"Ombudsman Strategies for Getting to Yes and Beyond: Acceptance and Implementation of Recommendations"

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1. Preparing the Ground: Building Relationships

The role of an ombudsman is to promote accountability, transparency, and fairness in the public sector. This mandate is fulfilled by receiving citizens' complaints about a branch of government or a public sector body, determining whether the complaint has merit, and if so, working collaboratively with stakeholders to get the problem resolved.

As an independent and impartial officer, it is important for the ombudsman to have credibility with, and the trust of, all stakeholders. The ombudsman's office is not an advocate for the complainant nor a defender of the public sector bodies within its jurisdiction. Demonstrating impartiality and fairness is essential to building the productive and appropriate relationships necessary for the ombudsman to be able to effect positive change. That sometimes involves validating the work done by a public sector body or branch of government (giving credit where credit is due), as much as shining a light on instances of maladministration or lapses in administrative fairness. The work done and the relationships established in the day-to-day interactions between the ombudsman's office and public sector bodies in resolving individual complaints will have a tremendous impact on the ombudsman's effectiveness in reporting on systemic issues and making recommendations for changes in policy and procedure.

If ombudsman offices only look at individual complaints in isolation, they miss the opportunity to address root causes of complaints and recommend corrective actions designed to prevent them from recurring. This is why systemic investigations are so important and why they provide an opportunity for the ombudsman to have such significant positive impact on society. The ombudsman is uniquely positioned to propose solutions to problems that affect vast segments of society.

The key to adding maximum value is getting the ombudsman's recommendations accepted and implemented. The Office of the Ombudsman of Ontario has successfully deployed several techniques for doing this, which we describe later in this paper.

What I want to underscore, however, is what comes first: The process of getting recommendations accepted begins before they are even presented.

Start from a position of trust

It begins with relationship building. That involves establishing credibility and trust with all stakeholders, including the public sector bodies the ombudsman oversees. Trust and credibility are gained in large measure by employing a fair and credible process.

If an ombudsman is going to promote procedural fairness, he or she must "walk the talk" and be fair in the investigative process. This involves providing advance notice of the systemic investigation – ideally by the ombudsman meeting with the head of the organization, to explain the reasons for the investigation, to pledge a fair and impartial investigative process, to underscore that a collaborative approach is preferred, and to invite input and commentary from the organization at any time.

Demonstrate value

Whenever possible, it is helpful to demonstrate to the organization that the ombudsman's systemic investigation will provide value; it serves not only the public interest, but can be in the best interest of the organization as well. Either the organization's work will be validated by an independent third party – which can be a great boost for internal morale – or constructive feedback will be provided that will enable it to address the root causes of complaints and prevent recurrence.

One of the things I try to impress upon the leadership of public sector bodies is that they should not fear or try to discourage complaints. Rather, progressive and forward-looking organizations should embrace complaints as opportunities to enhance relationships with stakeholders and improve operations. As Microsoft's Bill Gates had said, "a dissatisfied customer is your best source of feedback."

If people think an organization is unfair or not concerned about treating them properly, they will be less likely to engage with it and accept its decisions. Then the organization has to devote time, energy, and money to dealing with appeals, litigation, and the costs of non-compliance. Conversely, if stakeholders feel they have been heard and treated fairly, they are more likely to accept the organization's actions and decisions.

By being responsive to complaints, and accepting and implementing the ombudsman's recommendations to address systemic issues, a public sector body can demonstrate that it puts a priority on fairness and sound administration. That in turn will enhance the public's faith and confidence in that organization.

Quite often, a ombudsman's systemic investigation addresses an issue that middle management is aware of and would like to rectify, but cannot secure the resources to address adequately. Once the ombudsman's report becomes public, it is not uncommon for resources to become available and for the leadership to be grateful for the ombudsman's intervention. I call this a "win-win-win" result.

Make feasible recommendations

The credibility of the investigation and the emotional impact of the resulting report will also affect the palatability of the recommendations, and the likelihood of their implementation. Key factors are:

- Compiling irrefutable evidence;
- Employing a procedurally fair and thorough investigative process;
- Telling compelling stories that resonate with people;
- Making feasible recommendations; and
- Publicizing the report as widely as possible.

With such an approach, the ombudsman makes it difficult for a reasonable organization not to accept the resulting recommendations. Once the body has committed publicly to accepting and implementing the recommendations, the ombudsman's practice of following up and insisting on regular progress reports comes into play.

Follow up

The Ombudsman can also add value and contribute to win-win-win situations beyond the context of investigations into complaints or systemic issues. With the knowledge and data collected through receiving and assessing citizen complaints, the parliamentary Ombudsman is uniquely positioned to be able to advise government stakeholders about emerging trends and potential systemic issues on the horizon. Providing regular feedback to government on the issues that appear to be creating citizen dissatisfaction creates an opportunity for more timely corrective action. My office does this through quarterly meetings with several public sector stakeholders, including the provincial departments that generate frequent or numerous complaints.

In some jurisdictions, either by law or convention, the Ombudsman is consulted on proposed policy or legislation before it is enacted. Drawing on input from the Ombudsman's unique perspective can only enhance the development process and the resulting policy. Through regular contact and formal submissions to government the Ontario Ombudsman make significant contributions to policy discussions on matters ranging from policing and corrections to municipal affairs, health and beyond.

