

Annual Report 2014-2015 – Facts and Highlights

Total cases received: 23,153 in 2014-2015 (p. 7); **193,038** in past 10 years
Increase in past 5 years (since Annual Report 2009-2010): **86%**

Top 5 most complained about organizations (excluding jails) – page 90:

- 1. Hydro One (3,499 complaints)**
- 2. Family Responsibility Office (1,167)**
- 3. Ontario Disability Support Program (684)**
- 4. Workplace Safety and Insurance Board (481)**
- 5. Private Career Colleges Branch, Ministry of Training, Colleges and Universities (274)**

MUSH sector complaints (p. 21): 24,065 received in past 10 years despite sector being outside of mandate; 2014-2015 total: **3,383** (down slightly from last year's record of 3,400)

- **Municipalities (excluding 152 complaints about closed meetings): 1,656** (a new record)
- **Universities: 72** (up 75% from last year)
- **School Boards: 260** (a new record)
- **Hospitals and long-term care homes: 475** (hospitals); **84** (long-term care)
- **Children's aid societies: 478**
- **Police: 358**

What's new – historic mandate expansion: “Bill 8,” the *Public Sector and MPP Accountability and Transparency Act, 2014*, opens “MUS” sector to Ombudsman*. Key dates:

December 9, 2014: Legislation passed

September 1, 2015: Ombudsman can take complaints about **school boards**

January 1, 2016: Ombudsman can take complaints about **municipalities** and **universities**

(*Ombudsman will oversee new “Patient Ombudsman” for hospitals, long-term care and Community Care Access Centres; Provincial Advocate for Children and Youth will have power to investigate children's aid societies; police oversight does not change.)

Significant cases, complaint trends and proactive work in 2014-2015:

Segregation and inmate health and safety (pages 36-38, 76): Complaints about **segregation** (sometimes called “solitary confinement”) increased **54%** over last year, to **225** (p. 36). In several cases, inmates were wrongly placed in segregation for months at a time without any of the legally required reviews. There were also **2,138** complaints about **inmate health care**, including one man who fainted from wisdom tooth pain and was denied medication despite being hospitalized, and another whose cancer-related colonoscopy was unfairly delayed. The brand-new **Toronto South Detention Centre** received **422** complaints – many about sick inmates put in segregation because the new infirmary units were not open. Meanwhile, the Ministry of Community Safety and Correctional Services changed its approach to **inmate-on-inmate**

assaults so investigations of even serious injuries are not mandatory. The Ombudsman is monitoring the impact of this change.

Everest College shutdown: The private career college's abrupt closure left 2,700 students in the lurch, affecting potential income, child care arrangements, professional exams and career plans for many. Ombudsman staff worked with the Ministry of Training, Colleges and Universities' Private Career Colleges Branch to help **261** students and staff who complained make new arrangements and get needed help.

Flexibility in health/drug benefits: Proactive efforts by Ombudsman staff resulted in the temporary extension of funding for a **chemotherapy drug** that will benefit 100 women in the next three years (p. 78), an appeal process for **Northern Health Travel Grant** applicants whose cases warrant exceptions to its eligibility criteria (p. 39) and improved procedures and staff training at **Trillium Drug Program** after its staff told a woman to write three different letters simply to inform them her insurance coverage had changed (p. 81).

Co-ordinating services for vulnerable people: Ombudsman staff worked with various ministries and government-funded agencies to improve communication between them and ensure they were aware of programs and services that could benefit vulnerable complainants. For example, several families of **adults with developmental disabilities** were given wrong or inadequate information about available resources (p. 53), a **Family Responsibility Office** client was wrongly told she could not access \$46,000 in support due to her ex-husband's bankruptcy (p. 73), and two **Ontario Disability Support Program** clients were abandoned when their case workers went on maternity leave without assigning anyone to their files (pages 71 and 72).

Poor customer service: Besides the disastrous customer service the Ombudsman investigated at **Hydro One** after it implemented a new billing system (p. 47), Ombudsman staff are monitoring serious ongoing customer service problems at the **Family Responsibility Office** (p. 33) and the **Office of the Public Guardian and Trustee** (p. 31).

Systemic investigations and updates:

Systemic investigations completed since 2005: 35 (see "timeline" of highlights, pages 6-19)

Ongoing investigations: Two, relating to the province's direction to police on **de-escalation** of conflict situations, and services for **adults with severe special needs** who are in crisis (p. 52).

- *In the Dark* (Billing and customer service at Hydro One, released May 2015 – pages 47-49): The Ombudsman's largest-ever investigation drew nearly **11,000** complaints and revealed systemic problems with the corporate culture at Hydro One, which accepted 65 of the Ombudsman's recommendations. The government did not accept the 66th which called for continued Ombudsman oversight of the utility – its privatization plan, passed with the budget in June, ends all independent oversight in late November. The Ombudsman has until then to complete 578 outstanding cases, and Hydro One will report back on its progress on the recommendations.
- *Careless About Child Care* (monitoring of unlicensed daycares, released October 2014 – p. 50): The government accepted all 113 of the Ombudsman's recommendations to ensure

better protection of children in the unlicensed child care sector. The new *Child Care Modernization Act*, addressing **35** of the recommendations, including increasing fines for illegal operations, passed in December 2014.

- *Better Safe Than Sorry* (monitoring of drivers with uncontrolled hypoglycemia, released April 2014 – page 54): Bill 31, *the Transportation Statute Law Amendment Act (Making Ontario Roads Safer)*, 2015, was passed in June, addressing several of the Ombudsman’s recommendations to improve reporting and monitoring of drivers with potentially dangerous medical conditions.
- *The Code* (use of excessive force by correctional officers, released June 2013 – pg. 55): The Ministry has addressed **37** of the Ombudsman’s 45 recommendations, including committing to eradicating the “code of silence” among guards – however, complaints about the use of excessive force increased (to 79 from 71 last year), and there were also complaints about delays in the new process for investigating such incidents.
- *In the Line of Duty* (operational stress injury and suicide among Ontario Provincial Police, released October 2012 – p. 56): The OPP has implemented all of the Ombudsman’s recommendations to improve support for officers, and we continue to monitor its progress in expanding psychological service and hiring a full-time psychologist. The Ministry of Community Safety and Correctional Services is also surveying all police services to determine the need for supports provincewide.
- *Caught in the Act* (expansion of police powers for the 2010 G20, released December 2010 – p. 59): Two days short of the fifth anniversary of the G20, new legislation (passed in December 2014) was proclaimed in force, replacing the World-War-II-era *Public Works Protection Act* as the Ombudsman recommended.
- *The Right to be Impatient* (newborn screening, released September 2005 – p. 60): Ten years after the Ombudsman’s investigation resulted in the expansion of newborn screening tests from two to 29, Ombudsman staff made inquiries with Newborn Screening Ontario in the wake of media reports that delays were putting babies at risk. Officials are now considering operating on weekends to avert delays and analyzing the time it takes to transport and test newborn blood samples.
- *Between a Rock and a Hard Place* (services for children with acute special needs, released May 2005 – p. 61): Ten years after the Ombudsman’s investigation revealed the disturbing problem of parents being forced to surrender custody of children with severe special needs to children’s aid societies in order to obtain residential care for them, similar cases continue to surface. In six such cases this year, Ombudsman staff ensured that the children received the care they needed.