Office of the Ombudsman

Annual Report
2013 - 2014

"...fairness, integrity, good governance"

NOVA SCOTIA

March 31, 2015

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 of 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, 2014.

Respectfully,

Christine Delisle-Brennan
A/Ombudsman

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I - A Message from the Ombudsman

The year under review has been unique for the Office of the Ombudsman. It has been a time of balancing change with essential continuity.

The former Ombudsman for Nova Scotia, Dwight Bishop, retired at the end of 2013 after a decade in the position. His leadership largely defined the office and the role of Ombudsman in this province.

Our challenge has been to prepare for and absorb the change that such a transition entails, and to maintain and extend the services of the office. As Acting Ombudsman, I believe we continue to achieve our objectives, with the support of a dedicated staff.

The Nova Scotia Office of the Ombudsman discharges three oversight mandates. It provides a general avenue for complaints of all Nova Scotians about their municipal and provincial governing bodies. It offers specialized services for youth and seniors. It is responsible for the Public Interest Disclosure of Wrongdoing Act (PIDWA).

Under the Ombudsman Act Nova Scotians can bring forward complaints about the administration of any law of the province by a government department or official. The same applies to municipal units or municipal officers. Investigations by this office usually are triggered by such complaints. The Ombudsman also has the right to investigate matters at his or her initiative, known as own-motion investigations.

The Ombudsman acts as a child and youth advocate. In carrying out this mandate Ombudsman Representatives make frequent visits to residential child-caring and other facilities responsible for children in care and custody of the province. They meet face to face to hear the complaints and concerns of residents and staff, and they usually resolve issues quickly with the co-operation of staff at each home or facility.

Under the PIDWA, the office hears and investigates complaints from public service whistleblowers and members of the public. Typically these involve allegations that can range from malfeasance to criminal activity. Such complaints are few in number, but they usually entail extensive and in-depth investigations.

"I believe we continue to achieve our objectives, with the support of a dedicated staff."

This year the office completed an extensive investigation into the death of a child whose family had been receiving government services. The bulk of this investigation was carried out in 2013-2014, and the report was released to the public in July of 2014.

An investigation into the province's Residential Child-Caring Facilities was completed this year. It was initiated by this office as an own-motion investigation and recommendations were issued.

The Office of the Ombudsman generally receives the co-operation of government officials and senior managers, even as we investigate the work of their departments and agencies when complaints are received.

Under the Ombudsman Act Nova Scotians can bring forward complaints about the administration of any law of the province by a government department or official... Under the PIDWA, the office hears and investigates complaints from public service whistleblowers and members of the public.

Opportunities for respondents to comment on or challenge our conclusions and recommendations before reports are finalized help ensure this co-operation, as do our efforts to approach our inquiries in a non-confrontational manner, and to be determinedly fair.

This year we did receive a challenge to our jurisdiction from a government department which asserts we are not mandated to carry out investigative functions regarding departmental business. This office has applied to the Nova Scotia Court of Appeal for a determination of the issue.

In 2014-2015 we are optimistic about our work, and we appreciate the trust and reliance Nova Scotians continue to demonstrate in the services we provide.

Christine Delisle-Brennan, A/Ombudsman

II - About the Office

Mission

Our mission is to promote the principles of fairness, integrity, and good governance.

Role and Mandate

Our role is to ensure government decisions and processes are open, transparent, consistent, and fair.

Our mandate extends to all individuals who receive services from, or are impacted by, provincial and municipal governments.

Provincial government employees and members of the public have an avenue to make allegations of government wrongdoing to the Ombudsman under the Public Interest Disclosure of Wrongdoing Act (PIDWA), for which the Ombudsman is responsible.

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Organization

Administration and General Operations

- Assessment Officers provide initial assessments and referrals and create records of all inquiries.
- Office Manager fulfills administrative and office management functions.
- Ombudsman Representatives handle casework and investigations.
- The core business of the office under the Ombudsman Act is the investigation and resolution of public complaints against government.

Investigation and Complaint Services (I&CS)

- Reviews and investigates general concerns about services provided by provincial and municipal government organizations and, where appropriate, makes recommendations.
- Undertakes own-motion investigations that can include policy and systemic reviews.

Youth and Seniors Services

- Reviews, investigates, and reports on the concerns of children, youth, parents, guardians, and those working in government child and youth services.
- Examines issues affecting senior citizens, particularly those who reside in provincially-licensed long-term care facilities.
- Promotes dispute resolution and makes recommendations where appropriate.
- Operates proactively to inform potential complainants of our services and to identify and address issues before they escalate.

Disclosure of Wrongdoing

- Our service under the Public Interest Disclosure of Wrongdoing Act provides an independent reporting and investigation mechanism for employees of provincial government bodies and members of the public regarding allegations of wrongdoing within government.

Human Resources

- The office has 17 full-time positions, including that of Ombudsman. It continues to benefit from a small roster of trained casual employees. This past year the roster enabled the office to accommodate staff vacancies while continuing to carry out in-depth investigations.
- Along with former Ombudsman Dwight Bishop, two other senior staff members announced their retirements during the year. Records Analyst Tom West ensured the integrity and status of the filing and records system used by the office. Prior to her retirement, Kay Rogers-Lidstone, former Manager of Youth and Seniors Services, led a team that expanded and sustained our ongoing child advocacy and seniors support services.

Training and Professional Development

In the year under review, the Nova Scotia Office of the Ombudsman was at the centre of a national developmental event for Ombudsman personnel. From June 9 to 12, 2013, our office co-hosted a joint conference in Halifax of the Forum of Canadian Ombudsman and the Association of Canadian College and University Ombudspersons.

The Forum of Canadian Ombudsman (FCO) is an umbrella organization made up of ombudsmen and their staff from public and private sectors across Canada. It provides a global network for oversight officers from all sectors to meet and exchange information and experiences.

Close to 50 speakers and presenters participated in the conference which was attended by most members of our staff. Nova Scotia presenters included former Ombudsman Dwight Bishop; James Crombie, an associate professor of philosophy at l'Université Sainte-Anne, Pointe-de l'Église, and Wayne MacKay, Professor of Law at the Schulich School of Law, Dalhousie University.

In-house training at our office continues with the integration of service units as an ongoing priority. Beyond general office training, individual representatives have had other training opportunities such as French language and management programs.

The office makes its expertise available to government and the community on request, and offers input on governance and oversight issues or policies in development or under review.

