed to clean up all the ice and snow on his sidewalk within 48 hours or he would be fined – and if he didn't pay it, the amount would be added to his municipal taxes. It also said that if there were additional fines, the amount of each fine would increase.



We encouraged Roy to email the City to explain his situation and to attach some photos he had taken of the snow packed on his sidewalk We also explained that if he is fined, he can ask the City how to appeal the fine.

We called him back later, to see how his complaint went. He said that after he sent his email, he received a response from the City the same day, with an apology and acknowledgement that the City crews had piled up the snow – so he would not receive a fine.

Status: Resolved





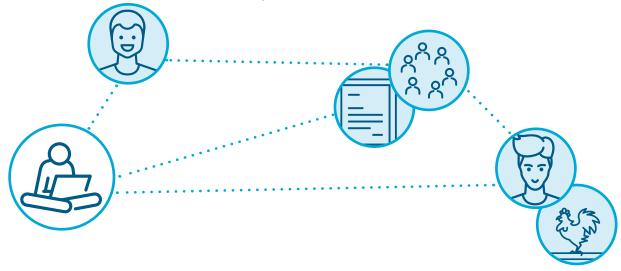
#### **UNDERSTANDING CODE OF ETHICS RESPONSIBILITIES**

Roscoe contacted us about the way the Town of Wolseley was dealing with his complaints. He told us he wrote to the Town about a councillor keeping chickens on a residential property in violation of the Town's zoning bylaw. He alleged the councillor was in a conflict of interest when she participated in the council's discussions about the matter at a council meeting, and that the council did not properly address his formal Code of Ethics complaint about the issue.

We confirmed that the councillor's chickens were being kept in the residential district where keeping livestock is not permitted under the zoning bylaw. The councillor participated in the council's discussion about Roscoe's letter. A resolution "that no poultry or chickens be allowed in residential zoned areas in the Town of Wolseley limits" was defeated 4-3. The recorded vote indicates the councillor in question voted to defeat the resolution.

After the Town informed Roscoe about the vote and that his letter had been received and filed, he submitted a formal code of ethics complaint alleging that the councillor was in a conflict of interest when she voted on the resolution. The Town council discussed his complaint in an *in camera* session. The councillor participated in the discussion and voted to dismiss the complaint.

Based on the information we gathered, some council members felt that while Roscoe's complaints had merit, it wasn't worth the council's time to pursue them. We found that, even if council members did not feel his complaints had merit, the council still had a duty to address them properly.



We wrote to the council, outlining our tentative findings, and offering council members the opportunity to make representations to us. By then, we had learned that the council had made improvements to its process. We said we were interested in hearing about how it ensures it deals with code of ethics complaints fairly and reasonably, and about what, if any, education or training council members have taken to fully understand their conflict of interest responsibilities.

The councillor responded to our letter. She agreed with our findings, admitted to making the mistakes "unwittingly" and committed to taking education about conflicts of interest and the code of ethics. The council likewise wrote, saying it would educate itself on these matters and that it would conduct a bylaw review. We accepted these responses and followed up with them in six months to confirm that these steps had been taken.

Status: Resolved

#### **Previously Published Investigations**

#### **R.M. OF PLEASANTDALE NO. 398**

A resident complained to us about being charged \$30 to get copies of the RM's council meeting minutes. Under section 117 of *The Municipalities Act*, any person at any time during regular business hours, is entitled to inspect and obtain copies of certain municipal documents, including, among other things, contracts approved by the council, bylaws, and all approved council meeting minutes. Municipalities can charge for furnishing copies of these documents, but the fee set by the council must not exceed the reasonable costs incurred by the municipality in furnishing the copies. We found that the \$30 fee was unreasonable and had been set by the council to discourage citizens from asking for copies of documents. We recommended that the RM immediately take steps to fix the fees it charges so that they do not exceed the reasonable costs to furnish them.





#### **VILLAGE OF HODGEVILLE**

A resident complained to us about the fees the Village charged to get copies of municipal documents. The Village's policy set the rate for making copies of municipal documents at \$2.00 for meeting minutes, \$0.50 per sheet for other public documents, plus a \$20.00 administration fee. After the resident requested copies of documents, the council passed a resolution, doubling the administration fee to \$40.00. We found the Village's fees were unreasonable and not in accordance with *The Municipalities Act*.

The resident also complained to us about the council's decision to ban him from the Village office based on allegations made by the administrator. While municipalities have a duty to ensure staff have a safe, harassment free workplace, they still must make any decisions to ban someone from the Village office fairly. We found that the resident was not given reasonable notice that the council intended to consider whether to ban him, was not given any opportunity to respond to the administrator's allegations, or to provide the council with his version of events or his perspective on what happened.

We recommended that the Village ensure the fees it charges for furnishing copies of municipal documents reflects the actual, reasonable costs of furnishing them, and that it establish a process for determining when an individual's access to the Village office will be restricted due to unreasonable conduct.

### **Additional Investigations**



#### **BRIGHTSAND LAKE REGIONAL PARK AUTHORITY**

We received two complaints about the way the Brightsand Lake Regional Park Authority (controlled by the RM of Mervin No. 499 and the Town of St. Walburg) handled complaints.

Alleged Leak of Confidential Information

Reese alleged that Brightsand directors improperly shared confidential information.

Brightsand accused Reese of taking documents from the park office without permission. It wrote Reese (and copied the RM and Town) to say it had reported the incident to the RCMP. Later, a community member

confronted Reese about being investigated by the RCMP. Reese thought a board member must have leaked the information and complained to the board. The board chair twice asked the other board members if they had leaked the information, which they denied. The community member told the chair he overheard two former board members talking about it in public.

