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ONTARIO'S WATCHDOG

2010-2011

ANNUAL REPORT

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June 21, 2011

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, 2010 to March 31, 2011, pursuant to section 11 of the *Ombudsman Act*, so that you may table it before the Legislative Assembly.

Yours truly,

André Marin
Ombudsman

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Ombudsman's Message: The Future of Government is Open

In his greeting to the Office of the Ombudsman of Ontario on our 35th anniversary this past year, Premier Dalton McGuinty spoke of our **"vital role … in ensuring that the Ontario government works in the best interests of our citizens."** This Office has been performing that function since 1975. It is a role that I personally have had the privilege of fulfilling for a full five-year term. This Annual Report is the first of my second term as Ontario's Ombudsman. Both our 35th anniversary and my reappointment provide welcome opportunities to use this space to praise what this Office has achieved over the years – however, it is far more productive to look to the future.

Photo by Brian Willer

As anyone familiar with this Office knows, we pursue our "vital role" of ensuring that government works in the best interests of its citizens by helping people navigate bureaucracy, by brokering settlements, and by exposing the kind of technocratic thinking that sometimes impedes access to public services. We ensure good governance by investigating complaints and making public reports and recommendations.

Yet there is something more that we can do. We can help ensure that government works in the best interests of its citizens by offering a vision for the future. This Office is uniquely placed to do so. We can identify smart changes by tapping into our considerable experience. That experience borrows from our unique perspective, gained by working daily not with the successes of government, but with its failures.

> "I want to challenge the government and its administrators to embrace openness and transparency not just as generic policy, but as their creed and their greatest contribution."

The vision for the future that I want to offer here is one of openness and transparency. "Openness," of course, is about access to information. It describes the practice of ensuring that the citizens served by government have the means to know what their government is doing. "Transparency," in turn, is about access to the reasons for decisions. A transparent decision can be seen for what it is. It is not spun or buried behind ingenuous explanation. It is one whose motives, influences and reasoning are shared. I have no doubt that the government of Ontario and its administrators aspire to be open and transparent. The vision I offer is a way of achieving those objectives. I want to challenge the government and its administrators to embrace openness and transparency not just as generic policy, but as their creed and their greatest contribution.

Openness and transparency are the keys to the kind of government that, in the Premier's words, it is the Ombudsman's "vital role" to pursue. We in Ontario are, of course, blessed with responsible government, run and administered with integrity by democrats. Still, the pages of this Annual Report are salted with illustrations of our government failing to work in the best interests of its citizens, and where it has failed, it is often because the imperatives of openness and transparency were forgotten. Let me offer just a few examples.

Perhaps the most egregious is also the most notorious – found in our December 2010 report, *Caught in the Act*. When the Toronto Chief of Police wanted exceptional police powers to ensure security for the G20 summit in June 2010, a secret regulation was passed in a closed cabinet session under the authority of an antiquated statute. This regulation granted the police exceptional powers. The normal right of citizens to be left alone by the police was replaced by powers of search and seizure if citizens approached a designated security zone. If they approached that zone, their freedom of movement was replaced by police powers of detention. The decision to give the police this remarkable authority was not exposed to public debate before it was taken. It was a decision made in the shadows. Even after the regulation was passed, the Ministry decided not to publicize it. Instead, it was "announced" unceremoniously by reproducing the regulation, without comment or explanation, on the government's e-Laws website a few days before the summit. Police, emboldened by their newfound authority, searched, detained and arrested thousands of citizens. Some of those citizens were doing no more than exercising their constitutionally protected right to protest; others just happened to be in the wrong place at the wrong time. These secret powers operated as a trap for those who thought they knew their rights and insisted on them – not knowing those rights had been secretly suspended.

Across the province, 14 Local Health Integration Networks (LHINs) have been established with the aim of increasing community involvement in decisions involving health services, so that diverse community needs across the province can be met. Citizen participation is the *raison d'être* of this plan. Yet our report into the handling of hospital restructuring plans by the Hamilton Niagara Haldimand Brant LHIN, *The LHIN Spin*, revealed a failure to communicate. The highly-touted "community engagement" mandate was undefined – so much so that one board member thought speaking with acquaintances privately on the golf course or in line at the grocery store constituted public consultation. No minimum standards for consultation and publicity had been established. Worse, the LHIN held secret meetings, under a bylaw that it and all other LHINs adopted, flying in the face of the promise of public involvement.

A similar case where the promise of openness was shamefully unfulfilled was revealed in my investigation into the province's monitoring of long-term care homes, which house more than 75,000 Ontarians. As I noted in the findings I released in December, although a great deal of information about long-term care inspections was posted publicly online – paying lip service to transparency – it proved to be grossly outdated, incomplete and at times inaccurate. There was an appalling lack of communication about the Ministry's complaint investigation process, and the homes themselves complained that the compliance standards were so complex as to be a disservice – equating minor issues with those directly affecting residents' quality of life.

35th Anniversary

November 1, 2010 (from top left): Ombudsman André Marin addresses attendees at the Office's 35th anniversary commemoration; Hon. Roy McMurtry pays tribute to 35 years of Ombudsman history in Ontario; Ombudsman Marin with (from top right): United Nations Ombudsman John Barkhat; Assistant Information and Privacy Commissioner of Ontario Brian Beamish and Information and Privacy Commissioner Ann Cavoukian; Deputy Chief Electoral Officer of Ontario Loren Wells and Environmental Commissioner of Ontario Gord Miller; Taxpayers' Ombudsman Paul Dubé, Ontario Human Rights Commissioner Barbara Hall and Ontario Human Rights Commission Executive Director Nancy Austin.

These examples are not unique. This report also describes our ongoing involvement with the province's Special Investigations Unit (SIU), which investigates cases where citizens have been killed or "seriously injured" during encounters with police. Among the litany of problems revealed in our 2008 report on the SIU was the ongoing failure of the Ministry to provide details to the public about investigations that have not led to charges. The Director's reports are suppressed. Disturbingly, three years after the release of that report, *Oversight Unseen*, this chronic failure of openness and transparency continues.

We also describe in this report how a number of municipalities have breached their open-meeting obligations. Some municipal councils remain oblivious to the legal requirements for open meetings, while others calculate ways, often illegitimately, to close the doors to the public. While most local governments respect the *Municipal Act* requirements – and the public complaints system established in 2008 – some continue to flout it.

A number of the individual cases reported here are also about government bodies closing themselves off to citizens. They involve coverups or suppression of information relating to the use of force by jail guards, inscrutable hydro bills, shoddy record-keeping – all things that frustrate openness and transparency.

November 1, 2010: Ombudsman André Marin with 35th anniversary attendees (from top left): NDP MPP Peter Kormos; Fairness Commissioner Jean Augustine and Speaker of the Legislature Steve Peters; Minister of Community and Social Services and Francophone Affairs Madeleine Meilleur; Hon. Coulter Osborne; NDP Leader Andrea Horwath; Progressive Conservative Party MPP and House Leader John Yakabuski.

Certainly, these kinds of problems are not new to the past year. Since 2005, our reports have frequently uncovered problems made grave by a lack of openness and transparency. To take only a few of the more notorious examples: We uncovered that the Ontario Lottery and Gaming Corporation was willfully blind to insider wins, suppressing its suspicions – and with them, any hope that theft would see the light of day. We exposed the habit of the Municipal Property Assessment Corporation of treating its methods as trade secrets, all the while using them to determine the assessments affecting people's property taxes. And we found the Ministry of Health and Long-Term Care had been less than forthcoming about the reasons for its arbitrary cap on funding the cancer drug Avastin.

The failure to achieve openness and transparency is not a problem unique to Ontario. Most democratic governments fall short of their promise to be open and transparent. U.S. President Barack Obama, for example, owed much of his electoral success to his transparency initiatives – yet many of those programs are now threatened by budget pressures. Five years after the Canadian federal government was elected on a platform of accountability, critics charge it has become less transparent, not more. Openness and transparency make an eloquent campaign slogan, but can easily, in practice, become empty buzzwords. Yet in the Middle East, as I write this report, citizens are prepared to die in a struggle to overcome despotic governments. What is it that they are demanding? Open and transparent government. The reasons are legion, and stirring.

Philosophers, jurists and politicians have long recognized that incompetence, mismanagement, and even corruption thrive in the dark but cannot bear the sanitizing light of day. Openness therefore advances moral, conscionable, and ethical government. It also promotes honesty and enables the rule of law to apply. Since the embrace of openness by the Ontario Lottery and Gaming Corporation about suspicious insider wins in the years after our investigation, theft is being exposed. The rightful winners of prizes from years ago are getting their due. This did not happen when the system was closed.

Ontario Ombudsman André Marin releases Caught in the Act, *his report on the expansion of police powers for the G20 summit, on December 7, 2010.*

Openness also improves the quality of decision-making and enhances effective government. It exposes those who are indolent and those with poor judgment, and reveals errors so they can be repaired. Would the secret G20 regulation have passed had its merits been debated publicly? More likely, the sting of public outcry would have given the government pause. And had it chosen to pass the law openly in spite of this, the citizens of Ontario would have had the opportunity to challenge it under the *Charter of Rights and Freedoms*. Certainly, the Toronto Police Service would not have been operating under its Chief's mistaken belief that the law empowered officers to detain and search anyone within five metres of the security fence. His error would have been shown for what it was.

Openness also strengthens democracy. It arms citizens with the information required to participate in government. Participation, in turn, improves the quality of decision-making by enabling a cross-section of knowledge, ideas, values and perspectives to enrich decisions and put their wisdom to the test. This, after all, was the whole idea behind the LHINs. Instead, the failure to define and enforce this idea left hundreds of citizens in Hamilton and Niagara believing that the restructuring process was decidedly undemocratic.

The natural inference when decision-making remains closed is that there is, at worst, a coverup, or at best, disinterest or ineffectiveness. This serves neither the government nor its citizens. The government is tarnished and those it serves are left frustrated and anxious. When decisions are made openly and transparently, their reason can be seen – and if the decisions are wise, or even defensible, the public is reassured and the outcomes are more apt to be trusted, as are those who make the decisions. Bury the process and public trust suffocates.

The government of Ontario, has, of course, pursued a vision of openness and transparency. Like other Canadian governments, this vision is unduly reliant on Access to Information and Freedom of Information legislation. Such legislation constitutes a marked improvement over earlier closed-government practices, and has become commonplace internationally, including in countries that can make little or

Ontario Ombudsman André Marin welcomes special guests to the reception for "Sharpening Your Teeth" training course attendees, December 1, 2010: From left, Ontario Minister of Health and Long-Term Care Deb Matthews, former president of the International Ombudsman Institute and Iowa Ombudsman William Angrick, and South Africa Public Protector Thulisile Madonsela.

Ontario Ombudsman André Marin with Dr. Peter Kostelka (left), secretary-general of the International Ombudsman Institute (IOI) at IOI headquarters in Vienna, where the IOI sponsored the Ontario Ombudsman's "Sharpening Your Teeth" training course for ombudsmen from around the world, November 17, 2010.

no claim to democracy. The problem is that it provides what I would call "pigeonhole openness," in which governments are open only if they cannot find a locked pigeonhole exception into which to force the request. This kind of legislation invites litigation. Ultimately, it is only as effective as the resources committed to it, and the readiness of governments to respond in a timely and sincere way to the requests that are made. Governments have been known to engage in strategic delay of requests in controversial matters, and even to create new documents before responding. When today's citizens demand openness, they mean much more than a successful freedom of information request.

When Ontario does pursue openness and transparency, it tends to embrace a "follow the money" vision of accountability. To cite just a few examples, expansion of the Auditor General's role to hospitals and other broader public sector organizations, pro-active disclosure requirements for expenses and the "Sunshine List" are all about dollars and cents. This is important, of course, but openness and transparency are also about good sense. Good policy and fair and effective delivery of services are as necessary to value for money as good financial accounting, and they are even more central to quality government. Being open and transparent is about more than where the money goes. It should also be about how decisions are made.

> "Without proper oversight - including effective investigative powers - openness, transparency, accountability and the opportunities for citizen participation are all compromised."

It is no secret why this Office has been so effective. It is in large measure because we report publicly. We investigate the facts, bring a critical eye to them, and lay them before those to whom the government is accountable. While most of our recommendations would no doubt be accepted by well-intentioned managers and administrators without the additional moral suasion furnished by public support, public support and participation is essential. After all, most of our work originates with complaints from ordinary citizens. Citizen participation is what lubricates the wheels of democracy.

However, without proper oversight – including effective investigative powers and public reporting – openness, transparency, accountability and the opportunities for citizen participation are all compromised. This, of course, is why my Office has, throughout its 35-year history, implored successive governments of Ontario to extend the jurisdiction of the Ombudsman. As this report again highlights, Ontario lags behind all other Canadian jurisdictions in ombudsman oversight of the "MUSH sector" – Universities, School boards and Hospitals, as well as children's aid societies, long-term care homes and police. What oversight there is of these institutions is, frankly, inadequate. The mandate of the Child and Family Services Review Board is so narrow it has sparked complaints to our Office about the Board itself. The *Broader Public Sector Accountability Act* aims to make hospitals more accountable by making them subject to the *Freedom of Information and Protection of Privacy Act*, but an exemption passed in May 2011 will impose significant restrictions on the information that can be accessed – restrictions that go beyond legitimate patient privacy concerns.

A more vital and complete vision of openness and transparency is inevitable. The days when governments could control the message and choose how to manage public information are gone. This is the age of information. Even Middle East autocracies that survived for centuries are being felled by protests galvanized by social media and stoked by real-time information about government atrocities and misconduct. Information, coupled with courage, is proving to be more potent than firepower. It is therefore both good policy and good politics to embrace it. Ontario has an opportunity to be a leader here.

> "Embracing a broad vision of openness and transparency is the right thing to do and will improve the quality of government."

This is a lesson we in the Office of the Ombudsman have learned for ourselves. We have worked to lead by example, while maintaining the crucial confidentiality obligations we must uphold in order to protect our complainants from retribution and maintain the integrity of the process. We are one of the first ombudsman offices in the world to embrace social media like Facebook, Twitter and YouTube. This past year, we pioneered the use of social media in a major investigation. We continue to champion openness in oversight.

Not so long ago, this Office was largely hidden behind a veil of secrecy, refusing to confirm or deny even the mere existence of a complaint. The Office only showed its face with the release of its annual reports. Beyond that, it relied on mall kiosks and community visits to get the word out. That might have been defendable in a bricks-and-mortar era, but no longer.

In recent years, we have opened the Office to the world through technology, with online complaint forms and increased opportunities for the public to communicate directly with us, through social media, live webcasts, e-newsletters and our website. In the coming year, we will be making it even easier for the public to interact with us by launching our own web app – another first for the ombudsman world. We are plugged in and better for it.

The government of Ontario has already made some strides in this direction, but there is much more it can do, and should do, if it and its administrators are serious about ensuring that it works in the best interest of our citizens. Embracing a broad vision of openness and transparency is the right thing to do and will improve the quality of government.

I am excited to be back as Ontario's Ombudsman for the next five years. There is much to be done. And as this Annual Report shows, we have the facility and the motivation to do it well.

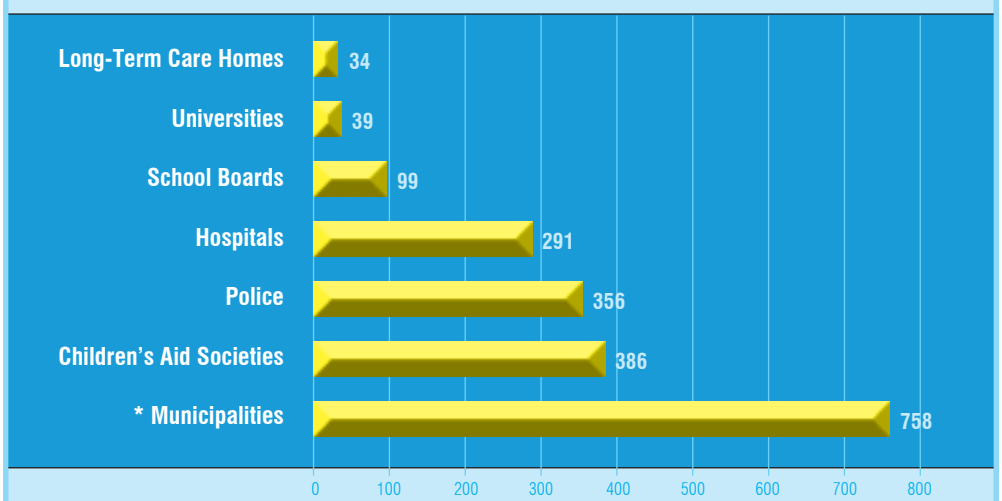
The Year in Review

Beyond Scrutiny: Opening up the MUSH sector to oversight

Municipalities, **U**niversities, **S**chool boards and **H**ospitals, together with other public bodies providing vital services such as long-term care homes, children's aid societies and police, comprise the "MUSH sector." None of these organizations are open to review by Ontario's Ombudsman, whose oversight in this sector continues to be the most limited in Canada. The table below compares the jurisdiction of all provincial ombudsmen with respect to the MUSH sector.

Every year, the Ombudsman's Office receives many compelling complaints about MUSH sector services that we are forced to turn away. In 2010-2011, **1,963** such cases were received, as detailed in the accompanying chart.

MUSH SECTOR CASES
RECEIVED DURING FISCAL YEAR 2010-2011 **TOTAL: 1,963**



** Excludes cases received about closed municipal meetings.*

LAGGING BEHIND
HOW ONTARIO'S OMBUDSMAN MANDATE COMPARES TO OTHERS IN KEY AREAS OF JURISDICTION

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

It has now been more than 35 years since Ontario's first Ombudsman, Arthur Maloney, called for expansion of the Office's authority to include this sector. In recent years, a host of private member's bills, petitions and public demonstrations have appealed to government to change this, but none have been successful.

On November 15, 2010, NDP MPP Rosario Marchese introduced private member's **Bill 131**, the *Ombudsman Amendment Act (Designated Public Bodies), 2010*, for first reading. The bill provides for the Ombudsman's authority to be extended to apply to hospitals, long-term care and retirement homes, school boards and children's aid societies. Mr. Marchese reintroduced his bill on April 19, 2011 as **Bill 183**, the *Ombudsman Statute Law Amendment Act (Designated Public Bodies), 2011*, adding universities and the Office of the Independent Police Review Director to the list of organizations that would fall under the Ombudsman's expanded jurisdiction. On May 5, 2011, the bill was defeated at second reading.

Petitions have been circulated and public rallies have been held in support of Mr. Marchese's efforts, including in Toronto, Sudbury, Cornwall, Kingston, London, Owen Sound, Pembroke, Peterborough, Sault Ste. Marie, Timmins and Woodstock. Many supporters turned out to watch the vote in the Legislature on May 5. Trustees at the Bluewater District School Board in Bruce and Grey counties also voted unanimously to support the bill in a letter to the province in early May.

> "There's enormous frustration out there. When people with complaints about these public institutions try to get answers, they hit a wall. Ontarians need somewhere to turn to when no one else is listening."
>
> ***– NDP MPP Rosario Marchese, November 17, 2010***

The **MUSH** sector is accountable for 50% of provincial government expenditures. The province has responded to growing concerns about spending practices in the broader public sector by increasing its financial transparency, requiring greater financial disclosure, subjecting these organizations to value-for-money audits, and providing more direction relating to expense practices. However, no progress has been made in opening these organizations to Ombudsman review of the policies and practices that directly affect Ontarians in their daily lives.

Municipalities

Since 2008, the Ombudsman has had the authority to investigate complaints about closed meetings in Ontario municipalities (more detail about this can be found in the **Open Meeting Law Enforcement Team** section of this report). But the Ombudsman has no authority to consider complaints about local government. Municipal issues affect citizens where they work and live – and not surprisingly, many spark complaints. The Office received **758** complaints and inquiries about municipalities on a wide range of topics in 2010-2011, including:

- problems with permits and licences;
- inconsistent, inadequate and inappropriate bylaw and building code enforcement;
- conflicts of interest involving municipal officials;
- unsafe conditions, evictions, and delays in obtaining public housing;
- errors and poor service in welfare administration; and
- billing errors and threats of disconnection relating to local utilities.

The City of Toronto is the only municipality in Ontario with its own ombudsman, established in 2009, and when appropriate, we refer complaints to that office. However, we must turn away hundreds of complaints about other municipalities.

Universities

The Ombudsman has jurisdiction over Ontario's 24 colleges of applied arts and technology, and has resolved student complaints and initiated several systemic changes (some of these cases are included in the **Case Summaries** section of this report). Unfortunately, the Office is unable to achieve similar results for people complaining about Ontario universities. There were **39** complaints and inquiries about universities in 2010-2011, including allegations of poor service, inadequate handling of complaints, problematic program requirements and practices, and student suspensions. None of these complaints could be investigated.

School boards

In 2010-2011, the Ombudsman received **99** complaints and inquiries about school boards, involving such serious issues as inadequate responses to bullying of students, insufficient support of children with special needs, student transportation, and discipline, including student suspensions.

> Giving the Ombudsman power over school boards would allow parents to hold the school boards and the provincial government accountable. We must demand accountability and transparency.
>
> *– Dominic Peluso, Letter to the Editor,* **Mississauga News**, *September 17, 2010*

> "I think everyone needs an area where they can go and have someone further investigate."
>
> *– Linda Steel, trustee, London District Catholic School Board, quoted in the* **London Free Press**, *May 10, 2011*

There is one exceptional circumstance when a school board is open to Ombudsman scrutiny: When it is directly taken over by the government, through the appointment of a provincial supervisor. This occurred in 2009 with the Toronto Catholic District School Board. The Ombudsman received two complaints relating to the board, which were resolved informally. On January 28, 2011, an elected board of directors replaced the supervisor, meaning the Ombudsman no longer has oversight of this board.

Hospitals and long-term care homes

The Ombudsman received **325** complaints and inquiries about hospitals and long-term care homes in 2010-2011 (**291** for hospitals; **34** for long-term care homes). Many complainants raised serious issues including allegations of unsafe conditions, inadequate care, neglect and abuse of patients.

While the Ombudsman cannot investigate long-term care homes directly, he is able to review the Ministry of Health and Long-Term Care's involvement in this area. In December 2010, the Ombudsman announced the results of his investigation into the province's monitoring of long-term care homes. Details of this investigation are contained in the **Special Ombudsman Response Team** section of this report.

> "We get thousands of complaints a year, so we would welcome the addition of the Ombudsman looking at some of these issues and providing some remedies."
>
> *– Judith Wahl, Advocacy Centre for the Elderly, as quoted by CBC News, November 14, 2010*

Provincial expenditure in the health care sector continues to grow rapidly, with hospitals and long-term care homes receiving about $18 billion a year. These organizations have become increasingly subject to greater financial scrutiny. As a result of amendments ushered in by **Bill 122**, the *Broader Public Sector Accountability Act, 2010*, hospitals will become subject to the *Freedom of Information and Protection of Privacy Act* on January 1, 2012. However, an amendment introduced in the provincial budget and passed on May 12, 2011 will further restrict access to information relating to assessing or evaluating quality of health care.

