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Ombudsman Annual Report 2021-2022
Office of the Ombudsman
June 2022



William A. Smith, Ombudsman

This Annual Report is my last as Nova Scotia's Ombudsman. After six years in the position, I have chosen retirement at this point in my career and life. It is one of those unusual milestones that can be simultaneously happy and sad.

The Nova Scotia Ombudsman is appointed for a five-year term but can be re-appointed. My first term ended in June of 2021. I had planned to retire at that point but was asked to accept re-appointment so I could serve at least one more year during a period of major government stresses, most of them COVID-related. My retirement finally took effect on June 30, 2022.

Like all major personal and career changes, the accompanying emotions are mixed - optimism about retirement opportunities, sadness at leaving a great public service experience.

My priority for this note is to thank the staff of the Ombudsman's Office, most of whom have been my colleagues during all my time there. They are a dedicated, diverse, and talented group. Working with them has been a privilege and a pleasure.

I also want to salute the thousands of Nova Scotians who placed their trust in the Office during my tenure by coming forward seeking Ombudsman services. By the same token, I want to acknowledge and thank the many hundreds of Nova Scotia public servants who responded to our inquiries and - overwhelmingly, and mostly graciously - accepted our suggestions and recommendations. Working with both groups has given me a constant sense of satisfaction and achievement.

Over the past six years, our Office, with a staff of 17, has dealt with more than 12,000 files. The last year itself has been a particularly busy one, with the ongoing COVID challenges and with several major investigations completed and several others launched.

Among its highlights, we completed a complex investigation of a provincially funded employment support agency in Cape Breton, with all our recommendations accepted and being implemented by the department involved. I was also pleased that long-standing Ombudsman recommendations regarding a Child Death Review structure were finally implemented during my final year. Requirements for reviews of deaths of children in provincial care or custody at last have been enshrined in law and regulation.

A point of personal pride of my years in office included initiatives to protect the Ombudsman's independence and authority, most notably by pursuing a critical 2019 decision from the Nova Scotia Court of Appeal which upheld the Ombudsman's right to review certain files initially withheld by a government department. Such rights and prerogatives are crucial to the effectiveness of Parliamentary Ombudsman offices. I am proud of our team for their commitment to both defend and reinforce them.

Cape Bretoners, of course, celebrate their roots, and I am no exception. My childhood was in Whitney Pier, where my parents shared equally challenging jobs - my father with DEVCO at the International Coal Pier and my mother as a homemaker. But if the family was typical of its day in its limited financial but extensive social resources, it was certainly unique in its composition. I was the last of ten children - efficiently produced as four sets of twins - then me and my second oldest sister, who swears she is my twin!

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I have always felt fortunate to have been able to realize the major ambitions of my time - foremost among them a 33-year career as an RCMP officer, retiring in 2012 as Assistant Commissioner and Commanding Officer of "B" Division in Newfoundland and Labrador. My RCMP experience was rich, varied, and very Canadian: service in six provinces and in seven different divisions of the force, in First Nations communities, at times in two languages; and including a uniquely satisfying tenure as Officer in Charge of Security for then Governor General - His Excellency Romeo LeBlanc.

My career as a Mountie provided me with countless growth and training opportunities, including a university education at St. Mary's in Halifax and extensive police-work training and experience at national and international levels. My road to the Ombudsman's Office also included four valuable years as Executive Director of Correctional Services for the Province of Nova Scotia, overseeing both Custodial and Community Corrections.

Ultimately, I am retiring with a strong sense of good fortune for the public service opportunities I have realized for more than four decades, and gratitude to both Nova Scotia and to Canada for the career privileges I've enjoyed.

To put succinctly, I am retiring with a profound sense of respect for the institutions and people who serve Nova Scotians and all Canadians in public roles, and with gratitude for the opportunities to serve and assist many Canadians who have been, or may be, less fortunate than others.

William A. Smith

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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).

Organization



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.

Office of the Ombudsman staff sit on the following committees:

- Diversity Roundtable
- Pride Nova Scotia Government Employee Network
- Nova Scotia Disability Employee Network
- French Language Services Committee

This year, due to the Novel Coronavirus Pandemic (COVID-19) we were unable to host any in-person student placements.

Training and Professional Development

This year our staff participated in the following training and development opportunities:

Internal and Public Service Commission Training

- Identifying and Addressing Unconscious Biases
- Identifying and Addressing Microaggression
- Respectful Workplace
- Diversity, Inclusion & Employment Equity
- Privacy & Access Awareness Training
- Leadership Development Program
- First Aid/CPR & OHS Training
- Teams and Teleconference Training
- Human Rights 101

External Training

- The Working Mind for Employees – Mental Health Commission of Canada
- Report Writing, How to Investigate, Investigating Allegations of Harassment & Sexual Harassment in the Workplace – Workplace Institute
- Daring To Do (Anti Racism Action in Child Welfare) – KOJO Institute
- Children First Canada, Raising Canada 2021 – A Deeper Look at the Top 10 Threats to Childhood in Canada
- Disabilities Webinar Series – Best Practices Case Coordination & Investigation
- Best Practices in Child Legal Representation Conference – Office of the Child & Youth Advocate Alberta
- Provincial Webinars & Presentations

Finances

The Office of the Ombudsman’s 2021-2022 Budget is shown in Figure 1. This year the Office spent 100% of its budget.

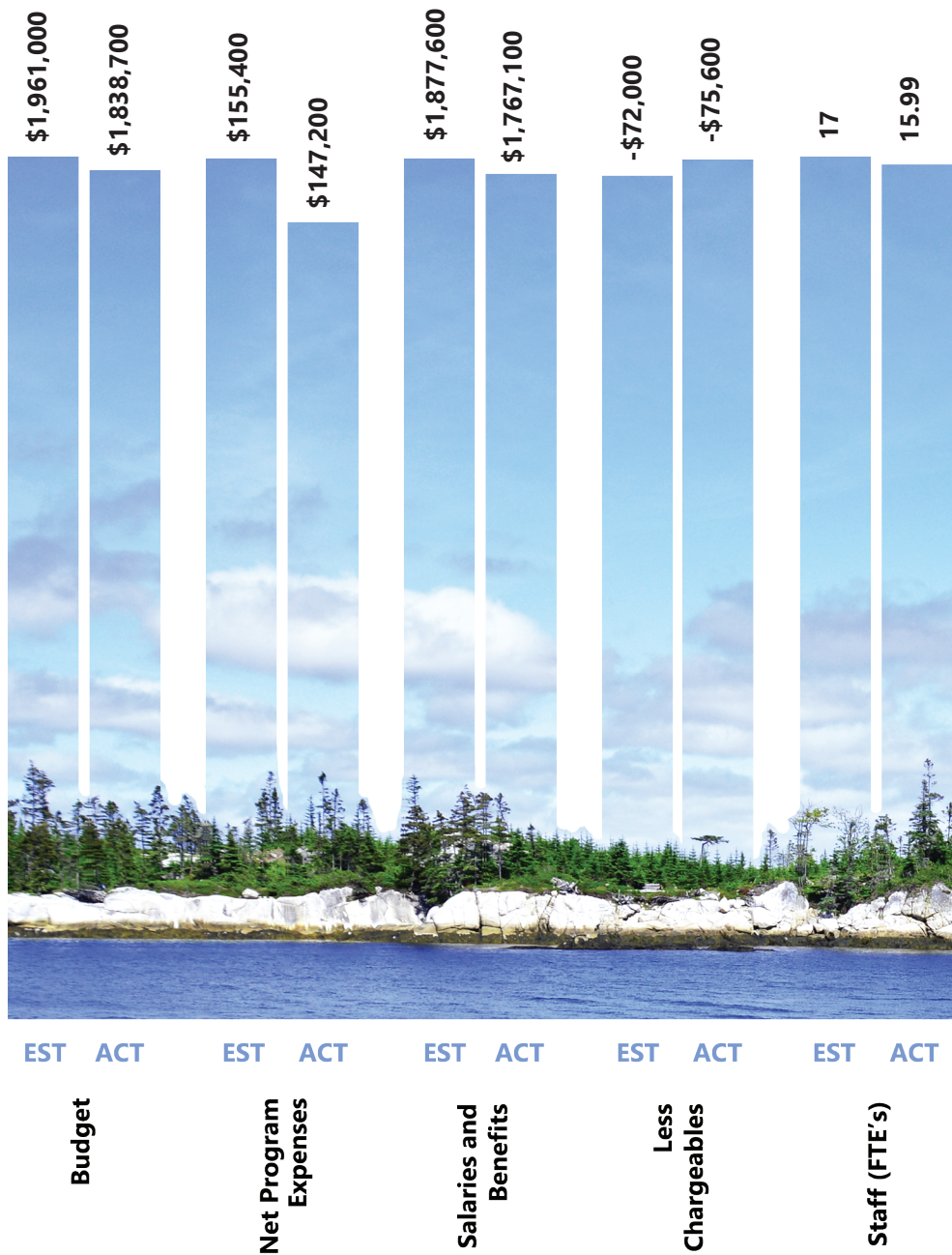


Figure 1

The wheels of administrative fairness, like the wheels of justice, can often turn slowly. Ombudsman cases occasionally may take over a year to complete. Cases of such duration usually are complex investigations of government entities. But a few may simply entail sticking with a process through administrative thickets that take longer than usual.

In this case, a 60-year-old individual with Multiple Sclerosis was admitted to a Nova Scotia health facility for treatment. They were treated extensively but deemed too ill to be released.

Ongoing tests and consultations resulted in the individual being declared incompetent and incapacitated. The Office of the Public Trustee was engaged. In the world of trusteeship, competency speaks to a person's ability to manage money, while capacity goes to decision-making. The Trustee legally assumed all responsibility for the individual's financial and personal affairs.

Social workers and medical personnel at the hospital concluded that the patient must remain at a health-care facility until a continuing care facility could be found.

There was difficulty finding an appropriate place, a difficulty compounded by the fact that the individual did not wish to enter a seniors' facility. At age 60, the patient was considered a younger senior and most homes are geared to older persons. Moreover, the individual was personally convinced that they could leave the hospital and live independently in an apartment, as they had done for years.

During this period, the individual's daily health and comfort fluctuated. After several months of what they considered confinement, they contacted the Office of the Ombudsman to determine whether they could appeal their designations of incapacity and incompetence.

The ensuing questions essentially were legal questions. The Ombudsman's Office makes assessments that may be legal in nature, but it does not offer legal counsel.

However, it was determined that there are potential processes available under various pieces of legislation, including the *Hospitals Act* and the *Involuntary Psychiatric Treatment Act*, that could provide avenues of appeal.

The Ombudsman Representative concluded that to challenge their declarations and continuing retention the individual needed legal representation or legal advice. A commercial lawyer was beyond their means and the Complainant's best hope appeared to be Nova Scotia Legal Aid Services.

This process proved difficult and lengthy. It also generated extreme frustration and anxiety for the Complainant.

