



ONTARIO'S WATCHDOG

2007-2008

ANNUAL REPORT • 2007-2008



June 17, 2008

The Honourable Steve Peters
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, 2007 to March 31, 2008, pursuant to section 11 of the *Ombudsman Act*, so that you may table it before the Legislative Assembly.

Yours truly,



André Marin
Ombudsman

Bell Trinity Square
483 Bay Street, 10th Floor, South Tower
Toronto, Ontario M5G 2C9
Telephone: 416-586-3300
Facsimile: 416-586-3485
TTY: 1-866-411-4211

Table of Contents

Ombudsman's Message	5
The Year in Review	17
Operations Overview	17
Communications and Outreach.....	19
Special Ombudsman Response Team (SORT).....	22
Overview	22
SORT Investigations	23
<i>A Test of Wills</i>	23
<i>Life and Breath</i>	24
<i>Building Clarity</i>	26
Ongoing SORT Investigations.....	27
<i>PET Peeves</i>	27
<i>Investigating the Investigators</i>	27
Updates on Completed Investigations	28
<i>A Game of Trust</i>	28
<i>Collateral Damage</i>	29
<i>Adding Insult to Injury</i>	30
<i>The Out-of-Country Conundrum</i>	32
<i>Losing the Waiting Game</i>	32
<i>Getting It Right</i>	33
<i>The Right to Be Impatient</i>	34
Ongoing SORT Assessments	35
<i>The Scarborough Hospital</i>	35
<i>William Osler Health Centre</i>	35

Table of Contents

Case Summaries	36
Your Feedback	46
Appendix 1: Complaint Statistics	51
Total Complaints and Inquiries Received	51
Complaints and Inquiries Outside the Ombudsman’s Authority.....	51
Complaints and Inquiries Within the Ombudsman’s Authority.....	52
Regional Distribution of Complainants.....	52
How Complaints and Inquiries Were Received.....	53
Top 20 Provincial Government Organizations and Programs Complained About	54
Most Common Types of Complaints Investigated.....	54
Disposition of Complaints and Inquiries.....	55
Total Complaints and Inquiries Received for Provincial Government Ministries and Selected Organizations	56
Complaints and Inquiries Received by Provincial Riding	58
Appendix 2: How We Work	59
Appendix 3: About the Organization	60
Appendix 4: Financial Report	61



Ombudsman's Message: Shining the Light

Once again this year, this Office's efforts to expose government to the light of scrutiny have shown great success. We have called provincial officials to account for their conduct and worked with them to improve the service they offer to millions of Ontarians. Through early resolution as well as formal investigation, we have resolved more than 16,000 complaints. Our Special Ombudsman Response Team (SORT) investigations have tackled complex new issues and continue to spark sweeping systemic reforms. We have built on previous achievements, while also undertaking a brand-new responsibility to foster openness and transparency in communities across the province.



PHOTOS BY BRIAN WILLER

This year, we prompted Legal Aid Ontario (LAO) to move beyond the “not my job” mentality that had characterized its handling of legal bills paid through the Ministry of the Attorney General.* My report, *A Test of Wills*, documented LAO's abject failure to properly scrutinize the costs of the legal defence of accused murderer Richard Wills. It was a glaring example of public servants forgetting that their duty is to serve the public, not their own misguided motives. Fortunately, as a result of our investigation, LAO has recognized the error of its ways and made systemic improvements to ensure that all legal accounts will be rigorously reviewed. The Ministry of the Attorney General has also taken steps to protect the public interest by seeking to have the bills from most of Mr. Wills' lawyers reviewed by the courts, and by attempting to recoup some of the \$1.2 million in taxpayers' money that paid for Mr. Wills' defence after he deliberately impoverished himself.

We helped deliver a wake-up call to the Assistive Devices Program (ADP) at the Ministry of Health and Long-Term Care. This program also suffered from a “not my job” mentality, as well as a classic case of “rulitis.” For years, its officials ignored the urging of senior medical professionals that it fund the home use of oxygen saturation monitors for infants and children with respiratory problems. Without them, scores of children were enduring needlessly prolonged and costly hospital stays. But these machines weren't on the list of devices approved for funding, and ADP officials treated the list as sacrosanct. They chose to stick to the rules at the expense of the public interest, and families of severely disabled children suffered as a result. Fortunately, following our investigation, not only is funding now available for oxygen saturation monitors for children, but a full external operational review is underway, which will include evaluation of how devices are added to the approved list.

In the case of the Ministry of Government and Consumer Services' oversight of Taron Warranty Corporation, the public was left dazed and confused about what the bureaucrats' job actually was. The Ministry sent mixed messages to consumers about how much it could do for homeowners concerned about Taron's practices. As a result of our investigation, the Ministry has committed to making its role clearer to the public it serves.

In addition, this year saw our earlier investigative efforts continue to bear fruit, as dramatic reforms progressed in diverse areas of government administration. In several cases, the arrogant “puffery” among organizations that I lamented in last year's report has given way to a welcome new focus on the public good.

* All major investigations referred to in this section are detailed in the SORT chapter of this report.



FEBRUARY 26, 2008:

The Ombudsman releases his report on Legal Aid Ontario's handling of the Richard Wills case.

As recommended in my 2007 report, *A Game of Trust*, there is now a new regulatory regime in place to foster the integrity and security of the province's lotteries. The Ontario Lottery and Gaming Corporation itself has also undergone a radical reorientation. With a renewed organizational commitment to public service, it now seeks to promote the public interest over profits, and has implemented proactive practices to safeguard the confidence of lottery players. This is good news for all Ontarians, who benefit from the public works funded by billions of dollars in lottery revenues every year.

The Criminal Injuries Compensation Board, once a moribund institution that was hurting those it was created to serve, is also now under major renovation. It has trained and hired new staff and board members, and has made operational changes according to the recommendations made in my 2007 report, *Adding Insult to Injury*. The government has also committed significant new funding – \$100 million, announced in April 2008 – to clear the CICB's victim backlog, and it continues to review ways to improve the victim compensation system overall.

The Ministry of Health and Long-Term Care made improvements this year to the administration of its program for funding out-of-country treatment, making more information available and communicating more clearly with physicians and patients. The Ministry's initiatives in this area are a testament to what can be done when organizations are held up to independent investigative oversight, and when individuals have the courage to challenge the system, as the late Suzanne Aucoin did when she came to my Office in 2007 and wound up with a \$76,000 reimbursement.

Many in our society are voiceless when it comes to government injustice, and must depend on others to bring their troubles to light. This year, the Ministry of Community and Social Services continued to make reparations for the harm it caused some 19,000 disabled Ontarians dependent on the Ontario Disability Support Program. After my 2006 report, *Losing the Waiting Game*, the Ministry began reimbursing those who had been unjustly denied retroactive benefits because of Ministry backlogs. To date, about \$10 million has been disbursed. The Ministry has also shown initiative in identifying additional cases that may be eligible for compensation.

This year saw our earlier investigative efforts continue to bear fruit, as dramatic reforms progressed in diverse areas of government administration.

We continue to encounter ingrained organizational attitudes and practices that at times can make public service seem more like public nuisance.

The Municipal Property Assessment Corporation (MPAC) and the government have come closer to *Getting it Right* – the title of my 2006 report – by implementing my recommendations for reforming property assessment in Ontario. When the government’s property tax freeze is lifted later this year, the changes put in place by MPAC will be seen by millions of Ontarians, while newly introduced legislation will bring greater fairness to the system of property assessment and appeal.

Newborn screening in Ontario has improved steadily since my 2005 report, *The Right to Be Impatient*. Even since my last annual report, more tests have been added to the roster, bringing genetic tests conducted at birth in this province to 29. No longer does Ontario bear the dishonourable distinction of a Third-World-level newborn screening program. Children with potentially fatal disorders that previously went untested can now be diagnosed and treated.

These investigations and the broad changes they prompted have gained much public attention, but Ombudsman staff also find behind-the-scenes solutions for thousands of individuals who are frustrated with their government. We continue to encounter ingrained organizational attitudes and practices that at times can make public service seem more like public nuisance. In my last annual report, I identified the most common symptoms of bad bureaucracy as rulitis, policy paralysis and “customer disservice syndrome.” These maladies persisted this year, leaving many Ontarians in what I can only describe as the twilight zone of public service.

The Twilight Zone

Too often, government organizations become so fixated on following the rules that they forget to address the human suffering they’ve caused. Or they are so hamstrung by policy – or a lack thereof – that they are unable to take obvious and necessary action.

The Ministry of Health and Long-Term Care refused to reimburse a man for out-of-province surgery in British Columbia because it didn’t fit its preconceived notions of how health care should be delivered.* The same ministry cut off funding for medication for a man whose doctor was out of town and unable to complete the necessary forms, leaving the man with excruciating headaches. Officials at the Ontario Disability Support Program refused to grant a man retroactive benefits after he was forced to wait two years to be transferred to the program – telling him it was his fault that he had missed the deadline to request a review.

Customer disservice syndrome continues to plague the Family Responsibility Office (FRO). In one case, the FRO not only refused to remove a writ it had improperly filed against a man’s property – even though the man had made all his family support payments – it refused to acknowledge that the writ even existed. The Trillium Drug Program also used this “the customer is always wrong” approach when it delayed reimbursing a university student’s drug costs for years, before finally admitting it had lost his receipts. When he submitted duplicates, it promptly refused to reimburse him, saying they were too old. In the same spirit, GO Transit ignored its own policy for disabled persons and refused to let a man get on a bus with his guide dog because of the driver’s allergies.

* All stories referred to in this section are detailed in the Case Summaries chapter of this report.

Another top reason why people end up dissatisfied with their government is the classic “communication warp.” Often the problem is simple carelessness in passing on critical information. A court clerk forgets to explain to a man that his punishment includes the threat of jail time, leaving him surprised to find himself needlessly behind bars. The Public Guardian and Trustee neglects to give notice of a change of address, resulting in a disabled senior incurring hundreds of dollars in rent charges. A college fails to inform a learning-disabled man that courses must be completed within a certain time period, almost costing him years of study and a hard-earned degree. Various organizations omit to inform a family with two severely disabled children and a terminally ill father about the services available to them, leading them to incur further financial hardship. A man suffering from prostate cancer spends \$40,000 to have surgery in the United States because Ministry of Health and Long-Term Care officials don’t tell him the surgery is available in Ontario for free.

Sometimes there is communication, but it’s wrong. A foster mother of two special-needs boys is wrongly told she is now their legal parent, and is denied nearly a decade’s worth of payments for her services in caring for them. A woman searching for her brother is mistakenly informed by Adoption Disclosure Register officials that they have no record of him; by the time their mistake is discovered, the rules have changed and they claim they can no longer help her. A man who loses his wallet and requires surgery suffers for no reason, because he’s led to believe he has to get a new birth certificate before he can renew his OHIP card.

At other times, there’s no communication at all. A mother seeking a birth certificate is put on hold by the Office of the Registrar General for more than three hours – during which time she obtains our Office’s assistance via mobile phone. A woman whose ex-spouse has defaulted on tens of thousands of dollars’ worth of support payments is unable to get through to the FRO staff handling her case. A family concerned about standards of care in a long-term care home where a loved one lives can’t pry basic information from the Ministry of Health and Long-Term Care. And a participant in an Ontario Labour Relations Board hearing is shocked to find his name posted on the board’s website because it didn’t bother to tell him the decision would be public.

We were able to help all of these people. In all of these cases, we assisted by holding poor public service up to the light, by reminding officials of the real people affected by their actions, by filling the communication gap, and ultimately by giving those under our scrutiny a second chance to do the right thing.

Sharing the Spotlight

This success is not ours alone. It is shared with all those who recognized where their duty lay and then took decisive action. We could not have achieved the outcomes we did without the government’s co-operation. I commend and thank the organizations and individuals who worked with us toward our common goal of improving Ontario public services.

I am very encouraged by the enlightened attitude demonstrated by the organizations that have refocused their internal cultures on putting the public first. Legal Aid Ontario, once aware of its poor service, set out to overhaul its practices. The Ministry of Health and Long-Term Care sought a solution to the issue of funding for oxygen saturation monitors, and agreed to an intensive program review, all without the need for a formal Ombudsman report. It also kept improving its newborn screening program. The Ministry of Community and Social Services continued to seek out those who may have suffered from its past transgressions. The Ontario Lottery and Gaming Corporation not only implemented my recommendations but made its own proactive innovations to further improve public trust in its operations. MPAC and the Ministry of Finance also continue to pursue improvements in property assessment policies.



DECEMBER 5, 2007:

Premier Dalton McGuinty signs the guest book for a reception at the Ombudsman's Office.

All of this co-operation within government has been complemented by strong support for the Ombudsman's Office from the province's political leadership. All three parties in the Legislature have strongly backed the principle of independent oversight and the recommendations arising from my investigations.

The Premier demonstrated his appreciation for our work this year in a unique way – by becoming the first sitting Ontario premier to visit the Office of the Ombudsman in person. The occasion for what he jocularly termed a visit to “the lion's den” was a reception for a group of ombudsmen and investigators from watchdog agencies across Canada and around the world, all of whom were here to learn about our Office's innovative investigative methods. The secretary of Cabinet also spoke to the same group at a training session, and both he and the Premier made the same key point: Far from being adversaries, the Ombudsman and government staff share the same duty to the Ontario public and the same goal of making government work better.

This constructive attitude was echoed in a letter the Premier wrote to me in April 2008, and which, given the message, I think should be shared publicly:

“*You've got it right: In the end, we're on the same side.
Our higher duty will always be owed to those we are both
privileged to serve.*”

Towards the Light

All of that, of course, is the good news, and I don't mean to diminish any of it by turning now to stories that are less encouraging. If anything, the fact that we have seen such successful outcomes as a result of Ombudsman intervention makes it that much more baffling when we are shut out in other areas. But it is clear that in some quarters in Ontario, there remain many who are reluctant to have their conduct held up to the light of oversight.

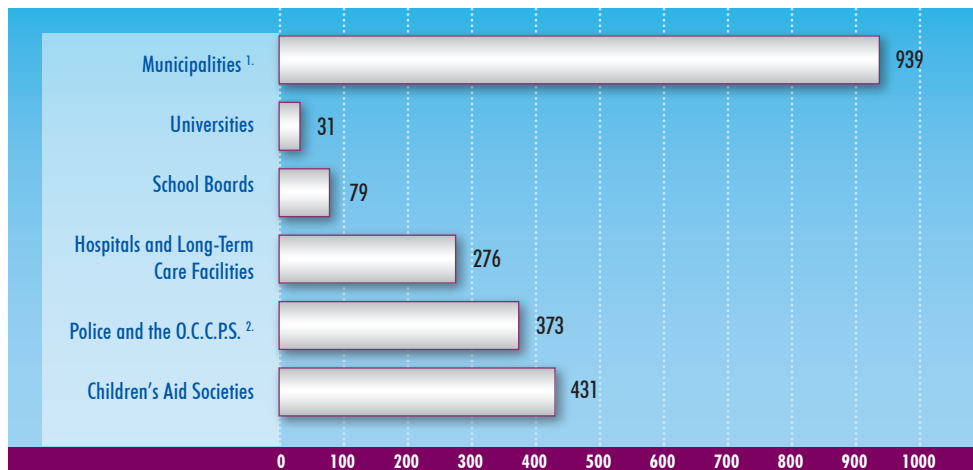
Despite 33 years of efforts by this Office and many others to garner government support for the expansion and modernization of the Ombudsman's mandate, the **MUSH** sector continues to elude scrutiny. The public still has nowhere to turn for independent investigative oversight of **municipalities, universities, school boards, hospitals and long-term care facilities**, as well as organizations such as police and children's aid societies. The government mantra of openness, transparency and accountability has yet to filter down to these zones of immunity. In this, Ontario lags behind all other provinces, and our Office is unable to help the hundreds of people who complain to us about these institutions (see accompanying charts).

LAGGING BEHIND

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

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

MUSH SECTOR COMPLAINTS AND INQUIRIES RECEIVED DURING FISCAL YEAR 2007-2008 ■ TOTAL: 2,129



¹ Excludes complaints and inquiries received after January 1, 2008 about closed municipal meetings.

² Ontario Civilian Commission on Police Services

As noted in my last Annual Report, attempts have been made to spur the government into action. Although they eventually died on the order paper when the House was prorogued for the 2007 election, three private member's bills were introduced in 2006 by New Democratic Party members, supporting Ombudsman oversight of hospitals, long-term care facilities, school boards and children's aid societies.

Over the last fiscal year, however, there have also been some positive indicators that the momentum for oversight is building in at least one sector. The public of Ontario has become increasingly outspoken regarding the need for greater accountability over **hospitals and long-term care facilities**. This is not surprising, given our reliance on these institutions from cradle to grave, and the profound impact they have on the quality of our lives.

From spring 2007 to present, the media have highlighted horror stories of nursing home residents sitting helpless for hours in soiled diapers, of a disoriented 87-year-old woman who strangled in restraints that tied her to her wheelchair, and of hospital patients left unattended to suffer in overcrowded emergency rooms. In Burlington and elsewhere, hundreds of hospital patients have died in outbreaks of the "superbug" *C. difficile* – the sort of problem that cries out for an independent, systemic investigation. In other areas, we have heard of facility administrators failing to protect staff and patients from physical abuse, and concerns about medical secrecy have led to government promises to improve the reporting of medical malpractice and hospital safety records.

