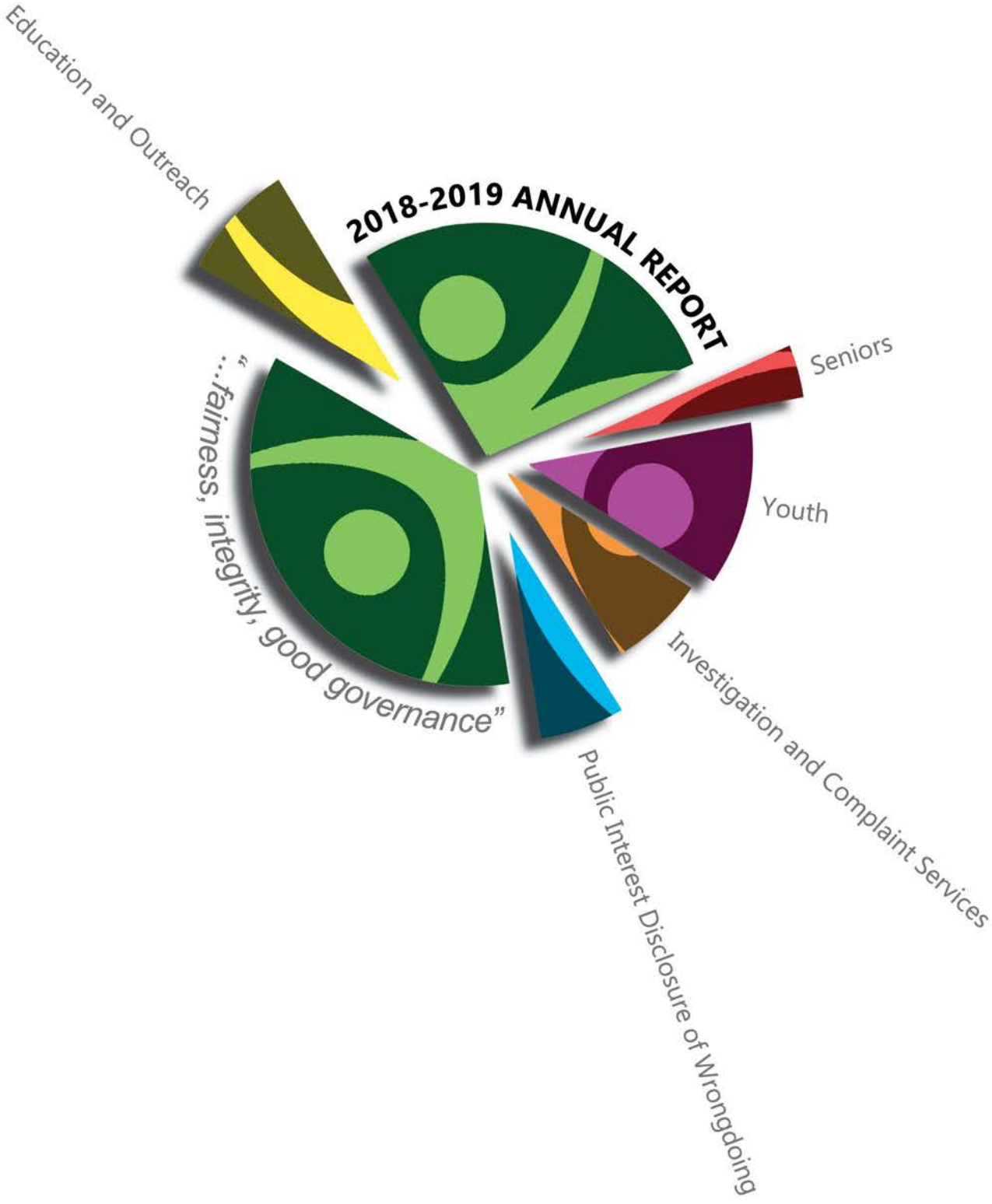


NOVA SCOTIA
OFFICE OF THE OMBUDSMAN

Ombudsman Annual Report 2018-2019
Office of the Ombudsman
September 2019

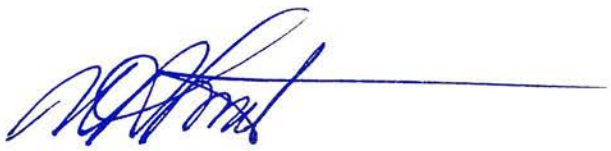
September 2019

The Honourable Kevin Murphy
Speaker of the House of Assembly
Legislative Assembly of Nova Scotia
Province House
Halifax, Nova Scotia

Dear Speaker Murphy,

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, 2019.

Respectfully,



William A. Smith
Ombudsman

MESSAGE FROM THE OMBUDSMAN

William A. Smith, Ombudsman

Each year when I issue this report it reiterates to me the vital role an independent oversight body such as the Office of the Ombudsman provides for Nova Scotians and their government.

Thousands of contacts with this Office demonstrate there is work to be done in fostering fairness, integrity, and good governance. Some complaints can be complex while others may be relatively straightforward, however, every complaint reviewed by Ombudsman Representatives is important to the individual who has decided to reach out to the Office of the Ombudsman.

While investigating complaints, we also have the opportunity to observe public servants and agencies working to generate better service delivery and outcomes for Nova Scotians. Ombudsman Representatives view each case as an opportunity to address individual grievances and pursue best practices in government policy in a fair and impartial way. This may include issuing recommendations to public bodies that are intended to enhance service delivery and access.

The Office of the Ombudsman undertakes three oversight functions. First, pursuant to the Ombudsman Act, we strive to resolve complaints regarding the administration of provincial and municipal governments. This includes all municipal units, provincial departments, agencies, boards, and commissions. Second, we work with departments and agencies who provide services directly to children, youth, and seniors in the care of the province, to help better those services, and to function as an independent review mechanism when complaints arise involving the delivery of those services. Third, this Office reviews and investigates allegations or disclosures of wrongdoing from provincial government employees and members of the public.

These three oversight functions represent one of the broadest mandates for an Ombudsman office in Canada. When concerns are brought forward or identified by Ombudsman Representatives that are complex in nature, involving multiple government entities, this broad mandate provides the opportunity to address matters in an efficient and effective way.

All Nova Scotians can benefit from learning what the Office of the Ombudsman can do, the services we provide, and how we may be able to help. The intent of this report is to outline how the Office works as an impartial organization that both assists in resolving complaints, as well as promotes constructive changes in public policy and service delivery. The report includes statistics on the number of complaints addressed by Ombudsman Representatives, case examples, as well as a summary of the recommendations issued in the year under review.

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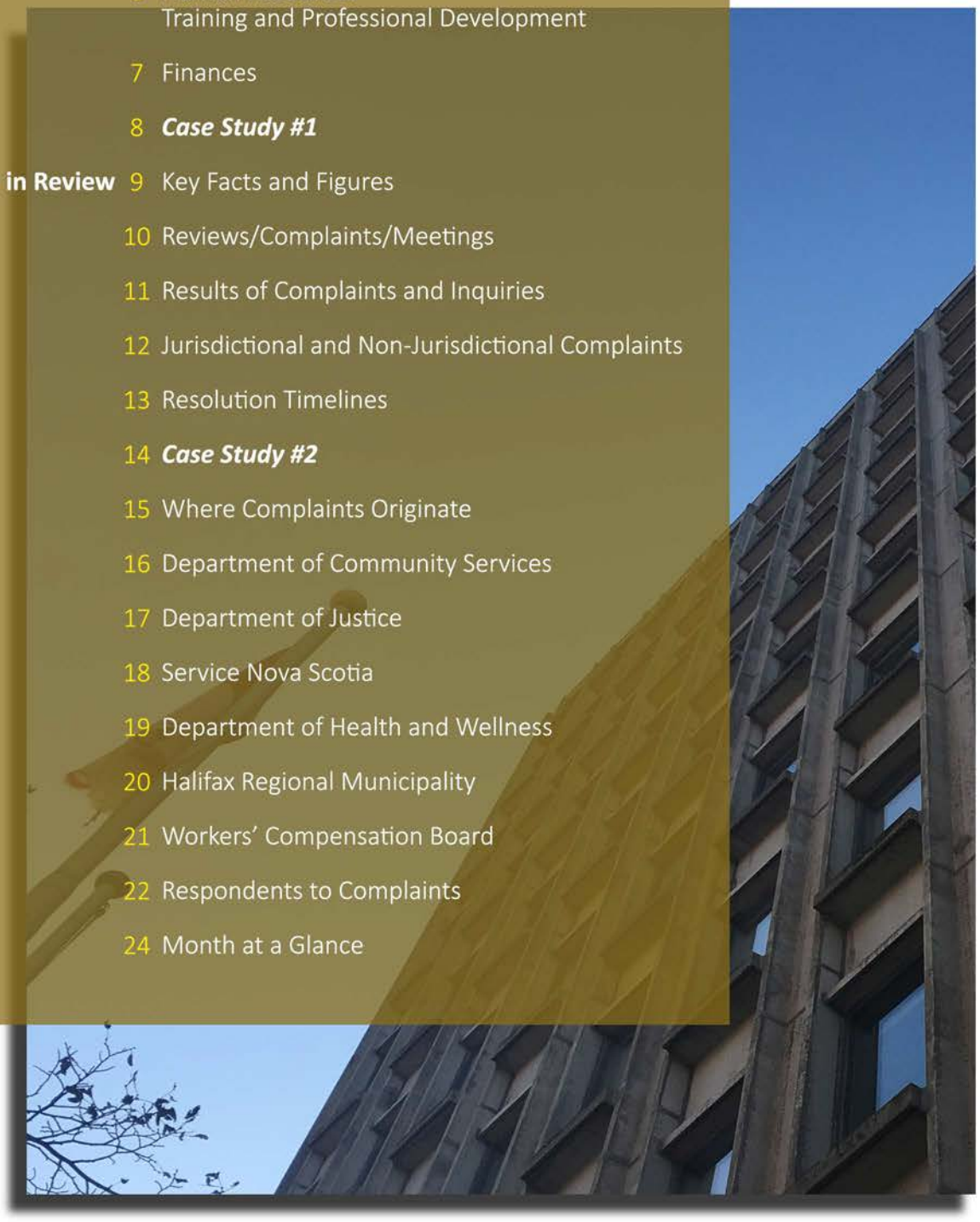

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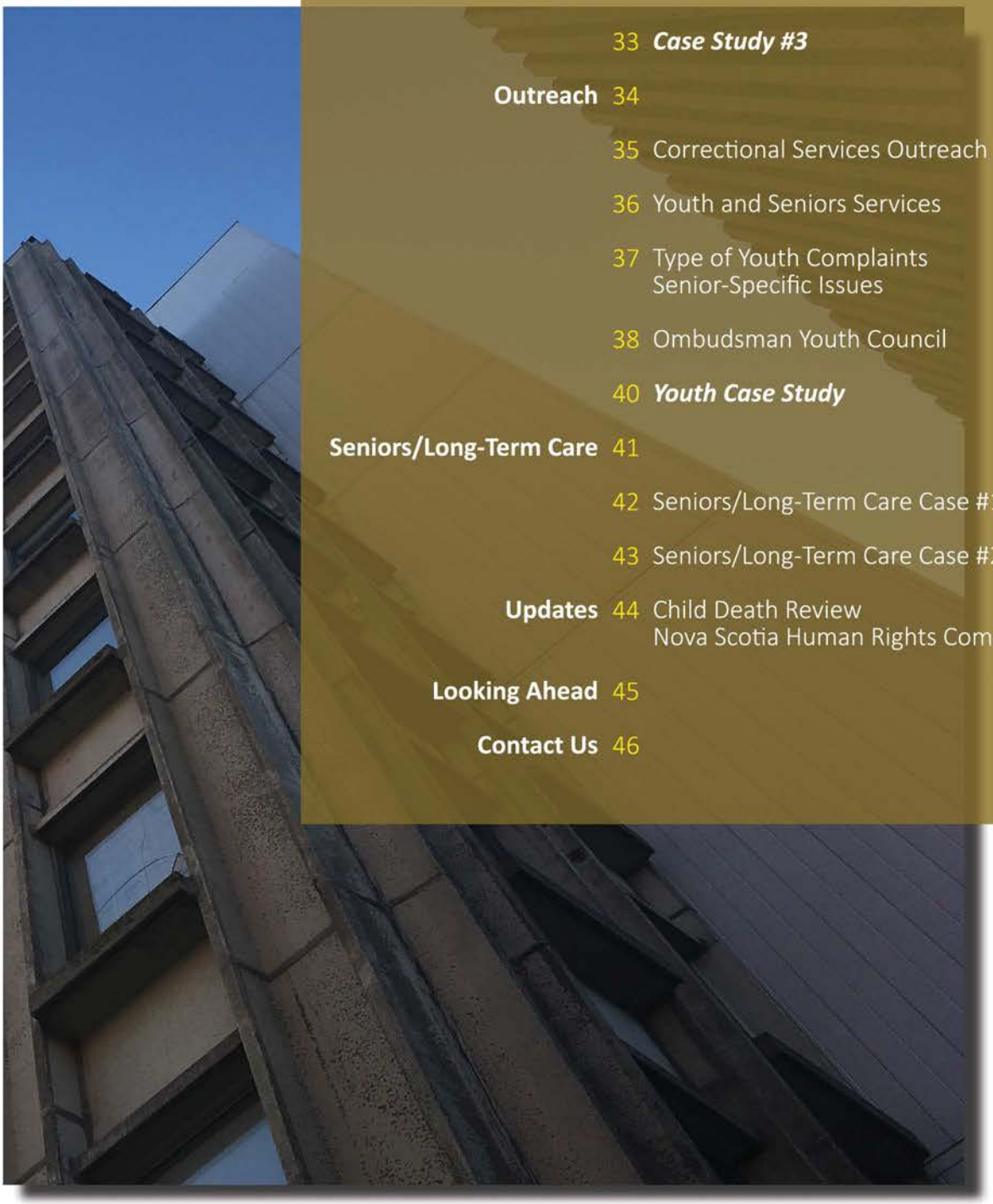
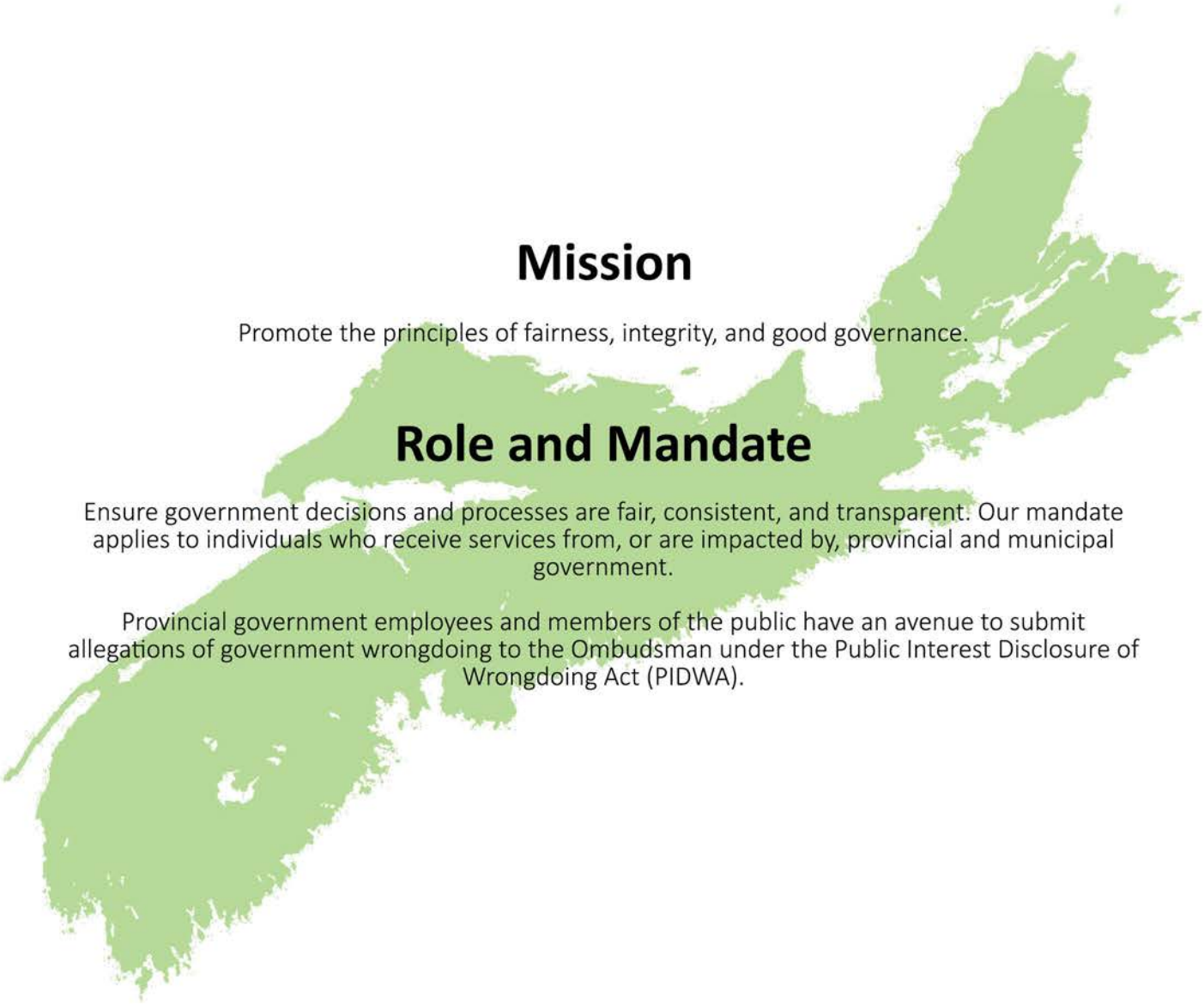


