Ombudsman
ONTARIO

ONTARIO'S WATCHDOG

2011-2012
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June 19, 2012

The Honourable Dave Levac
Speaker
Legislative Assembly
Province of Ontario
Queen's Park

Dear Mr. Speaker,

I am pleased to submit my Annual Report for the period of April 1, 2011 to March 31, 2012, pursuant to section 11 of the *Ombudsman Act*, so that you may table it before the Legislative Assembly.

Yours truly,

André Marin
Ombudsman

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Ombudsman's Message: Limit Spending, Not Fairness

PHOTO BY BRIAN WILLER

As I write this message, I am acutely aware that Ontario's public service and its citizens are bracing for the impact of new cost-containment measures. To their immense credit, parliamentarians and senior government officials have continued to show support and respect for the work of my Office. They have recognized the value of Ombudsman oversight, even in tough times, as a means to ensure accountability and spur increased efficiency and fairness in the provision of public services.

Through the dedicated efforts of my staff, my Office has been able to return good value for public dollars spent. As we close the books on our operating year 2011-2012, we have seen a significant increase in complaints and inquiries (27%), with **18,541** cases opened.

The **Operations Overview** and **Case Summaries** sections of this report contain ample evidence of how our Office has helped Ontarians navigate the complexities of government bureaucracy – and flagged problems to the bureaucracy before they mushroomed. We have helped severely disabled children and adults obtain access to necessary resources, such as home care, medical assessments, residential placements, assistive devices and drug funding. We have ensured money improperly collected is returned and charges arising from bureaucratic bungling reversed. We have prompted corrective action where there has been only delay, inattention, or defensiveness. And we have served as a catalyst for better communication, improved policies, and more common sense and compassion in public administration.

With its latest budget, the province has signalled that we are moving to a new level of austerity in public spending, as it grapples with a deficit of some $15 billion. Fiscal restraint will undoubtedly affect the citizens of Ontario, as services and programs are scaled back or eliminated. While Ontarians understand the need for belt-tightening, it is crucial that efficiencies and savings are not achieved at the expense of fairness and good public administration. My Office can help ensure that, despite spending cuts, citizens continue to be treated reasonably, fairly and justly. This is why I recently sounded a public warning about proposed shifts, through the budget and other means, of the delivery of public services to private agencies, private-public hybrids and/or "delegated administrative authorities." The issue is not privatization, but the spectre of these services – without proper legislative safeguards – being removed from Ombudsman scrutiny, leaving Ontarians no recourse to complain about them or have them independently investigated. We do not want to go down that slippery slope of oversight erosion.

This past year, throughout our Office, we employed innovative, cost-effective and efficient ways to communicate with Ontarians, including pioneering the first Ombudsman mobile "app" and conducting training and confidential interviews using Internet video messaging (Skype). We hope to encourage government through our example to embrace modern interactive technology to improve the accessibility and effectiveness of public services.

"My Office can help ensure that, despite spending cuts, citizens continue to be treated reasonably, fairly and justly."

We also continued to focus attention on significant systemic issues, achieving maximum benefit from our investigative resources – a model that has been emulated by other ombudsmen around the world (as noted in this report's **Consultation and Training** section). Our **Special Ombudsman Response Team** investigation into non-emergency medical transportation services led to a government commitment to regulate this industry to better ensure the health and safety of Ontario's citizens. And just months into our review of Herceptin funding for breast cancer patients, the government agreed to increase access for patients with small tumours. Legislation was also introduced in February 2012 to do away with the archaic *Public Works Protection Act* – which featured so prominently in the policing of the 2010 G20 summit in Toronto – as I recommended in my 2010 report, *Caught in the Act*.

Investigating the investigators

In September 2008, I issued *Oversight Unseen*, my first investigative report relating to the Ministry of the Attorney General's Special Investigations Unit (the SIU). Aside from some recent backsliding, when some SIU investigators displayed signs of pro-police bias, since that time, the SIU has generally demonstrated greater investigative rigour in its dealings with police. However, the Ministry of the Attorney General's failure to follow through on my recommendations was the focus of my second investigation, reported in *Oversight Undermined*, issued in December 2011.

In *Oversight Undermined*, I found lack of police co-operation continued to frustrate the SIU in its efforts to investigate serious injuries and deaths of civilians and that the Ministry was undermining the SIU's ability to function effectively. I again put forward recommendations for reform, including proposing penalties for non-compliance.

In the wake of that report, the SIU has observed a significant increase in notifications from police officials about incidents coming within its mandate – from 57 in the first quarter of 2011 to 101 in the first quarter of 2012. My report also resonated in a number of Ontario communities – for instance, in Windsor, where the police chief retired suddenly, and in Ottawa, where the police chief pledged to respond (though not necessarily substantively), to every SIU letter in future.

Ombudsman André Marin releases *Oversight Undermined*, his report on his second investigation involving the Special Investigations Unit and the Ministry of the Attorney General, on December 14, 2011.

> “The SIU has observed a significant increase in notifications from police officials about incidents coming within its mandate.”

Requests for leave to appeal and cross-appeal the Ontario Court of Appeal’s decision in the case of *Schaeffer v. Ontario (Provincial Police)*, which put a stop to the thorny problem of lawyers vetting police notes, have been made to the Supreme Court of Canada. That court’s consideration of this matter has the potential to affect the integrity of future SIU investigations.

While modest progress has been made to date in the area of SIU oversight of police, I continue to monitor this situation closely, and if necessary, will launch a third investigation. Further details about my latest investigation and updates on others can be found in the **Special Ombudsman Response Team** section of this report.

Clear as MUSH

Unfortunately, there are many organizations that provide direct and vital public services to Ontarians, without the important check and balance of Ombudsman oversight.

Government continues to spend tens of billions of dollars each year funding the **MUSH** sector, comprised of **m**unicipalities, **u**niversities, **s**chool boards and **h**ospitals, as well as children’s aid societies, long-term care homes and the police.

I have followed my Ombudsman predecessors in repeatedly calling for modernization of my mandate to include the MUSH sector. The reason is simple. MUSH organizations have a profound and immediate effect on the lives and welfare of individual citizens. They impact Ontarians where they work, live and play, and when they are at their most vulnerable.

This has been clear even in the one narrow area of this sector where my office has a sliver of jurisdiction: Investigating public complaints about closed municipal meetings. People care a great deal about openness at the local government level, and when doors are closed to them, they complain. We saw a substantial increase in these cases this year (to **119**, up from 84 in 2010-2011). Because these investigations – handled by our **Open Meeting Law Enforcement Team** – involve important issues of transparency and open government, I have decided to devote a separate Annual Report to them, to be tabled later this year.

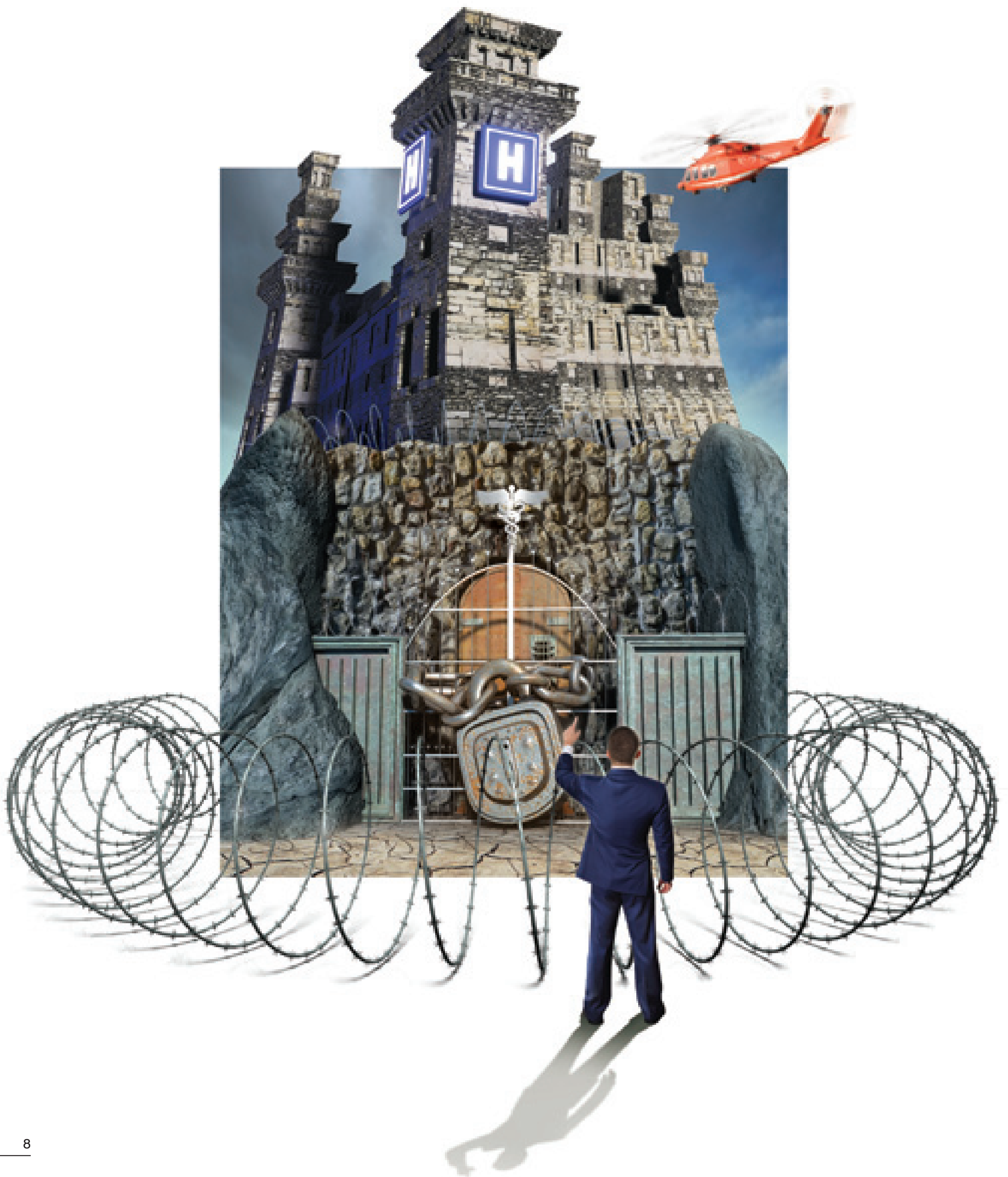
Sadly, as the next section of this report details (**Beyond Scrutiny: The Push for MUSH**), despite a succession of private member’s bills, public petitions, and the dedicated efforts of advocacy groups, Ombudsman oversight of MUSH bodies in general remains off the government agenda, and Ontario continues to rank dead last when it comes to giving its Ombudsman authority in these zones of immunity. Last year, my ombudsman colleagues across Canada were able to achieve concrete results, helping students get a fair shake at universities, looking into hospital and treatment wait times, infection control protocols and billing issues, and assisting seniors in long-term care homes and parents dealing with child protection officials. However, we turned away a record **2,539** MUSH cases in 2011-2012 – up from 1,963 in the previous year.

> “Ontario continues to rank dead last when it comes to giving its Ombudsman authority in these zones of immunity.”

Give us an "H" – Hospitals

Of particular concern to me this year is the "H" in MUSH.

Since 2005, there have been four private member's bills, and more than a dozen petitions tabled, calling for the Ombudsman's jurisdiction to be extended to hospitals. While the government spends some $15 billion annually on hospitals, and has recently indicated that it wants to increase efficiencies in the health-care sector, to date, it has resisted turning to the Ombudsman as a means of effectively resolving complaints about hospital administration.



It is hard to find someone in Ontario whose life hasn't been touched by a local hospital. You may have had to wait for hours in a crowded emergency room to be seen by a doctor, or watched a family member die tragically of a hospital-acquired infection. Or you may simply have been mystified by hospital policies, practices or procedures that appear to defy common sense.

When something goes wrong at a hospital, if you or your loved ones suffer because of unfair, unreasonable or negligent administration, where can you turn? In every other province, you can call on your Ombudsman for help. But not in Ontario.

In the spring and summer of 2011, a *C. difficile* epidemic concentrated in the Niagara region swept the province, resulting in more than 30 deaths, and the appointment of a supervisor to take over the Niagara Health System hospital sites. While recourse to my Office wouldn't obviate the need for government intervention in extreme cases, the experience of other provinces has shown that Ombudsman oversight can be an effective and efficient way to address improvement in hospital practices and protocols.

This past year, the media highlighted cases where hospitals required patients to call 911 for help getting to the emergency room, even though they were at the hospital already. While the affected hospitals committed to reviewing the incidents, resolving these types of administrative issues is the bread and butter of Ombudsman work. Instead of addressing such cases internally, institution by institution, on a piecemeal basis, Ombudsman oversight would allow for broader review and recommendations to improve the hospital system as a whole.

"The experience of other provinces has shown that Ombudsman oversight can be an effective and efficient way to address improvement in hospital practice."

Whenever the subject of Ombudsman oversight over MUSH bodies comes up, MUSH sector administrators invariably protest that avenues of redress already exist. In the hospital sector, this argument is particularly weak. You can complain about medical professionals to their respective regulatory bodies. But if you have a concern about hospital administration, your only recourse is to contact the hospital's own in-house patient relations officer, advocate or ombudsman. Whatever their title, these hospital officials are a poor substitute for impartial Ombudsman oversight. The bottom line is that these officials work for hospitals, not patients. They have no independent authority or formal powers of investigation. They cannot exercise moral suasion through public reporting to encourage systemic change. At best, they operate as internal customer relations departments – clearing houses for complaints. And as the cases noted in the next chapter demonstrate, at worst, they may be unresponsive, insensitive, and/or apologists for hospital interests.

In an article published this April in the *Canadian Medical Association Journal*, researchers promoted the adoption of patient charters of rights, including recourse to an independent complaints process, through an ombudsman or commissioner. With respect to the current reliance on internal complaint handling, they observed:

"[P]atients may question the independence of these internal processes given the institution's interest in protecting its own reputation and its close relationship to medical staff…

"[M]oral suasion from a sufficiently resourced and independent ombudsman or commissioner can positively drive system change."

While it is laudable that the hospitals must now comply with freedom of information measures, making public large amounts of previously inaccessible raw information, it remains just that – raw information. There is still no body that can connect the dots, investigate, review the evidence and determine whether problems in hospitals stem from a deeper systemic malaise – or recommend how they can be healed.

As budgets shrink, there is an even greater need to ensure that economy doesn't trump fairness and common sense in the delivery of health care services. The government may wish to reflect on why Ontario remains the only province that has not given its Ombudsman the ability to help citizens with their hospital complaints.

Policing the police

This year, we continued to see a flood of concerns expressed publicly about another MUSH area – police. The credibility of police in this province is increasingly coming under scrutiny as citizens await the outcome of charges arising from the policing of the 2010 Toronto G20 summit and ponder recent media stories about officers caught lying in court and a Windsor detective convicted in a brutal assault.

Police cannot effectively carry out their mandate "to serve and protect" unless they enjoy the confidence and trust of Ontarians. It is one of the reasons I have devoted considerable attention to the SIU, which plays a critical role in police oversight. Unfortunately, while the SIU comes under my authority, its cousin, the Office of the Independent Police Review Director (OIPRD), does not. The OIPRD reviews internal police investigations of public complaints, and, in some cases, conducts its own investigations. It has enjoyed a relatively low profile since it opened in October 2009. However, in July 2010, the OIPRD announced a "systemic review of G20 police complaints" after receiving hundreds of complaints, including a number referred by my Office. On May 16, 2012, nearly two years after the G20 weekend, the OIPRD released its report. The Director found, based on hundreds of interviews with police and civilians, that many officers had "ignored the basic rights that citizens have under the ... Charter," and used excessive force in several incidents over those days in June 2010. He also noted that there were long delays in police turning evidence over to his office. Aside from the recommendations in his review, the Director also recommended charges for misconduct in a number of G20-related incidents – but in at least some of the cases, the police union response was that too much time had passed.

My Office has received complaints about the adequacy of the OIPRD's investigative processes (**37** this past year), but as it is outside of my mandate, I cannot intervene. I continue to believe – as I stated before the legislative amendments creating the OIPRD were passed – that making the OIPRD accountable to my Office would assist in building public confidence in Ontario's police community.

> "Police cannot effectively carry out their mandate 'to serve and protect' unless they enjoy the confidence and trust of Ontarians."

Putting the accountability squeeze on Ornge

Finally, I would like to address an organization that has recently served as a lightning rod for debate in the Legislature and that clearly demonstrates the need for Ombudsman scrutiny.

When Ontarians spot the air ambulance service's signature orange helicopters hovering overhead these days, they are more likely to be reminded of Ornge's service problems and spending abuses than its emergency patient transfers. In the fall of 2011, the public learned that the federally incorporated non-profit company, which has held a monopoly on administering air ambulance services in Ontario since 2005, and received some $150 million in public funding annually to do so, had played fast and loose with public funds and trust.

Ornge has been embroiled in a multi-million-dollar scandal that has seen its chief executive officer turfed, its board of directors replaced, a Ministry of Finance forensic audit, a scathing special report by the Auditor General, hearings by the Standing Committee on Public Accounts, and an ongoing police investigation into financial irregularities. This is an organization that is crying out for independent oversight.

> “When an entity goes rogue, and its board goes AWOL, who safeguards the public interest? That's the challenge [Premier Dalton] McGuinty's government must wrestle with…
>
> “McGuinty acknowledges losing sleep over the various agencies, boards, commissions – and quasi-public hybrids such as Ornge – that deliver major public services. It is a major topic of debate within his office…
>
> “'Why can't we have people who see around corners?' McGuinty continues. 'We need to find a better way to anticipate these things and uncover these things in government before they take place.'”
>
> **Martin Regg Cohn, *Toronto Star*, May 7, 2012**

Even though we have no jurisdiction to investigate Ornge, my Office has received **17** complaints about its operations since 2005, including allegations about misuse of funds. While we made inquiries and referrals where we could, we were unable to directly assist these complainants. The Auditor General reviews financial matters, but he does not investigate complaints, and typically, only conducts value-for-money audits periodically. Who knows? If we'd had the ability to investigate allegations about Ornge received from patients and their families, industry insiders and whistleblowers, we might have been able to prompt the government into taking action to rein in Ornge sooner. This is exactly the kind of proactive work we have done with many ministries and organizations, as the **Operations Overview** section of this report attests.

There have been remarkable turnarounds in the many Crown corporations, agencies, boards and commissions I have investigated since 2005. The Ontario Lottery and Gaming Corporation (OLG), the Municipal Property Assessment Corporation (MPAC) and the Criminal Injuries Compensation Board (CICB) – to name just three well-known examples – had all lost sight of the public interest. Lottery players, property owners and crime victims were all but abandoned to motives of profit, secrecy and inertia. But my recommendations, implemented by government, helped them get back on track – as the CICB chair notes in the **Your Feedback** section of this report. Similarly, in 2008, the OLG's board of directors offered this summary of how my investigation into insider ticket theft and fraud changed the organization's culture:

"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."

With the introduction of Bill 50, the *Ambulance Amendment Act (Air Ambulances), 2012*, the government has a unique opportunity to ensure that what happened with Ornge is never repeated. As Parliamentarians proceed with their consideration of Bill 50, I encourage them to consider adding a provision including air ambulance service providers under my authority, as has already been suggested by some Members of Provincial Parliament. Similarly, Parliamentarians should heed the lessons learned from the Ornge debacle when considering the measures proposed in schedules 16 and 28 to Bill 55 – the budget bill. While alternative delivery of government services and regulatory programs might result in cost savings, it could also come at the heavy price of reduction of Ombudsman oversight.

Back to the future

Since 1975, the Ontario Ombudsman's Office has served as an effective buffer between citizens and government administration, particularly during lean economic times. My Office is poised to take on the challenges in 2012-2013 of oversight in an environment of fiscal restraint. We will be on watch to ensure that fairness to Ontario's citizens is not reduced, as administrators focus on limiting public spending.

Ontario Ombudsman André Marin received the Ontario Bar Association's Distinguished Service Award on April 26, 2012. In his acceptance speech, Mr. Marin dedicated the award to his staff and thanked Ontario public servants for their "professionalism, open-mindedness and good faith." He was congratulated by, among others, Premier Dalton McGuinty.

