Nova Scotia Office of the Ombudsman 2022-2023 Annual Report



Crown copyright, Province of Nova Scotia, 2023

Ombudsman Annual Report 2022-2023 Office of the Ombudsman September 2023

September 2023

The Honourable Keith Bain Speaker of the House of Assembly Legislative Assembly of Nova Scotia Province House Halifax, Nova Scotia

Dear Speaker Bain,

In accordance with subsection 24(1) of the *Ombudsman Act*, chapter 327 of the Revised Statutes of Nova Scotia, 1989, and section 28, subsections (1) and (2) of the Public Interest Disclosure of Wrongdoing Act, Chapter 42 of the Acts of 2010, I have the pleasure of presenting to you, and through you to the House of Assembly, the annual report on the exercise of my functions under those acts for the fiscal year ending March 31, 2023.

Respectfully,

Christine Brennan, Ombudsman



1 Table of Contents

2 About the Office

Mission

Role and Mandate

Organization

3 Human Resources

Training and Professional Development

- 4 Finances
- 5 Case Study 1
- 6 Year in Review

Reviews, Complaints, Meetings

- 7 Results of Complaints and Inquiries
- 8 Key Facts and Figures Resolution Timelines
- 9 Jurisdictional and Non-Jurisdictional Complaints
- 10 Case Study 2/Year in Review
- 11 Department of Community Services Halifax Regional Municipality Health and Wellness Justice
- 12 Case Studies 3/4
- 13 Respondents to Complainants
- **14 Complaint Resolution**

Complaint Resoluton Process

- 15 Ombudsman Act Investigations Own Motions and Policy Reviews Youth Act Investigations
- 16 Public Interest Disclosure of Wrongdoing Act (PIDWA) Investigations
- 17 Investigation Outcomes (Recommendations)
- 19 Ombudsman Youth Council/Raise the Bar
 Ombudsman Youth Council (OYC) Summary 2022/23
 Raise the Bar Advanced Investigator and Manager Webinar
- 20 Outreach

Correctional Services

21 Youths/Seniors

Youth and Seniors Services Senior-Specific Issues Types of Youth Complaints

22 Contact Us



Mission

Promote the principles of fairness, integrity, and good governance.

Role and Mandate

Ensure government decisions and processes are fair, consistent, and transparent. Our mandate applies to individuals who receive services from, or are impacted by, provincial and municipal government.

Provincial government employees and members of the public have an avenue to submit allegations of government wrongdoing to the Ombudsman under the *Public Interest Disclosure of Wrongdoing Act* (PIDWA).

Administration

The **Office Manager** fulfills administrative and business functions and is a committee member for the Occupational Health and Safety Legislative Committee.

The Complaint and Assessment Analyst provides initial intake, assessment, and referrals, and creates records of all inquiries

The **Records Analyst** manages the Office's program of records control and retention, adhering to provincial STAR/STOR standards.

Managers and the **Deputy Ombudsman** supervise staff, oversee investigators and business operations, and provide advice to the Ombudsman.

Investigation and Complaint Services (I&CS)

Ombudsman Representatives conduct investigations, including Own-Motion and systemic reviews.

The unit addresses departmental services, adult corrections, municipal services, and many other inquiries and complaints.

Staff also provide regular outreach visits to inmates and staff in provincial correctional facilities to advise of our services and discuss complaints in person.

Youth and Seniors Services (Y&SS)

Ombudsman Representatives review, investigate, and report on the concerns of children, youth, parents, guardians, and staff in relation to all provincial and municipal government child and youth serving programs and systems services; with an enhanced outreach to those living and working in provincial child and youth residential care and custodial facilities.

Ombudsman Representatives examine issues and complaints affecting senior citizens, particularly those who reside in provincially licensed long-term care (LTC) facilities.

Staff also provide regular outreach visits to Residential Child-Caring Facilities, Wood Street Centre Campus, the Nova Scotia Youth Centre (Waterville), and the Cape Breton Youth Detention Facility (Glace Bay).

The Ombudsman is an executive member of the Canadian Council of Child and Youth Advocates (CCCYA), and Ombudsman Representatives participate on various CCCYA working groups.

Human Resources

The Office of the Ombudsman is committed to providing a workplace that is free of discrimination and promotes equality of opportunity for all persons seeking employment with the Office.

The Office has 17 full-time positions, including that of Ombudsman and continues to benefit from co-op and student work placements.

Office of the Ombudsman staff sit on the following committees:

- Diversity Roundtable
- Pride Nova Scotia Government Employee Network
- Nova Scotia Disability Employee Network
- Child Death Review Community of Practice

This year, following the lifting of restrictions regarding the Novel Coronavirus Pandemic (COVID-19) we have been able to return to hosting in-person student placements.

Training and Professional Development

Internal Government and Public Service Commission Training

- Management and Leadership Development Programs
- Respectful Workplace
- Diversity, Inclusion & Employment Equity
- Privacy & Access Awareness Training
- First Aid/CPR & OHS Training
- · Mental Health First Aid

External Training

- Managing Unreasonable Conduct by a Complainant Training
- Attendance at The Biennial Provincial Diversity Conference
- Participation at The Whistleblowers and Public Integrity Conference in Vancouver, BC. Hosted by the Vancouver Anti-Corruption Institute and the Ombudsperson of BC.
- Chairing Committee and staff participation in the inter-provincial, territorial 'Raise the Bar Advanced Investigator & Manager Webinars'.
- Attendance of Senior Officials Committee for Human Rights, meeting with Civil Society Organizations on the Convention on the Rights of the Child.
- Collaborating with the Office of the Ombudsperson (PEI) researching Opioid Replacement Therapy Induction in Correctional Facilities
- Participation in other Provincial and Territorial Webinars & Presentations, with:
 - Office of Workplace Mental Health
 - Canadian Council of Parliamentary Ombudsman
 - Nova Scotia College of Social workers



Finances

The Office of the Ombudsman's 2022-2023 Budget is shown in Figure 1. This year the Office spent 100% of its budget.