Diversity

Our office reflects the diversity of our community.

As of March 31, 2014, one staff person self-identified as aboriginal and another self-identified as a person with a disability. Two employees are council members of the LGBTI Network.

The office also employs a number of supplementary employees each fiscal year on a term or casual basis, as well as student placements.

Gender and age representations are balanced.

One Ombudsman Representative continues intensive formal French Language training, currently at the Intermediate 4 level. That Representative also is a member of the province's French Language Services Coordinating Committee.

Financial Resources

The Office of the Ombudsman spent approximately 97 per cent of its allotted budget (Figure 1). The variance reflects savings in operational expenses. The increase in spending on salaries is due to government's implementation of revised pay levels for employees excluded from bargaining units.

Figure 1

Expenses	**2012 - 2013**	**2013 - 2014**
Core Business	Budget ($ 000s)	Actual ($ 000s)
Gross Expenses	1681	1640
Net Program Expenses	1681	1640
Salaries and Benefits	1488	1483

III - The Year in Review

Complaint Resolution Process

The Office of the Ombudsman brings a variety of tools and approaches to its oversight responsibilities.

It combines an effective early resolution process, called administrative reviews, with formal or in-depth investigations and detailed examinations of systemic policy issues.

Another key strategy is proactive or pre-emptive problem solving, which is used extensively by Youth Services.

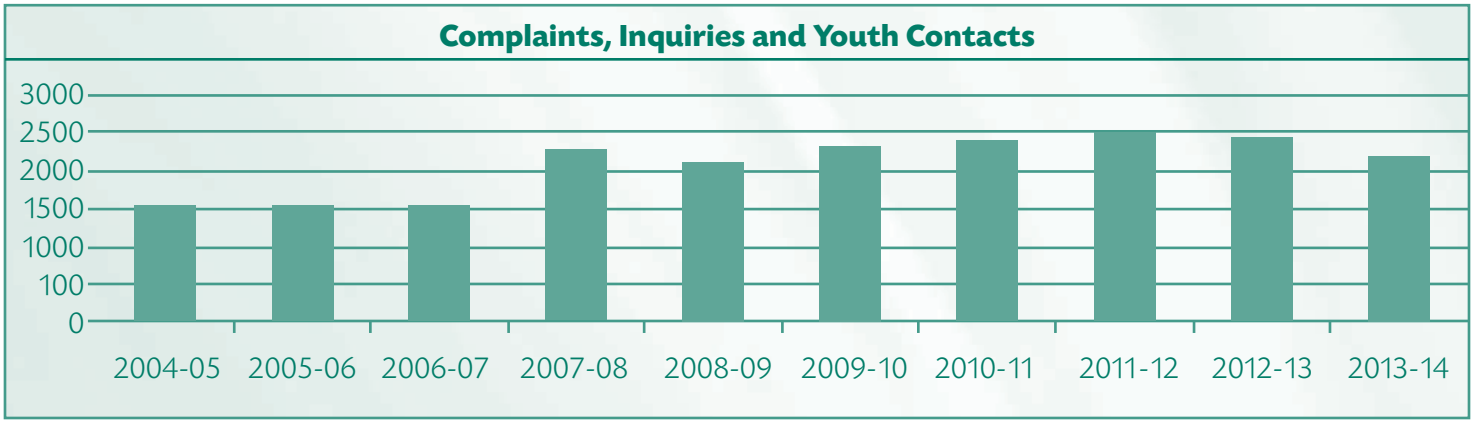
The strategy involves on-site meetings that can address specific complaints, or simply be information exchanges designed to identify issues in a preventive way before they become more complex. We do on-site visits to correctional institutions as well as to youth and seniors' facilities.

We address complaints and inquiries that come directly from the public through telephone calls, correspondence, on-site interviews, and visits to our office. While we separate inquiries and complaints on the basis of whether they are within our jurisdiction or not, all require our attention and response.

The Office of the Ombudsman brings a variety of tools and approaches to its oversight responsibilities. It combines an effective early resolution process, called administrative reviews, with formal or in-depth investigations and detailed examinations of systemic policy issues.

In 2013-2014 the number of new matters addressed within the scope of the Office of the Ombudsman was 2260, representing a small decrease from last year, but consistent with the long-term pattern. This total includes 1068 administrative review cases, 603 meetings with youth in care and custody, 23 allegations of wrongdoing under the Public Interest Disclosure of Wrongdoing Act, and 50 youth evaluation surveys. It also includes 516 inquires that were outside of the Ombudsman's jurisdiction, for which we provided various levels of assistance and information to help complainants find an appropriate review agency.

Figure 2



Administrative reviews are at the core of our resolution process. Of 1580 general complaints this year, excluding youth services, 1068 were handled as administrative reviews.

Administrative review complaints generally do not require major investigations, as the matters complained of often are less complex. A less formal approach to such complaints enables Ombudsman Representatives and staff of government departments, agencies, and commissions to resolve issues quickly and amicably. Most are resolved in a timely way through discussion with the complainant and the respondent. Typically the presence of an independent person willing to listen to all sides of an issue provides a climate and a process for agreement.

This year, 90 per cent of administrative reviews resulted in positive outcomes, exceeding our goal of 80 per cent.

Figure 3

Administrative Reviews* - Results	
Resolved through discussion with complainant and respondent ("Assistance Rendered")	819
Resolved for the complainant after brief investigation ("Resolved")	33
Resolved for the public body after brief investigation ("Properly Implemented")	99
Settled between the parties ("Settled")	9
Total with positive outcomes	**960**
Discontinued + withdrawn	92
Carried over to 2014-2015	16
Total	**1068**