If the administrative branch of government acknowledges the value of these practices and works collaboratively with the Ombudsman's office, some problems can be avoided, and others solved sooner, with benefits to all stakeholders. Citizens will have better administration and more fairness from their public sector. In return, these organizations will have more engagement and acceptance from citizens resulting in better compliance, less litigation and fewer complaints, as well as less bad publicity. It therefore actually possible for the Ombudsman in some instances to drive positive systemic change without the need for systemic investigations and reports with recommendations.

As stated above, the role of an ombudsman is to promote accountability, transparency, and fairness in the public sector. My view is that the key to an Ombudsman's success is appropriate and productive relationships built on trust and credibility. If an Ombudsman can establish the type of independent yet collaborative relationships described above, the recommendations that flow from a systemic investigation are more likely to be accepted and implemented because they will be seen not as a short-lived public relations set back, but rather as part of an ongoing public service partnership.

Drive positive change

While we do not have the power to compel acceptance and implementation of our recommendations, we do have an important and effective tool in the power to publish. Ultimately, our power is in our voice.

The Ombudsman's principal objective should not be to name, blame, and shame the public sector body being examined, but rather to drive positive change. Yet on occasion it may be necessary as a last resort to venture into the upper reaches of the moral suasion spectrum if an organization is intransigent.

If a public sector body does not see the value of working collaboratively towards appropriate outcomes and accepting recommendations that will benefit citizen stakeholders, the Ombudsman must increase the intensity of his or her advocacy in favor of those recommendations and engage public opinion as much as possible.

If a public sector body refuses to accept recommendations, or claims to accept them but does not make credible efforts to implement them, the Ombudsman's emphasis must shift from collaboration to a stricter form of oversight. Media engagement, the use of social media, press conferences, and even follow-up reports may be necessary as part of the Ombudsman's advocacy for recommendations if an organization fails to address them adequately.

That kind of response is not the norm. In fact, it is not uncommon for public sector bodies to begin reviewing programs and instituting changes once we begin a systemic investigation.

In the hopes of being able to respond to the Ombudsman's eventual recommendations by saying that much corrective action has already been taken, organizations often find the will and resources to make substantive program changes during the course of our investigations.

If the very fact of initiating a systemic investigation can lead to positive changes, that is another form of a win-win-win situation.

We are pleased to share our experience on this topic, based on the more than 35 in-depth systemic investigations our office has conducted over the past 12 years.

2. Monitoring the Implementation of Recommendations

The Office of the Ombudsman of Ontario's Special Ombudsman Response Team (SORT) is comprised of experienced and highly trained investigators who are tasked with planning and carrying out the field work for our systemic investigations. Each such case has a SORT investigator designated as the lead investigator, who is responsible for planning and conducting the investigation, assisted by other staff – including investigators, members of the legal team, and complaint intake staff.

Since our office established SORT in 2005, we have conducted 38 systemic investigations.[1] The team has also prepared numerous in-depth assessments in cases where the Ombudsman has subsequently decided that there is insufficient reason to launch an investigation.

SORT investigations have resulted in hundreds of recommendations to a wide variety of public bodies. The number of recommendations can vary, depending on the scope of the investigation and the subject matter. For example, our 2014 report *Careless About Child Care*,[2] resulting from a broad investigation into how the Ministry of Education oversaw unlicensed child care providers, contained 113 recommendations. But the 20015 report *Between a Rock and a Hard Place*[3] made only four recommendations in the wake of an investigation into why parents of children with severe disabilities were forced to place them into the custody of child welfare agencies. (Summaries of these and other case examples are included in the last section of this paper.)

Almost all (more than 95%) of the recommendations made by our office as a result of systemic (SORT) investigations since 2005 have been accepted and implemented.

The only significant exceptions are some key recommendations made in our investigation of the Special Investigations Unit and the resulting two reports, *Oversight Unseen*[4] (2008) and *Oversight Undermined*[5] (2011). These recommendations required legislative change, which has yet to take place.

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[1] Reports on all Ontario Ombudsman systemic investigations can be found online here: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations.aspx >
[2] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Monitoring-of-unlicensed-daycares.aspx >
[3] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Children-with-special-needs---em-Between-a-Rock-an.aspx >
[4] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Oversight-of-police---em-Oversight-Unseen--em-.aspx >
[5] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Oversight-of-police--Oversight-Undermined.aspx >

Monitoring strategies and techniques

Prior to the investigation

One technique that has proven effective for our office in having recommendations accepted is for the Ombudsman to speak with the head of the affected public sector body before the investigation begins. This provides an opportunity for relationship-building in which the Ombudsman can explain why the investigation has been deemed necessary and which issues it will focus on. At this point, we also ask if there is anything the organization would like investigators to know or take into account.

A pledge of ongoing communication and procedural fairness will go a long way to ensuring that the investigation goes smoothly and that eventual recommendations will be well received. Explaining that the public sector body will have an opportunity to review and comment on draft recommendations prior to the report being finalized and made public is also helpful and promotes buy-in.