In December 2007, three Ontario hospitals suffered the ignominy of making the Canadian Institute for Health Information's list of worst performers. Calls have been renewed for increased hospital and nursing home staffing, standards of care for nursing home residents, and, once again, for Ombudsman oversight.

“If truly independent eyes were watching hospitals, perhaps more people would be alive today, fewer patients would be suffering the consequence of “adverse events” and fewer dollars would have to be spent on medical lawsuits.”

– Letter to the Editor, Toronto Star, May 9, 2007

“Clearly, the Ontario Ombudsman is the “EMS” urgently required to take charge of Ontario’s dysfunctional long-term care facilities system.”

– Letter to the Editor, The Globe and Mail, August 6, 2007

“Ultimately, hospitals should be treated like other publicly funded institutions and come under Freedom of Information legislation, forcing disclosure of all relevant health data. And Ontario should give its Ombudsman the power to investigate complaints against hospitals as all other provinces have.”

– Editorial, Toronto Star, December 1, 2007

“Ombudsman André Marin’s office should be allowed to investigate hospital complaints. Marin has proven to be strong and effective and the government has been quick to accept his recommendations. Why not expand his role?”

– Editorial, Toronto Sun, January 6, 2008

6 Ontario retains the dubious distinction of being the only jurisdiction in Canada that has not given its Ombudsman some oversight of hospitals and long-term care facilities.

With the province's annual health care budget now in the \$40-billion range – more than 40% of the government's total spending – and hospitals and long-term care facilities receiving about \$18 billion in government funds each year, accountability in this sector is critical. While the Auditor General has the authority to monitor health services finances, the quality of hospital and long-term care administration remains unchecked by any independent oversight authority. Yet it is the day-to-day operation of these facilities, not their bookkeeping, that has the most profound effect on individual Ontarians.

Health care administrators predictably resist the prospect of being publicly held to account, proclaiming that they are already subject to enough controls, and that most complaints relate to the services provided by doctors and nurses, not to organizational administration. But these are the rationalizations of the self-interested. There is no well-founded public interest argument for ignoring Ombudsman oversight as a way to help remedy the ailing health care system.

Ontario has no independent watchdog poised to investigate concerns about poor service, delays, inconsistent application of policies, administrative errors, hiring of medical personnel, quality assurance measures or communications in hospitals. This year, my Office was forced to turn away 276 complaints about hospitals and long-term care facilities. Some of these complaints focused on the failure of hospital administrators to exercise compassion or common sense in their communication with patients and their families. A concerned daughter railed against hospital officials who insisted the rules required that her 84-year-old mother be shuttled away from her family, and the town she had lived in most of her life, to a hospital nearer the home where she had lived for less than a month before becoming ill. A distraught mother was left without answers after her infant son died in hospital. Complaints about long-term care facilities typically came from family members concerned about loved ones receiving inadequate care; bedsores left untreated, improper diets, and in one case, a death at the hands of a violent resident.

My predecessors and many others have called on the government to extend the Ombudsman's jurisdiction in this area. But Ontario retains the dubious distinction of being the **only** jurisdiction in Canada that has not given its Ombudsman some oversight of hospitals and long-term care facilities. In fact, Ombudsman oversight in Ontario health care has actually diminished over the past decade, with the transfer of nine of the province's 10 psychiatric hospitals from direct government control to the hospital sector. As a result, thousands of Ontario's most vulnerable citizens have lost the right of recourse to the Ombudsman. Recently, it was even recommended that the last provincial mental health facility, in Penetanguishene, be divested from government control. This would eliminate the last vestige of Ombudsman oversight in this area.

A Ray of Hope

In recent years, some small windows of opportunity for Ombudsman oversight of hospitals have opened as a result of provincial takeovers. When the provincial government takes control of a hospital and appoints its own supervisor – usurping the usual hospital board's authority – the hospital then falls under my Office's jurisdiction and I can receive and investigate complaints about it. And the government has been appointing supervisors at an unprecedented rate. From 2002 to 2006, hospital supervisors were appointed on just four occasions. But in 2007 alone, there were four takeovers – Stevenson Memorial Hospital, The Scarborough Hospital, Huronia District Hospital, and William Osler Health

Centre – and a fifth hospital, Kingston General, came under supervision in February 2008. It would seem the government is not content to stand back and admonish the health care system to heal itself. For one thing, the public won't let it.

There is a revolution building – not necessarily the revolution the government initially promised in long-term care, but a common revolt. We saw signs of this recently in Brampton in the community protests against mismanagement and poor service at the newly constructed Brampton Civic Hospital (part of the William Osler Health Centre). Less than two months after the hospital opened its doors, the government arrived with a supervisor to seize control.

My Office has received and acted on some complaints about these hospitals and continues to monitor others. However, this is a time-limited, ad hoc cure for a chronic condition of inadequate oversight. Some hospitals and long-term care facilities have sought to set up their own internal ombudsmen, but these complaint departments do not provide independent investigative review or address systemic failings. We have heard from individuals who have found such offices to be ineffective and others who feared retaliation for raising concerns internally.

While improvements have undoubtedly been made in accountability in the health sector, pressures continue to build. Ombudsman oversight is strong medicine that can provide a measure of relief, even if it may be a bitter pill for hospital and long-term care operators to swallow. It can act as an early warning system, perhaps forestalling the need for the government to swoop in with a supervisor. Hundreds of government organizations fall under our scrutiny and are the better for it; why should these most important institutions, which literally deal with matters of life and death, be left out?

While I will continue to argue that the entire MUSH sector would benefit greatly from Ombudsman oversight, I believe it is simply essential that it be extended to the hospital and long-term care sector. Ontario can no longer afford to be dead last in Canada in this area. The time for change is now.

Ombudsman oversight is strong medicine that can provide a measure of relief, even if it may be a bitter pill for hospital and long-term care operators to swallow.

Still in the Dark

I have warned before about the dire results of leaving vulnerable citizens with no recourse for their complaints about the MUSH sector. Another area where this is acute is that of child protection – the province's 53 independent children's aid societies are immune to Ombudsman scrutiny, although we continue to receive hundreds of complaints about them from families in crisis every year. This year, more than 400 parents, grandparents, foster parents, concerned friends and relatives – and, in one case, a child in care – came to us for help with the child protection system. We were powerless to help them. Even worse, as I feared, the latest changes put in place by the government in a bid to increase accountability have failed to deliver.

Amendments to the *Child and Family Services Act* came into force in November 2006, expanding the authority of the Child and Family Services Review Board (CFSRB) to consider complaints against children's aid societies (CASs). But the CFSRB's jurisdiction is essentially limited to individual complaints and concerns about process. It has no mandate to consider systemic issues.

In addition, only people who have sought or received a “service” under the Act can complain – and the CFSRB has interpreted its jurisdiction quite narrowly. As one of our complainants discovered this year, if you are a concerned grandparent worried about the care that your grandchildren are receiving under CAS supervision, the board will likely turn you away, because you personally did not “seek or receive child welfare services.”

While the board’s decisions may be supported by a strict legal interpretation of the Act, this situation does nothing for the hundreds of Ontarians who have grave concerns about the conduct of children’s aid societies. The child protection system spends about \$1.3 billion in public money each year, yet lacks an important fail-safe – independent investigative oversight. Systemic failures go undetected and children and their families suffer as a result.

Institutions like children’s aid societies, which have been shielded for decades from the sanitizing glare of public scrutiny, tend to be intransigent and even elitist in their objections to Ombudsman oversight. However, I am hopeful that such attitudinal resistance can be overcome. One of the latest voices to join the chorus calling for this change is the Ontario Bar Association Justice Stakeholder Summit, which included among its recommendations to the government in May 2008:

“Expand the mandate of the Ontario Ombudsman to include oversight of children’s aid societies and similar public bodies.”

With time, persistence and enough public demand for transparency and accountability, I am confident CASs and other such organizations will eventually have to come into the light.

Let the Sunshine In

This year, Ontario municipalities are being exposed for the first time to the enforcement of “sunshine laws” – legislation requiring all municipal meetings to be open to the public. The new era of accountability in local democracy arrived on January 1, 2008, when new provisions of the *Municipal Act, 2001* and *City of Toronto Act, 2006* came into effect.

Municipalities in this province have been required by law to hold open meetings for over a decade. But until this year, the only way for citizens to enforce this obligation was to go to court. There have been many efforts to change this, including a campaign by the Information and Privacy Commissioner and a number of private member’s bills. Now, at long last, anyone who believes a municipal meeting has been improperly closed to the public can lodge a formal complaint – and request an investigation.

The legislation designates my Office as the investigator of these complaints for all municipalities – except those that have chosen to appoint their own investigators. As of the writing of this report, about 240 municipalities had chosen to hire other investigators – some through contracts with individuals; others through the Local Authority Services (LAS) arm of the Association of Municipalities of Ontario. That leaves my Office as the investigator for closed meetings in an estimated 200 municipalities – some of which have expressly voted to use our services; others simply via the default designation in the Act.

Public debate and discussion in some municipalities has illuminated the fact that the Ombudsman’s investigations are truly independent, impartial, free of charge to complainants and municipalities, and rooted in more than 30 years of experience. Through speeches, communications and appearances before several municipal councils, I and my staff have worked to correct the mistaken impression of some local officials who had spoken of my Office as a backlogged, expensive agent of the provincial government with



OCTOBER 31, 2007:

The Ombudsman discusses his new responsibility for investigating closed municipal meetings at "Right to Know Day," hosted by Information and Privacy Commissioner Ann Cavoukian, background. Also on the panel were Auditor General Jim McCarter and Integrity Commissioner Sidney Linden.

little expertise in municipal affairs. But many misconceptions remain, highlighting the need for greater public discussion and education on this issue.

For instance, while some might think this means my mandate now extends to the "M" of the MUSH sector – municipalities – that is absolutely not the case. My investigations are strictly limited to the issue of whether or not meetings are properly closed under the law – nothing else. What's more, my role in the investigation of closed meeting complaints is a departure from my usual function of determining whether an organization's conduct is fair and reasonable. Investigation of closed meeting complaints is essentially an exercise in law enforcement without penalty. It involves answering legal questions regarding the legislative and procedural requirements for holding closed meetings, and whether or not local councils and committees have complied with them. As of the writing of this report, my Office has completed two investigations into closed meeting complaints and issued two public reports, both of which I hope will help light the way for others as we continue into what in Ontario is new legal territory.

My first investigation, into a closed "training session" held by the Fort Erie town council, found the council complied with the law, but my report, *Enlightening Closed Council Sessions*, advised it to provide more information prior to closing meetings in future, in the interest of transparency. The second investigation concerned a closed meeting held by Sudbury councillors to discuss the controversy over tickets to a sold-out Elton John concert in their city. In that case, I also found council in compliance with the law, but only barely. Because the investigation broke new ground in interpreting the legal definition of a "meeting," I tabled my report, *Don't Let the Sun Go Down on Me*, to the Legislative Assembly as well as to the City of Greater Sudbury, as a matter of interest to all Ontarians.*

This is an exciting time for all who care about official openness. Since my Office has been given an integral role in the development of this new law, I am determined to do what I can to ensure that it is successful. So far, we have encountered two trends that must be addressed – a thirst for government transparency on the part of the public, and a dearth of information about the new requirements and the investigative regime at the official level. Many Ontarians and their elected leaders remain in the dark about sunshine laws, even though other jurisdictions, including all U.S. states, have had them in place for decades.

This is an exciting time for all who care about official openness.

* Both reports are available at www.ombudsman.on.ca.



DECEMBER 3, 2007:
The Ombudsman addresses Fort Erie town council.

My Office has allocated resources to this new area to ensure timely and efficient investigation of closed meeting complaints, much as we did three years ago when we created the Special Ombudsman Response Team (SORT) for systemic investigations. **Beginning this summer, we will establish a dedicated Open Meeting Law Enforcement Team (OMLET), which will be responsible for investigating closed meeting complaints, as well as educating the public and municipalities about the open meeting obligations enshrined in law.** And yes, I do hope the memorable acronym will help draw attention to this important new issue and help “descramble” some of the confusion.

The regrettable fact is, Ontario’s new sunshine law came with its own dimmer switch; it contains no uniform standards to ensure the independence, credibility, consistency and fairness of closed meeting investigations. Municipalities are free to choose their own investigative process and who will conduct it – will it be former municipal officials who have set up shop as freelance investigators or contracted through LAS, or will it be the Ombudsman? The degree of public protection that these other investigators will be able to provide is uncertain. To date, LAS has refused to share information with my Office concerning its investigations, saying its investigative reports will only be made available to municipalities that use its services, pay its fee and gain access to its private website. This clearly does not bode well for universal protection of the principles of openness and transparency at the municipal level.

Similarly, I remain skeptical about some of the other legislative changes that came into effect with the new open meetings provisions. For instance, all municipalities now have the right to appoint their own ombudsman – but to my knowledge, not one has taken advantage of this opportunity to increase public accountability. Even the City of Toronto, which is required by law to appoint an ombudsman as part of its new powers, had yet to permanently fill the post at the time this report was written. The day-to-day administration of local government continues to remain immune to external investigative oversight.

Keep on Shining

As this report shows, this year we continued to shed light on the inner workings of provincial government administration, and to expose unreasonable, unfair, wrong and unjust practices and policies to public view. We will continue in the coming year to demonstrate the value of oversight, and encourage those we oversee to reflect the values of openness, transparency and accountability in the service of all Ontarians.

The Year In Review

OPERATIONS OVERVIEW

Over the past year, we have continued to build upon our past successes and modernize and improve our operations. In addition to overhauling our case management database in order to improve our tracking of trends in complaints, we have accelerated training and recruitment initiatives that have allowed us to improve upon our ability to resolve cases informally.

We are proud to report that we've been able to help **16,754** individuals this year and that we continue to do so in an expedient and efficient manner, with the majority of cases being resolved within three weeks. Examples of our successes of note can be found in the Case Summaries section of this report.

Many of this year's cases were complex and challenging, involving submissions from interest groups and multiple complainants about high-profile issues including broad concerns about government administration and policy in the areas of health care, the environment and natural resources. Operations staff were also trained and allocated in preparation for the Ombudsman's new responsibility for investigating complaints about closed municipal meetings as of January 1, 2008.

In addition, senior staff meet quarterly with managers from the Ministry of Community Safety and Correctional Services in order to proactively deal with emerging trends and resolve complaints in correctional facilities. Our focus in this area continues to be on addressing serious health and safety matters, while ensuring that the Ministry fulfills its responsibility for addressing complaints internally. The Ombudsman and senior managers also met with groups that monitor conditions for inmates to hear their concerns with respect to emerging correctional issues.

Quarterly meetings have also recently begun with the newly appointed Assistant Deputy Minister and senior managers at the Family Responsibility Office – consistently one of the top subjects of complaints to the Ombudsman – with a view to resolving individual complaints more quickly and addressing systemic issues related to the level of service provided to FRO clientele.

After the discovery in August 2007 of financial irregularities and potential fraudulent activity involving a former employee of the Office of the Public Guardian and Trustee (OPGT), we undertook a review of complaints to the Ombudsman about the OPGT. The OPGT promised to keep the Ombudsman fully informed of steps taken to address the matter, and Ombudsman staff have attended briefings by the Ministry of the Attorney General and OPGT in order to receive updates on the status of all internal reviews and actions taken. We continue to closely monitor complaints received about the OPGT.

As of May 2008, we are also reviewing numerous complaints regarding the provision of services for children with autism in Ontario schools and wait times for intensive behavioural intervention through the Autism Intervention Program. The assessment of these complaints is continuing and we are closely monitoring this issue.

In addition to our daily work of investigating and resolving thousands of complaints, our Office regularly receives requests from government agencies and complaints resolution organizations at home and abroad concerning our complaint handling methods. Many organizations have visited us to learn firsthand about our strategies and streamlined approaches to early complaint resolution and investigations.

Opening the Door on Closed Meetings

As of January 1, 2008, the Ombudsman can investigate public complaints about closed meetings in municipalities across Ontario, except those that have appointed their own investigator. Between January 1 and March 31, 2008, the Ombudsman's Office received 61 complaints and inquiries about closed municipal meetings. The majority of these related to municipalities that had appointed another investigator, meaning the Ombudsman had no authority to investigate; those complainants were referred back to their respective municipalities. Other complaints and inquiries were quickly resolved. Two complaints – one from Sudbury and one from Fort Erie, resulted in full investigations and reports by the Ombudsman.*

Town of Fort Erie

We received complaints that the Fort Erie Town Council had improperly held a closed meeting on January 7, 2008. Council had given prior notice that the meeting would be held at a facility outside of the Town Hall for “education and training” purposes, as provided for in section 239 of the *Municipal Act, 2001*. Our investigators interviewed everyone who was present at the meeting, including the facilitator hired for the event, and reviewed pertinent documentation.

The Ombudsman's report, *Enlightening Closed Council Sessions*, was issued on February 6, 2008. It concluded that no council business was discussed at the meeting, which focused on interpersonal relationships, team-building and communication – and as such, it fell within the “education and training” exemption in the legislation. However, the Ombudsman commented that the open meeting provisions of the Act should be broadly interpreted and the exceptions read restrictively. He also suggested that the Town might have averted complaints if it had given more detailed information in advance of the meeting about what it would entail and why it would be closed. The Town agreed to follow the Ombudsman's suggestions in future, in the interests of transparency.