We found the board did not take reasonable steps to try to resolve the complaint informally. Reese had asked to speak with the board about it in private but was refused because the board did not realize it could take its meetings *in camera* to discuss confidential matters. This was a missed opportunity.

Since the complaint was about the board, a reasonable person would question the board chair's ability to investigate it impartially. It would have been reasonable for the board to arrange for an independent person or body to review it. Further, while it took some steps to investigate the source of the leak, the board's efforts were incomplete. For example, it did not consider whether park employees, RM or Town officials, or the RCMP, may have discussed the situation publicly. Nor did it contact the other community members it learned had been talking about Reese in public. It also did not consider whether, under current laws and policies, it was required to keep confidential that it had reported Reese to the RCMP. Lastly, it did not give Reese a reasonable explanation for its decision.

#### Alleged Conflict of Interest

Remy complained Brightsand did not handle a complaint made about Remy to Brightsand fairly.

When Remy was a Brightsand board member, the cabin owners association alleged Remy used the board position to get information about its lease negotiations with Brightsand – that there was a conflict of interest due to Remy's "personal agenda". The association wanted Remy removed from all board decisions about it. Two board members asked Remy to stop getting involved with the association and let the board deal with it. Remy refused, so the board took disciplinary measures. Remy received a warning letter that further misconduct would not be tolerated and was removed from an executive board position. Remy later went to a cabin owners association meeting and refused to leave when asked. The association again complained to Brightsand, which suspended Remy from a board meeting as discipline. Remy resigned shortly thereafter.

We acknowledged that the board tried to resolve the complaint by speaking to Remy privately. However, we found it did not take reasonable steps to determine whether the allegations of the cabin owners association were true or whether Remy had contravened its rules for board members. Lastly, it did not provide reasonable reasons for its disciplinary actions.

#### Recommendations

Based on our findings in these two cases, we made the following recommendation:

- The Brightsand Lake Regional Park Authority develop procedures
  to supplement its code of ethics process to ensure alleged code of
  ethics contraventions are fairly dealt with, including procedures for:
  - a. receiving, acknowledging, informally resolving, investigating, deciding and providing reasons for its decisions;
  - arranging for an independent third party to handle complaints, when board members' conflicts of interest in the matter, or acrimony among board members, would make the board unable to fairly handle a complaint itself; and
  - c. determining when to ask the RM of Mervin No. 499 or the Town of St. Walburg to remove a board member from office due to a serious contravention of the code of ethics.

Status: Accepted

#### **SEL 33 PUBLIC UTILITY BOARD**

Roland complained to us that the SEL 33 Public Utility Board (established by the RM of Edenwold No. 158, the RM of Lajord No. 128, and the RM of Sherwood No. 159) disconnected his water service without giving him reasonable notice and then unfairly charged him additional fees to reconnect the water.

Originally, Roland's father was a SEL 33 customer, but moved out when Roland moved home. The water services remained in his father's name and SEL 33 sent invoices to his father – but Roland paid them. SEL 33 asked Roland to sign his own agreement but he refused. SEL 33 nevertheless continued to provide him service. Roland fell into arrears twice. After the second time, SEL 33 notified him it would shut off the water. In response, on September 11, 2019, Roland met with two SEL 33 board members who agreed in writing that he could make the first arrears payment on October 7, and further monthly payments until the



account was caught up. This arrangement was subject to the SEL 33 board's approval.

At SEL 33's September 16, 2019 board meeting, the two board members incorrectly told the rest of the board Roland had agreed to make the first payment immediately. The board approved this new arrangement thinking Roland had already agreed to it. Specifically, it decided the first payment had to be made by September 18 at noon or the water would be shut off, and that Roland was to be reminded he should (not must) sign a service agreement immediately.

On September 17, 2019, one of the board members sent him an email that began, "Sel33 board members have accepted the proposal set out on September 11, 2019 of account payment." This was incorrect. The email went on to say he needed to sign an agreement by noon on September 18, or his water would be shut off. This was also incorrect. Also, the email never told Roland he needed to make the first payment by noon on September 18.

The board member texted him on September 18, 2019, to see if he had received the email. He did not reply immediately as he was at work. When he did, he wrote: "Yes I did thank you. It was in my junk mail..." He told us he had only read the preview of the email on his phone, indicating the board had accepted his original proposal.

When he got home from work, his water had been shut off. He asked the board member if SEL 33 would turn the water on that day, given the miscommunication and the good faith agreement they made on September 11, 2019. The board member refused, saying (contrary to what the board decided) that if Roland had just signed the agreement before September 18 at noon, he could have made the first payment on October 7. The board member required him to sign the agreement and pay the full arrears before turning the water back on, which he did. SEL 33 charged him an additional \$800 in fees and deposits for having his water cut off and turned back on.

We found SEL 33 failed to give Roland proper and reasonable notice that it intended to terminate his water service. By agreeing to repayment terms with him, the board members committed to present the terms fairly and accurately to the board, and to encourage the board's acceptance of them. They did not. They gave the board incorrect information, which it relied on to make its decision. Then the board member notified Roland that the board had accepted his proposal, which it had not. We acknowledged Roland bore some responsibility for not reading the board members' full email, but found

that, even if he had, and signed the agreement by noon on September 18, he would have still not met the board's requirement that he make the first payment by September 18. We also found that a reasonable person would have not thought to read the whole email, since the first line said the board had accepted his proposal to make the first payment on October 7, 2019. Further, no one in the board member's position could reasonably have expected Roland to simply thank him upon learning the SEL 33 was going to cut off his water in a few hours if he did not act.

Roland was provided with incorrect and misleading information and was not given proper and reasonable notice that his water was going to be shut off if he did not sign a water service agreement immediately. Therefore, charging him an additional \$800 for turning his water off and on again was unfair.