Figure 1

	Figure 1
EST	\$2,101,000
ACT	\$1,851,300
EST	\$237,500
ACT	\$218,600
EST	\$1,935,500
АСТ	\$1,709,500
EST	-\$72,000
ACT	-\$76,800
EST	17
АСТ	15.9

Effective Communication

A property owner in the Cape Breton Regional Municipality (CBRM) contacted this Office expressing concerns regarding the application of By-Law enforcement procedures and the handling of their complaint made to the CBRM regarding those concerns.

According to the property owner, a By-Law Enforcement Building Inspector attended one of their properties and following an inspection deemed the property to be in an unsightly condition. In keeping with the Municipal Government Act the Building Inspector issued an Unsightly Premises Order and accompanying 'Schedule A' and posted it on the premises. This documentation outlined the process required by the owner to remedy the condition of the property in accordance with the Dangerous or Unsightly Operating Procedure used by the CBRM.

The property owner stated when they attended the property some time later, only the Schedule A was attached to the premises, and it was barely legible. The owner noted the posted document, attached to the outside wall of the building, was exposed to the elements with no protective cover applied. The property owner suggested that the Order could have detached and been blown away by the elements, and the absence of the Order meant they were not aware or fully informed that failure to comply would result in Summary Offence proceedings.

Having issued the Order and in keeping with operational procedure, the Building Inspector then mailed copies of the same Order and Schedule A via registered mail to the mailing address listed for the property on the provincial government Property Online service, unfortunately this was the same address the Building Inspector had just inspected and was a vacant building. The documents had been sent via registered post and were subsequently returned to the CBRM municipal office as having not been received.

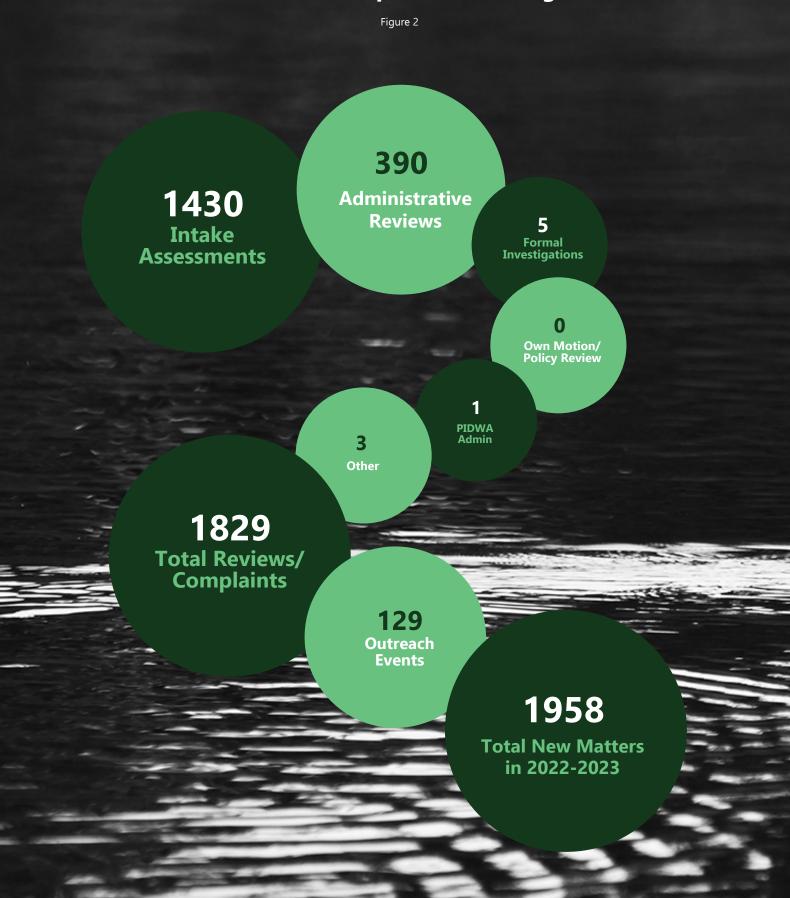
No information or evidence was provided by the CBRM to support any follow-up occurred when the registered mail was returned. The property owner stated they never received the appropriate documentation. File documentation showed a period of no communication among the parties, after which, without further notification, work was carried out at the premises by staff contracted by the CBRM and the property owner was invoiced the cost.

The property owner maintained they had not been informed of what the CBRM required to initially remedy the situation, despite the CBRM having their correct mailing address evidenced by receiving mail from the CBRM concerning any property tax or related requests.

During their investigation, the Ombudsman Representative revealed a breakdown in the By-Law Enforcement process as the Building Inspector did not have access to the municipal database that would have provided the mailing address of the property owner, which ideally would have allowed the Order and Schedule A to be sent directly to the listed property owner, rather than a vacant building and returned undeliverable.

Other deficiencies were also identified to improve processes. Recommendations were issued to address these circumstances and accepted by the CBRM. One of the recommendations included that Building Inspectors be provided appropriate and secure training and access to the internal municipal database system for the specific purpose of obtaining the listed mailing address of a property owner to send registered mail. The actual recommendations issued may be found in the recommendation section of the report.