* *Youth and in-depth Investigation matters are reported separately.*

Correctional Services

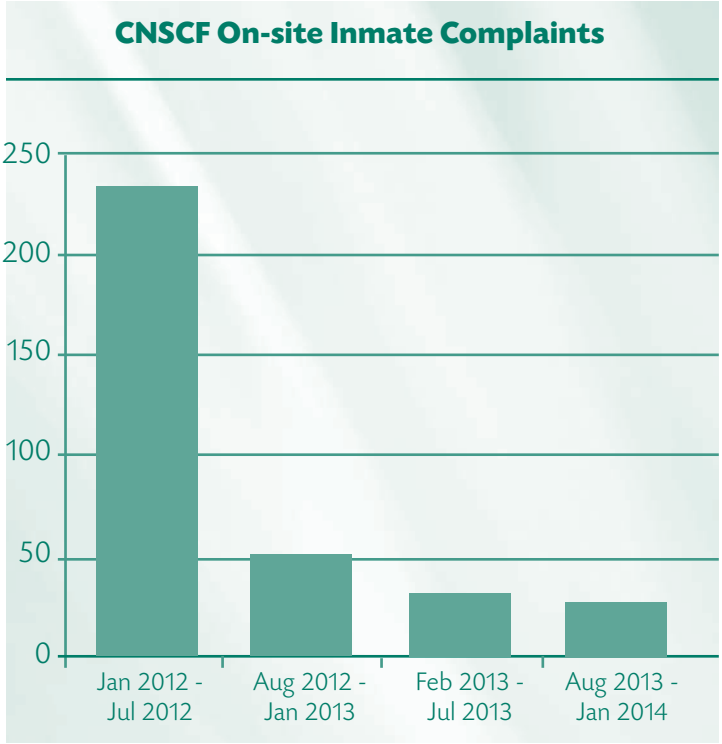
For the past three years, the office has worked to reduce the number of complaints to this office by inmates.

A key objective has been to work closely with Correctional Services staff to develop a more efficient internal complaints system. Ombudsman Representatives visit correctional facilities regularly to meet with inmates and staff, to hear complaints, and to promote on-site resolution to those complaints.

Part of the strategy has been to ensure that inmates understand and exhaust their internal complaints process. Most complaints now are addressed by Correctional Services staff at the facility level, shifting both the service and the accountability closer to the inmates and staff, and allowing this office to focus on more pervasive, system-wide corrections issues.

As illustrated in Figure 4, the decline in the number of on-site complaints at the Central Nova Scotia Correctional Facility (CNSCF) has been tracked at six-month intervals since January, 2012. During that period complaints have decreased to fewer than 30 from more than 200.

Figure 4



The drop supports the belief that many issues raised by inmates can be addressed at the facility level with improved communications. Emphasis has been placed on resolving problems informally through dialogue.

Internal initiatives launched by Correctional Services have helped address the issue. Increased training and more direct supervision have contributed to the reduction of complaints to this office.

This year the Office of the Ombudsman completed a review of a death that occurred at a Nova Scotia correctional facility. Our report contained nine recommendations for improvements at the facility. All have been accepted and implemented by Correctional Services.

Intake Analysis and Process

Three years ago the Office of the Ombudsman launched a strategy to improve the processing of complaints and inquiries. This strategy continues to work effectively and has become an ongoing feature of our operation.

The initiative involved reconfiguring the assessment and distribution process for inquiries received by the office. Most inquiries now are handled initially by experienced assessment officers. This results in more effective upfront assessment and disposition of inquiries and complaints. As a result delays for complainants have decreased, as has the number of cases previously dealt with as administrative reviews. Ombudsman Representatives now have more time to deal with complex issues, enabling an increase in the number of investigations.

Internal efficiency initiatives this year also included the consolidation under one supervisor of our two major services, Investigations and Complaints Services (I&CS) and Youth and Seniors Services (Y&SS).

Volume and Resolution of Complaints

Between 2004-2005 and 2011-2012 the number of complaints, inquiries and youth contacts by the Office of the Ombudsman increased steadily, from 1788 to 2538, a rise of more than 42 per cent.

For the past three years there have been small declines in the total numbers, mainly reflecting initiatives by the office and by Correctional Services to make the Correctional Services internal complaints system more effective.

Ombudsman investigations have benefited from this realignment of priorities, serving the greater public interest and maximizing the use of resources and skills. Examples include investigations into the South West Shore Development Association (SWSDA), the Cumberland Regional Development Authority (CRDA), and the recent Child Death Review.

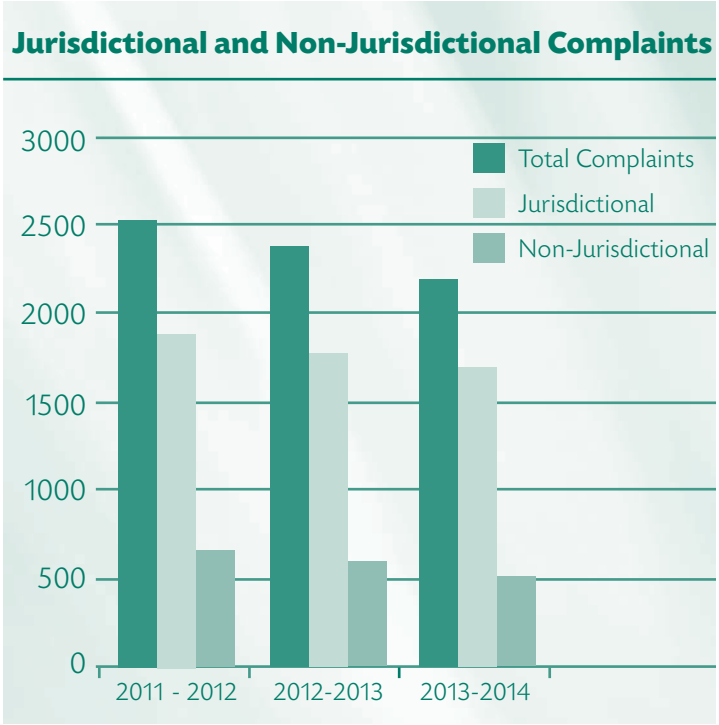
Another change has been our increased diligence in assuring that complaint mechanisms at the departmental and agency level are fully used before files are opened in this office. Our office promotes increased public awareness of avenues of redress available beyond the Ombudsman, to help move complaints to the department or agency level where they often can be addressed effectively.

Jurisdictional and Non-Jurisdictional

A third of the complaints we receive remain beyond the scope of our jurisdiction under the Ombudsman Act. This year there were 516 non-jurisdictional complaints. These frequently have other avenues of appeal and oversight, under federal agencies or departments, public service collective agreements, the courts, or through self-regulating professional associations.

Office staff redirect non-jurisdictional inquiries to the appropriate avenues of redress and provide information and follow-up. This is a significant and legitimate demand on our resources that helps citizens navigate government services. Surveys conducted by this office have indicated that this aspect of our operation is widely appreciated by complainants.