We made the following recommendations:

1. The SEL 33 Public Utility Board refund the complainant \$800 for the fees it charged him to suspend his water service, for the reconnection deposit, and to reconnect his water service.

Status: Not Accepted

2. The SEL 33 Public Utility Board establish procedures for dealing with subscribers who are in arrears and giving reasonable notice to terminate water service, which include establishing who has authority to make repayment arrangements with a subscriber, the extent of their authority, and how notice to terminate water service must be given to a subscriber so that a subscriber has sufficient time to respond to the notice.

Status: Not Accepted

# **Health**

# **Complaints Received**

HEALTH ORGANIZATIONS	2020	2019	2018
MINISTRY OF HEALTH			
Drug Plan and Extended Benefits	16	10	18
Health Other	49	11	15
TOTAL - MINISTRY OF HEALTH	65	21	33
eHEALTH SASKATCHEWAN	9	14	8
SASKATCHEWAN CANCER AGENCY	1	1	2
SASKATCHEWAN HEALTH AUTHORITY	156	141	111
OTHER HEALTH ENTITIES	26	16	19
TOTAL	257	193	173

### **Case Examples**

#### **AMBULANCE COSTS**

Roman contacted us because he did not think he should have to pay an ambulance bill to transport his wife, Rosie, to see a doctor in a larger community, since she was examined briefly and sent home.

Rosie and Roman lived in a rural community. Roman told us that, about a week after giving birth, Rosie had some complications. The doctor at the local hospital determined that she was dehydrated, so she was given an IV. The doctor consulted with an obstetrics physician at the urban hospital where she had given birth. The obstetrics physician recommended transporting her for further assessment. Roman said they could not afford an ambulance and he would drive her, but they were told she must go by ambulance.

Upon arrival at the urban hospital, the emergency room doctor conducted an initial assessment and consulted with the obstetrics physician by phone. Rosie was discharged within an hour and advised to return for outpatient diagnostics. After this, the couple received an ambulance bill for close to \$700.



Roman disagreed with being charged for the bill because he and Rosie had been clear that they didn't want an ambulance and they felt that Rosie did not receive care that justified an ambulance trip. He submitted a complaint with a request for a refund. The receiving hospital reviewed it, then the sending hospital reviewed it, and then the EMS service reviewed it. His request was denied each time. The reasons given were that the trip had been deemed clinically necessary by the physician, was in the interest of patient safety, and that adequate care had been provided at the receiving facility. It was also noted that ambulances are not an insured health service.

We developed a timeline of Rosie's care and approached the Saskatchewan Health Authority (SHA) with the view that the transfer was done on the assumption Rosie would be seen by the obstetric specialist. We were told rural physicians without expertise in certain areas will often recommend transfer to a larger facility in the interest of patient safety. We were also told that just because a specialist agrees to a consult, does not mean this would happen if the attending emergency room physician at the receiving hospital did not deem it necessary. We pointed out that this should have been explained to them before Rosie was transported, that it would have served to manage expectations and ensure transparency, especially given the significant costs involved. SHA officials agreed to revisit their decision on that basis and ultimately agreed there was reason to waive the charges, which they did. They indicated this would serve as a learning opportunity to ensure SHA staff provided clear communication with future patients.

Status: Resolved



# SPECIAL-CARE HOME: TRANSFER DECISION AND CONCERN-HANDLING

Roxanna contacted us with concerns about the quality of care provided to her daughter, Rae, at a special-care home operated by the Saskatchewan Health Authority (SHA), about her complaints to the SHA not being effectively addressed, and about the SHA's decision to transfer Rae to another facility further from Roxanna's home. We investigated whether the SHA's concern-handling process was reasonable and in keeping with provincial requirements, and whether its decision to transfer Rae was reasonable.

Roxanna lived in a village with a small special-care home whose residents were mostly elderly. Rae was in her 30s, and had irreversible, progressive dementia marked by childlike impulsivity, inattentiveness, and the need for assistance with complex activities. She was expected

to live as little as three or four more years. When it became impossible for Roxanna to take care of her at home, she was initially placed in a facility quite a distance away and Roxanna desperately wanted her moved to the special care home in her village. Though SHA officials had misgivings about whether the smaller home could care for Rae's significant and ever-increasing needs, it decided to try out of compassion for Roxanna. After the move, however, Roxanna immediately began raising concerns alleging, among other things, that staff were over-medicating Rae to minimize the effort required to care for her. The SHA approved additional resources so that she could receive 1:1 care, 16 hours a day.

Roxanna installed a web-enabled video camera in Rae's room. Although the camera footage showed no evidence to support her claims, she continued to make many serious allegations that staff were neglectful and abusive to Rae, and that they were taking their anger towards her out on Rae. She demanded several specific staff not be allowed to care for Rae. In response, some staff quit their jobs or went on stress leave. Others raised occupational health and safety concerns about Roxanna's behaviour. Eventually, the SHA decided to move Rae to another facility to give the staff respite and, hopefully, to allow the situation to de-escalate. In response, Roxanna decided to care for Rae at home again. The SHA arranged individualized funding to help her. Rae passed away about 6 months later.

We found the SHA's concern-handling procedures generally met the requirements of the Ministry of Health's Program Guidelines for Special-care Homes, with a few exceptions. For example, despite Roxanna raising numerous, frequent and wide-ranging concerns throughout Rae's stay, the SHA had no official records that reflected the nature and frequency of her concerns or the steps it took to address them. We also found that when frontline staff's efforts to deal directly with issues as they arose proved ineffective, any further solutions took longer to implement than they should have. This was because the small facility only had a part-time manager who did not effectively address Roxanna's concerns, and who mistakenly believed she was managing the situation, even after it was clear that Roxanna's trust in her was gone. Matters raised within the SHA at a higher level also did not result in solutions, because other SHA experts should have been consulted earlier for guidance or to explore what other resources were potentially available to improve the situation.