RECEIVED

May 11, 2012

Mr. André Marin
Ombudsman
Ombudsman Ontario
483 Bay Street
10th Floor, Bell Trinity Square, South Tower
Toronto, Ontario
M5G 2C9

Dear Mr. Marin: André

I learned recently that you received the Ontario Bar Association's 2012 Distinguished Service Award and would like to offer you my warmest congratulations on this well-deserved recognition. You can take great pride in knowing that this impressive honour has earned you further respect from your colleagues in the legal community, and from the people of Ontario.

Allow me to also commend you on the role you and your staff play in instilling in the people of this province greater confidence in their government. Through your work to make government more open and accountable, you are providing a vital service — one that lies at the core of our democracy.

Congratulations once again, and please accept my personal best wishes for much continued success.

Congratulations!

Yours truly,

Dalton McGuinty
Premier

Beyond Scrutiny: The Push for MUSH

In 2011-2012, as detailed in the accompanying chart, the Ombudsman received a record number of complaints and inquiries about the **MUSH** sector, which includes **m**unicipalities, **u**niversities, **s**chool boards and **h**ospitals, along with other broader public sector bodies such as long-term care homes, children's aid societies and police.

Unfortunately, the Ombudsman could not look into these **2,539** cases, as the MUSH sector remains exempt from his jurisdiction. Although many MUSH organizations are subject to freedom of information requests and, since 2004, value-for-money audits by the Auditor General, the public has no recourse to independent investigation of complaints about general maladministration in the MUSH sector.

The incongruity in this situation is that it represents an artificial line in the sand that the Ombudsman is unable to cross. He can investigate the policies that are set by provincial bureaucrats in glass towers in downtown Toronto, but is barred from investigating how they are implemented by MUSH sector organizations, where they touch people directly. For example, although the Ombudsman oversees the Ministry of Education, his office cannot examine whether the Ministry's policies are actually working as intended in Ontario schools. The same can be said of other MUSH areas.

It is long past time for the government to erase that line and allow this Office to follow administrative decisions of government right through to their delivery to the public. Ontario citizens appear to be growing weary and cynical of the government's use of buzzwords like "transparency" and "accountability" – as has been evidenced in their growing demand for Ombudsman assistance with MUSH-related issues, and reflected by acute interest from some parliamentarians.

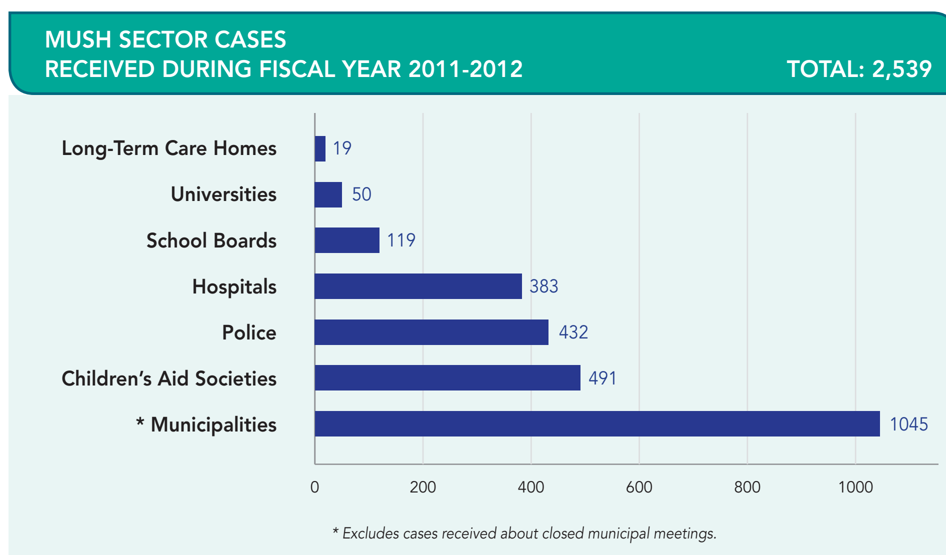
One of several citizen-initiated efforts in support of increased Ombudsman scrutiny of the MUSH sector in 2011-2012: This woman created her own t-shirts and handed out flyers to passersby on Bay Street in October 2011.

Since 2005, there have been **nine** private member's bills calling for expanded Ombudsman oversight over various MUSH areas. To date, none have progressed into law. The last effort was Bill 183, the *Ombudsman Statute Law Amendment Act (Designated Public Bodies), 2011*, introduced by NDP MPP Rosario Marchese on April 19, 2011. This bill provided for Ombudsman oversight of hospitals, long-term care and retirement homes, school boards, children's aid societies, universities and the Office of the Independent Police Review Director. It was defeated at second reading on May 5, 2011.

Nevertheless, momentum for modernization of the Ombudsman's mandate continues to build. Thousands of Ontarians have signed petitions supporting Ombudsman oversight in the **MUSH** sector. Some **65** such petitions have been presented in the Legislature since 2005, **16** of those in 2011-2012 alone. Citizens have also promoted increased scrutiny of **MUSH** organizations by holding public rallies, distributing flyers and campaigning via social media.

As can be seen by the accompanying table, Ontario continues to trail behind every other provincial Ombudsman when it comes to having authority over **MUSH**.

MUSH SECTOR CASES
RECEIVED DURING FISCAL YEAR 2011-2012 TOTAL: 2,539



* *Excludes cases received about closed municipal meetings.*

DEAD LAST
How Ontario's Ombudsman mandate compares to others in key areas of jurisdiction

	Municipalities	Universities	School Boards	Public Hospitals	Long-Term Care Homes	Child Protection Services	Police Complaints Review Mechanism
ONTARIO	NO	NO	NO	NO	NO	NO	NO
British Columbia	Yes	Yes	Yes	Yes	Yes	Yes	No
Alberta	No	No	No	Yes	Yes	Yes	Yes
Saskatchewan	No	No	No	Yes	Yes	Yes	Yes
Manitoba	Yes	No	No	Yes	Yes	Yes	Yes
Quebec	No	No	No	Yes	Yes	Yes	Yes
New Brunswick	Yes	No	Yes	Yes	No	Yes	Yes
Newfoundland and Labrador	No	Yes	Yes	Yes	Yes	Yes	Yes
Nova Scotia	Yes	No	Yes	Yes	Yes	Yes	Yes
Yukon	Yes	No	Yes	Yes	Yes	Yes	No

“M” - Municipalities

In addition to the complaints the Ombudsman receives in his role as closed meeting investigator for some **190** municipalities (details of which will be presented in a separate Annual Report later this year), hundreds of people also complain about general municipal issues outside the Ombudsman’s mandate. There were **1,045** complaints and inquiries relating to municipal services in 2011-2012.

These complaints cover the full gamut of municipal issues, from services like garbage collection and road maintenance to problems with public housing or public health, to allegations of corruption and conflict of interest.

The City of Toronto remains the only municipality in the province with its own Ombudsman. Nowhere in Ontario do citizens have recourse to an independent, external body to investigate allegations of municipal maladministration.

“U” - Universities

Unlike colleges of applied arts and technology, which have a different governance structure, universities remain beyond Ombudsman scrutiny. The Ombudsman received **50** complaints and inquiries about universities in 2011-2012. Issues raised included fees and refunds, course requirements, marks, expulsions, decisions of internal academic appeals committees, unfair policies – and in one case, the service provided by a university’s internal ombudsman. These complaints had to be turned away or referred elsewhere.

There are two provinces whose ombudsmen are able to help people who run into administrative problems with universities. For instance, in 2010-2011, both the Ombudsman of British Columbia and the Citizen’s Representative of Newfoundland and Labrador helped students get a second chance when they were in danger of failing or not getting into their desired graduate programs.

“S” - School boards

In 2011-2012, the Ombudsman received **119** complaints and inquiries about Ontario’s school boards. Many were from parents concerned about things like student suspensions, lack of adequate special education supports, the treatment of students with autism, insufficient consultation about school closures, and inadequate response to bullying. Once again, these complaints had to be turned away or referred elsewhere.

According to media reports, in December 2011, the Toronto Catholic District School Board moved to review appointing its own independent ombudsman, but deferred the motion in May 2012. This is an encouraging effort, but a long way from provincewide ombudsman jurisdiction, as is established in British Columbia, New Brunswick, Nova Scotia and Newfoundland and Labrador, as well as Yukon Territory.

“H” - Hospitals

In 2011-2012, the Ombudsman received **383** complaints about a range of serious hospital issues, including emergency room wait times, billing practices, breaches of patient confidentiality, and poor infection control.

Every other provincial and territorial ombudsman in Canada can deal with hospital complaints and obtain results for their citizens. For example, the Quebec

Ombudsman's work (detailed in her office's 2010-2011 Annual Report) has led to improved hospital emergency room wait times, infection control protocols, and palliative care practices. Similarly, the Saskatchewan Ombudsman helped a colon cancer sufferer obtain faster access to chemotherapy last year, and also recommended ways to improve the management of breast cancer treatment waiting lists. Ombudsmen in British Columbia, Quebec and Newfoundland and Labrador all reported helping patients with hospital billing problems last year as well.

While hospitals in Ontario became subject to the *Freedom of Information and Protection of Privacy Act* in January 2012, there is still nowhere to complain about their daily administration, except through whatever internal complaint processes hospitals choose to provide.

Losing patience with patient relations

The Ombudsman has received numerous complaints about hospital-designed complaints processes over the years. Whether labeled as "hospital ombudsmen" or some variation of "patient relations," these internal offices have little credibility with those who complain about their lack of independence, transparency, objectivity and investigative abilities.

The case of Dimitra Daskalos – widely reported in the media and discussed in the Legislature this past year – dramatically illustrates these concerns.

The 93-year-old Mrs. Daskalos was admitted to Toronto General Hospital in July 2010. By January 2011, after months of failed attempts to find her a long-term care home of their choosing, her family was told by the hospital that it would begin charging her the uninsured rate of $1,658 for every day she occupied a hospital bed. The hospital's internal patient relations department responded to the family's complaint by supporting the hospital's position – that they should take the first available long-term care bed – and sending them a bill for more than $18,000. When the family complained to the Ministry of Health and Long-Term Care about the hospital's conduct, they were redirected to the hospital.

Mrs. Daskalos died in February 2011. The Ministry of Health and Long-Term Care subsequently clarified that elderly patients awaiting long-term care placements cannot be charged daily uninsured hospital rates. The Daskalos family later spoke out publicly in support of Ombudsman oversight of hospitals.

In another case brought to the Ombudsman's attention, the family of a 74-year-old cancer patient was shocked to learn that a "do not resuscitate" order had been attached to her health record without their knowledge or consent. They complained that the hospital's patient relations staff argued with them. Only after they complained to the hospital president did they receive an apology for the erroneous order – but not for the insensitivity of the patient relations staff.

The Ombudsman also heard from a nurse whose father unexpectedly ended up on life support after surgery. She contacted the hospital's patient relations department to raise serious concerns, and was told they would send notice that the family wanted an internal investigation and get back to her in a few days. Patient Relations never contacted her again, and it was only when she later spoke with a doctor on staff that she learned an investigation had been launched.

The exception proves the rule

The only exception to the Ombudsman's general lack of oversight in the hospital sector occurs when the government appoints a supervisor to replace a hospital board of directors. At the time this report was written, supervisors were responsible for administration of the Hôtel-Dieu Grace in Windsor (since January 4, 2011), and the Niagara Health System (since August 30, 2011).

In 2011-2012, the Ombudsman received **16** complaints and inquiries about the Hôtel-Dieu Grace and **81** about the Niagara Health System, which includes seven sites serving 12 municipalities. The complaints ranged from poor communication by hospital staff and problems with hospital record keeping to inadequate infection control, overcrowding and long emergency room wait times. Ombudsman staff reviewed all of these complaints and followed up with the hospitals where necessary.

For example, the daughter of a psychiatric in-patient at Hôtel-Dieu Grace complained about the hospital's failure to discuss her mother's discharge planning with her. When she contacted the hospital's patient advocate to complain, she was initially told that she had to deal with a social worker, then assured that her feedback would be shared with the unit manager. When she never heard back from anyone, Ombudsman staff attempted to reach the patient advocate and received a voicemail message saying the relevant feedback had been shared, and the matter was closed. Three further messages to the advocate went unanswered. After senior Ombudsman staff raised the case with the hospital supervisor, the patient advocate promptly undertook to contact the patient's daughter and deal with her concerns.

Ombudsman staff also helped facilitate communication between the Niagara Health System and the families of three patients whose deaths were related to *C. difficile*. Hospital officials met with the families to answer their questions, and also committed to improving infection control procedures and communications in future.

Given the volume of complaints received about the Niagara Health System, senior Ombudsman staff conduct monthly conference calls with the supervisor and other officials to discuss complaint trends and significant cases.

Long-term care homes

The Ombudsman received **19** complaints about long-term care homes in 2011-2012. Most were from concerned relatives of residents and included serious allegations of resident abuse and overmedication, as well as unreasonable restrictions on visitors and problematic practices and policies.

Most other provincial ombudsmen have authority to review complaints about long-term homes. For instance, British Columbia's Ombudsman issued a second report on her systemic investigation into the care of seniors in February 2012. And Quebec's Ombudsman noted in her 2010-2011 Annual Report that her intervention led to 15 recommendations to reduce the risk to seniors of serious injuries and deaths due to exposure to overly hot water.

While the Ombudsman cannot investigate long-term homes themselves, he receives regular updates on changes to how they are being monitored by the Ministry of Health and Long-Term Care in the wake of his investigation of this issue, reported in 2010. An update on this case can be found in the **Special Ombudsman Response Team** section of this report.

A number of organizations have called for the Ombudsman's jurisdiction to be expanded in this important area, among them the Association for Care of the Elderly, which recommended this in its March 2012 submission to the Ministry's Long-Term Care Task Force on Resident Care and Safety. The independent task force, formed by representatives from across the long-term care sector in November 2011 in the wake of media reports of abuse and neglect in long-term care homes, issued a report in May 2012 recommending numerous improvements to the Ministry.

> "Ontario is the only province in Canada… where our ombudsman does not have oversight of long-term care homes. I would love for him to receive those complaints. He is an expert at giving a voice to people who face those kinds of issues."
>
> **NDP MPP France Gélinas, quoted by CBCnews.ca, February 24, 2012**

> "Unfortunately, the Ontario government prohibits Ombudsman André Marin from investigating complaints of abuse in hospitals and other health facilities. This only perpetuates abuse, staff silence, administrative coverup, and secrecy."
>
> **Don Weitz, letter to the editor, *Toronto Star*, November 19, 2011**

Children's aid societies

One **MUSH** area that continues to attract considerable attention is child protection. Ontario remains the only province that delivers child protection services through non-governmental agencies, with no ombudsman oversight.

In 2011-2012, advocates organized protests in dozens of cities, calling for increased accountability over children's aid societies. The Ombudsman received **491** complaints and inquiries about children's aid societies across the province. Concerns were raised about many compelling issues, including failure to investigate abuse allegations, inadequate investigations and problematic apprehensions of children. As well, there were **two** complaints from parents who were pressured to relinquish custody of their severely disabled children to children's aid societies in order to obtain care for them – an issue the Ombudsman investigated in 2005. An update on this can be found in the **Special Ombudsman Response Team** section of this report.

Other ombudsmen across Canada have been able to help families with their concerns about child protection authorities. Last year, the Citizen's Representative of Newfoundland and Labrador helped a father set the record straight after a flawed investigation by child welfare officials, and the Alberta Ombudsman persuaded officials to respond to the concerns of a mother whose children had been apprehended. On April 1, 2012, Alberta's Child and Youth Advocate also became a legislative officer, with increased resources and new powers to investigate serious injuries and deaths of children and youth in care.

In Ontario, there continues to be no provision for independent investigation of the conduct of children's aid societies. The only exception is when a government-appointed supervisor takes control. In 2011-2012, while the Huron-Perth Children's Aid Society was under supervision (up to September 6, 2011), the Ombudsman received **11** complaints, which Ombudsman staff resolved through inquiries and referrals and by dealing with the supervisor.

In response to calls for expansion of the Ombudsman's mandate into this field, children's aid societies as well as government administrators continually argue, much like a broken record, that multiple review mechanisms already exist to ensure adequate accountability of child protection services. In making this claim, they typically refer to the Ministry of Children and Youth Services, the Provincial Advocate for Children and Youth, the Child and Family Services Review Board, the courts, the Office of the Chief Coroner and the Pediatric Death Review Committee. However, none of the existing review bodies enjoys broad general authority to investigate complaints about allegations of maladministration, and the latter two only become involved after a child is dead. The May 2, 2012 sentencing in the 2008 murder of 7-year-old Katelynn Sampson highlighted problems of miscommunication and delay on the part of child welfare officials – issues that are well suited to Ombudsman consideration. While some improvements have been made in the wake of Katelynn's death, Ombudsman oversight would provide a layer of accountability where none exists, to expose systemic issues before disaster strikes.

The Child and Family Services Review Board gained jurisdiction in 2006 to consider complaints about children's aid societies. However, the board only deals with procedural issues and can only look at complaints from those directly receiving or seeking services from a children's aid society. It cannot deal with the type of complaints the Ombudsman typically receives, concerning problematic child apprehension or failure to investigate abuse. Although the board successfully appealed some of the restrictions on its authority in June 2011, its powers remain very limited. In 2011-2012, the Ombudsman received **18** complaints about the board itself, many criticizing the constraints on its jurisdiction.

Children's aid societies are in a state of flux. The government has committed to work with them to improve outcomes for children and youth, while containing costs through agency amalgamations, back-office consolidations and shared service delivery. As the number of local societies is reduced and a new funding model is introduced, there is increased potential for complaints and even greater reason to extend Ombudsman oversight into this area.

> “We need to make sure that, when families are yanked apart, when processes are brought to bear, everything is done in a way that is above reproach. The law has to be seen as fair not only to the child, but to the families and to the prospective people who may adopt them. We need to have an oversight which is not there.”
>
> **NDP MPP Michael Prue, *Hansard*, June 2, 2011**

Police

The Ombudsman received **432** complaints and inquiries about police in 2011-2012, including allegations of excessive use of force, assault, improper search, wrongful detention and arrest, harassment and threats, failure to investigate, inadequate investigation and improper discharge of a Taser. Complaints were referred to the Ministry of the Attorney General's Office of the Independent Police Review Director (OIPRD) and Special Investigations Unit (SIU), where appropriate.

The Ombudsman also received **37** complaints and inquiries about the OIPRD, raising allegations about failures to communicate and flawed investigations. The *Police Services Act* bars the Ombudsman from overseeing the OIPRD (although he does oversee the SIU). In 2011, the Ombudsman provided the OIPRD with information on 112 complaints received about police conduct during the June 2010 G20 summit in Toronto.

Operations Overview

The Ombudsman's Office received **18,541** complaints and inquiries in 2011-2012 – a **27%** jump over the previous year. Most (**59%**) were resolved within one week; **70%** within two weeks. The **Case Summaries** section of this report features examples of the many individual cases that were successfully resolved.

While the work of the Ombudsman's Early Resolutions team focuses on the resolution of cases, staff also watch for potential systemic issues. Both the Investigations team and the Special Ombudsman Response Team also work to resolve systemic problems proactively wherever possible. Some are referred for formal investigation, while others are successfully resolved once they are brought to the attention of senior government officials.

For example, in January 2012, as a result of the Ombudsman highlighting a case involving the incorrect application of an annual cost-of-living adjustment, the Family Responsibility Office announced it would correct errors in 1,700 similar cases, refunding or crediting support payors as warranted. Similarly, when Ombudsman staff alerted the Ministry of Transportation to a complaint about its identification requirements for renewing expired driver licences, it agreed to review and revise its policy. These are just a few examples of the government's positive responses to proactive work on the part of Ombudsman staff.

Senior Ombudsman staff also meet regularly with top officials from the most complained about ministries, organizations or programs, alerting them to complaint trends and significant cases. These meetings have been highly productive.

Complaint trends and significant cases in 2011-2012

Ministry of Community Safety and Correctional Services

Correctional facilities – Complaints from inmates

Due to the high volume of complaints from correctional institutions, the Ombudsman's strategy is to flag and focus resources on those involving serious health and safety issues. In addition to the Special Ombudsman Response Team's ongoing investigation into the handling of complaints about excessive use of force by correctional officers, Ombudsman staff are monitoring complaints about how inmate-on-inmate assaults are being handled. In some cases, Ministry policies are apparently not being followed – for example, required reports are not always completed and photographs are not taken – and there are allegations that some correctional staff have turned a blind eye to inmate-on-inmate conflicts.