During the investigation

Although we always seek to resolve issues – and therefore it is not assumed that every investigation will result in recommendations – systemic investigations almost always do. SORT investigations are typically launched after careful assessment of the case, where there is clear prima facie evidence of a systemic issue or issues. SORT staff also:

- Identify other jurisdictions (in Canada and abroad) that have dealt with similar issues, to obtain information for potential recommendations, especially best practices that have worked elsewhere.
- Canvass all parties to the investigation – e.g., complainants, individuals who are responsible for administering the affected programs, and any special interest groups or other stakeholders – for their suggested improvements or solutions.

Crafting recommendations

Our office's reports and recommendations are usually drafted by our in-house General Counsel, who works closely with investigators and the Ombudsman throughout the investigation. Recommendations are drafted during the report-writing process, with the input of the lead investigator and other members of our senior management team. The Ombudsman is involved throughout, from planning the investigation to finalizing the wording of recommendations.

Our overall goal is to create recommendations that are doable – i.e., they are grounded in the realities of any given situation and are feasible and practical. Creating vague, nebulous or "feel-good" recommendations – including those that will require resources that everyone knows do not and likely never will exist – is not in the interest of the public or our office. The reverse is also true: Feasible recommendations that are implemented can make a tangible

difference to the public and the affected organization – and this in turn can enhance our credibility.

In our experience, best practices for crafting doable recommendations include:

- Listening to the views of those who will have to implement them or be impacted by them, including senior officials from the public body being investigated.
- Seeking out this type of information during interviews for the investigation.
- Ensuring all affected parties feel part of the process.

Preliminary report – opportunity to review and respond

Once the field work of the investigation has been completed and the Ombudsman's findings and recommendations drafted, our practice is to provide a confidential preliminary draft to the relevant public body, summarizing the evidence gathered, our conclusions based on the facts, and our proposed recommendations. This process, conducted in private, gives public sector officials an opportunity to comment on the feasibility of implementing the proposed recommendations. On occasion, this stage of the process can include meetings between the Ombudsman and/or senior staff and senior public sector officials, during which modifications and alternative recommendations can be discussed collaboratively.

For instance, in our 2006 report *A Game of Trust,*[6] regarding an investigation into how the Ontario Lottery and Gaming Corporation protected the public from lottery fraud and theft, many of the recommendations took into account comments from the corporation's senior management about the inner workings of the lottery system and the feasibility of implementing stronger security measures.

We review and consider any comments from public sector officials received in response to the preliminary report. Where appropriate, recommendations are revised accordingly, though this is quite rare. The organization's comments are incorporated into our final report, as warranted (in some cases, a brief summary is sufficient; in cases where the organization provides a detailed written response, this is appended to the final report, which is made public).

Final report and follow-up

In our experience, most recommendations arising from our office's systemic investigations have been accepted without equivocation. However, occasionally a public sector body will merely commit to "consider" (or "study," or "review") one or more of the recommendations. (One such example is our 2006 report, *Losing the Waiting Game*[7], involving the Ministry of Community and Social Services, which is detailed in the final section of this paper.)

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[6] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Lotteries---em-A-Game-of-Trust--em-.aspx >
[7] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Disabled-support---em-Losing-the-Waiting-Game--em-.aspx >

A lot of thought goes into crafting recommendations. If the evidence indicates that the matter requires more study, our recommendations would acknowledge and reflect that. If it appears that the organization is using "more study" as an excuse, it is particularly important to follow up.

Our office incorporates a robust post-investigation monitoring process as part of every SORT investigation. Key elements of this strategy are:

- Including a recommendation in every SORT report that the public sector body report back to us – in writing, and at specific intervals – on its progress in implementing the recommendations (the interval depends on the scope of the recommendations, how long they would reasonably take to implement, and whether there is a genuine commitment on the organization's part to do so);
- Analyzing these reports and reporting publicly on the body's progress, e.g., in our Annual Reports and on our website;
- Engaging the public via the news and social media as warranted; and
- Monitoring relevant information from other sources.

The lead SORT investigator is responsible for reviewing and assessing the accuracy and comprehensiveness of the information provided in the organization's progress report. He or she will follow up with the public body for additional information and/or clarification, as necessary. In our experience, the public sector body will often provide us with a detailed chart, listing each recommendation and documenting the progress made in response.

Information from other sources can also help us gauge the impact of the recommendations on the issues they are meant to address. Primarily, this involves monitoring the number and type of related complaints we or other oversight bodies receive. It can also involve reviewing media reports, contacting special interest or advocacy groups, or keeping an eye on proceedings in the Legislature if the issue is raised there. This aspect of the monitoring process involves several areas of our office; for example, complaints or information submissions that may relate to completed SORT investigations are flagged by intake staff, and the communications team watches for relevant developments in the Legislature, news and social media.

Another important aspect of post-investigation monitoring in some cases is the potential for reprisals against individuals involved in the investigation, such as vulnerable complainants or whistleblowers. Whether or not this is directly related to the recommendations, any such reprisals would clearly undermine our work. For example, in our 2005 report *Between a Rock and a Hard Place*, the Ombudsman stressed that some of the parents of severely disabled children who had come forward expressed fears that they would be punished in some way by the officials they were so dependent on to assist them. The Ombudsman did not make a recommendation in this regard, but clearly stated in the report that our office would monitor outcomes and "act vigorously" if there was any evidence of reprisal against these vulnerable families.