Reviews/Complaints/Meetings



Results of Complaints and Inquiries

Figure 3

1059

Assistance Rendered: When this Office makes efforts to assist the complainant, but the matter has not progressed to the formal stages of investigation 20

Resolved: Through significant effort by this Office the complainant's concerns are addressed, and reasonable resolution has been reached (e.g. Formal Recommendations are issued to address the concern)

17

Properly Implemented: Review / Investigation of the complaint is undertaken, and it is determined that the respondent has followed policy and procedures

89

Discontinued by Complainant (Withdrawn): When a complainant decides to disengage from the review/investigation process

5
Discontinued by Ombudsman: When

the Ombudsman, or their designate, determines a complaint will not be investigated (e.g. when a complaint is

malicious or vexatious in nature or a complainant is seeking reinvestigation of a matter that was already addressed

by this Office

616

Non-Jurisdictional:

- Court or Tribunal
- Elected Officials
- Federal
- Private Matter
- Self-regulating body

23

Outcome Undetermined: File remains ongoing into the following fiscal year

1829 Total

Key Facts and Figures

In 2022-2023, the Office handled 1829 complaints, inquiries, and youth contacts. To see how that compares with the last ten years see figure 4.

3000 2500 2000 1500 1000 500 0 2015-2016 2013-2014 2014:2015 2017.2018 2016:2017 2018-2019 2019-2020 2020-2021 2022-2022

Figure 4

Resolution Timelines

Most files are resolved by Ombudsman Representatives in one to seven days. Figure 5 demonstrates the timeframes in which the various categories of complaints/investigations are concluded by this Office. These are general timeframes. Some matters may take more or less time depending on the complexity of the issue. Many Intake Assessments are resolved on first contact with the Complaint and Assessment Analyst.

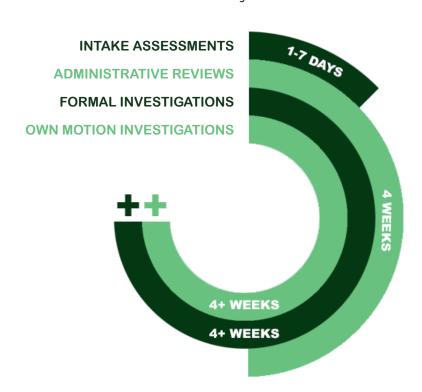


Figure 5

Jurisdictional and Non-Jurisdictional Complaints

All inquiries and complaints are assessed to determine whether they fall under one of two acts, the *Ombudsman Act* or the *Public Interest Disclosure of Wrongdoing Act* (PIDWA). In addition to those which fall under the jurisdiction of both acts, matters that do not fall under either act are considered for avenues of appeal or referral information that can be provided to the individual contacting the Office. Thirty percent of matters addressed by the Office in the year under review were non-jurisdictional. This calculation excludes visits with youth in care and custody.

Whenever possible, there are many organizations such as federal and private industry ombudsman, legal assistance organizations, and other oversight bodies to whom we may refer complainants. This service is not a technical component of our mandate however, over several years it was determined that assisting the public in this way was found to be helpful to those contacting the Office, as well as it enables Ombudsman Representatives to identify areas that may require additional education on our role and mandate.

Non-jurisdictional complaints are broken into the following categories:

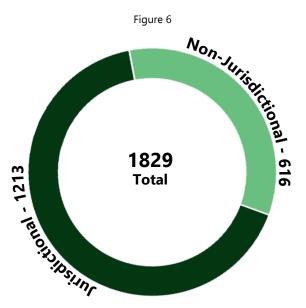
Self-regulating body – When the Office receives a complaint regarding a professional governed by a self-regulating body or about the services of a self-regulating body (e.g. complaints about lawyers)

Private – When the Office receives a complaint regarding a dispute between private individuals or a complaint about a private corporation (e.g. a complaint about a cellphone bill)

Federal – When the Office receives a complaint regarding the Government of Canada (e.g. a complaint about the Canada Revenue Agency)

Elected Official – When the Office receives a complaint regarding the decisions of an elected official(s) (e.g. a complainant disagrees with the decision made by a municipal council)

Court or Tribunal – When the Office receives a complaint regarding the decisions of a judge(s) or a tribunal (e.g. a complainant disagrees with the result of a custody hearing)



Personal Information and File Documentation

An individual contacted this Office expressing concern with respect to information they described as inaccurate and damaging to their reputation contained in an Adult Protection File. The individual explained that following an access to information request, they discovered a notation in the file records which suggested Adult Protection Services (APS) included this information in its file and shared this information with another government body.

A review of the matter by an Ombudsman Representative determined that as part of a past investigation by Adult Protection Services, collateral sources were interviewed who disclosed the information. There was no indication contained in the file whether the information was substantiated or not, nor was there any indication the information was a factor in the outcome of the APS investigation.

Following our investigation, a recommendation was issued that Adult Protection Services develop and implement policy on the sharing of information received from collateral sources. The recommendation stated that the policy should ensure the accuracy of information prior to it being disclosed to outside agencies and any attempt(s) to confirm the accuracy of the information be documented.

Furthermore, if it is not possible to confirm the accuracy of collateral source information in urgent situations, appropriate caveats should accompany the information being disclosed indicating that the information has not been substantiated or that the accuracy or source information is of an unknown origin.

The recommendation was accepted, and the Adult Protection Policy Manual has since been amended to clarify that APS workers must ensure the credibility of specific information extracted from a client file before the information is shared with a health professional or service provider.

Amendments were also made stating when it is not reasonable for a worker to confirm the accuracy of collateral source information due to an urgent situation, the worker must state that the information has not been verified. Further, that the worker must also record what unconfirmed information was shared, on what date, with whom, for what purpose, and the steps taken to verify information in the case notes.

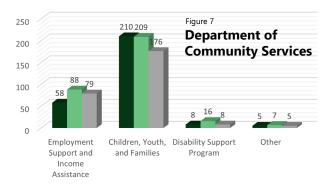
Where Complaints Originate

Government services are broad and can be multi-layered and complex. For each one of those services there is legislation, policy, and procedures that must be understood, adhered to, and implemented. If you think about how much government impacts your day to day life, from healthcare and education to roads and infrastructure, you will begin to see the broad mandate of the Office of the Ombudsman. Complaints can originate from any program or service, or multiple agencies, and can be related to several diverse and sometimes overlapping pieces of policy. Matters may also be referred to the Ombudsman for investigation by a committee of the House of Assembly, including complaints stemming from the House of Assembly Policy on the Prevention and Resolution of Harassment in the Workplace.