City of Greater Sudbury

Amidst a public outcry over councillors getting prior access to tickets to a sold-out Elton John concert in Sudbury, we received a complaint that the city council had held a secret meeting to discuss the ticket issue on February 20, 2008, after a regular open meeting had concluded. A team of investigators interviewed all members of council as well as senior staff, and reviewed minutes and other documents relating to the meeting.

The Ombudsman determined that 10 councillors had gathered in the council lounge and asked some city staff to leave so they could discuss the details of returning some of the concert tickets they had purchased. In the end, 71 tickets were returned, which the promoter then made available to the public.

The Ombudsman concluded that the gathering of councillors was within the law, but only barely. His report on the investigation, entitled *Don't Let the Sun Go Down on Me*, was issued April 25, 2008, and included an extensive appendix reviewing legislation and jurisprudence on closed meetings in Ontario and other jurisdictions.

The February 20 gathering did not constitute a “meeting” under the law, the Ombudsman found, because the councillors were not meeting to exercise their political powers, to discuss city business or policy, or to lay the groundwork for doing so – they only discussed the mechanics of returning their tickets and having their money refunded. Therefore, the gathering was not required by law to be open to the public. However, the Ombudsman cautioned that holding closed meetings is a highly dangerous practice, given the strong public interest in open and transparent local government.

The Ombudsman tabled his report with the Legislature as well as the City of Greater Sudbury, with the hope of raising awareness of the legislation on open meetings and contributing to its interpretation.

* These reports are available at www.ombudsman.on.ca.

COMMUNICATIONS AND OUTREACH

Communications plays a key role in the Ombudsman's work, whether it's in alerting the public and media about major investigations, announcing the important changes they bring about or simply letting all Ontarians know the Office is here to help them.

In 2007-2008, the Ombudsman continued to make news through investigations, reports, speeches and public appearances, reaching millions of people in Ontario, across Canada and internationally. Communications staff track media coverage through regular monitoring of print and broadcast stories, as well as traffic on our website at www.ombudsman.on.ca.

Media Coverage and Website

Overall, there were 1,081 newspaper articles published about the Ombudsman in the 2007-2008 fiscal year, reaching an aggregate audience of more than **92 million** people. The estimated advertising value of these articles (calculated by FPinfomart based on newspaper advertising rates and the size and play of the articles) was \$2.75 million. There were also more than 600 news stories about the Ombudsman broadcast on radio and television. Media coverage was concentrated in Ontario, but some stories received national and international circulation.

While these stories dealt with a wide range of issues, most media coverage surrounded the release of the Ombudsman's 2006-2007 Annual Report and various Special Ombudsman Response Team (SORT) reports – including developments arising from the 2007 report on the Ontario Lottery and Gaming Corporation, *A Game of Trust*.

Between April 1, 2007 and March 31, 2008, news stories relating to the lottery investigation reached an aggregate audience of more than 43 million people, with an estimated ad value of \$1.4 million. Other major news coverage this year included the Ombudsman's announcement of the SORT investigation into the province's Special Investigations Unit in June 2007 and the release of the SORT report on Legal Aid Ontario, *A Test of Wills*, in February 2008. The Ombudsman was also sought for media comment on the lack of independent oversight of hospitals and other areas of the MUSH sector, as well as on developments relating to the Office's investigations of the property tax assessment system and out-of-country health funding.



JUNE 7, 2007:

The Ombudsman announces a SORT investigation of the Special Investigations Unit.



DECEMBER 5, 2007:

Premier Dalton McGuinty greets Ombudsman staff and investigators from around the world attending the first-ever SORT training course.



OCTOBER 18, 2007:

Visting delegation from Albania, led by the Speaker of the Albanian Parliament, Jozefina Topalli, third from left.

The Ombudsman's website is emerging as an increasingly important communications tool as well as a conduit for complaints. It was redesigned in-house in the spring of 2007, as the Ombudsman conducted his first-ever **live online chat** with members of the public immediately after the release of his last annual report. Further structural changes were made in late 2007 to help educate the public about the Ombudsman's new responsibility for investigating closed municipal meetings, and a complete redesign and relaunch was done in conjunction with the release of this report, featuring such additions as an e-newsletter, RSS feeds and new sections devoted to "Hot Topics" and "Municipal Matters."

Outreach

Key speeches by the Ombudsman in the past year included addresses to the Association International des Jeunes Avocats (AIJA), the Canadian Centre for Ethics and Corporate Policy, the Ontario Bar Association, Canadian Property Tax Association, and Alberta Gaming and Research Institute, among others. The Ombudsman also received international delegations, including representatives from Russia, Albania and Brazil, and promoted the Office through such organizations as the Forum of Canadian Ombudsman (of which he is president) and the International Ombudsman Institute (of which he is vice-president for North America).

In addition, the Ombudsman and senior staff made numerous presentations and speeches on the Office's new area of responsibility for investigating closed municipal meetings. Communications efforts in this area will be expanded in the next year.

The Ontario Ombudsman is frequently consulted by other agencies for expertise in investigations, complaint intake and the establishment of a credible oversight office.

Consultation and Training

The Ontario Ombudsman is frequently consulted by other agencies for expertise in investigations, complaint intake and the establishment of a credible oversight office. In the past year, these have included the Ontario Integrity Commissioner, the new Federal Ombudsman for Victims of Crime, the new Procurement Ombudsman, the French Language Services Commissioner of Ontario, the Accessibility Directorate of Ontario and the Federal Task Force on Governance and Cultural Change in the RCMP. Ombudsman staff also share their skills in speeches and training workshops.

Most significantly, at the request of the Canadian Council of Parliamentary Ombudsman, the Special Ombudsman Response Team (SORT) conducted a four-day course for administrative investigators in December 2007, entitled “Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs.”

The course, the first of its kind, was conducted on a cost-recovery basis and attracted interest from investigative agencies across Canada and overseas. Space was limited to 50 investigators and ombudsmen, representing eight provinces and numerous Canadian federal agencies, as well as Bermuda, Samoa, the U.K. and Australia, and several U.S. states.

The workshop gave extensive training on SORT’s model for investigating systemic issues of significant public concern and focused on investigative techniques, including case assessment, investigation planning, field investigation techniques and report production. Presentations were given by the entire SORT staff as well as the Ombudsman and other senior managers.

In addition, the then Secretary of Cabinet, Tony Dean, spoke about how such investigations can improve public service, and Premier Dalton McGuinty spoke at a reception for participants, reinforcing the province’s support for the Ombudsman’s work. SORT will conduct a second edition of the course in September 2008.

In Memoriam

This report would not have been possible without Barbara Theobalds, the Ombudsman’s longtime Media Relations Advisor, who passed away in March 2008. A consummate professional known to journalists across Canada for her communications work, “Barbara T” was a key contributor to all of the Office’s major releases and spearheaded this year’s website redesign project. She is greatly missed.



Barbara Theobalds

Special Ombudsman Response Team



The Special Ombudsman Response Team (SORT) is responsible for conducting the major field investigations of the Ombudsman's Office. These are cases that generally arise from a cluster of complaints about an issue of significant public interest.

In the three years since its inception, SORT's approach has been highly successful. Its major investigations have covered such diverse and specialized topics as property tax assessment, medical screening of newborn babies, compensation for crime victims and the security of the lottery system. All of the Ombudsman's recommendations arising from these investigations have been accepted.

A typical SORT investigation is carefully planned according to a clear timeline, and involves a team of investigators interviewing dozens of witnesses and reviewing thousands of pages of documentation. All major interviews are tape-recorded and transcribed as necessary, and assistance of all other areas of the Ombudsman's Office is employed as needed.

SORT has been used as a model for other ombudsman offices and administrative investigators worldwide. In addition to the new "Sharpening Your Teeth" training course SORT conducted in December 2007 for 50 investigators – with a second session planned for September 2008 – the Director of SORT is frequently invited to share the team's

methods and techniques at conferences and workshops. In the past year, these have included events organized by the United States Ombudsman Association, the Association of Certified Fraud Investigators of Canada, the Ombudsman of British Columbia and the Forum of Canadian Ombudsman.

All SORT reports may be downloaded from our website at www.ombudsman.on.ca or obtained from our Office.



SORT Director Gareth Jones, left, and investigator Kwame Addo lead a workshop for administrative watchdogs.



Participants at "Sharpening Your Teeth," December 3-6, 2007.

SORT INVESTIGATIONS

A Test of Wills

In 2002, Richard Wills, a Toronto police officer, murdered his longtime lover, Linda Mariani. He sealed her body in a garbage bin and hid it behind a false wall in his basement for four months. He was eventually arrested and his case began a bizarre and protracted journey through the legal system – a journey that ultimately cost taxpayers more than \$1 million in Mr. Wills’ legal aid costs alone.

When Mr. Wills was convicted of first-degree murder on October 31, 2007, details surfaced in the media about how he had managed to get the province to pay for the long parade of defence lawyers he had hired and fired during the case – even though, prior to his arrest, he was a self-described millionaire.

Amid the public outcry, the Ombudsman received complaints from members of the Legislature, including the leader of the New Democratic Party, about the role of Legal Aid Ontario (LAO) in the funding of Mr. Wills’ defence. The Ombudsman notified LAO and the Ministry of the Attorney General of his intent to investigate on November 6, 2007.

SORT interviewed staff at LAO and the Ministry, as well as all the various Crown and defence lawyers associated with the case. Mr. Wills was interviewed on two occasions at Kingston Penitentiary. SORT reviewed thousands of pages of documentation provided by LAO and the courts. Several other Canadian jurisdictions were contacted to examine how they deal with similar cases.

In releasing his report, *A Test of Wills*, on February 26, 2008, the Ombudsman described the Wills case as “a perfect storm of mischief, mismanagement and perhaps even madness” that resulted in “obscene” costs to the taxpayer. The investigation found that Mr. Wills had deliberately impoverished himself after the murder by divesting his assets to family members. Then he demanded the government pay for his defence. Two special orders were issued by a judge, requiring the Ministry to cover this cost. Since the Ministry is also responsible for the prosecution, it relied in turn on LAO to vet the defence lawyers’ bills – although, ironically enough, LAO had initially refused Mr. Wills legal aid through the normal channels because of his wealth.

The Ombudsman found that LAO resented this responsibility. Some of its staff took the view that because the bills were being paid through the Ministry by special order of a judge, rather than from LAO’s coffers, it was not their job to keep a close eye on them. One of Mr. Wills’ lawyers also resented this supervision, and managed to convince LAO’s director of “Big Case Management” that his only job was to “check the math” on his bills, not to question his expenses. This manager then informed the Ministry that the bills had been vetted, even though no budget had been set and the bills were not being reviewed in detail.

LAO approved some \$608,901.44 worth of bills from one lawyer alone, before Mr. Wills fired him (he went through 11 lawyers in all, seven of them paid by the public purse). The Ministry did not learn of LAO’s rubber-stamp approach until the spring of 2007, but once alerted, its staff acted swiftly to put on the financial brakes.





FEBRUARY 26, 2008:

At his press conference on February 26, 2008, the Ombudsman urged the government to "follow the money" that was wasted in the notorious Richard Wills trial.

The investigation revealed that even as the Wills trial was grinding on, LAO and the Ministry had been developing a protocol for how legal bills paid through the Ministry should be reviewed. After news of the Wills fiasco broke, the Attorney General announced that this would be accelerated, and on December 12, 2007, a new protocol was released in which LAO acknowledged its shared responsibility for the administration of court-ordered defence funding.

The Ombudsman concluded that LAO's failure to adequately administer the funding arrangement in the Wills case was unreasonable and wrong. He did not find fault with the Ministry, as it had no way of knowing LAO was not vetting Mr. Wills' lawyers' bills as it had indicated. However, his key recommendations lay with the provincial government: That it take all available steps to recover the public moneys spent on Mr. Wills' defence, and that new legislation be drafted (as opposed to a non-binding protocol) to ensure there is a clear procedure for all similar cases in future. He also recommended legislation to deter legal aid applicants from hiding off their assets.

The Attorney General announced immediately after the Ombudsman's news conference that the province would "follow the money" as he recommended, and launched civil proceedings that very day to recover Mr. Wills' assets. Overall, the Ministry's response to the recommendations was positive and it agreed to report back in six months on its progress in implementing them, but it did not specifically commit to legislative change, saying it is confident that its protocol and "the processes now in place" will be enough to address the problems uncovered in the investigation. The Ombudsman will review the Ministry's update in August 2008 and assess whether it has taken tangible steps toward his recommended improvements.

Legal Aid Ontario, meanwhile, had undergone a change of leadership in the wake of the Wills fiasco, and its new President and CEO agreed to all of the Ombudsman's recommendations. LAO has since taken a number of constructive steps, including increasing senior management oversight of all cases costing more than \$75,000 and reviewing its management of "big cases."

Life and Breath

In February 2007, SORT was assigned to investigate a complaint regarding the province's refusal to fund oxygen saturation monitors for infants and children with chronic respiratory problems, for use outside of hospital. The devices, which measure a child's heart rate, respiratory rate and blood oxygen saturation levels, are routinely used by

hospitals and are acknowledged to be the standard of care for young patients who are transitioning from the hospital to the home. Long-term treatment for these children may include oxygen, mechanical ventilation, or a combination of both, meaning continuous monitoring of their oxygen levels is essential.

SORT investigators interviewed 27 families whose children had been or were still dependent on this technology, along with doctors, other health care professionals and Ministry of Health and Long-Term Care officials. Families were paying between \$2,000 and \$6,000 for the monitors, and many either had no private health insurance or were told it would not be covered by their insurer. SORT also found instances of hospitals not being able to discharge children who were otherwise well enough to go home, because their families could not afford the cost of a monitor. Instead, the health care system incurred the significantly higher cost of keeping them in a hospital bed.

The investigation also found evidence that senior staff from a children's hospital had stressed to the Assistive Devices Program (ADP) that the technology was a necessity for this select patient population, but ADP officials had ignored their request. What's more, the ADP had no process for tracking requests for funding, and had no sense of the number of requests for oxygen saturation monitors it had received.

The Deputy Minister of Health and Long-Term Care advised the Ombudsman in late March 2007 that he would review the matter along with the ADP. Four months later, he advised that oxygen saturation monitors would be added to the list of ADP-approved devices for children under 18 who experience unexpected drops in oxygen saturation due to life-threatening respiratory conditions. Funding for oxygen saturation monitors came into effect on November 1, 2007, and to date, 47 monitors have been provided to eligible children.

That left the question of all those families who had paid for the machines prior to November 2007. The Ombudsman asked the Ministry to consider reimbursing those families, retroactive to November 2002. Noting the ADP's lack of data on requests for the devices, the Ombudsman suggested that a review of the entire program might be warranted.

In March 2008, ADP officials advised the Ombudsman that it would consider requests for retroactive reimbursement for oxygen saturation monitors on a case-by-case basis. Following on the Ombudsman's suggestion, the Ministry also retained PricewaterhouseCoopers to conduct an operational review of the program, including an evaluation of the process ADP uses to decide which devices to list or delist. With the matter thus resolved, the Ombudsman opted not to issue a separate special report on the case.



DECEMBER 5, 2007:

Senior Counsel Wendy Ray, left, and Laura Pettigrew conduct evidence training at "Sharpening Your Teeth."

Building Clarity

In early 2007, the Ombudsman assigned SORT to review a growing number of complaints from owners of newly built homes – more than 100 in the past year. Many of these homeowners' complaints arose from their dealings with the Tarion Warranty Corporation, an independent, not-for-profit body that administers the Ontario New Home Warranty Plan and reports to the Ministry of Government and Consumer Services. Tarion is not a government agency or Crown corporation (it is not run by government or government funded but financed exclusively through builder registration and home enrolment fees), and as such, does not fall under the Ombudsman's jurisdiction. However, since many of the complainants also expressed frustration with their dealings with the Ministry, the Ombudsman announced in February 2008 that SORT would investigate how the Ministry represents its relationship with Tarion to the public.

Investigators reviewed all of the complaints and conducted in-depth interviews with several homeowners. They also looked at thousands of pages of documents provided by the Ministry and correspondence between the Ministry and homeowners dating back to 2005. Investigators compared Ontario's home warranty program to those in B.C. and Quebec, the only other provinces that have such programs.

The common refrain from the homeowners was one of frustration and bafflement over the Ministry's role. The Ministry has oversight of Tarion, in that it appoints five of the 16 members of Tarion's board of directors, and requires Tarion to submit an annual report, as well as quarterly operational data. It has at times portrayed itself as being on the consumer's side: It has referred to its appointees to Tarion's board as "consumer representatives" and speaking "for the consumer," and it has on occasion referred consumer concerns to Tarion to be addressed. It has also dealt with systemic issues. Yet when people call the Ministry responsible for "consumer services" for help with Tarion-related issues – as 199 of them did in 2007 – they are told the Ministry cannot intervene in individual complaints.

Ministry officials co-operated with the investigation and indicated that they value hearing homeowners' concerns from a broad policy perspective. But this does little for confused and frustrated consumers. The Ombudsman concluded the Ministry had failed to provide clear and consistent information to the public regarding its relationship with Tarion. He recommended it remedy this by providing more information on its website and in other communications with the public.