A Legal Aid lawyer took the case in early May of 2020 and was made aware of provisions in the Nova Scotia Hospitals Act which may have underpinned an appeal.

Unfortunately, through all of May and June and most of July of 2020 the lawyer did not return email and phone messages from both their client and the Office of the Ombudsman. At the end of July it was revealed that the lawyer had left Legal Aid and their whereabouts unknown.

A second Legal Aid lawyer was assigned to the case. This lawyer exhibited interest but appeared to have a workload that prevented them from giving the Complainant's case the time and attention it required.

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The lawyer eventually met with the client in late October. But for three subsequent months there was little contact with the client and no actual progress on the case.

Over time, the Complainant gradually became resigned to their need for some form of continuing care while remaining adamant it could not be a conventional senior's facility or any facility where they could not enjoy privacy and, subject to their physical condition, come and go as they pleased. Such a solution appeared remote, but not impossible. Meanwhile, COVID-19 had placed unexpected pressures on continuing care facilities.

Throughout December of 2020 and January and early February of 2021, the Ombudsman Representative maintained constant contact with the Complainant, and issued a series of reminders to Legal Aid of the importance of advancing the case and communicating with the client. The Complainant became increasingly reliant on frequent contact with this Office.

In mid February, the lawyer reported an arrangement for ongoing meetings with the Complaint and sporadic telephone contact between them was achieved. However, it was not until April of 2021 that the lawyer met with the client's social worker and medical personnel. A medical and social services review of the individual's circumstances was carried out. The review did not change the initial assessment regarding the client's capacity and competence.

This fork in the road enabled the Ombudsman Representative to pursue the issue on another front, dealing directly with the management of a health facility to which the client had been transferred earlier, and pressing the urgency to resolve the longer-term accommodation requirement.

In early May of 2021, an Ombudsman Representative contacted a Health Services Manager at the facility, who initially expressed impatience with the inquiry. They stated initially that the Complainant was the "least important thing on (their) mind at the moment." In fairness, there were serious COVID pressures in their area. With further discussion, however, the Manager undertook to review the matter.

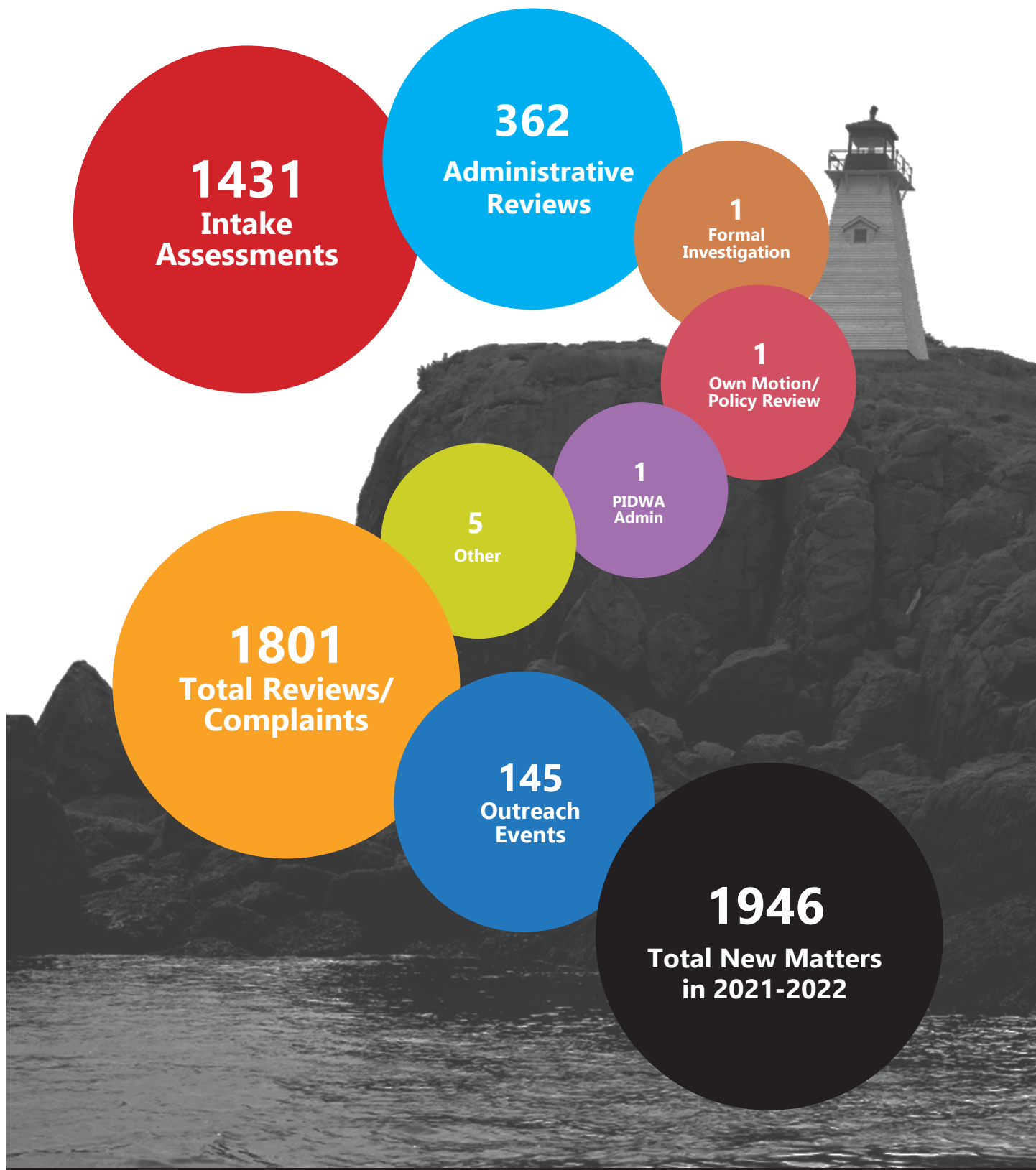
On May 21, 2021, the Complainant called the Ombudsman's Office to announce that they would be transferred permanently to a facility in which they had always been interested. The facility offers private rooms to individuals who qualify to live there. The patient qualified as a child of a Canadian military veteran.

In July of 2021, the Complainant reported that their new accommodation had worked out exactly as they had hoped. They were receiving physiotherapy twice a week. They reported food to be much better, and the room private and comfortable. They were taken out regularly in a wheelchair to a nearby park.

In effect, the Complainant in this case had fallen between cracks. They were effusive in their gratitude for the Ombudsman's Office involvement. They said they could resist being transferred to a continuing care home or a stopgap holding hotel only because of the Ombudsman Representative's involvement in the matter.

Reviews/Complaints/Meetings

Figure 2



Results of Complaints and Inquiries

Figure 3

1111

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

24

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)

18

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

67

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

6

Discontinued by Ombudsman: When the Ombudsman, or his 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)

547

Non-Jurisdictional:

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

28

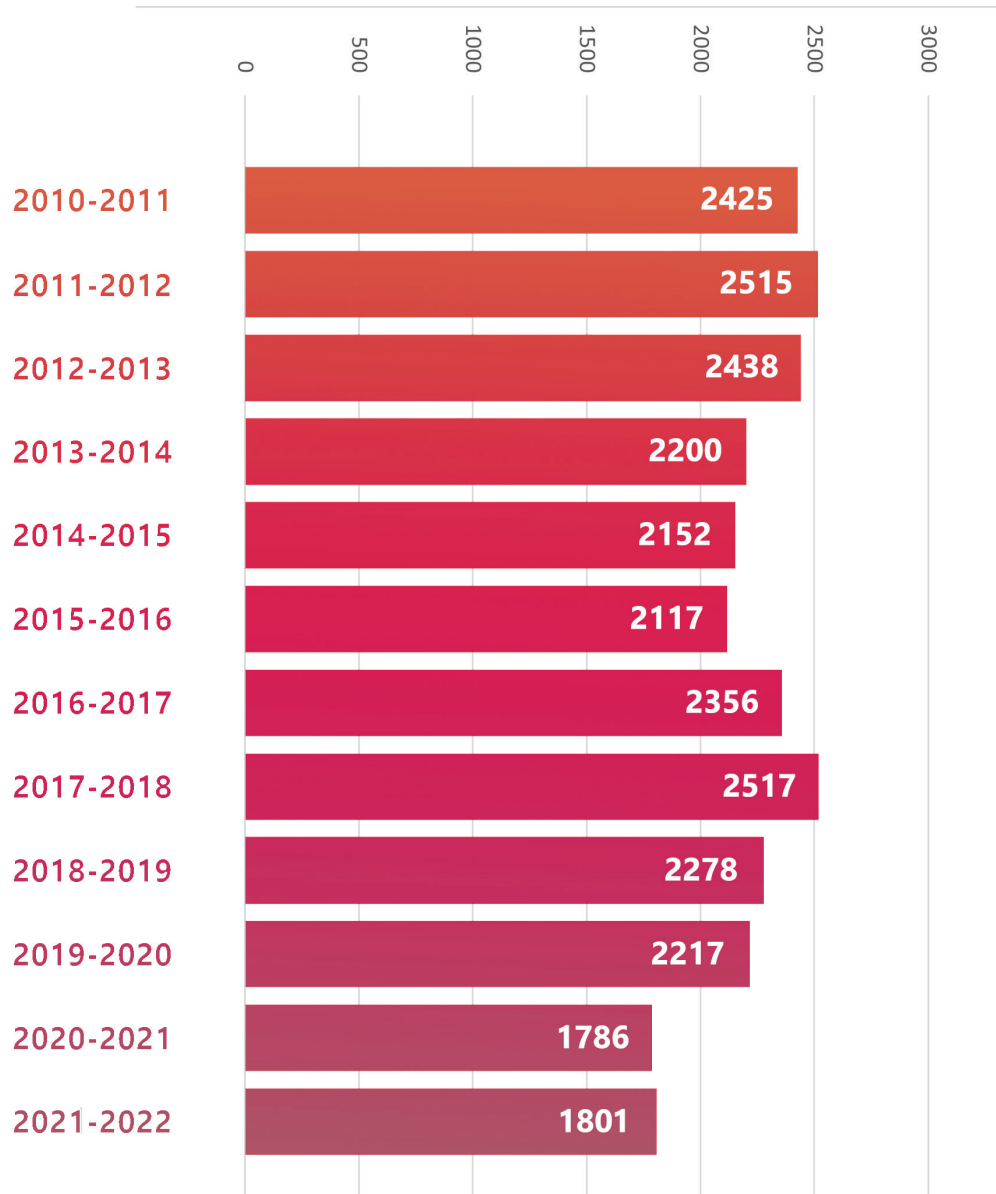
Outcome Undetermined: Outcome was undetermined when statistics were collected at year end

1801 Total

Key Facts and Figures

In 2021-2022, the Office handled 1801 complaints, inquiries, and youth contacts. To see how that compares with the last eleven years (see figure 4). Of the 1801 total complaints, inquiries, and youth contacts handled, 1431 matters were resolved at the intake and assessment stage and 362 at the administrative review stage. One was a formal investigation and one was an own-motion investigation. Various complaint outcomes can be seen in figure 4, including 547 non-jurisdictional complaints.