ABOUT THE OFFICE



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
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 standards.
Managers and the Executive Director supervise staff, oversee investigations, and provide advice to the Ombudsman.
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.
Investigation and Complaint Services (I&CS)
Staff provide regular outreach visits to inmates in provincial correctional facilities to advise of our services and discuss complaints in person.
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.
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 (Sydney).
Ombudsman Representatives examine issues and complaints affecting senior citizens, particularly those who reside in provincially licensed long-term care (LTC) facilities.
Youth and Seniors Services (Y&SS)
Ombudsman Representatives review, investigate, and report on the concerns of children, youth, parents, guardians, and those working in provincial child and youth residential care and custodial facilities.

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. It continues to benefit from a roster of supplemental trained employees, co-op and student work placements. The casual roster enables the Office to accommodate staff vacancies while continuing to carry out in-depth investigations.

This year, we hosted one student each from the following post-secondary programs:

- Bachelor of Social Work, Dalhousie University
- Office Administration Program, NSCC
- Child & Youth Worker Program, NSCC
- Master of Public Administration, Dalhousie University
- Juris Doctor, Schulich School of Law, Dalhousie University

Training and Professional Development

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

Internal and Public Service Commission Training

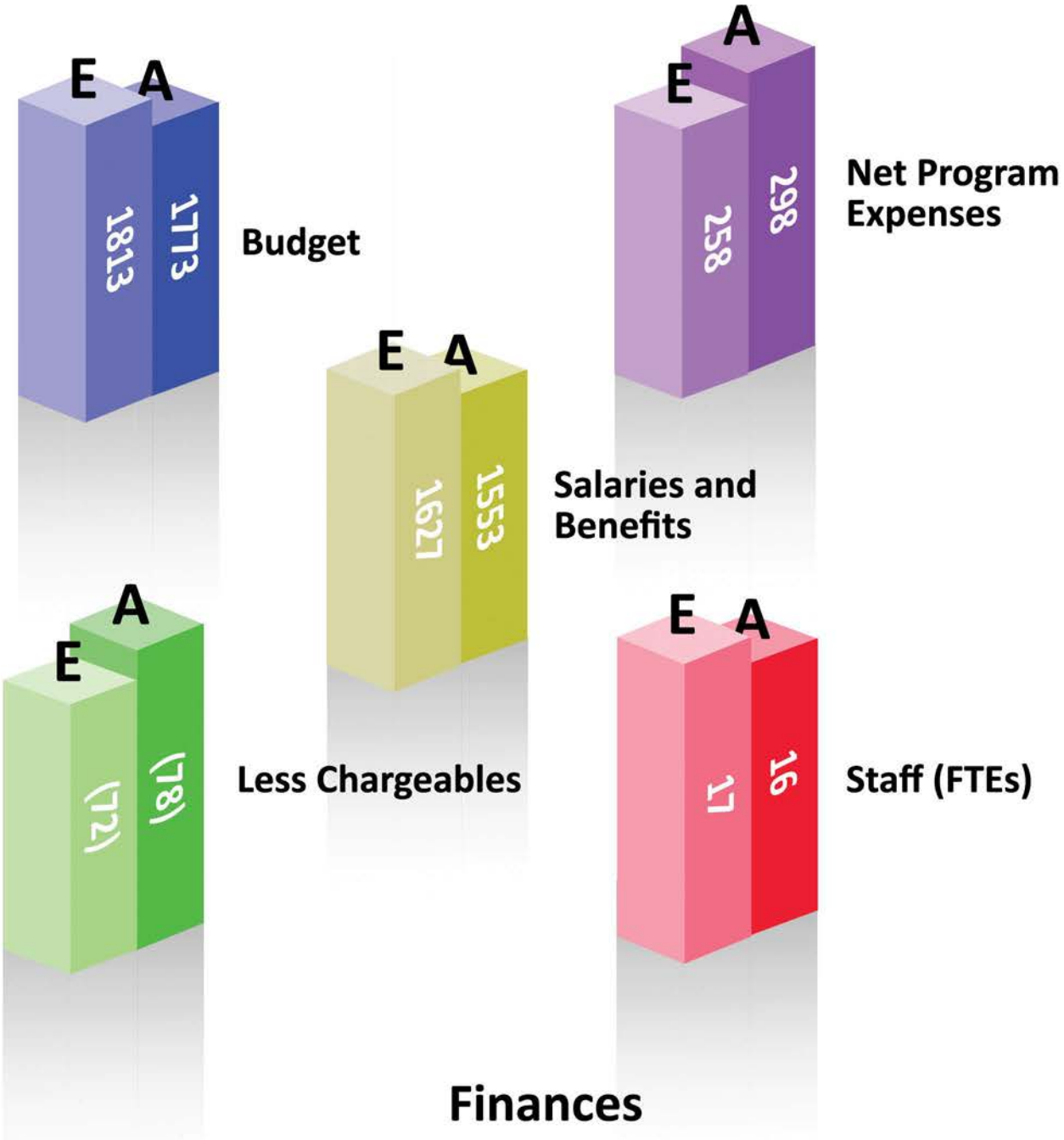
- Administrative Professional Development
- Diversity and Employment Equity
- Emergency First Aid
- Introduction to Occupational Health & Safety
- Leadership Development Program (Management)
- Privacy and Access Awareness Training
- Respectful Workplace for Employees
- Understanding Fraud in the Public Sector

External Training

- French Beginner 3 & 4 – Université Sainte-Anne
- Investigating and Information Gathering with Science-Based Techniques – IG Consultants
- Investigation Training – The Workplace Institute
- Managing Unreasonable Complainant Conduct – Ombudsman New South Wales
- Ombud Essentials Course – Osgoode Law School
- Policy Evaluation – Saint Mary's Executive and Professional Continuing Education

Core Business Expenses 2018-2019 Estimates/Actuals (E/A)

Figure 1



Finances

The Office of the Ombudsman's 2018-2019 budget is shown in (Figure 1). This year the Office spent 98% of its budget. The variance in budgeted and actual expenses reflects savings in operational costs, i.e. position vacancies. The increase in spending on salaries from previous years is due to government's implementation of revised pay levels for employees excluded from bargaining units.

CASE STUDY #1

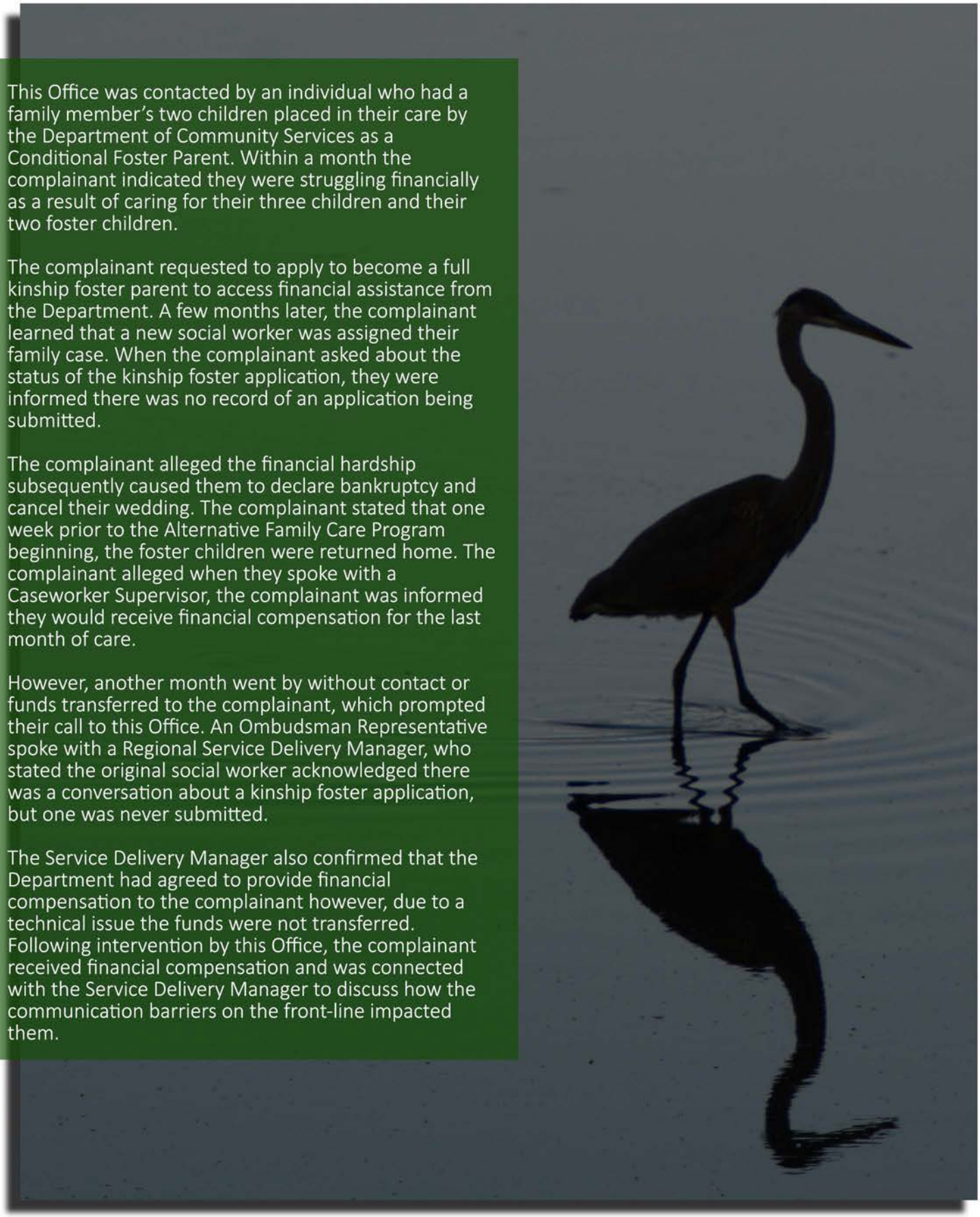
This Office was contacted by an individual who had a family member's two children placed in their care by the Department of Community Services as a Conditional Foster Parent. Within a month the complainant indicated they were struggling financially as a result of caring for their three children and their two foster children.

The complainant requested to apply to become a full kinship foster parent to access financial assistance from the Department. A few months later, the complainant learned that a new social worker was assigned their family case. When the complainant asked about the status of the kinship foster application, they were informed there was no record of an application being submitted.

The complainant alleged the financial hardship subsequently caused them to declare bankruptcy and cancel their wedding. The complainant stated that one week prior to the Alternative Family Care Program beginning, the foster children were returned home. The complainant alleged when they spoke with a Caseworker Supervisor, the complainant was informed they would receive financial compensation for the last month of care.

However, another month went by without contact or funds transferred to the complainant, which prompted their call to this Office. An Ombudsman Representative spoke with a Regional Service Delivery Manager, who stated the original social worker acknowledged there was a conversation about a kinship foster application, but one was never submitted.