We have found most organizations follow through with implementing our recommendations. In the rare cases where we are not satisfied with their progress, we may choose to:

- Attempt to resolve any outstanding issues informally and collaboratively; or
- Launch another investigation.

Launching another investigation is a last resort, used only when key problems identified in the initial investigation have been ignored or not dealt with effectively, resulting in ongoing injustice and/or maladministration. We have used this approach once, following up our 2008 investigation of the Special Investigations Unit and the Ministry of the Attorney General with a second investigation in 2011 (resulting in the reports *Oversight Unseen* and *Oversight Undermined*, cited above). The second investigation focused on how and why the Ministry had failed to implement the recommendations from the first.

Once the Ombudsman is satisfied that the public sector body has made significant progress on putting the recommendations into place, then formal reporting intervals may be extended – from six months to a year, for example – or removed altogether. However, the lead investigator normally keeps in informal contact with senior officials at the involved public body, and staff dealing with complaints and communications will flag relevant issues or trends if they emerge.

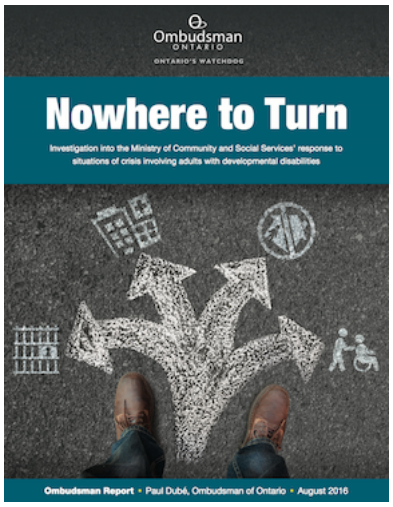
For example, our office's 2005 investigation of the province's program for screening newborn babies for preventable diseases (report: *The Right to be Impatient*[8]) resulted in significant improvements to that program, averting death and severe illness for hundreds of children. But 11 years later, through pro-active monitoring of complaints and news media, we learned of procedural glitches that were delaying test data, and our intervention prompted further improvements. Updates on cases like this are included in our Annual Reports and posted on our website alongside the original case report.

[8] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Newborn-screening---em-The-Right-to-be-Impatient--.aspx >

3. Case Examples

Team approach, personal touch and ongoing monitoring: Report – *Nowhere To Turn* (2016) – Adults with developmental disabilities

Experts, stakeholders and the investigators themselves were consulted in crafting the recommendations in this case. Persuading officials to accept them required a meeting between the Ombudsman, the Minister of Community and Social Services, and the Deputy Minister in the final weeks before the report was published. Less than a year later, we are following up on the Ministry's progress in implementing the recommendations, and its response to complaints that continue to come in.



Nowhere To Turn[9] reviewed more than 1,400 complaints and highlighted egregious cases of adults with developmental disabilities in crisis situations, including being abandoned, abused, unnecessarily hospitalized and jailed. The investigation revealed that inconsistencies in how funding is prioritized and distributed leave some families so desperate that they have abandoned loved ones with developmental disabilities and complex medical conditions.

The report made 60 recommendations, all of which were ultimately accepted by the Ministry of Community and Social Services. Among other things, we recommended that the Ministry establish urgent response resources, and direct that adults with developmental disabilities not be returned to abusive situations or housed inappropriately in hospitals and long-term care homes. Other recommendations called for improved tracking, monitoring and research to identify service gaps and allow for better planning and flexible solutions to crisis situations.

In an investigation so complex, in a difficult area and during a time when government policy and approaches were changing, the recommendations came from various sources – most notably from experts in the field who were able to pinpoint problems and propose solutions. For example, one local police team that dealt with many crisis situations pointed out the importance of having crisis workers available on short notice. After canvassing other stakeholders, assessing whether it was a feasible approach and looking at best practices elsewhere, we incorporated this idea into one of the recommendations.

SORT investigators often come up with potential recommendations based on the evidence they gather. The team met regularly throughout the lengthy investigation to discuss areas that clearly need improvement and what potential recommendations might look like. These

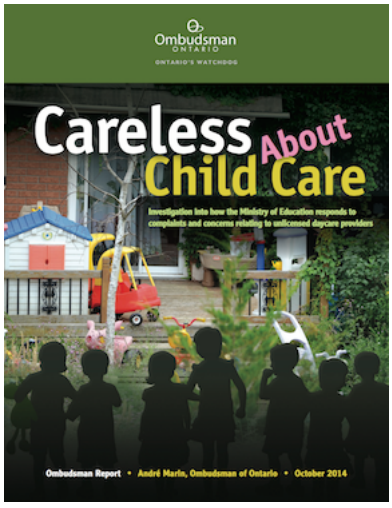
[9] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Adults-with-developmental-disabilities-in-crisis.aspx >

proposals were discussed in depth with the Ombudsman and General Counsel and incorporated into the report and recommendations.