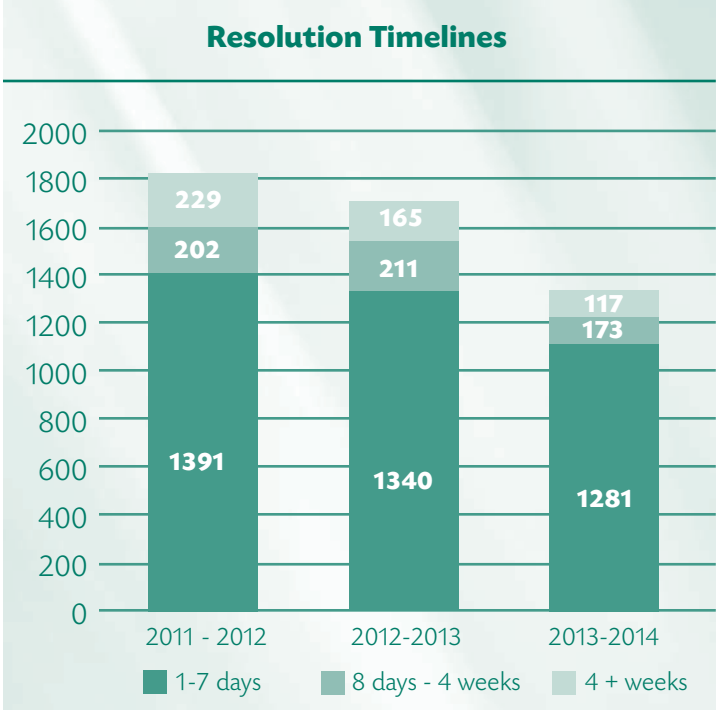
Figure 5



Resolution Timelines

Figure 6 illustrates the time frames within which our investigations and reviews are completed. The majority of cases are resolved within a week. This demonstrates the effectiveness of an informal resolution process.

Figure 6



In-Depth Investigations

The Office of the Ombudsman undertakes four types of in-depth or formal investigations.

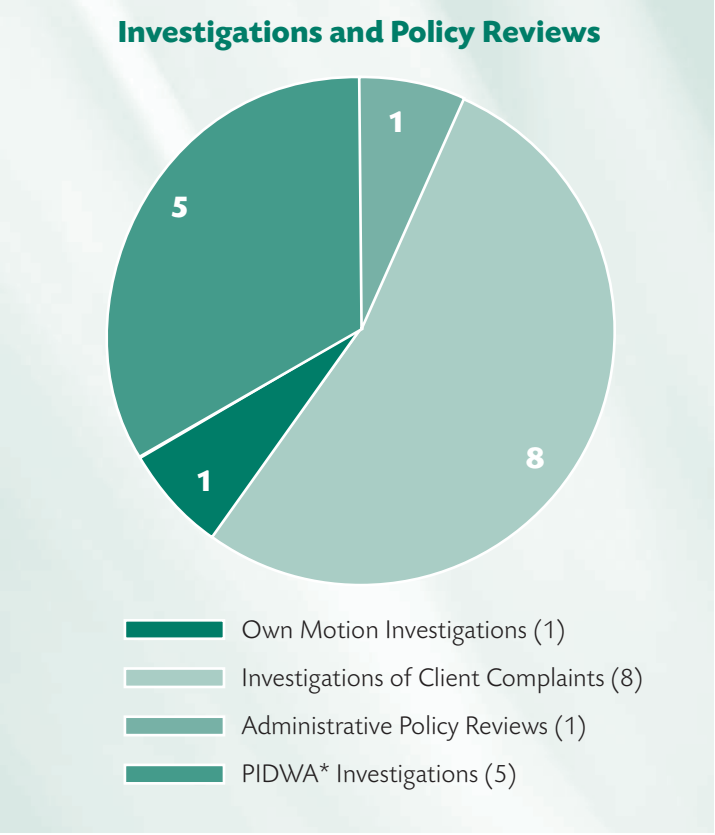
The most common types are those triggered by public complaints that cannot be resolved in a timely way by less formal means. Some cases present unusual complexity and require extensive research. Others have implications broader than the individual complaints themselves.

As noted earlier, the Ombudsman has the authority to initiate investigations that do not always arise from specific complaints. These can reflect a pattern of complaints, indicating that a particular matter requires attention. These initiatives are called own-motion investigations.

A third and relatively new genre of investigations are disclosure of wrongdoing or whistleblower cases. These usually arise from confidential information provided by public servants or members of the public regarding government activities. These cases also tend to be few in number but can be detailed and labor intensive. They often identify activities that are in breach of public policy or the law.

Finally, the office conducts reviews of existing or proposed government policies at the request of government departments and agencies or at its own initiative. The breakdown of in-depth investigations is illustrated in Figure 7.

Figure 7



** Public Interest Disclosure of Wrongdoing Act*

This year our office conducted 15 in-depth investigations. One was an own-motion investigation initiated by this office. Eight were investigations based on general complaints. Five were disclosure of wrongdoing (PIDWA) investigations and there was one review of a government policy.

The Ombudsman has the authority to initiate investigations that do not always arise from specific complaints. These can reflect a pattern of complaints, indicating that a particular matter requires attention. These initiatives are called own-motion investigations.

Investigation Outcomes

The Ombudsman Act (Section 20) sets out the authority for the Ombudsman to make recommendations to ministers and chief officers of provincial government departments and municipal units. This is done when investigations are completed. The Ombudsman requires chief officials to report back to the office on implementation of recommendations. By this authority our recommendations become mechanisms by which changes and adjustments are achieved.

Most administrative and in-depth investigations by the Office of the Ombudsman result in recommendations for change, ofte n for some type of administrative or policy adjustments.

All recommendations are supported by the findings of in-depth investigations or administrative reviews. The following (Figure 8) are examples of recommendations made during the year under review. We have noted the types of government departments and agencies that have responded and the general nature of each complaint.

Recommendations

Figure 8

Complaint	Respondent	Recommendations
Sewer Connection Permits in a Village	Village Commission	• The Village Commission to develop and implement policies relating to the Sewer Connection Permit Process and complaint resolution process. • The Village Sewer Connection Bylaw to be reviewed to ensure appropriate compliance with respect to the collection pipe and the discharging of wastewater from the property.
Discipline and Reappointment of a Physician	A District Health Authority (Physician's Privileges)	• The doctor's reappointment/recertification decision should not precede the complete execution of a settlement agreement. • The "term of reference" that insulates the doctor's position and privileges fate from the outcome of Clause 2 (in the settlement agreement) should be respected. • The doctor and the District Health Authority should consider asking Doctors Nova Scotia...or alternatively the NS College of Physicians and Surgeons, to recommend an appropriate expert to execute Item 2 of the Settlement Agreement.
County By-Law Enforcement	A County Administration	Preliminary Recommendations: • policy review; • development of Standard Operating Procedures; • development of complaint policy.