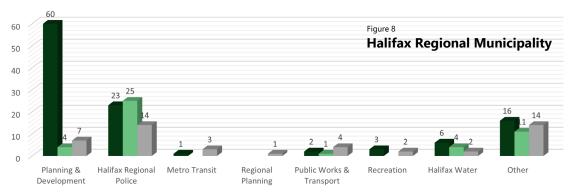
In addition to complaints under the *Ombudsman Act*, the *Public Interest Disclosure of Wrongdoing Act* (PIDWA), and matters referred by the House, the Office receives complaints that do not fall within our jurisdiction. In all cases, the variety of matters brought to this Office each year require staff at the Office of the Ombudsman to quickly adapt by researching and reviewing legislation, policy, and procedure from the spectrum of provincial and municipal government services.

This Office recognizes that receiving a complaint does not necessarily mean it is with merit in every instance. Nor does the number of complaints regarding a public body speak to the quality of programs and services it delivers. By their nature, the public bodies accessed more frequently by citizens, or who interact with a significant portion of the population, tend to generate the greatest number of complaints. Typically, these are the larger departments that come to mind when thinking about government, including departments and agencies serving vulnerable people or those in distress. Thus, it is not unreasonable that a higher number of complaints can arise. However, if a smaller agency were to receive a high number of complaints, it could be perceived as a reason for further inquiry by this Office and may point to a potential systemic issue. It is important to focus on the substance and issue of each complaint, rather than solely the number of complaints received.

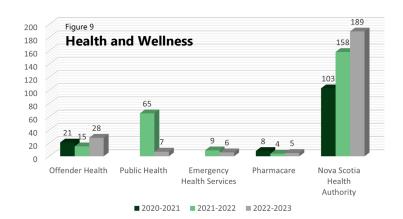
Figures 7-10 demonstrate from which government entities the most complaints originate, as well as the type of complaint. The statistics are demonstrated over a period of three years. Appearing on these tables does not necessarily suggest fault or maladministration by the respondent or public body.

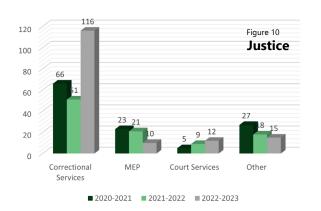


■ 2020-2021 ■ 2021-2022 ■ 2022-2023



■ 2020-2021 ■ 2021-2022 ■ 2022-2023





11

Long-Term Care Facility - COVID-19 Restrictions

Some family members of residents at a senior's long-term care facility contacted this Office alleging the Administrator of the facility was not complying with a Public Health Order related to Designated Caregiver access. The facility in this instance is licensed and funded by the Department of Health and Wellness. Assertions were made the Administrator was not allowing Designated Caregivers access to and visitation with resident family members.

Designated Caregivers can be family members, spouses, friends, or other support people. They must be associated with specific caregiving tasks like personal care support, mobility or help with eating, and have an established caregiving relationship with the resident prior to COVID-19. Designated Caregivers can also provide emotional support to their loved ones.

The Office of the Ombudsman determined the family members who reached out were in fact Designated Caregivers. Additionally, it was established the Public Health Order in place at the time allowed for each resident within a publicly funded Long-Term Care facility to have two Designated Caregivers permitted to visit and provide for their needs, including emotional support as long as COVID protocols in place for Long-Term Care Facilities were being adhered to.

The family members (Complainants) divulged they were unable to contact the Board of Directors for the facility to provide their concerns about the Administrator, which is the complaint resolution mechanism option to follow prior to contacting the Office of the Ombudsman. According to the family members, they were not provided with the contact coordinates for the Board and its members. Rather, they alleged being actively prevented from contacting the Board by the Administrator. The Complainants believed the health and mental well being of their resident family members were being negatively impacted because of their inability to visit and care for their needs.

Attempts by the Office of the Ombudsman to liaise with the Administrator were unsuccessful, resulting in an own-motion investigation being initiated and Ombudsman Representatives contacting the Department of Health and Wellness to intervene. As a result, the Department of Health and Wellness compiled a detailed Action Plan related to the oversight and operation of the facility, which this Office accepted and monitored its implementation through ongoing updates from the Department.

Among a list of directives, the action-plan included a requirement that the Administrator cooperate with all Ombudsman investigations and comply with Ombudsman recommendations. The Board of Directors were also required to provide the Department with quarterly written reports assessing the success of all Action Plan items. Ultimately, Designated Caregivers were provided access to the facility.

As part of their investigation, Ombudsman Representatives acknowledged that the COVID-19 pandemic was a challenging time for residents, their families, and staff at Long-Term Care facilities. Representatives also acknowledged many people wanted to go above and beyond the Public Health Order believing it would further ensure the safety of residents, perhaps not fully realizing the potential detrimental effects of restricting Designated Caregiver access to the residents.

Ambulance Fee

An individual contacted this Office regarding an ambulance bill they received. The individual explained that they had gone to their local emergency department and had been discharged home. A few days later, they called 911 for medical assistance and were taken by ambulance to the hospital, where they were subsequently admitted.

Shortly afterwards, they received a bill for the ambulance which they did not believe was fair given they had sought medical assistance earlier but were sent home. According to the individual, they had been trying for months to reach someone from Patient Relations to discuss the situation and request that they address the ambulance bill, to no avail. The individual hoped an Ombudsman Representative would be able to connect them with Patient Relations.

When contacted by an Ombudsman Representative, a representative from the Nova Scotia Health Authority responded advising that someone would follow-up directly with the individual. The individual later confirmed that they had received a response from someone at the hospital and they were provided with the opportunity to explain what had happened to them.

The individual was pleased to report that the representative from the Nova Scotia Health Authority addressed their concerns, and they were satisfied with the outcome.