Significant administrative decisions and omissions affecting the health and welfare of millions of Ontarians remain immune from Ombudsman oversight. Ontario continues to be the only province whose Ombudsman has no authority to investigate hospitals. In Saskatchewan, for example, the government allocated close to half a million dollars in additional funds in 2010-2011 to support its Ombudsman's oversight of health care complaints.

Ontario's Ombudsman is only able to consider complaints about hospitals in the exceptional case when they are directly taken over by the province, through **the appointment of a supervisor**. In 2010-2011, Cambridge Memorial Hospital was under supervision until October 22, 2010, and Hotel-Dieu Grace Hospital in Windsor was placed under supervision on January 4, 2011. The Ombudsman reviewed **22** complaints about these hospitals in the past fiscal year, ranging from billing issues to service delays to inadequate conditions. Complaints about treatment by medical practitioners were directed to the appropriate professional regulating body, as these are not within the Ombudsman's mandate. All complaints were quickly assessed and resolved.

Children's aid societies

Ontario's children's aid societies (CASs) are responsible for protecting thousands of the most vulnerable members of our society. Ontario is unique. No other province outsources child protection, and no other provincial ombudsman is prevented from reviewing allegations of maladministration relating to child protection.

The cost of publicly funding this system has tripled over the last decade, and at present, CASs spend about $1.4 billion annually in carrying out their crucial task. CASs are powerful agencies that have serious impact on the lives of children and families, and each year, the Ombudsman receives hundreds of complaints about them. Unfortunately, our Office is powerless to assist these people, even in the most egregious cases.

In 2010-2011, the Ombudsman received **386** complaints and inquiries about Ontario's child protection services (more than the previous year's 296; less than 2008-2009's total of 429). These included concerns about:

- opaque investigation and complaint processes, including refusal to investigate allegations of abuse, neglect or CAS staff misconduct;
- biased and incompetent investigations;
- apprehension of children and the care of children in CAS custody;
- inaccurate CAS records and misrepresentation of information to the courts;
- failing to disclose information to parents, or placing unreasonable demands on parents seeking visitation and access; and
- staff misconduct towards parents, including threats and harassment or reprisal actions against parents who challenged CAS decisions.

Some parents also alleged they had been pressured by CASs to relinquish custody of their severely disabled children in order to obtain necessary residential care for them. The Ombudsman has been monitoring this serious, persistent issue since his 2005 report, *Between a Rock and a Hard Place*. More information on this can be found in the **Special Ombudsman Response Team** section of this report.

CASs have persistently opposed opening up their operations to Ombudsman oversight. They argue that CASs are already subject to multiple layers of review; by the Ministry of Children and Youth Services, the Provincial Advocate for Children and Youth (which lacks investigative powers), the Auditor General (which may only conduct value-for-money audits), the Office of the Chief Coroner and Pediatric Death Review Committee (which can only become involved after a child has died), the Child and Family Services Review Board, and the courts. None of these organizations has the broad general authority of an Ombudsman to investigate complaints about serious allegations relating to the administration of CASs and to make remedial recommendations. And no effective mechanism exists to investigate and address serious problems before a crisis occurs.

> "Ombudsman oversight is vital to ensuring the best interest of Ontario's vulnerable children and youth."
>
> ***– Michele Farrugia, Foster Care Council of Canada, as quoted by the Canadian Press, November 10, 2010***

> "I can't think of any area more ripe for oversight than child welfare. Children die and no one takes responsibility, no one answers the important questions. It's just so sad."
>
> ***– Ombudsman André Marin, as quoted in the* Toronto Star*, February 23, 2011***

In 2006, the mandate of the Child and Family Services Review Board was expanded to consider complaints about services provided by CASs. However, the board's authority extends **only to procedural issues**, and standing to make a complaint is limited to those actually "seeking or receiving service" from a CAS, often leaving grandparents and other concerned relatives without recourse to complain. The board cannot address serious concerns about the conduct, policies and practices of CASs. Its authority is restricted to dismissing a complaint or ordering a CAS to process or respond to a complaint, comply with the complaint review procedure, or provide written reasons.

This very limited oversight was confirmed in a recent court case. On July 20, 2010, in a case known as *Children's Aid Society of Waterloo v. D.D.*, the Divisional Court found that the Child and Family Services Review Board had exceeded its authority when it considered a mother's complaint about CAS conduct during a period covered by an interim court order (the decision is currently under appeal). Our Office received **14** complaints about the board in 2010-2011. Many of those who complained expressed frustration over the limited powers of this agency.

The Commission to Promote Sustainable Child Welfare, established by the government in November 2009, is due to issue recommendations in September 2012 on ways to make Ontario's child welfare system, including CASs, more accountable, efficient and sustainable. Based on the many supportive submissions we have received from citizens, adding Ombudsman oversight to the accountability framework for child protection would go a long way to satisfying public concerns about the present complaint process.

As with other MUSH sector institutions, the one rare circumstance where a children's aid society can be subject to Ombudsman oversight is when it is directly taken over by the province through the appointment of a supervisor. On October 13, 2010, the Huron Perth CAS came under supervision after it threatened to close due to a funding shortfall. As of March 31, 2011, the Ombudsman had received **33** complaints regarding this agency. Many raised serious concerns about the treatment of children in care, and inappropriate conduct on the part of child protection officials. All were assessed and resolved quickly.

Police

The Ombudsman received **356** complaints about police conduct in 2010-2011. These were referred to the Ministry of the Attorney General's Office of the Independent Police Review Director (OIPRD), where appropriate. The Ombudsman also received **15** complaints about the OIPRD itself, relating to its service delivery and treatment of public complaints about police. Unfortunately, the *Police Services Act* bars the Ombudsman from overseeing this agency.

The Ombudsman provided the OIPRD with information on **112** complaints our Office received about police behaviour during the G20 summit in Toronto in June 2010. These complaints were received in connection with the Ombudsman's investigation into the Ministry of Community Safety and Correctional Services' decision to expand police powers during the summit. (That investigation is summarized in the **Special Ombudsman Response Team** section of this report.) They included allegations of aggressive or inappropriate comments and excessive force by police, wrongful detainment and arrest, aggressive behaviour, police use of the tactic known as "kettling" to control demonstrators, and conditions in the temporary detention centre. At the time this report was written, the OIPRD was preparing a report on the policing of the G20.

Operations Overview

Of the **14,531** complaints and inquiries our Office received during the 2010-2011 fiscal year, most were resolved within 15 days or less, usually with a call or two to the relevant Ontario government agency. Ombudsman staff usually find government officials highly co-operative and appreciative of the chance to resolve citizens' concerns. Examples of some of this year's successfully resolved cases can be found in the **Case Summaries** section of this report.

Operations staff also monitor trends in complaints to identify potential systemic issues. Some of these are referred to the Special Ombudsman Response Team for investigation, while others are addressed proactively with the affected organizations. Senior staff meet on a regular basis with high-level representatives from organizations that are the most frequent sources of complaints. This past year, these included the Ministry of Children and Youth Services, the Ministry of Community and Social Services and its Family Responsibility Office, the Ministry of Community Safety and Correctional Services, the Office of the Public Guardian and Trustee and Hydro One. Some examples of the results of those meetings follow.

Ministry of Community Safety and Correctional Services

In the wake of several complaints alleging the use of excessive force by correctional officers against inmates, Ombudsman staff flagged the issue to senior management at the Adult Institutions Branch of the Ministry of Community Safety and Correctional

Services. The complaints included allegations that correctional officers and operational managers had covered up incidents of violence and failed to follow policies and procedures regarding reporting and photographing, despite reminders from management. The Ministry did not dispute the facts we raised and agreed to do a thorough review of the more egregious cases. It has since informed the Ombudsman that it is making administrative changes that will be implemented provincewide. These will include updated forms for reporting use-of-force incidents, new risk monitoring teams and better monitoring at both the local and corporate levels. While the Ombudsman is encouraged by the initial swift action taken by the Ministry to respond to these serious complaints, he has directed his staff to monitor the effectiveness of these new measures closely.

Here are some details of the serious cases we reported to the Ministry:

- An anonymous letter was sent to the Ombudsman accusing correctional staff of assaulting an inmate, but when our staff called the institution, officials were not aware of the incident. They were, however, investigating the disappearance of a page from a log used to record the activities on the unit where the incident took place. The missing logbook page matched the date of the alleged assault. Senior officials at the institution were so concerned that they immediately launched an internal investigation, then brought in an external Ministry investigator to do a more thorough probe. That investigation was still in progress at the time this report was written.
- An inmate complained to the Ombudsman that, after several correctional officers assaulted him, an operational manager at the jail told him they would not write up the incident if he said nothing. Ombudsman staff discovered there was no record of any use of force and senior officials were not aware of the incident. An internal investigation at the facility was launched and an operational manager admitted that force was used and he had not followed required policies, nor had the correctional officers, at his instruction. The investigation resulted in disciplinary action against the staff involved.
- An inmate complained to the Ombudsman that two correctional officers took him from his cell and beat him up in a room away from the institution's video cameras. An internal investigation by the institution showed that documents completed by correctional officers on duty at the time conflicted enough with the available video evidence to point to a possible coverup. Three correctional officers were reassigned and removed from contact with inmates pending a formal investigation by the Correctional Investigation and Security Unit.
- A deputy superintendent who reviewed an inmate's complaint of being restrained and beaten by correctional officers concluded that the inmate suffered no serious injuries, based on the accident and injury report prepared by the jail's health care staff. Ombudsman staff requested a copy of this report and discovered it did not exist. The deputy superintendent's review was amended to note that health care staff had in fact not prepared a report as required, and the superintendent introduced a new process to review use-of-force incidents to ensure policies are followed and required reports are done.

Our Office continues to focus resources in the corrections area on complaints about serious health and safety issues, while encouraging inmates to use internal complaint processes to address other concerns. Our case management system also allows us to flag clusters of similar or recurring complaints, and in late 2009 we began receiving a large number of complaints from inmates about the new phone system that was being implemented at correctional facilities across the province. The new system suddenly left many inmates unable to access the 1-800 numbers they had been using to contact their lawyers and other organizations. As a result of follow-up from the Ombudsman's Office, the Ministry made changes to reinstate appropriate phone access for the inmates.

Ombudsman staff also addressed many serious complaints involving inmates' mental health and medical issues. These included delays in inmates getting to see health care professionals or obtaining necessary medication. More examples of such cases resolved by Ombudsman staff can be found in the **Case Summaries** section of this report.

Family Responsibility Office (FRO)

The FRO, which reports to the Ministry of Community and Social Services, deals with matters of child and spousal support for divorced or separated couples. It was the most complained about organization in the entire provincial government in 2010-2011, with 716 complaints received by the Ombudsman. Complaints commonly involve a lack of clear or timely communication from the FRO, delays in issuing or enforcing support payments, and administrative errors that go unchecked and have serious financial impact on FRO clients.

Specific problems commonly raised in complaints about the FRO include:

- Failure to execute default orders for unpaid support;
- Multiple adjournments of default hearings;
- Failure to properly review documentation such as court orders;
- Delays in registering and enforcing court orders for the payment of spousal and/or child support;
- Omitting to take enforcement action on support arrears;
- Taking enforcement action when support obligations have actually been met;
- Attempting to collect support arrears in the wrong amounts;
- Failure to properly account for support payments that have been made;
- Failure to forward support payments to recipients; and
- Not terminating support collection when obligations have ended.

In one case, FRO staff mistakenly entered a man's required support payments as being monthly instead of weekly when his file was opened in February 2010. The error wasn't identified until August, and by October, the man owed more than $10,000 in arrears.

In another case, the FRO held onto support payments made by a man in another country because it didn't believe it was authorized to forward the money to his ex-wife in Ontario. The woman ultimately received $5,600 that had been held back by FRO officials.

In another case, even though a man owed more than $30,000 in support, the FRO agreed to stop sending payments to his ex-wife at the request of his lawyer while he filed a motion in court to stop payment. The FRO failed to collect any support or follow up on the court action until the woman complained to the Ombudsman.

Complaints about the FRO's maladministration also came from those who pay support. One man complained to the Ombudsman after the FRO told him he owed more than $45,000 in arrears, which he denied. Once the Ombudsman looked into the case, FRO staff acknowledged their error and sent the man a refund cheque instead. Another man who had paid off his support obligations in 1998 complained that the FRO had issued a support deduction notice to his employer, saying he owed more than $45,000. Although the man provided the FRO with documented evidence that he did not owe any money, it failed to act on this information until he brought it to our Office's attention. FRO staff also insisted that a man owed $42,480 in arrears until they checked with his ex-wife and determined the amount was only $6,000.

Further examples of FRO cases resolved by Ombudsman staff can be found in the **Case Summaries** section of this report.

Office of the Public Guardian and Trustee (OPGT)

The Office of the Public Guardian and Trustee (OPGT) is an office of the Ministry of the Attorney General that, among other things, administers the estates of people incapable of doing so themselves. Many of those who deal with the OPGT and their families are coping with difficult and emotional issues, and in recent years, the OPGT has become a top source of complaints to the Ombudsman. In 2010-2011, it was the seventh most complained about organization, with **113** cases received.

Ombudsman senior staff meet quarterly with OPGT officials to discuss recurring issues involving complaints about customer service and staff conduct, the provision of incorrect information, delays and poor communication – both with OPGT clients and with Ombudsman staff.

Some OPGT clients complained to the Ombudsman of being treated with disrespect. One man reported that he was "afraid" of his case worker, who yelled at him. The worker admitted this to Ombudsman staff, saying she yelled at the man and hung up because she didn't know what to say to him anymore and she would "gladly give him up" to another worker. The man's case was reassigned.

Another OPGT client service representative made ethnic slurs when speaking to Ombudsman staff about a complainant and called him "cheap" and a "liar." OPGT staff also provided incorrect information regarding the payment of this client's credit card bills, resulting in a negative credit rating.

In another case, an OPGT client representative and a manager told our Office that the husband of their client was abusive toward his wife, with no objective information to support this statement.

Several people complained that they could not get through to their OPGT client representatives for long periods of time. Although the OPGT advised the Ombudsman that other workers assist on cases when their colleagues are absent, in one case involving an estate file, the estates officer was away for several months at a time, no other contact person was assigned, and there was no indication from the officer's voicemail or email that she was absent. In another case, while a new client representative had been assigned, the voicemail message had not been updated to reflect the change in staff and because the mailbox was full, no messages could be left. In another, a client service representative went on vacation and did not respond to the messages that had been left on her voicemail by the nephew of a client for 10 days, and she failed to leave any notice that she was out of the office.

These issues are troubling, given the important service that the OPGT is mandated to provide to vulnerable people on a daily basis. In a letter to the Ombudsman in March 2011, the Public Guardian and Trustee outlined her office's latest steps to improve file management and record keeping. She also outlined efforts to address delays in their estates department, including reorganizing and having new management focus on performance and customer service. Ombudsman staff continue to bring forward individual complaints and trends to senior OPGT management and to work collaboratively with them on these issues.

Ministry of Community and Social Services (MCSS) and Ministry of Children and Youth Services (MCYS)

Senior Ombudsman staff meet on a quarterly basis with MCSS officials to discuss issues that have prompted multiple complaints, such as changes to the special diet allowance for social assistance recipients, and the new standardized assessment process which allows it to prioritize adult special needs cases. Here are some other major issues we have raised proactively with MCSS:

Email communication

A number of disabled people have complained to the Ombudsman that the Ministry will not accommodate their disability by communicating with them by email. The Ministry has been considering the feasibility of doing this for some time but has made limited progress, although the Ontario Disability Support Program (ODSP) committed to developing an internal policy regarding email communication in the wake of a 2003 Ontario Human Rights Commission decision.

Our Office followed up with the Information and Privacy Commissioner and with the Ministry on this issue in February 2011. The Ministry has now put in place a second pilot project that will involve testing the proposed technology with a group of ODSP clients. We are continuing to closely monitor the progress of the pilot.

Assistance for children with severe disabilities

Ombudsman staff raised concerns with MCSS about families who were denied the Assistance for Children with Severe Disabilities benefit, which provides up to $440 a month for a family of four to assist with the costs associated with a child's severe disability. The families complained they were denied this benefit strictly based on their income, although the legislation states that income is one of four factors that should be considered – the other three are the child's age, the nature of the child's disability, and the expenses incurred in relation to the child's disability. The Social Benefits Tribunal overturned several Ministry decisions in these cases, because although the families' income was beyond the income cap imposed by Ministry policy, the expenses associated with their child's disability were so great that the families faced financial hardship. After much discussion of the issue, the Ministry agreed to conduct further research on how its staff are applying the eligibility criteria for this benefit.

ODSP/DAU delays

Ombudsman staff are also monitoring complaints about delays in processing ODSP applications at the Disability Adjudication Unit, after complaints were received about several cases taking longer to process than the unit's 90-day standard. The Ministry advised us that it is approving overtime, hiring contract staff and making other process changes to deal with a recent increase in applications. ODSP was the second most complained about organization in 2010-2011, with **493** cases received.

Day nurseries complaint

A mother complained to the Ombudsman about the lack of supervision of co-op students working at her local daycare centre. Three children, including the woman's three-year-old, were inappropriately touched by a co-op student who has develomental disabilities. The matter was reported to the Ministry of Children and Youth Services (MCYS), the local children's aid society and police. However, the mother was not satisfied with MCYS's response to her complaint about the need to supervise students.

The Ombudsman was concerned that, although the daycare centre in question had stopped using co-op students, many others across the province continue the practice and there are no provisions under the *Day Nurseries Act* that require daycare centres to have policies for their supervision. MCYS officials told Ombudsman staff that there was no requirement for a policy to supervise students, and pointed out that the Act required that "children be supervised at all times."

In April 2010, the province announced that responsibility for child care would be shifted from MCYS to the Ministry of Education. After Ombudsman staff contacted senior officials at that ministry, it approved the development of a policy directive requiring that students and volunteers be supervised in day nurseries and by private-home care operators. A draft copy of the directive was provided to the Ombudsman and we were advised that the Ministry will monitor its implementation when inspections begin in the fall of 2011.

Services for adults with developmental disabilities

The Ombudsman has also noted an emerging trend in complaints involving the need for services and programs for adults with developmental disabilities. Here are a few examples of these cases:

- The mother of a 36-year-old man with Down syndrome who had been in a group home contacted the Ombudsman after he was discharged to his family without a plan of care. He was facing possible jail time because he had broken into stores on several occasions to steal soft drinks and chips. The Crown attorney in the case was willing to release him on a peace bond if a plan for his return to a group home could be provided before his next court appearance, which was nine days away. When Ombudsman staff alerted senior MCSS officials to this, they dealt with it quickly so that the man could go to a group home and avoid jail.
- A 19-year-old woman with a dual diagnosis of developmental disability and schizoaffective disorder was ready to be discharged from the mental health unit of a hospital but could not be released because she required a residential placement. Ombudsman staff spoke with the Ministry of Community and Social Services, the Ministry of Health and Long-Term Care, the area LHIN and various community agencies to no avail. It wasn't until an assistant deputy minister at MCSS became involved that the Ministry confirmed that funding would be provided for an appropriate residential placement and that the woman's needs would be assessed.

Hydro One

Hydro One complaints increased from **227** in 2009-2010 to **306** in 2010-2011, making it the fourth most complained about organization. Complaints about unexplained increased electrical usage and billing amounts surged after the installation of new "smart meters" around the province, and the Special Ombudsman Response Team was assigned to conduct a review to determine if a systemic investigation was warranted. (More information about this assessment is contained in the SORT section of this report.)

Senior Ombudsman staff also met several times with Hydro One executives and senior managers to discuss complaints about customer service, billing and issues of communication with our Office. Hydro One staff have been very co-operative and are committed to working with our Office to resolve complaints. The timeliness and quality of the information provided to our Office has improved and Hydro One has provided considerable detail about its structure and billing processes.

The Ombudsman continues to receive complaints about significant and unexplained increases in Hydro One bills and treatment of customers who complain. Here are a few examples:

- A woman fell behind in her Hydro One payments after her smart meter was installed and her monthly bill increased from $280 to around $400, prompting Hydro One to demand she pay a security deposit. Ombudsman staff called Hydro One officials, who said the security deposit would not be necessary if the woman paid her bills on time in future. The woman arranged with Hydro to pay off her arrears over a two-year period without interest.
- A woman who was wrongly billed by Hydro One for another apartment unit in the same building as hers complained to the Ombudsman that Hydro would not acknowledge its mistake and was insisting she pay the bill or face late fees and disconnection. After Ombudsman staff intervened, Hydro One apologized to the woman and fixed the mistake.
- A resident of a northern First Nations reserve saw his Hydro One bills steadily increasing, but both he and his band council were unable to reach anyone at the local Hydro One office for an explanation. He said Hydro One's main call centre told him he had to pay his bills in full or face interest charges. Following inquiries from our Office, Hydro One reduced his bills.

Ombudsman staff are continuing to monitor complaints about Hydro One. Examples of Hydro One cases resolved in the past year can be found in the **Case Summaries** section of this report.

Sue Haslam, the Ombudsman's Manager of Investigations, delivers a training seminar for more than 100 staff of the Ombudsman of Thailand, Bangkok, March 8, 2011.

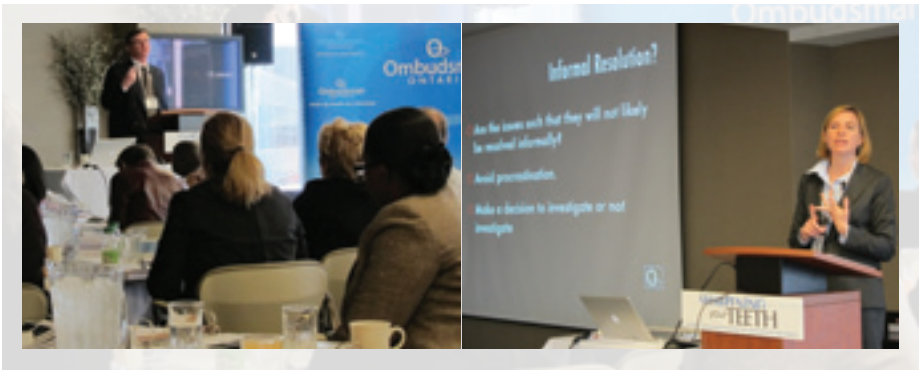
Training and Consultation

Aside from the daily work of resolving and investigating complaints about Ontario government services, the Ombudsman's Office receives regular requests for advice, consultation and training from government organizations and other watchdog agencies – in Ontario, across Canada and around the world.

In 2010-2011, several international visitors spent time with the Ombudsman and staff, learning about the structure of our operations and our investigative methods. These included representatives from the Public Service Ombudsman for Wales, the Bermuda Human Rights Commission, the Public Protector of South Africa, and a community legal centre in Melbourne, Australia.