Complaint	Respondent	Recommendations
Corrections Facility Death Review	Correctional Services	• review relevant protocols, policies and procedures with staff. The occurrence of this review should be documented; • establish documentation standards regarding proper completion of the Admission Form and Security Assessment and review with staff; • review the protected protocol outlined in Correctional Services policy and procedure Subject No. 38.04.00 and train staff accordingly; • educate staff on the primary care model agreement the facility has with the local health authority; • examine the appropriateness of correctional officers monitoring inmates on health related matters, specifically when placed in health segregation; • review the quality of rounds with staff and address accordingly; • intercoms to be functioning properly immediately, particularly in health segregation unit; • establish a routine maintenance schedule and inspection of the intercom system; • ensure appropriate documentation is maintained.
Secure Rooms and Physical Restraint in Residential Child-Caring Facilities	Department of Community Services	• the Children and Family Services Act and/or Regulations be reviewed and amended accordingly, to include provisions for the use of Secure Isolation Rooms (SIRs) and physical restraint in Residential Child-Caring Facilities; • review existing training for staff at a facility to assess whether further training is required that would improve service delivery to residents and assist staff in performing their duties. Specific focus in the area of behavior management, de-escalation processes, complex trauma, and mental health; • conduct a review of the de-escalation policy with staff to ensure clarity and comprehension of process. Additional and/or refresher training in de-escalation processes be considered, including timeframes for implementation;

Complaint	Respondent	Recommendations
Secure Rooms and Physical Restraint in Residential Child-Caring Facilities *Continued*	Department of Community Services	• utilization of a child rights impact assessment screening tool, based on the UN Convention on the Rights of the Child (UNCRC), when revising, updating, or developing policy, procedures, and standards, including but not limited to: a. impact of restraint and SIR placement; b. process for debriefing with residents; c. process for access to health care provider; • continue to monitor and develop strategic plan for reducing the number/frequency of restraints; • develop and implement policy and procedures for debriefing with residents and staff to include a checklist for the debriefing process; • develop and implement policy respecting mandatory access to health care provider following restraint and placement in SIR; • establish a crisis management team capable of responding in urgent and escalating situations; • review the licensing review process and amend to ensure the views of residents are incorporated according to Article 12 of the UNCRC; • ensure copies of quarterly and annual SIR reviews are provided to the Office of the Ombudsman for review.
Death of a Child Receiving Government Services	Departments of Community Services, Justice, and Health and Wellness	**Department of Community Services** • The department undertake a review of the Child Protection Services (CPS) Policy Manual to revise, update or develop standards, including but not limited to: a. CPS caseload/workload; b. clarification of referral response time standards, including specific parameters related to the response time of low/no risk (three to 21 days) to ensure an appropriate and timely response; c. response timeframes related to key activities in a CPS investigation, such as interviewing children; d. impact of multiple referrals on CPS intake investigation timeframes and risk assessment;

Complaint	Respondent	Recommendations
Death of a Child Receiving Government Services *Continued*	Departments of Community Services, Justice, and Health and Wellness	e. a process for follow-up with family physicians after hospital emergency department treatment and medical assessments where there are suspicions of abuse and neglect; f. criteria for a referral to the IWK Child Protection Team or other expert physician(s); g. clear documentation on the case notes/file when major presenting problems are addressed; h. indication that activities and timelines within an investigation plan are assessed when a Child Abuse Register search is completed; i. required documentation once a Child Abuse Register search is completed; j. contact with non-custodial parents, and, k. internal quality assurance processes to ensure they are adequate, including file review processes, and extension of intake investigations. • develop and implement protocols between Child Protection Services and Department of Health and Wellness and District Health Authorities/IWK to facilitate communication and collaboration among these agencies; • review Policy 78 with respect to the scope and depth of the internal review and establish accountability for addressing recommendations and timeframes for implementation; • participate in an initiative to develop and implement protocols between Child Protection Services and Department of Justice, applicable to all municipal police departments, and review existing agreements with RCMP; • participate in the establishment of a provincial inter-agency team to review child deaths and critical injuries, similar to those in other jurisdictions.

Complaint	Respondent	Recommendations
Death of a Child Receiving Government Services *Continued*	Departments of Community Services, Justice, and Health and Wellness	**Department of Justice** • lead an initiative to establish a permanent child death review team. Specifically, mandate a group to examine successful models in other jurisdictions and to develop terms of reference, including the appropriateness of legislation, for a provincial inter-agency team to review the circumstances surrounding child deaths and critical injuries; • develop and implement protocols between Department of Justice, applicable to all municipal police departments, and Child Protection Services to facilitate consistent communication and collaboration among these agencies. **Department of Health and Wellness** • ensure the development of standards regarding ongoing education for healthcare professionals in the detection of child abuse; • develop and implement protocols between Child Protection Services, Department of Health and Wellness, and District Health Authorities/IWK to facilitate communication and collaboration among these agencies; • ensure the provincial information management strategy in healthcare settings across the province accommodates the requirements for access to relevant clinical information for child protection purposes; • develop and implement a consistent process/protocol for District Health Authorities/IWK to communicate child protection concerns to appropriate professionals within the healthcare field; • District Health Authorities/IWK identify healthcare professionals with expertise in detecting child abuse for consultation purposes across the province; • participate in the establishment of a provincial inter-departmental team to review child deaths and critical injuries, similar to other jurisdictions.

Complaint	Respondent	Recommendations
Environmental Assessment Issues	Nova Scotia Department of Environment (NSE)	• consider incorporating the draft Registration Document review procedures into the consolidated policy document; • consolidate procedural steps in the environmental assessment (EA) process into a policy document to guide staff in administering the process; • review the relevance and applicability of the Alternative Dispute Resolution policy as part of the EA process; • review the standards for describing the nature of the undertaking in public notices.

Outreach – Representatives in the Field

Outreach to the public and to government, an essential activity of this office, continued in the year under review on a variety of fronts. Ombudsman Representatives made presentations to community groups, employees of government departments and agencies, and to members of the public.