Another recent trend in complaints by inmates involved lack of access to appropriate health care, missed medical appointments and abrupt discontinuation of anti-depressant and other psychiatric medications. Some complained about their medications being changed when they were transferred between jails. When these concerns were brought to the attention of the Ministry's corporate health care branch, it committed to review and revise the relevant health care policies and to train staff accordingly.

Private Security and Investigative Services Branch

Ombudsman staff are also monitoring complaints about the Ministry's Private Security and Investigative Services Branch, which is responsible for licensing private investigators and security guards and investigating complaints made against them.

When a systemic concern was flagged to its officials about the lack of reasons provided in the branch's decisions on complaints about security guards' conduct, the Ministry agreed to review and improve how it handles complaints and responds to complainants. However, the branch placed all complaints on hold while its new process was being developed – leaving about 200 complaints unacknowledged for about a year.

Senior management took immediate action when Ombudsman staff brought this to their attention, and provided detailed updates on how this self-imposed backlog of complaints was handled. The branch has since set up a process to help resolve complaints, trained staff, prepared pamphlets and updated its website with information about its responsibilities and how it deals with complaints.

The Ombudsman will continue to monitor the branch's progress closely.

Ministry of Community and Social Services

Family Responsibility Office

The Family Responsibility Office (FRO) is responsible for the enforcement of court-ordered child and spousal support in Ontario. With **759** complaints received in 2011-2012, the FRO is once again the most complained about government program in Ontario. Complaints about the FRO generally involve inadequate or failed enforcement of support orders or inappropriate/mistaken enforcement. There were also many complaints about miscalculation of support payments and general difficulties in communicating with FRO officials.

Among the complaint trends identified by Ombudsman staff was an apparent tendency by FRO officials not to consider all available facts or ensure their records were up to date before taking action. In other cases, enforcement was not timely or in compliance with FRO policies or procedures. Poor record keeping and poor customer service were also persistent issues, with serious consequences for many Ontarians.

For example, in one case where FRO staff had failed to update their records to reflect a new court order, they moved to suspend a man's driver's licence and garnish 50% of his income. When Ombudsman staff contacted them, they realized the man had complied with the order and there was no need to go after him for more money.

In another case, where a man owed $5,000 in support to his family, FRO officials failed to recoup any of the money when the man sold his house, because he used an alias and FRO did not include that name on its writ of seizure and sale.

FRO officials also failed to properly process a 2001 provisional court order ending a man's support obligations – he was refunded $1,200 in overpayments after Ombudsman staff intervened.

"The Ombudsman is optimistic that, after so many years as a 'most complained about' organization, the FRO is showing signs of improvement."

New senior managers at the FRO have been very responsive to the complaint trends and cases brought to their attention by Ombudsman staff. They have set up a policy review committee and recently implemented a new customer service model and case management system. They have made an effort to speed up registration of court orders and improve the way they respond to clients and the public.

The Ombudsman is optimistic that, after so many years as a "most complained about" organization, the FRO is showing signs of improvement. Regular meetings and monitoring of complaints will continue.

Services for children with special needs

For the past several years, the Ombudsman has monitored complaints about a lack of services for children with special needs. Working with the child's family, community agencies and the relevant ministries, Ombudsman staff resolve these cases as effectively as possible. In 2011-2012, there were **47** complaints about services and treatment for children with severe special needs. The availability of services for these children continues to be a concern for the Ombudsman.

Two of these cases echoed the issues raised in the Ombudsman's 2005 investigation and report, *Between a Rock and a Hard Place*, which revealed parents were being forced to surrender custody of their children to children's aid societies in order to place them in facilities that could care for them. Ombudsman staff resolved both of these cases – for more detail, see the **Special Ombudsman Response Team** section of this report.

Assistance for Children with Severe Disability benefit program

In 2010-2011, the Ombudsman reported on complaints from families who were denied the Assistance for Children with Severe Disability (ACSD) benefit purely on the basis of income. By law, Ministry officials reviewing a family's application for ACSD are supposed to consider three other factors in addition to income, including the child's age, the nature of the disability and the expenses associated with caring for the child's special needs. A number of families complained to the Ombudsman that they were denied the benefit because their income was above a cap set by the Ministry, regardless of the specifics of their children's needs.

Inquiries by Ombudsman staff prompted the Ministry to review how its officials were applying the eligibility requirements for the benefit, particularly the "extreme hardship" clause, which allows them discretion to approve ACSD benefits for families that exceed the Ministry's income cap if they have incurred extreme costs relating to a child's disability. The Ministry determined its staff were not considering all cases consistently – in fact, in one region, the income cap was applied strictly, with no exceptions.

The Ministry clarified the rules for all staff dealing with ACSD applications, and as a result, more families have received the benefit under the "extreme hardship" criteria. It also developed a system to track Social Benefits Tribunal cases where benefits are denied, in case further clarification or training of staff is necessary to ensure the rules are applied consistently across the province. The Ministry provides the Ombudsman with regular updates on this issue.

Ontario Disability Support Program – Email communication with recipients

Since 2010, Ombudsman staff have been monitoring complaints by recipients of Ontario Disability Support Program (ODSP) benefits that program officials refused to communicate with them by email, even if the recipients' disabilities made it all but impossible for them to use other means of communication. This review revealed that the Ontario Human Rights Commission had ordered the Ministry of Community and Social Services to address this issue as early as 2003.

The Ombudsman's last Annual Report noted that, in response, the Ministry was testing new technology to allow confidential electronic communication with ODSP clients. The Ministry advised the Ombudsman that **82** ODSP clients are now communicating with program staff via email. The Ministry plans to expand the service to others with similar needs and is exploring ways to allow all clients to submit information online. The Ombudsman will continue to monitor the Ministry's progress in this area.

Services for adults with developmental disabilities

Another persistent source of complaints to the Ombudsman – **28** in 2011-2012 – is an apparent lack of services to support adults with developmental disabilities – particularly young adults. In several cases, when they turned 18 and their care was no longer the responsibility of the Ministry of Children and Youth Services, these young people found themselves without corresponding care under the Ministry of Community and Social Services (MCSS). Ombudsman staff met with senior MCSS officials in August 2011 about this concern.

The MCSS advised the Ombudsman that it is working to streamline the application process and co-ordination of services through its new access point, Developmental Services Ontario. It also implemented a new "support intensity scale" to ensure community agencies evaluate people's needs consistently and fairly across the province.

Several individual cases were resolved when Ombudsman staff raised them with senior Ministry officials. For example, when a 19-year-old group home resident nearly ended up in a municipal homeless shelter (see the **Case Summaries** section of this report) because a placement couldn't be found for him, the MCSS Assistant Deputy Minister intervened to ensure he remained in a group home.

In another case, the father of a medically fragile and developmentally disabled 19-year-old woman called the Ombudsman because his wife had died and he was in desperate need of additional services to support his daughter at home. The local Community Care Access Centre (CCAC) was unable to find personal care workers who could travel to his rural home as needed. Ombudsman staff worked with the Ministry and officials from the CCAC and Local Health Integration Network to arrange a funding method that would allow the family to contract their own personal care workers.

Ministry of the Attorney General

Office of the Public Guardian and Trustee

The Office of the Public Guardian and Trustee (OPGT) is responsible for the guardianship and management of the financial affairs of people who are physically and mentally incapable. Sometimes this includes responsibility for decisions about their personal care. The Ombudsman received **130** complaints about the OPGT in 2011-2012; these complaints were generally about the OPGT's decisions or its communication with clients and customer service.

Complaints often come from family and friends of OPGT clients. In some of these cases, the OPGT either failed or was slow to respond to calls from these concerned people. Some clients also complained that they had trouble reaching their OPGT representatives.

In some instances, OPGT staff provided incorrect information to clients – and to Ombudsman staff. In one case (in the **Case Summaries** section of this report), a man who requested a capacity assessment was wrongly denied, and his OPGT case worker withheld information about a registered savings plan he had in the bank because she did not want to deal with his requests for money. In another, an OPGT worker admitted that she had told a man that his income tax refund had not been received when it had been.

Senior OPGT officials have welcomed regular meetings with Ombudsman staff to discuss complaint trends, potential systemic issues and individual cases. They have worked to improve customer service, beginning with an updated case management system, new phone protocols, audits and staff training.

Human Rights Tribunal of Ontario – Use of Skype

An applicant to the Human Rights Tribunal of Ontario complained to the Ombudsman when his request to have a scheduled teleconference via Skype was refused.

When Ombudsman staff followed up with the tribunal to find out why, the response was that Skype is not an approved business application in the Ontario Public Service. Tribunal officials advised that a business case would have to be made in order to use the technology, which would be onerous and possibly costly.

Skype technology has been used successfully by the Ombudsman's Office over the past two years to facilitate inquiries, confidential interviews and investigations and even to make speeches. It has proven to be a cost-effective tool that greatly improves stakeholder access to the Office's services. It is commonly used by the public and easy to implement. In the Ombudsman's view, it is difficult to accept the reasons provided by the OPS and the tribunal as to why Skype is not permitted for hearings and other communications.

Ombudsman André Marin and Deputy Ombudsman Barbara Finlay were both invited to make speeches via Skype in 2011-2012. Ms. Finlay conducted a workshop on investigations for Australian and New Zealand ombudsman staff in Melbourne (February 2012), and Mr. Marin addressed the Public Sector Legal Officers' Forum in Canberra (March 2012).

Ministry of Energy

Hydro One

Although complaints to the Ombudsman about Hydro One decreased in 2011-2012 – to **232**, from 306 last year – it remains the fifth most complained about organization in the province. The most common complaints continue to be about excessive or incorrect billing, high or inaccurate meter readings, "smart" meters and required security deposits. There were also complaints from people who received unreasonable "catch-up" bills, or charges that were calculated over a number of years, some complicated by delays in meter repairs. Some exasperated customers sought the Ombudsman's help in making sense of Hydro One's charges and accounting.

Ombudsman staff worked with Hydro One officials, who agreed to provide detailed letters of clarification and explanation to customers. In general, they were very co-operative and committed to working with the Ombudsman to resolve these issues.

Examples of this year's successfully resolved Hydro One cases can be found in the **Case Summaries** section of this report.

Ministry of Transportation

Licensing Service Branch – "Master" licences

A complaint from a man convicted of drunk driving led Ombudsman staff to discover a disturbing issue with thousands of "master licence" records at the Ministry of Transportation. When someone is stopped by the police for a driving offence or collision and no driver's licence record for the person can be found, a dummy (or "master") licence record is created by the Ministry in order to store the information about the offence. The dummy licence is supposed to be matched up with the person's official licence, if one exists, or if he or she applies for a licence in future.

However, Ombudsman staff learned there are more than 36,000 dummy licences created per year and the Ministry did not have an effective process to prevent duplication. In the case of the drunk driver, for example, his court conviction was entered against the dummy licence, but he continued to drive for years because he still had an official licence that the Ministry had failed to match up with the dummy one.

Ombudsman staff raised concerns about this problem to the Ministry and were informed that steps had already been taken to improve the Ministry's search tools to catch potential duplicate licences that may have resulted from incorrect information (e.g., misspelled names) being entered into its system. In addition, the Ministry advised that a new records system is in the works. However, at the time of writing this report, the Ministry had no concrete plans to review its existing database of dummy licences. Given the potential public safety implications, Ombudsman staff will continue to follow up with senior Ministry officials on this matter and assess whether a formal investigation is warranted.

Ministry of Training, Colleges and Universities

Private Career Colleges Branch

The Ministry's Private Career Colleges Branch – the subject of the Ombudsman's 2009 SORT investigation, *Too Cool For School* – is responsible for ensuring all private career colleges are in compliance with legislation, taking enforcement action against those that are unregistered or otherwise not in compliance, and handling complaints from students.

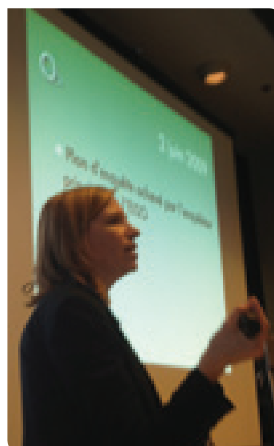
In 2011-2012, the Ombudsman received **26** complaints about this branch – about half of those from colleges, the rest from students. Many of these were about inadequate communication, unfair enforcement, or delays in approving programs, renewing schools' registrations, or responding to colleges' compliance efforts.

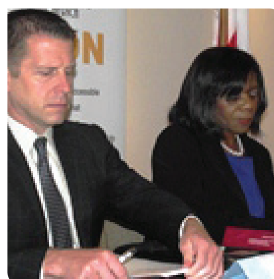
One college director complained that she had tried for two years to address concerns that a Ministry inspector had raised about her school. While she viewed the problem as a simple misunderstanding, she complained that it had forced her to close her college. She had even hired a lawyer, to no avail. Ombudsman staff worked for several months to obtain answers from the branch and discussions with senior Ministry staff were ongoing at the time this report was written.

Ombudsman staff continue to review complaints about this branch, including assessing whether a systemic investigation may be warranted.

Training and Consultation

Over the past five years, the Ontario Ombudsman's investigation techniques have been exported around the world, thanks to his innovative training course for ombudsmen and investigators, **"Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs."** The Ombudsman and senior staff are also frequently asked to consult with visiting counterparts and similar agencies from across Ontario, Canada, the U.S. and many other countries.





JACARANDA FM

NAMIBIAN SUN

Ombudsman André Marin was invited to deliver "Sharpening Your Teeth" training for the staff of several of his counterparts in 2011-2012 – including in Quebec City and Montreal with Deputy Ombudsman Barbara Finlay (top left and top right), South Africa (pictured with South Africa Public Protector Thuli Madonsela, middle right), and Namibia (pictured with SORT Director Gareth Jones, bottom right, and Namibia Ombudsman John Walters).

Training

The Ombudsman's "Sharpening Your Teeth" course has been delivered annually in Toronto since 2007, drawing representatives from hundreds of agencies across Canada, the U.S. and overseas. As well, the Ombudsman and other members of his senior team have delivered the course to other ombudsman offices and similar agencies in host countries in Europe, Asia, Africa, Australia and South America. All of this training is done on a complete cost-recovery basis.

In 2011-2012, the Ombudsman and Deputy Ombudsman trained colleagues from 24 countries in a "Sharpening Your Teeth" course at the International Ombudsman Institute headquarters in Vienna – and dozens more at a course hosted by the United States Ombudsman Association in Jacksonville, Florida. Other customized versions of the course were conducted this past year for the Office of the Public Protector of South Africa, the Ombudsman of Namibia, Canada's Ombudsman for Banking Services and Investments and the Trinidad and Tobago Police Complaints Authority.

The course was also delivered completely in French for the first time (as "*Aiguisez-vous les dents*"), for the Quebec Ombudsman's staff in Quebec City and Montreal.

> "In Canada, [Ombudsman André] Marin has an unsurpassed reputation for fair, thorough and objective investigations. His [investigative] model has resulted in major government reforms that improved the lives of the people of Ontario."
>
> **South Africa Public Protector Thuli Madonsela, press release, August 2011**

The Ombudsman's fifth annual "Sharpening Your Teeth" training conference in Toronto was held November 28-30, 2011, and attended by **75** participants, including representatives from several ombudsman offices, from Montreal and Amsterdam to Antigua and Curaçao. Other Canadian agencies represented at the course included the Taxpayers Ombudsman, National Defence, Manitoba Ombudsman, Newfoundland and Labrador Child and Youth Advocate and Saskatchewan Workers' Compensation Board. At the Ombudsman's invitation, the Ontario government sent senior officials from the ministries of Labour, Environment, Finance, Community and Social Services, Consumer Services, Health and Long-Term Care, Municipal Affairs and Housing, Revenue, and Colleges, Training and Universities.

Guest speaker Shelly Jamieson, then Secretary of Cabinet and head of the Ontario public service, addressed the group about the importance of strong, credible ombudsman oversight of government, calling the Ombudsman "one of my most valued allies."

> "We know that Ombudsman investigations are helping to uncover challenges that we might not have the distance to see, to bring those issues to light, and to make our services more responsive to the people who need them.
> No matter what, there is *always* room for improvement."
>
> **Secretary of Cabinet Shelly Jamieson,**
> **address to "Sharpening Your Teeth" participants, November 30, 2011.**

The next edition of "Sharpening Your Teeth" in Toronto will be held in January 2013.

Ombudsman André Marin invited then Secretary of Cabinet Shelly Jamieson, head of the Ontario public service, to address "Sharpening Your Teeth" participants about the impact of Ombudsman investigations, November 30, 2011.

Comments from "Sharpening Your Teeth" participants, November 2011:

"Not only has the course provided insightful tools and info, it has given me courage to go back to the office and start effecting change."

"It gives you techniques and methods you can apply to your local situation while conducting an investigation."

"André Marin and staff are inspiring."

"The course content was very relevant. It clearly reminded us, in order for an investigation to be effective and timely, it needs to be effectively planned."

"Listening to case studies of successful investigations of public sector programs has given me insight in how to apply critical evaluation to my own program."

Ombudsman André Marin addresses "Sharpening Your Teeth" participants in Toronto, November 30, 2011.

Consultation with other agencies

Many agencies – from the Ontario government to far-flung offices of ombudsmen, human rights organizations and other oversight bodies – consult the Ontario Ombudsman for advice and expertise. The Ombudsman and staff host visiting delegations throughout the year, and frequently give presentations to groups seeking to know more about the Office's services.

Visiting delegations in 2011-2012 included the Dutch National Ombudsman, the European Ombudsman, and a group of 13 high court judges from Nigeria's National Capital Territory, part of a visit organized by the International Development Institute in Washington, D.C. and the York University Centre for Practical Ethics.

Ombudsman staff were also asked to give presentations to several Ontario agencies, including the Ontario Network of Injured Workers Groups and the Financial Services Commission, and to conduct workshops in leadership and ethical decision-making as part of the Ministry of Government Services' leadership training program for public servants. As well, members of the Ombudsman's municipal closed meeting investigations team, OMLET (**Open Meeting Law Enforcement Team**) were invited to speak to several municipal councils about the Ombudsman's investigations and best practices for keeping meetings open to the public. (Details about OMLET investigations will be presented in a **separate Annual Report** later this year.)

Among the dignitaries who consulted with Ombudsman André Marin in 2011-2012 were European Ombudsman Nikiforos Diamandouros (October 2011) and Nigerian High Court Chief Justice Lawal Gummi (November 2011).

PHOTO BY HAROLD GODSOE

Communications and Outreach

From "live-tweeting" on Twitter to the publication of traditional reports, the Ombudsman uses all available means of communication to reach as many people as possible – and, increasingly, to allow them to reach him. Whether it's through the printed word, social media, the new Ontario Ombudsman website and mobile "app," in-person appearances or Skype, the Ombudsman and staff use the latest technologies available to communicate about the Office's work.

Communications

Since public complaints and concerns are the lifeblood of the Ombudsman's Office, broad, effective and efficient communication is essential to his work. In 2012, the Office continued to maintain a high profile in traditional media, increased its social media reach significantly, and became the first ombudsman office in the world to implement a mobile-optimized "app" to allow people to complain and use its resdesigned website right from their smartphones or tablets.

Traditional media

There were **834** print articles published about the Ombudsman's Office in 2011-2012, primarily in daily newspapers across Ontario and the rest of Canada. The estimated advertising value of these articles was **$1.7 million**, reaching an aggregate audience of **45.5 million** people, according to calculations by Infomart, based on newspaper advertising rates, circulation and page display.

There were also **393** items about the Ombudsman and his work broadcast on radio and television, both in Ontario and across the country.

Social media

The Ombudsman's social media following increased significantly in 2011-2012, as did the degree of public engagement with the Office's social media outlets. Since 2009, thousands of people across Ontario and the world have used **Facebook**, **Twitter**, **YouTube** and **Flickr** to stay up to date on the Ombudsman's work – and to comment on and contribute to investigations. The Ombudsman's successful use of social media has encouraged ombudsmen and other oversight agencies to follow suit. In recognition of this leadership, the Ombudsman's Communications staff were invited to share their expertise at GovCamp 2011, a social media conference in Toronto in June 2011.