> "We thoroughly enjoyed learning about the various processes and investigative techniques utilized by the Ombudsman of Ontario to resolve complaints of administrative unfairness and oversight in provincial government organizations. Additionally, we were impressed with the various sections of the Ombudsman, and the responsibilities and processes that each has in place to assist the office in operating in the utmost efficient manner."
>
> ***– Darnell Harvey and Graham Robinson, Bermuda Human Rights Commission***

Senior Ombudsman managers also met with provincial government offices to explain the Ombudsman's role, function and operations in detail. These included presentations to staff at various ministries, including Community Safety and Correctional Services, Economic Development and Trade, Research and Innovation, Community and Social Services and Community and Youth Services. Ombudsman managers also spoke about leadership and ethical decision-making at workshops co-ordinated by the Government Services and Finance ministries.



Gareth Jones, Director of the Special Ombudsman Response Team (left) and Barbara Finlay, Deputy Ombudsman and Director of Operations (right), speak to participants in the Office's fourth annual "Sharpening Your Teeth" training course in Toronto, November 30, 2010.

The Ombudsman's specialized training course in investigative techniques – **Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs** – is now in its fifth year and continues to attract trainees from across the globe. The course has been embraced by the International Ombudsman Institute (IOI), which invited the Ombudsman to deliver it to representatives from IOI member countries at its headquarters in Vienna in November 2010 and June 2011.

Comments from participants in the Ontario Ombudsman's "Sharpening Your Teeth" training for the International Ombudsman Institute (IOI):

"This training program is the best in the world. Your office has shown ombudsmen's real value to their constituents."

– Hee Eun Kang, Director of Anti-Corruption and Civil Rights Commission, Korea, participant in IOI "Sharpening Your Teeth" training

"Taking part in the IOI training was an outstanding experience for us."

– Dr. Julia Sziklay, Parliamentary Commissioner's Office, Hungary

Customized versions of the course were also conducted (always on a complete cost-recovery basis) in Thailand, Brazil and Bermuda – as well as at the Ontario Ministry of Labour's Pay Equity Commission. In addition, Ombudsman staff gave presentations on how to conduct interviews and when to conduct systemic investigations at the 2010 United States Ombudsman Association national conference in Dayton, Ohio.

The fourth annual Sharpening Your Teeth training conference was held in Toronto November 29-December 1, 2010, attended by 65 representatives from a wide range of offices, from the Public Protector of South Africa and Ombudsmen of Korea and Antigua to the Los Angeles Police Department's Inspector General. Ontario organizations represented among the trainees included the ministries of Health and Long-Term Care, Municipal Affairs and Housing, Government Services, Environment and Community Safety and Correctional Services, as well as the Provincial Advocate for Children and Youth, the Criminal Injuries Compensation Board, the Environmental Commissioner, Ontario Power Generation, Elections Ontario, the Financial Services Commission and the Alcohol and Gaming Commission. Other Canadian organizations that attended the training included Public Works and Government Services Canada, Foreign Affairs Canada, and the offices of the ombudsmen for National Defence, Taxpayers, Alberta, Manitoba and Toronto.

Featured guest speaker Deb Matthews, Ontario's Minister of Health and Long-Term Care, addressed a reception for conference attendees about the importance of oversight and the effectiveness of ombudsman investigations.

> "We all have the same goals. There's no question Mr. Marin does his work to benefit Ontarians – that's his job and he takes it very seriously, as does his staff. I have nothing but respect for the issues you choose, and the way you do your work. Because of the work you've done, our health care system is stronger, so thank you for that."
>
> ***– Ontario Health Minister Deb Matthews, addressing Ombudsman André Marin and Sharpening Your Teeth participants, November 30, 2010***

Former International Ombudsman Institute president and retired Iowa Ombudsman William Angrick also spoke at the conference about how he was inspired by Ombudsman Marin's systemic investigations model and how it can help ombudsmen everywhere demonstrate their value to citizens.

> "Marshalling his resources, steeling his resolve, Marin radically changed the way the Ontario office operated and was perceived. Making difference after difference, the Ontario Ombudsman became the champion of change for better government. After a hard-fought reappointment, the Office and its incumbent both continue and are already creating more change."
>
> ***– William Angrick, former International Ombudsman Institute president and Iowa Ombudsman/Citizen's Aide, keynote address to Sharpening Your Teeth course, December 1, 2010***

Ontario Ombudsman André Marin at reception for Sharpening Your Teeth participants, with former International Ombudsman Institute president and Iowa Ombudsman William Angrick (left) and Ontario Minister of Health and Long-Term Care Deb Matthews, December 1, 2010.

Comments from Sharpening Your Teeth Toronto participants, December 2010:

"This was a most worthwhile training activity for enhancing Ombudsman effectiveness. Ombudsmen and their investigation staff need this."

"Excellent course from beginning to end. Topics were all on point and presenters were well informed and clearly passionate and competent about their work."

"This course really puts some 'academic credibility' to the art and science of investigations."

"Nice to not only learn more about investigations, but to do it amongst colleagues from across the country and the world."

"The course was an eye-opener and should be used as an introductory course for all investigators within the Ombudsman fraternity."

"I am pleased to say that I have learned a lot from the training, and I will be using some of the practices that the Ontario Ombudsman uses in our jurisdiction.

– Joycelyn Richards-Wharton, Office of the Ombudsman of Antigua

"The course was both instructive and entertaining. I am really glad I was able to attend."

– Nicole Beaulieu, Office of the Conflict of Interest Commissioner of New Brunswick

"I really appreciate the SYT training and the efforts your staff made to deliver it. I came away from the training with some thinking to do about how important attitude, focus and leadership is in the investigative process."

– Deborah McLeod, North West Territories Human Rights Commission

"It was so helpful to me as a new investigator, and very inspiring to hear about the great work of the SORT team at Ombudsman Ontario."

– Kate J. Zavitz, Office of the Ombudsman, City of Toronto

Ombudsman André Marin holds a press conference for the release of his report Caught in the Act, *December 7, 2010.*

Communications and Outreach

Since the Ombudsman's work is driven by contact with the public, communications is a key part of everything the Office does. The Ombudsman uses all available forms of communications technology, from traditional media and in-person appearances at events to social media and live-streaming of news conferences, to inform and interact with the public.

In 2010-2011, the Office marked its 35th anniversary with a reception for staff and stakeholders celebrating the achievements of all six ombudsmen in its history. We also set new milestones in both traditional and social media reach, used social media for the first time in an investigation, held two live webcasts and launched a website redesign that will eventually allow users to reach our Office through their mobile devices via a special **app** (web application).

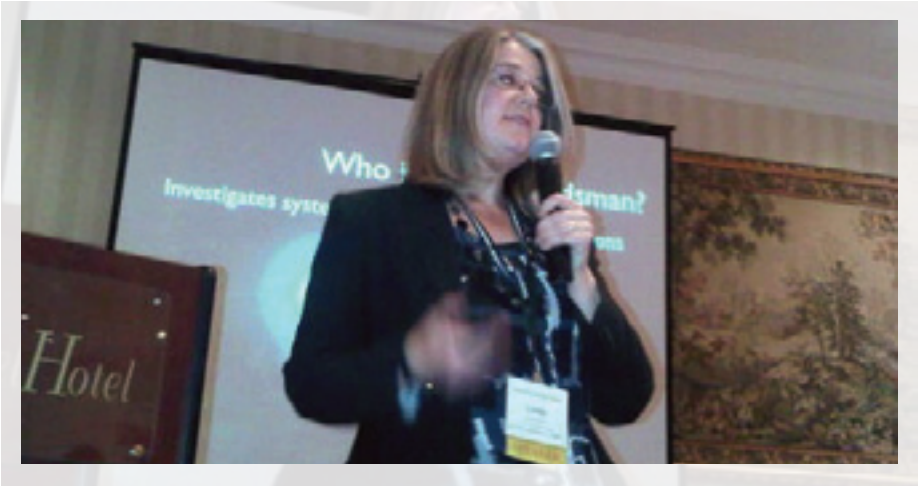
Traditional media

In 2010-2011, there were 1,032 print articles published about the Ombudsman's Office – primarily in daily newspapers in Ontario and across Canada – reaching an aggregate audience of **111.6 million** people. The estimated advertising value of these articles was **$3.9 million**, the highest in the Office's history. (Both the audience reach figure and the ad value are calculated by **FPinfomart** based on newspaper circulation and advertising rates, factoring in the number, length and display of articles.)

There were also **740** television and radio items broadcast about the Ombudsman and his work – including local, provincial and national coverage.

Social media

Since the Ombudsman first established a social media presence in early 2009, thousands of Ontarians – and interested people all over the world – have been able to use Facebook, Twitter, and YouTube to follow and comment on the Office's work and even contribute to investigations. The Ombudsman has been praised for his innovative use of social media, and Communications staff were invited to share the Office's expertise at a "Social Media for Government" conference in February 2011.



Communications Director Linda Williamson discusses the Ombudsman's use of social media at the Toronto conference, "Social Media for Government," February 2, 2011.

The Ombudsman's **Facebook** page – facebook.com/OntarioOmbudsman – had more than **1,400** followers at the time of writing this report (up from 985 a year ago) and received close to **30,000** visits in 2010-2011. The page serves as a virtual meeting place where people can ask questions, respond to press releases, news stories, job postings and other posted items and discuss issues related to the Ombudsman's jurisdiction.

Twitter has become an effective tool for the Ombudsman to promote his work, receive feedback, answer public questions directly and share news with his followers – more than **4,500** at the time this report was written (up from 1,800 a year ago). The Ombudsman personally maintains his Twitter account (@Ont_Ombudsman) and 2010-2011 marked the first time he used Twitter to reach out to the public for input in an investigation – into the expansion of police powers for the G20 summit.

The Ombudsman's branded **YouTube** channel assembles all of the Office's news conferences in one place. At the time of this writing, the total number of views for the channel's 34 videos was **10,900**. The most viewed video on the channel is the Ombudsman's press conference on the release of his G20 report, *Caught in the Act*. The video has been used, quoted and shared by community activists and various news producers, gathering close to **3,000** views on the Office's channel, and more than **20,000** views elsewhere on YouTube.

Website

The Ombudsman's website is a crucial communications tool for the Office, allowing people to file a complaint, read the Ombudsman's reports and speeches, comment on the latest news or watch a press conference at any time of day from wherever they may be. According to Google Analytics, the website had **83,164** unique visitors in 2010-2011 and **124,544** total visits, an increase of **20%** over the previous year. Complaints submitted via the website or email were also up 5%. Most visitors are from Canada, the U.S., the U.K., and France, but visitors came from a total of **181** countries.

Two of the Ombudsman's report release press conferences were live-streamed to the web for the first time in 2010-2011. Some **681** viewers tuned in live for the release of *The LHIN Spin* in August and more than **1,000** watched the *Caught in the Act* press conference as it happened in December.

The Ombudsman's website underwent a redesign in the spring of 2011 to modernize its design, better integrate social media and make it more accessible for mobile users. Later in 2011, it will incorporate another first for the Ombudsman world – an Ombudsman web app.

Outreach

The Office of the Ombudsman of Ontario was officially established on October 30, 1975. On November 1, 2010, Ombudsman André Marin and staff commemorated the Office's 35th anniversary with a reception attended by MPPs from all parties represented in the Legislature, most of the Ombudsman's fellow Officers of the Legislature, and many other distinguished guests.

Former Chief Justice of Ontario Roy McMurtry – who has known all six ombudsmen in the Office's history – gave an eloquent speech in tribute to the Office's achievements, as did the Speaker of the Legislature, Steve Peters, who praised the Office's contribution to democracy in Ontario.

Congratulatory greetings were also received from Premier Dalton McGuinty, Leader of the Opposition Tim Hudak and Third Party Leader Andrea Horwath.

> "In my view, the Office of the Ombudsman has served a legacy of which we all should be very proud. The Ontario Ombudsman has been an effective means of humanizing government and smoothing out the rough edges of relationships between the citizen and government and bureaucracy and bringing about important policy change...
>
> "The reality is we live in a society that's becoming increasingly bureaucratic and depersonalized. Even with the best intentions, governments are becoming more remote from the citizens whom they serve. While individual members of the Legislature continue to play a most vital role, they simply do not have the resources to effectively fight government bureaucracies.
>
> "Under the leadership of our present Ombudsman, André Marin, the work of the Office has continued to be extremely effective and vital, and his reappointment, in my view, was enormously deserved."
>
> ***– Hon. Roy McMurtry, former Ontario Chief Justice and Attorney General, speaking at the Office of the Ontario Ombudsman's 35th anniversary, November 1, 2010***

The Ombudsman was invited to speak about his work in a wide range of venues in 2010-2011, from symposia on health care to international ombudsman conferences to university law classes and public interest events. He was also the keynote speaker at the International Ombudsman Association's conference in April 2010 and spoke about assessing the quality of investigations at the National Association for Civilian Oversight of Law Enforcement in September 2010.

Ombudsman staff also participated in several outreach events and community fairs, including, among others, the Ontario Bar Assocation's Public Interest Day and the Student Public Interest Network Legal Action Workshop in March 2011.

Ombudsman André Marin and former Chief Justice of Ontario Roy McMurty at the Office's 35th Anniversary event, November 1, 2010.

Ombudsman staff met with members of the public at several events, including the Government and Community Services fair in Etobicoke in February 2011 (left) and the Ontario Bar Association's Public Interest Day in March 2011 (right).

Special Ombudsman Response Team – SORT

Since its creation in 2005 by Ombudsman André Marin, the Special Ombudsman Response Team, or SORT, has completed nearly **30** major systemic investigations. SORT investigations go beyond the immediate issue raised by an individual complaint and focus on the root cause of the problem. Through such investigations, the Ombudsman can resolve hundreds – even thousands – of potential complaints while making valuable contributions to the evolution of broader public policy.

SORT investigations are conducted using a team-based approach with an emphasis on face-to-face recorded interviews and painstaking gathering and review of evidence. Investigations are meticulously planned, identifying potential sources of evidence, developing realistic timelines and assigning sufficient resources in order to ensure those timelines are met. SORT's methods have become a model for administrative investigators around the world (for more information, see the **Training and Consultation** section of this report).

Not all SORT investigations result in a formal report and recommendations from the Ombudsman. In some cases, the mere prospect of a formal investigation prompts changes that resolve the problem. In other cases, an assessment reveals that an investigation is not warranted, or a resolution is possible. The Ombudsman does not issue a formal report and recommendations in such cases, but they are documented in this report.

The Ombudsman closely monitors the results of SORT investigations and what government organizations have done to implement his recommendations. In most cases, formal progress reports are submitted by the organizations at regular intervals. If the Ombudsman is of the view that a ministry has not followed through on its commitments or if progress appears too slow, he may decide to do a follow-up investigation.

SORT investigations completed in 2010-2011

The LHIN Spin – Hamilton Niagara Haldimand Brant LHIN

On August 10, 2010, the Ombudsman released *The LHIN Spin*, his report on the SORT investigation into the decision-making process of the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN). The investigation included an examination of the LHIN's approach to its mandate for community engagement in dealing with the restructuring of health services.

There are 14 LHINs across Ontario, established in 2006 to plan, fund and integrate the local health system. They are responsible for approximately $21.5 billion each year, most of which goes to local health service providers. The HNHB LHIN oversees about $2.4 billion of funding.

SORT's investigation was launched in March 2009 as a result of complaints from residents, community groups, health care professionals and other stakeholders about the LHIN's handling of two controversial hospital restructuring plans – involving Hamilton Health Sciences and the Niagara Health System. Complainants alleged that the LHIN failed to fulfill its mandate for "community engagement," there was insufficient consultation with stakeholders and the LHIN's decision-making process was generally lacking in transparency. By the end of the investigation, the Ombudsman had received more than **60** such complaints.

Ombudsman André Marin releases his report, The LHIN Spin, *August 10, 2010.*

The investigation did not address the merits of the restructuring plans themselves, as the Ombudsman does not have jurisdiction over hospitals or local health services. Instead, it focused on how the LHIN dealt with the plans and how it conducted community engagement. More than 50 people were interviewed, including all members of the HNHB LHIN board, key staff, health care professionals, community associations and residents, municipal politicians, senior representatives from other LHINs and government health officials from other jurisdictions. SORT also obtained and reviewed a substantial amount of documentation provided by the LHIN, the Ministry of Health and Long-Term Care and stakeholder groups.

The Ombudsman found that "community engagement," while required by the *Local Health System Integration Act, 2006*, is "undefined and inconsistent." The law provides no clear minimum standards for soliciting community views on priorities for things like integration plans. There had been considerable confusion about the nature of community engagement carried out by both health service providers and the LHIN. One LHIN board member even counted his discussions with people on the golf course or in line at the grocery store as "community engagement."

The Ombudsman also found that the LHIN had failed to ensure that its community had been adequately educated on what to expect in terms of community engagement. It also did not ensure the two health service providers had satisfied their community engagement obligations. He noted that the LHIN has an independent responsibility to ensure that any community engagement conducted by health service providers relating to local health services planning is open and transparent. To address this, he recommended that the Ministry of Health and Long-Term Care put forth guidelines to set out minimum standards for community engagement to be undertaken by both health service providers and LHINs, and that the LHIN educate the public – through its website, meetings and other methods – about its community engagement practices.

Particularly disturbing, the Ombudsman said, was that the LHIN had held several illegal secret meetings for the purposes of "education" of its members – a practice allowed by all LHINs across the province through a bylaw they had adopted. He recommended this practice cease immediately.

> "It is a very serious matter to close a LHIN board meeting to the public. While the LHIN may have been well-intentioned in holding its 'education' sessions, these meetings were plainly illegal.
>
> "I'm pleased the Ministry is going to direct the LHINs to change their bylaw, as I recommended. The public should never have been shut out of these meetings.
>
> "These LHINs are dealing with $21.5 billion of public funds. We don't want any hanky-panky. We don't want any cloak-and-dagger decision-making."
>
> ***– Ombudsman André Marin, release of The LHIN Spin, August 10, 2010***

The Ministry readily accepted the Ombudsman's recommendations on community engagement, but it initially did not agree with his finding that the bylaw allowing closed "education" meetings was illegal. However, the day before the Ombudsman's report was released, the Ministry advised him it would direct all LHINs across the province to rescind the bylaw allowing such sessions. The Ombudsman has since verified that this has been done.

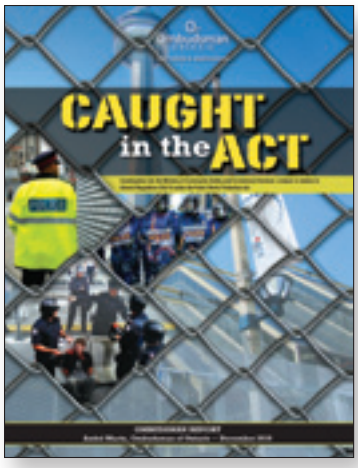
> "One of the good points the Ombudsman made was that you've got to be more open, more transparent, and be very careful about holding these in-camera meetings. If you're going to represent the community then the community should have access to you."
>
> ***– Premier Dalton McGuinty, as quoted in the* Globe and Mail*, August 13, 2010***

The HNHB LHIN did not initially accept the Ombudsman's findings and did not commit to take any actions in respect of the Ombudsman's recommendations.

In November 2010, the Ombudsman received the first quarterly follow-up reports from the Ministry and the HNHB LHIN. The Ministry reported that, in order to promote greater consistency, transparency and accountability, it had, in collaboration with a number of LHINs, developed a set of guidelines on community engagement, including principles, best practices and a set of performance indicators for use by all LHINs. The HNHB LHIN advised the Ombudsman that it had begun educating its health service providers and stakeholders on the new provincial guidelines.

In its second follow-up report in March 2011, the Ministry confirmed all LHINs had received its community engagement guidelines and it had conducted a training session on the guidelines, attended by Ministry and LHIN staff. All LHINs were to have posted their annual community engagement plans on their websites by the end of April 2011. These plans are intended to provide the public with an understanding of the community engagement activities anticipated in the coming years, goals for engagement, and how the community can participate.

The Ombudsman continues to monitor the progress made by the Ministry and the HNHB LHIN on his recommendations, as well as complaints about LHINs across the province.



Caught In the Act – Expansion of police powers for G20 summit

In the wake of the G20 summit in downtown Toronto during the weekend of June 25-27 – which saw massive demonstrations, property damage including smashed windows and several police cars set on fire, and more than 1,000 people arrested – the Ombudsman received hundreds of complaints from civil rights groups, protesters and individual citizens. Although the summit was planned by federal authorities, it was the Ontario government that expanded police powers during the event by passing Regulation 233/10 under the *Public Works Protection Act*. On July 9, 2010, the Ombudsman announced a SORT investigation into the Ministry of Community Safety and Correctional Services' conduct in relation to this regulation. On December 7, 2010, he released his report *Caught in the Act*, detailing how the Ministry's actions contributed to the now infamous events of that weekend.

The Ombudsman received a total of **255** complaints and submissions in relation to the G20 summit, including **88** after the release of his report. Many of those who complained had been detained, searched and/or arrested. Some alleged that police used excessive force. Other issues raised included the lack of notice and public debate surrounding the passage of the regulation and the lack of official communication about the wide-ranging powers it gave police.

The Ombudsman's investigation did not examine complaints about police conduct or conditions at the detention centre on Eastern Avenue in Toronto, since his jurisdiction does not extend to police – but those complaints were referred to the Office of the Independent Police Review Director, the RCMP complaints commission or municipal police forces as appropriate.

SORT investigators conducted **49** interviews with Ministry officials, senior members of the Ontario Provincial Police, City of Toronto officials, complainants and stakeholder groups, and reviewed thousands of pages of documents. They also used social media tools – Twitter, Facebook, YouTube and Flickr – to gather evidence for the first time, and obtained a wealth of information from citizens via websites and blogs as well. Twitter was used to track real-time events and comments and to communicate with potential witnesses, more than 5,000 G20-related videos were reviewed, and Facebook was among the means used to communicate with people and groups with information relevant to the investigation.

The investigation revealed that the Chief of the Toronto Police Service had written the Minister of Community Safety and Correctional Services on May 12, 2010, seeking legal reinforcement of police authority to protect the outer security perimeter around the G20 meeting area in downtown Toronto. He requested a regulation under the *Public Works Protection Act* – little-known legislation enacted in 1939 when Canada entered World War II. The Act is intended to protect public infrastructure and gives sweeping powers to police to protect streets, transportation, public buildings, etc.

Under the Act, those entering or attempting to enter a "public work" are required to identify themselves and state their purpose for entering. They and their vehicles can also be searched without warrant. If they refuse to produce identification or to submit to a search, they can be arrested, jailed and fined. They don't have the option of simply choosing to walk away.

The Ministry granted the Chief's request and a regulation was drafted to designate three areas along the security fence line as "public works," giving police authority to exercise powers under the *Public Works Protection Act* in the summit security zone.

The regulation was approved in a confidential cabinet session on June 2 and passed the next day.

The Ombudsman's investigation revealed that despite the fact that the regulation granted police exceptional and unprecedented powers under obscure wartime legislation (the likes of which don't exist in any other province), the Ministry decided not to make it public. It did not even consult stakeholders such as the City of Toronto or the RCMP, who had primary responsibility for the safety of delegates during the summit. The Integrated Security Unit only learned of the regulation when the media broke the story as the G20 was about to begin.