The Deputy Minister of Government and Consumer Services met with the Ombudsman in April 2008 and agreed to his recommendation, and the Ombudsman made his report public in early June. The Ministry also committed in writing to improve communications "by explaining the Ministry's role in handling consumer complaints about new home warranties" and "clearly explaining the role of ministerial representatives on the Tarion Board of Directors."



JUNE 7, 2007:

The Ombudsman announces his investigation into the Special Investigations Unit. The report will be issued later this summer.

ONGOING INVESTGATIONS

PET Peeves

Access to Positron Emission Tomography (PET) scans – or the lack thereof – has been controversial in Ontario over the past year. After receiving a complaint from a physician, the Ombudsman informed the Ministry of Health and Long-Term Care of his intention to investigate in September 2007. To date, the Ombudsman has received more than 30 complaints from physicians and patients concerned about access to PET scans in Ontario.

PET is a diagnostic tool used for patients with cancer, cardiac problems and other diseases. While the technology for PET has been around for many years and Ontario in fact has the second-largest number of PET scanners in Canada, it is also complex and expensive. The province has not approved the procedure under the Ontario Health Insurance Plan. Access is available for some patients involved in clinical trials, which the Ministry undertook to fund in 2002 as part of its evaluation of PET technology. It also launched a program in 2007 that allows physicians to apply for PET scans for their patients.

The Ombudsman's investigation is focused on two issues: Whether the process the province is using to evaluate the technology is reasonable and whether the access patients now have via clinical trials is fair.

SORT investigators met with senior staff at the Medical Advisory Secretariat at the outset of the investigation, and are reviewing extensive documentation from the Ministry. The investigation is expected to be completed in late summer 2008.

Investigating the Investigators

In June 2007, the Ombudsman launched a systemic investigation into the province's Special Investigations Unit (SIU), an arm's-length agency of the Ministry of the Attorney General. The SIU is the independent civilian agency that is responsible for investigating incidents where police are involved in a serious injury or death.

The investigation – SORT's largest to date – was prompted by complaints from affected individuals, family members, lawyers, and community groups who raised concerns about the SIU's independence and objectivity, as well as the thoroughness of its investigations. Concerns were also raised about a lack of information provided to the involved parties.

SORT conducted more than 100 interviews across the province with key stakeholders, including complainants, family members, police officers and their umbrella organizations, SIU staff, Ministry officials, experts in police oversight, and community groups. Investigators have also reviewed tens of thousands of pages of documentation and examined police oversight mechanisms in other jurisdictions.

At the time of the writing of this report, the SIU report was in the final stages of drafting and production. Once the report and recommendations are complete and the SIU and Ministry have had their customary opportunity to respond, the Ombudsman will report his findings publicly.

UPDATES ON COMPLETED SORT INVESTIGATIONS

A Game of Trust

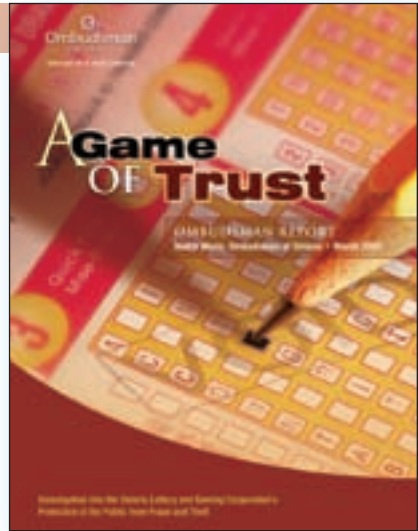
In March 2007, the Ombudsman reported on his investigation into how the Ontario Lottery and Gaming Corporation (OLG) protects the public from theft or fraud, and how it handles complaints about lottery ticket retailers. The investigation, launched in October 2006 in the wake of a stunning news report of lottery “insiders” claiming jackpots to which they weren’t entitled, had repercussions throughout Canada and even made headlines around the world.

In his report, *A Game of Trust*, the Ombudsman described how the OLG had put profit over public service, and had failed to treat the potential for retailer theft and fraud seriously. To restore public trust in the lottery system, which provides billions of dollars in government revenue, he recommended a completely new system of lottery regulation as well as numerous smaller changes. Both the OLG and the Ministry of Public Infrastructure and Renewal accepted all of the recommendations, and as of March 31, 2008, all of them had been implemented.

The Alcohol and Gaming Commission of Ontario (AGCO), which was already the oversight body for the OLG’s casino operations, has undertaken that function for the OLG’s lotteries; a new framework for registration of lottery ticket retailers and rules for their conduct is now in place, and the AGCO is responsible for verifying substantial lottery wins and mediating disputed prize claims. As for the OLG, it has made changes evident to anyone who plays the lotteries – it is now mandatory for players to sign their tickets, ticket-checking machines are available at all sales outlets, and retailers now have new procedures for validating tickets. A number of files regarding suspicious major prize claims by retailers are still under review by the Ontario Provincial Police.

Beyond all this, one of the Ombudsman’s key observations was that the OLG’s corporate culture needed to change, to return its focus to the public interest. The OLG has undergone changes in its leadership and has kept the Ombudsman informed, as he recommended, about its progress in implementing his recommendations. In January 2008, the Ombudsman met with OLG’s Board of Directors, noted that the corporation had embraced his recommendations, and suggested it review “lessons learned” from the scandal and investigation. In its final update to the Ombudsman at the end of March 2008, the OLG documented these “lessons,” noting that customers and the public interest should always be put first and that change starts at the top.

The OLG’s report also included internal polling to reflect its progress in regaining public trust. Among the findings: 65% of Ontarians now agree with the statement that OLG lotteries are run “openly and honestly” (up from 57% in June 2007), and 72% now believe OLG is doing “everything possible” to make the system safe and secure.



OLG officials also acknowledged the profound impact of the Ombudsman's investigation on the organization:

“In hindsight, the ‘shock’ of the Ombudsman’s report brought about deep and systemic change within the Corporation in very short order. It is unlikely that this could have been achieved through more conventional or traditional means of organizational reform.”

“The report swept aside any potential inertia or opposition to needed change ... The most noteworthy change is a shift in culture; a shift that has moved OLG away from an organization driven by profits only.”

Collateral Damage

The Ombudsman's March 2007 investigation into the provision of mental health services for the children of soldiers based at Canadian Forces Base Petawawa drew national attention to the problems faced by families of troops whose lives are at risk in the ongoing mission in Afghanistan. On March 1, 2007, the Phoenix Centre in Petawawa complained to the Ombudsman that the province was not providing adequate resources for the traumatized children of soldiers who had been killed or wounded overseas.

CFB Petawawa had sent 1,500 troops to Afghanistan in the months prior to the complaint – more than 80 had been wounded and some 14 killed in the fall of 2006 alone. The impact on the mental health of the children had been acute. Demand for psychological counselling had grown from just 2% of the Phoenix Centre's cases to 20%, and due to a lack of money and staff, children were waiting up to six months for treatment. But the Phoenix Centre's requests for resources were turned down by the province's Minister of Children and Youth Services, who stated it was a federal matter because it related to a federal military mission.

The Ombudsman's investigation, completed in 10 days, found that while national defence is a federal government responsibility, Ontario is responsible for mental health services for all children in the province, regardless of their parents' occupation. SORT investigators interviewed more than 20 people in Petawawa and Ottawa, including widows of soldiers who had been killed in action, base personnel, Phoenix Centre staff, as well as provincial and federal officials, and staff at bases in other jurisdictions.

The investigation determined that Petawawa was in a crisis situation. The Ombudsman recommended the Ministry provide immediate funding for children's mental health services in the area, and that it consult with the federal government on this matter in the long term. In response, Premier Dalton McGuinty confirmed the government had created a \$2-million contingency fund to provide children's mental health support to communities facing crisis or extraordinary circumstances – from which the Phoenix Centre would receive immediate funding. This new fund was part of a total \$24.5-million increase for children's mental health services. The Minister of National Defence also confirmed the federal government was open to further discussions with the province to ensure that the mental health needs of Petawawa's children were met.

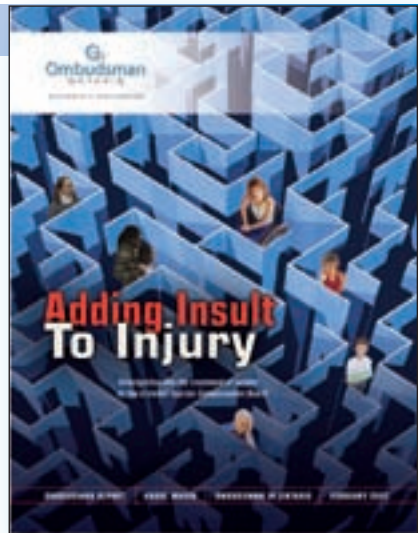
In early April 2007, the Ministry agreed on a budget increase for 2007-2008 that would allow the Phoenix Centre to hire two new therapists and two new youth workers, and the federal government provided \$100,000 to the Petawawa Military Family Resource Centre to allow it to contract with the Phoenix Centre for services. With the matter thus resolved, the Ombudsman did not issue a formal report, but released the results of his investigation on April 13, 2007.

Since then, the Ministry has reported monthly to the Ombudsman on the status of military families awaiting services from the Phoenix Centre. The number of clients increased from 46 in April 2007 to 71 in December 2008. There have been 1-6 clients waiting for group counselling per month. However, while there were only four clients reported waiting for family/child treatment in April 2007, there were 28 in December 2007.

According to the Phoenix Centre, these fluctuations are again due to an increase in military activity, which in turn puts stress on the families. Waiting lists began to increase in the fall of 2007 when a number of troops were sent away for extended training. **Another spike in counselling requests is expected in the summer of 2008, just before another 1,500 Petawawa-based troops are to be deployed to Afghanistan – and demand is expected to remain high through June 2009 (three months after they are due to return).** The Ombudsman will continue to monitor the situation and whether the government is adequately meeting the needs of children in the Petawawa area.

Adding Insult to Injury

The Ombudsman's report on the Criminal Injuries Compensation Board (CICB), entitled *Adding Insult to Injury*, described the agency as being "in a deplorable state" – so hopelessly backlogged and starved for cash that its staff and procedures were actually re-victimizing vulnerable crime victims and making them wait an average **three years** to process their claims. The SORT investigation found that the primary reason for the CICB's failings was that successive governments had failed to fund it properly, and that budget pressures from the Ministry of the Attorney General were illegally interfering with the board's independence in administering compensation awards.



The CICB and Ministry acted to respond to the report's recommendations within days of its release on February 27, 2007. The government first announced \$20.75 million in additional funding, including \$12.75 million for victim compensation, \$2 million to ease the board's backlog and \$6 million for emergency services for victims. Since then, the Ministry and CICB have provided the Ombudsman with regular reports on how they have implemented his 17 recommendations.

Actions taken at the CICB have included the hiring of additional staff, the establishment of a triage team to focus on processing older applications, the hiring of an outside consultant to devise a backlog reduction strategy, and the appointment of 14 new adjudicators. The Ministry and board also signed a Memorandum of Understanding which defines roles and responsibilities and reasserts the CICB's adjudicative independence.

The board has also worked to implement the Ombudsman's recommendations for making its processes more humane. Staff are now given sensitivity training in how to deal with vulnerable victims, documents are no longer returned to victims for minor errors, victims are no longer forced to rehash the painful details of their injuries repeatedly at the intake stage, and photocopied documents are now accepted. Some 22 new staff were to be hired early in 2008 and the board's facilities for holding hearings were being expanded. SORT reviewed the CICB's statistics in October and found it has made progress in speeding up its processing of applications.

Most significantly, the Ministry informed the Ombudsman in March 2008 that the government had approved **\$100 million in funding** for CICB to clear and compensate all the victims in its backlog. This funding was formally announced in the Legislature on April 14, 2008. The CICB reported that it had implemented 90% of the Ombudsman's recommendations and the remaining 10% would be addressed within the next few months, including further staff training. It projected a 40% increase in the number of hearings that would be completed in 2007-08 over 2006-07 and calculated that it now takes less than five months for an application to be assigned to a claims analyst from the time it is received – down from 15 months in 2006-07.

Meanwhile, the Ministry also retained retired Ontario Chief Justice Roy McMurtry to review the victim compensation system as a whole, consult with stakeholders and make recommendations to the government on possible improvements, due in late spring 2008. His task force consulted with interested parties by way of more than 40 public and private meetings, including with the Ombudsman, and received more than 30 written submissions. The CICB indicated it would revisit the Ombudsman's recommendation that it establish an advisory panel of crime victims, advocates and support workers after the McMurtry report is issued.

The Ombudsman will continue to monitor the Ministry and CICB as they implement the remaining recommendations, as well as any new complaints that arise. Complaints about the CICB have declined remarkably since the SORT investigation. Anecdotal reports from victims also indicate an improvement in service and treatment at the CICB. In early April 2008, we received a letter from a woman whose son had been murdered in July 2007, praising the compassion and personal attention to detail she had received from staff, management and adjudicators at the CICB. She also thanked the Ombudsman for his role:

“I wanted to write to you in the context of my association with the CICB and thank you and apprise you of the invaluable service provided by this board and the individuals I have encountered in my experience...”

“[A CICB staffer] made me feel like she was there just for me, to answer my questions and streamline a rather complicated and seemingly cold ‘business process.’ ... As individuals hurting, such as myself, find themselves wrapped in sorrow ... the caring response on the other end makes a wonderful world of difference to our pain and confusion.”

The Out-of-Country Conundrum

When Suzanne Aucoin came to the Ombudsman's Office in 2007, she was fighting two battles: She was refusing to give in to stage four colon cancer and she was demanding that the Ontario Health Insurance Program (OHIP) pay for the treatment she had undergone in Buffalo, New York, through the Ministry of Health and Long-Term Care's out-of-country funding program.

SORT's investigation of Ms. Aucoin's situation and the workings of the out-of-country program found that OHIP's forms and procedures were all but impossible for even physicians to understand, there was little explanation given for its decisions and it was failing to communicate basic information to patients and their doctors. The Ombudsman likened it to handing patients a "Rubik's Cube" and leaving them to figure it out for themselves.

In Ms. Aucoin's case, the Ombudsman recommended that she be reimbursed \$76,000 for her medical and legal fees. He also recommended an overhaul of the entire program. The Ministry agreed and, with the matter thus resolved, no formal report was issued.

The Ministry hired two external consultants and their review of the program was completed in the summer of 2007. A copy of their report was provided to the Ombudsman. Among the changes now in place are a redesigned website that makes more information about the out-of-country program available to patients and their physicians, and in more accessible language. The Ministry has revised the letter it sends to doctors who apply to the program on their patients' behalf, giving clearer reasons and fuller explanations to those whose applications are denied. Updated information about the program was also sent to physicians, hospitals, clinics and laboratories in an OHIP bulletin.

Sadly, Ms. Aucoin lost her battle with cancer in November 2007. "Her challenges to the system led to changes that ended up being far wider and deeper than I think she ever imagined," the Ombudsman said in a tribute in her hometown newspaper, the *St. Catharines Standard*. "She had a real sense that she had turned the system on its head and had accomplished something ... I think she's saved a lot of people from going down that same agonizing bureaucratic maze."



Suzanne Aucoin

Losing the Waiting Game

In May 2006, the Ombudsman released a report on SORT's investigation into delays in processing applications for disability benefits through the Ontario Disability Support Program (OSDP), specifically in its Disability Adjudication Unit (DAU).

The report, *Losing the Waiting Game*, featured the story of Lyndsey Aukema, a severely disabled young woman whose parents applied for disability benefits a month before her eligibility date – her 18th birthday. But the DAU was so backlogged, the application was not approved until seven months later. What's more,



the regulations governing the program limited retroactive payments to just four months, no matter how long it may have taken to process the application. The Aukemas lost out on three months' worth of payments – about \$2,500 – because of the DAU's own delays.

The family was far from alone. SORT uncovered Ministry of Community and Social Services statistics showing 4,630 disabled individuals lost out on at least \$6 million in benefits because of this unfair regulation between April 1, 2004 and December 31, 2005.

The Ministry revoked the regulation within a week of receiving the Ombudsman's report, and three months later, Cabinet approved a \$25-million fund to reimburse some 19,000 ODSP applicants who had similarly lost out on benefits due to bureaucratic delays. By the end of the 2006-2007 fiscal year, it reported the backlog had been eliminated and a new "service standard" set of 90 days to adjudicate applications, but it was continuing to assess claims of disabled Ontarians who were still owed benefits.

According to the Ministry's latest update to the Ombudsman, as of the end of January 2008, another 11,399 disabled applicants had been compensated, to the tune of about \$10 million. The Ministry had also conducted its own "due diligence" audit and found an additional 2,800 cases potentially eligible for compensation, which it is reviewing. ODSP clients who feel they may have lost out on benefits may still come forward.

Complaints to the Ombudsman's Office about ODSP in general have declined significantly in the past year, to just over 600, down from about 1,000 last year.

Getting it Right

The province immediately imposed a two-year freeze on property tax assessments in the wake of the Ombudsman's report on the Municipal Property Tax Assessment Corporation (MPAC) in March 2006. With that freeze being lifted in 2008, Ontarians will see for the first time the effects of the dramatic reforms put in place by both MPAC and the Ministry of Finance in response to the Ombudsman's 22 recommendations – all of which were accepted.