The Ombudsman's **Facebook** page (www.facebook.com/OntarioOmbudsman) had more than **1,700** "likes" at the time of writing this report (up from 1,400 last year) and received close to **24,000** visits in 2011-2012. The page welcomes comments, questions, and discussion about the Ombudsman's work, and followers are kept up to date with news stories, press releases, and job postings, as well as links to the Ombudsman's latest speeches and press conferences.

In early 2012, the new "Timeline" format was implemented on the Ombudsman's Facebook, showcasing an online archive of photos, news articles, speeches, and reports from the Office's creation in 1975 to the present day.

On **Twitter**, the Ombudsman's followers grew to more than **7,000** at the time this report was written – up from 4,500 a year ago. Followers of **@Ont_Ombudsman** – where all tweets are written personally by Ombudsman André Marin unless otherwise noted – are active; they ask questions, share press releases and news, and offer insight and tips for investigations. The Ombudsman uses Twitter to speak directly to the public – including media followers – about a wide range of subjects, 140 characters at a time. Events such as press conferences and speeches are "live-tweeted" – usually by Communications staff, while the Ombudsman is busy speaking – with the hashtag **#OOLive**, allowing anyone to follow, track or search for the full stream of related tweets.

The Ombudsman's **YouTube** channel (www.youtube.com/OntarioOmbudsman) also counted thousands of new users in 2011-2012, amassing about **14,000** views. The videos of the Ombudsman's news conferences and speeches are also embedded and linked on the Office's website.

More users also discovered the photo resources available at the Ombudsman's **Flickr** account (flickr.com/ont_ombudsman), where high-quality, professional photographs of press conferences, award ceremonies, speeches, and other events are available, primarily for media use. The account received **1,766** views in the past year.

Website and mobile app

The Ombudsman's website (www.ombudsman.on.ca) was redesigned and relaunched in June 2011 to improve the online complaint forms, better integrate social media and video, and make investigations, speeches, news items and other resources easier for users to find.

According to Google Analytics, the website had **80,689** unique visitors in 2011-2012. It received **131,422** total visits, an increase of 10% over the previous year. Page views also increased, to **528,315**. Most visitors are from Canada, the United States, the United Kingdom, and Australia, but others came to the site from **180** countries.

In November 2011, the Ombudsman unveiled the mobile-optimized version of the site, or web "app" (application), which users can download directly to the homescreen of a smartphone or tablet. It offers a simplified complaint form, intuitive navigation, and is searchable. At the time of writing this report, there had been **3,523** visits to the mobile site, with **2,470** unique visitors and an average of **170** visits per week, and about **50** complaints had been submitted via the mobile site.

Comments from Twitter about the new website design:

"Your website is top notch: I'd encourage all Ontarians to check it out."
@judahoudshoorn

"The best Ombudsman site we have seen! All other ombudsmen need to take note."
@crg_ltd

"Great mobile site and love the social media presence. Keep it up, @Ont_Ombudsman!"
@jeffbilyk

Outreach

The Ombudsman was invited to speak at a wide variety of events in 2011-2012, from law faculties at the universities of Western Ontario, Ottawa and Windsor to the social-media-themed "meetup" organized by Third Tuesday Toronto. He was the keynote speaker at the annual meeting of the Ontario College of Teachers, and gave the annual Public Policy Address at York University's McLaughlin College. Both the Ombudsman and Deputy Ombudsman also gave speeches to groups in Australia in early 2012 – without leaving Toronto, thanks to the video-calling service **Skype**.

Ombudsman staff also participated in a number of outreach events sponsored by community groups.

And the award goes to…

Ombudsman André Marin was honoured with the following prestigious awards in 2011-2012, recognizing his contribution to law and public service in Ontario:

DISTINGUISHED SERVICE AWARD, Ontario Bar Association, April 2012

This award is given in recognition of exceptional achievements in the legal profession in Ontario, including contributions to the development of the law and to significant law-related benefits to the residents of Ontario (announced March 2012).

A.D. DUNTON ALUMNI AWARD OF DISTINCTION,
Carleton University Alumni Association (Ottawa), November 2011

Given annually to one former graduate, this is Carleton's highest alumni honour, recognizing outstanding achievements in the recipient's field and individual accomplishments that act as a source of inspiration and motivation.

ORDRE DU MÉRITE (ORDER OF MERIT),
University of Ottawa Faculty of Law, Civil Law Section, September 2011

The highest distinction given to University of Ottawa civil law graduates, this award recognizes those who have made remarkable contributions to the advancement of law, established themselves as national or international leaders, and demonstrated exceptional social or community engagement.

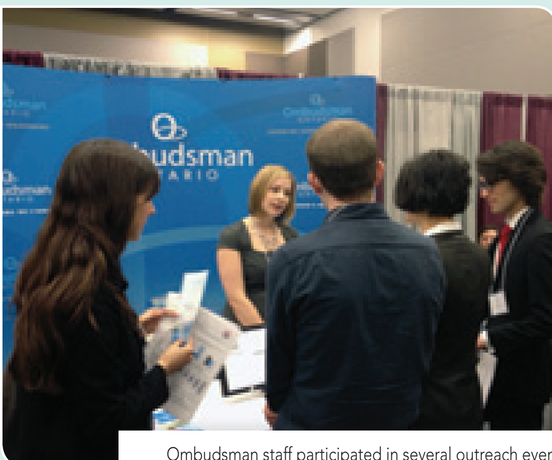
Speeches

Ombudsman André Marin was part of the Distinguished Speakers Series at the law faculty of the University of Western Ontario (right, October 2011) and lectured at the University of Windsor faculty of law (left, January 2012).

Awards

Ombudsman André Marin received three awards in 2011-2012 for his contributions to Ontario law and his achievements as Ombudsman: The Ontario Bar Association's 2012 Distinguished Service Award (left, presented by OBA Vice-President Morris Chochla); the Order of Merit from the University of Ottawa's Faculty of Law, Civil Law Section (presented by Dean Sébastien Grammond); and the Carleton University Alumni Association's A.D. Dunton Award (presented by University President and Vice-Chancellor Roseann Runte, left, and Alumni Association Chair Jane Gilbert).

Events



Ombudsman staff participated in several outreach events in 2011-2012, including Public Interest Day in Toronto (right, March 2012) and the University of Ottawa's Social Justice Fair (also March 2012).

Special Ombudsman Response Team

The Special Ombudsman Response Team is responsible for conducting the Ombudsman's investigations of serious, high-profile issues that affect large numbers of people. Many of these investigations have a systemic component. By tackling the root cause of a problem, SORT investigations can resolve many complaints at a time and avert future ones.

SORT consists of a group of skilled and experienced investigators. Its methodology involves careful case assessment, rigorous planning and a "no-stone-left-unturned" approach to evidence gathering. When necessary – as in cases with many witnesses or a large volume of documents – the Ombudsman will augment the team with other staff, including legal counsel, investigators and Early Resolution Officers.

These investigations usually result in a public report, focusing on the underlying causes of the administrative problems found, and making practical recommendations to resolve them. An important part of SORT's role is to follow up on the implementation of the Ombudsman's recommendations. The Ombudsman receives regular updates from government agencies and can investigate further if necessary.

Created by Ombudsman André Marin in 2005, SORT has been acknowledged as a leader in the global ombudsman community for its advanced investigative techniques. These methods are the heart of the Ombudsman's training course, **"Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs,"** which has trained hundreds of ombudsmen and investigators from across Canada and around the world (for more on this, please see the **Consultation and Training** section of this report).

SORT investigations completed in 2011-2012

Oversight Undermined **– Ministry of the Attorney General and the Special Investigations Unit**

In December 2011, the Ombudsman released his second report involving the Ministry of the Attorney General and the Special Investigations Unit (SIU) – the agency that conducts independent investigations in cases where police are involved in the death, serious injury or sexual assault of a civilian. *Oversight Undermined* was the result of a follow-up investigation into the Ministry's response to the Ombudsman's recommendations in his 2008 report, *Oversight Unseen*.

The first investigation revealed, among other things, a lack of rigour in SIU investigations, a lack of police co-operation with the SIU, and a preponderance of retired police officers among its investigators – all of which contributed to public perceptions that it had a pro-police bias. The Ombudsman recommended the SIU make internal changes, and also called on the Ministry and government to support its work through clearer, stronger legislation outlining both the SIU's mandate and police obligations to it.

Both the SIU and the Ministry welcomed the Ombudsman's recommendations in September 2008, and the Ministry committed to begin consultation on new legislation. The SIU, under the leadership of new Director Ian Scott, made significant strides to dispel its image as a "toothless tiger," as the Ombudsman described it at the time. Among other changes, for the first time in its history, it appointed an investigations supervisor with a non-police background.

But while the Ministry did give the SIU more resources to purchase needed equipment, including a mobile command centre, it did little else after 2008 to implement the Ombudsman's recommendations. It was this inertia that prompted the Ombudsman to announce a follow-up investigation in September 2010.

The follow-up investigation, like the first, was exhaustive, including the review of more than 1,000 documents from the SIU and Ministry and interviews with numerous high-level officials at both.

SORT investigators learned that as early as March 2009, conflict between the SIU and police prompted the Ministry to decide not to move forward on the Ombudsman's recommendations for stronger legislation. An internal briefing note revealed that this was "largely due to vehement police opposition."

The same briefing note indicated that the Ministry had simply bought time and was counting on the Ombudsman to move on from the important issue of police oversight. It said: "Marin typically does not conduct any public communications regarding 'report-backs' – he usually gets his media hit off report releases and then moves on. We need not be overly concerned that he will criticize us." The Ombudsman found it highly disturbing that the Ministry would develop public policy based on such misguided considerations.

> "The Ministry has failed the SIU and by doing so it has failed the public and the police. For a bulwark of democracy, the SIU's legal foundation is embarrassingly flimsy."
>
> **Ombudsman André Marin, release of *Oversight Undermined*, December 14, 2011**

Then, just days apart in June 2009, there were two fatal shootings by Ontario Provincial Police officers. Although no officers were criminally charged in the deaths of the two men – Douglas Minty, 59, and Levi Schaeffer, 30 – controversy erupted because in both cases, police association lawyers consulted with the officers involved and vetted their notes before they were given to the SIU. The SIU deplored this practice, and the families of Minty and Schaeffer went to court, seeking a declaration that it not be allowed.

Meanwhile, the Ombudsman found, rather than supporting Director Scott in his efforts to hold police to account when they failed to co-operate with the SIU, the Ministry was actively undermining him. It suppressed the SIU's 2009 Annual Report, in which Director Scott called attention to, among other things, problems with police association lawyers interfering with the preparation of notes by officers under investigation. Ministry officials called the report "provocative" and not "useful."

Instead, the Ministry quietly appointed retired justice Hon. Patrick LeSage in December 2009 to consult privately with police and the SIU on ways to resolve their ongoing disputes. Mr. LeSage issued a three-page report in April 2011, addressing some of these issues, and recommended the Ministry revisit issues affecting the SIU and police in another two years. The Ministry finally permitted the release of the SIU's delayed 2009 report in May 2011.

Ombudsman André Marin discusses his findings on the lack of police co-operation with the Special Investigations Unit at a press conference to release his report *Oversight Undermined*, December 14, 2011.

Director Scott told SORT investigators that between 2008 and 2011, he wrote more than 200 letters to police chiefs, identifying cases in which their members had failed to co-operate with the SIU, warning they risked violating the *Police Services Act*. These were cases where police delayed notifying the SIU of fatal or serious injuries – or never called at all; cases where police impeded SIU investigators' access to incident scenes or interfered with their investigation; and cases where police lawyers interfered with the notes of witness officers. Director Scott received substantive replies to fewer than 10% of his letters.

In November 2011, the Ontario Court of Appeal released its decision in the case brought by the Minty and Schaeffer families. It clearly declared that police association lawyers are prohibited from vetting or assisting in the preparation of police notes in SIU investigations. The Ombudsman released *Oversight Undermined* four weeks after the court's decision.

He made 16 recommendations, most of which reiterated those from 2008. He urged the government to reconstitute the SIU under new legislation that clearly defines its mandate, the obligations of police services to notify the SIU of incidents that fall within that mandate, and consequences for those that fail to comply. He noted that the follow-up investigation had shown half-measures and attempts to soothe tensions through silence had only made matters worse for all concerned.

While the Ministry's response to the latest recommendations was generally positive, the Ombudsman found it disappointing in its lack of detail or commitment.

> “I thank the Ombudsman for bringing these issues to the public's attention… I look forward to working with the Ministry of the Attorney General and the Government of Ontario in implementing the Ombudsman's recommendations in order to facilitate a more independent oversight body.”
>
> **SIU Director Ian Scott, statement in response to Ombudsman's report, December 14, 2011**

> “The situation needs to be improved. We’re going to improve it.”
>
> **Attorney General John Gerretsen, quoted in *The Globe and Mail*, December 15, 2011**

> “A report that our police oversight system isn’t working properly is cause for alarm. It should be debated in the Legislature and, ultimately, lead to changes in law.”
>
> ***Toronto Star* editorial, December 16, 2011**

The report also sparked a variety of responses from police chiefs about the letters issue. In Windsor, the police chief abruptly resigned in January 2012 after a media storm sparked in part by questions about cases in which his service failed to notify the SIU. In April 2012, the Ottawa police chief publicly committed to responding to the SIU’s concerns – although he did not commit to a substantive response to the SIU Director’s letters in future. The Ombudsman expressed his opinion that the chief must show accountability and meaningfully address the SIU’s concerns; mere pro-forma acknowledgment of the letters would achieve nothing but the waste of a stamp. The Ombudsman noted that it is part of the duty of all police chiefs to respond to and investigate complaints by the SIU that its efforts were frustrated by police services.

In the wake of the Ombudsman’s report, the SIU has seen a marked increase in notifications by police services of serious incidents – from 57 in the first quarter of 2011 to 101 in the first quarter of 2012. For the SIU’s part, while the Ombudsman has been generally satisfied with its response to his recommendations, he raised concerns in April 2012 about a television documentary in which one SIU investigator could be seen wearing a police ring (although it was intentionally blurred in the video, an internal investigation later confirmed it to be a ring from Durham Regional Police). Given that this type of behaviour had been specifically targeted in the Ombudsman’s 2008 report and subsequently prohibited by the SIU, the Ombudsman drew this disturbing evidence to the attention of the SIU Director. Shockingly, cases of police ring bearing by SIU staff continued to emerge. In all, four as-needed SIU investigators were disciplined for wearing police rings on duty – one resigned, two were terminated and the other was suspended. The Director issued a further directive, reinforcing once again that displays of police paraphernalia would not be tolerated.

Every employee of the SIU, from the Director down, must be committed to strict impartiality. Not only is it in the public interest, it is actually the law in Ontario. The Ombudsman will continue to closely scrutinize the SIU to ensure that it remains vigilant and there are no further relapses. The effectiveness of police oversight in Ontario will be vigorously monitored in the coming year, and the Ombudsman has said a third investigation is a possibility.

Non-emergency medical transportation services – Ministry of Health and Long-Term Care, Ministry of Transportation

In January 2011, the Ombudsman began an investigation into whether the Ministry of Transportation and the Ministry of Health and Long-Term Care were adequately protecting the public who use non-emergency medical transportation services.

Although their vehicles look like ambulances, these services are private companies that are not regulated. They transfer hundreds of thousands of non-critical patients per year between hospitals and other facilities or medical appointments.

The Ombudsman received more than **60** complaints, many raising concerns about patient safety in these vehicles, citing cases of inadequate equipment, lack of infection control, poorly maintained vehicles and insufficient training of staff.

SORT investigators conducted more than 100 interviews with officials from the ministries, hospitals and long-term care facilities, the medical transportation industry, patients and their families. Investigators also reviewed how such services are regulated in other provinces.

The Ombudsman found that regulation of the medical transfer industry had been discussed for more than 15 years, and there had been several calls for standards to be put in place immediately, including from two coroner's inquests and a report by the Auditor-General. Many owners and operators of medical transportation firms themselves strongly supported regulation, but, at the start of the investigation, the Health ministry advised it was "not on the radar."

The Ombudsman shared a working draft of his findings with the ministries in May 2011, and the respective ministers jointly announced on June 10, 2011 (after the Legislature had prorogued for the October 2011 election) that legislation to regulate the industry would be introduced "at the earliest opportunity," with the Health ministry taking the lead. With the matter apparently resolved, the Ombudsman did not release a report.

Since the election, SORT investigators have received monthly updates on the progress of the Health ministry in fulfilling the commitments made to the Ombudsman. Consultation with hospitals and other stakeholders began in early 2012. The Minister of Health and Long-Term Care also personally advised the Ombudsman in April 2012 that regulation will be introduced as soon as the consultation process is complete.

> "I want to commend you and your office on a fantastic job. You seemed to accomplish something that we've been trying to advocate for the last few years."
>
> **Emergency medical services manager**

Limited funding of Herceptin – Ministry of Health and Long-Term Care

In March 2011, the Ombudsman launched an investigation into the Ministry of Health and Long-Term Care's decision not to fund the drug Herceptin for breast cancer patients because their tumours were too small – i.e., one centimetre in diameter or less.

Two months later, the Ombudsman suspended his investigation when the Ministry announced it would extend funding to these patients through a new Evidence Building Program (EBP). The program would allow for the collection of real-world data on clinical and cost effectiveness where there is evolving but incomplete evidence of the benefits of a cancer drug.

Although the investigation was suspended, the Ombudsman asked the Ministry for regular updates on the implementation of the EBP. The Ministry obtained stakeholder input in the summer of 2011 regarding the program's policies and framework. As of February 2012, **45** patients including Jill Anzarut, who first brought the issue to the Ombudsman's attention, had been approved to have Herceptin funded through the program. The Ministry and Cancer Care Ontario continue to consider using the EBP process for other conditions and other drugs. Ms. Anzarut's recovery is going well.

SORT assessments in 2011-2012

Wind turbines – Ministry of the Environment

The Ombudsman continues to receive complaints and submissions related to wind turbines – **78** in 2011-2012. As in the past two years, they involved concerns about the potential health effects of wind energy and how the Ministry of the Environment deals with wind turbine noise complaints. Many people asked the Ombudsman to launch a systemic investigation into these issues, as well as the municipal-level consultation and approval process for wind turbine projects.

The Ombudsman's review has focused on whether the government has an adequate administrative process for complaints related to wind turbines, and investigators have monitored the Ministry of the Environment's actions.

In October 2011, SORT investigators were briefed by senior Ministry officials on their new compliance protocol to measure wind turbine noise and an expert report they commissioned on infrasound and low-frequency sound from wind turbines. The report, released publicly in December 2011, concluded that there is no direct health risk from wind turbine noise and that the Ministry's rules to control it were appropriate. The Ministry indicated that it would continue to monitor scientific developments in this area, including developing approaches to address complaints related to indoor low-frequency sound in specific situations. Many people opposed to wind turbines did not accept these findings.

Other developments being monitored by investigators include:

- The Ontario Environmental Review Tribunal's July 2011 ruling that it could not conclude, based on the evidence provided, that a wind farm development near Thamesville would cause serious harm to human health. However, the tribunal found that wind turbines could cause harm to humans if they are placed too close to residents, and commented that further research should help to resolve some of the health issues cited in such cases.

- Ontario's Research Chair in Renewable Energy Technologies and Health, funding for which is arranged by the Ministry, is conducting health studies on humans and wind turbines, including clinical and epidemiological studies on the effects of different frequency and sound pressure levels and other factors.

Given the ongoing developments related to wind turbine issues, the Ombudsman has decided not to launch a systemic investigation, but will continue to monitor this issue.

Ongoing SORT investigations

Monitoring of drivers with uncontrolled hypoglycemia – Ministry of Transportation

In March 2012, the Ombudsman announced an investigation into how the Ministry of Transportation monitors drivers who have uncontrolled hypoglycemia and could be a danger on the roads.

The investigation was sparked by the 2009 case of a Hamilton driver who caused a crash that killed three people when he was in "diabetic shock." Family members of the accident victims asked the Ombudsman to look into the Ministry of Transportation's process of obtaining information about drivers with uncontrolled hypoglycemia and taking action when warranted. In the Hamilton incident, the man's condition was reported by police and a physician to the Ministry, but it did not suspend his licence until 2011.