The Service Delivery Manager also confirmed that the Department had agreed to provide financial compensation to the complainant however, due to a technical issue the funds were not transferred. Following intervention by this Office, the complainant received financial compensation and was connected with the Service Delivery Manager to discuss how the communication barriers on the front-line impacted them.

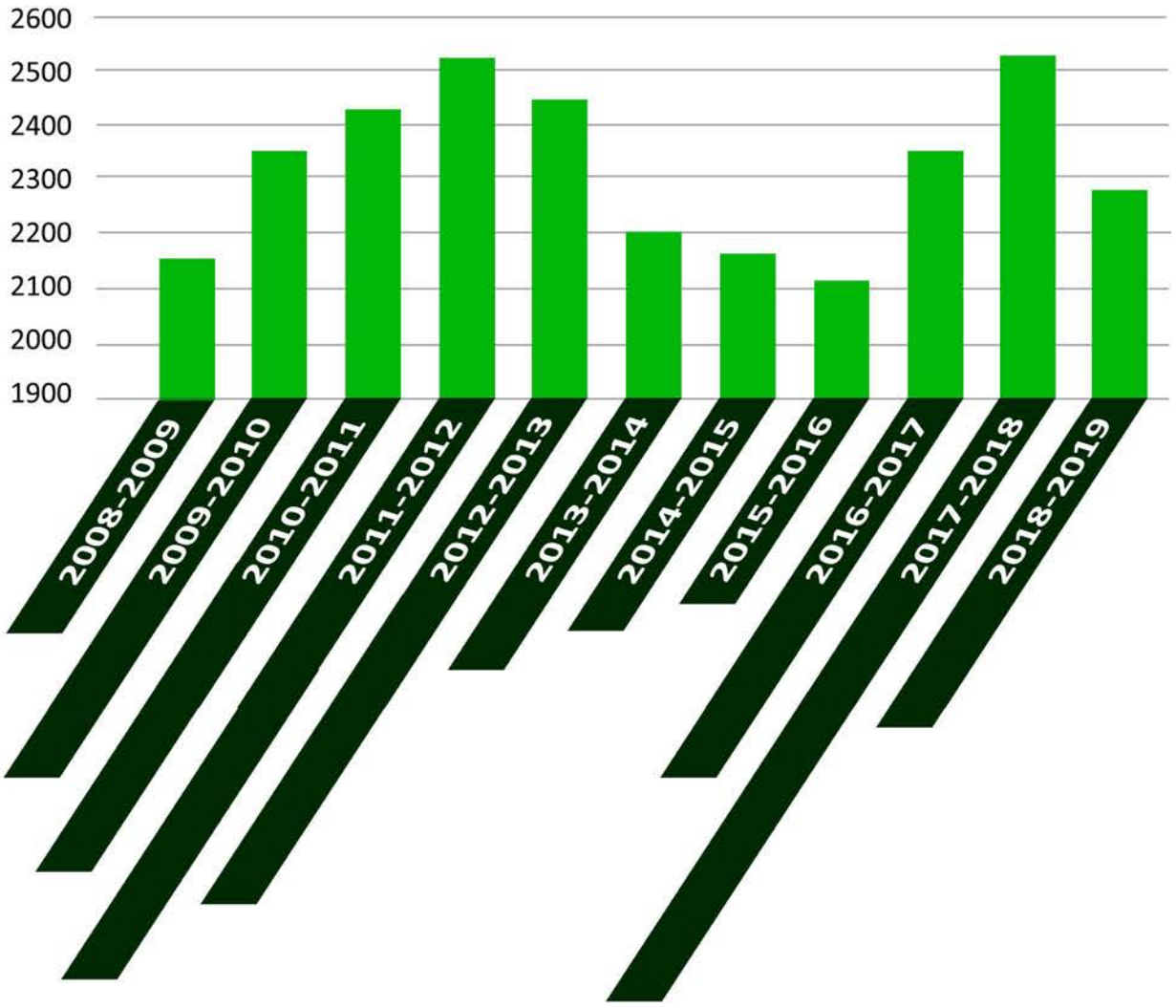


Key Facts and Figures

In 2018-19, the Office handled 2,278 complaints, inquiries, and youth contacts/meetings, which is consistent with the 10-year trend of surpassing 2,000 new matters in the year under review (Figure 2). Of the 2,278 total complaints, inquiries and youth contacts/meetings handled, 1,375 matters were resolved at the intake and assessment stage, 660 at the administrative review stage, 5 own motion and policy reviews, 2 disclosures of wrongdoing, 1 formal investigation, 4 other complaints and inquiries, and 231 youth contacts/meetings (Figure 3). Various complaint outcomes can be seen in Figure 4, including 476 non-jurisdictional complaints.

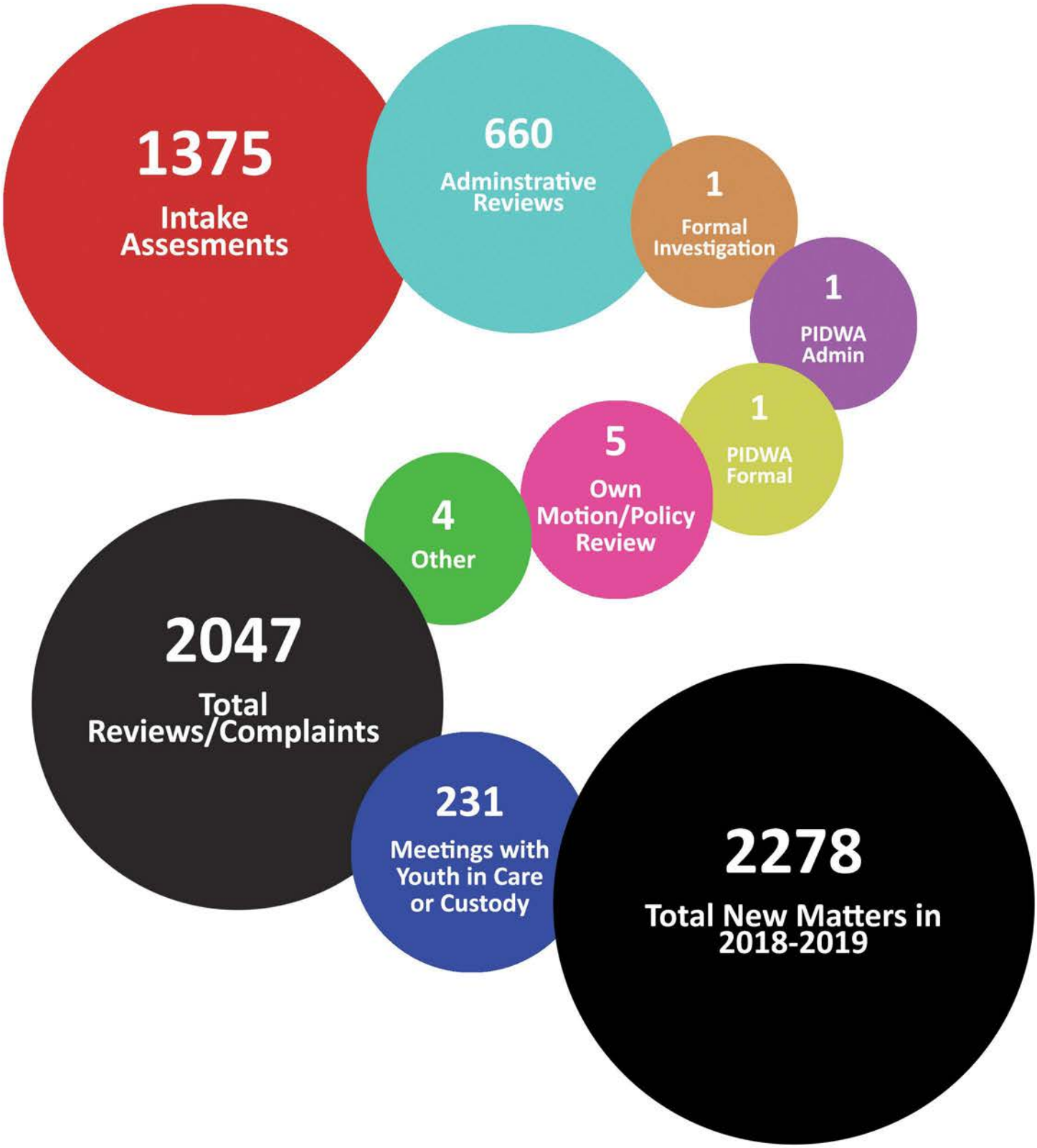
Complaints, Inquiries, and Youth Contacts

Figure 2



Reviews/Complaints/Meetings

Figure 3



Results of Complaints and Inquiries

Figure 4

1208	**Assistance Rendered**: When this Office makes efforts to assist the complainant, but the matter has not progressed to the formal stages of investigation.
27	**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)
9	**Settled***: When a matter is settled but there is limited (but some) intervention by this Office.
30	**Properly Implemented**: Review / Investigation of the complaint is undertaken, and it is determined that the respondent has followed policy and procedures
173	**Discontinued by Complainant (Withdrawn)**: When a complainant decides to disengage from the review / investigation process
82	**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)
476	**Non-Jurisdictional** Court or Tribunal (104) Elected Official (14) Federal (111) Private (167) Self-regulating body (56) Other* (24)
18	**Other Outcome***: This category captures any complaints or inquiries that do not fit above (e.g. explaining our mandate to callers or providing service information to government officials)
2023	**Total****

* Categories to be discontinued next fiscal year
** Total excludes meetings with youth in care and custody. Total excludes files still open when this data was collected following year end

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). 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. Twenty-three 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.

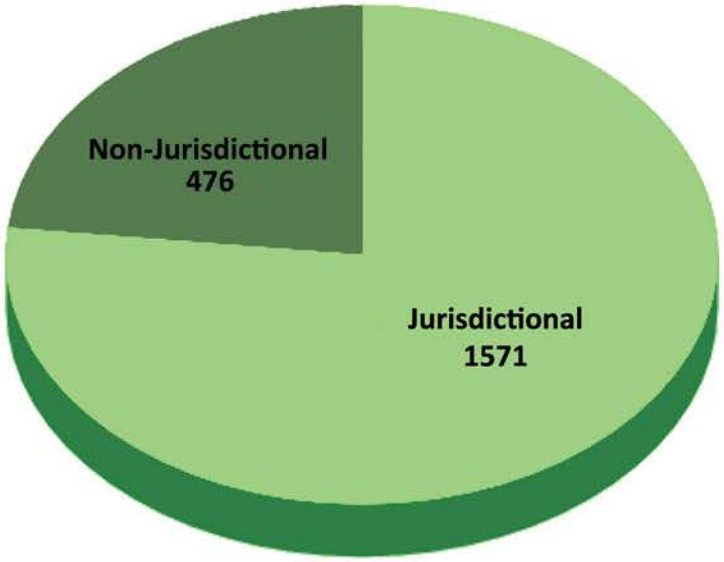
Non-jurisdictional complaints are broken into categories:

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

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)

Figure 5



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)

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.