Our report reflected that attitudinal and leadership changes had taken place within the Ministry during the course of the investigation, making it more receptive to the recommendations. Throughout the systemic investigation, our office also dealt with individual complainants' situations on a case-by-case basis, helping families find placements for loved ones (we helped 20 people move out of hospitals and into more appropriate homes). Similar complaints continue to come in – more than 100 since the release of the report. We continue to raise these cases with the Ministry in addition to following up with officials for detailed information on their progress in implementing the recommendations; this information will be summarized in our next Annual Report.

Collaboration before and after:
Report – *Careless About Child Care* (2014) – monitoring of unlicensed daycares

This case demonstrates how the Ombudsman's intervention can galvanize change, even while an investigation is ongoing. In the wake of several deaths of children in unlicensed care, this investigation explored the failures of the Ministry of Education to monitor these operations, and the antiquated legislation that governed them. The Ministry worked collaboratively with SORT throughout the investigation and implemented all 113 recommendations swiftly thereafter.



Our office's 2014 report revealed serious systemic problems in the monitoring of private, unlicensed daycares, where four children had died within seven months. The responsible Ministry agreed to implement all of the recommendations, and less than two months after the release of the report, passed new legislation to strengthen the regulation of child care.

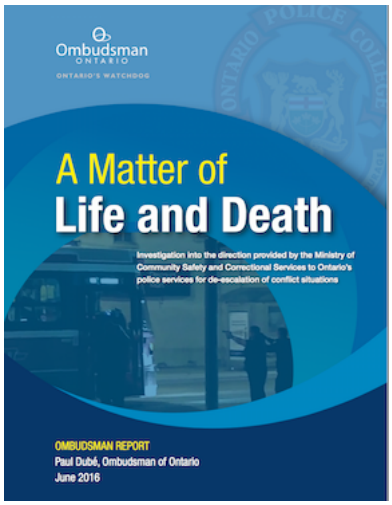
Senior Ombudsman management staff and SORT investigators worked closely with senior Ministry officials throughout the investigation. The Ministry had already identified problems and was working on resolving them, but our investigation served as a catalyst, helping the Ministry focus on key areas. In its response to our preliminary report, which was published as part of the final report, the Ministry stated that it was already addressing 95 of the 113 recommendations.

The lead investigator kept in close contact with the Ministry throughout the implementation process, receiving regular informal updates in addition to those required every six months by recommendation. SORT verified that the Ministry's claim that 55 of the 113 recommendations were fully implemented within six months. By 2016, all had been addressed. The improvements include a dedicated enforcement unit to deal with complaints about unlicensed

daycares and a toll-free complaints line; a public awareness campaign to educate the public about child care options; and an online registry that allows people to check which daycare operators have violated the law.

Last-minute persuasion:
Report – *A Matter of Life and Death* (2016) – police de-escalation training

The Ministry of Community Safety and Correctional Services repeatedly rejected our recommendations and attempts at collaboration – until the newly-appointed Minister met with the Ombudsman the day before he published our report.



This investigation was launched in the wake of the fatal police shooting of an 18-year-old man on a Toronto streetcar in the summer of 2013, but reviewed similar situations in which persons in crisis, often due to mental illness or drugs, were killed by police over the past two decades. The investigation explored how the Ministry of Community Safety and Correctional Services directs how police are trained to use force. SORT investigators compared de-escalation training and use-of-force models from around the world with those provided to police in Ontario.

Based on interviews with policing experts in Ontario and elsewhere, as well as family members of people killed by police, we made 22 recommendations, starting with a call for the Ministry to direct that de-escalation techniques be used before force whenever public and officer safety allow. We also recommended that the Ministry introduce a new regulation setting out guidelines on de-escalation for all police services, as well as a new use-of-force model.

The Ministry was first provided with a draft of the report and recommendations in 2015, but its response to the recommendations was largely non-committal; as well, ongoing legal proceedings related to the 2013 shooting meant it was not an ideal time to finalize the report. In May 2016, the preliminary report was completed and the Ombudsman met with the then-Minister – but again, the Ministry did not make any substantive commitment to implement the recommendations. We included this response with our final report, noting that it was "disappointing and perplexing."

However, the day before we were slated to release the report at a press conference, we were able to arrange a meeting between the Ombudsman and the new Minister, who had been appointed two weeks before in a cabinet shuffle. The new minister committed to implementing all 22 recommendations. Although this occurred too late to be incorporated into the published

report, the Ombudsman and Minister both announced this commitment at press conferences the next day, and it was posted alongside our report on our website.[10]

Senior Ombudsman staff and the lead investigator have since been in regular contact with senior Ministry staff, including the Deputy Minister, about progress in implementing the recommendations, and the Ministry has provided detailed updates on the steps it is taking to put the recommendations into effect. The Ombudsman and Director of SORT also visited the Ontario Police College in December 2016 to for a demonstration of the improved de-escalation training. These developments will be made public in the Ombudsman's next Annual Report, in June 2017.

Never too late to do the right thing: Report – *A Vast Injustice* (2009) – Drug funding for colorectal cancer patients

Personal intervention by the Ombudsman and the appointment of a new Minister of Health and Long-Term Care led to the reversal of an initial refusal to implement recommendations. Media pressure and efforts by the Ministry to reduce costs associated with the recommendation were additional factors in this case.