Over the past two years, MPAC has acted to address the findings in the Ombudsman's report, *Getting it Right*, which criticized its practices and procedures as being unfair to property owners, secretive and even "cutthroat." SORT has monitored the progress of these improvements and has also noted a significant drop in complaints about MPAC during the freeze – from 916 in fiscal 2006-2007 to 131 in fiscal 2007-2008. The initial investigation dealt with some 4,000 complaints.



In March 2008, MPAC reported to the Ombudsman that it had fully implemented 13 of the recommendations and had taken action on the rest. Its plan is to have all the recommendations implemented in time for the mailing of property assessment notices in the fall of 2008. In May, MPAC staff outlined proposed alternatives for implementing two of the Ombudsman's recommendations. Improvements completed by MPAC so far include changes to its forms, a much more informative website that allows property owners to access things such as statistics on comparable properties, and public statements in its literature such as, "If an error has been made, we will correct it."

The government announced a number of changes to the property tax assessment system in its March 2007 budget, including a new four-year reassessment cycle and a four-year phase-in of increases. However, until recently there had been very little movement with respect to the Ombudsman's key recommendation – reversing the onus in the assessment appeal system so that it is up to MPAC to prove that its assessments are accurate, rather than the onus being on the property owner to prove they are not.

The Ombudsman wrote to the Ministry in January 2008 requesting an update on this matter. The Minister of Finance met with the Ombudsman in March 2008 and briefed him on proposed legislative changes, including placing the onus on MPAC to prove the accuracy of property assessments that are appealed to the Assessment Review Board. **These changes became law on May 14, 2008.** In addition, the government will make changes to the assessment appeal system and is working with MPAC and the ARB to release more comprehensive valuation information to property owners about their assessments, starting in the 2009 taxation year.

The Right to Be Impatient

Ontario's program for screening newborn babies for disease and inherited disorders has improved dramatically since the Ombudsman's report on the program, *The Right to Be Impatient*, was released in September 2005. As Premier Dalton McGuinty has said repeatedly, Ontario's program has gone from being "one of the worst to one of the first."

When the Ombudsman's investigation was announced in August 2005, the province was screening for just two disorders – well short of most industrialized countries. At that time, an estimated 50 children per year were dying or becoming severely disabled due to disorders which could have been detected and treated soon after birth, had the program been expanded.

The province immediately committed to dramatically expanding testing, and by the end of last year, screening for 27 conditions was underway. The program continues to expand. On April 6, 2008, Ontario became the second province in Canada (after Alberta) to test for cystic fibrosis, bringing the total number of tests to 29.



DECEMBER 5, 2007:

Secretary of Cabinet Tony Dean addresses participants in SORT's "Sharpening Your Teeth" course.

ONGOING SORT ASSESSMENTS

Although Ontario's Ombudsman, unlike all his other provincial counterparts, does not generally have jurisdiction over hospitals, this changes when the government appoints a supervisor. Over the past fiscal year, several hospitals have been taken over by provincial supervisors, meaning the Ombudsman has been able to investigate complaints about those hospitals. In the two cases below, SORT has assessed complaints but a formal investigation is on hold as the Ombudsman monitors the supervisors' progress in dealing with the problems raised.

The Scarborough Hospital

On July 30, 2007, the province appointed a supervisor for The Scarborough Hospital. Within days, SORT received a lengthy submission from a lawyer raising concerns on behalf of almost 30 patients claiming to have suffered post-operative complications as a result of surgery performed by a physician at Scarborough General Hospital (part of The Scarborough Hospital). Civil proceedings were initiated in about eight of these cases. Similar allegations were raised by another 15 patients who contacted the Ombudsman's Office directly. All were women complaining about the hospital allowing this doctor to continue to operate despite the serious allegations raised against him.

SORT investigators reviewed documentation from several sources before meeting with the supervisor and senior staff in October 2007. The supervisor advised that the physician had not performed surgery at the hospital since May 2007, although he has been assisting with surgery, at all times under another physician's supervision.

The supervisor has kept SORT up to date about a number of systemic and policy changes taking place at the hospital to improve such things as the handling of public complaints and feedback about physicians' performance. SORT is in regular contact with the supervisor about the progress of these changes.

William Osler Health Centre

The province appointed a supervisor for the William Osler Health Centre on December 31, 2007. Nine days later, an MPP requested that the Ombudsman investigate several issues at Brampton Civic Hospital, part of the William Osler complex, including emergency room wait times, staff shortages and poor communication with patients. SORT was assigned to conduct an assessment of the issues raised, as well as eight complaints received from the public.

On January 30, 2008, SORT investigators met with the supervisor, the hospital's patient ombudsman and other senior staff. The supervisor noted that the Auditor General would also be conducting an audit of the "P3" – i.e., public-private partnership – aspects of the hospital, which is Ontario's first hospital built through such a partnership.

The supervisor also outlined several initiatives that the hospital had undertaken to address issues raised by the public and in the media, including the creation of an independent panel to review patient concerns, internal reviews of the hospital's human resources and information technology needs and its communications with the community. As well, a consultant was hired to conduct an independent review of patient safety and best practices.

Based on SORT's assessment, and given the ongoing initiatives by the supervisor as well as the Auditor General's probe, the Ombudsman decided not to launch a full investigation at this time but to continue to receive and monitor complaints about the hospital.

CASE SUMMARIES

MINISTRY OF THE ATTORNEY GENERAL

Arresting Development

A 60-year-old man called the Ombudsman's Office from the Toronto Jail, insisting he had been arrested by mistake. He said he had been ill and missed his court date for driving with a suspended license, for which he was convicted in absentia and given a \$6,000 fine. But he had since filed all the necessary paperwork with the court clerk for a new court date.

Instead, three weeks later, two police officers came to his home and took him to jail, where he faced a sentence of 30 days plus two months' probation. He had no lawyer present and was told he could not get legal aid to deal with a driving offence.

The man had already been in jail for six days when he called the Ombudsman's Office. When our repeated requests to get him access to legal counsel failed, we asked the provincial prosecutor on his case to review the file. The Crown discovered there was indeed a mistake – the court clerk had never told the man that his conviction in absentia included a 30-day jail term in addition to the fine, much less that he risked being arrested if he didn't make bail arrangements immediately.

Once this error was discovered, the necessary papers were drawn up and the man was granted bail the next day, pending his new court date. As soon as he was free, he called the Ombudsman's Office to thank staff for their help.

Change of Address

Ms. L's 83-year-old mother suffered from dementia and had recently moved into a long-term care facility. Her financial affairs were being handled by the Office of the Public Guardian and Trustee (PGT). Ms. L discovered that the PGT had failed to give notice of her mother's change of address to her former landlord – and as a result, she had been paying rent on her old apartment for several months, on top of the fees for her new residence at the long-term care facility.

When contacted by the Ombudsman's Office, the PGT explained it had had a backlog that had since been cleared. Ms. L's mother was reimbursed \$931.



MINISTRY OF COLLEGES AND UNIVERSITIES

A Matter of Degree

A learning-disabled man who was enrolled in college as a mature student had been taking courses since 1999, repeating several of them until he successfully passed. When he finally completed enough courses to apply for his diploma, he was shocked to discover the college had a policy that courses must be completed within a four-year time limit. He complained to the college registrar, but the decision to deny him his college degree remained unchanged.

That's when he decided to reach out to the Ombudsman's Office. Upon our request, the college reviewed the man's records and agreed it was unlikely that he had ever been advised of the requirement to complete the courses within a four-year limit. It sent him a letter of apology and better still, awarded him his diploma.



MINISTRY OF COMMUNITY AND SOCIAL SERVICES

Fostering Confusion

Ms. C called the Ombudsman's Office at her wit's end, after a decade-long battle with a children's aid society (CAS). In 1992, she became a foster parent for two brothers, both with special needs, aged 1 and 2. The CAS that placed the boys with her paid her the standard foster parent fee for their care.

But in January 1998, Ms. C received a letter from the CAS stating that the legal custody of the boys had been transferred to her – therefore, the boys were discharged from CAS care and she would no longer receive payments for being a foster parent. Ms. C was stunned – she said there had been no such custody order and she was not the boys' legal parent. Her repeated complaints to the CAS and Ministry of Community and Social Services went unheard; meanwhile, she continued to care for the boys, not wanting to abandon them.



Our investigation discovered the CAS had done an independent review of the case and in 2006 had offered Ms. C a settlement of \$10,000, which she rejected. We interviewed several ministry staff and pressed for some documentation of their position that the woman had been given legal custody of the boys. The Ministry undertook a six-month mediation process, during which it offered the woman \$7,800, also rejected.

After further discussions with our Office, the Ministry advised it was considering compensating the woman for caring for the boys all these years, at the normal rate the CAS would have paid her as a foster parent. In December 2007, it offered Ms. C full compensation in the amount of \$184,299.

Help at Last

A woman in a tragic situation contacted our Office for help. She was on welfare, she had two severely disabled children and her husband was dying of cancer. She was receiving only \$25 a month in aid for her disabled kids and on top of all this, the Family Responsibility Office (FRO) was clawing back half of her husband's unemployment benefits because of an old debt.



A few phone calls from Ombudsman staff determined this family had fallen through the cracks of several agencies that could have helped them. We explained her situation to a manager at the Assistance for Children With Severe Disabilities Program (ACSD), who determined that they could reimburse her for thousands of dollars in expenses she had already incurred. Her monthly entitlement was also increased.

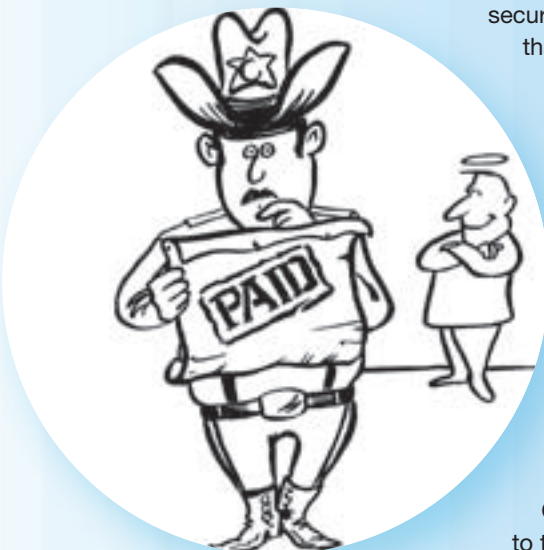
We also asked the Disability Adjudication Unit to process her husband's application for disability benefits on a priority basis, which it did in less than five business days. We also contacted staff at the Social Assistance and Municipal Operations Branch of the Ministry of Community and Social Services, who asked Ontario Works to waive the husband's old debt of \$1,288, thereby ending the FRO clawback of his unemployment benefits.

Three days later, the family had received a \$2,420 ACSD reimbursement, the husband's debt was waived and his disability benefits had begun, and ODSP was paying the mother \$1,438 a month – a huge difference for a family in dire straits.

FAMILY RESPONSIBILITY OFFICE

The Writ that Time Forgot

In September of 2000, Mr. P paid \$1,600 that he owed in child support. But unbeknownst to him, in July of that year, the Family Responsibility Office (FRO) had filed a Writ of Execution against him to secure the debt. This was filed with the Sheriff's Office that September, even though by that time FRO's records indicated Mr. P's debt was clear.

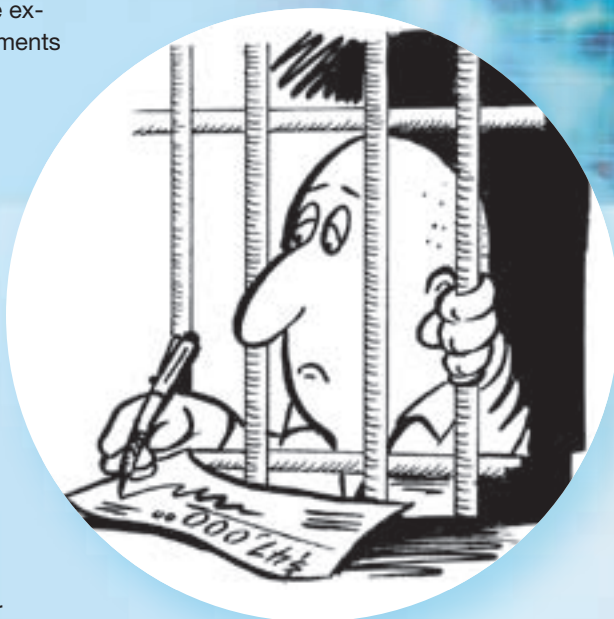


In March 2007, Mr. P attempted to refinance his mortgage and discovered that there was a seven-year-old writ filed with the Sheriff's Office – indicating he now owed \$6,900. FRO staff told him his file was closed and they would not discuss it further.

With just five days to go before his refinancing deadline, Mr. P contacted the Ombudsman's Office, and FRO staff gave us the same story – they had no record of a writ. Only when we faxed a copy of the actual writ to them did they acknowledge its existence – and they quashed it three days later, in time for Mr. P's refinancing. The FRO sent him a letter of apology.

Gotcha!

A mother of two young children whose ex-husband had defaulted on his support payments couldn't believe he was getting away with it. A final default order had been issued in September, threatening him with jail, but now it was December and nothing had happened. His employer was supposed to remit up to 50% of his income to the FRO, but she suspected this wasn't happening, and she was desperately afraid he was going to leave the country. She also complained that she had never been able to speak to the FRO staff person handling her case.



Ombudsman staff discovered that the necessary paperwork had never been drafted after the man's last court appearance – so no steps had been taken to incarcerate him for non-compliance. Nor had the FRO done anything to seize the man's driver's license and passport. FRO staff could not explain this delay, but at our request, they contacted the woman directly, and also the man's employer, who sent the FRO an immediate payment of \$2,371.

Once the FRO completed the paperwork, it followed through on the court order and the man was incarcerated. He quickly made a payment of \$47,000 – about one-third of what he still owed.

ONTARIO DISABILITY SUPPORT PROGRAM

Better Late than Never

A son complained that it took two years for his father to be transferred from the Ontario Works Program to the Ontario Disability Support Program (ODSP). Yet once the transfer was finally made, ODSP would not grant the man retroactive benefits. What's more, he was told he could not appeal because he had missed ODSP's 15-day deadline for requesting an internal review.

The Ombudsman's Office contacted ODSP and the Ministry of Community and Social Services with respect to the delay in transferring the man's case from Ontario Works. ODSP determined it could grant the man retroactive benefits of \$6,000, covering the two-year gap. The son wrote a thank-you card to Ombudsman staff, urging us to "keep up your good work speaking for those who cannot speak for themselves."

ADOPTION DISCLOSURE REGISTER

O Brother, Where Art Thou?

In the hopes of making contact with her brother who was given up for adoption at birth, a woman listed her personal information with the province's Adoption Disclosure Register (ADR). When the search turned up nothing, she suspected it had not been done properly.



Ombudsman staff discovered the birth mother's name had in fact been spelled incorrectly in ADR records, preventing an accurate match. But while the ADR acknowledged the error, it still would not give out any information about the brother because the legislation on adoption records had now changed, and the woman's request no longer fit its criteria.

The woman argued that she had made her request prior to the change and she shouldn't be penalized for the time it took the ADR to discover its own mistake. The Ombudsman's Office asked that special consideration be given in this case. The ADR agreed and located the woman's brother, who was happy to meet his long-lost sister.

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

When a Prisoner Calls

Following up on complaints from a number of female prisoners and an advocacy group, Ombudsman investigators conducted a surprise inspection of the Central East Correctional Centre (CECC) in the winter of 2008. Although we found no evidence of overcrowding during the inspection, our investigation found evidence of female inmates who had a history of sexual abuse and mental illness being placed in the men's unit at least twice in early 2007, due to a lack of space in the women's unit. We also determined that emergency call buttons in the women's unit had been disabled, leaving them unable to call for help in a medical emergency.

The CECC told our Office overcrowding was rarely a problem after the number of women's beds was increased in June 2007, but its officials initially would not give us assurance that they would no longer place women in the men's unit. As for the call buttons, which are used in other correctional facilities, CECC staff deemed them unnecessary and a potential "nuisance," saying the women's unit was patrolled twice an hour.

Our investigation, however, found that it is virtually impossible to hear noise from within a cell, unless a guard is very close by. In one 2007 case, a woman suffered an epileptic seizure alone in her cell and pressed the call button desperately before she became unresponsive.

As a result of our investigation and discussions with the Regional Director, the Ministry committed to activating the call buttons in the women's cells. The Ministry also committed to ensuring that women would only be housed in men's segregation cells as a last resort and with the prior approval of the Regional Director's Office.

MINISTRY OF GOVERNMENT AND CONSUMER SERVICES

Your Call is Important to Us

A mother who telephoned the Office of the Registrar General (ORG) about a birth certificate for her son was put on hold – for 3 hours and 15 minutes – even though the pre-recorded message on the line said the wait would be 20-30 minutes. While she was on hold, she used her cell phone to call the Ombudsman's office. She explained that the ORG had previously attempted to deliver the certificate to her by courier, but she had been unwell and unable to pick it up from the courier depot, so it had been returned.

The Ombudsman's Office asked the ORG to call the woman directly. The ORG had her confirm her mailing address and sent her the birth certificate. The mother was so pleased, she called a Toronto radio show regarding her experience, telling the host the Ombudsman's office had managed to settle the matter in less time than she had waited on hold.