Figure 4



The difference between fiscal 2019-2020 and 2021-2022 is attributed to the COVID-19 pandemic. In-person outreach numbers for instance were significantly reduced over the past two years as we complied with public health orders and adapted our outreach sessions remotely (i.e. teleconference, virtual) particularly to locations such as long-term care facilities, correctional facilities, and residential child-caring facilities.

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)

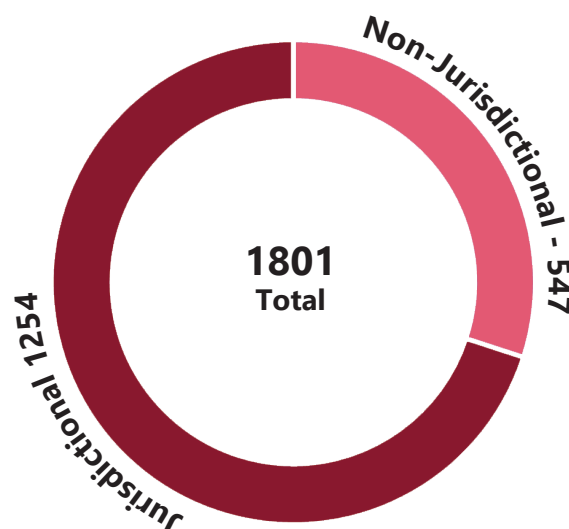
Private – When the Office receives a complaint regarding a dispute between private individuals or a complaint about a private corporation (e.g. a complaint about a cellphone bill)

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)

Figure 5



Resolution Timelines

Most files are resolved by Ombudsman Representatives in one to seven days. Figure 6 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.

Intake Assessments	1-7 Days
Administrative Reviews	1-4 Weeks
Formal Investigations	4 Weeks +
Own Motion Investigations	4 Weeks +

Over a three-month period, two individuals complained separately to the Office of the Ombudsman that the warden of their municipality appeared to be in breach of a law which they understood requires a warden to reside in the municipality where they hold office.

The inquiry was an interesting one that raised both legal and ethical questions, and, for good measure, included an undercurrent of politics.

Both complainants believed the *Municipal Government Act* (MGA) forbids wardens from living elsewhere than in the municipalities where they serve. They also believed that the current warden of their municipality was doing just that.

The MGA does speak to the subject, but not with perfect clarity. A second piece of legislation, the *Municipal Elections Act* (MEA), also addresses the matter, but again with degrees of ambiguity.

Section 17(3) of the *Municipal Government Act* provides that "a mayor or councillor who ceases to be ordinarily resident in the municipality ceases to be qualified to serve as mayor or as councillor."

Wardens are not mentioned in the clause, although other sections of the Act suggest that both are included in references to one. Wardens and mayors have duties and responsibilities that are similar. However, they serve in different local government structures, and they are chosen differently - mayors at large in general town or city elections, and wardens by the group of councillors elected in county of district elections.

That section of the MGA introduces a concept that invites interpretation and can cause confusion: The concept is "ordinarily resident." The *Municipal Elections Act* weighs on that concept, providing various criteria for determining "ordinarily resident." Section 16 of the MEA elaborates:

- (1) A person is ordinarily resident in the place where the person lives and to which, whenever absent, the person intends to return.
- (2) A person may be ordinarily resident in only one place at a time.
- (3) A person does not cease to be ordinarily resident in a place by leaving the place for a temporary purpose only.
- (4) Where a person usually sleeps in one place and has meals or is employed in another place, the person is ordinarily resident in the place where the person sleeps.
- (5) Where a person has temporary residential quarters, those quarters are considered to be the place in which the person is ordinarily resident only if the person has no other place the person considers as that person's ordinary place of residence.
- (6) ... N/A
- (7) Where the rules set out in subsections (1) to (6) are not sufficient to determine the place where a person is ordinarily resident, the place where the person is ordinarily resident must be determined by the appropriate election officer with reference to all the facts of the case.

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In Nova Scotia, county and district councillors who elect their wardens have an important additional power to prescribe the warden's term of office, and to end it early if necessary. Under section 12(7) of the MGA, the appropriate council can dismiss a warden at any time. They also can offer approval for a warden to reside outside the municipality for extended periods of time, indeed up to six months in a given term.

Not only has the municipality in question not voted to remove their warden, two different Councils, elected in 2016 and in 2020 respectively, have voted on three separate occasions to re-elect the warden for two-year terms.

For the Ombudsman's Office, the relevant laws provide only one dimension in an assessment of such complaints.

Our review established that the warden in question grew up in the municipality in which they now serve. They worked for the municipality for many years before seeking elected office. The warden currently maintains a residence in the municipality and recently purchased land within the municipal boundaries on which to build a new home.

The impetus for the Complainants' concerns about where the warden lives rests is the fact that the warden travels frequently to a different municipality to visit a friend. By the warden's own admission, they are frequently away for two or three nights a week, and sometimes for as long as a week if on vacation. But the warden is adamant that they reside "ordinarily" and predominately within the municipality where they serve.

The Ombudsman Representative drew two conclusions in this case.

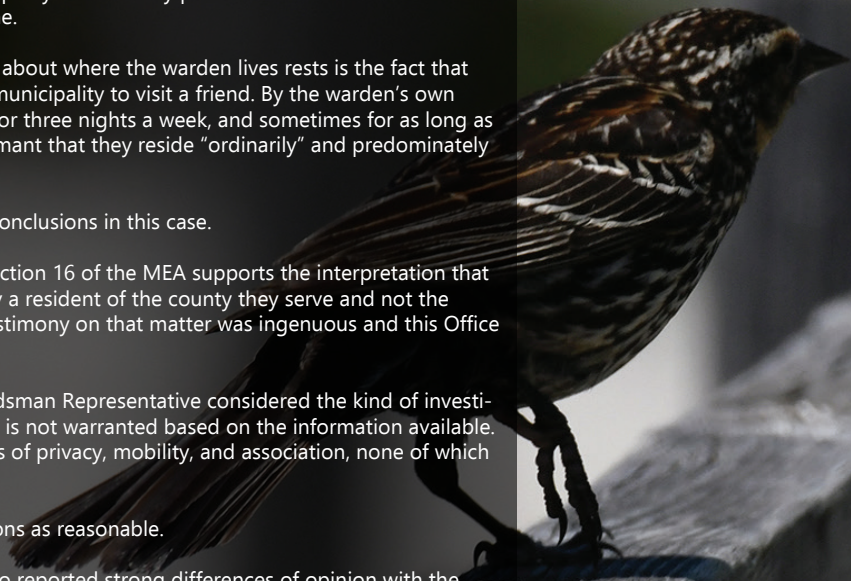
The first is that a fair and close reading of Section 16 of the MEA supports the interpretation that the warden is ordinarily and therefore legally a resident of the county they serve and not the county they often visit. The warden's own testimony on that matter was ingenuous and this Office accepted it.

Second, and as an ethical matter, the Ombudsman Representative considered the kind of investigation that would be required in such a case is not warranted based on the information available. Such an investigation could cross boundaries of privacy, mobility, and association, none of which could be justified in the circumstances.

Both Complainants accepted those conclusions as reasonable.

On the political front, both Complainants also reported strong differences of opinion with the warden and council on a matter of public concern in the municipality.

One complainant acknowledged that those differences played a role in their decision to raise the question of the warden's residency.



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.

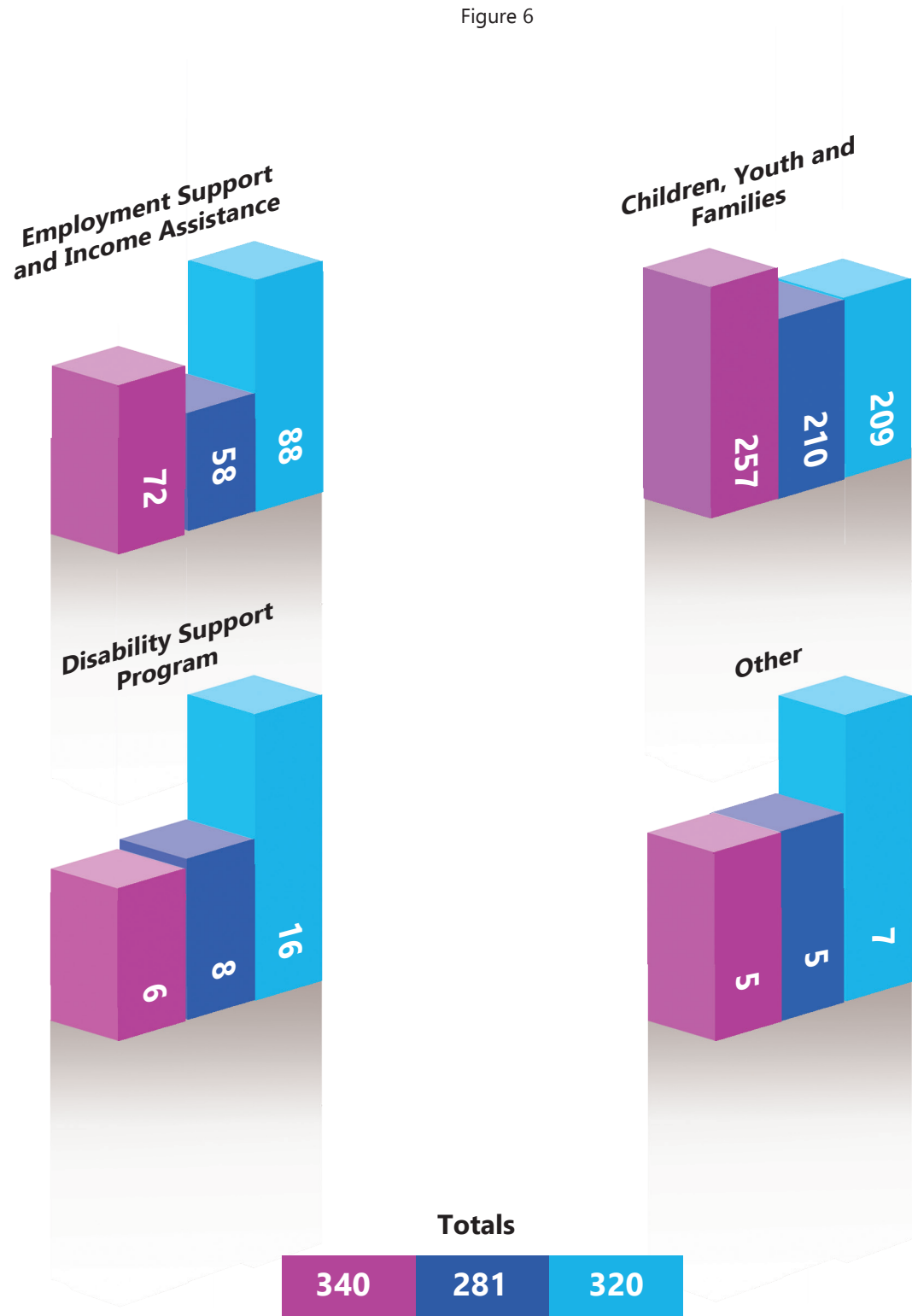
In addition to complaints under the *Ombudsman Act*, the *Public Interest Disclosure of Wrongdoing Act* (PIDWA), and matters referred by the House, the Office receives complaints that do not fall within our jurisdiction. In all cases, the variety of matters brought to this Office each year require staff 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 6-9 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.