By the time the decision to transfer Rae out of the small facility was made, the relationship had become strained to the point

where Roxanna had a complete lack of trust regarding Rae's care, and while SHA staff remained empathetic to the situation, tension and fear resulted in a breakdown in their working relationship with her. Given this, we found transferring Rae was the right decision, despite missteps in the SHA's decision-making process. Notably, the SHA never gave Roxanna adequate warning that if she continued to intimidate, shame and otherwise behave unreasonably towards staff, it would have no choice but to transfer her daughter. Overall, we found that the SHA's failure to effectively address Roxanna's concerns and her behaviour towards staff significantly contributed to the situation escalating.

Lastly, though it was not the focus of our investigation, it was clear that the SHA's decision to try to care for Rae in the small facility was made with the knowledge that it might be difficult for its local staff to effectively deal with her deteriorating condition. Given this, we found it would have been reasonable for the SHA to have, at a minimum, developed a respite plan, trained staff on Rae's type of dementia and age demographic, scheduled regular and ongoing in-person follow-up from clinical professionals, and developed a contingency plan in case she posed a safety hazard to herself or others – before she was admitted to the facility.

We made the following recommendations:

1. The Saskatchewan Health Authority develop and implement a consistent concern-handling policy and procedures that meet the requirements of the Ministry of Health's *Program Guidelines for Special-care Homes* and ensures all staff are educated about them and required to comply with them.

Status: Accepted

2. The Saskatchewan Health Authority ensure residents and families have access to a written concern-handling policy and procedures, which describe their right to contact quality care coordinators and the Ombudsman at any time.

Status: Accepted

 The Saskatchewan Health Authority ensure that all facility managers document concerns that are unresolved at the point of care as required by the Ministry of Health's *Program Guidelines for* Special-care Homes.

Status: Accepted

4. The Saskatchewan Health Authority ensure its concern-handling policy and procedures include provisions to help its staff effectively and fairly address unreasonable conduct of people who are responsible for making decisions on behalf of residents.

Status: Accepted

5. The Saskatchewan Health Authority ensure that all residents of special-care homes and the persons responsible for residents have reasonable access to the services of social workers or other professionals to assist with their psychological, social and financial needs as required by the Ministry of Health's *Program Guidelines* for Special-care Homes.

Status: Accepted

# ADMINISTRATION OF OUT-OF-PROVINCE/OUT-OF-COUNTRY MEDICAL SERVICES REQUESTS

We have received several complaints about the Ministry of Health's Medical Services Branch (MSB) denying payment for out-of-province or out-of-country medical services, and about the Health Services Review Committee (HSRC) review process. We looked at whether the MSB's process of applying for payment was fair and transparent, whether it gives patients and doctors meaningful reasons for denying payment, and whether it uses a fair process to advise the Minister to reject HSRC recommendations to approve payments against the MSB's original decision.

The Saskatchewan Medical Care Insurance Payment Regulations, 1994 gives the Ministry of Health the discretion to pay for medically required health services provided in the private system outside of Saskatchewan. To exercise the discretion, a qualified specialist in Saskatchewan must notify the Ministry that the service is needed, it is not available in Saskatchewan, and whether, to the best of the specialist's knowledge, it is available elsewhere in Canada. Then, if the Ministry is of the opinion that the payment should be paid after reviewing the case and considering the nature of the service and its availability, it can be paid. If the service is available elsewhere in Canada, the Minister can pay at the same rate as if it was provided in Saskatchewan, whether it is provided elsewhere in Canada or in another country. If it is not available in Canada, the Minister can pay at a rate the Minister considers fair and reasonable.

The MSB is responsible for initially approving or denying out-of-province or out-of-country medical services requests. We found that the information the MSB provides applicants and specialists about the application process, the criteria the MSB uses to consider requests, and the process of appealing to the HSRC, is ambiguous. Given how important it is to applicants and to the public health care system generally for these decisions to be made with proper discretion, we found it would be reasonable for the Ministry to develop and implement fair and more transparent processes. Applicants and specialists should have access to clear information about how to request approval and what specific criteria need to be met.

Part of the Ministry's process includes researching whether a service is available in Canada, even if a specialist says they believe it is not. This



is because it must independently assess the availability and nature of the service before deciding whether to pay. Since the availability of the service in Canada's public system is a key criterion, we found that the Ministry should clearly advise applicants in writing when it is aware that a service is available in the public system and from whom.

We also found that while some of the MSB denial letters we reviewed included meaningful reasons, they were not always consistent. When the Ministry denies payment, the applicant should receive meaningful reasons so they can understand why the decision was made. This also helps the HSRC understand the MSB's rationale if an applicant appeals the decision. Meaningful reasons need to include a summary of the facts relied on, a description of the relevant rules, and meaningful explanations for the conclusions reached.

The HSRC's role is to review the MSB decisions to deny payment of out-of-province or out-of-country health care services, and to make recommendations to the Minister. The HSRC cannot recommend payment for health services that are not covered under Ministry legislation, policies and guidelines, but it is to operate and make its recommendations to the Minister completely independently from the Ministry. The decisions the Minister of Health makes based on the HSRC's recommendations can have a significant impact on applicants' interests. Because of this, it is important that the way the HSRC's recommendations are presented to the Minister for consideration be procedurally fair to applicants.