In announcing the investigation, the Ombudsman emphasized that although most drivers who have diabetes are perfectly safe, the condition of uncontrolled hypoglycemia is deemed serious enough that Ontario and other provinces require medical professionals to report it to the Ministry. "If that requirement doesn't result in appropriate action by the Ministry, it is meaningless," he said, noting the investigation will determine whether the Ministry's processes adequately protect the public.

At the time this report was written, the investigation was ongoing and the field work (interviews and other evidence gathering) was expected to be completed by early fall 2012.

Use of force in jails – Ministry of Community Safety and Correctional Services

In response to more than **100** complaints from inmates claiming to have been assaulted by correctional officers, and concerns – detailed in his 2010-2011 Annual Report last June – about violent incidents possibly being covered up or not reported, the Ombudsman launched an investigation in August 2011 into how the province deals with allegations of excessive use of force by correctional officers against inmates in its jails.

SORT investigators have conducted more than 150 interviews across the province, including with inmates, officials from the Ministry of Community Safety and Correctional Services and its Correctional Investigation and Security Unit, correctional officers and other stakeholders.

At the time this report was written, the field work of the investigation was nearing completion.

Ontario Provincial Police handling of operational stress injuries – Ministry of Community Safety and Correctional Services

At the end of March 2011, the Ombudsman announced an investigation into how the Ontario Provincial Police (OPP) handles operational stress injuries among its members, and the Ministry of Community Safety and Correctional Services' administrative processes relating to such injuries in municipal police services.

SORT investigators spoke with numerous retired and current OPP members and their families about the sometimes debilitating depression, anxiety, addiction and post-traumatic stress disorder they suffered as a result of being exposed to violent, stressful or traumatic events on the job. Many of these members complained that they were poorly treated by the OPP, that there was no training or education available about operational stress injuries and little or no support available for those affected.

At the time the investigation was launched, the Ombudsman had received **34** complaints and submissions from active and retired members of the OPP and **16** from members of municipal police services. Once news of the investigation became public, another **44** OPP-related complaints were received, along with **13** from active and former members of municipal police forces.

Investigators conducted more than 185 interviews, travelling across the province to interview a range of OPP staff and senior leadership, senior staff from the Ministry, the Workplace Safety and Insurance Board as well as representatives from the Canadian Forces, the Royal Canadian Mounted Police, and other law enforcement agencies from Canada and the U.S. that have dealt with operational stress injuries. Other interviews included staff from health care institutions specializing in treating operational stress. Information was also received from the Police Association of Ontario, the Ontario Provincial Police Association and the Ontario Association of Police Services Boards.

At the time this report was written, the investigation was completed and the Ombudsman was in the process of drafting his report and recommendations. The Ombudsman hopes to release the report in late summer 2012.

Updates on previous SORT investigations

Monitoring of long-term care homes – Ministry of Health and Long-Term Care

In December 2010, the Ombudsman released his findings on his investigation into the province's monitoring of long-term care homes. He noted at that time that this area "continues to be a work in progress" and he would monitor the Ministry's ongoing progress closely.

Although the Ombudsman does not have jurisdiction over long-term care homes themselves, his investigation focused on the effectiveness of the Ministry's monitoring of the homes and whether its standards were realistic or detracting from effective compliance monitoring and patient care. The Ombudsman identified four areas of concern in his investigation: Inconsistent application of the standards used to monitor long-term care homes, delayed inspections, less-than-rigorous investigation of complaints, and inadequate public reporting of compliance.

Complaints received by the Ombudsman included concerns about the timeliness and reactive nature of Ministry inspections, the level of detail available on the Ministry's public reporting website and potential reprisals against residents or family members who bring forward complaints.

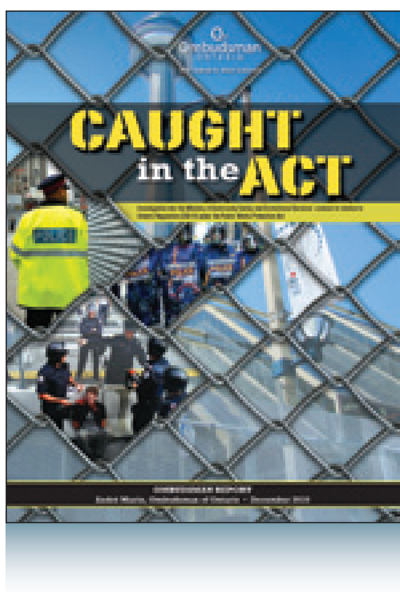
The Special Ombudsman Response Team continues to meet and receive regular updates from Ministry officials, as well as other stakeholders. In his December 2011 letter updating him on the Ministry's progress on these issues, the Deputy Minister of Health and Long-Term Care wrote to the Ombudsman:

> "Thank you for your recognition of our progress in the December 21, 2010 report. Most importantly, thank you for your attention to this critical issue and for your guidance. There is greater accountability in the [long-term care] home system today because of your work."

The Ombudsman has also noted a number of positive initiatives, which include the launch of the new Long-Term Care Home Quality Inspection Program for inspections, complaints and investigation of critical incidents. The new compliance inspection program focuses on resident risk issues, quality of life and resident care outcomes and includes additional staff training, updates to policies and stakeholder consultation. The Ministry launched a new version of its inspection reporting website in March 2012. As well, the Long-Term Care Task Force on Resident Care and Safety, formed by long-term care sector representatives in response to media reports about abuse and neglect of long-term care residents, made 18 recommendations to the Minister in May 2012. Among the recommendations were calls for increased staffing, changes to legislative reporting requirements and processes that detract from resident care, and a "zero-tolerance" policy for abuse.

The Ombudsman continues to actively monitor the Ministry's progress in this area in order to assess whether a follow-up investigation may be necessary in the future.

Caught in the Act – Expansion of police powers for Toronto G20 summit – Ministry of Community Safety and Correctional Services



Released just six months after the June 2010 G20 summit meeting in Toronto, the Ombudsman's report *Caught in the Act* revealed serious problems with the Ministry of Community Safety and Correctional Services' role in granting the Toronto Police Service's request for additional powers during that event.

The report chronicled the confusion that ensued after the Ministry quietly agreed to sponsor a new regulation under the little-known *Public Works Protection Act (PWPA)* of 1939, to assist Toronto police in protecting the security fence around the downtown meeting site. The Ombudsman's investigation determined that not only was the public not told that, in effect, anyone approaching the fence could be detained and asked for identification without the right to walk away, but even the various security forces at the summit either knew nothing about the regulation or were misinformed about what it entailed.

In *Caught in the Act*, the Ombudsman found that the regulation under the *PWPA* served as a trap for protesters and innocent bystanders who had no idea their normal civil rights had essentially been suspended for that weekend, when more than 1,000 people were arrested and many others were detained and searched. The Ombudsman recommended the outdated *PWPA* – a legal relic originally intended to protect Ontario infrastructure from invasion in World War II – be scrapped or replaced, and that the Ministry establish a protocol to ensure any future changes to police powers are properly communicated to the public.

The Ministry agreed to the Ombudsman's recommendations. The government appointed former chief justice Hon. Roy McMurtry to conduct an independent review of the *PWPA*. In April 2011, building on the Ombudsman's recommendations, Mr. McMurtry called for the *PWPA* to be replaced. The government then began consultations on replacement legislation.

On February 22, 2012, the new Community Safety and Correctional Services Minister moved the first reading of Bill 34, *An Act to repeal the Public Works Protection Act, amend the Police Services Act with respect to court security and enact the Security for Electricity Generating Facilities and Nuclear Facilities Act, 2012.* As its title indicates, the bill replaces the PWPA with specific provisions to secure courts and electricity generating facilities, including nuclear facilities. At the time this report was written, the bill had passed second reading and was being considered by the Standing Committee on Justice Policy.

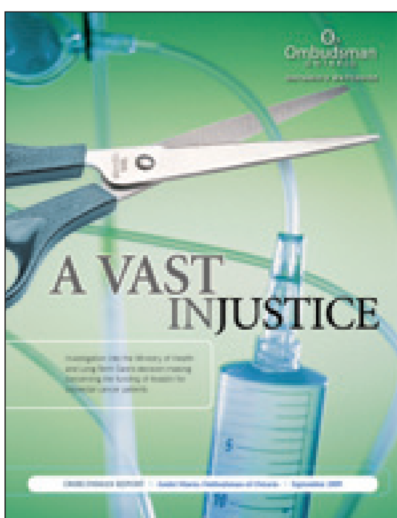
> “In 2010, the Ombudsman produced a report which raised important questions about how the *PWPA* works and how it was used at the time of the G20. In the wake of this, our government asked former Chief Justice Roy McMurtry to review the scope and appropriateness of the *PWPA* and to provide recommendations… I would like to thank both the Ombudsman and Mr. McMurtry for their work on this important issue.”
>
> **Minister of Community Safety and Correctional Services Madeleine Meilleur, introduction of Bill 34, *Hansard*, February 24, 2012**

> “The Ombudsman did, I think, a very fine job in reviewing [the G20] travesty and providing a number of recommendations. I am very pleased to see that this government has indeed taken steps in their Bill 34 to minimize the opportunities for that sort of injustice to happen again.”
>
> **PC MPP Randy Hillier, *Hansard*, March 20, 2012**

The Ministry has also developed a protocol for public communication where there is an amendment to police authority, as the Ombudsman recommended.

The Ombudsman continues to monitor issues related to the Toronto G20, including the status of pending investigations and inquiries into complaints about policing during the event.

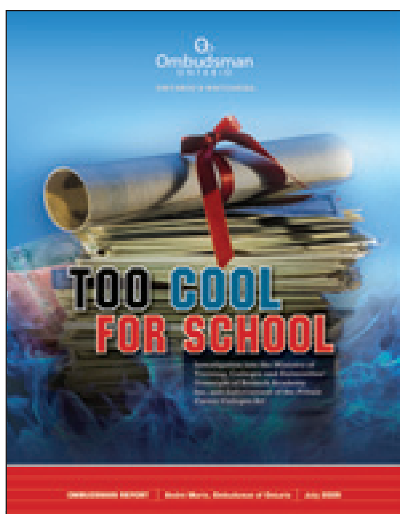
A Vast Injustice – Funding for the colorectal cancer drug Avastin – Ministry of Health and Long-Term Care



In his September 2009 report, *A Vast Injustice*, the Ombudsman called on the Ministry of Health and Long-Term Care to lift the arbitrary cap on the number of treatments it funded for patients taking the drug Avastin for metastatic colorectal cancer. The government agreed to lift the cap in November 2009, allowing patients who are responding well to treatment with Avastin to have it covered beyond 16 cycles.

In its latest update to the Ombudsman, the Ministry advised that as of September 2011, some **712** patients had received more than 16 cycles of treatment with Avastin since the change in the funding criteria. This represents 24% of all patients who have received Avastin for metastatic colorectal cancer.

Too Cool for School – Private career colleges – Ministry of Training, Colleges and Universities



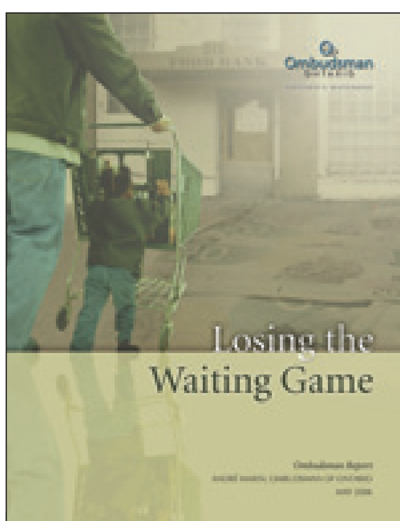
The Ombudsman's 2009 report, *Too Cool for School*, detailed the results of the SORT investigation into the Ministry of Training, Colleges and Universities' oversight of private career colleges – specifically, those that are unregistered and thus illegal, such as the former Bestech Academy, which had campuses in Stoney Creek and St. Catharines. Bestech closed down with no warning to students or staff.

In response to the Ombudsman's recommendations, the Ministry increased its enforcement and oversight efforts over private career colleges. It has also been working to address delays in its processes. In October 2011, Ministry officials reported to the Ombudsman that 944 private career college program applications had been approved in the past 12 months, and it is working toward a six-month delivery standard for such approvals.

In his December 2011 Annual Report, the Ontario Auditor General also reported on problems with private career colleges – similar to those cited by the Ombudsman in *Too Cool for School*. He too called for stronger oversight of the sector by the Ministry, noting his audit revealed that some unregistered private career colleges continue to operate illegally and there is no system for checking whether colleges that the Ministry orders to close remain closed.

An ongoing area of concern for the Ombudsman has been complaints about the Ministry's Private Career Colleges Branch, from college operators and students. These were flagged to the Ministry and are discussed in the **Operations** section of this report. The Ombudsman continues to monitor similar complaints and the Ministry's progress in this area.

Losing the Waiting Game – Disability Adjudication Unit delays – Ministry of Community and Social Services



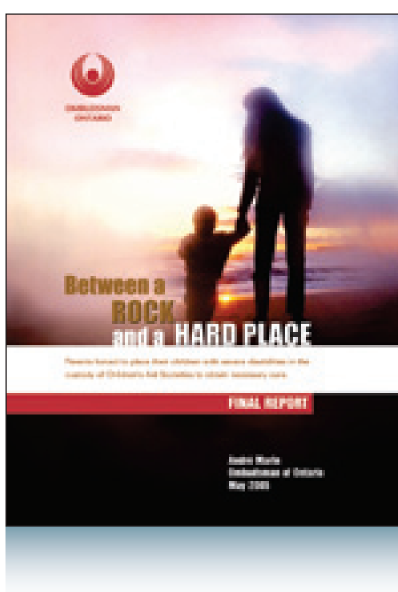
After the Ombudsman's investigation in 2006 into severe delays at the Disability Adjudication Unit (DAU), the Ministry of Community and Social Services committed to processing DAU applications within 90 days. For years, it met this target consistently – until 2010, when the Ombudsman again began receiving complaints about delays. Even more complaints about this issue came in this past fiscal year – in 2011-2012, there were **54**; up from 27 in 2010-2011.

Ombudsman staff alerted the Ministry to this trend and were advised that the DAU had experienced a 22% increase in applications since 2008. This caused processing times to grow steadily – by September 2011, the average was 98.5 days, while some applications were not dealt with for more than 120 days.

In an effort to bring the response time back within its 90-day target, the Ministry hired eight new adjudicators and plans to hire two or three more this summer. The Ministry continues to approve overtime for all staff and has at times brought in staff from other departments to assist with the initial adjudication and triage of cases.

In addition, the Ministry plans technological improvements this fall that will allow more efficient assessment of applications and streamline information sharing between the DAU and the Social Benefits Tribunal. At the time this report was written, the Ministry was also awaiting the final report of the Commission for the Review of Social Assistance in Ontario, due in June 2012, which could affect how this issue is addressed. The Ombudsman continues to monitor the Ministry's progress in dealing with the DAU case backlog.

Between a Rock and a Hard Place – Care and custody of children with severe special needs – Ministry of Children and Youth Services



In his 2005 report, *Between a Rock and a Hard Place*, the Ombudsman revealed the very disturbing problem of parents of children with severe special needs being forced to surrender them to custody of children's aid societies in order to obtain the care they needed. At that time, and several times since, the government committed to ensuring this would no longer happen. Nevertheless, parents continue to complain that they have been pushed to make this heart-wrenching choice. There were **two** such cases in 2011-2012.

In one case, a children's aid society case worker sought a court order for custody of a 14-year-old boy with severe autism and a seizure disorder in order to allow him to stay in the group home where he had been in care for a year. She told the boy's mother there were no concerns for his welfare, but surrendering custody was the only way the mother could keep the boy in the home. Ombudsman staff flagged the case to the Ministry of Children and Youth Services, triggering a meeting between officials from the group home, the local service co-ordination agency and the children's aid society. The necessary funding was arranged for the boy's group home placement, while the mother retained custody of her son.

Similarly, in the second case, the mother of a severely disabled 13-year-old girl was told by a children's aid worker that the best way for her to have the girl's group home paid for was to surrender custody. There were no protection concerns for the child, but she has Down syndrome and significant special needs that required group home care. After Ombudsman staff alerted the Ministry to the case, its Complex Special Needs committee arranged funding so the mother could retain custody and the daughter could stay in the group home.

Ombudsman staff continue to monitor this issue closely and similar complaints are brought directly to the attention of senior Ministry officials.

MINISTRY OF THE ATTORNEY GENERAL

Criminal Injuries Compensation Board

Beyond borders

A woman who had been physically and sexually abused as a child in foster care in both Alberta and Ontario complained to the Ombudsman that the Ontario Criminal Injuries Compensation Board (CICB) had denied her compensation because she had already been compensated by the Alberta Criminal Injuries Review Board. The woman produced a letter from the Alberta board that clearly stated its award was only for injuries suffered in that province, but to no avail.

Ombudsman staff reviewed the CICB decision and found it had not actually decided whether or not the woman had been the victim of a crime in Ontario or if she was entitled to compensation. It simply concluded that the Alberta board had already dealt with the matter. Ombudsman staff also advised the CICB that the Alberta board's mandate did not extend to awarding compensation for injuries incurred in crimes outside of Alberta. It was also noted that the woman had submitted medical information to the CICB that was never considered by either board.

The CICB ultimately agreed to have a new panel hear the woman's claim and she was awarded $12,000 in compensation for the Ontario crimes and $3,600 for therapy.

Office of the Public Guardian and Trustee

Unaccounted for

A man who felt he no longer needed the Office of the Public Guardian and Trustee (OPGT) to manage his financial affairs for him contacted the Ombudsman when his request for an assessment to determine whether or not he was capable was refused. Because previous assessments in the past two years had found him not capable, the OPGT advised him he would have to arrange and pay for any new assessment himself.

Ombudsman investigators discovered that the OPGT's policy actually provided for assessments for clients who had not been assessed within the past six months – and that, in cases of financial hardship, financial assistance was available through the OPGT's Capacity Assessment Office. In response, the OPGT agreed to pay for the man's assessment, which found that he was in fact capable of managing his affairs.

Investigators also revealed that the OPGT had been holding about $4,000 in a Registered Disability Savings Plan on the man's behalf – but had not told him about it because he could not access it before age 65 and his case worker did not want to have to answer his requests if he asked for the money.

Senior OPGT officials acknowledged that the man should have been made aware of the savings and agreed to clarify with all OPGT staff that it is not acceptable to withhold information from clients about their funds.

Lack of consciousness

A man had a heart attack in July 2009 and went into a coma, leaving his wife and two children, aged 17 and 20, struggling to deal with his affairs. His wife thought she had power of attorney over his estate, but there was no paperwork specifying that she should have that power if he became mentally incapable. Instead, the OPGT took over management of the man's financial affairs in December 2010.

When the wife applied for her husband's Canada Pension Plan disability benefits, 15 months' worth of payments were sent to the OPGT. The OPGT also froze the couple's line of credit, leaving the family with no access to funds to pay monthly bills and debts. The rehabilitation hospital where her husband was being cared for sent her costly bills – the OPGT had not advised the hospital that it was in charge of the man's finances. The woman complained to the Ombudsman that the OPGT was of no help and treated her with disrespect, not seeming to care how its actions affected her and her children.

The OPGT asked the wife to provide a copy of her last income tax assessment in order to get the hospital to waive its residency fees based on the family's income. Fearful that the OPGT might try take over her financial affairs as well, she and her adult son offered to send the information directly to the hospital instead, but the OPGT did not respond.

Ombudsman staff met with OPGT officials and they agreed to let her send the income information to the hospital, which then waived about $10,000 in fees.

The OPGT also agreed to provide some income from the man's funds to the family to pay outstanding bills. Subsequently, it returned guardianship of the man's estate to his son. The Ombudsman continues to monitor the case, as the OPGT retains some involvement with the family home and the couple's line of credit.

MINISTRY OF CHILDREN AND YOUTH SERVICES

Hours of need

The parents of a 10-year-old girl, diagnosed with a genetic disorder for which there is no cure, complained to the Ombudsman that they were not receiving enough support or funding to allow them to continue to care for her at home. They had nine hours a week of nursing care provided through the local Community Care Access Centre and some funding from the Special Services at Home and Assistance for Children with Severe Disabilities programs, but it was not enough. The girl was having an average of 10 seizures per day, had trouble swallowing and needed constant suctioning to breathe.