Playing Your Cards Right

A run of bad luck prompted a man to call the Ombudsman's Office: He had lost his wallet, and was waiting for a replacement birth certificate to arrive from the Office of the Registrar General (ORG). Then he had an accident and required surgery – but his health card had expired and the Ontario Health Insurance Program (OHIP) told him he couldn't get a new one without a birth certificate.

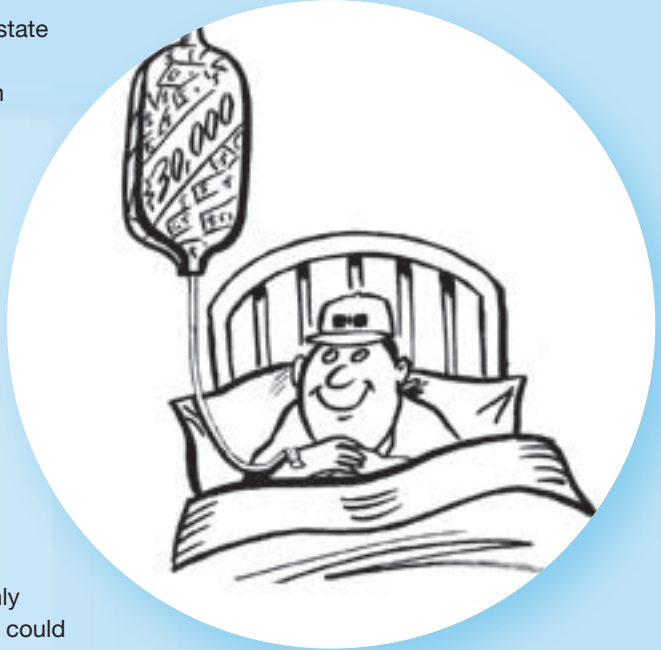
Our staff found out from the ORG that the man's birth certificate application had been stalled because of some missing information, which we asked him to provide immediately. Meanwhile, we determined that OHIP did not need a birth certificate to renew his health coverage, as it was already on file – all he needed to provide was proof of his identity and residence. The man received both documents shortly thereafter.

MINISTRY OF HEALTH AND LONG-TERM CARE

A Costly Guess

A patient diagnosed with prostate cancer was turned down by the Ontario Health Insurance Program (OHIP) for a surgical procedure that he and his physician believed to be available only in the United States. After spending \$40,000 on the U.S. surgery, however, the man learned that it had in fact been available in Ontario. OHIP officials had failed to inform him of this.

The Ombudsman investigated and found that OHIP's letter of denial was too vague for either the patient or his physician to understand; it certainly did not make it clear that the man could have had the surgery at home. Presented with the Ombudsman's findings, the Ministry of Health and Long-Term Care agreed to reimburse the man for 75% of his costs, or \$30,000.

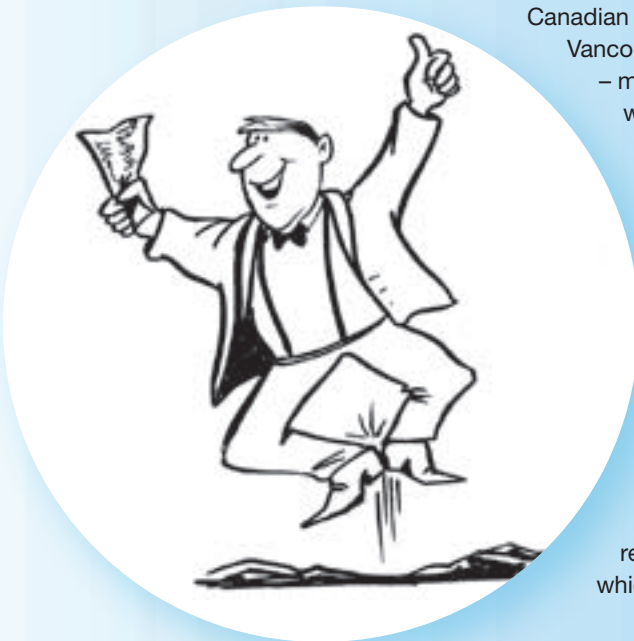


A 'Private' Matter

After a decade of unsuccessful treatments and pain, Mr. J's orthopedic surgeon recommended that he have ankle replacement surgery. Since the local wait time was three years, the man was granted \$35,000 through OHIP's out-of-country funding program to have the procedure performed in the U.S. – but one month before the scheduled operation, he was turned away because the implants he needed were no longer approved by U.S. authorities.

The U.S. surgeon referred Mr. J to a Canadian colleague at a private clinic in Vancouver, where the surgery cost \$19,463 – much less than in the U.S. But OHIP would only reimburse him \$1,066 – the fee for the B.C. physician's services – because it deemed the other fees charged by the B.C. private clinic ineligible for coverage.

The Ombudsman's investigation determined that reciprocal agreements between the provinces do not cover reimbursement for costs of prosthetic devices. However, the Ministry of Health and Long-Term Care reviewed the case and agreed to reimburse Mr. J an additional \$12,915, which he accepted.



The Right to Know

Mr. D's family was concerned that the long-term care home he was living in was not meeting the standards of care set out by the Ministry of Health and Long-Term Care. The Ministry investigated the family's concerns and advised them it had required the facility to fix things – but it would not give further details.

Family members obtained a copy of the Ministry's report on the case through its Access and Privacy Office, but when they could not convince the Ministry to review their concerns, they asked the Ombudsman's Office to, essentially, investigate the Ministry's investigation.

Through our Office's intervention, the Ministry met with the family and agreed to investigate two new complaints they raised. When it again failed to share its report with them, the family complained again to us. In the end, the Ministry provided our Office and the family with a copy of its investigation report. It also advised that it would provide more information in similar circumstances in future.

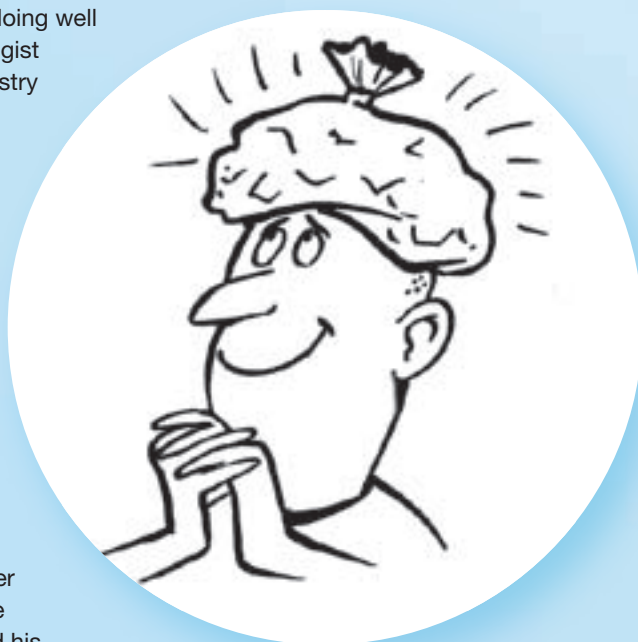


Fast-Acting Relief

A man who suffers from a rare and debilitating disorder that causes more than 50 severe headaches a day was doing well on a combination of drugs prescribed by his neurologist – one of which required special approval by the Ministry of Health and Long-Term Care for coverage.

The man had been taking the drug for three years, but in the summer of 2007, when it came time to renew its approval, the Ministry asked for more information on the drug's effectiveness from the man's doctor. Unfortunately, the doctor was away on vacation, the approval for reimbursement expired and, since the man could not afford the drug himself, his headaches returned.

The Ombudsman's Office contacted the Ministry on the man's behalf and within a day, it agreed coverage for the drug would be grandfathered on compassionate grounds for another 3-5 years. The man was so happy with this result, he referred to the Ombudsman staffer who had handled his complaint as a "miracle worker."



TRILLIUM DRUG PROGRAM

Happy Customer

A university student tried for two years to obtain reimbursement of thousands of dollars in medication costs from the Trillium Drug Program. He had sent in all his information and receipts in 2005, but when he called in 2006 to ask why he had not heard back, he was told Trillium had moved and his receipts had apparently been lost. Staff said they would look into his case and contact him.

Several months later, with no word from Trillium, he sent in duplicates of his original receipts. When Trillium then denied his claim because the receipts were too old, he contacted the Ombudsman.

Our Office called Trillium and explained the man's situation. Within a month, he received a reimbursement of \$5,274.

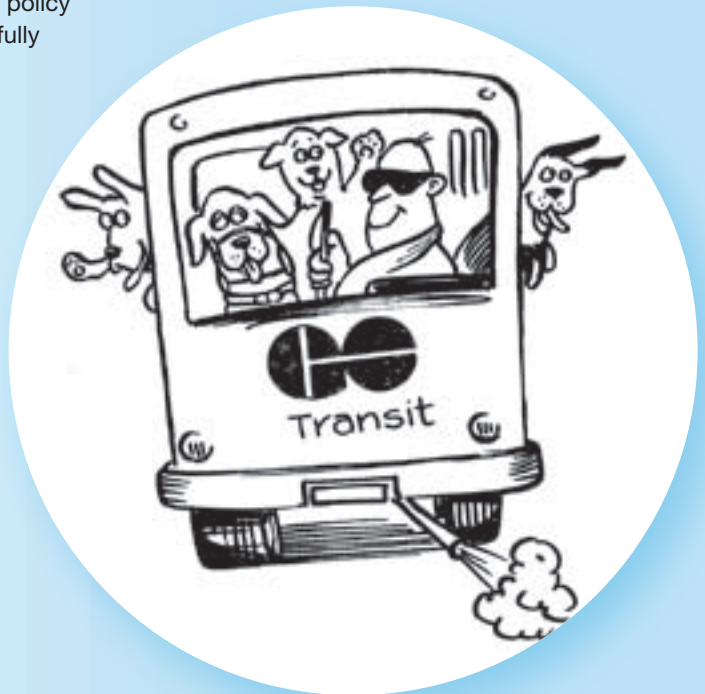
MINISTRY OF TRANSPORTATION

GO-ing to the Dogs

A visually impaired man who relies on a guide dog was denied access to a GO Transit bus on two occasions because the bus driver was allergic to dogs. Despite his complaints to GO, the man and his guide dog were again denied access by the same allergic driver.

GO officials advised the man that they would make special arrangements for him if he notified them in advance of his travel plans. The man argued that this was unfair to him and other guide dog users, who should be able to board any bus at any time.

The Ombudsman's Office contacted GO and pointed out that its stated policy indicated that its services are fully accessible to persons with guide dogs. GO officials said "operational decisions" had been made in the man's case, but they would not amend their website to tell the public that sometimes people in such situations might have to make alternative arrangements. After more discussions, GO implemented an internal initiative to ensure that all persons with companion animals would enjoy the same access to GO buses as anyone else, without prior notice.



ADMINISTRATIVE TRIBUNALS

In the Public Eye



Mr. G complained that the Ontario Labour Relations Board (OLRB) had posted its decision in his case on its website for all to see – without informing him.

Ombudsman staff discovered that he was not alone – applicants and respondents before the OLRB were not generally notified that the decisions in their cases were accessible by the public through its website and other sources.

The OLRB agreed to amend its forms – more than 80 of them – to let people know that its hearings are open to the public, unless otherwise decided by the panel, and that its decisions, which may include the names and personal information of those appearing, are available from a variety of sources, including the website.

Money in the Kitty

The owner of a missing cat was relieved to find it at the local animal shelter. But before he could take the cat home, he had to pay for the food, care and treatment that had been provided. He was also ordered by the Ontario Society for the Prevention of Cruelty to Animals (OSPCA) to continue the veterinary care the cat had been receiving while at the shelter.

Believing some of the veterinary expenses to be unnecessary, the man asked the Animal Care Review Board (ACRB) to revoke the order and have him reimbursed. During the board's proceedings, the OSPCA expressed concerns about the health of the cat and the man agreed to take it to a vet. Upon receiving the vet's report, the OSPCA revoked its order, meaning the ACRB no longer had jurisdiction to hear the man's appeal, or deal with the issue of his costs.

The man contacted the Ombudsman and after our discussions with them, the ACRB and the Ministry of Community Safety and Correctional Services offered the man \$300. To avoid similar situations, the ACRB is using this case as a training tool for staff regarding the importance of explaining its process and jurisdiction to the public.

YOUR FEEDBACK

“The Ombudsman has reinforced for us that our obligation to the citizens of Ontario to preserve and protect the public interest at all times is the foundation of everything that we do.”

– Ontario Lottery and Gaming Corporation final report to Ombudsman, March 28, 2008

“Mr. Marin, I commend you and the Ontario government for not only providing this service but ensuring that the individuals assigned to these roles have the knowledge, compassion and desire to serve those of us who need it at these most desolate times in our lives.”

– Mother of a murder victim, regarding improvements to the Criminal Injuries Compensation Board

“I can tell you from observing the Ombudsman’s work with a number of ministries and in a number of investigations, he and his staff operate with a sense of dispatch. They tend to leave no stone unturned; they are extremely thorough. He delivers meaty recommendations. Some of those reports are tough, but he’s there for a good reason, for a good public purpose: he adds public value. We learn a lot from him.”

– Tony Dean, Secretary of Management Board of Cabinet, speaking to Standing Committee on Estimates, May 1, 2007

“We greatly appreciated the time you spent with us listening to our complaints, plus the respect you showed us.”

– Complainant

“It’s refreshing to see that there are still public servants out there willing to go the extra mile to help.”

– Complainant

“Thank you from the bottom of my heart for everything you have done for me and for putting a smile on my face in dark days.”

– Complainant

“The Ontario Ombudsman’s office seems to excel in putting human faces to the myriad problems caused by bureaucracy, i.e. re-humanizing the process.”

– Participant in Special Ombudsman Response Team’s “Sharpening Your Teeth” training course

“Ombudsmanship has never been more refreshing.”

– Participant in Special Ombudsman Response Team’s “Sharpening Your Teeth” training course

“You people are truly workers for the little guy (and girls).”

– Complainant

“He’s the most colourful ombudsman I’ve been involved with and certainly a force to be reckoned with.”

– Greater Sudbury City Councillor Doug Craig, as quoted in the Sudbury Star, January 18, 2008

“[The Ombudsman] takes no prisoners and that is what municipalities need ... he’s a pit bull.”

– Sarnia Mayor Mike Bradley, as quoted in the London Free Press, Nov. 28, 2007

“Your report reflects the sentiments of many civil servants inside the OPS. We resent the ‘puffery’ language we are forced to use and listen to from senior leaders. Carry on!”

– A public servant re: 2006-2007 Annual Report

“You have, once again, provided a comprehensive report, which contains the very high standard of response expected of those of us who serve the Ontario public.”

– Hon. Leona Dombrowsky, Minister of Agriculture, Food and Rural Affairs, re: 2006-2007 Annual Report

“We would like to express our gratitude for everything that you have done in favour of homeowners and low-income families regarding MPAC... It has been hard for all of us, since we are already paying more than we should or can afford... We have confidence in your justice and humanity to continue to help us, as you have been doing thus far. It is a shame that there are not more men like you in public office.”

– Letter from a group of pensioners

“The citizens of Ontario should be grateful and appreciative of the integrity, capability and dedication being shown by all the staff at your office in the conduct of this work.”

– Complainant re: MPAC

YOUR FEEDBACK

IN THE MEDIA

“In less than three years as ombudsman, Marin has had a huge impact in Ontario. In that short time, he has arguably done more for Ontarians than anyone else.”

— Alan Shanoff, *Toronto Sun*, March 9, 2008

“Marin has been charged with an important task in this province, and has proven adept at bringing accountability to agencies and ministries which have strayed off the path. There is no reason for the government to deny him investigating any complaints about the government.”

— *Sarnia Observer* editorial, June 28, 2007

“Ontario Ombudsman André Marin is a passionate and highly successful hunter of bureaucrats gone wild.”

— *Barrie Examiner* editorial, July 3, 2007

“Whichever party wins the Oct. 10 election should immediately start the legislative process in order to expand Marin’s jurisdiction.”

— *Toronto Star* editorial, July 3, 2007

“No matter which party wins the October 10 election, it should quickly examine plans to expand Mr. Marin’s office’s responsibilities.”

— *Pembroke Daily Observer* editorial, July 23, 2007

“We’ve said it before and we’ll say it again: This is the person we want looking out for the public.”

— *St. Catharines Standard* editorial, Nov. 24, 2007

“It’s not just the big scams that Marin has tackled. He is, in every sense, the voice of the Little Guy around here. When you’ve reached the end of your tether fighting heartless bureaucracy, Marin’s the guy you turn to.”

— Christina Blizzard, *Toronto Sun*, June 28, 2007

FAMILY RESPONSIBILITY OFFICE COMPLAINTS

“**M**ay I express my gratitude to you to my case.... for your diligent attention to my case.... In a period of only four weeks, the FRO has dealt with my case in a more professional manner. I question whether this information would have been provided as promptly without your assistance.... Thank you once again for your assistance and support.”

– Complainant

“I have little regard for most government organizations, like most Canadians I’m sure, but you have helped restore in me a little bit of faith in our system.”

– Complainant

“I just wanted to express my gratitude and appreciation for the efforts and understanding of your staff in resolving this matter. There is no doubt in my mind that I would not have been able to get the FRO to properly calculate the amount of support as mandated by my support order without your Office’s involvement.”