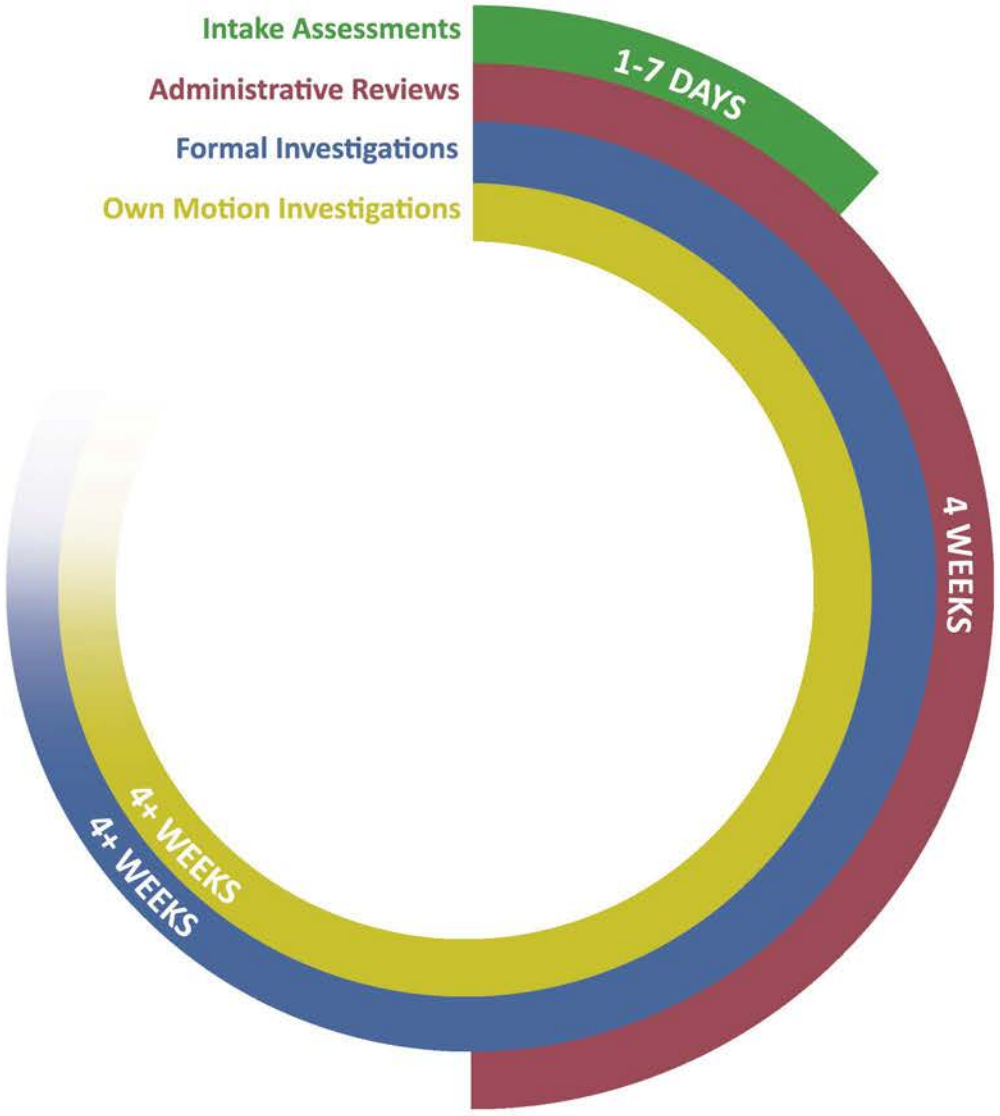
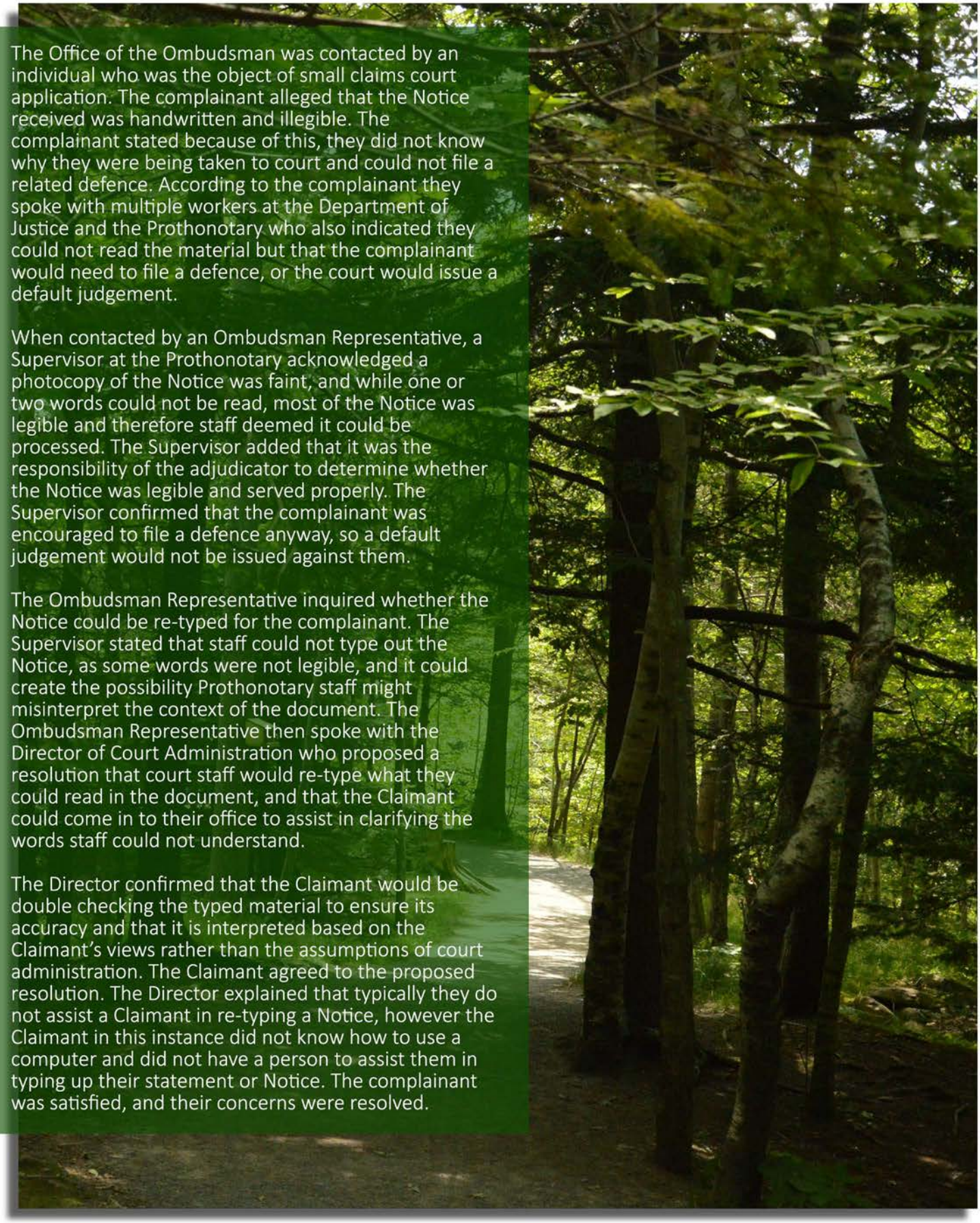


Figure 6

CASE STUDY #2



The Office of the Ombudsman was contacted by an individual who was the object of small claims court application. The complainant alleged that the Notice received was handwritten and illegible. The complainant stated because of this, they did not know why they were being taken to court and could not file a related defence. According to the complainant they spoke with multiple workers at the Department of Justice and the Prothonotary who also indicated they could not read the material but that the complainant would need to file a defence, or the court would issue a default judgement.

When contacted by an Ombudsman Representative, a Supervisor at the Prothonotary acknowledged a photocopy of the Notice was faint, and while one or two words could not be read, most of the Notice was legible and therefore staff deemed it could be processed. The Supervisor added that it was the responsibility of the adjudicator to determine whether the Notice was legible and served properly. The Supervisor confirmed that the complainant was encouraged to file a defence anyway, so a default judgement would not be issued against them.

The Ombudsman Representative inquired whether the Notice could be re-typed for the complainant. The Supervisor stated that staff could not type out the Notice, as some words were not legible, and it could create the possibility Prothonotary staff might misinterpret the context of the document. The Ombudsman Representative then spoke with the Director of Court Administration who proposed a resolution that court staff would re-type what they could read in the document, and that the Claimant could come in to their office to assist in clarifying the words staff could not understand.

The Director confirmed that the Claimant would be double checking the typed material to ensure its accuracy and that it is interpreted based on the Claimant's views rather than the assumptions of court administration. The Claimant agreed to the proposed resolution. The Director explained that typically they do not assist a Claimant in re-typing a Notice, however the Claimant in this instance did not know how to use a computer and did not have a person to assist them in typing up their statement or Notice. The complainant was satisfied, and their concerns were resolved.

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 7-12 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