An Ombudsman investigator contacted staff at the Ministry of Children and Youth Services, who said it wasn't clear to them what the parents were asking for. When this was shared with the parents, they contacted their case manager to discuss and clarify their needs. The Ministry arranged for the Community Care Access Centre to increase the nursing care for the girl to 40 hours a week, including physiotherapy and occupational therapy.

Welcome respite

The mother of a 15-year-old boy with a rare genetic disorder called the Ombudsman after she was unsuccessful in getting her son into a residential facility. The youth was blind, incontinent, in a wheelchair, had daily seizures, slept very little at night and sometimes harmed himself. He had been on a waiting list for a group home for more than five years.

The mother was also undergoing treatment for cancer that left her very weak, and had two other children at home. Although she had respite care every other weekend, it was not enough.

Ombudsman staff contacted the Ministry of Children and Youth Services, which immediately provided emergency funding for increased respite care to help the mother at home. The Ministry also approved funding for the youth to be placed in a residential facility for one year, with a commitment for the placement to continue as needed.

Taking it upstairs

The mother of a developmentally disabled 16-year-old girl in northern Ontario turned to the Ombudsman for help when she became ill and could not continue to care for her daughter at home. The teen could not speak or walk, had a severe respiratory problem and was prone to pneumonia. Because the family lived in a small, isolated community, they could only get 8-10 hours per week of assistance from a personal support worker, provided by their local Community Care Access Centre.

A case worker from the local service co-ordination agency had tried to place the girl in the only appropriate group home in the area – two hours away from her home – but was told there were no beds available. Regional officials from the Ministry of Children and Youth Services confirmed this, but told Ombudsman staff they would continue looking for ways to help the family.

After three months, when there was no change in the girl's circumstances, Ombudsman investigators brought the case to the attention of more senior Ministry officials, who worked with regional staff to obtain a permanent group home placement for her.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

Nowhere to go

A 19-year-old developmentally disabled man who is unable to live independently contacted the Ombudsman when his placement in a private youth group home was about to end. He is estranged from his family, and as a child was frequently in and out of the care of a local children's aid society. Officials from the Ministry of Community and Social Services and the local service co-ordination agency were having trouble finding a Ministry-funded placement for him because he had a tendency for aggressive behaviour.

With only two weeks left in his private group home placement, the service co-ordination agency advised that its only option would be to bring him to a municipal shelter – and there was a good chance he could become homeless if he exhibited aggressive behavior there.

Ombudsman staff brought the young man's plight to the attention of the Assistant Deputy Minister. As a result, staff at the Ministry and the service co-ordination agency arranged for him to remain in the private group home month-to-month until an appropriate placement could be found for him.

Three weeks after the Ministry made this commitment, funds became available to keep the young man at the private group home for another year, during which staff will prepare him for semi-independent living in future.

Family Responsibility Office

Made to pay

A mother of two turned to the Ombudsman for help because she was not receiving child support payments from her ex-husband. She had a court order, registered with the Family Responsibility Office (FRO), that said her ex could be jailed for 10 days if he failed to pay. Despite this, she had only received one payment and was owed more than $35,000. She had complained to the FRO numerous times over the past three years and was extremely frustrated.

An Ombudsman investigator followed up with FRO staff, who said some steps had been taken to enforce the court order, including reporting the ex-husband to a collection agency, suspending his driver's licence and garnishing any federal monies he might receive, such as an income tax refund. There was also a writ of seizure and sale placed on his property. In response to the Ombudsman's inquiries, the FRO also obtained an address for the ex-husband's employer and made arrangements to garnish his pay.

As a result, the woman began receiving payments for support of the children, and accumulated arrears. The FRO promised to report the ex-husband to the regulatory body of his profession, which could revoke his licence if he stopped payments again.

Caught in the middle

When the parents of a disabled girl split up, the father paid child support for her through the Family Responsibility Office. Although she began receiving benefits from the Ontario Disability Support Program (ODSP) when she turned 18 in 1995, the father continued to make monthly support payments for her through the FRO until 2008. In all, he overpaid $17,000 over the years.

Both parents attempted to get the money reimbursed, dealing with both the ODSP and the FRO. They turned to the Ombudsman for help after each agency said the other was responsible.

Ombudsman staff contacted FRO officials, who said the support payments had been signed over to the ODSP and they could not direct it to reimburse the father. ODSP staff then indicated they were aware of the situation and would work on a solution. Within a month, the father was refunded $17,421.47. The mother thanked the Ombudsman for "easing the communication" between the two agencies.

Ontario Disability Support Program

Debt and taxes

A British Columbia woman complained to the Ombudsman after the Canada Revenue Agency advised her it was withholding $1,266 from her income tax refund because she owed money to the Ontario Disability Support Program (ODSP). The woman had received ODSP benefits while living in Ontario from 2000 to 2008. She had also received support payments from her ex-husband during that time, through the Family Responsibility Office.

In 2003, the ODSP advised the woman it had incorrectly calculated her ODSP benefits because she had not reported her spousal support payments. It demanded she repay $8,881. She appealed this decision to the Social Benefits Tribunal, which determined that she had in fact provided the ODSP with a copy of her support order. Because the overpayment error was the ODSP's, the tribunal rescinded the decision to collect the money. Nevertheless, in 2011, Ontario began to collect from her through the federal government.

Ombudsman staff contacted ODSP officials and reminded them of their policy that allows overpayment debts to be written off if they are a result of ODSP's own administrative error. Normally, these cases are reviewed annually – but in the woman's case, no internal review was conducted.

As a result, the overpayment of $8,881 was deemed uncollectible and the woman was reimbursed for the federal payments that had been withheld.

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

Ticket to ride

A young man who was about to be released from jail complained to the Ombudsman that due to lockdowns at the facility, he had not been able to phone his parents to obtain money to allow him to travel home. He had also not been able to speak to the jail's discharge planner to find out if he would be given a bus ticket upon his release. He was particularly concerned because his court-ordered curfew was 11 p.m. – if he was not home by that time, he could be arrested and sent back to jail.

Ombudsman staff spoke to the discharge planner who acknowledged that she hadn't yet had a chance to speak to the young man. She arranged to have a bus ticket and bag lunch provided to him, and offered to call his parents to arrange for him to be picked up at the bus station. The young man thanked the Ombudsman's Office for helping him make sure he could get home.

The red tape diet

A jail inmate with diabetes who required a 3,400-calorie daily diet for medical reasons complained to the Ombudsman that he was only receiving the jail's standard 2,800 calories per day. He said his blood sugar level was low and he was worried about his health.

Ombudsman staff spoke to the food services manager at the institution, who reviewed the inmate's file and discovered that although the jail's doctor had approved the special diet, the appropriate authorization form wasn't filled out. The manager made sure the paperwork was completed and the man's diet was changed immediately.

Pre-labour pains

After being in jail for three weeks without seeing a doctor, an inmate who was seven months pregnant called the Ombudsman, saying she was in increasing pain and discomfort and needed over-the-counter medication and medical attention.

Ombudsman staff called the jail's health care co-ordinator, who said that the doctor had missed the inmate on his last biweekly visit, and nurses were reluctant to provide the inmate with even over-the-counter medication because there was no authorization on her file.

Arrangements were immediately made for the doctor to visit the inmate, and she was given a prescription for the medication she needed. Preparations were also made for her to be transferred to the jail's high-risk clinic in the later stages of her pregnancy; however, she subsequently made a plea bargain and was released from jail before giving birth.

Shrink slip

An inmate called the Ombudsman for help after making five requests to see the jail psychiatrist, whom he had not seen in two months. He was on methadone and an antidepressant, which he had stopped taking because he was having hallucinations and other side effects.

Ombudsman staff relayed the man's plight to the jail's health care staff and they discovered that he had missed an appointment with the psychiatrist because of a mistake in their records. A mental health nurse spoke with him immediately and he was booked for the soonest available appointment with the psychiatrist. Jail staff apologized to the inmate for the oversight.

Counting the days

An inmate complained to the Ombudsman that he was being held in jail past his release date. Records staff at the jail advised him they could not confirm his release date because his warrant of committal was unclear.

Ombudsman staff contacted the jail's records department manager, who said the inmate's warrant of committal had been amended by a judge to credit him for time served – but the exact length of the sentence wasn't specified, and they hadn't been able to reach the judge. After speaking with Ombudsman staff, they called another judge, who immediately amended the inmate's warrant of committal to say he should be released the next day – and he was.

Looking for answers

The elderly mother of an inmate who committed suicide in a jail cell contacted the Ombudsman to complain that she did not have any information about how her son died. She was distraught about her inability to find out the details of what happened to her son. She wondered if it could have been prevented and whether there would be an investigation.

Ombudsman staff contacted Ministry officials, who confirmed that there was a full investigation into the inmate's death, but they had been unable to contact his next of kin. Once the situation was brought to the Ministry's attention, the jail superintendent travelled to meet with the mother and provided her with more information.

MINISTRY OF EDUCATION

Sign of compassion

A refugee assistance group contacted the Ombudsman on behalf of a profoundly deaf 20-year-old woman from a refugee family who had been denied entry into the Sir James Whitney School for the Deaf. This was an urgent complaint as the school year was just about to start.

After spending 18 years in a refugee camp, the young woman had been in Ontario two years, where she had taken classes and studied American Sign Language – but she had never been informed that she might be eligible to attend a school for the deaf. The Ministry of Education denied her entry to Sir James Whitney (an elementary and high school) because she was not apparently working toward a diploma and because she was too old. The Ministry had referred her to various college programs that either were unable to admit her or did not meet her needs.

After an Ombudsman investigator contacted Ministry officials to discuss the woman's situation further, she was admitted to Sir James Whitney for the 2011-2012 school year.

MINISTRY OF ENERGY

Hydro One

Here a meter, there a meter

A man complained to the Ombudsman that Hydro One had overbilled him for electricity on his farm for 15 years. The utility had installed two meters on his property – one for his residence and the other for the other buildings – but they were incorrectly installed and as a result, he was billed twice for the power used in his home.

Hydro One had repeatedly dismissed the man's concerns. When he first complained in 2009, he was told the high bills were accurate. Unconvinced, he hired an independent electrician in 2011, who discovered the meters were wrongly connected. Hydro One then reviewed his billing history and agreed to reimburse him the amount he was overbilled for the past six years. The man insisted he should be reimbursed for the full 15 years.

After Ombudsman staff contacted Hydro One, it reviewed his file again. It acknowledged responsibility for the meter connection error and noted that it would have been difficult for the man to identify the error on his own. Still, Hydro officials would only reimburse him for the past six years – a credit of $9,000 plus $800 interest. They pointed to new Ontario Energy Board rules, effective April 2011, that only required them to reimburse him for two years. They suggested the six-year offer, based on 2009 rules, was "above and beyond" what was required.

Ombudsman staff then took the case to the executive management level at Hydro One, who ultimately conceded there was "no logical reason" to restrict the reimbursement to six years. They agreed to reimburse the man $20,000 to cover the overbilling back to 1997.

Horse power

A woman whose monthly hydro bill on her agricultural property was normally about $34 complained to the Ombudsman when it shot up to $500. She suspected Hydro One had charged her commercial rates on her barn, where she kept five horses for her grandchildren.

Ombudsman staff contacted Hydro One officials, who said the woman was being billed under their "general service" category. They then reviewed her bill and found her meter reading – which she had phoned in – had been wrongly transcribed. An agent had mistaken one digit, resulting in a bill that was about 15 times her normal rate.

Hydro One recognized the error and adjusted the bill to $34.

MINISTRY OF FINANCE

Municipal Property Assessment Corporation

Not-so-free parking

A woman complained to the Ombudsman about problems with the Municipal Property Assessment Corporation's (MPAC's) assessment of her condominium. In 2009 and 2010, MPAC assessed her for two parking spaces when she only owned one. It acknowledged the error after she requested a reconsideration of her assessment in 2011, but would not correct the error retroactively unless she appealed in writing to the Assessment Review Board (ARB). The woman filed an appeal but never heard back.

Ombudsman staff contacted the ARB, which confirmed her file had been lost. Meanwhile, upon reviewing the woman's case with MPAC officials, Ombudsman staff determined that the woman's purchase of a second storage locker for her condo had been mistakenly listed on MPAC's assessment as a second parking space.

MPAC reviewed its assessments of the property back to 2008 and confirmed the woman was wrongly assessed in 2009 and 2010. It agreed to file an adjustment to her municipal taxes and as a result, the woman was refunded $226.76.

MINISTRY OF GOVERNMENT SERVICES

Registrar General

Why wait?

A man who needed a new copy of his birth certificate to obtain a licence for work complained to the Ombudsman that it was taking too long, putting his employment in jeopardy.

One month after he applied for the new birth certificate, the Registrar General asked him for more information, because he had legally changed his name in the past. The man gave the necessary information over the phone, but was then told it would take a further six to eight weeks because the birth certificate process had to start again from scratch. When he complained about this, he was told he was now at the back of the line and would have to wait his turn.

Ombudsman staff asked Registrar General officials to review the man's file because he urgently needed the birth certificate for work. They responded that his birth certificate would be printed the next day and mailed to the man, who was very grateful to have his case expedited.

MINISTRY OF HEALTH AND LONG-TERM CARE

A moving complaint

A 56-year-old man on a disability pension through the Canada Pension Plan hoped to obtain a scooter through the Ministry of Health and Long-Term Care's Assistive Devices Program. When he was told by his local Community Care Access Centre (CCAC) that he would have to have an assessment that would cost $200, he complained to the Ombudsman that he could not afford it. Because of his knee problems and pulmonary fibrosis, he said he could not get around without a scooter.

Ombudsman staff contacted a case manager at the CCAC who said they had determined the man wasn't eligible for a CCAC-funded assessment because he didn't need the scooter for "primary mobility." They suggested he could have the assessment paid for through Ontario Works or the Ontario Disability Support Program, but he didn't qualify for either program.

Ombudsman staff then followed up with the manager of the CCAC's client service centre and pointed out that in order for the man to receive CPP disability benefits, his disability had to have been deemed severe and prolonged. The CCAC agreed to send a case worker to meet with the man and assess his condition. As a result, the man was assessed at no charge and it was determined that the most appropriate device for his needs would be a wheelchair – which he received through the Assistive Devices Program.

Closer to closure

A woman whose husband died while in the care of paramedics complained to the Ombudsman about the adequacy of an investigation conducted into the incident by the Emergency Health Services Branch of the Ministry of Health and Long-Term Care. She complained that she had been given no information about what the branch had done to address the findings it made in its investigation.

An Ombudsman investigator who contacted the branch learned it had made recommendations directly to the central ambulance communication centre and paramedics involved in the case, as part of an internal process separate from the investigation report. According to branch policy, recommendations were released only to the subject organizations in order to assist them in improving their services – but not to the public. Branch officials said the widow would only be able to obtain a copy of the recommendations by filing a request under the *Freedom of Information and Protection of Privacy Act*.

Ombudsman staff raised the case with senior branch management, emphasizing the importance of providing as much information as possible to those affected by such investigations. The branch director agreed to send the widow a detailed letter about the recommendations and how they were linked to the findings in the investigation report. The woman thanked Ombudsman staff for helping her find some closure after the loss of her husband.

Exceptional Access Program

Medic vs. Ministry

A man who has suffered from Crohn's disease for 25 years had been receiving funding for the drug Remicade for 18 months under the Ministry of Health and Long-Term Care's Exceptional Access Program. The man's doctor advised that the drug, in combination with a steroid, was the most effective way to treat his disease, but the Ministry asked him to eliminate the use of the steroid.

The Ministry had an external medical expert review the case and denied further funding for the drug as long as it was being used with a steroid. The man turned to the Ombudsman for help, explaining that without the steroid, he would experience a flare-up of his disease. His doctor had explained this to the Ministry with no luck.

After an Ombudsman investigator spoke to his doctor and senior Ministry staff, the Ministry decided to have a second external medical expert review the case. This time the recommendation was to follow the man's physician's advice about using Remicade with a steroid. Funding was approved for the drug for another year.

Reaction meets action

After his patient – a 20-year-old man who has autism and complex seizure disorder – experienced a severe reaction to the government's approved seizure medication, a neurologist prescribed two other drugs as an alternative. He applied to the Ministry of Health and Long-Term Care's Exceptional Access Program (EAP) for funding for the drugs but was turned down. The man's parents complained to the Ombudsman on his behalf after they had to pay $500 for the drugs from their limited budget.

Ombudsman staff spoke with senior EAP officials. They acknowledged that the neurologist should have been advised that the alternative medication would be funded if he completed a "severe adverse reaction" form. Once this was done, the Ministry immediately faxed the neurologist its approval for funding.

The Ministry acknowledged that it had also omitted to review the physician's request for the second drug. The Ministry approved the second drug as well.

Ontario Health Insurance Program

Special delivery

A 92-year-old woman who misplaced her Ontario Health Insurance Program (OHIP) card called the Ombudsman for help, saying it would be impossible for her to travel to an OHIP office or a Service Ontario kiosk to replace it. She also wasn't sure if she had the documents OHIP would need to give her a new card.

Ombudsman staff explained the woman's plight to OHIP officials, who agreed to contact her. They arranged to send her a new card – without requiring her to have a photo taken – and assured her it would be valid for medical appointments. The woman thanked the Ombudsman when her card arrived in the mail.

No time to lose

The mother of a 10-year-old girl who needed medical attention applied for an OHIP card for her, but was turned down. Both mother and daughter were immigrants to Canada and had permanent resident status. OHIP rejected the daughter's application because there was no "client identification number" on her immigration paperwork.

The mother quickly obtained the eight-digit number from federal officials over the phone and went back to OHIP, but was told this wasn't sufficient – she would have to produce a hard copy of this information, which could take up to eight weeks. The mother was quite concerned, as her daughter was very ill.

Ombudsman staff spoke with OHIP officials about the family's situation, and they agreed to contact Citizenship and Immigration Canada and have the necessary paperwork faxed to them immediately. The mother was then directed to the nearest Service Ontario kiosk so she could get her daughter's health card the next day.

Put on the map

The mother of a 19-year-old man with Asperger's syndrome contacted the Ombudsman when she was unable to renew her son's OHIP card because she did not have any documentation of his address in order to prove he was a resident of Ontario.

An Ombudsman staff member contacted OHIP staff and learned that a guarantor's form could be completed on the son's behalf. Arrangements were then made for a Service Ontario representative to meet with a family member and have the form completed, and a photo OHIP card was issued.

MINISTRY OF LABOUR

Workplace Safety and Insurance Board

Lost in the shuffle

A man who had suffered a workplace injury in 2009 wanted to appeal part of the Workplace Safety and Insurance Board's decision on his compensation. He turned to the Ombudsman for help after waiting more than 18 months for someone to contact him.

Ombudsman staff made several calls to the board and the Workplace Safety and Insurance Appeals Tribunal and discovered the man's file had been mistakenly designated as "unassigned." It had been sent from the tribunal to the board at around the same time as the man's case worker had moved to another position – and it was never transferred to a new worker.

A new case worker immediately took over the man's file and quickly referred it to the appeals branch, which agreed to expedite his case.

Fast relief

A widow receiving survivor benefits from the Workplace Safety and Insurance Board (WSIB) called the Ombudsman when her monthly payment of $1,200 – her only source of income – didn't arrive.

She was in a desperate financial situation and said her WSIB case worker had been of no help. When Ombudsman staff contacted the WSIB, officials blamed a computer glitch for the error and offered to issue the cheque the next morning for the woman to pick up. However, the woman lived in Hamilton and could not even afford the trip to Toronto to get the cheque.

Once the case worker was made aware of this, she obtained approval from her manager to send the cheque to the woman by overnight courier. She received it the next day and thanked Ombudsman staff for their help.

MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING

Landlord and Tenant Board

Caught on tape

A man complained to the Ombudsman that the Landlord and Tenant Board had withdrawn his application against his former landlord without his consent. He had been out of the country when his case was heard, but a friend had attended in his place and told him the hearing had been adjourned. Instead, the man received an order from the board stating, "The parties agreed to withdraw their application."

The man complained to the board, but staff there dismissed his concerns, saying the friend must have misunderstood what happened at the hearing.

Ombudsman staff asked the board for a copy of the audio recording of the hearing, which confirmed it had in fact been adjourned to another date, and that the parties had been told they would receive a new hearing date in the mail.

As a result, the board set a new hearing date, at which the man won the decision against his former landlord.