The Ministry also chose not to inform social justice groups – who were working with summit organizers to plan protests – that the government was contemplating issuing a regulation that would have significant impact on their normal civil rights. Instead, the Ombudsman's investigation revealed, Ministry officials deliberately kept the regulation under wraps. It was published on the government's e-Laws site on June 16, but, the Ombudsman noted, this did not constitute actual notice. This meant there was no opportunity to challenge the regulation in court, as was done with the sound cannons purchased by the Toronto Police for the summit.

> "Going into the G20 weekend, no one except for the police and a few government officials had any idea that the rules of the game had changed."
>
> **– *Ombudsman André Marin,* Caught in the Act**

The confusion surrounding the regulation was further compounded on the Friday of the G20 weekend when the Toronto Police Chief mistakenly said at a press conference that the regulation gave police new powers extending "five metres" outside of the security zone. The Ministry did not issue a press release to clarify this, and despite some efforts to get the correct information out, the Ombudsman's investigation revealed that police were detaining, searching and demanding identification of people well outside of the security perimeter – often miles away. Many people who had nothing to do with the protests – who were simply going to or from work or grocery shopping – were stopped and searched.

Noting that some officials had attempted to downplay the impact of the regulation by emphasizing that only a few people were actually charged under the *Public Works Protection Act* during the G20, the Ombudsman stressed that police had used these

Ombudsman André Marin points to a photo of a police search in his report Caught in the Act, *December 7, 2010.*

powers to routinely detain people who were not committing offences. They were asked to provide identification and submit to searches and were not free to remain silent or simply walk away – if they refused to comply, they could be arrested.

The Ombudsman found that the Ministry's actions in relation to Regulation 233/10 contributed to a massive breach of civil rights. He noted that the regulation **"was of dubious legality and no utility"** and that its effect **"was to infringe on freedom of expression in ways that do not seem justifiable in a free and democratic society."** He also noted it was "opportunistic and inappropriate" to use the *Public Works Protection Act*, a war measure which allows for extravagant police authority, to arrest and search people in the name of protecting public works.

> "Here in 2010 is the province of Ontario conferring wartime powers on police officers in peacetime. That is a decision that should not have been taken lightly or kept shrouded in secrecy, particularly not in the era of the Canadian Charter of Rights and Freedoms."
>
> ***– Ombudsman André Marin,* Caught in the Act**

The Ombudsman recommended that the Ministry of Community Safety and Correctional Services revise or replace the *Public Works Protection Act*, and examine whether the range of police powers conferred by the Act should be retained or imported into any new statute. He also recommended that it develop a protocol that would require public information campaigns when police powers are modified by subordinate legislation, particularly in protest situations.

On November 1, 2010, in response to the Ombudsman's preliminary report, the Minister of Community Safety and Correctional Services acknowledged that the Ministry should have handled the enactment of the regulation better and pledged that the public would be given notice of such changes in future. The Minister also confirmed, on behalf of the government, his "unequivocal commitment" to act on all of the Ombudsman's recommendations. The Ministry's first progress report to the Ombudsman is due in June 2011.

> "The ministry could have, and should have, handled the enactment of Regulation 233/10 better. In future, we will take greater care to ensure that the Ontario public is given more adequate notice of regulation changes of this nature."
>
> ***– Hon. Jim Bradley, Minister of Community Safety and Correctional Services, written response to Ombudsman's report***

Although Regulation 233/10 expired long ago, repercussions from the weekend of the G20 summit continue. Several reviews and investigations into the impact on civil rights and police conduct continue, including a systemic review of G20-related complaints about policing, announced July 22, 2010 by the Office of the Independent Police Review Director (OIPRD). In February 2011, at the OIPRD's request, the Ombudsman provided anonymized details of 112 complaints he received about police conduct during the summit (this information is also posted on the Ombudsman's website).

On March 25, 2011, the House of Commons Standing Committee on Public Safety and National Security issued its report, *Issues Surrounding Security at the G8 and G20 Summits*. One of its 12 recommendations was:

That the Standing Committee on Public Safety and National Security congratulate the Ontario Ombudsman on the quality and accuracy of his report, which focused on such details as misuse of "war measure" legislation – a Public Works Protection Act – in the present-day context of G20 demonstrations; confusion on the part of the Ministry of Community Safety and Correctional Services regarding

powers of arrest, which led police to mistakenly believe they had certain powers; miscommunication by the Toronto Police Service in its dealings with partners and the public regarding Regulation 233/10, passed under the Public Works Protection Act; lack of co-operation by the Toronto Police Service in the Ontario Ombudsman's investigation; no public announcement of the Regulation; no notices to other interested parties; and the ensuing human rights violations.

On April 28, 2011, the Ministry released the results of a review by Hon. Roy McMurtry of the *Public Works Protection Act*, first announced on September 22, 2010. Mr. McMurtry's recommendations built on those of the Ombudsman. He found that the Act was inconsistent with the *Charter of Rights and Freedoms* and called on the province to scrap it, replacing it with new legislation to protect such public works as nuclear energy facilities, courthouses, etc. as warranted. Mr. McMurtry also noted that police had sufficient powers under existing common law to protect events such as the G20. The Ministry agreed with all of Mr. McMurtry's recommendations.

> "It has been said that too much haste makes waste... We moved pretty quickly on this thing in order to help our police at the earliest possible opportunity. We did not take the appropriate steps to communicate this to the public... We acted on the basis of a law that has now been brought into disrepute. This was an extraordinary regulation and it deserved more transparency."
>
> ***– Premier Dalton McGuinty, as quoted in the* Globe and Mail*, December 8, 2010***

Long-term care homes

On December 21, 2010, the Ombudsman released his findings in his investigation of the province's monitoring of long-term care facilities. The investigation focused on the effectiveness of the Ministry's monitoring of the homes and whether the Ministry standards were realistic or detracting from effective compliance monitoring and patient care.

There are approximately 650 long-term care facilities in Ontario, with 75,000 residents. Run by both the public and private sector, they receive nearly $4 billion of public money every year.

The Ombudsman received some **450** complaints in the course of this investigation. Although SORT investigators could not directly investigate a large number of these complaints because long-term care homes are outside of the Ombudsman's jurisdiction, about **170** focused on issues involving the Ministry and how it handled complaints about the treatment of long-term care residents. These included a perceived lack of communication and transparency during the complaint investigation process and concerns that the Ministry's inspection and monitoring of homes was superficial, overly bureaucratic and not objective – and in some cases, actually interfered with the homes' ability to provide quality care.

In one of the largest probes in SORT's history, investigators conducted more than 250 interviews with long-term care residents and family members, unions, regulated health profession associations, compliance advisors, advocacy groups, Ministry officials, and long-term care staff, owners and operators. Investigators also visited 11 long-term care facilities, reviewed thousands of pages of documents and looked at best practices in other jurisdictions.

Throughout the investigation, which first began in July 2008, the Ministry's monitoring system for long-term care homes was "a work in progress," the Ombudsman noted in releasing his findings. (For example, the *Long-Term Care Homes Act*, enacted in 2007, finally came into force on July 1, 2010.) The Ombudsman provided the Ministry with input on the problems he had identified, and, because the Ministry showed it was

taking these issues seriously, the Ombudsman opted not to release a full report, but tabled a summary of his findings with the Legislature, including details of what the Ministry has done so far to address the issues.

The Ombudsman's investigation identified four main systemic problems:

- The standards being used to monitor long-term care homes were inconsistently interpreted and applied. There were so many criteria to check that compliance staff often lumped serious deficiencies in with less serious ones – a problem that "can result in dangerous situations continuing unchecked," the Ombudsman said.
- Inspections and follow-ups weren't done in a timely manner. Some homes went for 18 months without follow-up inspections after problems were identified. Several hadn't seen a specialist advisor in more than 15 years.
- The complaint investigation process lacked rigour and transparency – and in some cases residents and family members were threatened. The Ministry routinely referred complainants back to the homes themselves. People who complained were given little information about the basis for any findings.
- The public posting of inspection information on the Ministry's website was "partial, incomplete and at times inaccurate," as well as practically incomprehensible and grossly outdated.

In tabling his findings, the Ombudsman wrote to the Ministry:

> **"I am guardedly optimistic that the proposed organizational reforms and new regulatory scheme will lead to more effective oversight by the Ministry and ultimately, improvement in the living conditions and care experienced by long-term care home residents. I intend to monitor the Ministry's ongoing progress closely."**

The Ombudsman is monitoring the Ministry's progress in: Developing more effective risk indicators, using technology to enhance inspections and decrease resident risk, improving training for compliance staff, responding more quickly to serious complaints and reporting inspection findings more transparently. He indicated that he will reopen his investigation if there is no progress or if it is otherwise warranted.

The Deputy Minister of Health and Long-Term Care thanked the Ombudsman for his **"attention and guidance in helping the Ministry meet its commitment on this critical issue."** The Ministry's next progress report to the Ombudsman is due in June 2011.

SORT assessments completed in 2010-2011

Hydro One – Smart meters

The Ombudsman has seen an increase in complaints about Hydro One in recent years as electricity rates have risen and the province has moved to install "smart meters" in all homes and implement "time of use" billing, where electricity costs more at certain peak-use times of day. In 2010-2011, **306** complaints were received about Hydro One – many of them from people who saw large increases in their bills after the new meters were installed.

SORT conducted an assessment of complaints about smart meters to determine whether a systemic investigation was warranted. Although the Ombudsman does not have jurisdiction over municipal utility companies, he does have jurisdiction over Hydro One, which has 1.2 million customers.

Hydro One implements time-of-use billing in three stages, starting with the installation of the smart meter. The meter has to be activated, and then the customer is transitioned to time-of-use bills. By October 2010, Hydro One had installed just over 1 million smart meters, but only 200,000 customers had been switched to time-of-use billing, with another 100,000 expected to be transitioned each subsequent month.

SORT reviewed individual complaints, met with Hydro One staff and researched the implementation of smart meters in other jurisdictions. They also examined Hydro One's complaints process.

A number of factors appear to have contributed to complaints and public frustration about the implementation of smart meters, including: Discrepancies found when the new meter was installed and a so-called "true-up" reading done by Hydro; errors in estimated meter readings; changes in customer electricity use; and an overall rise in electricity rates, combined with the application of the Harmonized Sales Tax to electricity. In cases where customers believe their meter is not reading correctly, Hydro One can have the meter tested, or request that it be tested by Measurement Canada – the federal agency responsible for certifying smart meters.

The Ombudsman decided that a systemic investigation was not warranted, but will continue to monitor complaints about smart meters and, in particular, how Hydro One responds to them.

Unfair college appeal process

A nursing student complained to the Ombudsman that her college of applied arts and sciences had an unfair appeals process. She had been given a failing grade by an ad hoc review committee that reviewed her performance. She had tried to appeal within the allowed timeframe, but the college said no appeal was received.

SORT investigators interviewed staff at the college and reviewed documentation and determined that, although it had reasons for issuing the failing grade, the college's review and appeal processes were not sufficiently clear, leading to confusion for the student. In a letter to the college president in July 2010, the Ombudsman made suggestions to make these processes more transparent.

The College was receptive to the Ombudsman's suggestions and made changes immediately. It amended its program policies and procedures to clarify the information to be provided to students about committee proceedings and the process for submitting appeals of committee decisions. The college's academic calendar was also updated to indicate that decisions of the committee can be appealed.

North East LHIN

The Concerned Citizens Committee of North Bay and Area filed a complaint with the Ombudsman about a decision of their Local Health Integration Network (LHIN) to transfer 31 specialized long-term mental health beds from North Bay to Sudbury. The group complained that the decision was unreasonable and that the LHIN had failed to consult with patients, families and specialized care professionals about the impact such a change would have.

SORT investigators assessed the matter to determine whether a formal investigation was warranted. They spoke to LHIN staff, including the CEO and the interim board chair, and gathered documentation from the LHIN and from the citizens' group. Seven members of the group were interviewed via Internet video calling (Skype) – a first for the Ombudsman's Office.

SORT's review focused on the decision-making process, not the merits of the decision itself, as it was within the LHIN's mandate to determine where the 31 beds should be located. The review revealed that there had in fact been considerable consultation about the issue over several years, including an advisory panel created by the LHIN to examine the issue and consult with those whom it affected. As a result, a task force was set up to review and make recommendations on the location of the 31 beds. It canvassed input from a variety of stakeholders and recommended relocating the beds to Sudbury. The LHIN accepted the task force's recommendation.

The Ombudsman noted that the decision to move the 31 beds away from North Bay was contentious. Many local people disagreed with the decision and the Concerned Citizen's Committee was a powerful advocate for keeping the beds in North Bay. However, he concluded that the LHIN had lived up to its obligation to engage the community when making plans, and opted not to conduct a formal investigation.

Ministry of Labour – Employment Practices Branch

The Employment Practices Branch (EPB) enforces the *Employment Standards Act, 2000,* which provides for minimum workplace standards that employers and employees must follow. After a 2009 SORT assessment of complaints about delays in claims handling at the EPB, the Ombudsman decided not to conduct a formal investigation but to monitor ongoing initiatives to address the problem.

The EPB created a temporary task force to eliminate its claims backlog, and by January 31, 2011, it had been reduced to 4,500 claims from 7,200. Also in January 2011, it introduced a new process for filing employment standards claims to expedite claim resolution and to prevent recurrence of a backlog. The new process focuses on informal resolutions and sets timelines for processing new claims, including assignment for initial assessment in less than a month. EPB advised the Ombudsman that it expects the backlog to be cleared by spring 2012.

As well, EPB has created several new resources for employers and employees, including interactive web tools to assist in the calculation of holiday, severance and termination pay, and publications in several languages.

The number of complaints about the EPB to the Ombudsman decreased from **76** complaints in 2009-2010 to **47** this past year – less than half of which were about delays. The Ombudsman will continue to monitor the EPB's progress in streamlining its processes and reducing its backlogs.

Wind turbines

Since SORT's initial assessment of **30** complaints about wind turbines in 2009-2010, the Ombudsman has actively monitored this issue, particularly concerns raised about the potential health effects of wind energy. We received more than **40** additional complaints and submissions from individuals and groups in 2010-2011. The Ombudsman has focused on whether the government has in place, or is creating, an adequate administrative process to consider and respond to complaints related to wind turbines.

As part of SORT's monitoring of this issue, investigators have interviewed staff from the Ministry of the Environment about its handling of wind turbine noise complaints. They also reviewed documentation from the Ministry's Sector Compliance Branch about its inspections of wind farm sites. We continue to receive updates from the Ministry regarding its work on the measurement of wind turbine noise.

In March 2011, Ontario's Divisional Court ruled on an application seeking to stop the development of wind turbines until more studies on their health effects are conducted. The court found that the Ministry of the Environment followed the processes in place, but it did not address the issue of whether or not wind turbines cause health problems.

In February 2011, the government announced that it would not be proceeding with proposed offshore wind turbine projects pending further scientific research. Also, the Ontario Research Chair in Renewable Energy Technologies and Health, funding for which is arranged by the government, is conducting studies of potential health effects associated with wind energy.

The Ombudsman has determined that a systemic investigation is still not warranted, but has tasked SORT to continue to monitor the issue, including ongoing related legal applications.

Ongoing SORT investigations

Non-emergency medical transportation services

On January 11, 2011, the Ombudsman launched an investigation into whether the Ministry of Health and Long-Term Care and the Ministry of Transportation were ensuring adequate measures to protect the public amidst serious concerns raised about non-emergency medical transportation services.

Medical transportation services (MTS) are private companies that transfer hundreds of thousands of non-critical patients each year between Ontario hospitals or from hospital to home. The vehicles are not ambulances – although they generally look like ambulances – and they are not regulated.

The investigation was sparked by dozens of complaints to the Ombudsman from patients, their families and whistleblowers from within the MTS industry. Many raised concerns about the complete absence of formal regulations for the industry. Others raised concerns about patient safety, including allegations of a lack of infection control, poor or non-existent equipment and insufficiently trained staff.

After the investigation was announced, the Ombudsman received more than **60** additional complaints and information submissions from municipalities, emergency health services, former and current MTS employees and employers, as well as patients. SORT investigators reviewed hundreds of documents provided by the Ministries and other sources and conducted more than **100** interviews, including with senior staff from hospitals and long-term care homes, Local Health Integration Networks, the Association of Municipal Emergency Medical Services of Ontario, the Association of Municipalities of Ontario and the Ontario Hospital Association. They also reviewed how other provinces deal with similar issues. The evidence-gathering phase of the investigation was completed within 90 days, as promised by the Ombudsman.

At the time this report was written, the Ombudsman was preparing his preliminary report and recommendations for submission to the Ministries.

Funding of the breast cancer drug Herceptin for small tumours

The Ombudsman asked SORT to assess the issue of the Ministry of Health and Long-Term Care's limited funding of Herceptin after receiving a complaint on February 28, 2011 from Jill Anzarut, a breast cancer patient who was denied funding for the drug because her tumour was too small. On March 18, 2011, he announced an investigation into the Ministry's decision not to provide funding for the drug to breast cancer patients whose tumours are less than one centimetre in diameter.

The Ombudsman's investigation focused on whether or not the Ministry's decision to limit the funding was informed and reasonable. SORT interviewed seven patients in a similar situation to Ms. Anzarut and reviewed policies in other jurisdictions.

On May 12, 2011, the Ombudsman suspended his investigation after the Ministry decided it would fund Herceptin to treat tumours of one centimetre or less, as the first drug covered by its new Evidence Building Program.

Although the investigation was suspended, the Ombudsman asked the Ministry for regular updates on the implementation of the new program and will continue to monitor developments and complaints regarding this issue.

Ontario Provincial Police operational stress injuries

Over the past year, the Ombudsman has received several complaints from officers with the Ontario Provincial Police (OPP) – some retired, some still on the job – about the way the OPP handles members suffering from psychological injury as a result of being exposed to traumatic events on the job. These injuries, known collectively as operational stress injuries, include depression, anxiety, addictions and post-traumatic stress disorder.

The bulk of the complaints related to alleged poor treatment by the OPP when operational stress injuries became apparent, including that affected officers were ostracized and stigmatized. Other issues raised included a lack of training and education for serving officers about operational stress injuries and a lack of support systems for those who need help.

In assessing the complaints, SORT spoke to dozens of current and retired police officers, the OPP and municipal police services, family members, counsellors, psychologists, traumatic stress specialists and other stakeholders. The review revealed that the issues raised in the complaints were not limited to the OPP alone but existed in other police forces outside the Ombudsman's jurisdiction.

On March 31, the Ombudsman announced he was launching a formal investigation into how the OPP deals administratively with operational stress injuries among its members. He also announced that the investigation would look at the Ministry of Community Safety and Correctional Services' administrative processes relating to operational stress injury in police services across Ontario.

Updates on previous SORT investigations

Too Cool for School – Bestech Academy

The Ombudsman's July 2009 report *Too Cool for School* revealed systemic problems in the Ministry of Training, Colleges and Universities' lax oversight of private career colleges. Since then, the Ministry has reported to the Ombudsman on a quarterly basis about its progress in implementing his 11 recommendations. It has dramatically improved its enforcement processes against unregistered colleges and has hired more inspectors.

One remaining area of concern relates to the Ombudsman's recommendation that the Ministry address delays in processing of registrations and approvals for private career colleges. The Ombudsman continues to receive complaints that the Ministry takes too long to approve programs. Ombudsman investigators have met with Ministry officials to discuss their progress in dealing with these delays. They advised that they would be implementing service delivery standards – a development that the Ombudsman will continue to monitor.

A Vast Injustice – Funding for the colorectal cancer drug Avastin

The Ombudsman's September 2009 report, *A Vast Injustice*, recommended that the Ministry of Health and Long-Term Care lift the arbitrary cap on funding the drug Avastin for patients with metastatic colorectal cancer. SORT's investigation of the Ministry's decision to limit the funding to 16 treatment cycles – regardless of the recommendations of patients' oncologists – led the Ombudsman to conclude that cap was unsupported by medical evidence, unreasonable and wrong.

Two months after the Ombudsman's report was released, Ontario removed the funding cap and, like other provinces that fund Avastin, agreed to continue funding treatments past 16 cycles for patients who continued to do well on the drug. The decision came as an enormous relief to patients for whom the drug was a lifeline – it is not a cure, but it prolongs life by arresting the growth of tumours. Most patients could not afford to pay for Avastin themselves at up to $2,000 per two-week cycle – some were forced to stop treatment, and others resorted to raising funds in the community to cover their costs.

Since late 2009, the Ministry has reported regularly to the Ombudsman on its response to his recommendations, including posting a detailed rationale for funding Avastin on its website, and improving its monitoring of patients receiving drugs under the New Drug Funding Program.

The Ministry advised that as of October 31, 2010, some **400** patients had received more than 16 cycles of treatment with Avastin since the change in funding criteria, representing 18% of all patients who have received Avastin for the treatment of metastatic colorectal cancer.

> *Emails to the Ombudsman from the family of a patient who was still being treated with Avastin, a year after the cap was lifted:*
>
> Her overall condition was described as being more of a miracle than anything else... mostly thanks to the Avastin she was on …
>
> All of her scans have shown very positive results, each being better than the last, which leads us to be hopeful that at some not too distant time, she will be declared in remission.
>
> Without all your hard work, and most importantly, your genuine, kind concern … there is no question of what the outcome would have been.

Oversight Unseen – Special Investigations Unit

On September 27, 2010, the Ombudsman informed the Ministry of the Attorney General that SORT investigators would be conducting a follow-up investigation into the Ministry's implementation of his recommendations from his 2008 report, *Oversight Unseen*.

The SIU has a statutory mandate to conduct independent investigations into incidents where a police officer is involved in a serious injury or death. In *Oversight Unseen*, the Ombudsman directed 25 recommendations to the SIU to promote greater independence, rigour and integrity in its investigations. Six recommendations were focused on the need for the Ministry of the Attorney General to fully support the SIU in its independent oversight role, and 15 called for the government Ontario to clearly define, enhance and entrench the SIU's authority in new legislation.

Since then, the SIU has made steady and welcome progress in implementing the recommendations directed at it, including assigning sufficient resources to investigate incidents, hiring more civilian investigators and supervisors, providing the public with more details about investigations that have not led to charges, and publicizing instances of police practices that negatively affect its ability to perform its oversight function effectively.

However, the SIU continues to be hampered in its role by the lack of clear statutory direction as to the scope of its mandate. For example, there are competing definitions of what constitutes a "serious injury" triggering SIU jurisdiction. There is controversy surrounding the rights of witness and subject officers to share the same lawyer in SIU cases and to consult a lawyer when preparing their notes. The SIU has also publicly questioned the reliability of police notes prepared this way. At the time this report was written, these issues were before the courts.

The Ministry of the Attorney General agreed to the Ombudsman's recommendations when *Oversight Unseen* was released. However, little progress has been made with respect to key recommendations for legislative reform. It was not until December 2009 that the Ministry retained Hon. Patrick LeSage to explore "the potential for consensus" among the parties on issues affecting SIU and police relations, including the definition of "serious injury," the right to counsel and note-taking, and the purpose and content of SIU press releases.