2016-2017 - 2017-2018 - 2018-2019

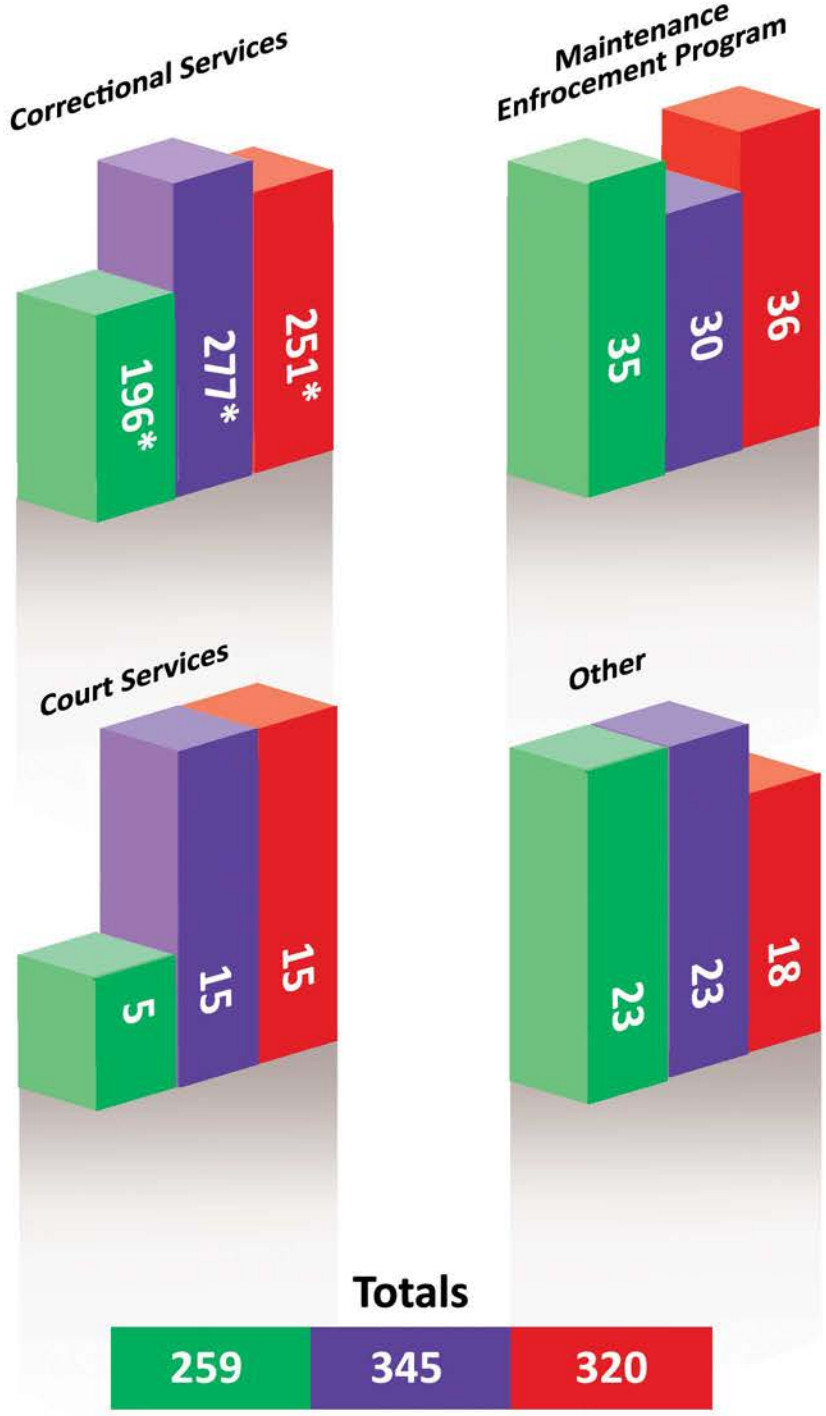
Figure 7

* includes complaints by youth in care

Department of Justice

2016-2017 - 2017-2018 - 2018-2019

Figure 8

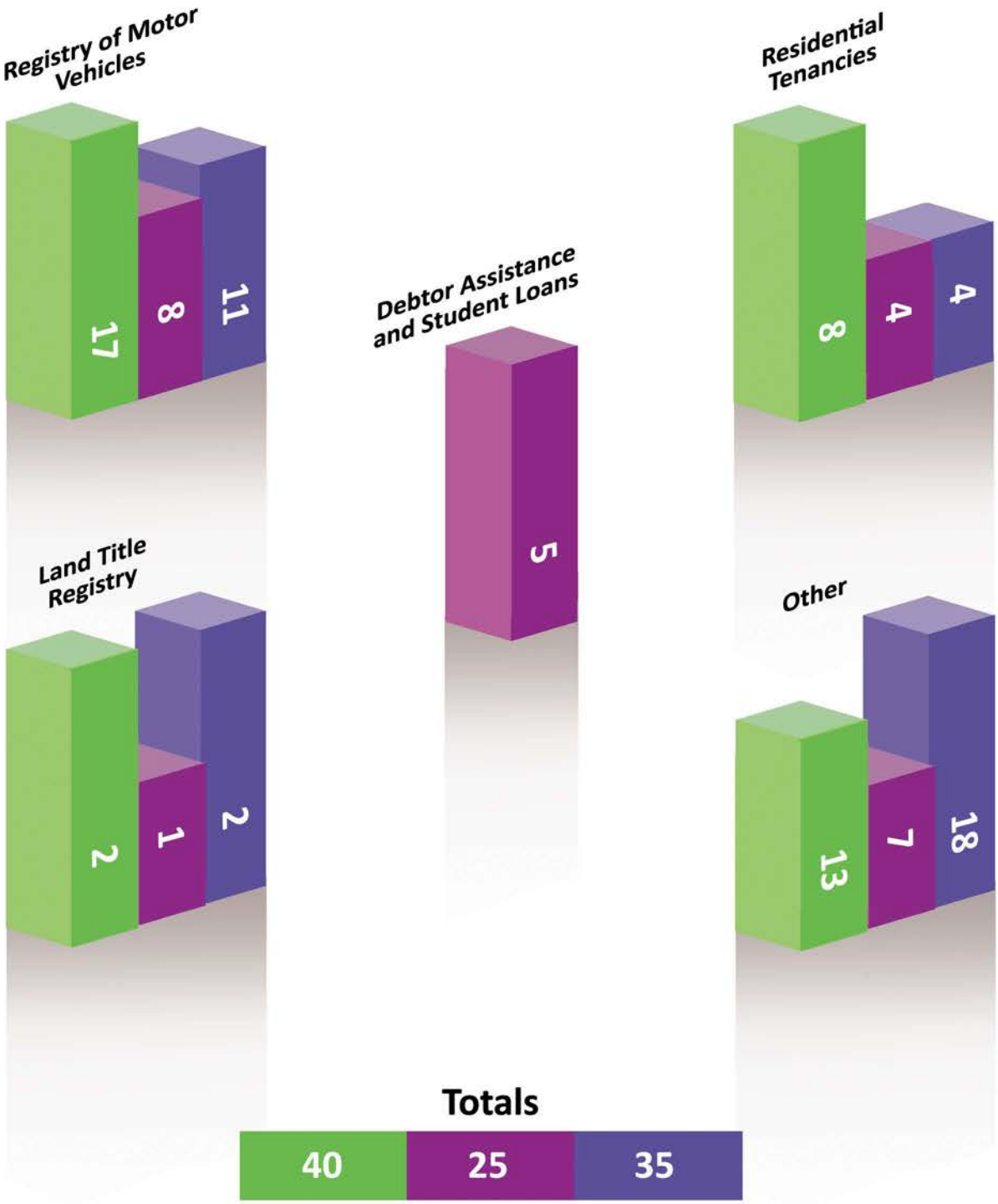


* includes complaints from adults and youth in custody

Service Nova Scotia

2016-2017 - 2017-2018 - 2018-2019

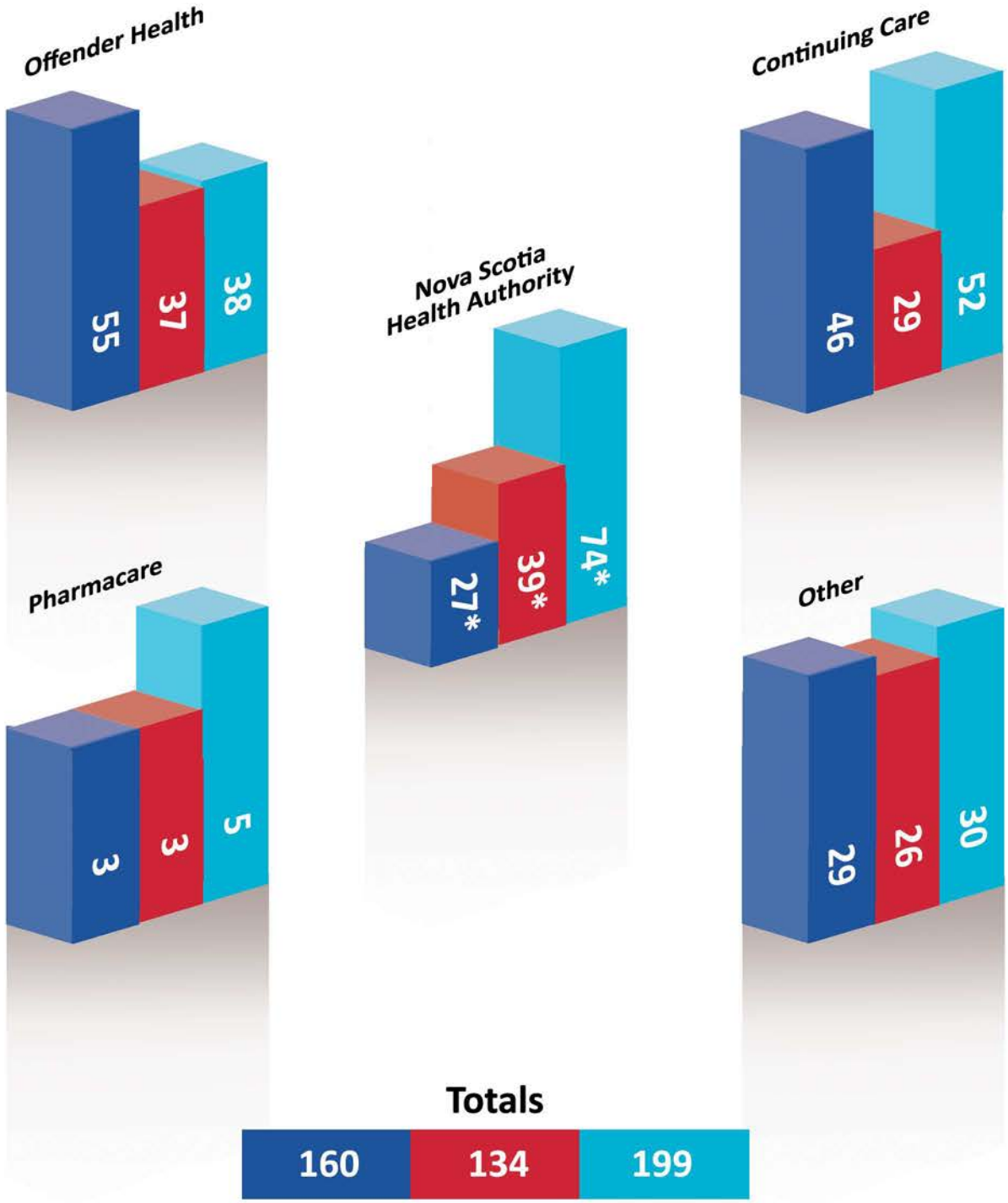
Figure 9



Department of Health and Wellness

2016-2017 - 2017-2018 - 2018-2019

Figure 10

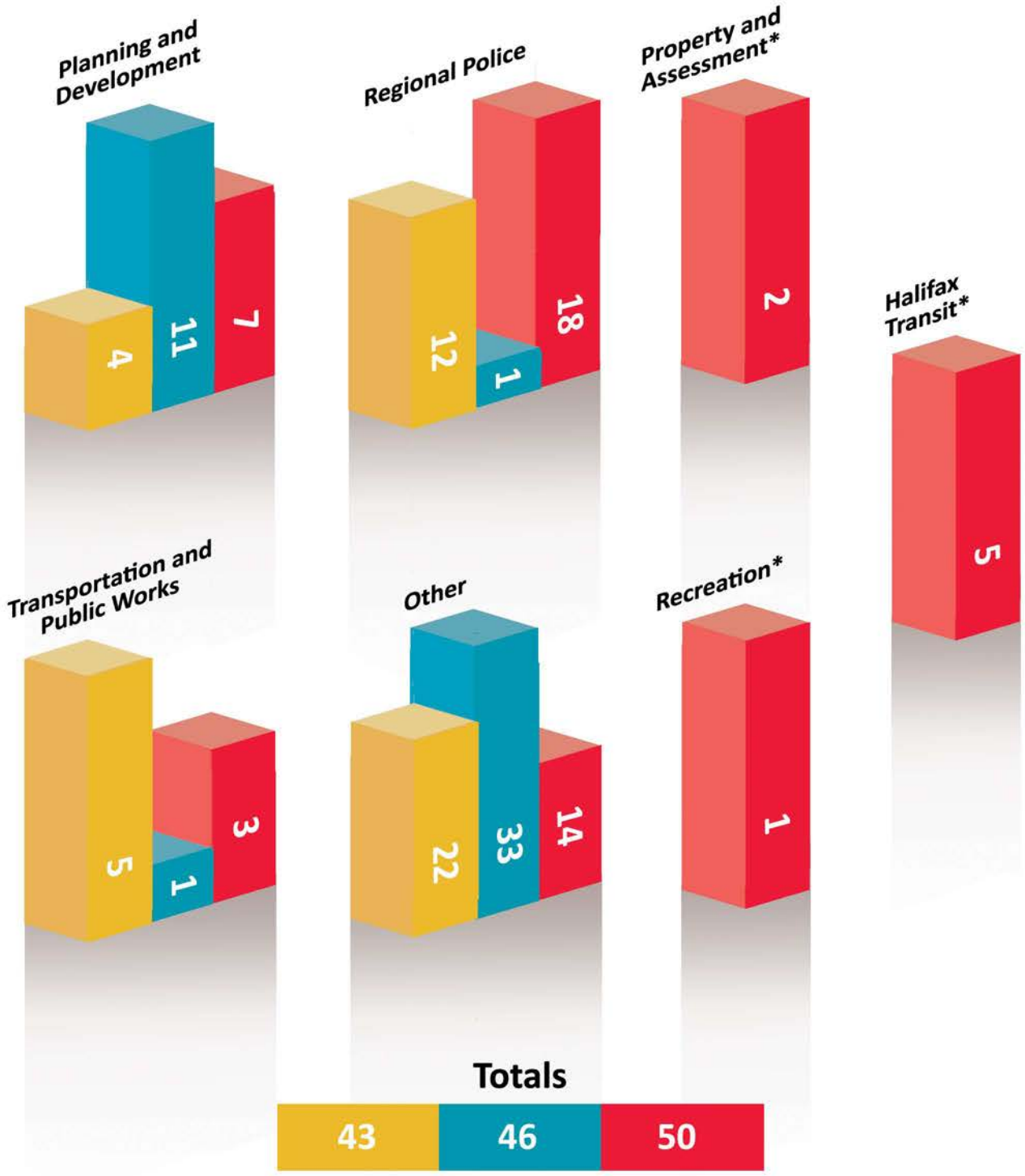


* Excluding Offender Health

Halifax Regional Municipality

2016-2017 - 2017-2018 - 2018-2019

Figure 11

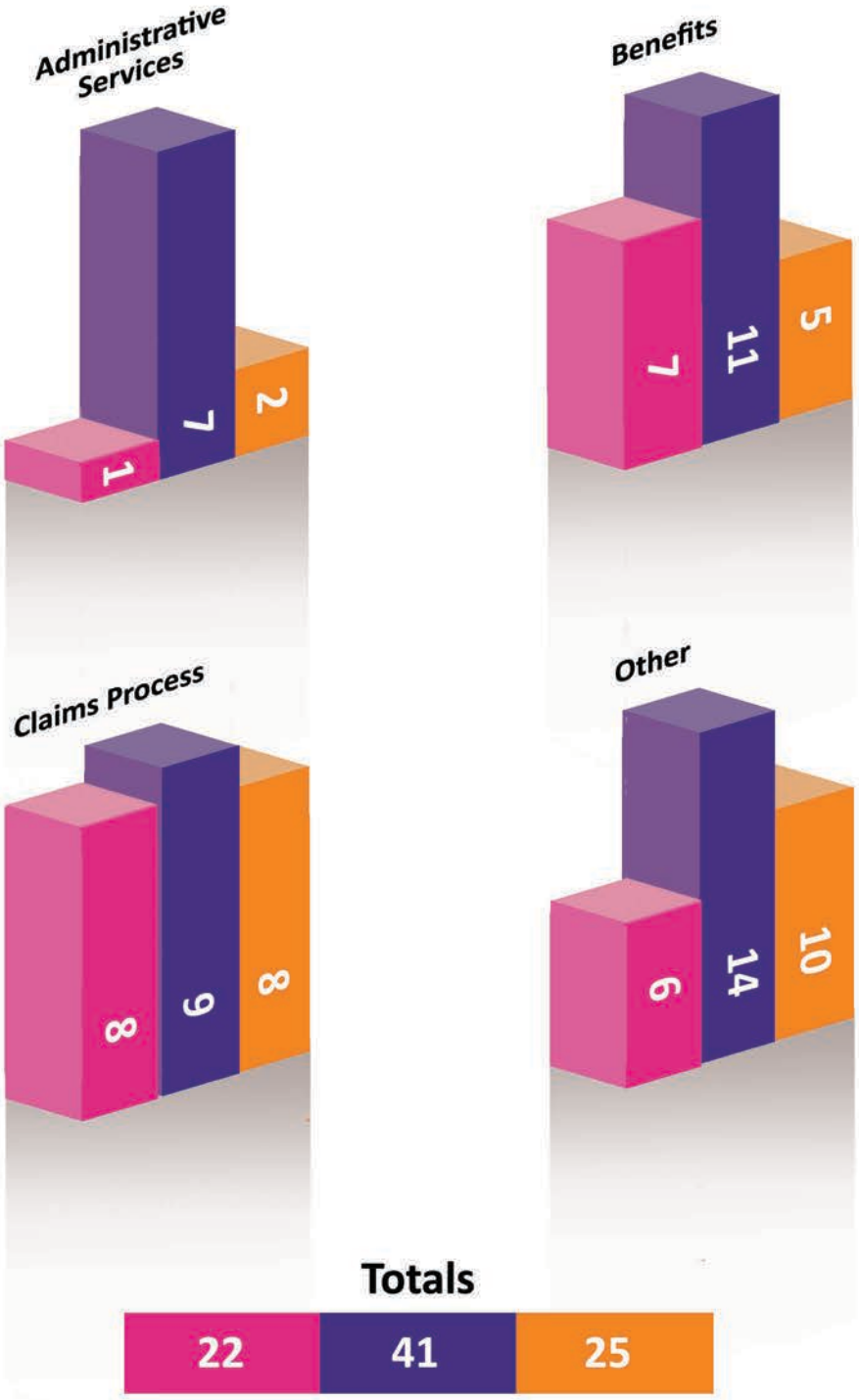


* Category added this fiscal year

Workers' Compensation Board

2016-2017 - 2017-2018 - 2018-2019

Figure 12



Respondents to Complaints

The table below (Figure 13) lists all public bodies that were the object of complaints under the Ombudsman Act and the PIDWA for 2018-2019. 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 13

1	Amherst (Town)
2	Antigonish (Municipality)
1	**Business**
13	Cape Breton Regional Municipality
1	Clare (Municipality)
4	Colchester (Municipality)
1	Communications Nova Scotia
2	**Communities Culture and Heritage**
498	**Community Services**
5	Cumberland (Municipality)
1	Digby (Town)
3	Digby (Municipality)
4	**Education and Early Childhood Development**
1	Efficiency Nova Scotia
8	**Environment**
1	**Fisheries and Aquaculture**
1	Guysborough (Municipality)
50	Halifax (Municipality)
87/112 (199)	**Health and Wellness**/Nova Scotia Health Authority*
35	Human Rights Commission
3	Information and Privacy Commissioner
2	Inverness (Municipality)
2	Internal Services
3	IWK Health Centre
320	**Justice**
1	Kentville (Town)
2	Kings (Municipality)
18	**Labour and Advanced Education**
2	Labour Board
15	**Lands and Forestry** (formerly Natural Resources)
3	Lunenburg (Municipality)
4	Lunenburg (Town)
2	Mulgrave (Town)
2	**Municipal Affairs**
1	Nova Scotia Archives
3	Nova Scotia Community College
43	Nova Scotia Legal Aid Commission
3	Nova Scotia Liquor Corporation
8	Nova Scotia Police Complaints Commission
16	Office of the Ombudsman**

1	Pictou (Municipality)
3	Property Valuation Services Corporation
4	Public Prosecution Service
3	Public Service Commission
4	Queens (Municipality)
20	Regional Centres for Education (Former School Boards)
	Annapolis Valley (4)
	Cape Breton-Victoria (3)
	Chignecto-Central (1)
	Halifax (6)
	South Shore (6)
2	Richmond (Municipality)
35	**Service Nova Scotia**
3	Shelburne (Municipality)
1	Stewiacke (Town)
1	St. Mary's (Municipality)
24	**Transportation and Infrastructure Renewal**
1	Truro (Town)
3	West Hants (Municipality)
1	Westville (Town)
3	Wolfville (Town)
1	Workers' Compensation Appeals Tribunal
25	Workers' Compensation Board
1	Yarmouth (Municipality)
2	Yarmouth (Town)
1422	**Total Complaints with respondents**
625	**Total complaints with no respondent - include non-jurisdictional complaints, information requests and general inquiries**
2047	**TOTAL**

* Includes Offender Health

** the Office of the Ombudsman was the respondent for 16 matters which include concerns regarding the progress, process, or outcome of files handled by Ombudsman Representatives. In all cases these matters have been reviewed and responded to by managers.

Month at a Glance

This past year the Office received on average 171 complaints and requests per month, excluding contacts with youth in care and custody. Year by year approximately one third of complaints to the Office are non-jurisdictional and referred elsewhere. In this month at a glance 39% were non-jurisdictional.

The following table (Figure 14) breaks down the month of September 2018. 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.