MINISTRY OF TRANSPORTATION

Salt of the earth

A young couple living in rural Ontario complained to the Ombudsman that road salt from the highway next to their property was affecting their drinking water. They had the water tested and found it had high levels of salt, so they asked the Ministry of Transportation to provide them with a water treatment system.

The Ministry hired a hydrogeologist, who found that elevated amounts of salt in the water were not due to road salt, but the natural composition of the shale bedrock – known for high salt content – under their property. The Ministry denied the couple's request.

Ombudsman staff learned that a specialist from the Ministry of the Environment had been testing the well water in the area for several months, and determined the source of the salt to be road salt. They then contacted the Ministry of Transportation, which agreed to arrange for isotope testing – the definitive test for establishing what kind of salt is in the water. This test showed the source was road salt.

The Ministry then agreed to arrange for a water filtration system to be installed and a replacement well to be drilled away from the highway, at a total cost of $20,374.68.

Where did you come from?

A 67-year-old woman who was born in Britain but had been a licensed driver in Ontario for more than 40 years was shocked to discover that she could not renew her driver's licence after she inadvertently let it lapse for more than a year.

Although the Ministry accepted a marriage certificate to prove her legal name and a health card to prove her signature, she needed a document to prove her birth date. She did not have any original immigration documents or a passport to prove her birth date and the Ministry would not accept her United Kingdom birth certificate.

The woman's story was featured in an Ottawa newspaper, and Ombudsman staff contacted her to discuss her predicament. Ombudsman staff met with senior Ministry officials, who implemented a new interim policy to deal with drivers with expired licences who lack identification documents. The policy allows the person to use the expired licence to obtain a new one as long as it is within three years of the expiration date. As well, for those who no longer have their expired licence, the Ministry will retrieve the person's photo from its database as a means of identification.

The woman received her new licence, as did a man who later contacted the Ombudsman with a similar complaint. The Ministry also promised to conduct a full policy review on the issue of identification documents required for licence renewals.

Double jeopardy

A woman complained to the Ombudsman that a conviction for a traffic violation had been wrongly registered on her driving record. She had paid a traffic ticket for one offence but later discovered two convictions on her record. She recalled that she had sent two cheques to pay the fine – the first one had been incorrectly dated, so she had sent a second cheque to correct it.

Court records verified that there was only one violation, and only one of the two cheques had been applied to the fine. The provincial offences court told the woman it would send information confirming this to the Ministry of Transportation. But the Ministry told her it would take up to 15 days after this information was received before her driving record could be corrected.

The woman's auto insurance was about to expire in six days. She wanted to switch to a new provider before that date and worried that the incorrect driving record would affect her ability to switch insurance providers, or her future premiums.

Ombudsman staff contacted the Ministry's Driver Control Section, which confirmed that when the woman's second cheque was received, a second conviction for the same offence was wrongly entered on her record. The second conviction was deleted and Ministry officials advised the woman immediately. She thanked the Ombudsman's Office for resolving the issue in less than a week, in time for her to obtain new insurance.

Your Feedback

“I have noted your recommendations with regard to fostering transparency in government organizations. My colleagues and I value your scrutiny and oversight, as do the citizens of Ontario. We will continue to work with you and the Ombudsman's Office to ensure that we meet Ontarians' priorities and deliver the results they deserve.”

Premier Dalton McGuinty, letter to Ombudsman, July 2011

“The loss of confidence in our public institutions has become an unfortunate – though understandable – and widespread phenomenon. Examples like yours, which become models for others, are encouraging and comforting.”

Quebec Ombudsman Raymonde Saint-Germain, letter to Ombudsman

“It is extremely encouraging as both a taxpayer and Ontario citizen to see a government agency as efficient as yours and as dedicated to its mission. As unfortunate as it is that your office has to exist, it is comforting to know that there are options or avenues for citizens to voice their concerns with government services.”

Complainant

“The Premier values the Ombudsman's advice. In fact, he almost universally adopts all the Ombudsman's recommendations… The Ombudsman's work leads to real, systemic change, change that makes a real difference for the people of Ontario. I want to thank André and his team for their leadership... They're helping to strengthen public services in Ontario – and around the world.”

Secretary of Cabinet Shelly Jamieson, address to “Sharpening Your Teeth” participants, November 30, 2011

“Mr. Marin, you and your staff are indeed heroes to regular Ontario citizens that just want accountability and responsibility in this province.”

Anne Patterson

“My wife and I would like to take this opportunity to thank your office for all the help you provided in getting [drug] funding …reinstated for our son. Without it, it would have been a certain catastrophe for him.”

Complainant

“I just wanted to thank you for your report about the G20. It was about as hard-hitting as you can get away with in government.”

Complainant

“On behalf of the members, staff and management of the Board, I would like to express my appreciation for this opportunity to share with you the story of our efforts to transform our organization into one that provides adjudicative and administrative excellence to victims and the public at large. Your 2007 report [*Adding Insult to Injury*] was a catalyst for change… We welcome your feedback and appreciate the positive change your efforts have made in helping this agency deliver better service to the public.”

Maureen Armstrong, Chair, Criminal Injuries Compensation Board of Ontario

“It was a pleasure working with [your Office]. Without your intervention, I am certain this matter would not have been brought to a positive conclusion. On behalf of our constituent and this office, please accept our sincere gratitude.”

Constituency assistant for PC MPP Bob Bailey (Sarnia-Lambton)

“I was quite impressed with your honesty, your straightforward manner and your commitment. Thanks so much for being there for Ontarians.”

Complainant

“Your effort to kick [ODSP] into motion …is appreciated. The Ombudsman has big teeth and can bite, I see.”

Complainant

“I can’t tell you how much your assistance was appreciated. I really would not have been able to accomplish what I did without the help of the Ombudsman and your tenacity!”

Complainant

“Knowing that there is someone out there like yourself giving a voice to people’s concerns brings me a lot of relief. The Ombudsman’s Office really is an important organization and meets so many needs of the public.”

Complainant

“I spoke to you last week regarding the Family Responsibility Office. They started doing what they were supposed to do quite a while ago now… they were on it right after you called them.”

Complainant

“Without your assistance… I feel my case would have dragged on far too long. With your dedication and professionalism I have been able to get back to living my life.”

Complainant

“You did in one month what no one could do in six, and for that I am grateful. I hope that you can help all the other people that are in the same situation as I was. Excuse my language, but you kicked ass!”

Complainant

“I appreciate your dedication to help people in a disadvantaged position. You do it with warmth and I know that you really care.”

Complainant

Your Feedback

Your Feedback

In the media

"[Ombudsman] André Marin… keeps everybody honest in Ontario and backs down from no one… The name Marin is synonymous with fearless honesty and unshakable integrity."

Joe Warmington, *Toronto Sun*, December 2011

"The Ombudsman's office is our last line of defence. Its budget is money well spent to protect us all."

Ian Harvey, freelance columnist, *Law Times*, June 2011

"To date, close to 90% of the recommendations he has made thus far have been adopted. So why not let the Ombudsman in to investigate these institutions otherwise known as the MUSH sector?"

Phil Paquette, letter to the editor, *Stoney Creek News*, June 2011

"With an aging population and young families who use the services these institutions provide (and their tax dollars fund), many still find themselves vulnerable and defenceless when something goes wrong. When in need of assistance they have nowhere to turn, and no independent body exists to help those in need. This is precisely what the Ombudsman's role is intended to be."

Neil Haskett, letter to the editor, *Sudbury Star*, June 2011

"Expanding Marin's mandate would be a good step toward a more open provincial government. He has demonstrated over and over again the value of his position to public policy.... Besides, individuals who deal with the multifarious arms of the provincial government deserve a powerful advocate and a recourse in times of disagreement."

Ottawa Citizen editorial, June 22, 2011

Comments from Twitter

"Wow, look at that – substantive engagement from a public official on social networks. That's transparency."

@adriandz

"Congrats on being approachable, interactive & transparent in your role as Ombudsman! An example for all of us to emulate!"

@NatriceR

"Thank you for helping to relieve my anger at Service Ontario. It's nice to have a rant fall on not-deaf ears for once."

@nealjennings

"Truly respect the fact that you're available and open to ideas."

@HelenWainman

"Makes me proud to be Canadian to read about action at this level with fairness, justice and equity. Keep up the good work!"

@davethebrave371

"We're lucky to have an Ombudsman in Ontario. An advocate for we, the citizens."

@thornley

Comments from Facebook

"An update: After contacting the Ombudsman's Office, I have received results within a one-week period."

Complainant

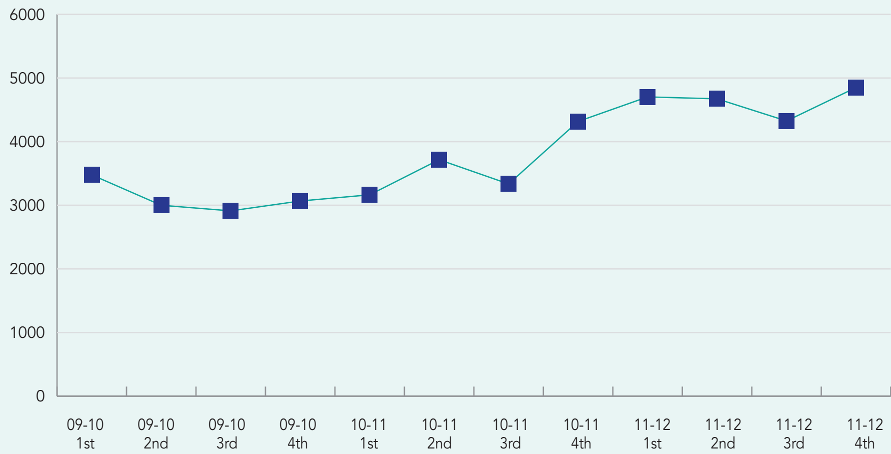
"All the good work you and your Office have done has made Ontario a better place to live in for citizens. Only wish your mandate can expand (like the rest of Canada's provinces) into the MUSH sector."

Gina Konjarski

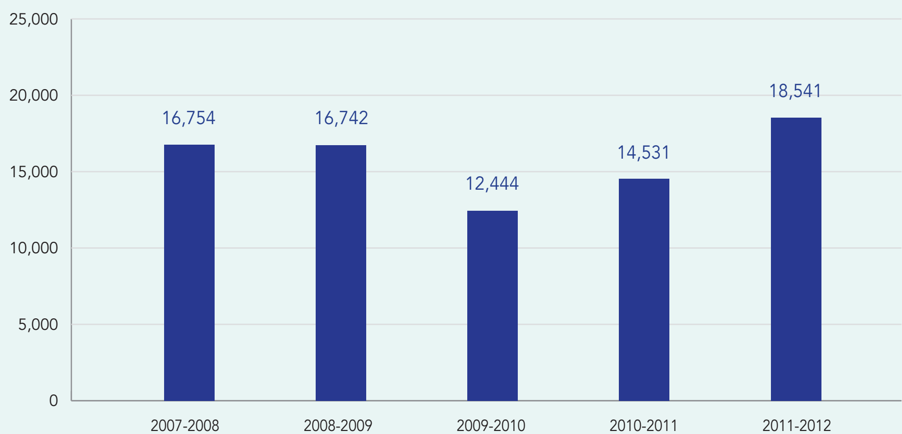
APPENDIX 1

Complaint Statistics

CASES RECEIVED BY QUARTER 2009-2010 TO 2011-2012



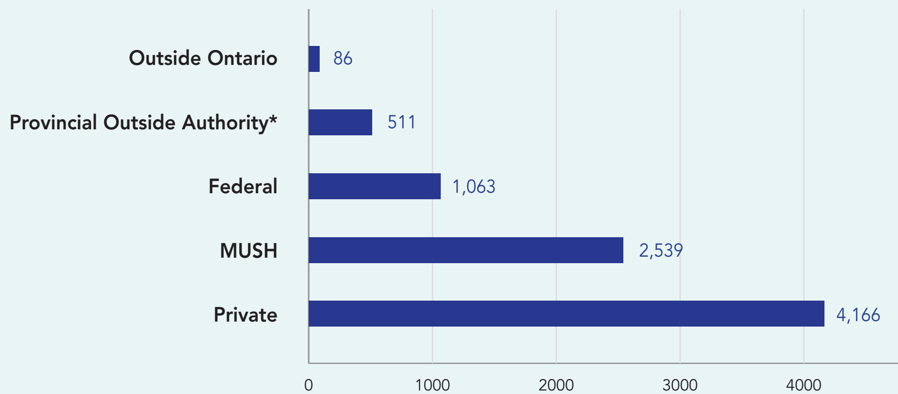
TOTAL CASES RECEIVED FISCAL YEARS 2007-2008 TO 2011-2012



APPENDIX 1

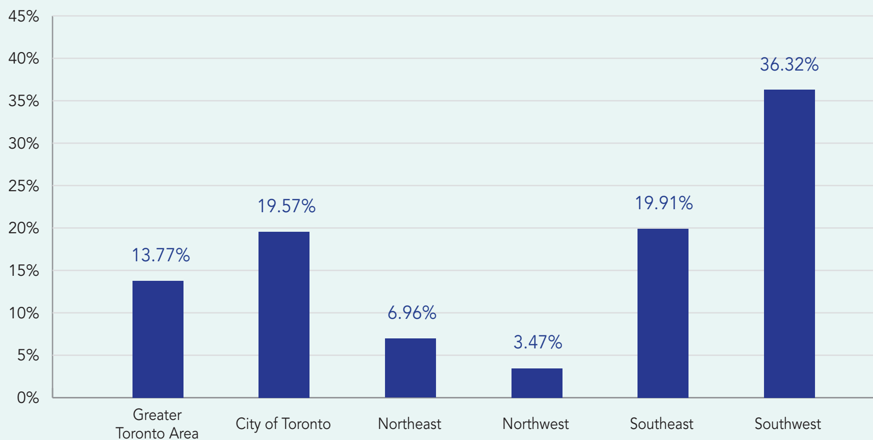
Complaint Statistics

CASES OUTSIDE THE OMBUDSMAN'S AUTHORITY RECEIVED 2011-2012 — TOTAL: 8,365



** For example cases received about Courts, Stewardship Ontario and Tarion*

REGIONAL DISTRIBUTION OF COMPLAINANTS* 2011-2012



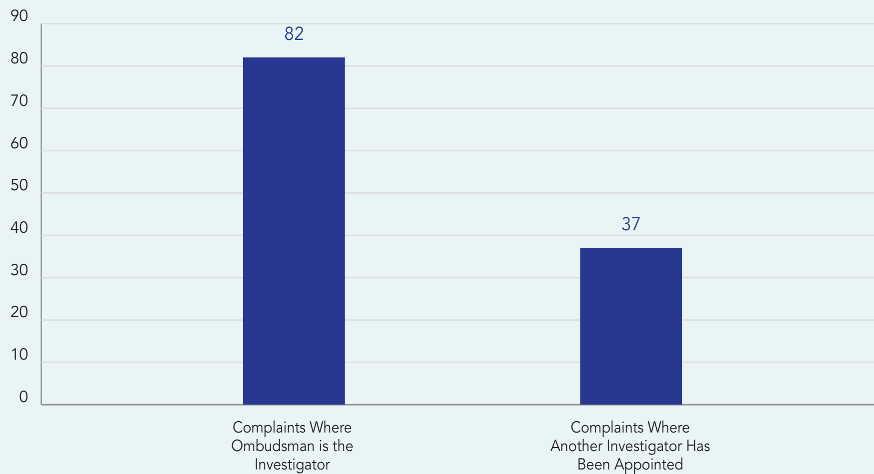
** Excluding inmates of correctional facilities*

Greater Toronto Area: Bounded by Oakville, Lake Simcoe and Oshawa, but excluding the City of Toronto
City of Toronto: Bounded by Etobicoke, Steeles Avenue and Scarborough
Northeast: Bounded by Ottawa, Penetanguishene and Marathon north to Hudson's Bay
Northwest: West of the Marathon/Hudson's Bay boundary
Southeast: Bounded by the GTA, Penetanguishene and Ottawa
Southwest: Bounded by the GTA, Barrie and Penetanguishene

APPENDIX 1

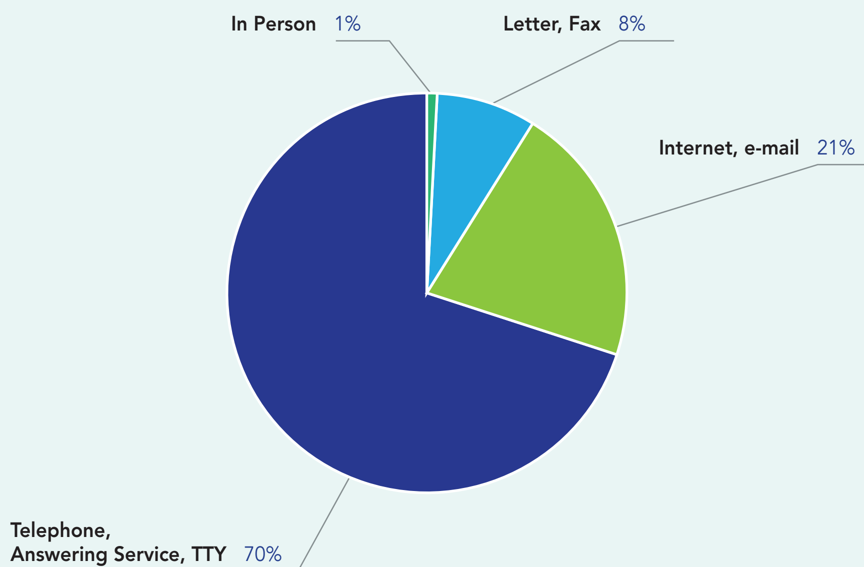
Complaint Statistics

CASES RECEIVED ABOUT CLOSED MUNICIPAL MEETINGS 2011-2012*



** Note: Details of these cases will be released in a separate Annual Report later this year.*

HOW CASES WERE RECEIVED 2011-2012



APPENDIX 1

Complaint Statistics

TOP 15 PROVINCIAL GOVERNMENT ORGANIZATIONS AND PROGRAMS COMPLAINED ABOUT IN 2011-2012

		Number of Cases	Percentage of All Cases Within Authority
1	FAMILY RESPONSIBILITY OFFICE	759	7.55%
2	WORKPLACE SAFETY AND INSURANCE BOARD	582	5.79%
3	ONTARIO DISABILITY SUPPORT PROGRAM	575	5.72%
4	DRIVER LICENSING	351	3.49%
5	HYDRO ONE	232	2.31%
6	LEGAL AID ONTARIO	159	1.58%
7	OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	130	1.29%
8	LANDLORD AND TENANT BOARD	128	1.27%
9	ONTARIO STUDENT ASSISTANCE PROGRAM	120	1.19%
10	ONTARIO PROVINCIAL POLICE	110	1.09%
11	ONTARIO HEALTH INSURANCE PLAN	97	0.96%
12	WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	96	0.95%
13	REGISTRAR GENERAL	89	0.88%
14	HUMAN RIGHTS TRIBUNAL OF ONTARIO	86	0.86%
15	COMMUNITY CARE ACCESS CENTRES	83	0.83%

TOP 10 CORRECTIONAL FACILITIES COMPLAINED ABOUT IN 2011-2012

		Number of Cases	Percentage of All Cases Within Authority
1	CENTRAL NORTH CORRECTIONAL CENTRE	654	6.50%
2	CENTRAL EAST CORRECTIONAL CENTRE	611	6.08%
3	MAPLEHURST CORRECTIONAL COMPLEX	319	3.17%
4	OTTAWA-CARLETON DETENTION CENTRE	300	2.98%
5	TORONTO WEST DETENTION CENTRE	279	2.77%
6	HAMILTON-WENTWORTH DETENTION CENTRE	231	2.30%
7	ELGIN-MIDDLESEX DETENTION CENTRE	209	2.08%
8	TORONTO JAIL	178	1.77%
9	NIAGARA DETENTION CENTRE	174	1.73%
10	VANIER CENTRE FOR WOMEN	138	1.37%