As a component of our Youth Services, Representatives regularly visit the Nova Scotia Youth Facility, the Cape Breton Youth Detention facility, and the Wood Street Centre. They make quarterly visits to residential child-caring facilities. They prepare written reports on those visits.

Representatives made a presentation to the chairs of the Province's Community Child Welfare Boards, who together form the Minister's Advisory Committee on child welfare issues. Presentations were made to family resource centres in Sydney and Yarmouth. We met with the Department of Community Services to discuss making their internal complaint process more child-friendly.

As a component of our Youth Services, Ombudsman Representatives regularly visit the Nova Scotia Youth Facility, the Cape Breton Youth Detention facility, and the Wood Street Centre. They make quarterly visits to residential child-caring facilities. They prepare written reports on those visits.

As part of our regular services to seniors, we made presentations to long-term-care facilities involving residents, family councils, and staff of nursing homes and

Jean Donovan, Ombudsman Assessment Officer and a keen member of the our Outreach Committee, chats with Tim McInnis, Client Relations Officer, Workers' Compensation Board of Nova Scotia.

residential care facilities. This has enabled us to connect more effectively with this level of care in facilities licensed by the Department of Health and Wellness.

In addition to addressing seniors' complaints, Representatives increasingly are involved in community activities. During the year, Representatives made 112 visits to long-term-care facilities and made 13 presentations to groups such as continuing-care students at the Nova Scotia Community College, long-term care family councils, the Victorian Order of Nurses, and the Transitional Care Team at the Department of Health and Wellness.

Ombudsman Representatives are members of seniors' support and services committees such as Chebucto Links and the Department of Seniors Committee on Abuse Awareness and Prevention. In the year under review, our Representatives participated in seven expos in Halifax and elsewhere. They were exhibitors at the Shelburne Seniors' 50+ Expo, the Silver Economy Summit, and the Tools for Life Conference.

One of our Representatives broadened our outreach initiatives with community based organizations through presentations to family resource centres and a site visit to the Supportive Housing Youth Focus Team (SHYFT). Meetings also were held with the Executive Directors of the Yarmouth Association of Community Residential Options (YACRO) and the Tri-County Women's Association.

An Ombudsman Representative continued as board member for *The Voice*, a newsletter produced by and for youth in care. Our office is represented on the board of the Nova Scotia Council for the Family, the Council's Youth in Care Committee, the Child Welfare League of Canada, and the Canadian Council of Child and Youth Advocates.

We attended the annual Youth Achievement Awards. An Ombudsman Representative is a member of the organizing committee. And we addressed the Minister's Advisory Committee on the Children and Family Services Act to explain the role and mandate of the office and our services to youth.

Each year, the Office of the Ombudsman holds a children's poster contest reflecting themes based on articles from the United Nations Convention on the Rights of the Child. This year's contest drew several hundred entries and all contestants received certificates of accomplishment. We attended several schools to present prizes and certificates.

Conducting structured surveys of youth in care and custody is another regular activity. This year the office conducted 50 such surveys.

In May of 2013, former Ombudsman Dwight Bishop spoke at a conference of the Nova Scotia Secondary School Students' Association, attended by 700 students from 60 schools across Nova Scotia. An Ombudsman Representative attended the same conference as well as the association's gala held later in the summer.

A Representative attended a two-day conference on cyber-bullying at Mount Saint Vincent University and a Department of Justice Community Mobilization Conference focussing on community interventions and solutions for youth at risk.

In an effort coordinated by a staff member, our office participates annually in the United Way fundraising campaign to support organizations that help the most vulnerable in our communities.

Records Management

The office follows the government requirements for records management, formally known as the Standard for Administrative Records and the Standard for Operational Records, or STAR/STOR. Our Records Analyst manages the project and updates the database daily. The Central Registry also is responsible for collecting and compiling statistics on external presentations, site visits and outreach.

A new Central Registry location was made operational towards the end of the previous fiscal year, and has worked well during the year under review.

Our Records Analyst, Tom West, has been diligent in reorganizing outdated records, resulting in the Central Registry exceeding STAR/STOR standards.

IV - Services and Cases

Investigation and Complaint Services (I&CS)

General Ombudsman complaints are addressed by the Investigation and Complaint Services (I&CS) section of our office.

This area provides an independent process for resolving public concerns about services delivered by provincial and municipal government departments, agencies, boards, and commissions. These complaints are considered general because they do not affect particular groups such as children or seniors, and they usually are not allegations of wrongdoing of the type contemplated by the Public Interest Disclosure of Wrongdoing Act.

When individuals contact our office, they are encouraged to first seek resolution using the respondent's internal complaint process. Most provincial departments, municipalities, and agencies have such services, which provide opportunities to resolve problems early and efficiently. Those internal processes promote accountability within an organization by offering avenues of redress at the departmental or agency level. As one of our responsibilities, this office encourages internal government complaint processes and offers guidance to help make them effective.

When there is no internal complaint resolution process, when one has been exhausted, or when a matter requires an independent review, Ombudsman Representatives work with government respondents and complainants to resolve the issue through an administrative review. If this less formal method of resolution proves inappropriate or ineffective, a more formal approach is adopted which focuses on in-depth research and recommendations.

This area provides an independent process for resolving public concerns about services delivered by provincial and municipal government departments, agencies, boards and commissions.

Case Study – Investigation and Complaint Services

The following cases illustrate the range of issues addressed by Investigation and Complaint Services:

A Compassionate Solution

A person living alone contacted us regarding recurring basement flooding problems over many years at her home in the Halifax Regional Municipality.

The sources of the flooding were difficult to establish. It occurred during rain storms and increased over several years as new infrastructure and homes were developed and new ditches and culverts created near her house. Three major floods proved profoundly stressful and costly for the senior, who had to install electric sump pumps to mitigate damage.

One source of water was a roadside ditch maintained by Halifax Water which ran by the front of the complainant's home and then deposited the water onto a small piece of Crown Land next to her property. Bordering this piece of swampy land is a driveway, also on Crown Land, over which two homeowners have enjoyed a long-standing right of way under an agreement with the Department of Natural Resources.

A culvert across this driveway had not been maintained and, in heavy rain, water that needed to flow across the driveway and into a lake would build up in the swamp and leach in the opposite direction towards the complainant's basement.

Over many years numerous provincial and municipal agencies issued permits and other licences that contributed to the changes.