Respondents to Complaints

The table below (Figure 11) lists all public bodies that were the subjects of complaints under the Ombudsman Act and the PIDWA for 2022-2023. The respondent to a complaint is captured when the complaint is made, prior to any review or investigation taking place. Appearing on this list does not imply fault or maladministration by the respondent. (Departments in bold)

Figure 11

1	Advanced	Educat	tion. [Dept of
---	----------	--------	---------	---------

- Amherst, Town of
- Annapolis Royal, Town of
- Atlantic Provinces Special Education Authority
- Bridgewater, Town of
- Cape Breton Regional Municipality
- Chester, Village of
- Communications Nova Scotia
- Communities, Culture, Tourism and Heritage

Community Services

- County of Annapolis, Municipality of the
- County of Antigonish
- County of Colchester
- County of Cumberland
- County of Inverness, Municipality of the
- County of Kings, Municipality of the
- County of Pictou
- County of Richmond, Municipality of the
- Develop NS
- District of Chester, Municipality of the
- District of Guysborough, Municipality of the
- District of Lunenburg, Municipality of the
- District of St. Mary's, Municipality of the 3
- District of West Hants, Municipality of the
- District of Yarmouth, Municipality of the
- Education & Early Childhood Development
- **Emergency Management Office**
- Environment and Climate Change
- **Finance and Treasury Board**
- Halifax Regional Municipality
- Halifax Regional Police
- **Health and Wellness**
- Human Rights Commission, Nova Scotia
- Inclusive Economic Growth
 Information and Privacy Commissioner, Office of the
- Infrastructure and Housing
- **IWK Health Centre**
- Justice
 - Kentville, Town of
 - Labour Board

Labour, Skills, and Immigration

- Lands and Forestry Legislative House of Assembly
- Lockeport, Town of

- Mahone Bay, Town of
- 33 **Municipal Affairs**
- Municipality of Clare Municipality of Shelburne
- **Natural Resources and Renewables**
- New Glasgow, Town of
- Nova Scotia Community College
- Nova Scotia Health Authority
- Nova Scotia Legal Aid Commission Nova Scotia Police Complaints Commissioner
 - Nova Scotia Utility and Review Board
 - Office of the Ombudsman
 - Port Hawkesbury, Town of
 - Premier, Office of
- Property Valuation Services Corporation (Municipal)
- **Public Prosecution Service**
- **Public Service Commission**
- **Public Works**
- Regional Centres for Education
- **Seniors & Long Term Care**
- **Service NS & Internal Services**
 - Stellarton, Town of
 - Stewiacke, Town of
 - Trenton, Town of
 - Truro, Town of

 - Westville, Town of Windsor West-Hants Regional Municipality
 - Wolfville, Town of

 - Workers' Compensation Appeals Tribunal
- Workers' Compensation Board
- Yarmouth, Town of
- No respondents includes non-jurisdictional complaints, info requests, and other inquiries
- TOTAL 1829

COMPLAINT RESOLUTION

Most of the in-depth investigations undertaken by this Office begin as complaints or concerns brought to our attention by a member of the public. While our initial approach is to resolve these matters informally, sometimes the nature or complexity of an issue requires a more formal approach. These types of more formal investigations can involve extensive research, review of documentation, and interviews with relevant parties, among other methods of accurately determining what took place. In some cases, the need for a formal investigation is derived from recurring issues and others may have broader systemic implications beyond the initial concern or complaint. When an investigation moves to the next stage of investigation, a manager will further assess and decide on the direction. If a more formal investigation or investigation is decided, management will meet and provide direction.

Through monitoring trends in complaints, Ombudsman Representatives may identify potential systemic issues in policy or process. Pursuant to the *Ombudsman Act*, the Ombudsman has the authority to initiate an investigation of their own volition. These "Own-Motion" investigations usually, but not always, pertain to a potential systemic issue observed within a government agency or department. This type of investigation enables the Ombudsman to pursue issues and matters that may not necessarily be complaint driven, that require an in-depth review.

Complaint Resolution Process Ways in which complaints are handled by the Office of the Ombudsman

Intake/Assessment



Complaint is received by phone, email, online complaint form, or in person

> Complaint and Assessment Analyst creates a file, determines if the matter is jurisdictional or non-jurisdictional

If non-jurisdictional, the complaint is recorded

If jurisdictional, a manager assigns it to an Ombudsman Representative

Inquiry

The Ombudsman Representative confirms the nature of the complaint with the complainant and beings analyzing how it may be handled

Often inquiries or adminstrative reviews may be addressed in a timely and less formal process

Investigation

Generally, includes more in-depth or complex matters, and a more formal process

Consultation



Formal investigations result in the issuance of a report summarizing the complaint and its findings

Before a report is finalized, both complainant and respondent are offered the opportunity to comment during the consultative process

Recommendations



Formal investigations result in the issuance of a report summarizing the complaint and its findings

The purpose of recommendations is to address areas of concern uncovered during the investigative process

Recommendations



In most cases, respondents choose to implement the recommendations in full

This Office monitors recommendations until they are implemented

Ombudsman Act Investigations

A large portion of the complaints submitted to the Office are received primarily over the telephone and are addressed by Investigation and Complaint Services. These complaints are either handled by the Complaint and Assessment Analyst during intake and assessment or are referred to Ombudsman Representatives as Administrative Review Investigations. Of these complaints, a small number warrant or become Formal Investigations. Many of these complaints involve departments and municipalities that have their own internal complaint resolution process or avenue of appeal available. In those instances, we often ensure the complainant has exhausted those processes before this Office becomes involved. If an Ombudsman Representative determines a complainant may require additional assistance, they may help them to navigate the complaint resolution process or provide general procedure related direction. If a complaint received is a part of an ongoing or active process, that appears to have come off track, informal intervention by Ombudsman Representatives may help to get it back on track. Having said that, Ombudsman staff are impartial and do not provide legal advice or serve as advocates to a complainant or respondent – rather they advocate for fair process.