Department of Community Services
2019-2020 - 2020-2021 - 2021-2022

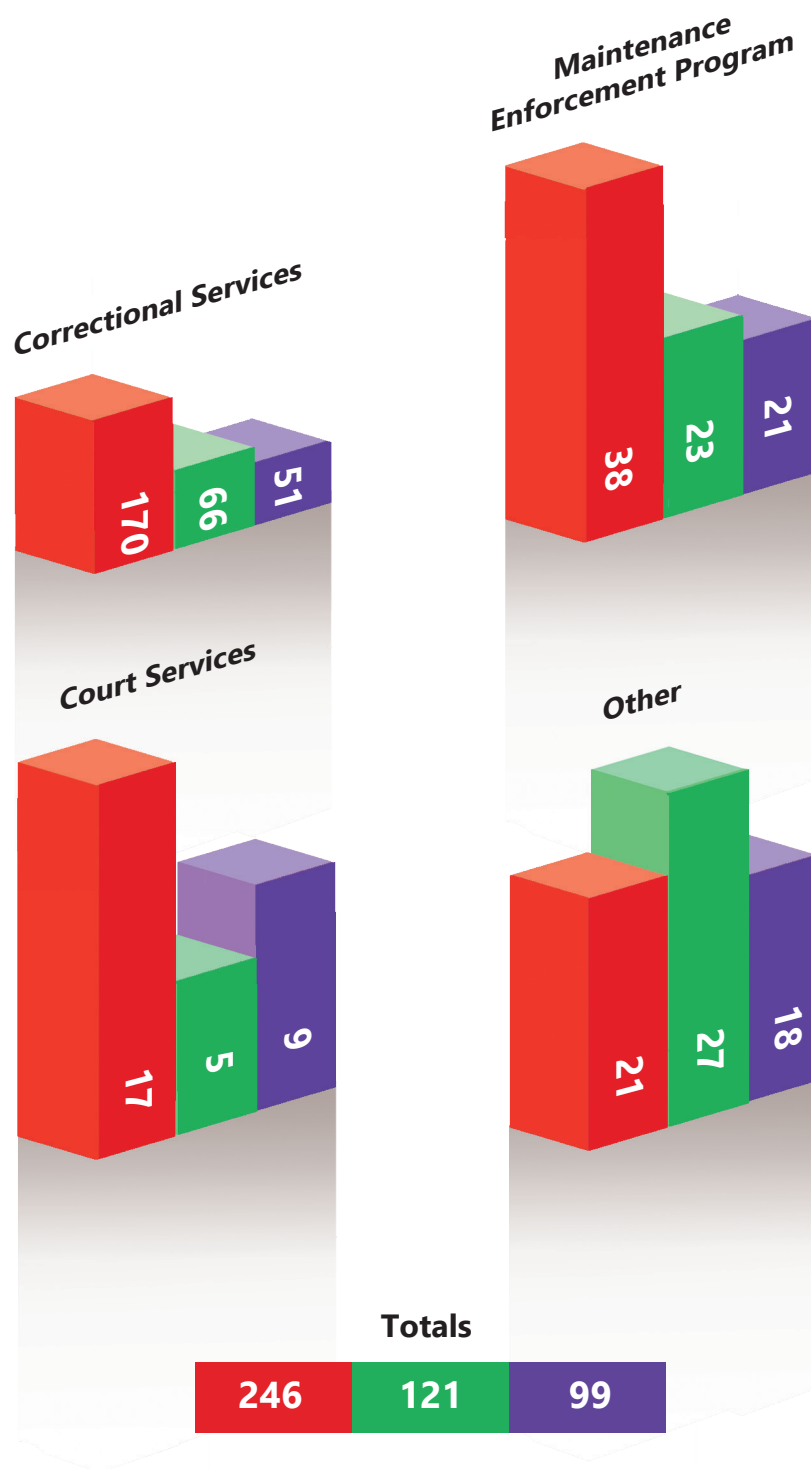
Figure 6



Department of Justice

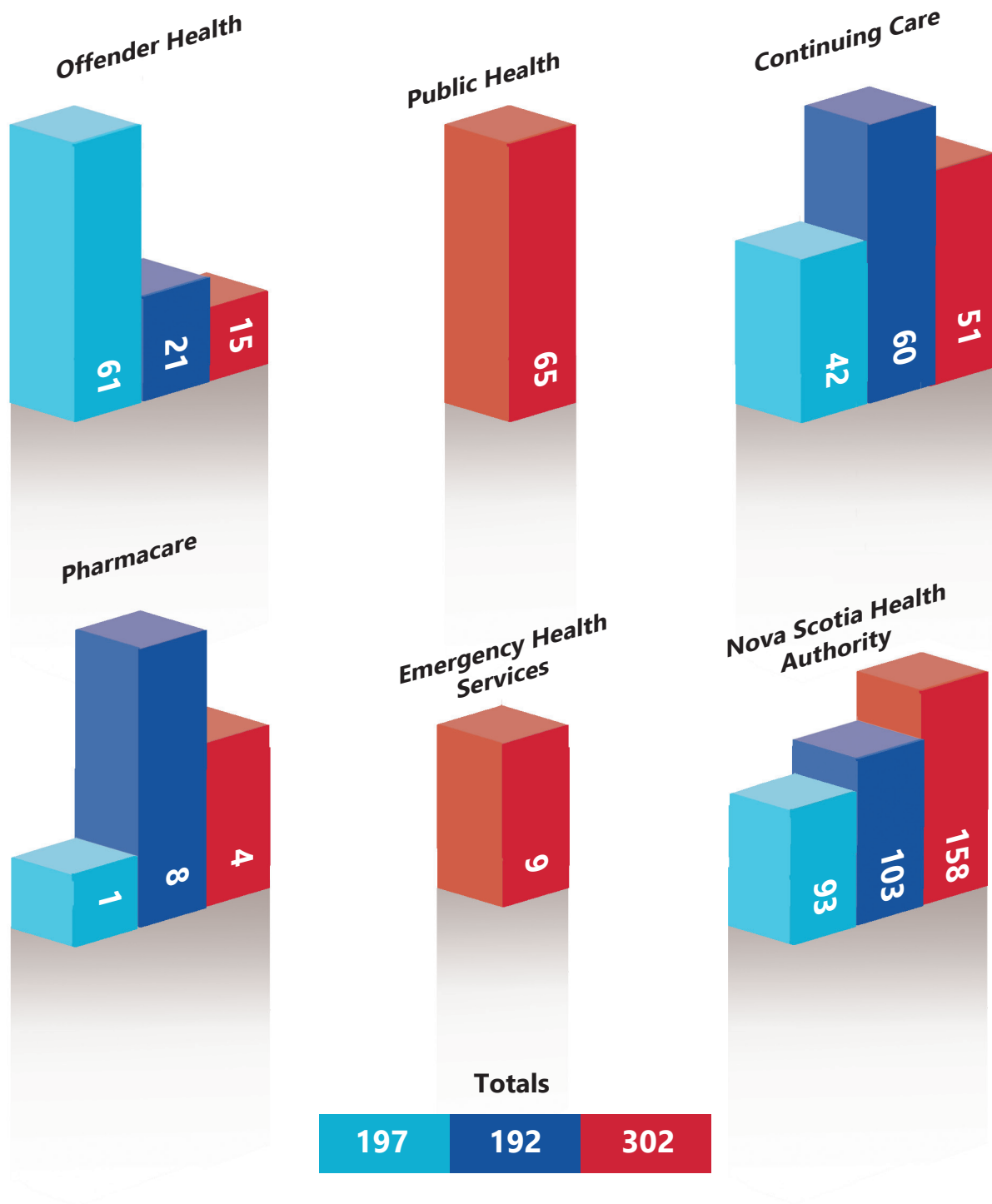
2019-2020 - 2020-2021 - 2021-2022

Figure 7



Department of Health and Wellness
2019-2020 - 2020-2021 - 2021-2022

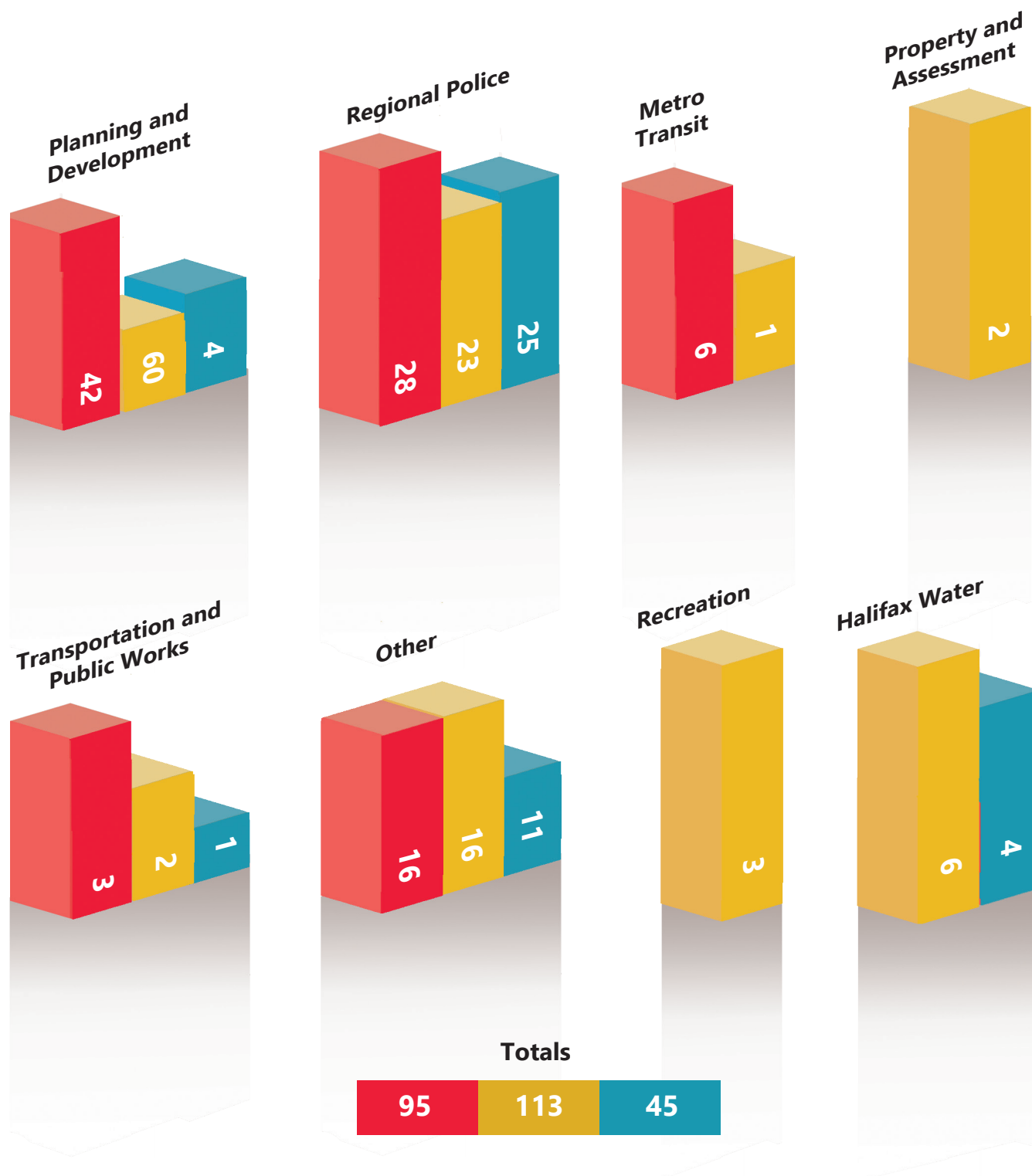
Figure 8



Halifax Regional Municipality

2019-2020 - 2020-2021 - 2021-2022

Figure 9



The following is a summary of a widely publicized maintenance enforcement case notoriously entered in the annals of social justice in Nova Scotia and in Canada as a testament to the durable challenges of maintenance enforcement for enforcement agencies and especially for recipient families.