Halifax Water denied responsibility for the flooding. Discussions with officials at the Department of Natural Resources continued for some months. There were sympathetic responses from the department, but no firm solution until the department indicated it would rebuild the culvert across the right-of-way at the department's expense under an existing policy.

The culvert was constructed and the matter was resolved.

Implications of the Case

In this case citizen discomfort and individual financial hardship appeared to have resulted from a series of routine regulatory decisions such as the issuance of building permits, the assertion of water disposal rights, and Crown Land easements. This constituted a complex problem that had taken more than two decades to develop, involving several municipal and provincial departments and agencies and possibly some private entities such as contractors and individual home owners. Sorting out responsibility and potential liability could take years, with all implicated agencies spending much more than the cost of an 18-inch culvert, and with a private citizen caught in the middle.

In such cases government departments or agencies are commonly advised by legal counsel to be cautious about doing anything they are not legally obligated to do because of the so-called floodgates affect. This is the concern that if a remedy is provided in one case, it will have to be provided, at potentially great public expense, in all cases. In this type of case it can become the role of the Ombudsman to work with government officials to explore ways to find appropriate and reasonable solutions without having to resort to legal action which few individuals can afford and which also costs taxpayers.

Youth and Seniors Services

Youth and Seniors Services (Y&SS) provides specialized Ombudsman services for youth and seniors. It assures children and youth of quality responses to their particular complaints, and it offers informed assistance to the province's growing number of senior citizens.

Representatives independently investigate and resolve the concerns of children, youth and seniors who are receiving provincial and municipal government services. Representatives also monitor emerging issues and research regarding issues affecting these groups.

This office has a general oversight function and mandate for children and youth. This responsibility was created in response to a 1995 provincial audit, *In Our Care* (Samuels-Stewart), and the subsequent report by retired Judge Stuart G. Stratton, Q.C., regarding allegations of abuse at provincial youth facilities.

In the years since then, our youth services role has evolved and broadened. Through site visits, Ombudsman Representatives connect directly with children, youth, staff and service providers to address individual and systemic issues and to build confidence and trust. Our on-site presence at residential and secure care and custody facilities provides opportunities for individuals to come forward early and informally to seek resolutions to problems.

The role of Representatives in residential settings for youth in care or custody often is a connecting role between the residents and staff. They are empathetic listeners to the complaints. This role includes explaining rules and actions in a neutral but reinforcing way. While some complaints can be serious, such as alleged injuries incurred during restraint, many are not so different in kind from those of youth everywhere: unfair restrictions regarding movement and noise, conflicts related to personal property and personal rights, and accusations of unfair and selective treatment.

The Wood Street Centre in Truro is a 20-bed facility for youth with emotional and behavioral challenges who are in the care of Community Services. The Nova Scotia Youth Facility in Waterville houses young persons in the custody of the Department of Justice. Separate but similar agreements with each department, based on the Office of the Ombudsman's Complaint Resolution Process, require Ombudsman Representatives to foster and promote "early, appropriate, and fair intervention by recognizing the importance of acting on complaints proactively." These agreements also require Ombudsman Representatives to visit the facilities regularly.

The role of Representatives in residential settings for youth in care or custody often is a connecting role between the residents and staff. They are empathetic listeners to the complaints. This role includes explaining rules and actions in a neutral but reinforcing way.

While Ombudsman services are available to all youth, there is a focus on youth who are in the care of Community Services and youth in the custody of the Department of Justice.

This year, there were 603 contacts with youth in care or custody, the majority of which were face to face meetings. Most issues raised were resolved through discussions with residents, youth care workers, and facility managers.

Figures 9, 10, and 11 illustrate the types of complaints received in the three major categories of Youth Services: Secure Care, Custody, and Residential Child-Caring Facilities.

Figure 9

Youth Services - Secure Care and Residential Treatment Issues	
Education	1
Policies and procedures	41
Conflict among residents	4
Staff	26
Food	1
Health care	4
Restraint	4
Phone access	2
Recreation	5
Care plan	5
Transfer	2
Other	12
Total	**107**

Figure 10

Youth Services - Custody Issues	
Discipline	1
Staff	6
Policies and procedures	13
Conflict among residents	1
Programming	3
Transfer	1
Other	6
Total	**31**

Figure 11

Youth Services - Residential Child-Caring Facilities Issues	
Policies and procedures	12
Staff	9
Health care	2
Conflict among residents	1
Access to phone	1
Care plan	1
Discharge plans/placement	10
Programming	2
Access to family	1
Safety	1
Food	1
Other	2
Total	**43**

The Office of the Ombudsman also deals extensively with seniors on a broad range of issues. We recognize that not all complaints by seniors are unique to seniors. As a result we identify certain issues that affect only seniors, in order to track and more effectively respond to challenges that are primarily a function of their age.

This year there were 79 such complaints. They included issues related to seniors' housing grants, Seniors' Pharmacare Program costs, funding for "In Home" supports, seniors' tax rebates, and subsidized housing.

We recognize that not all complaints by seniors are unique to seniors. As a result we identify certain issues that affect only seniors, in order to track and more effectively respond to challenges that are primarily a function of their age.

Case Studies – Youth and Seniors Services

The following are examples of cases addressed by Youth and Seniors Services:

Allegation and Follow-Up

A resident of a youth facility complained to an Ombudsman Representative that she had been physically injured while being restrained by a supervisor and another staff person. The resident also accused the staff of engaging in inappropriate "triggering" behaviour prior to the restraint.

The Ombudsman Representative met with the Unit Supervisor and requested a copy of the incident report and any other documentation related to the matter. The Representative asked whether there would be a debriefing with the complainant regarding the incident and was advised that there would be. The Representative noted that the complainant had reported injuries from the incident and asked whether she could see the nurse. The supervisor assured the Representative that this would happen, and the visit was later confirmed.

Management at the facility agreed to follow up with the complainant. At the end of each month, the Director of Residential Services reports back to the Ombudsman on any matters requiring follow-up. Ombudsman Representatives must be satisfied that appropriate follow-up has taken place and sufficient action taken. This was the case with this incident.

Protocol for Interviewing Children

An individual contacted this office questioning the authority of Department of Community Services (DCS) Child Welfare Division to interview children at school without parental consent.

The Office of the Ombudsman accepted clarification from DCS of their authority to interview children at school, which recognizes that managing the risk to the child is paramount.