APPENDIX 1

Complaint Statistics

CASES EXCLUDING CORRECTIONAL FACILITIES RECEIVED 2011-2012 BY PROVINCIAL RIDING*

Riding	Cases
Ajax-Pickering	70
Algoma-Manitoulin	128
Ancaster-Dundas-Flamborough-Westdale	78
Barrie	172
Beaches-East York	83
Bramalea-Gore-Malton	64
Brampton-Springdale	55
Brampton West	92
Brant	73
Bruce-Grey-Owen Sound	129
Burlington	125
Cambridge	126
Carleton-Mississippi Mills	41
Chatham-Kent-Essex	103
Davenport	55
Don Valley East	70
Don Valley West	48
Dufferin-Caledon	128
Durham	96
Eglinton-Lawrence	60
Elgin-Middlesex-London	95
Essex	122
Etobicoke Centre	41
Etobicoke-Lakeshore	106
Etobicoke North	58
Glengarry-Prescott-Russell	65
Guelph	114
Haldimand-Norfolk	70
Haliburton-Kawartha Lakes-Brock	128
Halton	85
Hamilton Centre	115
Hamilton East-Stoney Creek	100
Hamilton Mountain	99
Huron-Bruce	97
Kenora-Rainy River	108
Kingston and the Islands	59
Kitchener Centre	44
Kitchener-Conestoga	47
Kitchener-Waterloo	64
Lambton-Kent-Middlesex	75
Lanark-Frontenac-Lennox and Addington	81
Leeds-Grenville	101
London-Fanshawe	110
London North Centre	89
London West	89
Markham-Unionville	24
Mississauga-Brampton South	44
Mississauga East-Cooksville	39
Mississauga-Erindale	59
Mississauga South	70
Mississauga-Streetsville	57
Nepean-Carleton	46
Newmarket-Aurora	65
Niagara Falls	195
Niagara West-Glanbrook	73
Nickel Belt	85
Nipissing	138
Northumberland-Quinte West	140
Oak Ridges-Markham	70
Oakville	57
Oshawa	139
Ottawa Centre	66
Ottawa-Orleans	58
Ottawa South	53
Ottawa-Vanier	62
Ottawa West-Nepean	65
Oxford	69
Parkdale-High Park	88
Parry Sound-Muskoka	120
Perth-Wellington	99
Peterborough	89
Pickering-Scarborough East	31
Prince Edward-Hastings	165
Renfrew-Nipissing-Pembroke	59
Richmond Hill	34
Sarnia-Lambton	156
Sault Ste. Marie	174
Scarborough-Agincourt	45
Scarborough Centre	60
Scarborough-Guildwood	101
Scarborough-Rouge River	25
Scarborough Southwest	74
Simcoe-Grey	119
Simcoe North	168
St. Catharines	80
St. Paul's	152
Stormont-Dundas-South Glengarry	87
Sudbury	158
Thornhill	52
Thunder Bay-Atikokan	95
Thunder Bay-Superior North	85
Timiskaming-Cochrane	122
Timmins-James Bay	74
Toronto Centre	152
Toronto-Danforth	76
Trinity-Spadina	86
Vaughan	58
Welland	130
Wellington-Halton Hills	69
Whitby-Oshawa	93
Willowdale	73
Windsor-Tecumseh	89
Windsor West	85
York Centre	66
York-Simcoe	79
York South-Weston	67
York West	37

** Where a valid postal code is available.*

Note: Breakdown of organizations complained about in each riding is available online at www.ombudsman.on.ca.

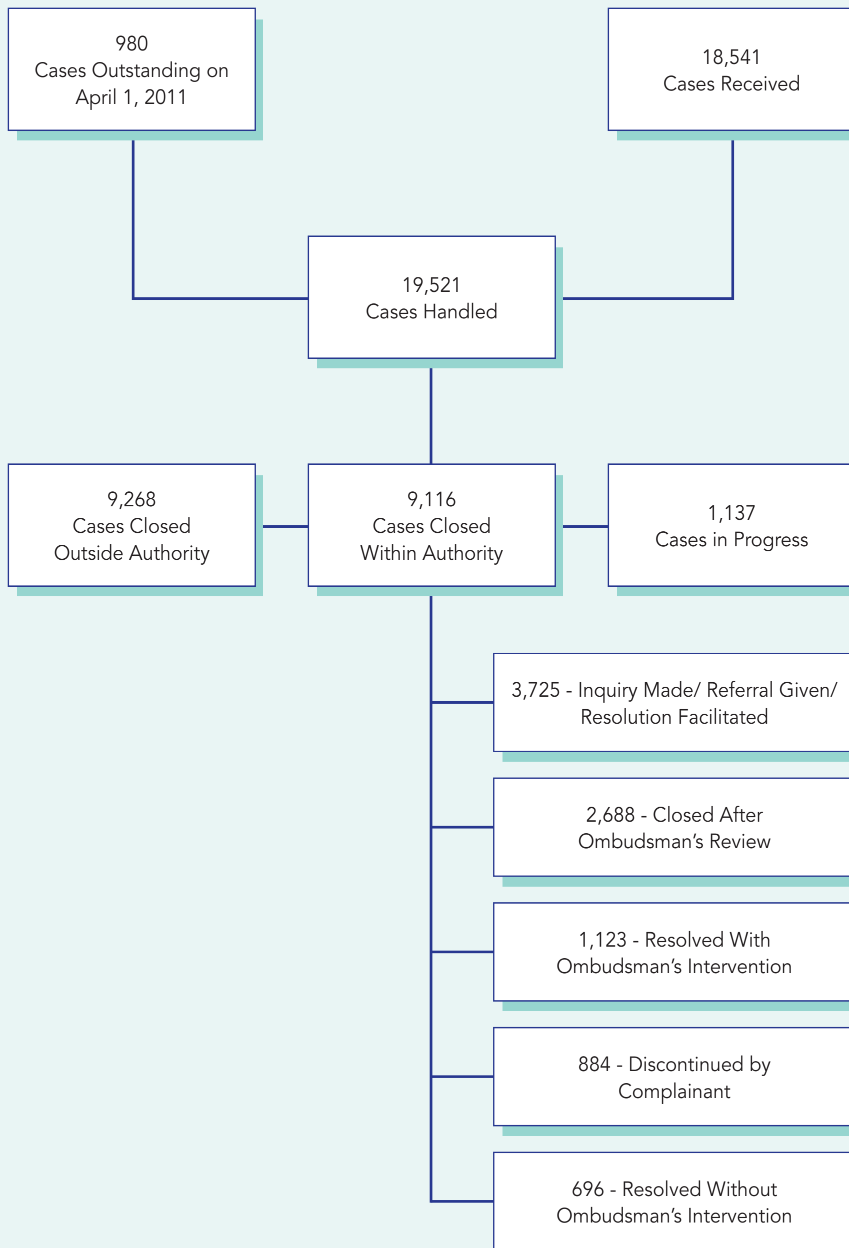
APPENDIX 1

Complaint Statistics

MOST COMMON TYPES OF CASES RECEIVED DURING 2011-2012	
1	Decision wrong, unreasonable or unfair
2	Access to, or denial of services; inadequate or poor service
3	Delay
4	Wrong or unreasonable interpretation of criteria, standards, policy, procedures, guidelines, regulations, laws, information or evidence
5	Communication inadequate, improper or no communication
6	Enforcement unfair or failure to enforce
7	Government policy and/or procedures
8	Failure to adhere to policies, procedures or guidelines or to apply them consistently; unfair policy/ procedure
9	Internal complaint process; lack of a process, unfair handling of complaint
10	Legislation and/or regulations
11	Failure to provide sufficient or proper notice
12	Broader public policy issue
13	Insufficient reasons or no reasons provided for a decision
14	Government funding issue
15	Improper use of discretion

APPENDIX 1

Complaint Statistics



APPENDIX 1

Complaint Statistics

TOTAL CASES RECEIVED 2011-2012 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*		
MINISTRY OF AGRICULTURE, FOOD AND RURAL AFFAIRS		19
MINISTRY OF THE ATTORNEY GENERAL		854
ALCOHOL AND GAMING COMMISSION OF ONTARIO	19	
ASSESSMENT REVIEW BOARD	31	
CHILD AND FAMILY SERVICES REVIEW BOARD	18	
CHILDREN'S LAWYER	33	
CRIMINAL INJURIES COMPENSATION BOARD	42	
HUMAN RIGHTS LEGAL SUPPORT CENTRE	16	
HUMAN RIGHTS TRIBUNAL OF ONTARIO	85	
LANDLORD AND TENANT BOARD	128	
LEGAL AID ONTARIO	159	
OFFICE OF THE INDEPENDENT POLICE REVIEW DIRECTOR	37	
ONTARIO MUNICIPAL BOARD	20	
OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	130	
SOCIAL BENEFITS TRIBUNAL	32	
SPECIAL INVESTIGATIONS UNIT	13	
MINISTRY OF CHILDREN AND YOUTH SERVICES		122
CHILDREN'S AID SOCIETY – HURON PERTH	11	
SECURE CUSTODY FACILITIES FOR YOUTH	26	
SPECIAL NEEDS PROGRAMS – CHILDREN	47	
MINISTRY OF CITIZENSHIP AND IMMIGRATION		1
MINISTRY OF COMMUNITY AND SOCIAL SERVICES		1388
FAMILY RESPONSIBILITY OFFICE	759	
ONTARIO DISABILITY SUPPORT PROGRAM	575	
SPECIAL NEEDS PROGRAMS – ADULT	28	
MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES		4421
CORRECTIONAL FACILITIES	4135	
OFFICE OF THE CHIEF CORONER	18	
ONTARIO CIVILIAN POLICE COMMISSION	11	
ONTARIO PROVINCIAL POLICE	110	
PRIVATE SECURITY AND INVESTIGATIVE SERVICES BRANCH	26	
PROBATION AND PAROLE SERVICES	38	
MINISTRY OF CONSUMER SERVICES		38
MINISTRY OF EDUCATION		27
MINISTRY OF ENERGY		275
HYDRO ONE	232	
ONTARIO ENERGY BOARD	17	
MINISTRY OF THE ENVIRONMENT		101

** Total figures are reported for each provincial government ministry including all agencies and programs falling within its portfolio. Each government agency or program receiving 10 or more cases is also included.*

APPENDIX 1

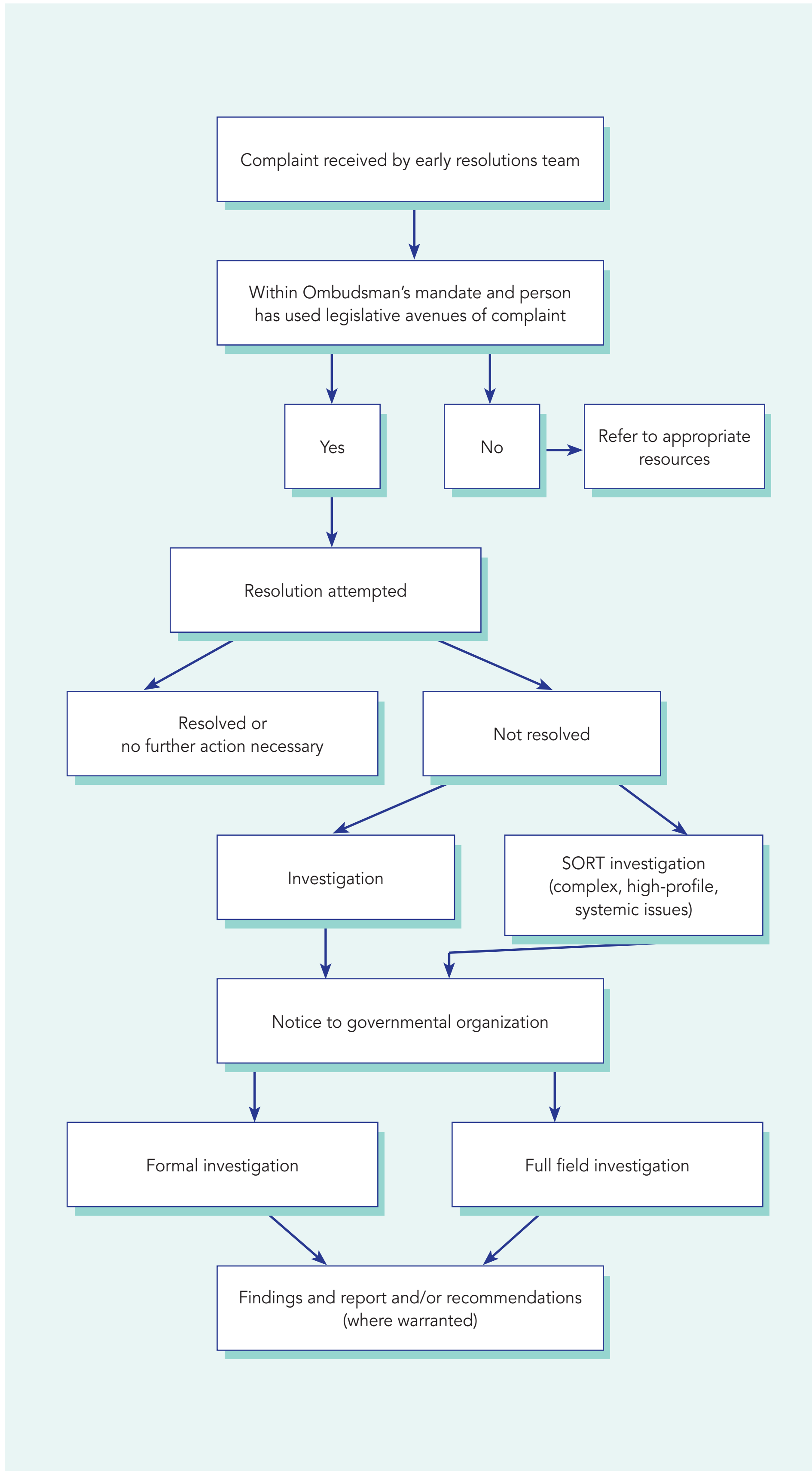
Complaint Statistics

TOTAL CASES RECEIVED 2011-2012 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*		
MINISTRY OF FINANCE		282
FINANCIAL SERVICES COMMISSION	44	
LIQUOR CONTROL BOARD OF ONTARIO	16	
MUNICIPAL PROPERTY ASSESSMENT CORPORATION	66	
ONTARIO LOTTERY AND GAMING CORPORATION	64	
MINISTRY OF GOVERNMENT SERVICES		213
LICENCE APPEAL TRIBUNAL	14	
REGISTRAR GENERAL	89	
SERVICEONTARIO	64	
MINISTRY OF HEALTH AND LONG-TERM CARE		616
ASSISTIVE DEVICES / HOME OXYGEN PROGRAMS	17	
COMMUNITY CARE ACCESS CENTRES	83	
DRUG PROGRAMS BRANCH	74	
HEALTH PROFESSIONS APPEAL AND REVIEW BOARD	30	
HEALTH SERVICES APPEAL AND REVIEW BOARD	14	
HÔTEL-DIEU GRACE HOSPITAL	16	
LOCAL HEALTH INTEGRATION NETWORKS	13	
LONG-TERM CARE BRANCH	39	
NIAGARA HEALTH SYSTEM	81	
ONTARIO HEALTH INSURANCE PLAN	97	
PSYCHIATRIC PATIENT ADVOCATE OFFICE	18	
MINISTRY OF INFRASTRUCTURE		4
MINISTRY OF LABOUR		797
EMPLOYMENT PRACTICES BRANCH	30	
OFFICE OF THE WORKER ADVISOR	14	
ONTARIO LABOUR RELATIONS BOARD	42	
WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	96	
WORKPLACE SAFETY AND INSURANCE BOARD	582	
MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING		27
MINISTRY OF NATURAL RESOURCES		65
CROWN LAND	12	
MINISTRY OF NORTHERN DEVELOPMENT AND MINES		8
MINISTRY OF ECONOMIC DEVELOPMENT AND INNOVATION		1
MINISTRY OF TOURISM, CULTURE AND SPORTS		7
MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES		293
APPRENTICESHIPS / WORK TRAINING	35	
COLLEGES OF APPLIED ARTS AND TECHNOLOGY	79	
ONTARIO STUDENT ASSISTANCE PROGRAM	120	
MINISTRY OF TRANSPORTATION		422
DRIVER LICENSING	351	
VEHICLE LICENSING	27	

** Total figures are reported for each provincial government ministry including all agencies and programs falling within its portfolio. Each government agency or program receiving 10 or more cases is also included.*

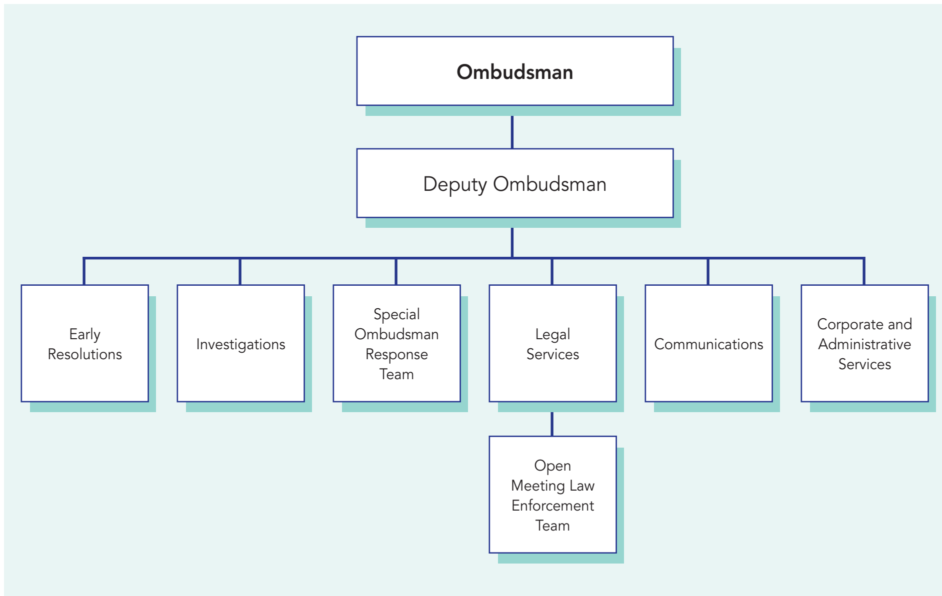
APPENDIX 2

How We Work



APPENDIX 3

About the Office



Early Resolutions: The Early Resolutions team operates as the Office's front line for receiving, triaging and assessing complaints, providing advice, guidance and referrals to complainants. Early Resolution Officers use a variety of conflict resolution techniques to resolve complaints that fall within the Ombudsman's jurisdiction.

Investigations: Complaints that cannot be easily resolved are referred to Investigations. The Investigations team conducts issue-driven, focused and timely investigations of individual complaints and systemic issues.

Special Ombudsman Response Team (SORT): The Special Ombudsman Response Team conducts extensive field investigations into complex, systemic, high-profile cases. SORT investigators work in collaboration with Early Resolutions, Investigations and Legal Services, and additional staff are assigned to SORT as needed.

Legal Services: The Legal Services team ensures that the Office functions within its legislated mandate and provides expert advice to the Ombudsman and staff in support of the resolution and investigation of complaints, the review and analysis of evidence and the preparation of reports and recommendations.

Open Meeting Law Enforcement Team (OMLET): OMLET investigates complaints about closed municipal meetings (received pursuant to the *Municipal Act*) and engages in education and outreach with municipalities and the public with regard to open meetings.

Communications: In addition to co-ordinating the Ombudsman's reports, brochures, other publications and videos, the Communications team maintains the Ombudsman's website and social media presence, assists in outreach activities, and provides support to the Ombudsman and staff in media interviews, press conferences, speeches, presentations and public statements.

Corporate and Administrative Services: The Corporate and Administrative Services team supports the Office in the areas of finance, human resources, administration and information technology.

APPENDIX 4

Financial Report

During the fiscal year 2011-2012, the total operating expenditures for the Office were **$10.774 million**. Miscellaneous revenue returned to the government amounted to $27,000, resulting in net expenditures of **$10.747 million**. The largest categories of expenditures relate to salaries, wages and employee benefits at $8.249 million, which accounts for 76.6% of the Office's annual operating expenditures.

SUMMARY OF EXPENDITURES 2011-2012

	(In thousands)
Salaries and wages	$6,707
Employee benefits	$1,542
Transportation and communications	$335
Services	$1,510
Supplies and equipment	$680
Annual Operating Expenses	**$10,774**
Less: Miscellaneous revenue	$27
Net Expenditures	**$10,747**

2011-2012

ONTARIO'S WATCHDOG

2011-2012 ANNUAL REPORT

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