The Office of the Ombudsman was an active player in the matter from March of 2014 to November of 2021. Our involvement was rooted in three separate complaints to our Office from the Payee involving the Maintenance Enforcement Program (MEP).

Over those years, the Payee waged a relentless, meticulously researched, and finally an effective battle for their rights – and, even more determinedly, for the rights and needs of their two children. They were rights the Payee believed were rooted in the Maintenance Enforcement Act which they thought was not being fully enforced.

The Office of the Ombudsman carried out one formal investigation and a series of administrative inquiries and reviews. Often our Office was an agency with standing and authority to seek answers to questions that the Payee generated on their own. On several occasions our role was to explain the realities of the enforcement system, acknowledging certain resource deficiencies and, in a few instances, inadequate training.

For several years following their separation and divorce, the Payor consistently made monthly maintenance payments of \$700. The Payor fell into arrears after 2013 when a Nova Scotia Court increased their payments to \$3,242 per month in 2013 based on evidence of much higher Payee-income levels than the Payor had reported. The revised maintenance order was based on information about the Payor's various income streams researched and revealed primarily by the Payee. A disturbing dynamic of the case was the extraordinary lengths to which the Payor was prepared to go to reduce or simply default on their court-ordered obligations.

Ultimately, those practices – defiance of Courts orders; concealment of their means – landed the Payor in a correctional facility for nine and a half months. It was a reckoning too long in the making, but one deemed by both the Courts and the Payee to be the only reliable route to a settlement; the only sanction of sufficient severity to shock a 'dead-beat' parent determined to end-run the system.

In March of 2014, the Payee made their first and most compelling complaint to this Office. The Payee had been thrown out of the Maintenance Enforcement Program in Nova Scotia, accused of breaching a provision of the *Maintenance Enforcement Act* which prohibits recipients of support from taking their own measures to enforce their court orders. The alleged self-enforcement focused mainly on social media postings by a friend of the Payee's; blunt and shaming messages highlighting the Payor's defiance of their maintenance obligations. The MEP blamed the Payee for the postings; indeed the Payee had supplied some of the information. The agency declared the material to be self-enforcement and repealed the Payee's membership as a client.

The Payee's characterization of events is that they were removed from the program arbitrarily, at great cost to their children and themselves. The Payee asserted that their dismissal was punishment for the Payee's persistent demands that the MEP intensify enforcement, and for complaining about the MEP to political representatives such as the Payee's Member of the Legislative Assembly (MLA) and the Premier of the day.

In January of 2015, the Office of the Ombudsman issued its final report on the matter concluding that the social media posts, were not helpful, were innocently done, and did not impede MEP's ability to enforce. The Payee was found to have been unaware of the MEP restrictions. The Payee's dismissal from the program was found to have been an arbitrary and extreme response by the MEP. While technically permitted at the sole discretion of the Director, the dismissal was not required under the Act and indeed appeared punitive in the circumstances.

The report, which eventually was leaked to the media, was severely critical of the agency for its disregard of the negative impacts on the Payee's two children. It recommended reinstatement of the Payee in the program and renewed efforts to enforce the Payor's maintenance order. The Payee was reinstated. The Payee continued as a client of MEP until the Payee's case was settled in 2021.

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In the meantime, the Payor and their new spouse and child left Canada. The MEP did step up enforcement, succeeding, among other things, in having the Payor's passport suspended. By 2017, the efforts of both the Payee and MEP firmly established that the Payor and their new spouse shared ownership of a residence in an up-market Halifax suburb. The house was being used as a rental property. It was valued in the range of \$350,000. As a matrimonial home, the Payor owned 50 percent. If sold, the Payee could have shared 50 percent of the return, net of any mortgage.

MEP placed a lien on the house, but for various reasons, including its projected maintenance and sales costs and potential liabilities, concluded it could not be sold.

On March 2, 2017, the Payee made a second complaint to the Ombudsman: could the MEP force a sale of the house?

In the Payee's written complaint, the Payee argued that "Their (MEP's) policy to not seize assets is inconsistent with the Act itself and its intent. Seizure and sale is in the legislation because they were meant to do that. No one is asking them to paint the fence, weed the garden or rent it out. (A) receiver would look after everything, deduct their costs and give MEP what is left of my $\frac{1}{2}$ interest. The other $\frac{1}{2}$ to be put aside for (the co-owner.)"

The complaint was investigated in detail. This Office agreed with the Payee and recommended that pursuant to Section 28(4) of the *Maintenance Enforcement Act* the house be sold, as potentially the Payee's last best hope of ever realizing any of the arrears that continued to increase while the Payor lived out of the country. If there were impediments, the Office suggested, MEP should seek the advice of the court regarding the potential to issue a court order to sell it, freeze the Payor's share, and direct it to the Payee's benefit.

MEP flatly refused the recommendation. The Payee interpreted MEP's refusal as a by-product of what the Payee believed to be an ongoing personal vendetta against the Payee by the MEP Director of the day. The Payee regarded the agency as both hostile and vindictive. By then, there had been significant publicity and media attention to the case, much of it adverse of the MEP. In 2019, developments that were largely independent of both this Office and the MEP had a major impact on the case. After nearly two years abroad, the Payor was deported from the country they were residing in and returned to Canada.

In June of 2019 a Canada-wide arrest warrant was issued for the Payor who by then owed child support payments of more than \$450,000. The Payor communicated with Nova Scotia Court and MEP officials by a mobile device and refused to disclose their location. The Payor was alleged to have used a different mobile device for each of their calls, possibly destroying the devices after use. In the June hearing, a Nova Scotia Supreme Court Justice found the Payor in contempt of court for not revealing their location. On that count alone the Payor was fined \$10,000 and sentenced to 60 days in jail.

An extended and somewhat confusing phase of the drama ensued during which efforts were made by both the Halifax Regional Police and Department of Justice officials to locate the Payor, return them to Nova Scotia, and have them appear in court to face contempt charges for ignoring a continuing court order.

It was during this period, in December of 2019, that the Payee brought their third complaint to the Office of the Ombudsman. The Payee was frustrated with what the Payee felt were inadequate efforts to locate the Payor and deliver them back to Nova Scotia. The Payee complained limited communication on the part of MEP.

On the often-forgotten human side of the equation, the Payee noted at the time that the Payee was approaching their seventh Christmas season without their children receiving any of the overdue maintenance payments from the other parent. The children had grown to young adults. One child was an architect practising in Europe. The other child was an engineering student in Canada. In 2018, the Payee had to sell their family home and move into a two-bedroom apartment in the same neighborhood. At the time the Payee held a clerical job at a law firm in Halifax, which the Payee had taken four years earlier to help pay legal bills owed to lawyers in that firm.

(cont'd)

(cont'd)

At the MEP agency, a new Director had been installed, and the agency appeared to be gathering strength and greater stability after several difficult years that followed its move to New Waterford from Halifax. The move was disruptive, with the loss of several experienced staff members who were unwilling or unable to move.

In the summer of 2020, the MEP finally supported the sale of the Halifax house owned by the Payor and their spouse. In the early phase of the rising Halifax real estate market, the house sold for \$455,000.

Meantime, in early 2020 an officer from the Halifax Regional Police Services stated that they were pursuing the Payor and believed they could be found. However, our Office was informed that the hunt was frustrated because there were no assurances of resources to send officers to travel to Toronto where the Payor was believed to be residing or elsewhere.

A Department of Justice official alluded to disagreements between the Department and MEP regarding funding for the manhunt. By then as well, in spring of 2020, COVID-19 issues were being invoked as impediments.

It was discovered that that the Payor had moved from Toronto to Montreal. Despite ongoing confusion, quiet collaboration between police in Montreal and Nova Scotia was achieved, culminating with the arrest of the Payor in November of 2020. The Payor was returned to Nova Scotia in December to face sentencing for various convictions already registered against them.

In December 2020, the Payor appeared before the Supreme Court of Nova Scotia and was denied bail. Later that month the Payor was sentenced to 4.5 years for contempt of court.

During this period the communications issues with MEP that the Payee had complained were sorted out. The Payee informed the Office of the Ombudsman that they were finally kept fully up to date by the new MEP Director with whom the Payee formed a functional relationship after an extended period of mistrust.

The Payor was incarcerated. Outstanding questions by this Office surrounding delays in their capture were deflected and never satisfactorily answered. At the Complainant's request, and because of the lingering uncertainty of the matter, our file was kept active, monitoring slow but hopeful steps towards a settlement.

While incarcerated, through a lawyer, the Payor negotiated with a lawyer acting for the Payee. Their arrears had increased to more than \$500,000.

In September 2021, at 8:12 PM, the Payee sent a short email to the Ombudsman Representative handling the file informing they had received their settlement money that day, with \$15,000 still owing. The Payee accepted a compromised amount as the full settlement of the Payee's child support claim against the Payor. The amount was substantial, but it was not exactly "restitutio in integrum."

The Payee and the Payee's legal advisers had concluded that in order for the Payee to have had any hope of collecting the remainder, the Payee would have had to seek a new settlement order based on the Payor's new circumstances. That would have meant waiting out another potentially endless round of hearings, challenges, new contempt convictions, the possibility of new jail terms, in short of enduring many more years of deprivation living, too near the edge of poverty.

The extra funds that the Payee received from the house sale was a negotiated amount enabling a final settlement and the Payor was released from custody.

The Payee claims to have spent \$30,000 on lawyers on the case over the years, an amount the Payee has paid off largely by working extensively for the Payee's own legal advisers.