In one case we reviewed, the HSRC recommended that the Minister reject the MSB's decision and use ministerial discretion to pay the applicant. Instead of just forwarding the HSRC's recommendation to the Minister, the MSB prepared another submission to the Minister (a briefing note) advising the Minister to reject the HSRC's recommendation. While we acknowledged that the Minister should have the benefit of the perspectives provided by the Ministry in the briefing note, in our view, putting it forward to the Minister along with the HRSC recommendation was procedurally unfair to the complainant because they had no opportunity to review the information in it or to refute or comment on it before it was considered by the Minister. In other words, the Ministry availed itself of the opportunity to make another submission to the Minister that neither the applicant nor the HRSC had any opportunity to review or consider. This was procedurally unfair to the applicant and undermined the fairness of the HRSC process.

#### We made the following recommendations:

- 1. The Ministry of Health take steps to ensure that health care providers in Saskatchewan and applicants requesting coverage for an insured service not available in Saskatchewan, either in another province or in another country, have ready access to clear and reasonably detailed information about the application process, which includes:
  - a. the information they are required to submit in order for their applications to be considered (for example, as detailed in clause 9(2)(a) of The Saskatchewan Medical Care Insurance Payment Regulations, 1994;
  - b. timelines: and
  - c. the criteria against which their applications will be assessed.

Status: Accepted

- 2. The Ministry of Health take steps to ensure that its initial decision letters and any final letters following a review by the Health Services Review Committee to applicants who apply for insured services not available in Saskatchewan, provide reasonable, intelligible reasons to support the decision including:
  - a. summarizing all the relevant information relied upon in making the decision including explaining how contradictory information was dealt with;
  - summarizing all relevant legal and policy rules to establish the authority to make the decision and to explain their applicability to the decision;
  - c. providing a rationale for the decision by connecting the information relied upon to the rules to support the conclusions reached; and
  - d. addressing the major arguments submitted by the applicants.

Status: Accepted

3. The Ministry of Health establish and follow a process that ensures its submissions and recommendations to the Minister in response to the Health Services Review Committee recommending that the Minister reconsider the Ministry's decision to deny an applicant coverage for insured services not available in Saskatchewan, are made in a manner that is procedurally fair to the applicant.

Status: Accepted

# **Crown Corporations**

## **Complaints Received**

CROWN CORPORATIONS	2020	2019	2018
FINANCIAL & CONSUMER AFFAIRS AUTHORITY	4	1	0
SASKATCHEWAN CROP INSURANCE CORPORATION	4	6	6
SASKATCHEWAN GOVERNMENT INSURANCE			
Auto Fund	35	60	39
Claims Division - Auto Claims	49	68	64
Claims Division - No Fault Insurance	31	32	41
Claims Division - Other / SGI Canada	22	31	39
Other	2	13	21
TOTAL - SGI	139	204	204
SASKATCHEWAN LIQUOR AND GAMING AUTHORITY	2	3	5
SASKATCHEWAN PUBLIC SAFETY AGENCY	0	0	1
SASKATCHEWAN RESEARCH COUNCIL	0	1	0
SASKENERGY	21	34	46
SASKPOWER	79	134	135
SASKTEL	23	37	42
WATER SECURITY AGENCY	2	6	13
TOTAL	274	426	452

NOTE: Crown corporations about whom we received no complaints in the last three years are not listed in this table.

## **Case Examples**

#### **GETTING DATA TO THE DOC**

Ron contacted us because he was having trouble getting SaskTel to install Wi-Fi access, which he needed to collect and share medical data from his Continuous Positive Airway Pressure (CPAP) machine.

Ron told us that before the pandemic, he would bring his CPAP machine with him to his medical appointments, where his doctor would review the data stored on the machine and adjust his treatment accordingly. He said once the pandemic started, his doctor instructed him not to risk coming into the office, but to use Wi-Fi to access the machine's data and submit it electronically.

Ron had been living in a support home setting where he was able to use the home's Wi-Fi to transmit the data to his doctor, but had recently moved into his own apartment. When he called SaskTel to set up Wi-Fi, he was reminded that he still had money owing from a previous telephone bill and couldn't get new services until he paid. He said the support home tried to help him by mailing a cheque to SaskTel, but whenever he called SaskTel, he was told the cheque had not arrived and he couldn't arrange for services. Someone from the support home also tried to help him talk to SaskTel, but without success. He told us he had tried to explain his medical reasons for needing Wi-Fi, but that this did not seem to help. He felt no one at SaskTel would listen to him.

We contacted SaskTel and asked about Ron's account. According to its records, Ron had not mentioned his medical reason for needing Wi-Fi and they had never received the cheque. We spoke with the case manager at the home, who explained that, when they realized the cheque had not reached SaskTel, the home's bookkeeper had cancelled it and mailed a new one. The home also said it understood that Ron was indeed on a CPAP machine and needed access to Wi-Fi to send the data to his doctor. We relayed this information back to SaskTel and Ron's Wi-Fi was connected within a few days.

Status: Resolved



# **Other Ministries and Entities**

## **Complaints Received**

	2020	2019	2018
MINISTRIES			
ADVANCED EDUCATION	7	7	11
AGRICULTURE	2	7	11
CENTRAL SERVICES*	5	3	0
EDUCATION	2	3	1
ENERGY AND RESOURCES	0	0	1
ENVIRONMENT	8	14	5
FINANCE	6	8	5
GOVERNMENT RELATIONS	4	6	5
HIGHWAYS AND INFRASTRUCTURE	8	12	10
IMMIGRATION AND CAREER TRAINING	3	7	1
JUSTICE			
Court Services	13	10	10
Maintenance Enforcement Branch	37	23	29
Public Guardian and Trustee	19	21	15
Office of the Public Registry Administration	5	2	1
Office of Residential Tenancies / Provincial Mediation Board	65	107	64
Justice - Other	15	22	21
TOTAL - JUSTICE	154	185	140
LABOUR RELATIONS AND WORKPLACE SAFETY	9	24	24
PARKS, CULTURE AND SPORT	5	5	4
TRADE AND EXPORT DEVELOPMENT	2		
MINISTRY NOT DISCLOSED	0	0	1

<sup>\*</sup> On November 9, 2020, SaskBuilds and the Ministry of Central Services were replaced by the Ministry of SaskBuilds and Procurement.