– Complainant

“**T**hank you for obtaining in two weeks what took me one year to achieve with the FRO.”

– Complainant

Your Feedback

YOUR FEEDBACK

HEALTH CARE

“I had no idea what the Office of the Ombudsman did, but it was suggested to me to try calling. I expected to have to go through an extensive menu, be asked to leave a detailed voice message, and then be told that the system is backed up and the wait time for assistance is 18 months... I cannot say thank you enough for the work the Office of the Ombudsman does for all of us who have slipped through a crack in the system.”

– Complainant re: Trillium Drug Program

“There is no doubt in my mind that I would be still be fighting for the money owed had it not been for the Ombudsman of Ontario Office's involvement...Your work is needed and appreciated.”

– Complainant re: Trillium Drug Program

“Thank you for giving [Suzanne Aucoin] and other people similarly discriminated against hope that they too can receive life-prolonging medical treatment and be treated fairly under OHIP.... Thank you for your courage and for your compassion.”

– Shirley Darling, Toronto

“I agree that citizens themselves need a voice. If a provincial ombudsman will do that, then I'm in full support.”

– Dr. Caroline King, as quoted in the Toronto Star, May 26, 2007

“It's one thing to put out the statistics, but bringing in an ombudsman who has the mandate to follow through...would be a good way to make sure hospitals that rate poorly take it really seriously and do something about it.”

– NDP Health Critic France Guelinas, as quoted in the Toronto Star, December, 1 2007

“We believe that patients across the health-care sector would benefit not only from the Ontario ombudsman's oversight but also from access to independent advocacy services.”

– Letter from David Simpson, Psychiatric Patient Advocate Office program manager, published in the Toronto Star, August 4, 2007

“It's about time that the Ontario ombudsman's mandate be expanded to include the power to investigate long-term care.”

– Letter from Janis Jaffe-White, Toronto Family Network co-ordinator, published in the Toronto Star, April 3, 2007

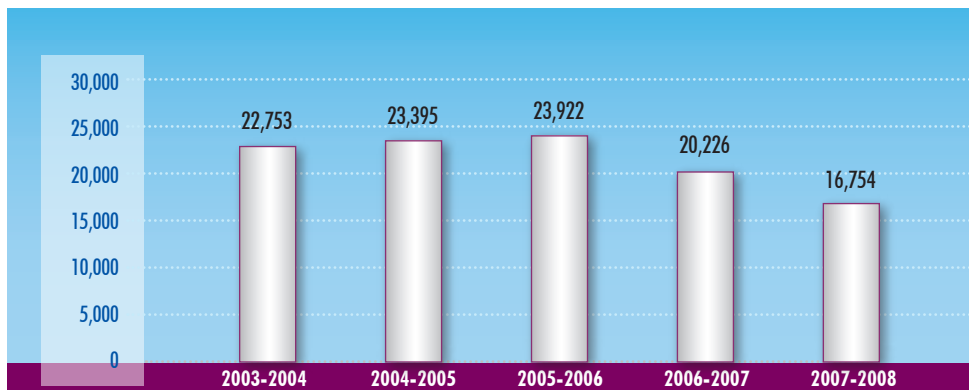
“It is time the provincial ombudsman had the power to investigate and oversee Ontario's nursing homes and hospitals.”

– Letter from Betty Miller, Guardian Angels Program, published in the St. Catharines Standard, May 16, 2007

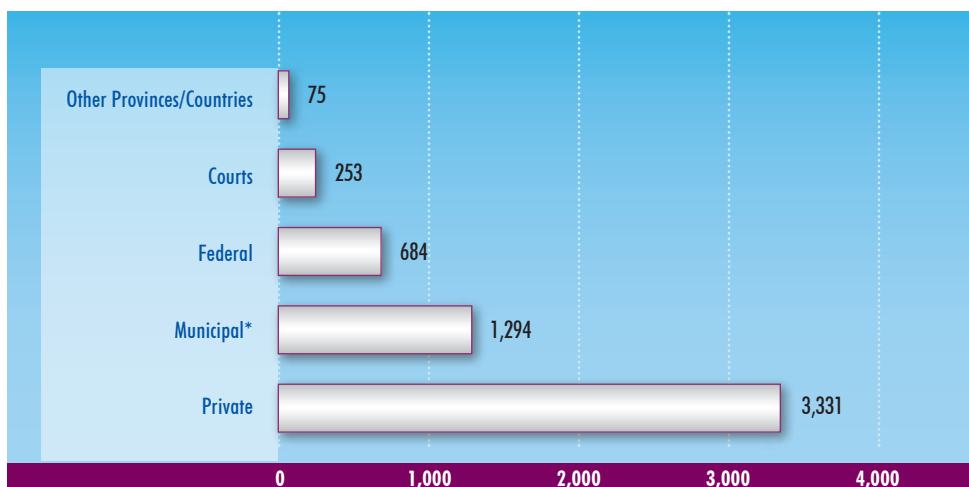
APPENDIX 1:

Statistical Overview of Complaints and Trends

TOTAL COMPLAINTS AND INQUIRIES RECEIVED
FISCAL YEARS 2003-2004 TO 2007-2008



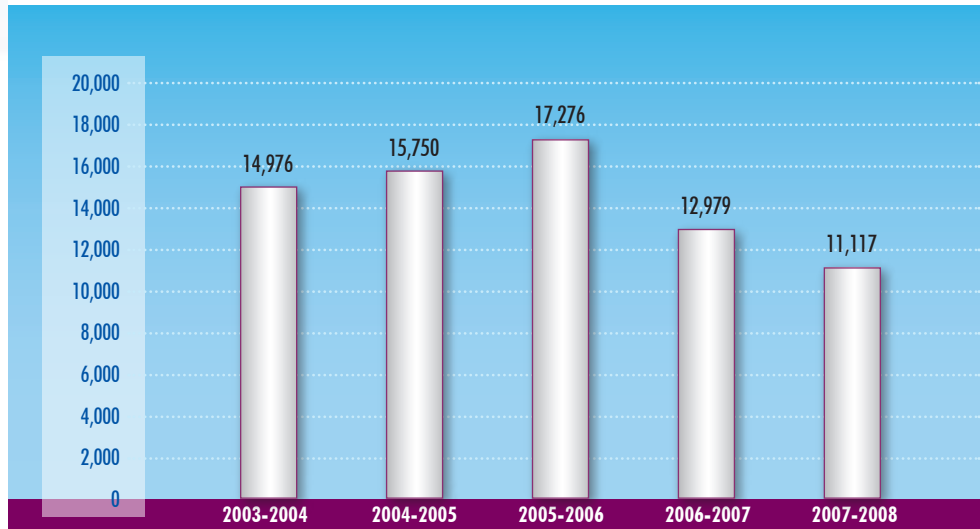
COMPLAINTS AND INQUIRIES OUTSIDE THE OMBUDSMAN'S
AUTHORITY RECEIVED 2007-2008 ■ TOTAL: 5,637



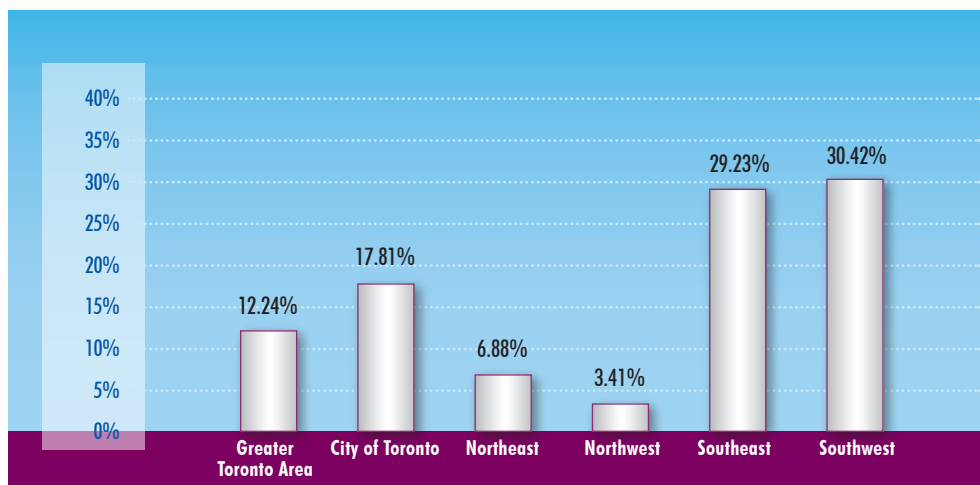
* Includes complaints and inquiries about municipalities, school boards and police.

APPENDIX 1: Statistical Overview of Complaints and Trends

COMPLAINTS AND INQUIRIES WITHIN THE OMBUDSMAN'S AUTHORITY RECEIVED FISCAL YEARS 2003-2004 TO 2007-2008



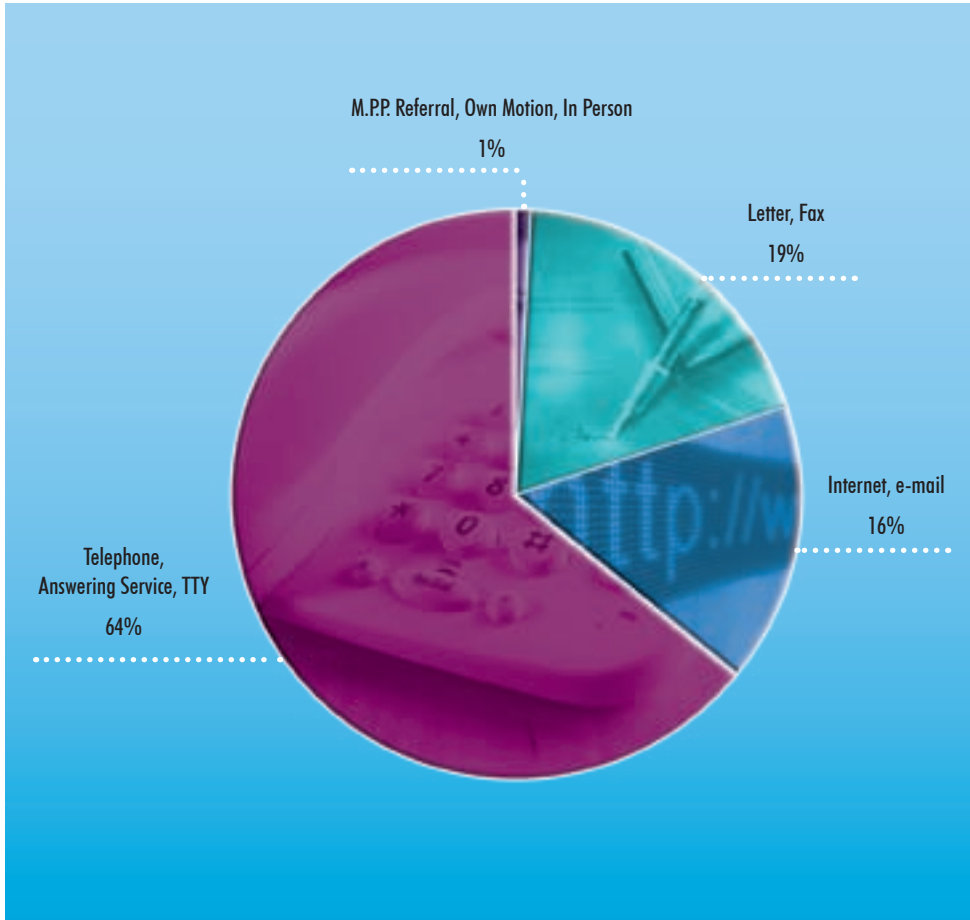
REGIONAL DISTRIBUTION OF COMPLAINANTS 2007-2008



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: Statistical Overview of Complaints and Trends

HOW COMPLAINTS AND INQUIRIES WERE RECEIVED 2007-2008



APPENDIX 1: Statistical Overview of Complaints and Trends

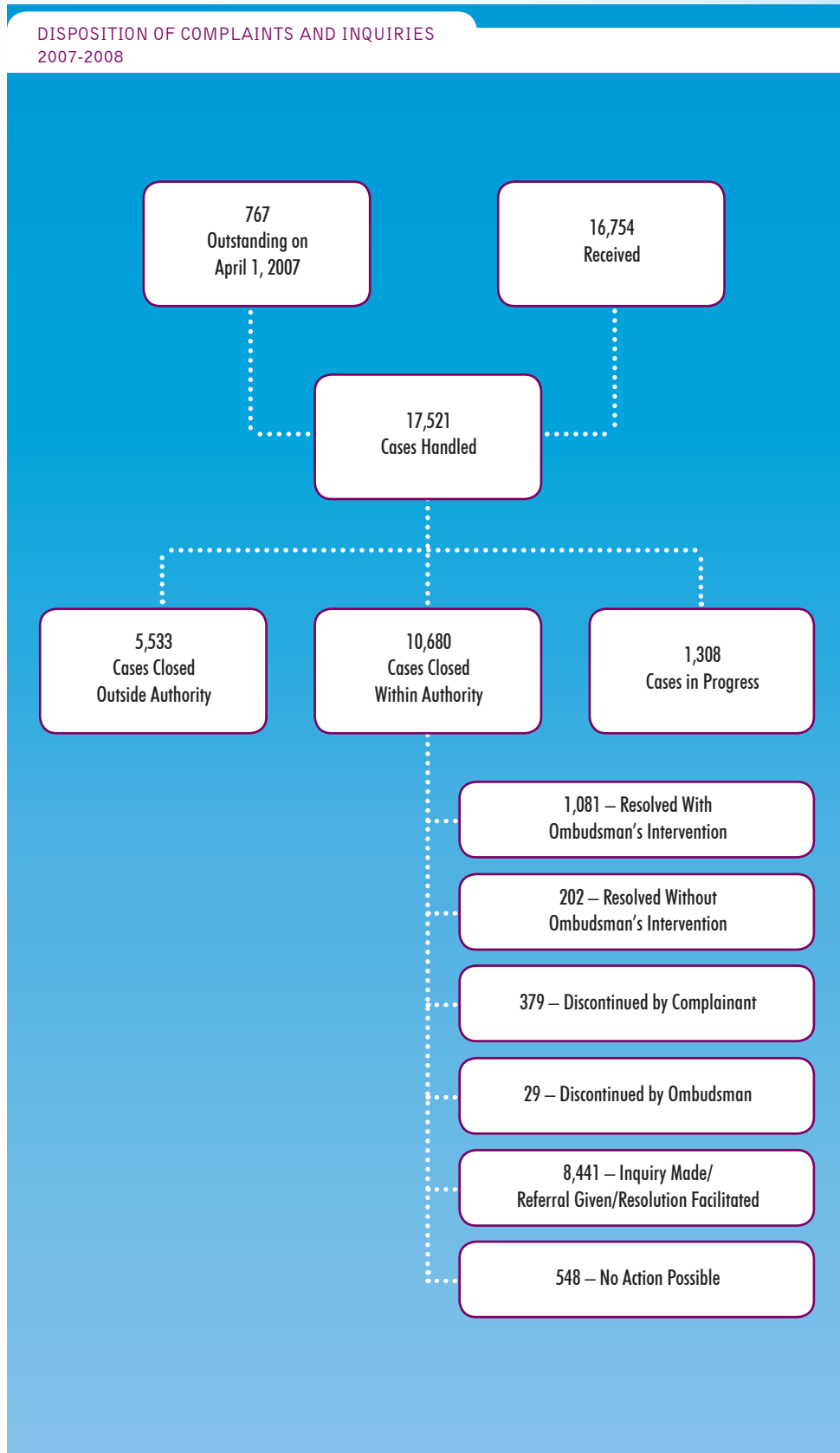
TOP 20 PROVINCIAL GOVERNMENT ORGANIZATIONS AND PROGRAMS COMPLAINED ABOUT IN 2007-2008

		Number of Complaints and Inquiries	Percentage Provincial Complaints and Inquiries
1	CENTRAL NORTH CORRECTIONAL CENTRE	806	7.29%
2	FAMILY RESPONSIBILITY OFFICE	769	6.96%
3	ONTARIO DISABILITY SUPPORT PROGRAM	620	5.61%
4	CENTRAL EAST CORRECTIONAL CENTRE	610	5.52%
5	WORKPLACE SAFETY AND INSURANCE BOARD	574	5.19%
6	MAPLEHURST CORRECTIONAL COMPLEX	378	3.42%
7	TORONTO WEST DETENTION CENTRE	344	3.11%
8	OFFICE OF THE REGISTRAR GENERAL	343	3.10%
9	OTTAWA-CARLETON DETENTION CENTRE	301	2.72%
10	TORONTO JAIL	235	2.13%
11	ONTARIO LOTTERY AND GAMING CORPORATION	233	2.11%
12	ELGIN-MIDDLESEX DETENTION CENTRE	218	1.97%
13	DRIVER LICENSING	215	1.94%
14	ONTARIO HEALTH INSURANCE PLAN	185	1.67%
15	VANIER CENTRE FOR WOMEN	185	1.67%
16	HYDRO ONE NETWORKS INC.	159	1.44%
17	ONTARIO HUMAN RIGHTS COMMISSION	142	1.28%
18	ONTARIO STUDENT ASSISTANCE PROGRAM	142	1.28%
19	LEGAL AID ONTARIO	141	1.28%
20	MUNICIPAL PROPERTY ASSESSMENT CORPORATION	131	1.18%