When a complaint is within the jurisdiction of the Office, and avenues of appeal have been exhausted, typically the first step after the initial Intake Assessment is an Administrative Review Investigation. An Ombudsman Representative is assigned to review the complaint and will work with the complainant and responding government officials to address the issue. General assistance may be provided by opening lines of communication, offering suggestions based on best practices, or by guiding either party to an unaddressed or overlooked step in policy or procedures. If a resolution cannot be achieved informally, a more formal investigation may be initiated. As mentioned earlier, formal investigations rely on more in-depth research, interviews, and other reference materials; and may lead to the issuance of recommendations.

Own Motion Investigations and Policy Reviews

The Office of the Ombudsman may investigate government activities, practices, and policies under its own initiative, categorized as Own Motion investigations. Policy reviews may be undertaken at the request of a government department, agency, board, or commission, or the Ombudsman may determine that a specific policy warrants review. These reviews and investigations frequently address concerns which may be systemic in nature. In the year under review, this Office conducted no Own-Motion Investigations.

Youth Investigations

Complaints that are submitted to the Office by children and youth or their families, guardians, or staff providing services are categorized under Youth & Seniors Services. These complaints are handled similarly to others, but special attention is given to the needs of children and youth, both in terms of conveying information in an age-appropriate way, and in terms of ensuring their safety and security at all points of the complaint and investigation process. Many complaints are first heard by Ombudsman Representatives during site visits to Residential Child-Caring Facilities, Wood Street Centre Campus, the Nova Scotia Youth Centre, and the Cape Breton Youth Detention Facility. These visits help ensure that both youth and staff are aware of the Office's role and can present complaints in as easy a manner as possible.

Public Interest Disclosure of Wrongdoing Act (PIDWA) Investigations

The *Public Interest Disclosure of Wrongdoing Act* (PIDWA) provides public servants and members of the public with a clear and accessible method to disclose allegations of wrongdoing regarding provincial government. While the PIDWA covers provincial government employees only, disclosures regarding municipal government may be reviewed and addressed under the *Ombudsman Act*. Public employees making disclosures may contact the Designated Officer in their department or their supervisor/manager, or they may contact the Office of the Ombudsman directly. Concerns that are more appropriately addressed through an established grievance mechanism, such as an employment matter, are generally not investigated through the PIDWA and are referred to an organization such as a union. All matters received are subject to an assessment, and where appropriate, a referral. For instance, if a public employee were to bring an allegation of discrimination to this Office, Ombudsman Representatives might refer that person to the Nova Scotia Human Rights Commission.

When the *Public Interest Disclosure of Wrongdoing Act* was amended in 2016, the definition of government bodies which fell under the jurisdiction of this legislation expanded to include public sector agencies, board, commissions, and educational entities. A communication was sent by the Public Service Commission to these government entities to remind them of their responsibilities under the legislation, including the development of procedures related to disclosures of wrongdoing and the identification of a Designated Officer to handle the disclosures. As a result of this communication, this Office was contacted by some of these government entities for assistance in understanding their new responsibilities and in the development of procedures. The Office welcomes this proactive approach and is reviewing ways to provide further resources and support in relation to disclosure of wrongdoing in the future.

There were no disclosure of wrongdoing inquiries, allegations, or investigations specific to the Office of the Ombudsman received/submitted in 2022-2023. Figure 12 contains information required to be reported under section 18 of the PIDWA.

Figure 12

Information Required under Section 18 of the Act

The number of disclosures received

The number of findings of wrongdoing

Details of each wrongdoing

Recommendations and actions taken on each wrongdoing

n/a

Investigation Outcomes (Recommendations)

The Ombudsman Act provides the authority to make recommendations to provincial government departments, agencies, boards, commissions, and municipalities. Recommendations are generally the result of in-depth, usually formal, investigations conducted by the Office.

For every recommendation issued, the public body involved is required to report back to this Office on their plans to give effect to and implement the recommendation, often within a prescribed time frame. The authority to issue recommendations is how this Office informs and enhances government public policy, procedures, and service delivery. The public body may choose to accept and implement the recommendations, implement them in part, or refuse to accept them. That said, most government departments choose to accept and implement the recommendations in full. There are several reasons why a party responding to a recommendation may choose to implement in full, including a genuine desire by public officials to improve policy and procedures, and concerns about how failure to do so may be perceived by the public.

Figures 13-14 describe the recommendations issued in 2022-2023. The table also describes the public body involved as the respondent, as well as the nature of the complaint. There were 6 formal recommendations issued. Not all recommendations stem from new matters addressed in the year under review, some examples are derived from investigations initiated in an earlier fiscal year that were concluded in 2022-2023. Of the 6 recommendations issued, 5 have been accepted and are being monitored for implementation and 1 is pending acceptance from the respondent.

Figure 13

Complaint

This Office received a complaint alleging inaccurate and damaging information regarding the complainant's character had been documented in an Adult Protection file, then inappropriately accessed/disseminated among provincial government employees.

An investigation of the matter indicated collateral sources revealed the information – without any indication of efforts to confirm the information.

Respondent

Department of Seniors and Long-Term Care

Recommendations

In keeping with Section 20 of the Ombudsman Act, it is recommended that the Department of Seniors and Long-Term Care:

- 1. Adult Protection Services develop and implement policy on the sharing of information received from collateral sources. Such policy should consider:
 - a. Ensuring the accuracy of information being disclosed to outside agencies and document attempts to confirm the accuracy of the information prior to disclosing or further dissemination with another agency and/or party,
 - b. When it is not possible or reasonable (in urgent situations) to confirm the accuracy of collateral source information, appropriate caveats should accompany the information being disclosed indicating the information has not been substantiated and/or its accuracy or source is of unknown origin.