In November of 2021, our Office closed its third file in matter. The Payee was already in possession of the MEP settlement funds.

(cont'd)



(cont'd)

The Payor was released after spending 9.5 months in various provincial and federal correctional facilities.

An interesting remaining dynamic in the case continues. The Payee launched a civil suit against the Province five years ago on a contingency basis with a lawyer. The Payee sued for what the Payee believes was negligence and incompetence on the part of MEP and the Department of Justice.

The last known action on that case was a successful initiative by the Department of Justice in October of 2020 to have the Payor joined with the Province as a co-defendant. The Payee had opposed that change, which the Payee believed was a delaying tactic and a formula for providing the Payor with information related to the Payee's case that the Payee believes should have been denied.

An offer for settlement in the civil case, made several years ago by the Payee's lawyer at the invitation of the Department of Justice was never acknowledged or responded to. The civil case stands as a separate chapter providing its own burdens of discomfort and uncertainty for the Payee and their children.

On the emotional front, the Payee has said that the greatest loss in the Payee's world was the time the Payee has missed with the Payee's children. There were countless limitations imposed on them directly by the disparity in income between the Payee and the Payor. For those deprivations and much else, the Payee continues to hold the Nova Scotia Maintenance Enforcement Program and the Province fully responsible.

The Payee gives the Office of the Ombudsman substantial credit for accepting the Payee's complaints and for the various questions and challenges our Office was able to generate. Perhaps the Payee is unduly generous. The Office played a role. But that role has had less to do with specific solutions or with MEP reform, and more about having identified a malignancy and unusual attitudes in the process early on, and with a commitment to stay with the process throughout.

As a general practice, the Office of the Ombudsman attempts to resolve complaints through assessments of legislation and policy, coupled with discussions with complainants and respondents to help identify the fault lines. It is probable that publicity played a role in this case. Media reports at least achieved the undeniable benefit of increased public awareness of the intractable nature of some maintenance enforcement cases and related resource issues. The public also was reminded that in many of the toughest enforcement cases, the major impediment is an enraged and vindictive former spouse or partner who often can afford to pay but simply refuses to do so. During the final years of the Payee's case, MEP reported unpaid maintenance debts had been reduced by 30 percent. In November of 2021, after the Payee's MEP case had finally closed, the Payee wrote one last email to the Office of the Ombudsman:

"When everyone turned their backs and shut their doors, you let me in and really listened to me and reviewed volumes of evidence. You changed my life, my children's lives and the lives of children whose faces and names we will never know. Well done. With gratitude, The Payee."

Respondents to Complainants

The table below (Figure 10) lists all public bodies that were the subjects of complaints under the *Ombudsman Act* and the PIDWA for 2021-2022. 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 10

2	Agriculture
1	Amherst, Town of
3	Bridgewater, Town of
20	CBRM
1	Communications Nova Scotia
5	Communities, Culture, Tourism, Heritage
320	Community Services
6	County of Annapolis
1	County of Colchester
1	County of Cumberland
1	County of Inverness
3	County of Kings
2	County of Richmond
1	Digby, Town of
3	District of Digby
2	District of Lunenburg
3	District of St. Mary's
15	Education & Early Childhood Development
2	Elections Nova Scotia
1	Emergency Health Services
10	Environment and Climate Change
2	Finance and Treasury Board
3	Fisheries and Aquaculture
45	Halifax (HRM)
1	Halifax Harbour Bridges
136	Health and Wellness
32	Human Rights Commission
2	Inclusive Economic Growth
3	Information and Privacy Commissioner
52	Infrastructure and Housing (legacy)
3	Internal Services
5	IWK Health Centre
99	Justice
3	Kentville, Town of
1	Labour Board
12	Labour, Skills, and Immigration
6	Lands and Forestry

1	Legislative House of Assembly
1	L'nu Affairs, Office of
1	Metropolitan Regional Housing Authority
3	Municipal Affairs
5	Municipality of Clare
3	Municipality of Shelburne
2	New Glasgow, Town of
3	Nova Scotia Community College
158	Nova Scotia Health Authority
27	Nova Scotia Legal Aid Commission
1	Nova Scotia Liquor Corporation
2	Nova Scotia Pension Services Corporation
1	Nova Scotia Utility and Review Board
2	NS Immigration and Population Growth
5	NS Police Complaints Commission
12	Office of the Ombudsman
1	Pharmacare
1	Pictou, County of
4	Premier, Office of
2	Property Valuation Services Corporation
5	Public Prosecution Service
7	Public Service Commission
2	Public Trustee
27	Public Works
5	Region of Queens Municipality
20	Regional Centres for Education
1	Residential Tenancies
1	Riverport Electric Light Commission
1	Seniors & LTC
24	Service Nova Scotia
5	Truro, Town of
2	Windsor West-Hants Regional Municipality (2)
2	Workers' Compensation Appeals Tribunal (2)
25	Workers' Compensation Board (25)
2	Yarmouth, Town of (2)
629	No respondents - includes non-jurisdictional complaints, info requests, and other inquiries
1801	TOTAL

Month at a Glance

The following table (figure 11) breaks down the month of November 2021. This table demonstrates the variety of complaints received in any given month. The information below includes the respondent to the complaint as well as the general nature of the issue. Ombudsman Representatives must maintain a broad knowledge of legislation, policy, and procedures, and consider all types of administrative complaints, ranging from those regarding provincial acts to specific municipal policies. The presence of a complaint in this table does not necessarily indicate fault or maladministration. The respondent is captured when the complaint is received.

Figure 11

November 2021 - 186 Complaints and Inquiries

- 1 Amherst, Town of**
- 2 CBRM**
CBRM police services (2)
- 1 Communications Nova Scotia**
- 3 Communities, Culture, Tourism and Heritage**
Provincial library (2)
Arts NS (1)
- 32 Community Services**
Children, Youth and Family Support (17)
Disability Support Program (1)
Employment Support and Income Assistance (13)
Other (1)
- 1 County of Richmond, Municipality of the (1)**
- 1 District of Digby, Municipality of (1)**
- 1 District of Lunenburg, Municipality (1)**
- 3 Education & Early Childhood Development**
Public Schools (2)
Home Schooling (1)
- 1 Fisheries and Aquaculture (1)**
Coastal Management (1)
- 2 Halifax (HRM)**
Halifax Regional Police (1)
Other (1)
- 8 Health and Wellness (8)**
Continuing Care (5)
Public Health (2)
Primary Health Care (1)
- 6 Human Rights Commission**
- 7 Infrastructure & Housing (Legacy)**
Housing Nova Scotia (7)

- 1 **Internal Services**
Public Works (1)
- 14 **Justice**
Adult Correctional Services (4)
Maintenance Enforcement Program (5)
Police Services (1)
Public Trustee (3)
Victim Services (1)
- 1 **Kentville, Town of**
- 1 **Labour, Skills, and Immigration**
- 2 **Lands and Forestry**
Policy, Planning and Support Services (1)
Renewable Resources (1)
- 1 **Municipality of Shelburne**
- 18 **Nova Scotia Health Authority**
Central Zone (5)
East Coast Forensic Hospital (2)
Northern Zone (5)
Offender Health (3)
Western Zone (1)
Other (2)
- 2 **Nova Scotia Legal Aid Commission**
- 2 **Public Service Commission**
- 2 **Public Works**
Highways (1)
Public Works (Legacy) (1)
- 1 **Regional Centres for Education**
Chignecto-Central Regional (1)
- 4 **Service Nova Scotia**
Access Nova Scotia (4)
- 2 **Workers' Compensation Board**
Benefits (1)
Other WCB issue (1)
- 52 **Non-Jurisdictional**
- 14 **No Respondent**

CASE STUDY #4

The Complainant in this matter purchased a property located in the Municipality of the County of Annapolis (the Municipality) in 2018 and planned to open a bed and breakfast in their home and develop a small agricultural operation to grow some crops. At that time, the neighbours were all residential properties and the lot beside their property was undeveloped.

In October 2019, the adjacent property was purchased and the new neighbours built a house and barn on the property. The Complainant was displeased they now shared a property line with a small farm and the close proximity of a number of horses and cattle. The Complainant had concerns whether the size of the land was appropriate for the number of livestock as well as the increased presence of flies, and that odours from the farm were negatively impacting their health and ability to enjoy their property.

Tensions rose between the neighbours and the Complainant brought their concerns forward to the Municipality, the Department of Agriculture and ultimately the Farm Practices Board, as well as other government entities. The Complainant contacted this Office in April, 2021, regarding concerns involving the response to their complaint from the respective bodies.

The concerns involving the Municipality relate to their response to the situation and the lack of bylaws to establish minimum separation distances between residential properties and livestock operations. In the Complainant's view, the lack of Land-Use bylaws limiting certain activities in residential areas created a situation where their neighbour's use of their property infringed on the Complainant's ability to use and enjoy their own property. This was complicated by the absence of a formal complaint policy for reference.

The Department of Agriculture were also involved in this matter, as a result of which certain aspects of their investigative process were noted as insufficient. These processes included the intake and assessments of complaints made by the public, the process for responding to complaints and the documenting of actions taken when interacting with concerned parties.

The other party involved in investigating this incident was the Farm Practices Board (Dept. of Agriculture) which acted by issuing recommendations to alleviate the situation - which were unfortunately unenforceable as not issued as orders. Specific recommendations by the Ombudsman for all concerned parties can be found in the recommendation section of the report.