	2020	2019	2018
BOARDS		-	
HIGHWAY TRAFFIC BOARD	1	8	10
LABOUR RELATIONS BOARD	0	1	1
SASKATCHEWAN MUNICIPAL BOARD	0	3	1
SASKATCHEWAN PENSION PLAN BOARD	0	0	1
SASKATCHEWAN SOCIAL SERVICES APPEAL BOARD	3	5	3
WORKERS' COMPENSATION BOARD	59	76	90
COMMISSIONS			
APPRENTICESHIP AND TRADES CERTIFICATION COMMISSION	0	3	0
AUTOMOBILE INJURY APPEAL COMMISSION	1	2	3
PROVINCIAL CAPITAL COMMISSION	1	2	2
PUBLIC SERVICE COMMISSION	1	2	2
SASKATCHEWAN HUMAN RIGHTS COMMISSION	9	14	11
SASKATCHEWAN LEGAL AID COMMISSION	23	42	46
SASKATCHEWAN PUBLIC COMPLAINTS COMMISSION	9	7	5
AGENCIES AND OTHER ORGANIZATIONS			
ANIMAL PROTECTION SERVICES OF SASKATCHEWAN	3	0	2
PRAIRIE AGRICULTURE MACHINERY INSTITUTE (PAMI)	0	1	0
SASKATCHEWAN ASSESSMENT MANAGEMENT AGENCY	1	0	6
SASKATCHEWAN EMPLOYMENT ACT ADJUDICATORS	1	2	1
SASKATCHEWAN POLYTECHNIC	2	3	3
TOTAL: OTHER MINISTRIES AND ENTITIES	329	452	406

NOTE: Ministries and other government entities about whom we received no complaints in the last three years are not listed in this table.

## **Case Examples**



#### IT WAS WORTHWHILE TO TRY AGAIN

Rosemary contacted us because she thought the Public Guardian and Trustee should have accepted Rory's application.

Rosemary told us that, although she and Rory were not biologically related, they had grown up in the same household as siblings. She explained that Rory was a vulnerable adult with disabilities, who had a certificate of incapacity and was living in a group home setting. He was also a recipient of the Saskatchewan Assured Income for Disabilities (SAID) program and his benefits were being paid directly to the home.

An advocate from the home had applied for Rory's affairs to be managed by the Public Guardian and Trustee, but this application was eventually rejected. The advocate, Rosemary, Rory's SAID worker and other concerned parties who knew him didn't understand why the application had been rejected. Rosemary felt the Public Guardian and Trustee had not fully understood Rory's situation.

We listened to Rosemary's concerns and encouraged her to try again. We suggested she put her concerns in writing to the Public Guardian and Trustee. She did and Rory's application was reconsidered and accepted.

Status: Referral



#### A MATTER OF TIMING

Robin, a doctoral student, contacted us because she disagreed with the way the Ministry of Advanced Education first approved and then reversed her Saskatchewan Canada Student Loan. Her loan application was for a period of study starting September 1, 2020.

On July 24, 2020, Advanced Education sent Robin a formal notice of assessment stating that she had a calculated need of about \$24,000, which would be disbursed to her according to a schedule, which was provided. She began to prepare for her school year by securing a place to live and buying textbooks.

On August 5, 2020, Advanced Education reviewed a data restriction file it receives weekly from the federal government and became aware that Robin had exhausted her lifetime maximum assistance limit of 400 weeks. Two weeks later, Advanced Education contacted Robin to let her know that she was not eligible for funding. Advanced Education

acknowledged the financial impact this would have on her and offered an apology. Then on September 8, 2020, Advanced Education issued Robin a written notice confirming it was unable to provide her with funding because, "The Federal Government has advised that you have been enrolled in more than 400 weeks of post-secondary study and that you are ineligible for additional assistance."

We considered whether Advanced Education had reasonable processes for ensuring it does not approve loan applications for students who will have exhausted their maximum lifetime weeks of study as of the beginning of the period of study for which they are applying.

First, we acknowledged that Robin bore some personal responsibility. When applying, she would have known or been able to find out how many weeks of study she would have completed by the beginning of the new loan period. The student loan handbook, which is available on Advanced Education's website, mentions the maximum lifetime limit. The loan application she completed also references instructions that state a person cannot have exhausted the lifetime maximum weekly assistance limit.

Second, we found that, as the administrator of the program, Advanced Education is responsible for ensuring it correctly assesses students' eligibility and gives them accurate notifications of these assessments. Advanced Education told us it was a matter of timing – that it could not have known that Robin would be ineligible until it received the data from the federal government. However, since one of the key application criteria is that students do not exceed the lifetime maximum weeks of study, we found it would be reasonable for Advanced Education to confirm this when it assesses applications, even though this is complicated by the fact that students can accumulate weeks of study based on loans from other provinces – information that is not available to Advanced Education unless it asks the student or waits for the exception data file to be updated by the federal government.

Based on our assessment, we made the following suggestions:

- That the Ministry consult with the federal government with a view to ensuring the Ministry has appropriate and timely access to the information it needs to ensure it does not approve applications for funding for students who will not be eligible for funding for the period of study to which the application relates.
- 2. That the Ministry consider adding a line to the Notice of Assessment, stating that if a reassessment of the students' weeks of study shows they are or will be over the maximum lifetime limit during the course of study for which the loan was approved, that the loan approval will be rescinded or amended accordingly.