The recommendation was accepted by the respondent who reviewed all existing policies to ensure there is clear direction related to sharing of information received from collateral sources. The policy manual was amended accordingly.

Figure 14

Complaint

This Office received a complaint from a member of the public who alleged that they had been treated unfairly by the Cape Breton Regional Municipality (CBRM), following the issuing of an Order (Dangerous & Unsightly Premises) to their property.

The investigation confirmed inconsistencies in the application of enforcement procedures by CBRM staff resulting in the following recommendations:

Respondent

Cape Breton Regional Municipality

Recommendations

Cape Breton Regional Municipality (CBRM):

In keeping with Section 20 of the Ombudsman Act, it is recommended that the CBRM:

- 1. Develop and implement policies and/or procedures regarding the accessing of information held on relevant CBRM internal databases specified in policy, to allow By-Law Enforcement staff to remain in compliance with CBRM operating procedures.
 - a. Once complete, By-Law Enforcement staff be notified of the policy and/or procedure and training in accessing the necessary information provided
- Review the current procedure of posting completed Orders in paper format to properties with consideration to the use of protective coverings or films (for paper Orders) to mitigate damage or destruction to paper documents from the elements and/or weather.
- 3. Develop and implement a Municipal Complaint Handling or Resolution Policy to ensure a consistent and transparent approach to handling citizen complaints. This policy should be publicly available and posted on the CBRM website.
- 4. Review the handling and associated events in relation to the Unsightly Premises Order and 'Schedule A' issued to the address, to ensure compliance with the CBRM policy and procedures, the MGA, and the principles of administrative fairness.
 - a. If a deviation from the policy/procedure is confirmed, representatives from the CBRM engage in discussion with the property owner (the Complainant) regarding a mutually satisfactory resolution, in this instance, including the outstanding lien in whole or in part.

The recommendations have been accepted and are being monitored for implementation, respecting budgetary constraints.

Ombudsman Youth Council (OYC) Summary - 2022/23

Since its inception in 2018, the Ombudsman Youth Council (OYC) has been a youth-led and designed initiative. As described by our members, the purpose of the OYC is to act as a forum for youth to bring forward concerns they have involving government departments and agencies.

The OYC is a platform for youth voice regarding issues that impact Nova Scotia's young people. Upon bringing concerns forward, the OYC aims to engage in dialogue with representatives of the relevant provincial and municipal agencies, with a focus on learning and positive development.

During early 2022, the OYC completed work on a year long initiative involving a subject matter of interest to the group and their peers. Through collaboration with our office, the OYC issued a letter of concern to the relevant department on the matter. Along with corresponding with the department's Deputy Minister and a Director, a meeting was held in February 2022 during which representatives from two departments provided a presentation to the OYC on what steps their departments were taking to address the concerns brought forward. After the presentation, open discussion took place in which members of the OYC were able to raise questions or request further clarification on aspects of the presentation.

Upon completion of this project, the OYC began recruiting new members for the 2023 year, with a first meeting taking place in March 2023 that included 12 youth from across the province.

Raise the Bar - Advanced Investigator and Manager Webinar

The Nova Scotia Office of the Ombudsman played an integral role in the formation, facilitation, implementation, and funding of Raise the Bar, an advanced Investigator and Manager Seminar delivered via webinar to the Canadian Council of Parliamentary Ombudsman (CCPO).

Ombuds staff from 5 provinces and territories (Alberta, Nova Scotia, Manitoba, Newfoundland and Labrador, Northwest Territories) met and formed a Steering Committee through the fall of 2021 to design an advanced program for experienced investigators or managers employed by members of the CCPO.

In May 2022, the Steering Committee transitioned to an Implementation Committee comprised of Ombuds representatives from Alberta, British Columbia, Ontario, Nova Scotia, and the Yukon.

The inaugural bilingual webinar was launched the week of November 28, 2022, targeting in excess of 40 individuals divided into 8 groups comprised of various CCPO participants. The webinar was deemed successful in not only providing/sharing expertise on how investigations are conducted amongst the various CCPO members, but also for networking and building partnerships within the Ombuds community.

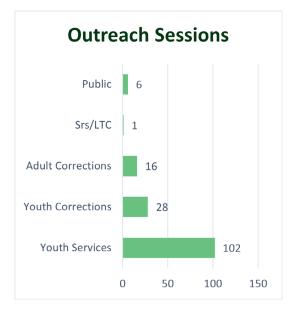
Based upon the analysis of feedback provided by the participants, the Implementation Committee is currently proposing the implementation of Raise the Bar as a regular training initiative for members of the CCPO.

OUTREACH

A significant portion of the work completed by this Office is through outreach. Outreach can take many forms, from an information booth at a Seniors' Expo, to visiting youth in care or custody, or providing formal presentations to government employees and community groups. There are three areas that receive regular outreach attention: adults in Long-Term Care (LTC) facilities, youth in Residential Child-Caring Facilities (RCCFs), as well as Young Persons and inmates in correctional facilities. Ombudsman Representatives engage children, youth, seniors, inmates, and staff by offering to speak with them in private or with their peers. Representatives also collect data, dispense educational materials, listen to concerns or complaints, familiarize themselves with a facility through site-visits, and build a rapport with residents, inmates, and staff. Site-visits are scheduled on a regular and as needed basis. For example, adult correctional facilities and RCCFs are visited quarterly, Wood Street Centre Campus, the Nova Scotia Youth Centre, and the IWK Secure Care Unit are visited monthly. Ombudsman Representatives also prepare written reports detailing their visits, regardless of whether a complaint is filed by someone in attendance.

In addition to our regular site-visits, Ombudsman Representatives attend special events that allow them to engage with new groups and individuals. Ombudsman Representatives also sit on the Nova Scotia Council for the Family Youth in Care Committee, the Canadian Council of Child and Youth Advocates, the Forum of Canadian Ombudsman, the International Ombudsman Institute (IOI), and the Canadian Council of Parliamentary Ombudsman. The Office continued to participate in the annual Provincial Government Employees United Way fundraising campaign and coordinated our efforts through the Public Service United Way Steering Committee.