Complaint Resolution

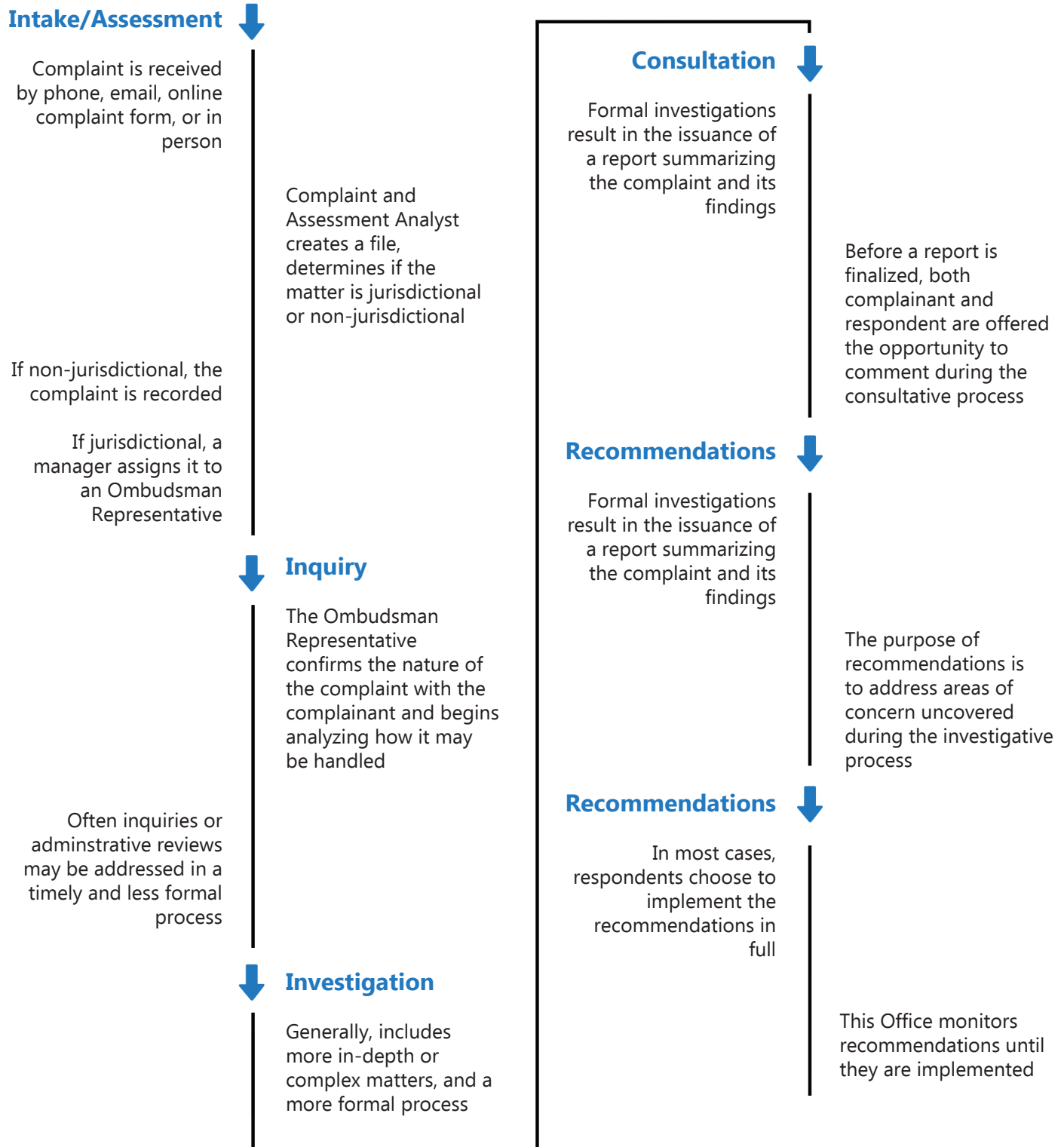
Most of the in-depth investigations undertaken by this Office begin as complaints or concerns brought to our attention by a member of the public. While our initial approach is to resolve these matters informally, sometimes the nature or complexity of an issue requires a more formal approach. These types 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.

This year five in-depth investigations were conducted. The Office did not investigate any new matters as disclosures of wrongdoing under the *Public Interest Disclosure of Wrongdoing Act* (PIDWA), but continued PIDWA investigations initiated in previous fiscal years. Many issues are received as disclosures of wrongdoing, but following assessment, may be investigated under the *Ombudsman Act* or warrant referral to other resolution processes. Disclosures of wrongdoing must meet specific criteria pursuant to the PIDWA.

Complaint Resolution Process

Ways in which complaints are handled by the Office of the Ombudsman



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 two 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 2021-2022. Figure 12 contains information required to be reported under section 18 of the PIDWA.

Figure 12

Information Required under Section 18 of the Act		2021-2022
The number of disclosures received		0
The number of findings of wrongdoing		0
Details of each wrongdoing		n/a
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.

Figure 13 describes the recommendations issued in 2021-2022. The table also describes the public body involved as the respondent, as well as the nature of the complaint.

Figure 13

Complaint

This Office received complaints from members of the public who alleged that a select number of private roads are being maintained by the Department of Public Works (DPW).

The following investigation confirmed 348 private roads received maintenance from DPW in contradiction to the mandate of DPW which is to maintain public infrastructure.

Respondents

Department of Public Works

Recommendations

In keeping with Section 20 of the *Ombudsman Act*, it is recommended that the Department of Public Works:

1. Review existing public road infrastructure maintenance practices, including Z Class and private roads currently serviced by the DPW, to ensure such practices align with the role and mandate of the DPW.
 - a. Develop and implement policy and procedures with respect to the classification and maintenance of public road infrastructure.
 - b. Ensure policy regarding the classification and maintenance of public road infrastructure is publicly accessible and/or available.
 - c. Identify all Z Class and private roads serviced by the DPW directly impacted by the 2019 decision of the DPW to discontinue the provision of road maintenance and/or seasonal services, to determine the appropriateness of extending maintenance services pending the development, implementation, and communication of DPW policy and procedures in this regard.
2. Develop and implement a communications strategy or notification process to ensure existing residents and/or property owners of Z Class and private roads serviced by the DPW are advised in advance, within a practical time frame, of any potential change or cessation in maintenance and/or seasonal services.

The recommendations have been submitted to the respondent and the status of their acceptance is awaited pending departmental review.

Figure 14

Complaint

A resident of the Municipality of the County of Annapolis (MOCA) contacted this Office after their attempt to resolve a complaint with the municipality and the Department of Agriculture (DOA) was unsuccessful.

Respondents

Municipality of the County of Annapolis
Department of Agriculture

Recommendations

Municipality of the County of Annapolis:

In keeping with Section 20 of the *Ombudsman Act*, it is recommended that the Municipality of the County of Annapolis:

1. During the revision of the Municipal Planning Strategy and Land-Use Bylaw, consider developing zoning bylaws which would assist in minimizing competing uses of neighbouring lands and promote more complementary uses of land in specific areas. It may be beneficial to contact Municipal Affairs, other municipalities who have established such bylaws to control and manage Land-Use, and the Department of Agriculture Agricultural Extension staff who may be able to provide insight into potential conflicts where agricultural and residential uses coexist.
2. Develop and implement a Municipal Complaint Policy to ensure a consistent and transparent approach to handling citizen complaints. This policy should be publicly available and posted on the Municipal website.
3. Develop and implement a policy or procedure which addresses situations where a decision has been made to no longer communicate with an individual. This should include who has the authority to make such a decision, notifying the individual if municipal staff will no longer be communicating regarding an issue, the reasons why, and avenues to discuss the matter further in the event that they disagree with this decision.

(cont'd)

(cont'd)

Recommendations

Department of Agriculture:

In keeping with Section 20 of the *Ombudsman Act*, it is recommended that the Department of Agriculture:

1. Develop and implement policies and/or procedures which outline the process for dealing with public complaints handled by the Agricultural Extension Division. The policies and/or procedures should include:
 - a. Intake and assessment processes;
 - b. Process for responding to complaints, including but not limited to contact with Complainants and Respondents, site visits, and the collection of evidence;
 - c. Documentation of actions undertaken by staff in response to the complaint, including process to record file notes of interactions with relevant parties.
2. Review the *Farm Practice Board Act* to ensure the legislation and Farm Practices Board are operating in accordance with departmental goals and objectives and to ensure the Board is meeting its intended purpose.
3. Review current membership of the Farm Practices Board to ensure there is adequate membership and develop a plan to recruit members to ensure the Board is adequately resourced.
4. Develop and implement policies regarding the administration of the *Farm Practices Act*, including but not limited to:
 - a. How "normal farm practices" are determined, including what policies, guidelines, standards, and best management practices are considered in this assessment;
 - b. Site visits and the collection of evidence;
 - c. Evaluation of evidence presented by the parties;
 - d. Writing decisions; and
 - e. Issuing orders.
5. Develop orientation and training programs for Farm Practices Board members, including a review of relevant policies and procedures, investigative training, decision writing, and any other areas identified in consultation with the Board to ensure members have adequate training to effectively achieve the Board's objectives.
6. Identify other adjudicative boards associated with the Department, assess whether the above-noted recommendations would be relevant to those boards, and implement any of these recommendations that would be of benefit to those boards.

The recommendations were accepted by the respondents and are being monitored for implementation.

Figure 15

Complaint

This Office was contacted by a member of the public concerned that the Department of Community Services (DCS) was not following its policies for foster parent applications, alleging social workers did not have the means to follow their own policies.

Following investigation, it was determined a gap existed in the Child Welfare Policy and the records as obtained from a police record check, resulting in recommendations.

Respondents

Department of Community Services

Recommendations

The preliminary recommendations are:

1. DCS reconsider their stance on applying for access to the Justice Enterprise Information Network (JEIN) for the purpose of screening foster parents.
2. Broaden the current use of JEIN in child protection matters to similarly include user status or access for applications from foster parents.

The status of these recommendations is pending with DCS.

Figure 16

Complaint

The complainant was referred to this Office with two concerns regarding Child Protection Services (CPS).

The first was related to a *Freedom of Information and Protection of Privacy Act* (FOIPOP) request made to DCS by the complainant resulting in the Ombudsman Rep facilitating necessary communication between the Manager and the complainant.

The second related to the handling of the CPS case for the family, resulting in the complainant receiving a letter concerning the results of the internal review.

Information from the case and internal review was reviewed by Ombudsman Representatives and it was determined many of the concerns of the complainant involved decisions made by CPS workers, not the process. These issues identified resulted in the following recommendations.

Respondents

Department of Community Services

Recommendations

The preliminary recommendations are:

1. Develop and implement a policy on the internal file review process. Such a policy should:
 - a. Outline the scope and depth of these types of reviews
 - b. Ensure clear communication of the recommendations resulting from the review
 - c. Identify who is accountable to address recommendations as well as time frames to implement the recommendations
 - d. Identify who is responsible to monitor the implementation of the recommendations and ensure they address the issues identified in the review
 - e. Provide record management processes to ensure appropriate documentation of the review report and outcomes
 - f. Establish what information is shared with the client with respect to the internal review of their file

The status of these recommendations is pending with DCS.

Figure 17

Complaint

A member of the public contacted the Office of the Ombudsman concerning their application to the Director by the Residential Tenancies Officer (RTO). The primary concern being the service of documents to the respondents of the application, who were the former tenants of the complainant.

Following investigation by this office it was determined the following recommendations were required to address issues of a lack of documentation and inconsistent messaging to support and evidence the decision-making process

Following investigation, it was determined a gap existed in the Child Welfare Policy and the records as obtained from a police record check, resulting in recommendations.

Respondents

Service Nova Scotia and Internal Services

Recommendations

Preliminary Recommendations

In keeping with Section 20 of the *Ombudsman Act*, it is recommended that Service Nova Scotia and Internal Services:

1. Develop and implement documentation standards for Access and Contact Centre staff to ensure accurate and complete records of interactions with the public are maintained.
2. Develop and implement documentation standards for Residential Tenancies Board staff, specifically, Residential Tenancy Officers.
3. Ensure the current information management system supports efficient documentation of case notes by relevant Program staff.
4. Review relevant policies and information provided to applicants to ensure there is sufficient information regarding the acceptable forms of evidence to demonstrate documents have been sufficiently served via registered mail. This information should also be reviewed with all relevant Program staff.
5. Review and revise the Unreturned Certificate of Service Policy to ensure that written correspondence is sent to applicants regarding the closure of their file, and that this correspondence includes detailed information regarding the reasons the file was closed and options available for applicants to reapply.
6. Review all policy changes implemented, as recommended above, with relevant Program staff to promote consistency.
7. Review the mediation model and techniques with Program staff and assess whether additional training and/or resources for Program staff are required in this regard.