Advanced Education agreed that "students should be better informed about the lifetime maximum limits .... [and] should be provided regular updates or warnings if and when they approach the limit" and that we provided good suggestions. However, since few students reach this threshold, Advanced Education said it favoured a more targeted approach, so it first planned to connect with Canada Student Loans to propose direct messaging be given to students on the federal student portal.

Status: Resolved



#### WCB DECISION TO TERMINATE WAGE LOSS BENEFITS

While working as a construction labourer, Randall injured his leg and was unable to work. He received wage loss and medical benefits from the WCB. The WCB concluded that, though he had permanent restrictions, he was capable of full-time, sedentary work. It asked his pre-injury employer if it had a suitable position that he could do, given his restrictions. The employer offered him a newly created position as an administrative assistant. Randall refused it because he did not believe he had the language skills and abilities to perform the job. He was not fluent in English, as it was his third language. WCB terminated his wage loss benefits because he turned down the job offer.

Randall lost his appeal to the WCB's appeals department, which stated "suitable productive employment" meant work he could functionally perform given his work injury-related medical restrictions, and that "a language barrier is not a medical restriction." The WCB's Board Appeal Tribunal denied his further appeal on the same basis, stating that the offered position was suitable, and language is not a suitable rationale for a medical restriction. In a dissenting opinion, a tribunal member agreed with the complainant's position and found that he should be provided with ongoing wage loss and vocational rehabilitation. Randall contacted us because he felt the tribunal's decision was unfair and unreasonable.

The Workers' Compensation Act, 2013 says vocational rehabilitation is intended to return an injured worker to suitable employment. It includes, among other things, assessment, education, training, and assistance with job placements. However, if a worker, without good reason, declines to accept employment in an occupation in which the worker - in the opinion of the board, after having consulted with the worker - is capable of engaging, the WCB may terminate compensation.

According to the WCB's policy, when a worker cannot return to his preinjury job because of compensable restrictions, some type of alternate work with the pre-injury employer must be explored "that is within the worker's functional capabilities." The WCB has discretion to decide whether to assess a worker's transferable skills and qualifications to determine whether the alternate work is within the worker's "functional capabilities."

We found no indication that the WCB reasonably considered Randall's claim that he did not have the English language skills necessary to perform the duties of the administrative position he was offered. According to the employer's description of the position, it clearly required him to be somewhat proficient in English – both spoken and written.

In response to a draft report of our tentative findings, the WCB said that it is not required to perform a formal employability assessment or transferable skills analysis in every case – that this is discretionary. However, based on our investigation, we found no indication that the WCB even considered consulting with a vocational rehabilitation specialist about the adequacy of the complainant's English language skills – even after he specifically raised it. Nor did it provide him with a reasonable rationale for rejecting his request.

We found that the Board Appeal Tribunal's majority decision focused on an issue that was not in dispute in the complainant's case – whether his proficiency in English could be the basis for a medical restriction. We also found that it failed to consider relevant issues: first, whether his proficiency in English had been objectively determined; and second, whether his tested proficiency meant that the accommodated position was (or was not) suitable productive employment for him.

We made the following recommendations:

1. The Saskatchewan Workers' Compensation Board assess the complainant's employability and transferable skills in accordance with its vocational rehabilitation policy and procedures.

Status: Not Accepted

2. The Saskatchewan Workers' Compensation Board review the accommodated employment offer made by his pre-injury employer in accordance with the findings of the vocational assessment to determine if the offer was for suitable productive employment.

Status: Not Accepted

 If the accommodated employment offer made by his preinjury employer was not for suitable productive employment, the Saskatchewan Workers' Compensation Board provide the complainant with any additional wage loss and vocational services to which he was entitled.

Status: Not Accepted

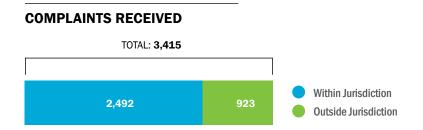


## **Statistics**

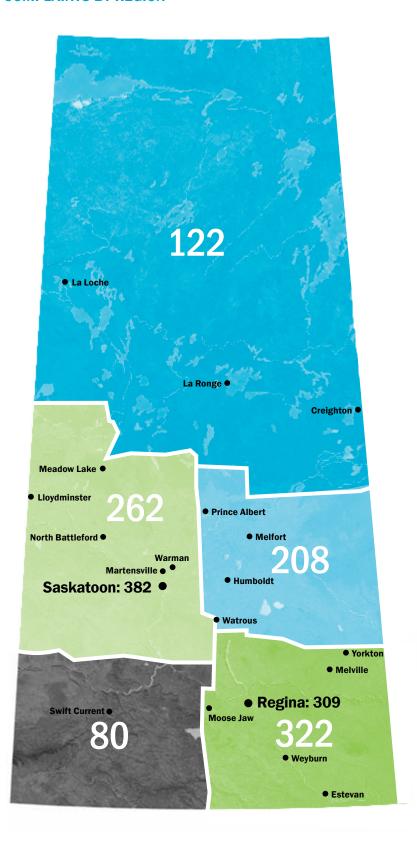
#### **Receiving Complaints**

Most complaints we receive fall 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 2020, we received 3,415 complaints: 2,492 that were within jurisdiction and 923 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**