September 2018 - 178 Complaints

Figure 14

34 Community Services
Children, Youth, and Families (21)
Employment Support and Income Assistance (6)
Housing (7)

1 Cumberland (Municipality)
Communication / employment issue (1)

1 Department of Business
Innovacorp (1)

1 Halifax (Municipality)
Halifax Regional Police (1)

9 Health and Wellness
Continuing care (7)
Pharmacare (1)
Health information inquiry – referral (1)
-

1 IWK Health Centre
Nova Scotia Youth Centre – Young Person healthcare (1)

32 Justice
Adult Corrections (22)
Court Services (1)
Legal Services (1)
Maintenance Enforcement (5)
Public Trustee (1)
Youth Corrections (2)

1 Kings (Municipality)
Municipal Airport (1)

2 Labour and Advanced Education
Training program (1)
Wrongdoing allegation (1)

1 Lands and Forestry (formerly Natural Resources)
ATV enforcement (1)

1 Nova Scotia Environment
Culverts / watercourse (1)

11 Nova Scotia Health Authority
East Coast Forensic Hospital (2)
Mental Health (3)
Offender Health (3)
Service Delivery (3)

3 Nova Scotia Human Rights Commission
Communication (2)
Complaint handling (1)

1 Nova Scotia Legal Aid
Representation (1)

2 Regional Centres for Education
Halifax Regional (1)
Cape Breton-Victoria Regional (1)

1 Service Nova Scotia
Registry of Motor Vehicles (1)

1 Town of Wolfville
Public Works (1)

4 Transportation and Infrastructure Renewal
Highways (2)
Human Resources (1)
Vehicle Compliance (1)

1 Workers' Compensation Board
Claims (1)

70 No Respondent
Includes non-jurisdictional complaints and general inquiries / information requests

COMPLAINT RESOLUTION PROCESS

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

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 begins analyzing how it may be handled

Often Inquiries or Administrative 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

Most final reports include recommendations from this Office

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

Recommendations

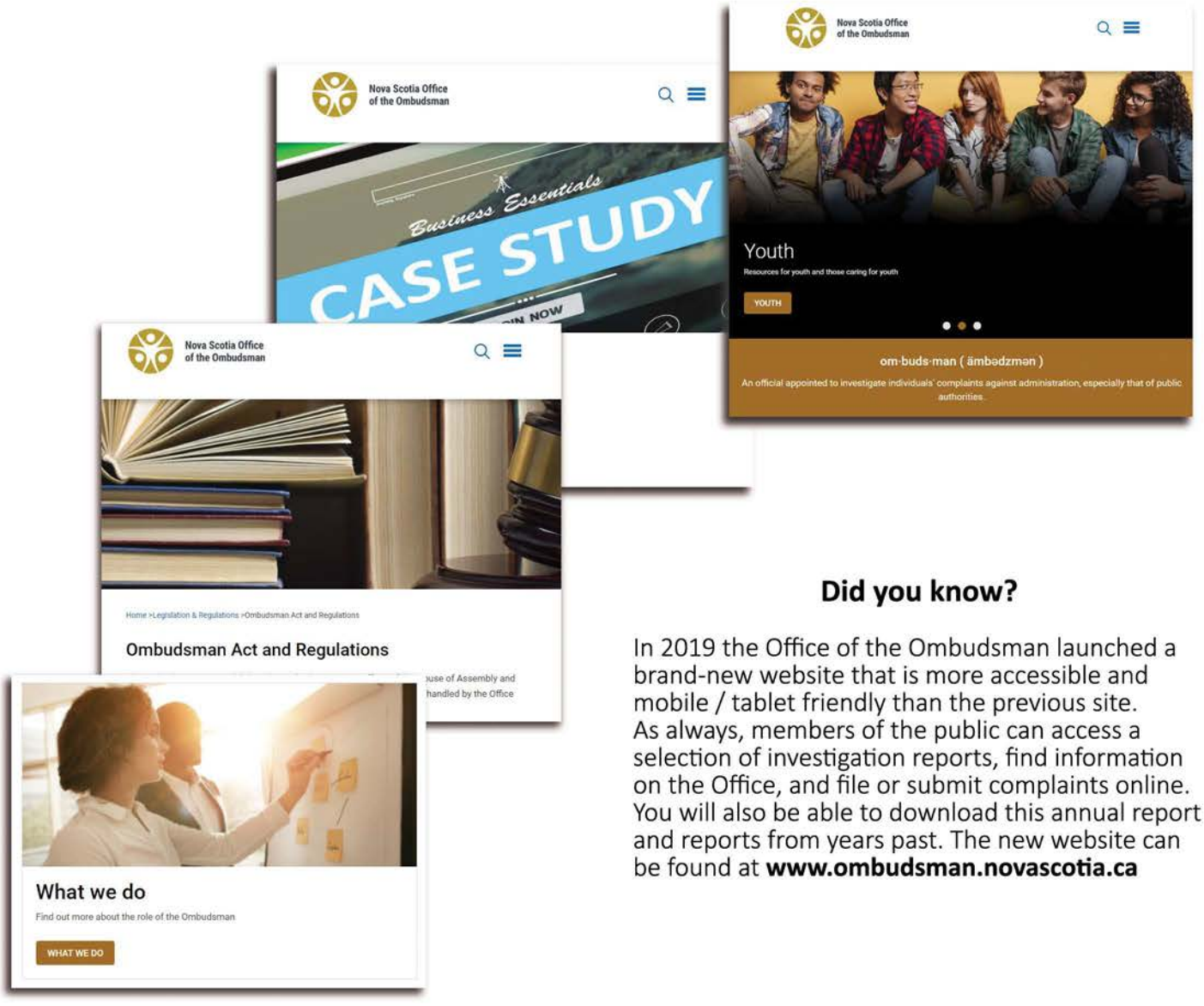
In most cases, respondents choose to implement the recommendations in full

This Office monitors recommendations until they are implemented

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 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.

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 eight in-depth investigations were conducted. The Office received two disclosures of wrongdoing under the PIDWA that were investigated pursuant to that Act. One allegation of wrongdoing led to a formal investigation under the PIDWA. There were no findings of wrongdoing, and no recommendations issued under the PIDWA.



Did you know?

In 2019 the Office of the Ombudsman launched a brand-new website that is more accessible and mobile / tablet friendly than the previous site. As always, members of the public can access a selection of investigation reports, find information on the Office, and file or submit complaints online. You will also be able to download this annual report and reports from years past. The new website can be found at **www.ombudsman.novascotia.ca**

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 Reviews. Of these complaints, a small number become Formal Investigations. Many of the 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. 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 five Own Motion Investigations and Policy Reviews.

Youth Investigations

Complaints that are submitted to the Office by children and youth in care or custody of the Province 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 are able to 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 Human Rights Commission. This past year, two complaints were investigated under the PIDWA.

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 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.

Pages 30-32 describe the recommendations issued in 2018-2019. They also describe the public body involved as the respondent, as well as the nature of the complaint. There were 17 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 2018-2019. Of the 17 recommendations issued, 14 have been accepted and are being monitored for implementation. One recommendation was accepted and implemented, and two recommendations were not accepted by the Department of Agriculture.

COMPLAINT RESOLUTION

Complaint

This Office received a complaint with concerns regarding the operation of the Nova Scotia Farm Loan Board (NSFLB), including allegations involving procurement practices, and ineffective management

Respondents

Department of Agriculture
Nova Scotia Farm Loan Board (NSFLB)

Recommendations

1. The Department of Agriculture, in consultation with the Crown Lending Agencies, clarify and re-state its position regarding the mandate of the Agencies, in particular to establish whether the current orientation towards competing with private lending agencies adequately reflects the Department's intentions and purposes.

2. The Department of Agriculture, in consultation with the Crown Lending Agencies, undertake an assessment of the NSFLB and the Fisheries and Aquaculture Loan Board (FALB) to determine if they are adequately resourced in terms of the number and descriptions of employee positions, and equipped in terms of office space, database, and records systems.

3. The Department of Agriculture, in consultation with the Crown Lending Agencies, develop and implement guidelines and/or policy regarding conflict of interest that requires employees to recuse themselves from any decision-making or advocacy regarding loans that may benefit family members. Education should be provided to staff on conflict of interest guidelines and confidentiality requirements.

4. The Crown Lending Agencies, in collaboration with the Department of Finance and Treasury Board, review procurement practices to ensure adequate and clear documentation regarding the administration of procurement contracts and compliance with all procurement policies.

Recommendations 1 and 3 were not accepted by the respondent. Recommendations 2 and 4 have been implemented.

Complaint

A senior contacted this Office after their home care nursing service was discontinued. The investigation included a review of the senior's continuing care file and review of relevant provincial and Nova Scotia Health Authority (NSHA) policy. There were conflicting reports as to why the home care nursing services were removed from the senior's home. The investigation determined that the approach taken was out of line with policy and procedures. *See the full case study on page 43 of this report.*

Respondents

Nova Scotia Health Authority (NSHA)
Department of Health and Wellness (DHW)

Recommendations

Nova Scotia Health Authority (NSHA):

1. Review current policy utilized in the NSHA zones to identify, investigate, and respond to risk in the provision of Continuing Care services, such as the former [District Health Authority] High Risk Notification and the Written Client Contracts Policy, to ensure zones are utilizing current NSHA policy, promote consistency, and to identify policies that require development on a NSHA-wide basis.

2. Finalize and implement procedures, such as those associated with the Safety Risk Assessment in Community Settings Policy, across all NSHA zones related to addressing risk/safety concerns in providing care to home care clients. This should include procedures, protocols, and/or guidelines related to:

- defining and identifying risk
- investigating risk
- evidence-based risk assessment and decision-making processes
- documentation of any investigation/assessment of risk, including any consultation with internal and external stakeholders
- involvement of client/substitute decision makers in the process.

3. Complete the review of the draft NSHA Continuing Care Appeals Policy to ensure it reflects the DHW Home Care Policy requirements and incorporates clients/substitute decision makers ability to appeal decisions related to their access to home care nursing services, including situations where the client and/or environment is considered high-risk.

4. Develop and implement a NSHA Continuing Care Policy on client's rights, to ensure compliance with the DHW Home Care Policy and to promote awareness of client's rights and a consistent understanding and approach to client rights. This information should be made readily available to clients and/or family/substitute decision makers.

5. In collaboration with the DHW, ensure that refusals and terminations of home care services initiated by the service provider due to assessed risk/safety concerns, including nursing services provided by the NSHA, is incorporated into regular reporting to the DHW to ensure adequate oversight and compliance with provincial policy. Such a process should include a method to track statistics to identify and address trends and gaps in service delivery in this area.

6. Provide training and education to relevant staff and managers on NSHA policy related to
• identifying, assessing, and addressing risk/safety concerns in providing care to home care clients;
• the home care client appeal process; and
• client rights.

7. Develop and implement policy regarding receiving and responding to complaints involving home care nursing services, specifically those nursing services provide by the NSHA.

8. Conduct an independent assessment of the complainant's file to assess risk and eligibility for home care nursing services.

Department of Health and Wellness (DHW):

1. Explore options to review and amend existing legislation related to home care services to ensure it provides an adequate regulatory framework for the administration of home care services.

2. In collaboration with the NSHA, review and, where appropriate, revise the Continuing Care Home Care Policy Manual to ensure it reflects the organizational changes established in the Health Authorities Act and any requirements of the Accountability Framework.

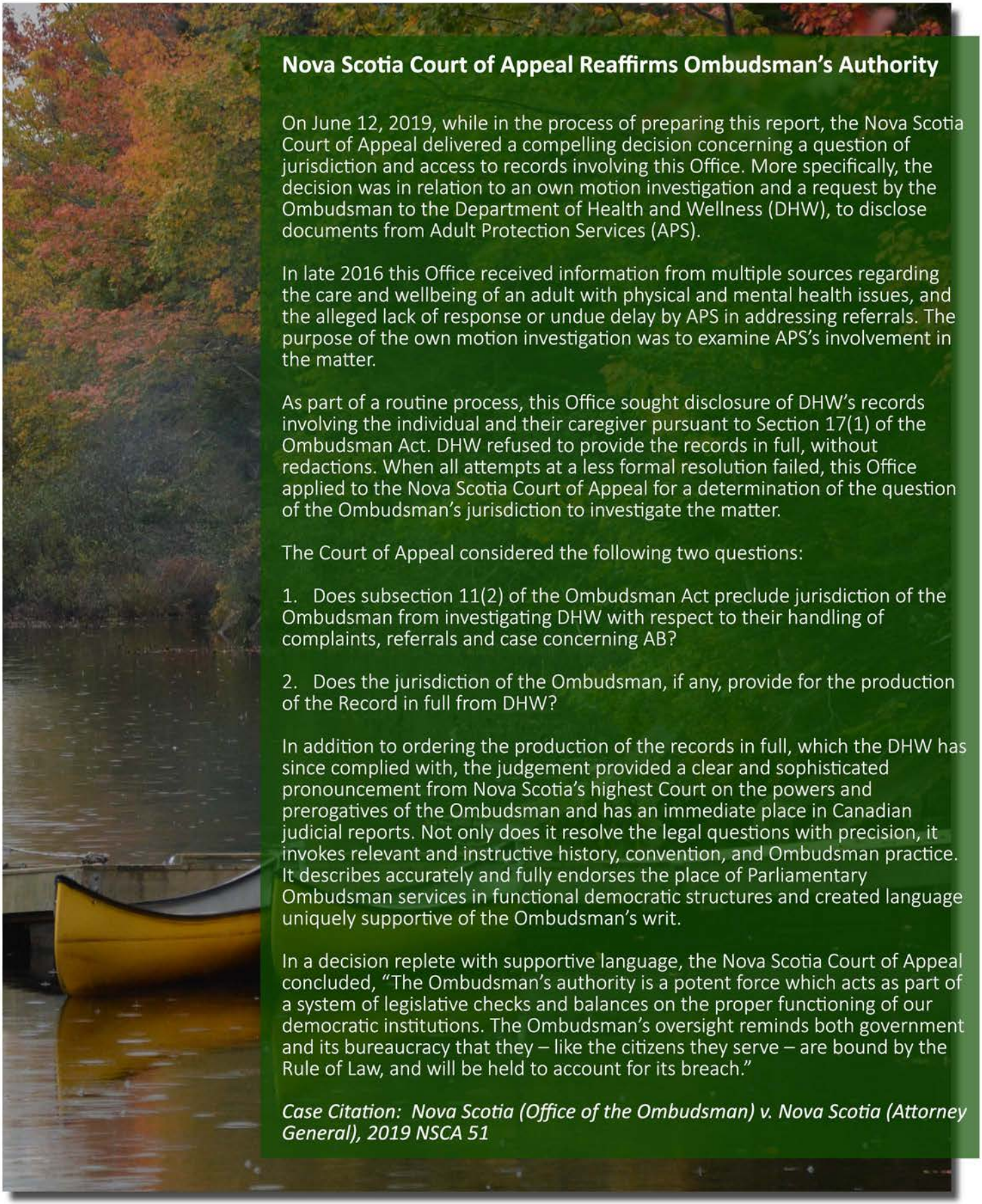
3. Incorporate NSHA-provided home care nursing services into the established home care audit process to confirm compliance with provincial policy, standards, and service agreements.