Our office's September 2009 report, *A Vast Injustice*[11], called on the Ministry of Health and Long-Term Care to lift its arbitrary funding cap on the drug Avastin for patients with metastatic colorectal cancer. SORT's investigation of the Ministry's decision to limit the funding to 16 treatment cycles – regardless of the recommendations of patients' oncologists – led the Ombudsman to conclude that the cap was unsupported by medical evidence, and therefore unreasonable and wrong under Ontario's *Ombudsman Act*[12]. SORT's investigation also reviewed other jurisdictions, and revealed that Ontario was the only province whose funding of Avastin included such a cap.

The Ministry rejected recommendations that it lift the cap and compensate patients who had paid for it out of pocket, although it agreed to other recommendations to improve drug funding. The Ombudsman released the report at a press conference, noting the "cruelty" of the Ministry's decision, and made similar comments in media interviews and an opinion piece published in a national newspaper.

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[10] The Minister's remarks were also added to the Ombudsman's press release: < https://www.ombudsman.on.ca/Newsroom/Press-Release/2016/Ombudsman-urges-province-to-ensure-police-are-trai.aspx?lang=en-CA >

[11] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/Cancer-drug-funding-A-Vast-Injustice.aspx >

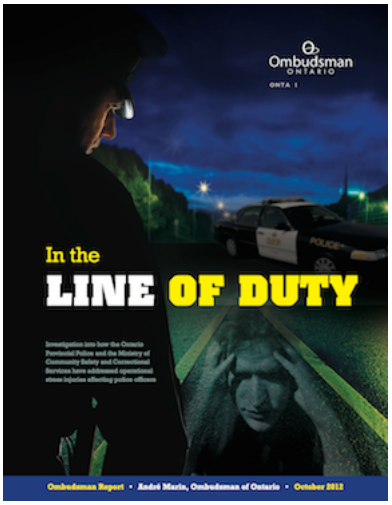
[12] The Act can be found online here: < https://www.ontario.ca/laws/statute/90o06 >

Within days of the release of the report, the responsible Minister resigned in the wake of an unrelated controversy. The Ombudsman approached the new Minister in a further attempt to resolve the matter. Two months after the report release, the new Minister announced the funding cap would be lifted so patients who continued to do well on Avastin would be funded past 16 cycles; the government had also negotiated a better price with the manufacturer in the interim.

The Ministry provided regular updates for the next several years on the number of patients who received the life-extending drug beyond 16 cycles; by September 2011, 712 patients had benefited from this funding who would not previously have had access to it.

Enthusiastic reform, broad benefits: Report – *In the Line of Duty* (2012) – Operational stress injuries and suicide among police officers

After our investigation exposed longstanding problems, the recommendations – many of which reflected the advice of experts, complainants and best practices in other jurisdictions – were wholeheartedly embraced by the Ontario Provincial Police. Since the release of our report, the OPP has publicly promoted its response to the recommendations, and shared its reforms with similar bodies, further broadening their positive impact.



In October 2012, our office released *In the Line of Duty,* our report on how the Ontario Provincial Police (OPP) and the Ministry of Community Safety and Correctional Services were dealing with operational stress injuries, including post-traumatic stress disorder affecting police officers. The investigation revealed a lack of services, support, training and education for OPP members on the issue of operational stress injuries. There was also no suicide awareness and prevention strategy or tracking of suicides within the police service, which outnumbered deaths of officers in the line of duty between 1989 and 2012.

Investigators asked many interviewees – including police officials, family members of officers who had been traumatized or committed suicide, and experts in the field – to suggest improvements, and these were taken into account in the recommendations.

In concluding the report, the Ombudsman noted that the OPP's initial reaction to our preliminary report amounted to a "bureaucratic brushoff." But a few days before the report release, the OPP Commissioner sent a letter committing to all of the recommendations – this was shared publicly along with the report.

Senior OPP leadership made the recommendations a corporate priority, providing direction, encouragement and resources as they were implemented over the next two years. Improvements included:

- Creating seven full-time positions for leaders of teams to provide peer support for officers;
- A workshop for OPP supervisors on how to recognize early signs of operational stress injury;
- Meeting with municipal and regional police services to exchange ideas on how to address operational stress injuries;
- Enhanced assistance services for retired officers;
- Annual training on available support services;
- Establishing a wellness unit to provide peer-based support services, training and prevention programs; and
- Implementing a mental health and resilience training program, based on that used in the Canadian Forces.

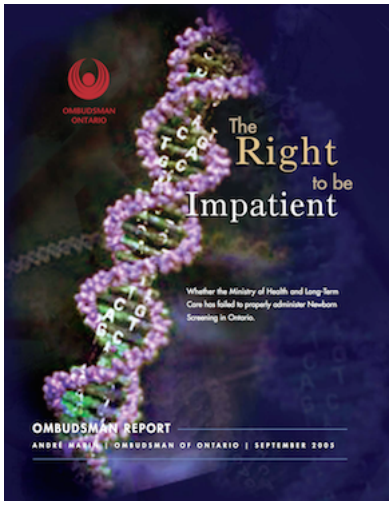
In September 2014, the Ombudsman wrote to the Commissioner of the OPP to confirm that it no longer needed to provide us with formal updates every six months, given the remarkable progress it had made to help active and retired officers deal with operational stress injury, stigma and suicide since the release of the report.