Mr. LeSage's brief report, released in April 2011, reaffirmed several of the concerns that the Ombudsman had identified in his 2008 report, and built on some of the Ombudsman's suggestions for improvement. Among Mr. LeSage's recommendations was that a definition of "serious injury" be codified in the legislation, that the same lawyer not represent subject and witness officers, and that the Ministry request that the Law Society of Upper Canada amend the Commentaries to the Rules of Professional Conduct to ensure that the prohibition against officer communication until SIU interviews are completed is not undermined through joint retainers.

Mr. Lesage's review has added value to the ongoing dialogue concerning the SIU. However, there are outstanding issues that the Ombudsman is considering as part of his investigation. Delayed notification and failure to notify the SIU on the part of police officials continues to be an area of concern, particularly given the Ontario Provincial

Ombudsman André Marin discusses his plan to follow up on his 2008 report on the SIU at his last Annual Report press conference, June 2010.

Police's recent adoption of preliminary screening for "criminality" prior to notification of the SIU. Lack of effective enforcement for regulatory contraventions is also a continuing problem. In addition, there continues to be limited transparency around incidents investigated by the SIU.

The Ombudsman expects to report on this investigation later in 2011.

A Game of Trust – Ontario Lottery and Gaming Corporation

The repercussions of the Ombudsman's 2007 report on the Ontario Lottery and Gaming Corporation (OLG) continued to be felt in 2010-2011. The Ombudsman's report, *A Game of Trust*, detailed the problem of suspicious "insider wins" by OLG retailers who had taken customers' tickets and claimed them as their own. The largest known suspicious case, he reported, was that of a $12.5-million lottery prize paid to the sister of a lottery ticket retailer in Burlington in early 2004.

At the time of the Ombudsman's investigation, OLG management took a "hold your nose" attitude to such cases – prizes were paid with few questions asked, and little thought was given to finding the rightful winners. But in the years since, new OLG management has embraced the Ombudsman's recommendations to change its culture and remember its role as a public servant. It has passed suspicious cases, including those several years old, to the Ontario Provincial Police for investigation, and implemented new technology called "DART" – Data Analysis and Retrieval Technology – in order to trace ticket purchasers through their playing patterns.

In June 2010, a Toronto retailer was convicted of stealing a ticket worth $5.7 million. In September 2010, the OPP laid charges in the 2004 $12.5-million case against a former OLG retailer, his father and sister. Thanks to DART, the OLG announced in January 2011 that, in consultation with the OPP, it had found the rightful winners of the $12.5-million prize – a group of seven former co-workers who had purchased the winning ticket on December 26, 2003. With interest, their prize came to $14.8 million.

Adding Insult to Injury – Criminal Injuries Compensation Board

The Ombudsman continues to monitor the implementation of the recommendations from his February 2007 report, *Adding Insult to Injury*, to ensure that victims of violent crime and their families receive timely and appropriate services from the Criminal Injuries Compensation Board.

In March 2010, the board chair advised the Ombudsman that his report has had an important role in improving the CICB's administration of compensation efforts for victims of crime. Only one of the Ombudsman's recommendations has yet to be implemented – the creation of an advisory committee consisting of crime victims and their advocates. The board has advised the Ombudsman that it is considering establishing a formal advisory relationship with the Office for Victims of Crime to enable it to obtain input from stakeholders in a timely and cost-effective manner.

In September 2010, the CICB implemented a "regional triage team" pilot project to improve the overall service it offers and to reduce its claims processing time to under 12 months. (At the time of the Ombudsman's 2007 report, victims' claims took an average of **three years** to be processed by the CICB.) This project resulted in several improvements and two more triage teams were added in April 2011.

Statistics provided by the CICB indicate it has continued to reduce delays. On March 31, 2011, its caseload was approximately 5,294 – down from 5,916 in March 2010, 6,650 in January 2009, 8,290 in November 2007 and 9,640 in July 2006. It received an average of 310 claims per month in 2010-2011, slightly less than the previous year's monthly average of 336. It completed 3,975 hearings in 2010-2011 – slightly more than the previous year's 3,792. The average time to complete a claim in 2010-11 was approximately 20 months, an improvement over 2009-2010's 24 months.

Complaints to the Ombudsman about the CICB have continued to fall, from **192** in 2006-07 to **39** in 2010-2011.

Between A Rock and A Hard Place – Children with special needs

In his 2005 report, *Between a Rock and a Hard Place,* the Ombudsman found that as many as **150** families had been forced to surrender their parental rights to children's aid societies (CASs) in order to get residential care for their severely disabled children. He found that the Ministry of Children and Youth Services had failed these families in a manner that was "unjust, oppressive and wrong" and recommended the Ministry immediately restore custody rights and ensure funding was provided for residential placements outside of the child welfare system.

In response to the Ombudsman's recommendations, the Ministry provided additional funding for the care of children with severe needs and returned 65 children to their parents' custody. It did not agree, however, to remove its moratorium on special-needs agreements. Instead, it committed to better co-ordinating special-needs services for families in need.

Despite this, complaints to the Ombudsman about services and treatment for children with severe special needs have continued to increase over the past few years. In 2010-2011, there were **44** such complaints – up from 39 in 2009-2010 and 24 the previous year. Although not all of these cases involved parents who had reached the point of turning their children over to CAS care, most raised real concerns about the availability of services for these children. Some examples:

- The mother of a 15-year old girl with developmental disabilities, mental health and gender identity issues, contacted the Ombudsman after she had signed a temporary care agreement with the CAS that placed her daughter in a group home. She feared she would have to give up custody of her daughter to the CAS so it would continue to fund the group home placement. She had been told by her community's service co-ordination agency that her daughter did not meet the criteria for complex special needs funding. After Ombudsman staff asked the Ministry to review the case, the funding for the girl's placement was taken over by the local service co-ordination agency.
- A family who adopted a 13-year-old boy with special needs complained to the Ombudsman that they felt pressured to enter into a temporary care agreement with their local CAS when the special-needs agreement set up to fund the boy's residential placement had expired. In response to the inquiries of Ombudsman staff, the CAS extended the special-needs agreement and the Ministry confirmed it would fund the placement in the event that the CAS did not renew the agreement.
- The mother of a 15-year-old boy with special needs complained to the Ombudsman that her local child welfare agency told her repeatedly that she would have to give up custody in order to keep him in a necessary residential placement. She had originally placed him in care voluntarily through a temporary care agreement on the understanding this would allow her to remain his legal guardian. She was later told this arrangement could only last a year, after which she would have to give up custody of the boy to continue his placement. After Ombudsman staff spoke to the Ministry, it confirmed that the boy qualified for group home placement and he was moved into another home a few days before the temporary agreement expired.
- A retired grandmother who was the guardian of her 12-year-old grandson with special needs contacted the Ombudsman after the Ministry told her there were no available daytime treatment placements in the community. She had been given guardianship after her daughter had passed away, leaving her grandson in CAS care. The boy's psychiatrist also believed the case was urgent. In response to Ombudsman staff inquiries, the local service co-ordination agency found a suitable day program for the boy and provided in-home services and respite support for the grandmother.
- The father of a 17-year-old boy whose residential placement had been funded by a child welfare agency for 12 years contacted the Ombudsman when the agency decided the boy could be reintegrated into the community. The father said the boy had become extremely angry and withdrawn because the promised supports were not in place when returned to the family. Ombudsman staff worked with the Ministry and the local service co-ordination agency to assist the family with funding and a special support worker.

One of the initiatives launched by the Ministry in 2009 was the implementation of an "early alert" system to identify families in crisis who may require supports such as a residential placement for a child with special needs. This was established to ensure parents would not have to relinquish custody in order to obtain residential services. However, we continue to hear from families who are in crisis and are already involved with CASs, even though there are no protection concerns, in order to get the financial and other support required for their child. The Ministry was unaware of the families' situations in several of these cases. The Ombudsman has directed his staff to keep a close eye on these cases, particularly where the early alert system failed.

> "Families go to their government for help and they're told there's no money – but they discover there could be help available if they turn their child over to the state. That is bureaucratic dysfunction at its worst."
>
> ***– Ombudsman André Marin, as quoted in the* Ottawa Citizen*, June 16, 2010***

There has also been an emerging trend in cases involving the provision of special-needs services for children reaching age 18. The Ombudsman received **12** complaints from families who had funding for their child's services slashed or cut off abruptly at age 18. These families fell through the cracks between the Ministry of Children and Youth Services and the Ministry of Community and Social Services, which handles adult developmental services. They were told that funding in the adult services sector was "discretionary" and there was no provincial mandate to care for the special needs of adults. Funding was also limited by the March 2009 freeze on the Ministry of Community and Social Services' discretionary Special Services at Home program.

Although the Ministry of Community and Social Services has recently implemented a new standardized assessment tool for adult special needs cases, the complaints received by the Ombudsman indicate gaps in the availability of services for adults with special needs.

In one case, the single mother of an 18-year-old man contacted the Ombudsman after six months of trying to transition her son to adult services. Her funding had been cut by $15,000 a year. She and her son's psychiatrist had told the Ministry of Community and Social Services the situation was urgent but were advised there was no money available because all of the Ministry's resources had been allocated to the community and there was no provision for direct funding arrangements. The Ministry told Ombudsman staff that the man would have to go on a waiting list. The situation became serious when the mother became unwell and was concerned about her ability to continue to care for her son at home. As a result of Ombudsman staff inquiries with the Ministry and the Local Health Integration Network (LHIN), emergency funding was provided, plus increased funding for in-home care and personal support for the mother.

In another case, the Ministry terminated funding for respite services for the mother of a 20-year-old developmentally and physically disabled man when he turned 18. She was told her son would be placed on the adult services waiting list along with 124 others. The mother contacted the Ombudsman for help and her doctor later advised that she was unable to continue caring for her son. Ombudsman staff asked the Ministry to review the family's needs and within days, it found a placement for the son in a local adult residential facility.

The Ombudsman continues to monitor this emerging and disturbing trend in complaints.

Open Meeting Law Enforcement Team – OMLET

Under the *Municipal Act, 2001,* with limited exceptions, municipalities must hold their council, local board and committee meetings in public. Since January 1, 2008, Ontarians have had the right to complain about municipal meetings they think have been improperly closed to the public. The Ombudsman investigates these complaints for all municipalities that have not appointed their own investigators.

At present, the Ombudsman is the investigator for closed meeting complaints in **199** of Ontario's 444 municipalities.

The Ombudsman's **O**pen **M**eeting **L**aw **E**nforcement **T**eam (OMLET) reviews and investigates these complaints and works to educate the public and municipalities about the requirements for open meetings.

In 2010-2011, OMLET handled 95 cases (11 from the previous year and 84 new cases). Of these, 51 were closed, 31 were referred to investigators appointed by the municipalities, and 13 remained in progress at March 31, 2011.

The municipal elections in October 2010 resulted in changes to many local councils. In light of this, the Ombudsman's Office distributed about 9,000 copies of our guide to open meetings, the *Sunshine Law Handbook*, free of charge to every municipal councillor and clerk across Ontario, regardless of whether or not they use the Ombudsman as their investigator. The handbook reflects the Ombudsman's experience as an investigator of closed meeting complaints and includes frequently asked questions, excerpts from relevant legislation, and tips on best practices. It is also available on the Ombudsman's website.

OMLET formally investigated three cases in 2010-2011, involving closed meetings in **Mattawa** and **South Bruce Peninsula**. Reports on these investigations are available from those municipalities as well as on the Ombudsman's website. The other **48** cases were reviewed and resolved without formal investigation or the publication of formal reports. In these cases, OMLET staff reviewed relevant documentation, including meeting minutes and agendas, and communicated with municipal clerks and staff as needed to assess whether the open meeting requirements of the *Municipal Act*

were satisfied. When the Ombudsman found municipalities fell short of the Act's requirements or recommended areas for improvement, OMLET sent letters to the municipalities asking that the Ombudsman's findings and recommendations be made public at council meetings.

What follows is an overview of some of the more remarkable cases handled by OMLET in 2010-2011, as well as the common themes revealed in the 51 cases.

When is a meeting a "meeting"?

After the 2010 municipal elections, the Ombudsman received several complaints about "orientation" and "transitional" meetings that were held for newly elected and re-elected councillors. It is the Ombudsman's view that gatherings of a purely social nature are not subject to the open meeting requirements of the *Municipal Act*. However, if members of a body come together **for the purpose of exercising the power or authority of the body** or for the purpose of **doing the groundwork necessary to exercise that power** or authority, then the gathering should be considered a "meeting" and it must comply with the open meeting rules.

On **November 5, 2010**, the mayor-elect for the town of **Kearney** held a meeting at his home for newly elected council members, after the clerk confirmed with legal counsel that such a gathering would not violate the open meeting requirements. During the gathering, attendees created a list of issues to address in the upcoming term. Another meeting was held at the mayor-elect's home on **November 26, 2010**, to discuss committee appointments, changes to the municipality's voting procedure and other items. As only two of those present were serving councillors (the rest had yet to be sworn in), legal "quorum" did not exist, but clearly the meetings were not purely social. Those in attendance were setting the groundwork for future decision-making. The Ombudsman found that while technically, these meetings may not have violated the Act, they were inconsistent with its principles of transparency, accountability and openness. He encouraged all councillors to be vigilant in fulfilling the spirit of the Act in future.

The mayor-elect for the township of **Coleman** cancelled a private meeting for incoming council members at a local lodge, after concerns were raised about its propriety. However, on **November 17, 2010**, all the members of the new council met with the outgoing council members in a closed session to enable "free" discussion of various issues. There was little detail in the meeting minutes about what was discussed, but OMLET staff found at least one of the items was not identified in the resolution authorizing the closed session, and another did not fall under the permissible exceptions to the open meeting rules (e.g.,discussions about legal advice or personal matters).

On **November 30, 2010**, the newly elected council for the municipality of **Powassan** met privately to discuss council priorities and committee membership. The meeting lasted two hours. Since four attendees were re-elected councillors, there was a quorum, however, there were no municipal staff in attendance, no public notice, agenda or official minutes. OMLET staff determined that while no decisions were taken at the meeting, it contravened the open meeting rules because it laid the groundwork for decision-making. The mayor disputed this finding, saying legal "quorum" didn't exist because one councillor participated in the meeting by phone. The Ombudsman noted that it is the substance of a meeting, not technicalities of quorum, that is significant. It would be absurd if municipal bodies could circumvent the law simply by having members participate in meetings by telephone. This is the very type of clandestine practice that the open meeting law was designed to prevent.

Several cases in 2010-2011 raised the issue of whether gatherings of municipal officials at restaurants and other venues constituted "meetings" that should have

been open to the public. OMLET's **South Bruce Peninsula** investigation looked into some councillors' practice of meeting at a local Tim Horton's coffee shop after their council meetings. The Ombudsman warned that while there was no evidence that these gatherings were anything other than social, such gatherings (particularly in such close proximity to official council meetings) risked attracting public speculation and suspicion, and those in attendance should be extremely careful to ensure that casual conversation does not drift into improper areas – i.e., official council business.

OMLET also reviewed an impromptu meeting at the offices of the Downtown **Oshawa** Business Improvement Area Board of Management on March 4, 2010, involving the chair, administrator and a couple of board members. During this casual gathering, the administrator briefed the others on an earlier meeting of a city committee where concerns about the board were raised. The Ombudsman found that this was an improperly closed meeting. Similarly, his **Mattawa** investigation found council had held an improper meeting on November 23, 2009 after a guided tour at the local museum, when the Mayor briefed council members about a motion to be tabled later that evening at a public meeting.

When to make "exceptions"

The Act allows nine exceptions to the rule that municipal meetings must always be conducted in public. These involve:

1. The security of the property of the municipality or local board;
2. Personal matters about an identifiable individual, including municipal or local board employees;
3. A proposed or pending acquisition or disposition of land by the municipality or local board;
4. Labour relations or employee negotiations;
5. Litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
6. Advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
7. A matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
8. "Education and training" of the members of the council, local board or committee; and
9. Consideration of a request under the *Municipal Freedom of Information and Protection of Privacy Act*.

The first eight exceptions are discretionary – in other words, the municipality is not required to bar the public from sessions where such matters are discussed. (The ninth is not – in such cases, the Act says the meeting "shall" be closed.)

In many of the cases OMLET reviewed, the municipalities properly closed meetings under one or more of the exceptions. However, in some cases, they stretched their interpretation of the exceptions in order to justify closing meetings. In other cases, municipalities simply cited the wrong exception for the circumstances. The Ombudsman believes these exceptions must be narrowly construed and meetings should be open wherever possible.

Here are some of OMLET's 2010-2011 cases where these exceptions were cited:

Kearney town council resolved to discuss two issues in a closed session on August 25, 2010, on the basis that they concerned "**litigation** or potential litigation." One issue related to a lawyer's letter that threatened litigation over road closures, where there was a real possibility that legal action would be initiated. The second item concerned a rezoning application, where an appeal was possible, but legal action was not imminent. OMLET staff discussed these items with the municipality and observed that the second item lacked the degree of certainty necessary to support closing the meeting. Ultimately, the mayor had this item removed from the closed meeting agenda before it was considered.

On January 24, 2011, **Sudbury's** Audit Committee met in closed session to consider a report by the city's auditor general concerning shift trading and selling among transit workers. One of the reasons given for closing the meeting was that **personal** matters about an identifiable individual would be discussed. In fact, the discussion was quite general – no staff members were identified by name, and only two people were referenced by their titles. OMLET staff suggested to the city that the "personal matters" exception should only be used when absolutely necessary in order to protect privacy of an identifiable individual.

Sudbury's Audit Committee also used the **"security of property"** exception to justify closing the same January 24 meeting. OMLET staff observed that this was intended to refer to protection of property from physical loss or damage, not a risk of future litigation, which the committee cited in this case.

Clarence-Rockland council closed a meeting on April 12, 2010 using the **litigation** exception. In fact, the matter did not involve litigation but legal advice relating to an indemnity agreement. The resolution closing the meeting should have cited the exception for **legal advice** subject to solicitor-client privilege instead.

Hamilton council closed its February 18, 2010 meeting using the **land acquisition** exception in order to discuss potential sites for events of the 2015 Pan Am Games. The Ombudsman found that the session was properly closed under this and other statutory exceptions. However, because this issue was of significant community interest, OMLET suggested to the city that in future it should consider whether the public might be better served by discussing a matter openly rather than relying on statutory exceptions to close the doors.

Committees must be open too

While it seems clear to most municipalities that the open meeting requirements apply to council and local board meetings, confusion still exists about committees, particularly when they are ad hoc or temporary in nature. But if 50% or more of the members of a municipally created entity are also members of councils or local boards, then it should generally be viewed as a "committee," subject to the open meeting laws.

OMLET's investigation of **Mattawa** council also involved the town's Ad Hoc Heritage Committee, which was struck by town council to deal with designating an old hospital as a heritage site. Consisting of three councillors, the mayor and two members of the public, the committee followed no formal process, provided no public notice of its meetings, met in private and kept no minutes. Given the significant community interest in the development of this site, the secretive manner in which the committee operated cast serious doubt on its legitimacy. In his report, issued in December 2010, the Ombudsman found that the committee should have followed the open meeting rules. He recommended that council carefully consider whether the bodies it creates in future are required to hold open meetings and that it make members aware of this.

In the **Hamilton** Pan Am Games case, OMLET also looked at the "advisory group" created by council as part of the process of selecting a stadium site. The group had no substantive decision-making authority, but it did provide direction on key issues for future council decisions on the stadium. It did not hold public meetings or follow any of the procedures required of "committees" under the *Municipal Act* – but the Ombudsman concluded that it should have done so. OMLET advised the city to consider the open meeting requirements in forming similar bodies in future.

In **Sault Ste. Marie**, the mayor, clerk, chief administrative officer and two councillors met regularly to consider what issues should appear on council's agenda. This "agenda setting review committee" was, the Ombudsman found, laying the groundwork for council to exercise its authority, and therefore was required to follow open meeting procedures. The council subsequently changed the composition of the committee so that agenda setting is now done only by the clerk, chief administrative officer and mayor, which is in line with processes followed by other municipalities.

Last-minute changes

A frequent complaint in OMLET cases involves last-minute additions to the posted agendas of closed meetings. An extreme example of this occurred in **South Bruce Peninsula**, where the town council added items to closed meeting agendas in June and September 2009 without any prior notice or approval by a majority of council, as required by the town's own procedure by-law. In one instance, a motion was brought in closed session to remove the mayor from a negotiating team (the mayor was not at the meeting). The Ombudsman found the town had breached the *Municipal Act* and stressed that only matters of real urgency should be added to a closed meeting agenda, and only if appropriate procedures are followed.

Outside parties

Latchford town council held a closed meeting for the purposes of "education and training" of its members on January 9, 2011. The session included a local chartered accounting firm and focused on things like budgeting, taxation and financial statements. Although the Ombudsman found the meeting was legitimately closed under the "education" exception, council had completely overlooked the requirements for holding such a session – it gave no notice, did not pass an authorizing resolution and kept no formal record of the meeting. OMLET staff also advised the town that closed meetings including people from outside the council have the potential to create public suspicion, particularly when council fails to provide an explanation.

Changing the rules

Latchford council also passed its own by-law provisions relating to closed meetings, including its own process to screen complaints before forwarding them to the Ombudsman. According to the town's by-law, all closed meeting complaints were first to be presented to council for a ruling, and passed on to the Ombudsman only if the complainant was dissatisfied with council's findings. In addition, if the Ombudsman did not support the complaint, the town would investigate any future complaints by the same person to determine if they were frivolous or vexatious. The Ombudsman advised the town that none of this is allowed. The process for closed meeting investigations is set out in the *Municipal Act* and *Ombudsman Act* and can't be modified by a municipality. All complaints go directly to the Ombudsman's Office and are confidential. The Ombudsman also has discretion to decide not to investigate, if he considers the complaint to be frivolous or vexatious, and there is no charge to municipalities or to complainants for the Ombudsman's services. OMLET staff asked Latchford to amend its bylaw and ensure it follows the Ombudsman's processes.

Voting behind closed doors

Voting in a closed meeting is prohibited unless it is for a procedural matter or for giving directions or instructions to municipal officers, employees or agents. In a number of OMLET's cases in 2010-2011, directions and instructions were given to staff in a closed meeting, but there was no formal process or record of how this was accomplished. The Ombudsman suggested to a number of municipalities that as a best practice, a formal vote should be taken and recorded whenever direction or instructions are given in these circumstances.

At a closed session on January 19, 2010, the **Gravenhurst** council directed municipal staff to respond to a complaint, without taking and recording a vote. The council's treatment of the complaint in closed session resulted in a complaint to the Ombudsman. OMLET staff suggested to the town that following a more formal voting practice might avoid any misunderstandings amongst councillors and staff about the direction given. OMLET made similar comments to **Seguin** township council, which had instructed staff to respond to a taxpayer at a closed meeting on September 7, 2010. **Temiskaming Shores** council was also advised that the resolution it passed in closed session on December 15, 2010 should have been more clearly worded to indicate that it was a direction to staff rather than a substantive decision on a re-engineering plan, which could only be made in open session.