4. In collaboration with the NSHA, ensure that refusals and terminations of home care services initiated by the service provider due to assessed risk/safety concerns, including nursing services provided by the NSHA, is incorporated into the regular reporting to the DHW to ensure adequate oversight and compliance with provincial policy. Such a process should include a method to track statistics to identify and address trends and gaps in service delivery in this area.

5. Develop and implement a policy to receive and respond to complaints involving home care services, including nursing services administered by the NSHA, that are within the purview of the Department. This policy should be made publicly available and clearly outline the DHW responsibilities and actions when dealing with public complaints involving Continuing Care programs and services, including timeframes to respond and/or investigate these complaints.

Recommendations 1 and 3 – 7 for the Nova Scotia Health Authority are being monitored for implementation. Recommendations 2 and 8 have been implemented by the Health Authority

Recommendations 2, 4, and 5 have been implemented by the Department of Health and Wellness. Recommendations 1 and 3 are being monitored for implementation



Nova Scotia Court of Appeal Reaffirms Ombudsman's Authority

On June 12, 2019, while in the process of preparing this report, the Nova Scotia Court of Appeal delivered a compelling decision concerning a question of jurisdiction and access to records involving this Office. More specifically, the decision was in relation to an own motion investigation and a request by the Ombudsman to the Department of Health and Wellness (DHW), to disclose documents from Adult Protection Services (APS).

In late 2016 this Office received information from multiple sources regarding the care and wellbeing of an adult with physical and mental health issues, and the alleged lack of response or undue delay by APS in addressing referrals. The purpose of the own motion investigation was to examine APS's involvement in the matter.

As part of a routine process, this Office sought disclosure of DHW's records involving the individual and their caregiver pursuant to Section 17(1) of the Ombudsman Act. DHW refused to provide the records in full, without redactions. When all attempts at a less formal resolution failed, this Office applied to the Nova Scotia Court of Appeal for a determination of the question of the Ombudsman's jurisdiction to investigate the matter.

The Court of Appeal considered the following two questions:

1. Does subsection 11(2) of the Ombudsman Act preclude jurisdiction of the Ombudsman from investigating DHW with respect to their handling of complaints, referrals and case concerning AB?

2. Does the jurisdiction of the Ombudsman, if any, provide for the production of the Record in full from DHW?

In addition to ordering the production of the records in full, which the DHW has since complied with, the judgement provided a clear and sophisticated pronouncement from Nova Scotia's highest Court on the powers and prerogatives of the Ombudsman and has an immediate place in Canadian judicial reports. Not only does it resolve the legal questions with precision, it invokes relevant and instructive history, convention, and Ombudsman practice. It describes accurately and fully endorses the place of Parliamentary Ombudsman services in functional democratic structures and created language uniquely supportive of the Ombudsman's writ.

In a decision replete with supportive language, the Nova Scotia Court of Appeal concluded, "The Ombudsman's authority is a potent force which acts as part of a system of legislative checks and balances on the proper functioning of our democratic institutions. The Ombudsman's oversight reminds both government and its bureaucracy that they – like the citizens they serve – are bound by the Rule of Law, and will be held to account for its breach."

Case Citation: Nova Scotia (Office of the Ombudsman) v. Nova Scotia (Attorney General), 2019 NSCA 51

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.

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, and inmates 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 staff.

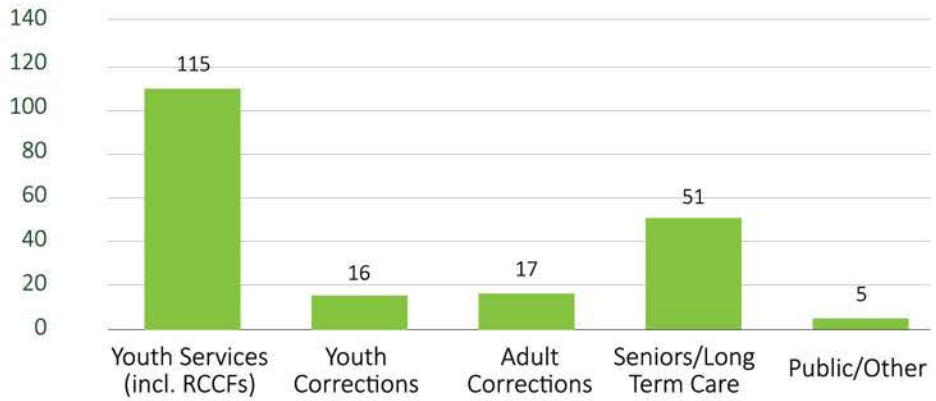
Site-visits are scheduled on a regular and as needed basis. For example, adult correctional facilities and RCCFs are visited quarterly, Wood Street Centre Campus, the Nova Scotia Youth Centre, and the IWK Secure Care Unit are visited monthly. Ombudsman Representatives also prepare written reports detailing their visit, 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.

For example, this year Ombudsman Representatives participated in the Yarmouth 50+ Expo, the Hants County Seniors Expo, and the Truro Seniors Wellness Expo. Ombudsman Representatives gave presentations to the Dartmouth Kiwanis Club, Laing House, Hope Landing, the Dalhousie School of Social Work, the Eastern College Child and Youth Care program, Schulich School of Law, and attended a meeting of the Nova Scotia Council of the Family's "Dream Team."

Ombudsman Representatives also attend the Federation of Foster Families Annual General Meeting, and the magazine launch party for The Voice Youth in Care Newsletter. The Ombudsman, joined by a staff person, who is a registered Social Work candidate, attended the "Reclaiming Social Work" symposium for Child Welfare Social Workers. The Ombudsman and the Executive Director also gave a presentation to the Nova Scotia Home for Colored Children Restorative Inquiry.

Outreach Sessions
Figure 15



The Office of the Ombudsman also continues to focus outreach on underrepresented or underserviced groups. Efforts continue in reaching out to the 2SLGBTQII community, Indigenous persons, African Nova Scotians, and new Canadians, among others. We continue to develop this approach and reach out to groups offering presentations and roundtable discussions.

Ombudsman Representatives sit on the board of the Nova Scotia Council for the Family, the Council's Youth in Care Committee, the Canadian Council of Child and Youth Advocates, the Forum of Canadian Ombudsman, 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.

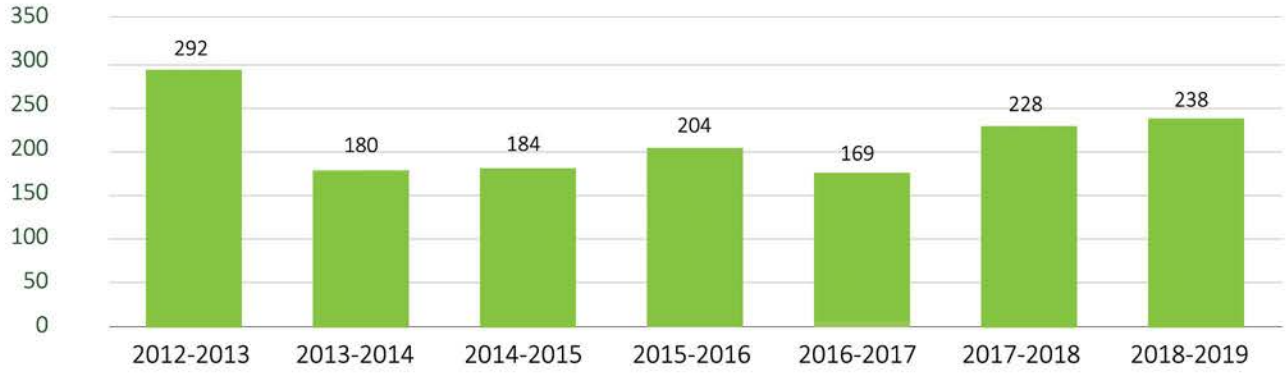
Correctional Services

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 and as needed basis. 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 the 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 systematic issues.

Figure 16 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 the Nova Scotia Health Authority. For a total of all inmate and public complaints about correctional services see figure 8. In 2018-2019 there were 238 new complaints by inmates about correctional services, several of those complaints were referred to the internal complaint process.

Correctional Services Complaints
Figure 16



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 vulnerable 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 or abuse.

Type of Youth Complaints

Most youth complaints come from youth in care and custody. This reality is reflected in the categories in Figure 17. For instance, the category "food" is referring to the food provided in government facilities that house youth or for another example, "staff" is referring to facility staff.

Figure 17

23	Staff
3	Programming
13	Education
15	Placement
24	Discipline
5	Amenities
18	Legal/Lawyer
6	Facilities/Building
3	Food
8	Recreation
2	Human Rights
9	Social Worker
6	Issues with co-resident
6	Communication
14	Healthcare
4	Personal Property
3	Privileges
15	Policy and Procedures
24	Other
201	**Total**

Senior-Specific Issues

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

Figure 18

10	Continuing Care/Nursing Homes
13	Housing
2	Pharmacare
3	Other Community Services
4	Other Health Care
23	Other
9	Non-Jurisdictional (referrals)
64	**Total**

OMBUDSMAN YOUTH COUNCIL

A product of the 2017 Youth Summit, the Ombudsman Youth Council (OYC) is an initiative that is youth designed, youth led, and offering a platform for youth voice within Nova Scotia.

In November 2018, thirteen (13) youth between ages 13 and 18 were selected from across all regions of the province. This group was selected as the first members of the OYC and the architects of the project, offering insight to the design and purpose.

Meetings have been held both in-person and via telecommunications, such as Skype and Google Hangouts.

As the inaugural year of the OYC draws to a close, the youth participants have provided the following information:

(1) The OYC will be used as a platform for youth to express concerns or complaints to the relevant government departments, agencies, or bodies.

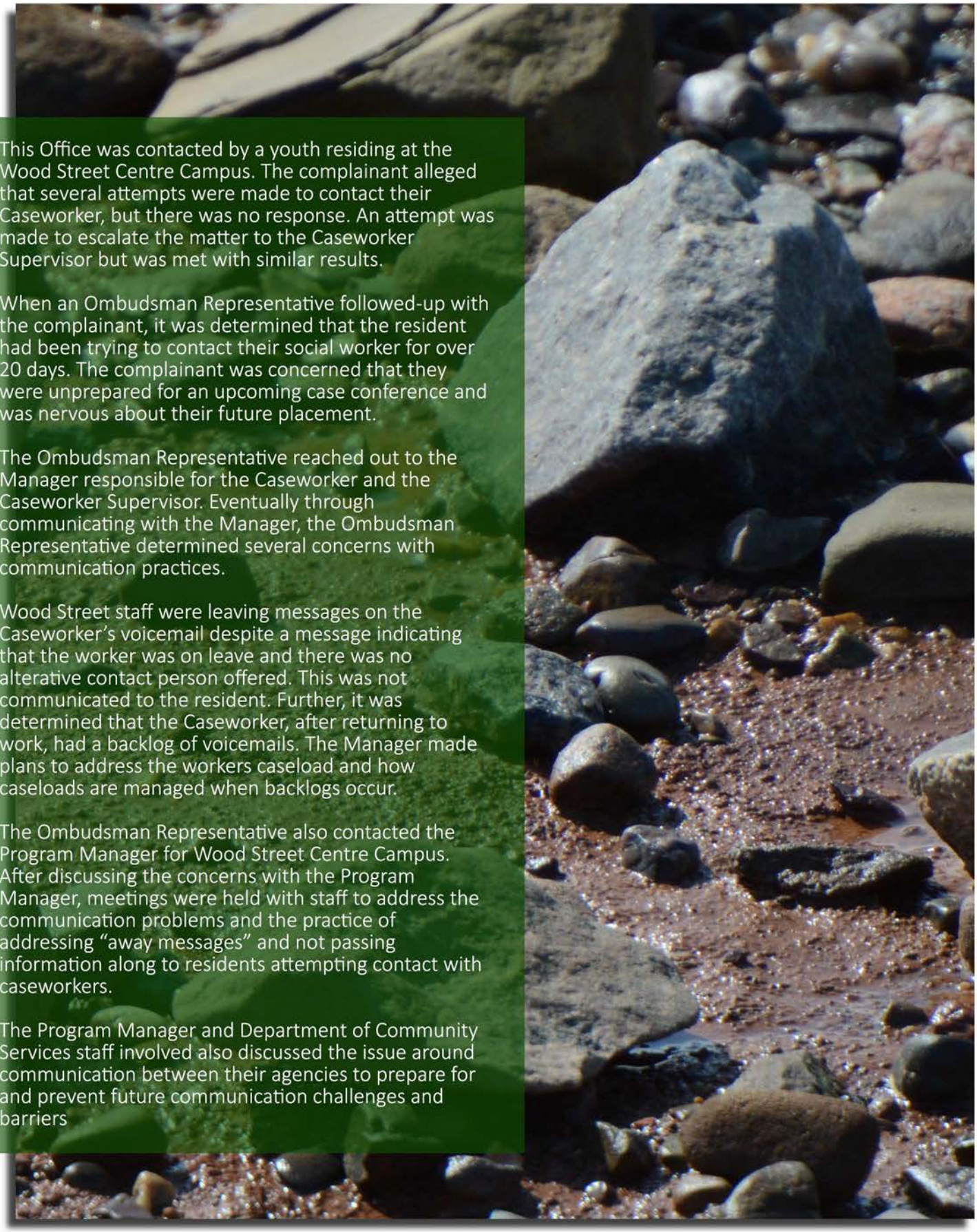
(2) The OYC will focus on promoting youth-focused initiatives across the province.

(3) The OYC will now be open to youth ages 12 to 19 years of age.

(4) Members will have the option of participating in a two-year term on the OYC.