However, SORT continued to obtain status updates from the OPP on an informal basis. In particular, we followed up on its progress in implementing a suicide prevention program and the expansion of psychological services for specialty units.

In December 2015, the OPP and Ministry announced a new integrated mental health strategy, which includes increased capacity for critical incident stress response, early intervention and referrals, as well as health care resources. The OPP Commissioner acknowledged that the strategy is based in part on the recommendations in the *In the Line of Duty* report. The benefits of the recommendations continue to be felt across the country, as the OPP is also sharing its approach with other police services and emergency service providers across Canada.

Lasting effects:
Report – *The Right To Be Impatient* (2005) – medical screening program for newborn babies

This case – in which an agreement was made not to make formal recommendations, through collaboration – not only prompted dramatic, life-saving reforms, but our follow-up more than 10 years later continues to help improve the program and benefit the public.



Our office's 2005 investigation revealed serious problems with Ontario's program that screens babies – through a blood test at birth – for treatable genetic disorders. It was screening for only two disorders, even though many jurisdictions in the world were testing for dozens more, and the technology to do so was created in and available to Ontario. An estimated 50 newborns per year were dying or becoming severely disabled from conditions that could be detected by screening.

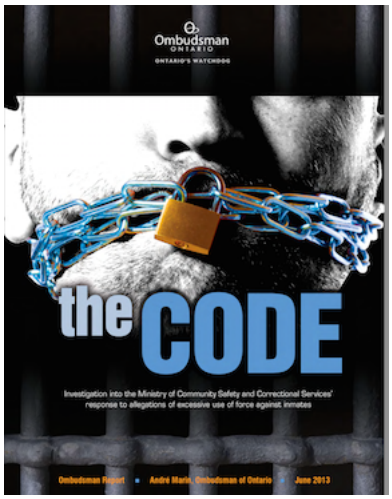
During the investigation, the Ombudsman met with the Minister of Health and Long-Term Care and Ministry officials, who advised our office that numerous improvements were already in progress. The Ombudsman opted to publish a report, but to hold off on issuing formal recommendations until the Ministry provided an update in 90 days; the report noted publicly that recommendations and a further report could be issued if the Ministry's action was not satisfactory.

After the release of our report, the government took immediate action to expand screening from two tests to 29, and improve co-ordination of testing across the province.

In April 2015, SORT followed up on media reports about delays – in the transportation of blood samples, particularly over holiday weekends – potentially placing babies at risk. Our investigator made extensive informal inquiries with the program and the responsible Ministry. By 2016, the Ministry had approved funding to allow some testing to be done on weekends and to improve transportation and tracking of blood samples. It also now tests for 30 disorders. We continue to share updates on this program in our Annual Reports.

More progress, fewer complaints:
Report – *The Code* (2013) – Use of force by prison guards

This is an example of an investigation where most of our recommendations have been implemented; we no longer request formal reports from the Ministry, but the lead investigator maintains contact regarding the few outstanding issues. Our monitoring also shows complaints about abuse of inmates have declined dramatically, illustrating the positive change effected by the recommendations.



Our report *The Code*[13] revealed the results of our investigation into allegations of excessive use of force against inmates by correctional officers in provincial correctional facilities. Our office routinely receives thousands of complaints from inmates every year, and we meet with officials from the Ministry of Community Safety and Correctional Services on a regular basis to alert them to complaint trends and brewing issues. The investigation was launched after the Ministry failed to respond to our warnings about a steady increase in complaints about excessive use of force by correctional officers, as well as some serious assault cases that were not properly investigated within the system. Once the investigation was underway, however, the Ministry was co-operative. It acknowledged the problems and committed to implementing all 45 recommendations, including zero tolerance for the "code of silence." It also committed to providing us with progress reports every six months.

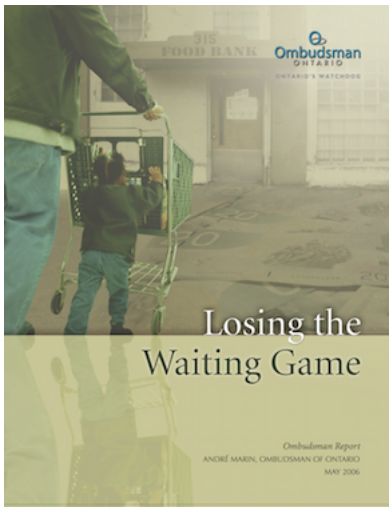
It has since implemented 38 recommendations and continues to work on the remainder, which include installing closed-circuit video in all correctional facilities and universal use of hand-held video recording in potential use-of-force situations. Along with specifically identifying the "code of silence" as grounds for discipline and dismissal, the Ministry has revamped its policies and procedures for the reporting and investigation of use-of-force incidents, and clarified the circumstances in which correctional staff are authorized to use force against inmates. As well, it has improved its recruitment process for correctional staff, including adding mandatory psychological assessments, and updated its training with material that provides clear instruction on ethical conduct and the use of force.