MOST COMMON TYPES OF COMPLAINTS INVESTIGATED 2007-2008

1	Failure of governmental organization to adhere to own processes, guidelines or policies or to apply them in a consistent manner
2	Adverse impact or discriminatory consequence of a decision or policy on an individual or group
3	Denial of service
4	Failure to adequately or appropriately communicate with a client
5	Unreasonable delay
6	Wrong or unreasonable interpretation of criteria, standards, guidelines, regulations, laws information or evidence
7	Insufficient reasons for a decision or no reasons given
8	Inadequate or improper investigation was conducted
9	Failure to provide sufficient or proper notice
10	Omission to monitor or manage an agency for which the governmental organization is responsible
11	Unfair settlement imposed
12	Harassment by a governmental official; bias; mismanagement; bad faith
13	Failure to keep a proper record

APPENDIX 1: Statistical Overview of Complaints and Trends



APPENDIX 1: Statistical Overview of Complaints and Trends

TOTAL COMPLAINTS AND INQUIRIES RECEIVED 2007-2008 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED ORGANIZATIONS *

Ministry	Selected Organizations	Organization Total	Ministry Total
MINISTRY OF AGRICULTURE AND FOOD			40
MINISTRY OF THE ATTORNEY GENERAL			716
	ASSESSMENT REVIEW BOARD	56	
	CHILDREN'S LAWYER	30	
	CRIMINAL INJURIES COMPENSATION BOARD	77	
	LEGAL AID ONTARIO	141	
	ONTARIO HUMAN RIGHTS COMMISSION	142	
	ONTARIO MUNICIPAL BOARD	18	
	PUBLIC GUARDIAN AND TRUSTEE	118	
	SPECIAL INVESTIGATIONS UNIT	50	
MINISTRY OF CHILDREN AND YOUTH SERVICES			146
	CHILD AND FAMILY SERVICES REVIEW BOARD	18	
	SPECIAL NEEDS PROGRAMS - CHILDREN	37	
	YOUTH FACILITIES	48	
MINISTRY OF COMMUNITY AND SOCIAL SERVICES			1529
	FAMILY RESPONSIBILITY OFFICE	769	
	ONTARIO DISABILITY SUPPORT PROGRAM	620	
	SOCIAL BENEFITS TRIBUNAL	71	
	SPECIAL NEEDS PROGRAMS - ADULT	17	
MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES			4739
	CORRECTIONAL CENTRES, DETENTION CENTRES, JAILS	4496	
	OFFICE OF THE CHIEF CORONER	30	
	ONTARIO CIVILIAN COMMISSION ON POLICE SERVICES	32	
	ONTARIO PROVINCIAL POLICE	66	
	PROBATION AND PAROLE SERVICES	35	
MINISTRY OF EDUCATION			61
MINISTRY OF ENERGY			212
	HYDRO ONE NETWORKS INC.	159	
	ONTARIO ENERGY BOARD	32	
MINISTRY OF THE ENVIRONMENT			54
MINISTRY OF FINANCE			219
	FINANCIAL SERVICES COMMISSION	39	
	MUNICIPAL PROPERTY ASSESSMENT CORPORATION	131	
	ONTARIO SECURITIES COMMISSION	12	
MINISTRY OF GOVERNMENT SERVICES			497
	ALCOHOL AND GAMING COMMISSION OF ONTARIO	28	
	LICENCE APPEAL TRIBUNAL	18	
	OFFICE OF THE REGISTRAR GENERAL	343	

* Ministry figures are for total complaints and inquiries relating to that ministry and its programs or agencies. Ministry totals may exceed individual organization totals, as only organizations receiving 10 or more complaints are listed.

APPENDIX 1: Statistical Overview of Complaints and Trends

TOTAL COMPLAINTS AND INQUIRIES RECEIVED 2007-2008 FOR
PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED ORGANIZATIONS *

Ministry	Selected Organizations	Organization Total	Ministry Total
MINISTRY OF HEALTH AND LONG-TERM CARE			580
	ASSISTIVE DEVICES / HOME OXYGEN PROGRAMS	26	
	COMMUNITY CARE ACCESS CENTRES	68	
	DRUG PROGRAMS BRANCH	70	
	HEALTH PROFESSIONS APPEAL AND REVIEW BOARD	18	
	HEALTH SERVICES APPEAL AND REVIEW BOARD	15	
	LONG-TERM CARE BRANCH	12	
	ONTARIO HEALTH INSURANCE PLAN	185	
	POSITRON EMISSION TOMOGRAPHY PROGRAM	25	
	SCARBOROUGH GENERAL HOSPITAL	30	
	WILLIAM OSLER HEALTH CENTRE	16	
MINISTRY OF LABOUR			850
	EMPLOYMENT PRACTICES BRANCH	56	
	OFFICE OF THE WORKER ADVISER	11	
	ONTARIO LABOUR RELATIONS BOARD	41	
	WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	114	
	WORKPLACE SAFETY AND INSURANCE BOARD	574	
MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING			155
	LANDLORD AND TENANT BOARD / ONTARIO RENTAL HOUSING TRIBUNAL	79	
MINISTRY OF NATURAL RESOURCES			95
	CROWN LAND	30	
MINISTRY OF NORTHERN DEVELOPMENT AND MINES			11
MINISTRY OF PUBLIC INFRASTRUCTURE RENEWAL			259
	LIQUOR CONTROL BOARD OF ONTARIO	19	
	ONTARIO LOTTERY AND GAMING CORPORATION	233	
MINISTRY OF REVENUE			22
	RETAIL SALES TAX	17	
MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES			321
	APPRENTICESHIPS / WORK TRAINING	13	
	COLLEGES OF APPLIED ARTS AND TECHNOLOGY	109	
	ONTARIO STUDENT ASSISTANCE PROGRAM	142	
MINISTRY OF TRANSPORTATION			431
	DRIVER LICENSING	215	
	HIGHWAYS	27	
	MEDICAL REVIEW	86	
	VEHICLE LICENSING	43	
ONTARIO GOVERNMENT			89

* Ministry figures are for total complaints and inquiries relating to that ministry and its programs or agencies. Ministry totals may exceed individual organization totals, as only organizations receiving 10 or more complaints are listed.

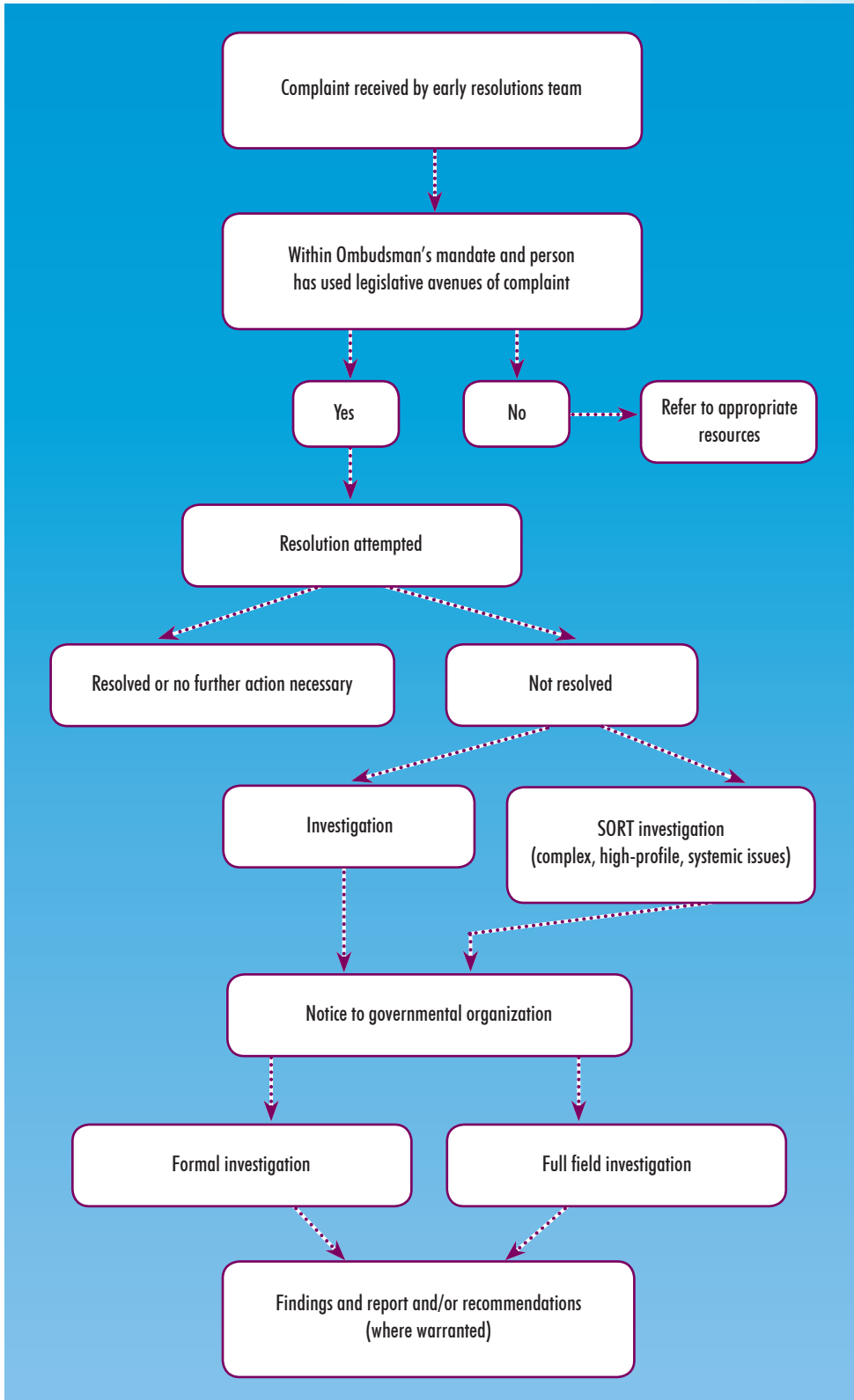
APPENDIX 1: Statistical Overview of Complaints and Trends

COMPLAINTS AND INQUIRIES RECEIVED 2007-2008 BY PROVINCIAL RIDING*

Ajax-Pickering	68	Niagara West-Glanbrook	54
Algoma-Manitoulin	147	Nickel Belt	74
Ancaster-Dundas-Flamborough-Westdale	69	Nipissing	237
Barrie	123	Northumberland-Quinte West	152
Beaches-East York	97	Oak Ridges-Markham	61
Bramalea-Gore-Malton	76	Oakville	96
Brampton-Springdale	43	Oshawa	117
Brampton West	66	Ottawa Centre	99
Brant	116	Ottawa-Orleans	321
Bruce-Grey-Owen Sound	139	Ottawa South	70
Burlington	121	Ottawa-Vanier	94
Cambridge	75	Ottawa West-Nepean	90
Carleton-Mississippi Mills	54	Oxford	64
Chatham-Kent-Essex	79	Parkdale-High Park	98
Davenport	84	Parry Sound-Muskoka	118
Don Valley East	63	Perth-Wellington	71
Don Valley West	65	Peterborough	93
Dufferin-Caledon	58	Pickering-Scarborough East	52
Durham	101	Prince Edward-Hastings	174
Eglinton-Lawrence	84	Renfrew-Nipissing-Pembroke	94
Elgin-Middlesex-London	326	Richmond Hill	58
Essex	164	Sarnia-Lambton	210
Etobicoke Centre	65	Sault Ste. Marie	316
Etobicoke-Lakeshore	131	Scarborough-Agincourt	62
Etobicoke North	405	Scarborough Centre	50
Glengarry-Prescott-Russell	63	Scarborough-Guildwood	99
Guelph	100	Scarborough-Rouge River	34
Haldimand-Norfolk	90	Scarborough Southwest	262
Haliburton-Kawartha Lakes-Brock	714	Simcoe-Grey	108
Halton	564	Simcoe North	927
Hamilton Centre	213	St. Catharines	113
Hamilton East-Stoney Creek	97	St. Paul's	90
Hamilton Mountain	92	Stormont-Dundas-South Glengarry	56
Huron-Bruce	99	Sudbury	209
Kenora-Rainy River	165	Thornhill	62
Kingston and the Islands	189	Thunder Bay-Atikokan	128
Kitchener Centre	91	Thunder Bay-Superior North	154
Kitchener-Conestoga	58	Timiskaming-Cochrane	253
Kitchener-Waterloo	55	Timmins-James Bay	85
Lambton-Kent-Middlesex	58	Toronto Centre	180
Lanark-Frontenac-Lennox and Addington	238	Toronto-Danforth	317
Leeds-Grenville	160	Trinity-Spadina	120
London-Fanshawe	102	Vaughan	48
London North Centre	135	Welland	219
London West	108	Wellington-Halton Hills	54
Markham-Unionville	35	Whitby-Oshawa	74
Mississauga-Brampton South	51	Willowdale	58
Mississauga East-Cooksville	43	Windsor-Tecumseh	138
Mississauga-Erindale	60	Windsor West	152
Mississauga South	72	York Centre	87
Mississauga-Streetsville	65	York-Simcoe	78
Nepean-Carleton	86	York South-Weston	83
Newmarket-Aurora	71	York West	60
Niagara Falls	168		

* Where a valid postal code is available.

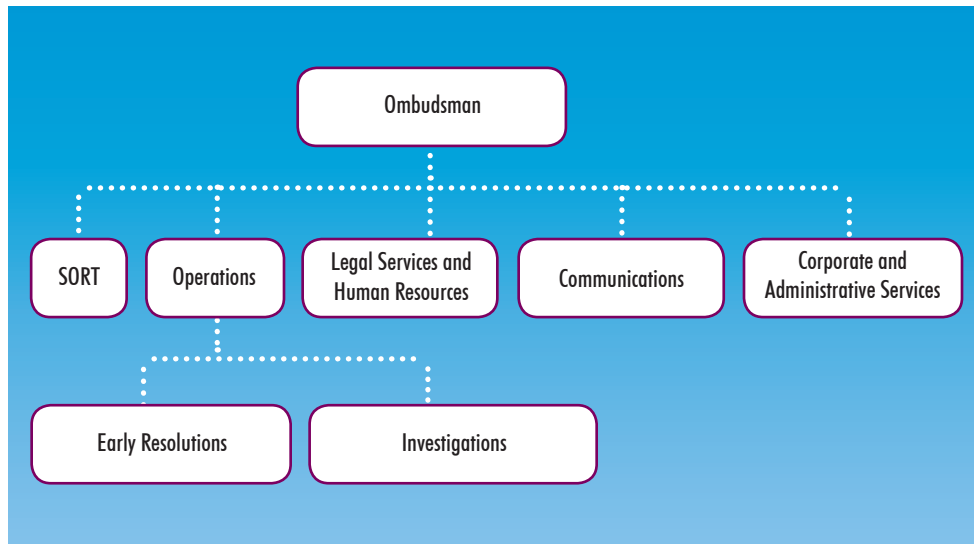
How We Work



APPENDIX 3:

About the Office

As of March 31, 2008, the Ombudsman's Office employed 83 staff. The following provides an overview of the Office's various teams, how they work together and how they contribute to the successful operation of the Office.



Special Ombudsman Response Team (SORT): SORT is tasked with conducting extensive field investigations into complex, systemic, high-profile cases. SORT works in collaboration with the Ombudsman's operations team and investigators are assigned to SORT on the basis of their specific abilities and areas of expertise.

Operations: The operations team, led by the Deputy Ombudsman, includes an early resolutions team and an investigations team. The early resolutions team operates as the Office's front line, taking in complaints, assessing them and providing advice, guidance and referrals. Early resolution officers use a variety of conflict resolution techniques to resolve complaints that fall within the Ombudsman's jurisdiction. The investigations team is comprised of experienced investigators who conduct issue-driven, focused and timely investigations of both individual and systemic complaints.

Legal Services and Human Resources: This team, led by the Office's senior counsel, supports the Ombudsman and his staff, overseeing human resources, ensuring that the Office functions within its legislated mandate and providing expert advice in support of the resolution and investigation of complaints. Members of the team play a key role in the review and analysis of evidence during investigations and the preparation of reports and recommendations.

Communications: In addition to publishing the Annual and SORT reports, as well as maintaining the Office's website and overseeing outreach activities, the communications team provides support to the Ombudsman in media interviews, press conferences, speeches, and public statements on the results of investigations.

Corporate and Administrative Services: The Corporate and Administrative Services team provides support in the areas of finance, administration and information technology.

APPENDIX 4:

Financial Report

During the fiscal year 2007-2008, the total operating budget allocated for the Office was \$9.70 million. Miscellaneous revenue returned to the government amounted to \$91,000, resulting in net expenditures of \$9.61 million. The largest categories of expenditures relate to salaries and benefits at \$7.20 million, which accounts for 74% of the Office's annual operating expenditures.

SUMMARY OF EXPENDITURES:	
	(\$000)
Salaries and wages	\$5,895
Employee benefits	\$1,301
Transportation and communication	\$339
Services	\$1,386
Supplies and equipment	\$783
ANNUAL OPERATING EXPENSES	\$9,704
Less: Miscellaneous Revenue	\$91
Net Expenditures	\$9,613





ONTARIO'S WATCHDOG



ONTARIO'S WATCHDOG

www.ombudsman.on.ca

www.ombudsman.on.ca