As we begin to recruit for the second year of the OYC, both youth participants and office members remain highly motivated and optimistic of the future of the OYC initiative.

YOUTH CASE STUDY



This Office was contacted by a youth residing at the Wood Street Centre Campus. The complainant alleged that several attempts were made to contact their Caseworker, but there was no response. An attempt was made to escalate the matter to the Caseworker Supervisor but was met with similar results.

When an Ombudsman Representative followed-up with the complainant, it was determined that the resident had been trying to contact their social worker for over 20 days. The complainant was concerned that they were unprepared for an upcoming case conference and was nervous about their future placement.

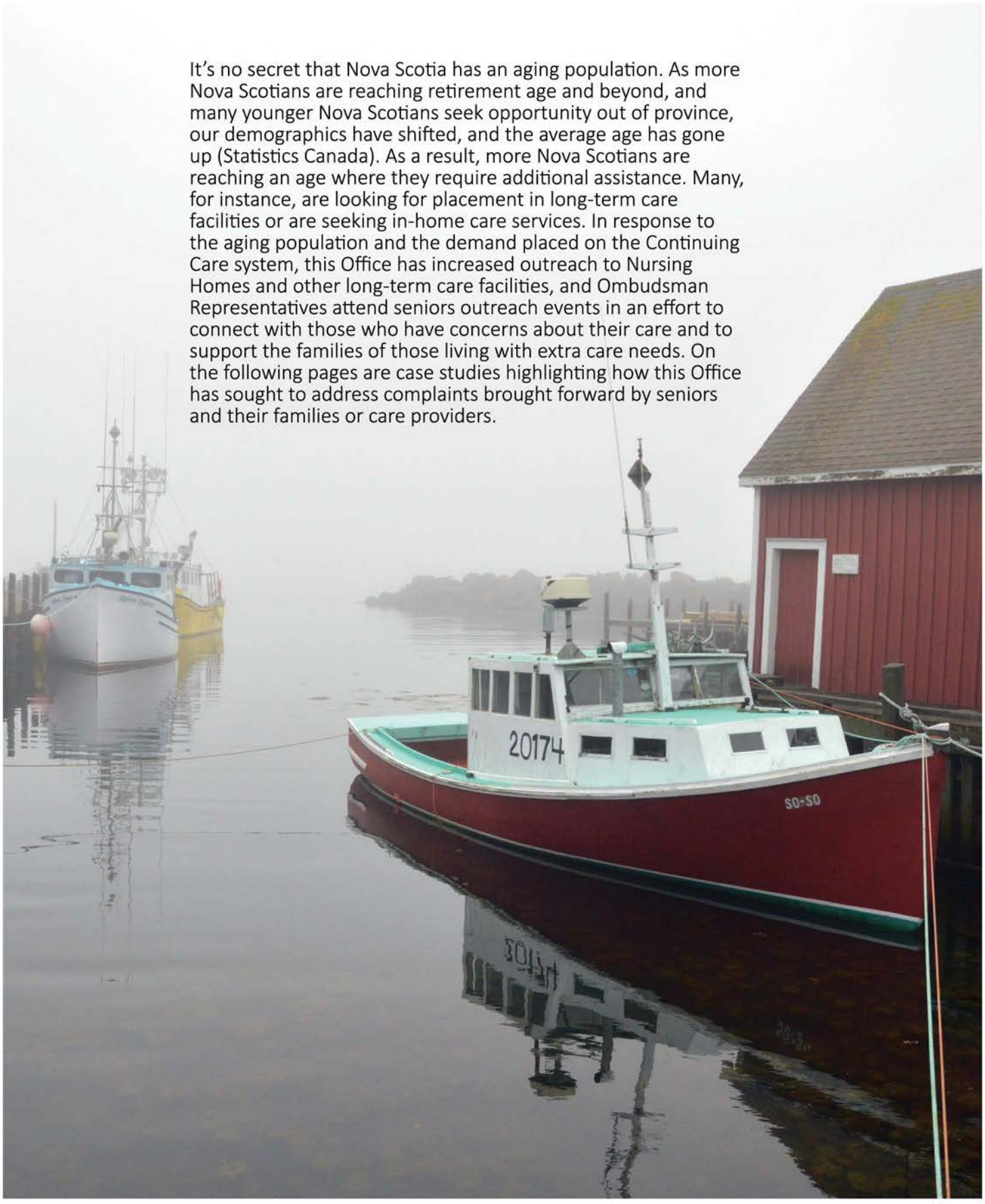
The Ombudsman Representative reached out to the Manager responsible for the Caseworker and the Caseworker Supervisor. Eventually through communicating with the Manager, the Ombudsman Representative determined several concerns with communication practices.

Wood Street staff were leaving messages on the Caseworker's voicemail despite a message indicating that the worker was on leave and there was no alterative contact person offered. This was not communicated to the resident. Further, it was determined that the Caseworker, after returning to work, had a backlog of voicemails. The Manager made plans to address the workers caseload and how caseloads are managed when backlogs occur.

The Ombudsman Representative also contacted the Program Manager for Wood Street Centre Campus. After discussing the concerns with the Program Manager, meetings were held with staff to address the communication problems and the practice of addressing "away messages" and not passing information along to residents attempting contact with caseworkers.

The Program Manager and Department of Community Services staff involved also discussed the issue around communication between their agencies to prepare for and prevent future communication challenges and barriers

It's no secret that Nova Scotia has an aging population. As more Nova Scotians are reaching retirement age and beyond, and many younger Nova Scotians seek opportunity out of province, our demographics have shifted, and the average age has gone up (Statistics Canada). As a result, more Nova Scotians are reaching an age where they require additional assistance. Many, for instance, are looking for placement in long-term care facilities or are seeking in-home care services. In response to the aging population and the demand placed on the Continuing Care system, this Office has increased outreach to Nursing Homes and other long-term care facilities, and Ombudsman Representatives attend seniors outreach events in an effort to connect with those who have concerns about their care and to support the families of those living with extra care needs. On the following pages are case studies highlighting how this Office has sought to address complaints brought forward by seniors and their families or care providers.



Case #1

Two separate individuals contacted this Office expressing concerns for the safety and well-being of a senior who was living in the community. According to the individuals, they believed the senior was at-risk and as a result, they submitted complaints or referrals to Adult Protection. This case presented an interesting issue relating to confidentiality involving multiple agencies and individuals.

The information provided by the complainants suggested the mental capacity of the senior was lacking, including their ability to provide informed consent to health care staff to speak with friends or family regarding their care. Based on the nature of the allegations, this Office determined that follow-up was required to ensure the safety and well-being of the senior. An Ombudsman Representative contacted Adult Protection to ensure they were aware of the situation. In the interim, the contact information for Mental Health Services and Adult Protection was provided to the individuals who contacted the Office. Further, they were encouraged to contact local police should they have immediate concerns over the safety of the senior.

The Ombudsman Representative confirmed that Adult Protection was aware of the situation and that Adult Protection determined the senior was not in need of protection, however a referral had been made to Continuing Care for services. The Ombudsman Representative provided details on the alleged current situation and concerns over the health and well-being of the senior, including their housing conditions. Adult Protection advised they would have a worker review the situation and again reach out to Seniors Mental Health regarding an assessment.

The Ombudsman Representative also contacted the Senior Safety Coordinator with the Victorian Order of Nurses (VON) Senior Safety Program. The situation was described to the Coordinator, without using any personal information, and the Coordinator confirmed that this was a situation they could assist with. The Coordinator advised that their contact information can be shared with anyone who calls the Office that may benefit from their services. Continuing Care was also contacted by the Ombudsman Representative to confirm what services, if any, could be provided to the senior.

During contact with Continuing Care and the two complainants, it was identified that there was a miscommunication or misunderstanding regarding the use of kitchen facilities by home care staff to enable them to provide meal service for the senior. This was clarified, and Continuing Care stated they would be following up regarding providing a meal service for the senior. After further involvement by Adult Protection, the decision was made to place the senior in a nursing home. Further communication from the complainants indicated they no longer had concerns regarding the senior's safety and that the senior appeared to be doing well in this placement.

This case highlights the multiple agencies and resources that can be involved in one situation. It can be challenging for individuals to know who to contact when dealing with a stressful situation. This Office can assist with identifying the stakeholders involved, contacting and making referrals to these agencies, and identifying options and resources for complainants to address the issues

Case #2

A senior contacted this Office after their home care nursing service was discontinued. They were receiving this service through the health authority and reported that they did not know why they were removed. This Office contacted the continuing care staff within the health authority zone but was unable to resolve the issue.

A formal investigation was launched that included the Nova Scotia Health Authority (NSHA) and the Department of Health and Wellness as respondents. The Department of Health and Wellness was named as a respondent as it has oversight responsibility and sets provincial policy for provincial home care services. The investigation included a review of the senior's continuing care file and review of relevant provincial and NSHA policy. Ombudsman Representatives also interviewed the senior, NSHA staff within the zone, and Department of Health and Wellness staff responsible for monitoring the administration of home care services within the province.

The investigation revealed that the NSHA zone was utilising a high-risk client policy from 2012, that had been previously developed under the District Health Authority. This policy was being used pending the development of a NSHA policy applicable to all zones. Utilising this policy, the NSHA zone developed a client contract with the senior to address safety concerns. All parties acknowledged that the terms of the contract were upheld by the senior.

There were conflicting reports as to why the home care nursing services were removed from the senior's home. Staff of the NSHA zone reported that it was due to safety issues. The NSHA's investigation into reported safety concerns in the senior's home was inadequate as it did not provide the senior with the opportunity to hear and respond to the alleged safety issues in the home. In addition, it became clear during the investigation that decision-makers did not have all the facts of the situation before supporting the decision to remove service.

The senior was initially advised by NSHA staff that they could appeal the decision to remove the service. However, they were later informed that this decision could not be appealed. It was at this point the senior contacted this Office.

It was determined that the staff of the NSHA zone believed the decision could not be appealed because it was related to safety concerns. Policy did not support this perspective. Further, the assessment of risk relied heavily on subjective information without evidence supporting the assessment.

With respect to the role of the Department of Health and Wellness in the matter, it was identified that continuing care nursing home care services provided through the health authority were not monitored through the Department of Health and Wellness home care auditing process for compliance with provincial policy and standards. While the proportion of home care nursing services provided through the health authority is small, it is important that these services are incorporated into the provincial auditing process to ensure the consistent delivery of service and adherence to provincial policy and standards.

As a result of the investigation several recommendations were issued to the NSHA and Department of Health and Wellness in July 2018 (see the recommendations section of this report).

The recommendations were accepted by the Department of Health and Wellness and the NSHA. The Office is continuing to monitor the NSHA and Department's progress in implementing the recommendations. The NSHA did complete the assessment of the senior's file, as recommended, and concluded that they could provide home care nursing services to the senior with certain provisions in place.

UPDATES

After formal recommendations are issued, this Office continues to monitor for implementation. In some cases, the monitoring may take years. Here we offer examples of some formal investigations that continue to be monitored by this Office:

Child Death Review

July 2019 will mark five years since the issuance of the Child Death Review Report and Recommendations. Since that time this Office has continued to monitor the progress of the Departments of Community Services, Justice, and Health and Wellness in implementing the recommendations.

This Office is pleased to report there has been progress in implementing some of the recommendations. Regrettably, there remain outstanding recommendations that have not been fully implemented to the satisfaction of this Office.

One of the key recommendations in the Final Report relates to the establishment of an independent inter-agency child death and critical injury review committee as a mechanism to review these types of cases with the aim to identify areas of improvement that could prevent future incidents of child death and injury. Establishing such a committee would bring Nova Scotia in line with other jurisdictions which have already established similar mechanisms and committees for this purpose. To date, this committee has not been established. This Office recognises the amount of work that can go into making the changes intended by the recommendations contained in the Final Report however, this Office also believes the amount of time that has passed since the recommendations were issued has been enough to give effect to the majority, if not all, of the recommendations.

Nova Scotia Human Rights Commission

This Office continues to monitor the implementation of the recommendations issued in March 2017 in our Own Motion investigation involving the Nova Scotia Human Rights Commission (NSHRC).

The implementation of the recommendations is moving forward, and this Office recently had the opportunity to review and provide comment on draft policies and procedures regarding the NSHRC dispute resolution process. This Office continues to monitor the implementation of the remaining recommendations.

LOOKING AHEAD

Looking toward the next fiscal year, the Office of the Ombudsman has several initiatives planned to support our outreach program and expand public awareness about the role and mandate of the Ombudsman. As a result of last year's Youth Summit, the Ombudsman Youth Council (OYC) will continue to meet and hear from youth who have shown interest in sharing their vision for how this Office and government interact with youth in Nova Scotia. That council was established in this fiscal year and will continue in the next. The OYC is designed so each cohort overlaps with the next, allowing for a mentorship system as one group moves from the council.

Given the success of the Youth Summit, this Office is also exploring the possibility of hosting a Seniors Summit within the next few years. The intention of the summit would be similar, educate seniors and their families or caregivers about the role of the Ombudsman, engage with seniors and hear what types of issues are affecting them as a group, and examine that information to help direct our Seniors Services team.

Ombudsman Representatives visit long-term care facilities to provide presentations to staff, residents, and family members. The intent is to support those in long-term care with any concerns they may have about services they receive from government funded programs. As the population ages it important to grow this component of our outreach program.

In fiscal 2019-20, Ombudsman Representatives are giving key presentations at the National Conference of the Forum of Canadian Ombudsman in Toronto. In September 2019, representatives from this Office will participate in the Canadian Council of Child and Youth Advocates Biennial Conference, held in Winnipeg. The conference will include a panel on youth outreach with one of our Ombudsman Representatives sitting on that panel.

This Office also has a mandate through the Public Interest Disclosure of Wrongdoing Act (PIDWA). That Act establishes Designated Officers within provincial government departments who may receive disclosures of wrongdoing from government employees. This Office will continue to expand its efforts to educate those Designated Officers on how to handle disclosures and what their responsibilities are according to the Act. In 2019 the Office will also host a conference of representatives from around the country who have legislated disclosure mandates in various jurisdictions. The conference will be an opportunity learn from our colleagues in the disclosure of wrongdoing field as well as to show them some Nova Scotian hospitality.

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:
5670 Spring Garden Road, Suite 700
Halifax, Nova Scotia B3J 1H6

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