The recommendations have been accepted and are being monitored for implementation

An individual living in Nova Scotia but studying in a professional program at a New Brunswick institution approached our office with an inquiry about whether they might qualify for forgiveness of all or part of their extensive student loans, incurred over the two-year program. The student is about to finish their program at a New Brunswick private college but plans to continue living in Nova Scotia and to practice their profession in this province where there is extensive demand for their particular skills.

The program in which the individual is enrolled is offered at only two schools in Atlantic Canada – a Nova Scotia University and a private college in New Brunswick. The individual was not admitted at the Nova Scotia facility but was accepted in New Brunswick. Both programs are certified by the national regulatory authority of the profession.

The Director of Portfolio Management for the Nova Scotia Student Assistance Agency agreed to review the case to determine eligibility or otherwise under the Loan Forgiveness Program (LFP).

Unfortunately, that component of the program applies only to students for whom there is no equivalent program in Nova Scotia. And it does not apply to students attending private colleges.

However, while affirming ineligibility for the Student Loan Forgiveness feature of the program, the agency concluded that the student could qualify for another provision in the program which converts 40 per cent of student loans into grants in certain circumstances.

The rationalization for the approach was that the individual's non-acceptance to the only program in Nova Scotia could be deemed to have made the program unavailable to the student in Nova Scotia. And their attendance at the only other available program at an out-of-province private school was deemed a necessary consequence of the unavailability in NS.

The student will benefit by having 40 per cent of their student loan debt converted to a non-repayable grant.

The agency also drew the student's attention to another feature of the student loan regime called RAP (Repayment Assistance Plan) which can offer more lenient and extended repayment options for individuals who have difficulty meeting normal payment schedules for their loans.

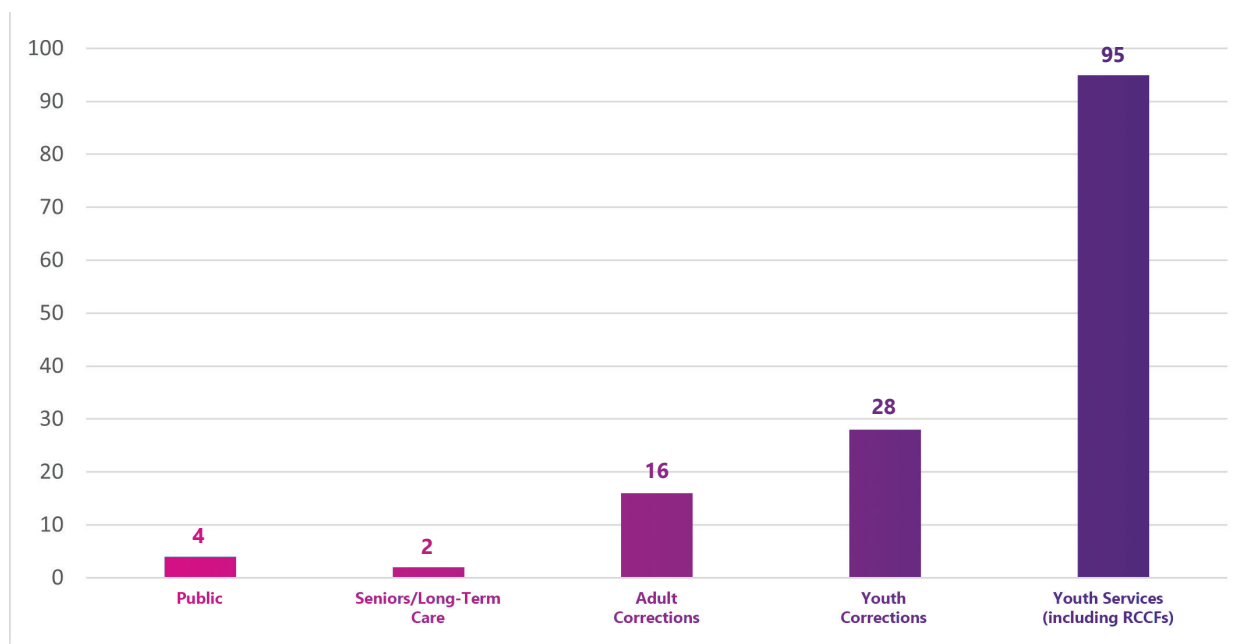
The student expressed gratitude to both the Office of the Ombudsman and to Scotia Student Assistance Agency.



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.

Outreach Sessions

Figure 18



In addition to our regular site-visits, Ombudsman Representatives attend special events that allow them to engage with new groups and individuals. This year Ombudsman Representatives endeavored to attend virtual events whenever possible, unfortunately many events that we would typically attend, such as seniors' or youth expos, were cancelled due to the COVID-19 Pandemic.

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 Public Service Commission United Way fundraising campaign and coordinated our efforts through the Public Service United Way Steering Committee.

Correctional Services

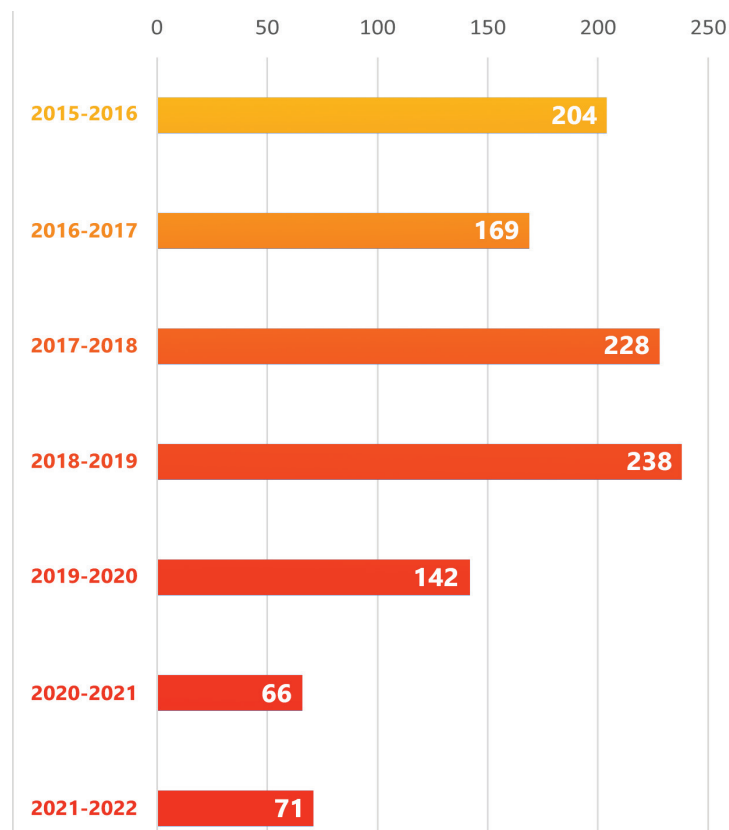
In Nova Scotia, there are four adult correctional facilities holding both sentenced inmates as well as those remanded to custody pending trial. These facilities are the Central Nova Scotia Correctional Facility (CNSCF), the Southwest Nova Scotia Correctional Facility (SNSCF), the Northeast Nova Scotia 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 19 illustrates the number of correctional services complaints by inmates over the last five 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). For a total of all inmate and public complaints about correctional services see figure 8. In 2021-22 there were 71 new complaints by inmates about correctional services, several of those complaints were referred to the internal complaint process. This figure is slightly higher than the previous year and is attributed to the relaxation of restrictions related to the COVID-19 pandemic.

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.

Figure 19
Correctional Services Complaints



Adult Corrections Case Example

Corrections, Sheriffs, and Healthcare

On February 9th, 2022, an inmate was released from custody at Central Nova Scotia Correctional Facility (CNSCF) and was transported via Sheriffs to Cape Breton via North East Nova Correctional Facility. Upon being released from custody in Cape Breton the inmate found himself with missing personal effects: \$190 cash, some missing clothing and much needed medication.

The inmate called the Nova Scotia office of the Ombudsman and an investigation ensued whereby the Sheriffs Department had located the missing cash and were in the process of returning it to the inmate. The inmate's claims that medication was supposed to be assembled before his release was confirmed and arrangements were made for the inmate to pick up his medication from the local pharmacy. In addition, the inmate was directed to the complaint's process at CNSCF. All matters were resolved for the complainant in this case.

Youth and Seniors 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 20


3	Community Services
1	Environment and Climate Change
3	HRM
19	Health and Wellness
10	Infrastructure and Housing
1	Internal Services
1	Justice
1	Metropolitan Regional Housing Authority
10	Nova Scotia Health Authority
1	Office of the Ombudsman
1	Office of the Premier
2	Public Trustee
1	Public Works
1	Region of Queens Municipality
1	Seniors & LTC
3	Service Nova Scotia
1	WCB
26	Other
86	Total

Type of Youth Complaints

Most youth complaints come from youth in care and custody. This reality is reflected in the categories in figure 24. 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 21

5	Communication
3	COVID-19
5	Discipline
3	Education
5	Facilities/Building
9	Facility Staff
2	Food
4	Lawyer/Legal
4	Personal Safety/Abuse Allegation
5	Placement
10	Policy and Procedures
4	Privileges
2	Recreation
3	Rights
9	Social Worker
16	Other
89	Total



The Office of the Ombudsman was contacted by a resident of a private road concerned that their road was to no longer receive any maintenance by the Department of Public Works (DPW) – despite having received such for the past 30 to 40 years. While acknowledging DPW's mandate is to maintain provincial roads and infrastructure, the Complainant and other residents wanted to know why their service had been removed although other private roads within the province kept their maintenance.

The resident formed a committee to represent themselves and their neighbours in dialogue with representatives of the DPW and the County in an attempt to keep the service and to establish the Respondent's justification for their withdrawal of service, as the only explanation provided was, they lived on a private road and the DPW only maintained provincial public roads and infrastructure. Despite support from representatives of the County, the DPW maintained their position that in keeping with their mandate, they would not service private roads.

Following this complaint, another resident of a different private road encountered the same issue and contacted our Office. That Complainant had filed a *Freedom of Information and Protection of Privacy Act* (FOIPOP) application which revealed there were 348 private roads in the province receiving a level of maintenance by the DPW. This led to frustration among the residents and raised questions of administrative fairness and why some roads received more favourable treatment than others.

The investigation conducted by this Office revealed an inconsistent application of DPW policy in maintaining a group of private roads based on past practices and history, in contrast to other private roads receiving no maintenance at all. The DPW recognized the contradiction in practice. While acknowledging the long-standing history behind such practice, this Office recommended the DPW undertake a review of existing public road and infrastructure maintenance, ensuring such practices align with the mandate of DPW.

As of the writing of this report, our file remains open.

The specific recommendations issued by this Office in this instance can be found on page 35 in the recommendations section of this report.

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