Some municipalities were found to have contravened the *Municipal Act* by voting in closed session. The Ombudsman's investigation of **South Bruce Peninsula** town council found that the members in attendance at the September 22, 2009 closed session conducted an illegal vote on removing the mayor from a negotiating team. **Nairn and Hyman** township council improperly voted *in camera* on October 4, 2010 on reprimanding councillors. And on February 10, 2011, the **Amherstburg** town council held a "show of hands" in closed session to change its by-laws regarding donations. Even such informal votes are, in the Ombudsman's view, improper under the Act.

Public notice

The Ombudsman and OMLET staff encouraged municipalities in 2010-2011 to provide advance public notice of all items to be considered in both open and closed sessions, and to make provision for such notice in their procedure by-laws. In some cases, we found that municipalities did not require public notice of all meetings, including those called for special purposes, as required by the *Municipal Act*. We encouraged them to ensure that this was corrected.

Keeping records

The *Municipal Act* requires that a record be kept, "without note or comment," of all resolutions, decisions and other proceedings of municipal bodies, whether meetings are open to the public or not. In a number of closed meetings reviewed by OMLET in 2010-2011, we discovered that the record of the session was inadequate, or non-existent. Municipalities often advised us that they only recorded decisions taken in closed session and nothing else, out of concern about the legislative admonition not to record "notes or comments." While subjective or personal reflections should not be included in a meeting record, it should contain a description of the general nature of what was discussed and what action was taken. In his reports on his investigations in **South Bruce Peninsula** and **Mattawa**, the Ombudsman provided a summary of what an ideal meeting record should include. He also recommended that municipalities report publicly, at least in a general way, what has transpired in closed sessions to foster greater openness and transparency.

Case Summaries

Case Summaries

Thousands of the complaints received by the Ombudsman every year are resolved quickly and often creatively by front-line staff known as Early Resolution Officers, generally through informal contact with the relevant government organizations. Cases that can't be resolved are referred to the Investigations team. The following are examples of cases where Ombudsman staff achieved results for Ontarians battling bureaucratic roadblocks such as delays, unfair or unclear policies, red tape and other issues of maladministration.

Ministry of the Attorney General

LEGAL AID ONTARIO

All in the family

A woman was paying $200 per month to Legal Aid for the services of a family law lawyer. After spending $3,600 and losing her case, she felt her lawyer had not adequately represented her. The lawyer agreed not to charge anything for his services and wrote to Legal Aid, asking that the woman's money be returned.

The woman complained to the Ombudsman when she found out that Legal Aid had mistakenly given her refund money to her ex-husband's lawyer instead. When she confronted Legal Aid staff about this, they refused to assist her and told her to "work it out" herself with her ex and his lawyer. The woman, who suffered from high blood pressure, was extremely frustrated and fearful that the stress of the situation would affect her health.

Ombudsman staff contacted a Legal Aid manager, who reviewed the file and found there had been a mix-up. The manager agreed it was Legal Aid's responsibility, not the woman's, to get the money back from the lawyer to whom it had been wrongly paid. Legal Aid provided the woman with her refund immediately and she thanked the Ombudsman's Office, noting: "You guys are awesome."

Collection confusion

A single mother with two daughters used Legal Aid for two family law matters in 2006. She had originally agreed to pay more than $6,000 in monthly installments, but stopped paying Legal Aid because she fired her lawyer and represented herself in court. In January 2010, when seeking financing for a new car, she was surprised to learn that Legal Aid had referred her case to a collection agency. She complained to the Ombudsman that Legal Aid had not brought this debt to her attention, and that she did not believe she owed the full $6,000. She did not know how she would be able to pay the outstanding debt, and she feared that the involvement of the collection agency could jeopardize her job in the financial sector, where she was required to pass a credit check.

Ombudsman staff reviewed Legal Aid's records and discovered the collection notices had been sent to an incorrect address. The records showed Legal Aid staff had agreed to contact the woman to discuss their concerns about the amount owed, but it was not clear this was done before the file was sent to the collection agency. As a result of the Ombudsman's review, a Legal Aid official met with the woman and agreed to reassess her financial circumstances dating back several years. The reassessment determined she was actually eligible for free legal assistance dating from when she regained custody of one of her daughters. Legal Aid reduced the amount it was owed to $580 and agreed to waive interest on this amount.

Ministry of Community Safety and Correctional Services

Job security

A man complained to the Ombudsman on the day that his security guard licence was set to expire. He had passed the necessary exam and submitted his renewal application, but accidentally made his cheque out to the wrong provincial ministry. When the error was discovered, Ministry staff told him he would have to resubmit his application and it would take an additional three weeks to process. His employer told him he would lose his job if his licence expired and he could not be rehired until it was renewed. The man feared the financial impact this would have on his family, including the loss of his benefits and accumulated vacation time. Once Ombudsman staff contacted the Ministry and explained the situation, the man's application was reviewed immediately. His licence was renewed the same day, allowing him to keep his job.

Location, location, location

The owner of a children's dance studio contacted the Ombudsman after he learned that the Ministry had decided to open a Probation and Parole office in the same building as his studio. He was concerned that some of the offenders who would be required to visit this office might have been convicted of offences against children – some might also be required by their parole and probation conditions to avoid places frequented by children. He was also worried that parents might withdraw their children from his dance classes once they became aware of this new neighbour. Ministry officials had refused the man's requests that they reconsider the move. But when Ombudsman staff contacted them, they agreed to further review the choice of location. The Ministry later wrote to the man to advise him that, in "the best interests of the community," it would find a new location for the probation and parole office.

Counting the days

An inmate called the Ombudsman because he was eligible for parole in one week and he was afraid his request for a parole hearing would not be submitted on time. His Institutional Liaison Officer had not met with him to begin the process, which takes four to six weeks. Ombudsman staff discovered that delays in processing parole hearing requests were routine at the institution. As a result of the Ombudsman's inquiries, the responsible manager was directed to clear up the backlog to ensure inmates were given the opportunity for parole hearings before their parole eligibility dates. Additional staff were hired and two senior probation and parole officers were assigned to work with the Institutional Liaison Officers to help improve their performance. An agenda and checklist were developed to ensure their work was on track. The Ombudsman was also assured that the institution would more closely monitor staff workloads to avert future delays.

A cry for help

An inmate who was suffering from psychological distress wrote to the Ombudsman for help. He had had mental and physical trauma many years before and felt his mental health concerns were not being addressed by his correctional facility. Staff at the institution were reluctant to respond to inquiries by Ombudsman staff and said the facility Health Care Coordinator was unavailable. A nurse even assured Ombudsman staff that the inmate was fine, despite information on his file indicating otherwise. When asked to check on the inmate, the nurse replied that she "would like to ask him what he hoped to accomplish" by contacting the Ombudsman's Office.

When Ombudsman staff reached the Health Care Coordinator, the inmate was immediately seen by a psychologist. His case was reviewed and a medication error was discovered that had likely contributed to his anxiety.

The next day, the grateful inmate told Ombudsman staff he had seen the psychologist twice and was feeling much better. The institution's Health Care Coordinator and superintendent also agreed to have staff respond appropriately to Ombudsman inquiries in the future.

Losing laundry

A group of inmates complained to the Ombudsman that they had not received clean clothes for some time – in some cases over a month. The inmates were upset and some expressed concern that fights might break out over the issue. When Ombudsman staff contacted senior staff at the jail, they acknowledged that there were problems with the clothing supply, including that items sometimes went missing when they were sent to be laundered at another correctional facility. In response to the Ombudsman's inquiries, the jail addressed the clothing shortages by ordering extra clothing stock, increasing the number of clean laundry deliveries per week and getting regular reports from the laundry officer so that shortages can be identified and dealt with quickly.

Bad medicine

An inmate who was being given methadone called the Ombudsman and reported that he had been accidentally given a double dose. Because such a high dose could potentially be fatal, he was taken to hospital as a precaution. The inmate complained that this caused him anxiety and discomfort and he wanted to make sure it would not happen again to him or any other inmate.

Ombudsman staff confirmed with the facility Health Care Coordinator and the Ministry's Health Care Manager that the double dose was a case of human error. An internal review was conducted and measures were put into place to avoid such errors in future, including reducing the noise levels in the health care unit when methadone was being distributed, purchasing a new medication cart with better lighting and where drugs are accessible at eye level, and ensuring all health care staff were aware that nurses are expected to confirm inmates' dates of birth and doses prior to administering medication.

Ministry of Community and Social Services

Displaced and denied

The mother of a developmentally delayed woman with severe intellectual and behavioural challenges contacted the Ombudsman on her daughter's behalf in the fall of 2010. The woman had been institutionalized since she was seven years old. In 2008, when the facility she lived in was about to be closed, she was transferred to a group home.

The woman's psychiatrist had prescribed the amino acid L-Tryptophan for her behavioural difficulties, which was paid for by the Ministry of Community and Social Services while she was institutionalized. Once in the group home, however, she no longer received funding for this treatment, although her other medications were covered by the Ministry of Health and Long-Term Care. Her mother complained that the family could not afford to continue paying for L-Tryptophan, which costs about $200 per month.

Ombudsman staff contacted the Ministry of Health and Long-Term Care's Exceptional Access Program, which had stopped funding L-Tryptophan for new applicants in 2001. Staff there explained the decision was made after a review of clinical evidence regarding the drug's effectiveness.

Ombudsman staff then contacted a regional director at the Ministry of Community and Social Services and determined that when the woman's institution had closed, the Ministry had undertaken that all former residents would continue to receive the same level of service. A Ministry program supervisor reviewed the case and noted that it was assumed that the woman would continue to receive coverage for her L-Tryptophan as a resident of the group home. As a result of this review, the Ministry of Community and Social Services agreed to continue funding the woman's L-Tryptophan and reimbursed her family $3,600 they had spent on the drug in the past two years.

FAMILY RESPONSIBILITY OFFICE (FRO)

Owe no!

A father contacted the Ombudsman out of frustration after trying in vain to find out from the Family Responsibility Office how much he owed in child support arrears. The debt was affecting his credit rating, but each time he contacted the FRO to clarify what he owed, he was given a different amount – ranging from $6,000 to $27,000. He feared that the FRO was attempting to get him to pay for a period when his child was living with him and he was not required to pay support.

FRO staff initially told the Ombudsman that the man owed $6,063.53, but once they were asked to review the file more closely, they found that in fact no arrears were owed. The FRO admitted to the Ombudsman that it had overlooked correspondence from the child's mother confirming that the father did not owe her any further child support.

ONTARIO DISABILITY SUPPORT PROGRAM (ODSP)

Slow start

An Ontario Works recipient applied for ODSP and had her application approved after an appeal. She was anxious for her ODSP benefits to start, as the extra funds and coverage available would assist her in paying expenses related to her ongoing battle with cancer, including chemotherapy treatments. She complained to the Ombudsman when, six weeks after her appeal, she still had not received any ODSP benefits, nor had she been assigned a caseworker.

Contacted by Ombudsman staff, ODSP officials agreed to expedite their review of the woman's file in light of her serious medical condition. Her ODSP coverage was confirmed and a week later, she received a benefits cheque for approximately $5,000 in arrears plus $1,300 for the first month's benefit. The woman called the Ombudsman's Office to say how appreciative she was that the matter was resolved.

Powerful difference

A woman entered into an agreement with ODSP in 2005 whereby ODSP deducted $240 from her monthly benefit cheque to pay her electricity bill. The agreement was supposed to last one year, but ODSP refused the woman's requests to end it. She also complained that the monthly deductions had been inconsistent.

The Ombudsman's Office reviewed the woman's benefit statements and found ODSP had not deducted electricity payments from August to December of 2008. The woman paid her own electricity bill during this period. In January 2009, ODSP resumed the deductions.

Ombudsman staff asked ODSP to review the woman's file and upon doing so, an ODSP manager discovered that information about her income had been entered incorrectly, resulting in an underpayment. She was entitled to $3,205 in retroactive benefits. Since she had also demonstrated she was able to pay her electricity bill herself, the $240 monthly deduction was stopped as well.

SOCIAL BENEFITS TRIBUNAL

No ill feelings

A woman contacted the Ombudsman after she received copies in the mail of two decisions by the Social Benefits Tribunal on appeals she had filed. She was shocked to read in the documents that she had been unwell on the day of the hearings and thus did not attend. She did not understand why the adjudicator had written this, since she had not even known about the hearing dates and had been waiting for an answer from the tribunal about when she could have her case heard "in writing" – a practice that involves the exchange of written documents instead of an in-person hearing.

A tribunal manager reviewed the woman's file at the request of Ombudsman staff, and found an unfortunate sequence of misunderstandings had led a tribunal staff member to incorrectly inform the adjudicator that the woman had been sick on the day of the hearings. Tribunal staff said they had tried to notify the woman of her hearing date but were unable to reach her.

The tribunal arranged to hold new hearings on both cases and the Executive Director apologized in writing to the woman for the mistakes. The woman thanked Ombudsman staff for putting her in touch with the "wonderful" tribunal manager, and for helping to make things right.

Ministry of Energy

HYDRO ONE

Battle of the bill

In March 2010, the wife of a Canadian soldier serving in Afghanistan moved to a new home with her daughter and father. Their first two Hydro One bills were small, manageable amounts. But their third bill was $1,500. Worried about having to pay such a large amount, the woman called Hydro One in May 2010 and was told that as long as she made regular payments, her service would continue. She continued to make bi-weekly payments to her account, but was unable to pay off the entire amount owed, as new bills continued to arrive.

In September 2010, Hydro One told the woman her service would be disconnected unless she paid her entire balance owing of $1,279.59. She explained that she needed an extension of eight days, when her husband's paycheque would be deposited into their account. When Hydro One refused, the woman called the Ombudsman for help. Ombudsman staff spoke with Hydro One, which reviewed her case further. Less than a week later, Hydro One agreed to cancel the disconnection order and gave the woman the time she needed to pay.

Confusing business

When a Hydro One representative called to discuss upgrades on her "commercial" property, a woman learned that it had been mistakenly charging her commercial rates for her residential electricity. She advised Hydro One of the error and it agreed to send an agent to visit her property. Hydro One also informed her she had been overcharged $500 because of the mistake.

When she did not receive a credit on her next bill, she complained to Hydro One and was told that she would not be receiving any credit because she should have alerted them to the error sooner. Hydro One's position was that she should have spotted the fact that her account set up information referred to "general" billing rates rather than "residential." The woman argued that it was unfair to expect average consumers to notice this or know that "general" meant they would be billed at a higher commercial rate. When Hydro One told her she could file a complaint in writing, she contacted the Ombudsman for help.

Ombudsman staff reviewed her account and Hydro One's response, policies and procedures, and confirmed Hydro One's error had resulted in her being overcharged. As a result, Hydro One agreed to credit the woman's account with $500.

Ministry of Government Services

REGISTRAR GENERAL

Name game

A father turned to the Ombudsman after delays in his request to the Registrar General to make changes to his two daughters' birth certificates. The parents' names on the certificates needed to be amended to match the parents' passports. This was necessary for the family to apply for visas for a trip to India to attend a family wedding. They had already spent $7,500 in booking the trip.

The man had applied to the Registrar General to make the changes two months earlier. He complained that Registrar General staff had asked several times for additional information that they had failed to request when he first applied. He was frustrated by the ongoing delay and by having to repeatedly communicate with Registrar General staff in writing and by phone. He feared that his request would not be processed in sufficient time for the family to obtain their visas and their trip might be jeopardized.

Ombudsman staff contacted the Registrar General who agreed that the circumstances justified having the man's file dealt with immediately. The man's request was finalized and approved and the amended documents sent to him by courier within two weeks of his call to the Ombudsman. He expressed his appreciation to Ombudsman staff for their assistance.

Double billed

A father sought the Ombudsman's help after he was billed twice for an online request for his daughter's birth certificate in 2009. When he initially filled out the online form, the session had timed out and he could not confirm that his payment was accepted. He had to log in again and, thinking that there might have been a problem with the credit card he used the first time, he used another one.

At the end of the month, he received statements showing that he paid twice for the birth certificate. When he approached the Ombudsman at the end of March 2010, he had been trying since August 2009 to obtain a refund of $35 from Service Ontario. He had submitted the necessary request form, only to be told that that Service Ontario does not process refunds for such small amounts.

Ombudsman staff worked with Service Ontario and the Office of the Registrar General to ensure that they obtained the necessary information from the man and a refund was provided to him less than a month later. The man thanked Ombudsman staff for ensuring the "lubrication of democracy."

Ministry of Health and Long-Term Care

Hospital-ity fee

A woman complained to the Ombudsman after she received a bill for $1,879 in co-payment charges from the hospital where her 94-year-old mother had been for about a month before she died in April 2010. Ombudsman staff contacted the Negotiations and Accountability Management Division of the Ministry of Health and Long Term Care, whose staff obtained records from the hospital and reviewed the charges.

The *Health Insurance Act* allows hospitals to charge a co-payment fee to a patient whose doctor has determined that the patient requires complex continuing care and is essentially a permanent resident of the institution. The co-payment is the patient's contribution toward accommodation and meals and is charged at a rate of $1,619.08 per month or $53.23 per day while the patient awaits transfer to a "complex continuing care" or long-term care bed.

Upon reviewing the hospital's records, the Ministry determined that the co-payment fee should not have been charged between March 13 and April 6 because the woman's mother had been receiving treatment during this time. In its decision, the Ministry noted that the hospital had contravened the *Health Insurance Act* and the *Commitment to the Future of Medicare Act.* The hospital agreed to reduce the co-payment charges from $1,879 to $624.

Lost in translation

An elderly man who travelled to China frequently to visit his family was notified by OHIP in May 2010 that he was no longer eligible for health coverage because he did not meet the residency requirements – i.e., he had to be present in Ontario for 153 days in a 12-month period. The man, who does not speak English, had turned to his MPP for help and filed an appeal with the OHIP Eligibility Review Committee. Staff at the MPP's office worked with the man and a translator for five months to obtain the information requested by OHIP, but became frustrated with the delays. The man had no OHIP coverage throughout this time.

An Ombudsman staff member spoke with OHIP and the man, using a translator, and determined that all OHIP needed was a translation of the stamps on the man's passport, to verify that he had not been away from Canada for more than 212 days. Once this was explained to the man and the information was provided, his OHIP coverage was reinstated.

No time to lose

A woman who was diagnosed with two potentially fatal aortic aneurysms in April 2010 was told she needed surgery immediately, but the procedure was not available in Canada. Her doctor applied to the OHIP Out-of-Country treatment program for funding approval in May 2010 but by mid-June had received no response. The woman was anxious to have the surgery and worried that the delay and stress from waiting could make her vulnerable to medical complications. An Ombudsman staff member alerted OHIP Out-of-Country program staff to the woman's circumstances and her concerns. Final approval for the woman's out-of-country surgery was given two days later.

Refill review

In October 2010, the Ombudsman received complaints from two families whose children were receiving human growth hormone medication through the Hospital for Sick Children. The Ministry of Health and Long-Term Care's Exceptional Access Program required that approval for funding the drug be obtained every year. The families were worried that their children's medication was about to run out and the Ministry had still not approved their applications for continued coverage for the year. One mother was told that no decision could be made for a few more weeks, even though her daughter had been receiving funding for the drug for over a year. The other family was told it would take three months to process their application. Both families feared that they would not be able to afford the medicine, which could cost up to $2,000 per month.

Ombudsman staff learned from the Ministry's Exceptional Access Program (EAP) that delays could result from sending each application and renewal to an independent medical specialist for review. After being made aware of the families' concerns, the EAP agreed to extend coverage of the medication for one month to allow time for a final decision. The hospital informed the Ombudsman's Office that it is working with EAP to develop criteria so that future renewal requests can be dealt with more quickly and without the need for independent reviews.

Ministry of Labour

WORKPLACE SAFETY AND INSURANCE BOARD

Winning and waiting

A man who had been injured at work when he was 29 years old had his loss-of-earnings benefits cut off by the Workplace Safety and Insurance Board (WSIB) in 2001 because his employer had offered him potentially suitable work. He continued to have severe pain and was unable to work. In 2004, he appealed the WSIB's decision to cut off his benefits. In June 2010, he was finally advised that his appeal was successful and he would receive a retroactive payment once he underwent a medical evaluation.

The man complained to the Ombudsman after he had the evaluation and heard nothing back from the WSIB for over a month, despite his calls to his case manager and worker representative. He was on social assistance because he was unable to work and was having serious financial difficulties.

Ombudsman staff followed up with the WSIB and confirmed that the man's medical evaluation report had been received but somehow overlooked. After the contact from the Ombudsman, the WSIB expedited its review of the man's file and he not only had his loss-of-earnings benefits reinstated – he received a cheque for $126,254.53 in retroactive benefits.

Ministry of Training, Colleges and Universities

Making the grade

A community college student was told that if she completed her program with sufficiently high marks, she would be eligible to have a portion of her student loans forgiven under the Ontario Student Opportunity Grant program, as she is a single mother of four children. After successfully completing her program with good grades in 2006, she was surprised to be told that she was no longer entitled to any loan reduction because she had an outstanding OSAP debt from 25 years ago. She was confused by this, as she recalled the OSAP debt had been garnished from her income tax return many years ago and she had heard nothing about it since.

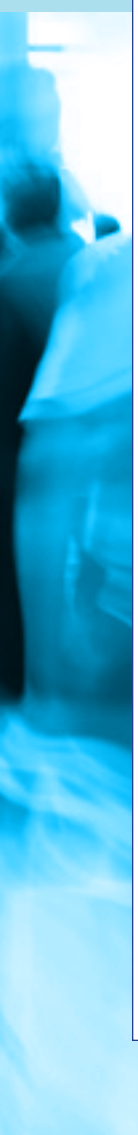
Ombudsman staff inquired with the Collections Management Unit of the Student Support Branch of the Ministry of Training, Colleges and Universities. Staff there determined that the woman's OSAP debt was paid off but they were never told. The Ministry agreed to remove the debt from the woman's file and her student loan was reduced by $7,400.

Never too late to learn

A stay-at-home mom decided to upgrade her skills to re-enter the workforce. At her local employment assessment centre, she was told she would be eligible for funding for community college through the Ontario Skills Development Program (OSDP) until October 2009. Upon her acceptance into the nursing program at her local community college, she applied for OSDP funding, only to be told her eligibility had expired in June 2009. She complained to the Ombudsman after her unsuccessful appeal to have the Ministry reconsider its decision.

The Ombudsman's review revealed that an error had been made in calculating her OSDP eligibility. Because she had taken sick leave prior to a period of maternity leave, her eligibility expiry date was in fact June 2009 and not October, as she had originally been told. Ombudsman staff determined that the career counsellor at the assessment centre had not been aware of this, and information about taking sick leave into account was not included in Ministry training materials provided to assessment centre staff.