Figure 15 Figure 16





Correctional Services

In Nova Scotia, there are four adult correctional facilities holding both sentenced inmates as well as those remanded to custody pending trial. These facilities are the Central Nova Scotia Correctional Facility (CNSCF), the Southwest Nova Scotia Correctional Facility (SNSCF), the Northeast Nova Scotia Correctional Facility (NNSCF), and the Cape Breton Correctional Facility (CBCF). These correctional facilities are visited by Ombudsman Representatives on a quarterly basis or as needed. During site visits, Representatives may receive complaints, provide information or referrals, and promote the resolution of complaints through correctional services' internal complaint resolution processes.

Ombudsman Representatives and the Complaint and Assessment Analyst educate inmates on correctional services internal complaint process and encourage them to exhaust all avenues of appeal before filing a complaint with the Office. This approach has reduced the total number of complaints involving correctional services. Fewer complaints of this nature enable the Complaint and Assessment Analyst and Ombudsman Representatives more time to address complex or systemic issues.

Figure 16 illustrates the number of correctional services complaints by inmates over the last seven fiscal years. The graph does not include complaints by inmates outside of correctional services, such as complaints about the Offender Health services provided by Nova Scotia Health (Nova Scotia Health Authority). In 2022-23 there were 109 new complaints by inmates about correctional services, several of those complaints were referred to the internal complaint process.

In addition to receiving complaints from inmates at correctional facilities, representatives from the Department of Justice approached our office about auditing the use of close confinement in its correctional facilities. Those discussions resulted in Ombudsman Representatives developing and conducting an independent quarterly review process on the use of close confinement and providing our findings to the Department of Justice.

Youth and Senior Services

While youth and seniors may be at the opposite ends of the age spectrum, they share some things in common. For instance, youth and seniors, including those in care and custody, are some of the most vulnerable people in our society. Because both groups rely more often on government services, they tend to have more opportunities for adverse interactions. Perhaps they are even dependent on one or more government service in their daily lives. This can create conflicts that complicate the level of service received. For instance, youth who reside in Residential Child-Caring Facilities (RCCFs), or who are in custody at the Nova Scotia Youth Centre, interact with government employees daily and are dependent on the services and care provided by government, especially when compared with the average young person in Nova Scotia. Ombudsman Representatives confidentially review and investigate the concerns of children, youth, and seniors that relate to government services. These groups receive focused attention when it comes to our referral service. While acknowledging potential vulnerabilities, sometimes it is appropriate for Ombudsman Representatives to help guide a person through a process rather than simply directing them elsewhere, and Ombudsman Representatives are continually educating themselves on ways to better address issues relating to youth and seniors.

The general oversight function and mandate for children and youth is not rooted in a specific piece of legislation, but in the findings of a provincial government audit which took place in 1995, and the Stratton Report which addressed allegations of abuse at provincial youth facilities. At that time government recognized independent oversight was a necessary component in helping to keep youth in care and custody safe from harm. This recognition has since led to regularly scheduled site visits to youth residential care and custodial facilities by Ombudsman Representatives. For more information on site-visits, you may wish to review the outreach section of this report.

Keeping informed on the policy, procedures, and operational protocols for these sites helps to resolve issues quickly. Ombudsman Representatives strive to make both residents and staff at provincial facilities comfortable with coming forward with complaints and concerns, including allegations of abuse and wrongdoing. While Ombudsman Representatives encourage those in care and custody to address basic concerns with staff first and to take advantage of internal complaint resolution processes, Representatives do not hesitate to investigate allegations of mistreatment.

Senior-Specific Issues

Complaints that are captured as senior-specific issues must be cases where the person's status as a senior citizen is directly relevant to the complaint. Therefore, not all complaints made by senior citizens will be captured here.

Figure 17

- 1 Community Services
- 1 HRM
- 8 Health & Wellness
- 5 Housing
- 5 NS Health Authority
- 1 Public Works
- 4 Seniors and LTC
- 2 Service NS/Internal Services
- 2 WCB
- 15 Other
- 44 Total

Type of Youth Complaints

Most youth complaints come from youth in care and custody. This reality is reflected in the categories in figure 18. For instance, the category "food" is referring to the food provided in government facilities that house youth. For another example, "staff" refers to facility staff.

Figure 18

- 17 Communication
- 1 COVID-19
- 1 Education
- 8 Facilities/Building
- 11 Facility Staff
- 4 Food
- 1 Lawyer/Legal
- 8 Policy and Procedures
- 7 Personal Safety/Abuse Allegation
- 5 Placement
- 2 Privileges
- 3 Rights
- 10 Social Worker
- 15 Other
- 93 Total

CONTACT US

Ombudsman Representatives are available to meet with groups or organizations to discuss the services the Office provides.

The Office also has communication materials to distribute such as brochures and posters. Additional reference documents supplementing the Annual Report may be found on our website or by contacting the Office.

There are several ways to contact the Office of the Ombudsman:

Telephone:

Public Inquiries/Complaints: 1-902-424-6780 or Toll Free: 1-800-670-1111 Youth Inquiries/Complaints: 1-902-424-6780 or Toll Free: 1-800-670-1111 Disclosure of Wrongdoing Inquiries/Complaints: Toll Free: 1-877-670-1100 Fax: 1-902-424-6675

In person:

5657 Spring Garden Road Suite 200 (Park Lane Terraces) Halifax, NS B3J 3R4

Mail:

PO Box 2152

Halifax, Nova Scotia B3J 3B7

Online:

Website: www.ombudsman.novascotia.ca E-mail: ombudsman@novascotia.ca



Facebook: Nova Scotia Ombudsman



Twitter: @NS_Ombudsman