Among the issues we continue to monitor are complaints that the Ministry's new policy relating to use-of-force investigations has resulted in lengthy delays. We have raised this concern with senior Ministry management. However, complaints from inmates have declined, to 43 in 2015-2016, from 79 the previous year and more than 350 total in the four years prior to the investigation. Updates about the remaining recommendations will be published in upcoming Annual Reports and on our website.

[13] Online: < https://www.ombudsman.on.ca/Investigations/SORT-Investigations/Completed/The-Code.aspx >

Moral suasion and preventing recurrence:
Report – *Losing the Waiting Game* (2006) – Disability support payments

In this case, moral suasion prompted the Ministry of Community and Social Services to implement recommendations that it was initially reluctant to accept. We also monitored the issue and intervened again five years later when we saw signs of the problem recurring.



After receiving numerous complaints, our office launched an investigation into delays in the processing of applications for disability support payments. The investigation found the Disability Adjudication Unit (DAU), which is responsible for determining eligible applicants who fit the stringent definition of a "person with a disability" as set out in legislation – had imposed an unfair and bureaucratic limit.

In brief, applicants were limited to receiving four months of retroactive Ontario Disability Support Program benefits, regardless of how long it may have taken for the DAU to process their application – which in many cases was much longer. Our investigation identified 4,630 disabled individuals who were affected by this rule, losing out on at least $6 million in benefits. In total, about 19,000 disabled Ontarians had suffered some loss due the delay in processing applications.

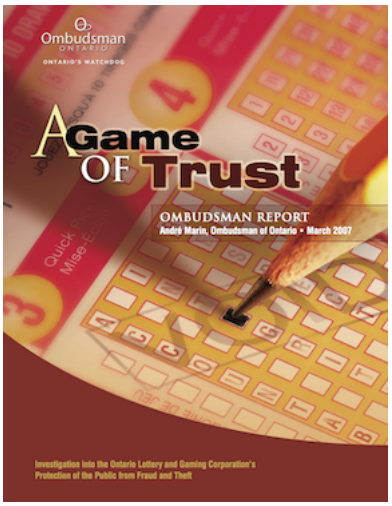
The Ombudsman made seven recommendations aimed at curbing delays and improving service standards, including revoking the arbitrary four-month limit. But initially, the Ministry only agreed to implement five of the recommendations, stating that it would "study" the other two (including paying restitution to those who had lost benefits due to processing delays). The Ombudsman responded that this was not an adequate response, and met with senior Ministry officials and politicians to persuade them to act.

Three months later, the government approved a $25-million fund to provide restitution to the 19,000 people affected by the delays, and the Ministry committed to processing applications within 90 days.

For years, the DAU met this target consistently – until 2010, when we again began receiving complaints. We received 27 in 2010-2011, and 54 the next year. We alerted the Ministry to this trend and were told the volume of applications had grown by 22% since 2008. By September 2011, the average processing time was 98.5 days, with many applications taking 120 days or more. We continue to monitor the Ministry's efforts to address this, which have included increasing its staff and upgrading technology. In 2015-2016, we received 32 complaints related to the DAU, though not all involved delays.

Cultural change within an organization:
Report – *A Game of Trust* (2007) – Lottery security

Although the Ontario Lottery and Gaming Corporation (OLG) initially argued that several of the Ombudsman's recommendations would not be feasible, it not only accepted them, but – after leadership changes – went above and beyond them. The case also illustrates how an Ombudsman investigation can prompt necessary cultural change within an organization, to its benefit as well as that of the public it serves.



In the wake of a media exposé revealing that Ontario's government-run lottery – which raises billions of dollars for public works – was vulnerable to theft and fraud by "insiders" (primarily the small retailers it relied on to sell its tickets), the Ombudsman launched an own-motion investigation, noting the strong public interest in the issue. Our report detailed how the OLG had failed to adequately screen and monitor retailers – there were numerous cases where they had taken customers' winning tickets and claimed the prizes for themselves. (The largest known suspicious case involved a $12.5-million prize.)

The Ombudsman's 75 recommendations, drafted after some consultation with experts and affected officials, included specific measures to improve security and to screen and monitor retailers – but they also addressed the corporate culture, stressing that OLG officials must remember that they are public servants.

The corporation's initial attitude toward recommendations for such measures as requiring players to sign their tickets was "it can't be done." Still, it and the government accepted all of the recommendations, and "sign your ticket" is now routine for all Ontario lottery players (in addition, ticket-checking machines were installed across the province, eliminating the need for retailers to inform players if they are winners).

Most importantly, after management changes, the OLG embraced our investigation as a catalyst for cultural change. In its final progress report to our office in 2008, the then-CEO wrote: "In hindsight, the 'shock' of the Ombudsman's report brought about deep and systemic change within the corporation in very short order. It is unlikely that this could have been achieved through more conventional or traditional means of organizational reform."

We continue to monitor the corporation's efforts to improve security and transparency, several of which went beyond the recommendations in our report. Most notably, it developed technology that can identify the rightful owner of a winning lottery ticket that has been stolen – something that was unimaginable in 2007.