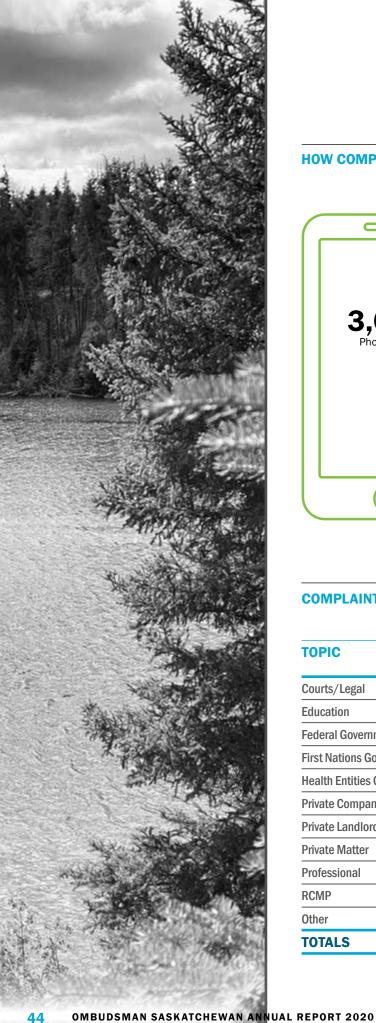
North	122
West Central	262
East Central	208
Southwest	80
Southeast	322
Regina	309
Saskatoon	382

#### **Other Locations**

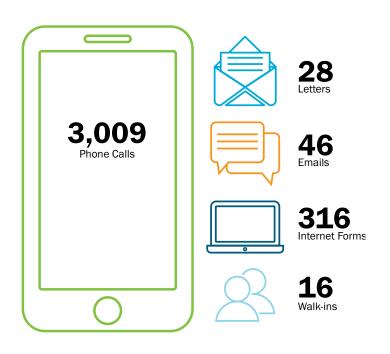
Correctional Centres	603
Out of Province	38
Unknown	166

#### **TOTAL Complaints**

TOTAL	2.492
101/1	_,



#### **HOW COMPLAINTS WERE RECEIVED**



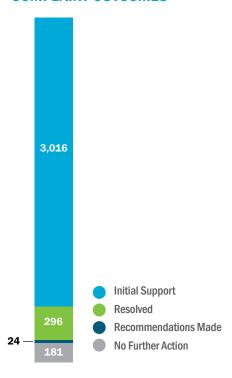
#### **COMPLAINTS RECEIVED OUTSIDE JURISDICTION**

TOPIC	COMPLAINTS RECEIVED
Courts/Legal	52
Education	12
Federal Government	137
First Nations Government	13
Health Entities Outside Our Jurisdiction	42
Private Company	218
Private Landlord/Tenant	204
Private Matter	86
Professional	47
RCMP	42
Other	70
TOTALS	923

#### **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 not all complaints are closed in the year they are received, so the number received in a year will not necessarily be the same as the number closed. Also, some complaints contain multiple issues, each of which may be closed with a different outcome.

#### **COMPLAINT 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

These complaints were resolved in some manner. For example, an appropriate remedy may have been reached or a better explanation provided for a decision.

#### **Recommendations Made**

This represents the total number of recommendations made on closed files.

#### **No Further Action**

There was no further action required on these files. For example: there was 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.

	TARGET	ACTUAL
Files Closed Within 90 Days	90%	94%
Files Closed Within 180 Days	95%	98%

## **Staff**



**Christy Bell** 

Assistant Ombudsman

**Leila Dueck** 

**Director of Communications** 

**Karin Dupeyron** 

Complaints Analyst

Renée Gavigan

Deputy Ombudsman

**Stacey Giroux** 

**Executive Administrative** 

Assistant

**Jennifer Hall** 

Assistant Ombudsman

**Adrienne Jacques** 

**Complaints Analyst** 

Yinka Jarikre

Assistant Ombudsman

**Ryan Kennedy** 

Executive Administrative Assistant

Pat Lyon

Assistant Ombudsman

**Lindsay Mitchell** 

Assistant Ombudsman

Stephanie Pashapouri

Complaints Analyst

**Sherry Pelletier** 

Assistant Ombudsman

**Nicole Protz** 

**Complaints Analyst** 

**Shelley Rissling** 

Administrative Assistant

**Andrea Smandych** 

Manager of Administration

Niki Smith

**Complaints Analyst** 

Will Sutherland

Assistant Ombudsman

**Greg Sykes** 

General Counsel

**Laurie Taylor** 

Administrative Assistant

**Kathy Upton** 

A/Deputy Ombudsman

**Harry Walker** 

**Complaints Analyst** 

**Rob Walton** 

Assistant Ombudsman

# **Budget**

	2018-2019 AUDITED FINANCIAL STATEMENT*	2019–2020 AUDITED FINANCIAL STATEMENT*	2020-2021 BUDGET**
REVENUE			
General Revenue Fund Appropriation	\$3,039,627	\$ 3,714,071	\$4,249,000
Miscellaneous	-	\$990	-
TOTAL REVENUE	\$3,039,627	\$ 3,715,061	\$4,249,000
EXPENSES			
Salaries & Benefits	\$2,345,487	\$ 2,383,693	\$3,175,000
Office Space & Equipment Rental	\$310,409	\$ 504,245	\$563,300
Communication	\$61,019	\$ 33,462	\$34,100
Miscellaneous Services	\$98,040	\$87,659	\$140,300
Office Supplies & Expenses	\$17,916	\$14,671	\$17,500
Advertising, Promotion & Events	\$60,424	\$34,931	\$62,500
Travel	\$57,047	\$52,766	\$55,200
Amortization	\$18,824	\$121,359	-
Dues & Fees	\$15,204	\$31,507	\$109,000
Repairs & Maintenance	\$51,524	\$93,242	\$92,100
Capital Asset Acquisitions	-	-	-
Loss on Disposal of Capital Assets	-	-	-
TOTAL EXPENSES	\$3,035,894	\$3,357,535	\$4,249,000
ANNUAL (DEFICIT) SURPLUS	\$3,733	\$357,526	

<sup>\*</sup>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.

<sup>\*\*</sup>Due to the timing of this report, 2020–2021 numbers reflect the budgeted amount rather than the actual.