Ombudsman staff reviewed the case with senior Ministry officials, who agreed that the woman had been misinformed and that the Ministry's training information needed to be improved. They also agreed to provide the woman with funding for tuition, books, transportation and daycare for her two years of study – costs that would have been covered under the OSDP. Pending an income assessment, the woman would also be eligible for funding for her living expenses in her second year of study.



Ministry of Transportation

Test, pay, repeat

A man in his eighties who had a record of good driving for more than 68 years was trying to complete the requirements for his driver's licence renewal. He complained to the Ombudsman about a delay in the Ministry of Transportation's review of the results of tests he had been required to undergo by an ophthalmologist, gerontologist, and occupational therapist, due to problems with his peripheral vision. He complained again after he received a letter from the Ministry advising him that he would have to be assessed all over again, at an additional cost of $550. He did not understand why the Ministry was asking him to repeat the process when the health care professionals he had dealt with had told him that he passed all the necessary requirements. When he called the Ministry, he was put on hold for long periods of time.

Ombudsman staff contacted Ministry officials who confirmed that the letter had been sent to the man in error and he did not have to repeat any tests or incur any additional costs. They agreed to send the man a new letter. Upon hearing the good news, the man remarked: "Let me sit down to take this in, because this is the absolute best news I've had in a long while." The man later informed the Ombudsman's Office that he had successfully renewed his licence – and to celebrate, he purchased a new minivan for himself and his dog.

Your Feedback

35th Anniversary

> Trust – between people and their institutions – is one of the fundamental elements of a healthy and progressive democracy. Ontarians recognize the value of cultivating fairness, transparency and accountability in every aspect of our society – including government. For 35 years, the Office of the Ombudsman of Ontario has been playing a vital role in ensuring that the Ontario government works in the best interests of our citizens – and that they are served effectively and fairly. My colleagues and I commend André Marin and everyone at the Office of the Ombudsman of Ontario for their hard work and dedication to helping government remain responsible, responsive and accountable to all Ontarians. Thank you for your outstanding efforts.
>
> *– Premier Dalton McGuinty, greetings to the Office of the Ombudsman on its 35th anniversary, November 1, 2010*

> The Ombudsman's Office plays a critical role in the political process, investigating complaints and issuing reports, highlighting where the office believes the government of the day can make positive changes in the delivery and execution of its services.
>
> *– Hon. Steve Peters, Speaker of the Ontario Legislature, address at the Ombudsman's 35th anniversary, November 1, 2010*

> One can only be proud of what the Ombudsman's Office has been able to do over the last number of years, and one can only be proud of the current Ombudsman and of his staff for what they have uncovered in a great many fields. This is the kind of person, the kind of group we need to look at our public institutions, to have some oversight.
>
> *– Michael Prue, MPP (NDP – Beaches-East York)*

> It is important today, when the government has gotten bigger and bigger, to have an office established to assist average citizens to have somewhere to go to when they are unhappy or dissatisfied with the response of that government. We are thankful we have the Ombudsman. Congratulations on 35 years.
>
> *– John Yakabuski, MPP (PC – Renfrew-Nipissing-Pembroke)*

Comments from complainants

> Because of your office's persistence over the last 11 months or so, I finally received a reimbursement cheque this week. I know I would never have gotten this far by myself. In a perfect world, we wouldn't need positions like yours. However, that not being the case, as far as I am concerned, the people of Ontario are certainly well served by your office and staff.
>
> *– Complainant*

> Thank you and your office again for all the commitment and attention that was put into resolving [my case]. If it weren't for the efforts of your office, the outcome may have not been as favourable as it has turned out to be today.
>
> *– Complainant*

> It is with extreme gratitude that I write this letter to express my sincere appreciation for the professionalism and commitment [your staff] dedicated towards my case. I thought I should write to you to say how thankful I am to your Office for the remarkable support I've received.
>
> *– Complainant*

> Good news – I have just received a call [that my] cheque is ready for pickup. I cannot believe that the matter is finally finalized. Again, I cannot express enough my gratitude for your incredible help, support and efficiency.
>
> *– Complainant*

> The information in your letter clearly shows that your office carefully analysed the pertinent documents from the municipality. Your conclusions are also clearly explained. I am therefore very satistifed with the results of your investigation and the recommendations that were provided to the municipality.
>
> *– OMLET complainant*

> I want you to know how much I appreciated your assistance, without which I am convinced there would have been no action at all on the matter which I brought to the attention of your Office. You opted to go to the trouble of assisting me, presumably for no other reason than that it appeared to be consistent with the public interest.
>
> *– Complainant*

> As a proud Ontarian I am so glad we have the Office of the Ombudsman to turn to in times of trouble, especially for those like me trying to seek resolution alone. The Ombudsman's reach must be extended so that the corrupt and the powerful in all areas of public service are held to account!
>
> *– Complainant*

> I just wanted to thank Mr. Marin and his entire staff for everything you do. Please know that all of your efforts are appreciated every day.
>
> *– Complainant*

your feedback

Comments on *Caught in the Act* – G20 report

> Your office has done a great service for civil rights and democracy itself.
>
> – *Rev. Dr. Oscar Cole-Arnal*

> This is a heartfelt thank you to all of you for speaking truth to power in your work on *Caught in the Act*. Many people who do not study history may be puzzled by the strong arguments advanced by your document, but any student of history will not be even slightly confused.
>
> – *Sean McShane*

> I am pleased to hear the results of the Ombudsman investigation. I am relieved to hear him speak to the events of the G20 with such candid comments and for addressing the issues of compromised civil liberties. Thank you!
>
> – *Shawn Grey*

> I just finished reading your report and I want to thank you for an outstanding, encompassing and articulate report. I could not ask for more from you.
>
> – *Brian Burns*

> Thank you for this G20 report. It says what needs to be said. Truth is the best defence of democracy and I believe you have served that well. We need more public figures like you. Well done!
>
> – *Fred Williams*

> I believe this report is an important aid in the healing that so many who witnessed police abuse that weekend are still going through. Thank you.
>
> – *Amanda Walsh*

> I wish to thank the ombudsman for his tenacious work re the G20 summit. It is important that we guard our civil liberties. To be silent is to be the voice of complicity. Thanks.
>
> – *Grace Scheel*

> Exceedingly well written and powerful. I was not able to disagree with even one word in the report.
>
> – *Stanley Pasternak*

> As a former law enforcement officer, a citizen of Ontario, and someone who was present in Toronto and witnessed many of the events of the G20, I want to express my congratulations to Mr. Marin and [his] employees for this important report. These are fundamental matters in a democratic society, and all Ontarians should be thankful for your balanced, frank and thoughtful report.
>
> – *James Edwards*

Comments on *The LHIN Spin*

> Thank you for your honest and well-researched report. It is good to know that our concerns have been addressed, and the public and government know we are not finished yet.
>
> *– June Robinson*

> We were so excited when you gave your report as it showed the skeptics that we were on the right track and that your office, and you, in particular, did care and did act upon our complaints.
>
> *– Joy Russell*

> I wish to express my sincere thanks and gratitude to you and your staff for your objective and comprehensive report on the Hamilton Niagara Haldimand Brant Local Health Integration Network. Many of our citizens felt the consultation process was one-sided and flawed and attempts at community engagement were superficial and window dressing.
>
> *– Pat Scholfield*

> I congratulate the Ombudsman for taking at least one LHIN to task on the process used to date for "public meetings." It would appear that there is need for improvement on a number of fronts.
>
> *– Dr. Merrilee Fullerton*

> Your hard work is appreciated, and all too often staff are ignored for their work, but to you and your office I wanted to say 'job well done'. Thank you.
>
> *– Complainant*

Comments from Twitter

> @Ont_Ombudsman I am thrilled that you will be around for the next 5 years. I look forward to your next report.
>
> *– Peggy Tupper*

> @Ont_Ombudsman Thank you for listening to the concerns of the public and investigating. We appreciate it.
>
> *– Ratsamy Pathammavong*

> Thank you Mr. Marin. Your honest acknowledgment of G20 events is a big step forward to begin the healing process.
>
> *– DebbieYTZ*

> Thank you @ont_ombudsman for Caught in the Act report. Clear, accessible. Restores some of my shaken confidence in Ontario government.
>
> *– Gilmour Taylor*

> Thank you. Our country regains some of its tarnished honour with your report.
>
> *– David de Weerdt*

your feedback

Comments from Facebook

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

– Anne Patterson

Your diligence and hard work are truly appreciated by myself and the people of Ontario. You and the staff at your office are doing a remarkable job. Thank you.

– Jeff Pinney

I just wanted to offer my congratulations for your report on the secret expansion of police powers. It's good for citizens - and for the political class - to know that someone is willing to stand up to authorities who trample on our rights in such a cavalier way.

– Ken Cox

[The Ombudsman] has proven to be a genuine defender of the public's interest and this latest report on the G20 Toronto protest is perhaps his most important statement on behalf of us all.

– Christian Gagnon

We had 6 months of problems with FRO and you fixed them in only ONE WEEK! Thanks to the Ombudsman's office for their help. I'm sure that if they hadn't helped we would have gotten nowhere.

– Complainant

Thank you SO much for defending our civil liberties!!!

– Ana Maria Carvalho

A Big Thank you to the Ombudsman. I contacted Ombudsman about FRO holding my children's support payments and two days later I got everything. Thank you so much for your help.

– Complainant

Congratulations Mr. Marin!!! You are, and have been, what Ontario needs to make things better within our government.

– Christine Reid

You demonstrate great courage, not only to Ontarians but those elsewhere as well. Keep it up – the public supports you completely.

– Joel Vien

In the media

Marin's report is a stand-alone condemnation of the provincial government's secrecy and negligence, and the police force's abuse of power. The report also sets out a policy framework for the future, a blueprint for accountability and transparency to make sure that something like the G20 doesn't happen again. For all that, we could not be more grateful.

– *Torontoist.com "2010 Hero: André Marin," December 21, 2010*

Marin has now added his powerful voice to the chorus calling for a radical overhaul of the *Public Works Protection Act* to bring that World War II-era legislation into the 21st century. What happened at Queen's Park (where laws were quietly changed without public input or subsequent explanation) and on our streets (where police misled citizens about the extent of their new powers and abused the powers they legitimately had) can never be allowed to happen again.

– Toronto Star *editorial, December 8, 2010*

Almost without fail, Marin's investigations of provincial agencies have found they evolve to operate by their own rules, and rarely do those rules satisfy the public interest. And rarely has the government done enough to ensure these agencies work in the public interest. That is exactly what has happened with the LHIN… The bottom line is the government has to exercise more oversight over its agencies, even if it means opening itself to more public backlash.

– *Kalvin Reid, columnist,* St. Catharines Standard, *August 11, 2010*

With an aging population and rising health-care budgets, it is difficult to imagine a year in which every health network in the province doesn't face some very tough decisions involving a region's crucial health-care services. Without public trust, those decisions will be much harder, if not impossible. Which is why Marin's [LHIN] findings are crucial.

– Ottawa Citizen *editorial, August 1, 2010*

Last week, the majority government voted down Bill 183 at second reading - killing a private member's bill that would have expanded the power of Ontario's Ombudsman to investigate school boards, hospitals, nursing homes and children's aid societies… Taxpayers deserve value for the dollars they invest in education and other government services. Education costs represent a huge slice of the public money pie. Why not open the door to more accountability? What could possibly be the negative?

– Hamilton Mountain News *editorial, May 11, 2011*

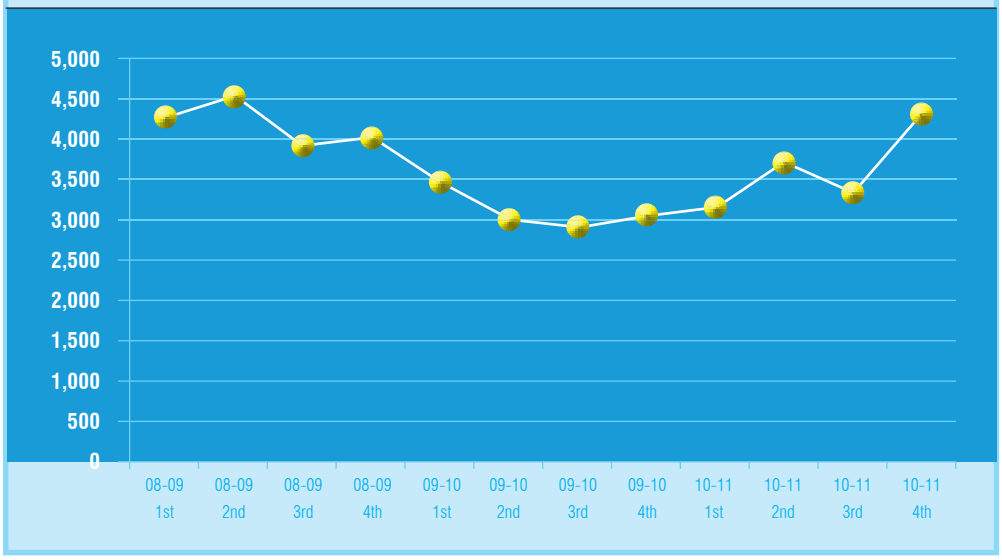
There is something wrong when the most vulnerable are left off the map of official oversight into the delivery of government services meant to support them. School boards, hospitals and nursing homes are beyond the reach of our Ombudsman's office and there's no sign the governing party wants to change that… The Ombudsman has hundreds of ministries, Crown corporations, boards, commissions and the like under its purview. But many of the everyday services people have the most interaction with are off-limits. Often their only recourse, when they can't get those in charge to uphold their responsibilities, is to get a lawyer.
It's time for Ontario to join the rest of Canada and, as [NDP MPP Rosario] Marchese points out, give a voice to the voiceless. Let the ombudsman in.

– *Moira Macdonald, columnist,* Toronto Sun, *May 3, 2011*

Appendix 1

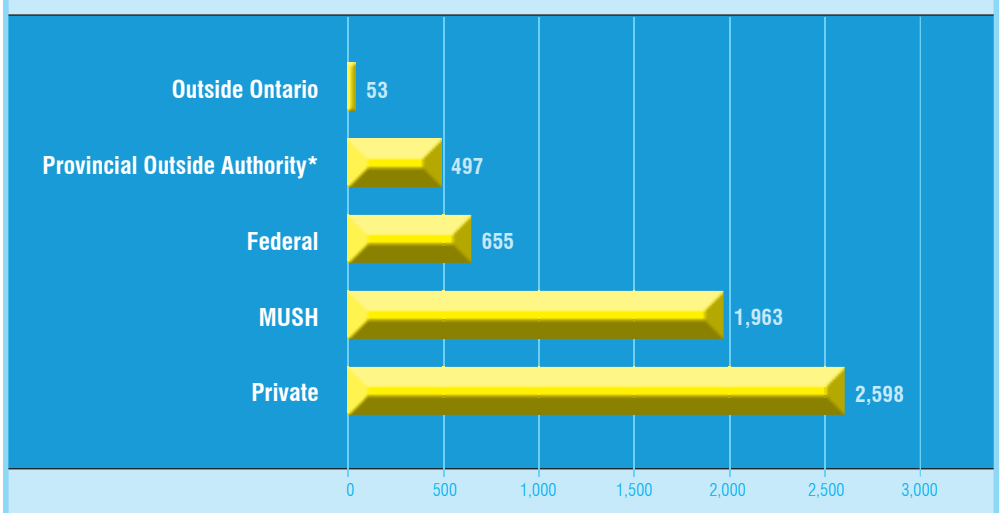
Complaint statistics

CASES RECEIVED BY QUARTER
2008-2009 TO 2010-2011



CASES OUTSIDE THE OMBUDSMAN'S AUTHORITY
RECEIVED 2010-2011

TOTAL: 5,766

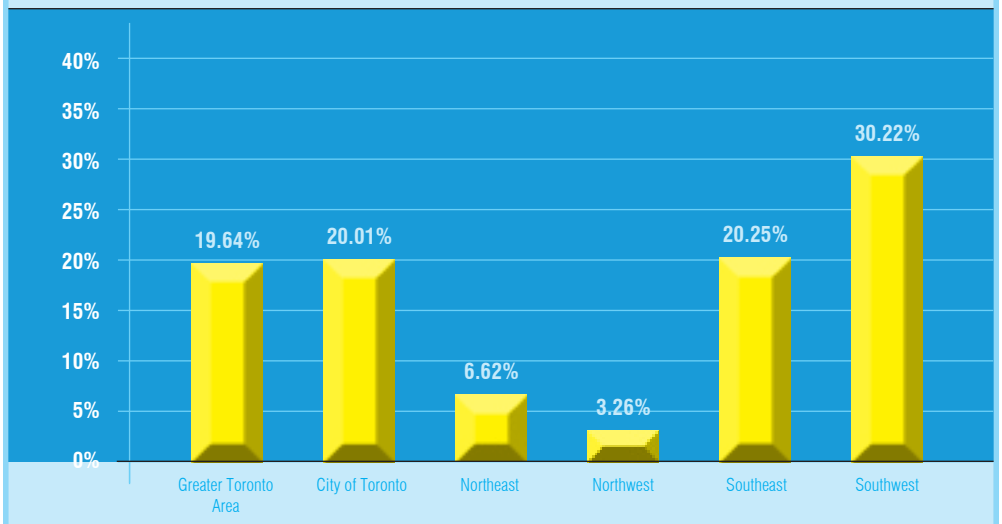


** For example cases received about Courts, Stewardship Ontario and Tarion.*

Appendix 1

Complaint statistics

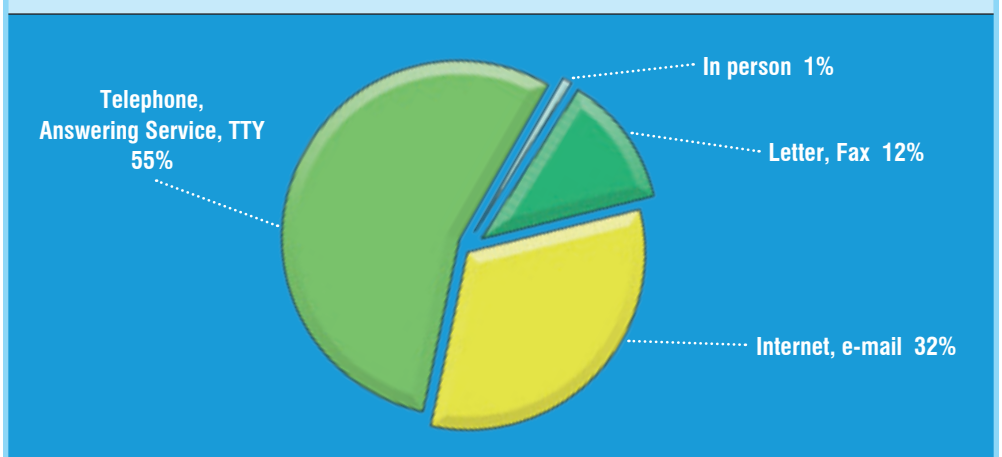
REGIONAL DISTRIBUTION OF COMPLAINANTS* 2010-2011



** Excluding inmates of correctional facilities.*

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

HOW CASES WERE RECEIVED 2010-2011



Appendix 1

Complaint statistics

TOP 15 GENERAL PROVINCIAL GOVERNMENT ORGANIZATIONS AND PROGRAMS COMPLAINED ABOUT IN 2010-2011

		Number of Cases	Percentage of All Cases Within Authority
1	FAMILY RESPONSIBILITY OFFICE	716	8.25%
2	ONTARIO DISABILITY SUPPORT PROGRAM	493	5.68%
3	WORKPLACE SAFETY AND INSURANCE BOARD	414	4.77%
4	HYDRO ONE	306	3.52%
5	DRIVER LICENSING	286	3.29%
6	LEGAL AID ONTARIO	125	1.44%
7	OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	113	1.30%
8	REGISTRAR GENERAL	110	1.27%
9	ONTARIO PROVINCIAL POLICE	108	1.24%
10	ONTARIO HEALTH INSURANCE PLAN	102	1.17%
11	HUMAN RIGHTS TRIBUNAL OF ONTARIO	101	1.16%
12	MUNICIPAL PROPERTY ASSESSMENT CORPORATION	99	1.14%
13	LANDLORD AND TENANT BOARD	99	1.14%
14	ONTARIO STUDENT ASSISTANCE PROGRAM	99	1.14%
15	DRUG PROGRAMS BRANCH	94	1.08%

TOP 10 CORRECTIONAL FACILITIES COMPLAINED ABOUT IN 2010-2011

		Number of Cases	Percentage of All Cases Within Authority
1	CENTRAL NORTH CORRECTIONAL CENTRE	404	4.65%
2	CENTRAL EAST CORRECTIONAL CENTRE	386	4.45%
3	MAPLEHURST CORRECTIONAL COMPLEX	270	3.11%
4	OTTAWA-CARLETON DETENTION CENTRE	227	2.61%
5	NIAGARA DETENTION CENTRE	161	1.85%
6	TORONTO WEST DETENTION CENTRE	156	1.80%
7	HAMILTON-WENTWORTH DETENTION CENTRE	150	1.73%
8	VANIER CENTRE FOR WOMEN	145	1.67%
9	TORONTO JAIL	131	1.51%
10	ELGIN-MIDDLESEX DETENTION CENTRE	105	1.21%

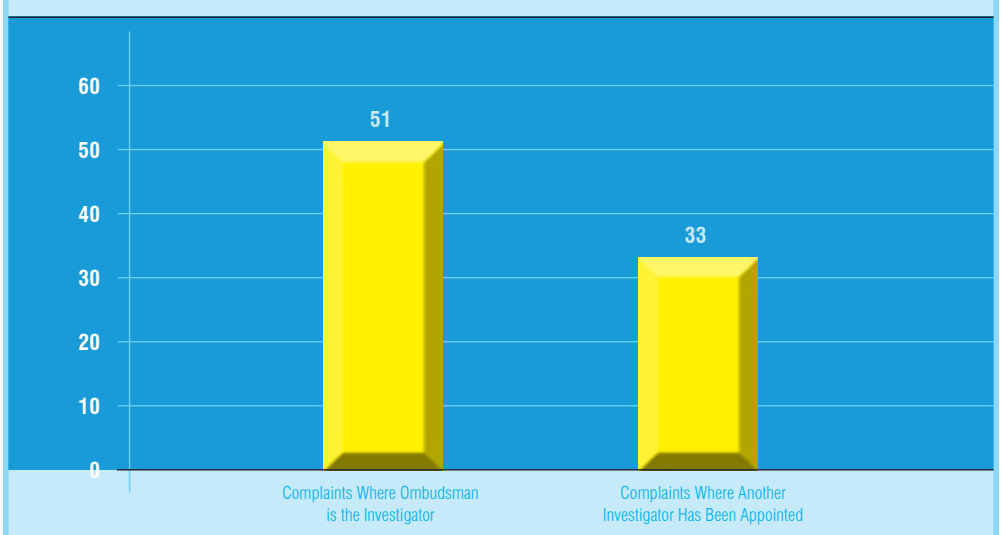
Appendix 1

Complaint statistics

MOST COMMON TYPES OF CASES RECEIVED DURING 2010-2011

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

CASES RECEIVED ABOUT CLOSED MUNICIPAL MEETINGS 2010-2011



Appendix 1

Complaint statistics

CASES EXCLUDING CORRECTIONAL FACILITIES RECEIVED 2010-2011 BY PROVINCIAL RIDING*

Ajax-Pickering	37	Niagara West-Glanbrook	33
Algoma-Manitoulin	96	Nickel Belt	43
Ancaster-Dundas-Flamborough-Westdale	56	Nipissing	76
Barrie	78	Northumberland-Quinte West	67
Beaches-East York	80	Oak Ridges-Markham	49
Bramalea-Gore-Malton	61	Oakville	66
Brampton-Springdale	35	Oshawa	96
Brampton West	75	Ottawa Centre	62
Brant	66	Ottawa-Orleans	37
Bruce-Grey-Owen Sound	78	Ottawa South	51
Burlington	67	Ottawa-Vanier	52
Cambridge	62	Ottawa West-Nepean	92
Carleton-Mississippi Mills	45	Oxford	31
Chatham-Kent-Essex	47	Parkdale-High Park	82
Davenport	69	Parry Sound-Muskoka	85
Don Valley East	61	Perth-Wellington	40
Don Valley West	44	Peterborough	47
Dufferin-Caledon	64	Pickering-Scarborough East	42
Durham	43	Prince Edward-Hastings	55
Eglinton-Lawrence	72	Renfrew-Nipissing-Pembroke	52
Elgin-Middlesex-London	48	Richmond Hill	36
Essex	55	Sarnia-Lambton	56
Etobicoke Centre	52	Sault Ste. Marie	61
Etobicoke-Lakeshore	79	Scarborough-Agincourt	46
Etobicoke North	52	Scarborough Centre	38
Glengarry-Prescott-Russell	58	Scarborough-Guildwood	79
Guelph	48	Scarborough-Rouge River	29
Haldimand-Norfolk	54	Scarborough Southwest	76
Haliburton-Kawartha Lakes-Brock	46	Simcoe-Grey	66
Halton	58	Simcoe North	85
Hamilton Centre	83	St. Catharines	58
Hamilton East-Stoney Creek	72	St. Paul's	108
Hamilton Mountain	55	Stormont-Dundas-South Glengarry	61
Huron-Bruce	32	Sudbury	77
Kenora-Rainy River	47	Thornhill	36
Kingston and the Islands	65	Thunder Bay-Atikokan	82
Kitchener Centre	53	Thunder Bay-Superior North	56
Kitchener-Conestoga	27	Timiskaming-Cochrane	64
Kitchener-Waterloo	54	Timmins-James Bay	53
Lambton-Kent-Middlesex	34	Toronto Centre	163
Lanark-Frontenac-Lennox and Addington	57	Toronto-Danforth	58
Leeds-Grenville	51	Trinity-Spadina	98
London-Fanshawe	65	Vaughan	35
London North Centre	102	Welland	43
London West	67	Wellington-Halton Hills	35
Markham-Unionville	20	Whitby-Oshawa	78
Mississauga-Brampton South	44	Willowdale	80
Mississauga East-Cooksville	47	Windsor-Tecumseh	78
Mississauga-Erindale	46	Windsor West	90
Mississauga South	64	York Centre	55
Mississauga-Streetsville	42	York-Simcoe	50
Nepean-Carleton	39	York South-Weston	49
Newmarket-Aurora	55	York West	32
Niagara Falls	103		

** Where a valid postal code is available.*

Appendix 1

Complaint statistics

TOTAL CASES RECEIVED 2010-2011 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*		
MINISTRY OF AGRICULTURE, FOOD AND RURAL AFFAIRS		24
MINISTRY OF THE ATTORNEY GENERAL		603
ALCOHOL AND GAMING COMMISSION OF ONTARIO	28	
ASSESSMENT REVIEW BOARD	31	
CHILDREN'S LAWYER	28	
CRIMINAL INJURIES COMPENSATION BOARD	39	
HUMAN RIGHTS LEGAL SUPPORT CENTRE	13	
HUMAN RIGHTS TRIBUNAL OF ONTARIO	101	
LEGAL AID ONTARIO	125	
ONTARIO HUMAN RIGHTS COMMISSION	10	
ONTARIO INDEPENDENT POLICE REVIEW DIRECTOR	15	
PUBLIC GUARDIAN AND TRUSTEE	113	
SPECIAL INVESTIGATIONS UNIT	12	
MINISTRY OF CHILDREN AND YOUTH SERVICES		144
CHILDREN'S AID SOCIETY - HURON PERTH	33	
CHILD AND FAMILY SERVICES REVIEW BOARD	14	
SECURE CUSTODY FACILITIES FOR YOUTH	33	
SPECIAL NEEDS PROGRAMS - CHILDREN	44	
MINISTRY OF CITIZENSHIP AND IMMIGRATION		2
MINISTRY OF COMMUNITY AND SOCIAL SERVICES		1295
FAMILY RESPONSIBILITY OFFICE	716	
ONTARIO DISABILITY SUPPORT PROGRAM	493	
SOCIAL BENEFITS TRIBUNAL	38	
SPECIAL NEEDS PROGRAMS - ADULT	21	
MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES		3355
CORRECTIONAL FACILITIES	3002	
OFFICE OF THE CHIEF CORONER	14	
ONTARIO CIVILIAN POLICE COMMISSION	13	
ONTARIO PROVINCIAL POLICE	110	
PROBATION AND PAROLE SERVICES	30	
MINISTRY OF CONSUMER SERVICES		33
MINISTRY OF CULTURE		3
MINISTRY OF EDUCATION		27
MINISTRY OF ENERGY AND INFRASTRUCTURE		404
HYDRO ONE	306	
ONTARIO ENERGY BOARD	22	
MINISTRY OF THE ENVIRONMENT		81
MINISTRY OF FINANCE		271
FINANCIAL SERVICES COMMISSION	39	
LIQUOR CONTROL BOARD OF ONTARIO	10	
MUNICIPAL PROPERTY ASSESSMENT CORPORATION	99	
ONTARIO LOTTERY AND GAMING CORPORATION	81	
ONTARIO SECURITIES COMMISSION	19	

Appendix 1

Complaint statistics

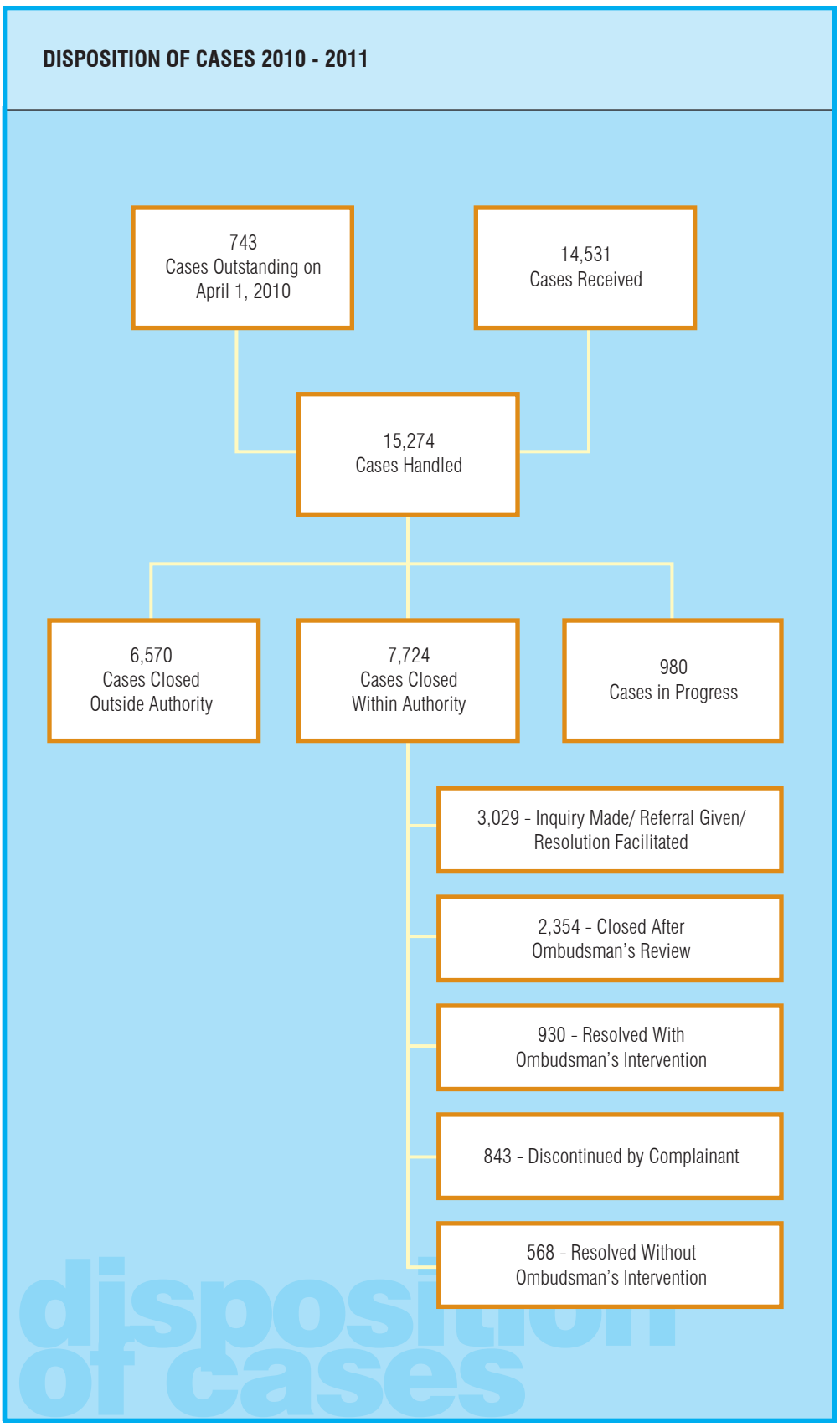
TOTAL CASES RECEIVED 2010-2011 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*

MINISTER RESPONSIBLE FOR FRANCOPHONE AFFAIRS		1
MINISTRY OF GOVERNMENT SERVICES		216
LICENCE APPEAL TRIBUNAL	12	
REGISTRAR GENERAL	110	
SERVICEONTARIO	47	
MINISTRY OF HEALTH AND LONG-TERM CARE		612
ASSISTIVE DEVICES / HOME OXYGEN PROGRAMS	13	
COMMUNITY CARE ACCESS CENTRES	51	
DRUG PROGRAMS BRANCH	94	
HEALTH PROFESSIONS APPEAL AND REVIEW BOARD	22	
HÔTEL-DIEU GRACE HOSPITAL	22	
LOCAL HEALTH INTEGRATION NETWORKS	46	
LONG-TERM CARE BRANCH	41	
NORTHERN HEALTH TRAVEL GRANT	18	
ONTARIO HEALTH INSURANCE PLAN	102	
MINISTRY OF HEALTH PROMOTION		3
MINISTRY OF LABOUR		610
EMPLOYMENT PRACTICES BRANCH	47	
ONTARIO LABOUR RELATIONS BOARD	29	
WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	79	
WORKPLACE SAFETY AND INSURANCE BOARD	414	
MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING		135
LANDLORD AND TENANT BOARD	99	
MINISTRY OF NATURAL RESOURCES		59
MINISTRY OF NORTHERN DEVELOPMENT, MINES AND FORESTRY		9
MINISTRY OF REVENUE		64
MINISTRY OF TOURISM		5
MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES		292
APPRENTICESHIPS / WORK TRAINING	68	
COLLEGES OF APPLIED ARTS AND TECHNOLOGY	71	
ONTARIO STUDENT ASSISTANCE PROGRAM	99	
MINISTRY OF TRANSPORTATION		381
DRIVER LICENSING	286	
VEHICLE LICENSING	34	

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

Appendix 1

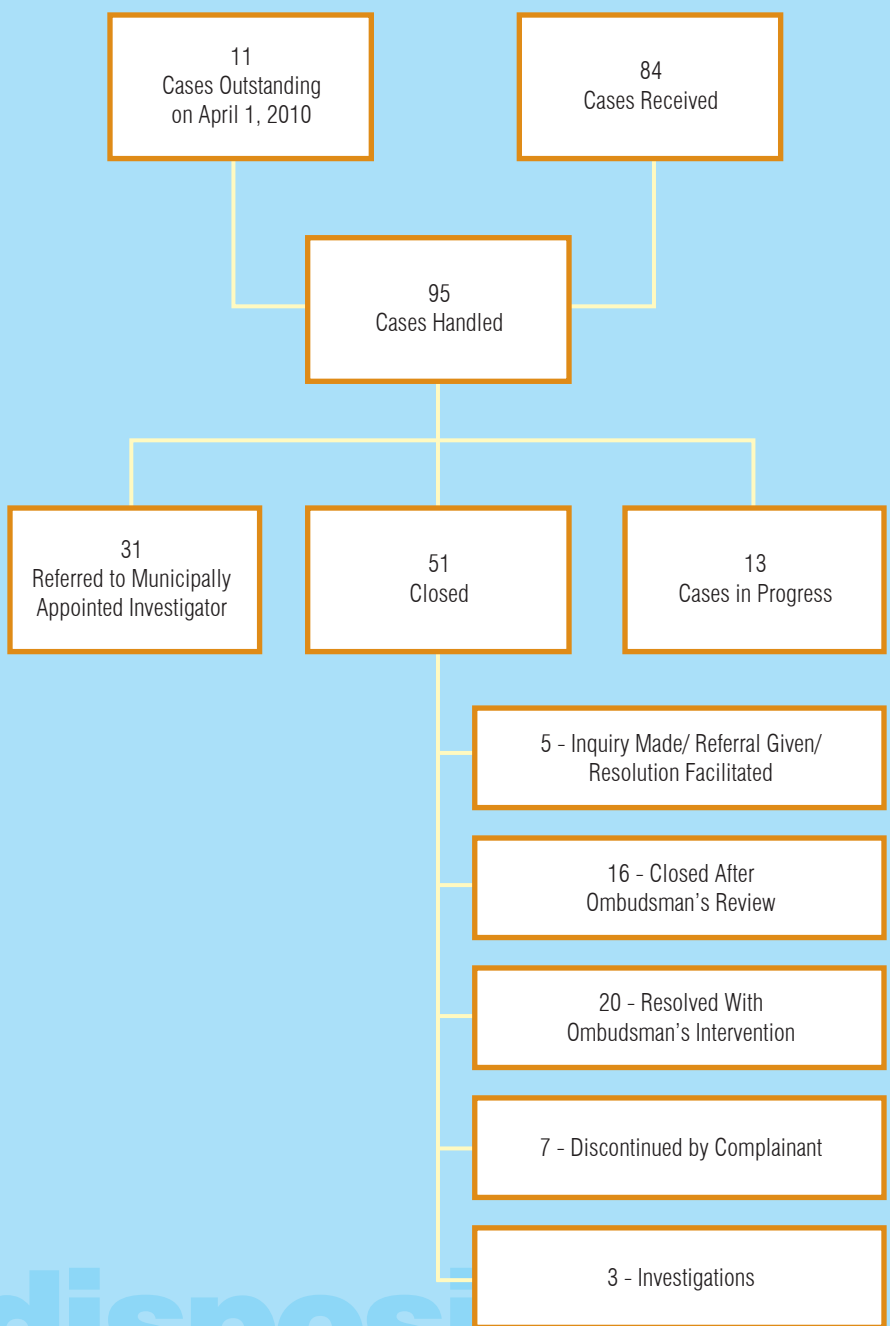
Complaint statistics



Appendix 1

Complaint statistics

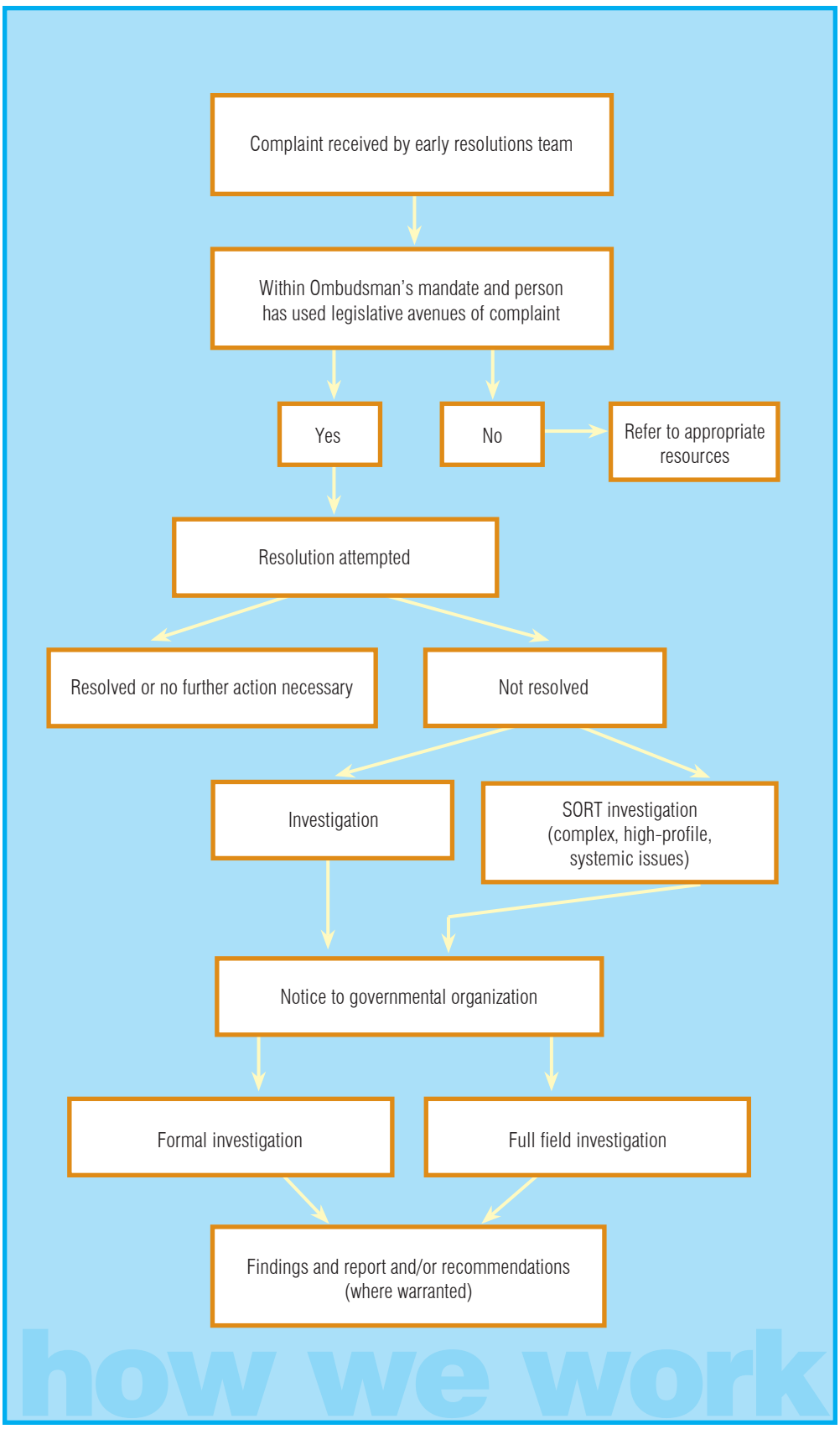
DISPOSITION OF CASES ABOUT CLOSED MUNICIPAL MEETINGS



disposition of cases

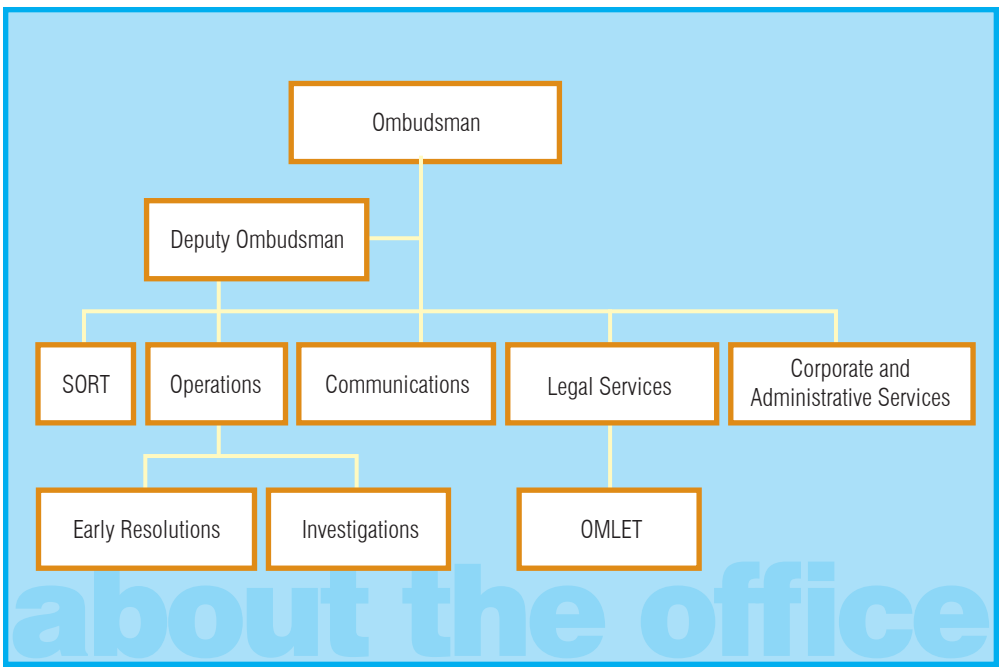
Appendix 2

How We Work



Appendix 3

About 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 conducts issue-driven, focused and timely investigations of individual complaints and systemic issues.

Legal Services: This team, led by the Office's senior counsel, supports the Ombudsman and his staff, 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. Legal Services oversees the Open Meeting Law Enforcement Team (OMLET), which reviews and investigates complaints about closed municipal meetings received pursuant to the *Municipal Act*, and engages in education and outreach with municipalities and the public with regard to open meetings.

Communications: In addition to co-ordinating the Office's publications, including the Annual and SORT reports, brochures and the *Sunshine Law Handbook*, the communications team maintains the Ombudsman's website and social media presence, assists in outreach activities, and provides support to the Ombudsman and staff in media interviews, press conferences, speeches, presentations and public statements.

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

Appendix 4

Financial Report

During the fiscal year 2010-2011, the total operating budget allocated for the Office was $10.48 million. Miscellaneous revenue returned to the government amounted to $29,000, resulting in net expenditures of $10.16 million. The largest categories of expenditures relate to salaries and benefits at $7.77 million, which accounts for 76% of the Office's annual operating expenditures.

SUMMARY OF EXPENDITURES 2010-2011

	(In thousands)
Salaries and wages	$6,364
Employee benefits	$1,404
Transportation and communications	$321
Services	$1,540
Supplies and equipment	$555
Annual Operating Expenses	**$10,184**
Less: Miscellaneous revenue	$ 29
Net Expenditures	**$ 10,155**

Ombudsman
ONTARIO

ONTARIO'S WATCHDOG

ANNUAL REPORT 2010-2011

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