This office recommended that DCS in collaboration with the Department of Education and Early Childhood Development develop a protocol for school boards outlining this authority, as well as the procedure to be followed when DCS staff interview children in schools pursuant to the Children and Family Services Act.

The best interests of the child and duty of care will be embedded in the protocol. The protocol has been completed and this office was asked to review it prior to implementation.

A Helping Hand

This office was contacted by an individual who was concerned about the amount his mother would be charged when she moved into a nursing home. He was having difficulty understanding the financial assessment and how the accommodation amount was calculated.

Contact information for the Manager of the Eligibility Review Office was provided to the complainant, who later called to advise that he had identified the discrepancy and thanked us for providing the information.

Disclosure of Wrongdoing (PIDWA)

The Public Interest Disclosure of Wrongdoing Act (PIDWA) gives employees of government bodies and members of the public a clear process for disclosing concerns about wrongdoing in the provincial government.

The act is not intended to deal with all concerns that public employees may have. Other avenues, such as the Occupational Health and Safety Act, the Human Rights Act, corporate human resources policies, and the grievance process for unionized employees, may provide more appropriate redress in some circumstances.

The PIDWA has expanded the responsibilities of this office. Government employees and members of the public may disclose concerns regarding wrongdoing by contacting the Office of the Ombudsman directly. Government employees may also disclose to their supervisor or to the designated officer at the government body for which they work. Allegations are assessed to determine whether they are best addressed under the Public Interest Disclosure of Wrongdoing Act, the Ombudsman Act, or by some other agency of oversight, review or appeal.

The PIDWA has expanded the responsibilities of this office. Government employees and members of the public may disclose concerns regarding wrongdoing by contacting the Office of the Ombudsman directly.

The Office of the Ombudsman assessed 23 allegations of wrongdoing during 2013-2014, and concluded one additional PIDWA case from the previous year.

One allegation required a formal investigation under the PIDWA. Five were investigated under the Ombudsman Act. Four complaints were discontinued by the initiators. Eight inquiries made under the PIDWA were referred to more appropriate authorities. The remaining five were addressed through administrative reviews under the PIDWA.

One case resulted in the launch of a formal investigation which in turn resulted in a challenge to the jurisdiction of the Ombudsman by the respondent department. This office has referred the matter to the Nova Scotia Court of Appeal. The case has yet to be heard.

A PIDWA case involving municipal water quality was launched in 2011-2012 and concluded this year. The four recommendations made in that case have been implemented and the file concluded. (See Figure 12)

Figure 12

PIDWA Inquiries and Cases 2013-2014	
Formal investigations under PIDWA	1
PIDWA complaints handled under Ombudsman's Act	5
PIDWA complaints referred to other authorities	8
Discontinued by complainants	4
Dismissed following administrative reviews	5
2012-2013 Cases concluded	1
Total PIDWA cases 2013-2014	**24**

Allegations of wrongdoing received in 2013-2014 reflected the following

- abuse of authority
- health and safety issues
- conflicts of interest
- abuse of public funds and equipment
- conduct of managers
- wrongful dismissal
- human rights issues
- protection of property
- procurement issues
- respectful workplace
- health and wellness issues

Case Study - Disclosure of Wrongdoing

The following example of a Public Interest Disclosure of Wrongdoing (PIDWA) case is described here only in general terms, to provide a sense of its complexity and of issues in PIDWA cases and to protect the confidentiality of the individuals and agency involved.

The Letter and the Spirit of the Law

A senior government official was accused of misusing a government office and its prerogatives to spend public money to benefit friends.

Section 3 (j) of the PIDWA defines wrongdoing as:

(i) A contravention of provincial or federal statutes or regulations if the contravention related to official activities of the employee or any public funds or assets,

(ii) A misuse or gross mismanagement of public funds or assets,

(iii) An act or omission that creates a substantial and specific danger to the life, health or safety of persons or the environment, or

(iv) Directing or counselling someone to commit a wrongdoing described in sub-clauses (i) to (iii).

Research by this office into the matter involved reviews of the Finance Act, Appropriations Act, Civil Service Act, the Conflict of Interest Act, the Government of Nova Scotia Sustainable Procurement

Regulations, Employment Equity Policies, Moving and Relocation Policies, and Conflict of Interest Policies as outlined in the Province's Management Manuals. Beyond the paper research, the office conducted interviews with the complainant, the respondent, agency and government officials, and other individuals.

One issue that has pervaded this case is typical of the issues that arise in PIDWA cases.

The province's Sustainable Procurement Policy (SPP) is based on good governance principles that include openness, fairness, sustainability, transparency, consistency, effectiveness, efficiency, and competitiveness.

The policy permits payments by departments under a $1,000 threshold without the approval of more senior levels. But the policy invites interpretation when a parcel of work that reasonably could be considered a unit worth $15,000 or $20,000 is broken down into smaller units of work, all costing $1,000 or slightly less.

Among the challenges for this office, and frequently for the courts, is fair and consistent interpretation of when such parcels of work legitimately are discrete and different, and when they may have been separated for inappropriate reasons.

The Office of the Ombudsman is not a court. But the office often shares similar challenges to interpret legislation and regulations that at times may be ambiguously worded, and at other times may reflect the best possible efforts to cover most circumstances that arise, but may not cover them all.

Own Motion Investigations and Policy Reviews

The Office of the Ombudsman may on its own initiative investigate government activities, practices and policies. Policy reviews can be initiated as own-motion reviews, or at the request of a government department, agency or commission. These investigations and reviews frequently address systemic concerns.

Case Study - Policy Review

Agency's Decision Accepted

An individual contacted this office regarding the enforcement of a court order by the Maintenance Enforcement Program (MEP). The individual had recently retired and indicated that they could no longer continue to provide the court-ordered maintenance amount due to the change in income. The individual had made an application to court to vary the order.

In the interim, the MEP was continuing to enforce the order and the individual was responsible for the arrears that were accruing. Action had been taken by Maintenance Enforcement to garnish the individual's sources of income. There is an internal complaint process at the MEP and the complainant was referred back to this process.

As the complainant had asked the MEP Director to cease enforcement, this office undertook a legislation and policy review regarding the MEP Director's discretion to not enforce a maintenance order.

The legislation and policy were reviewed and program staff provided further information describing limited and exceptional situations in which a Director could elect to not enforce a maintenance order. Through communications with Maintenance Enforcement staff, it was discovered that the complainant could, in certain circumstances, request the arrears not be garnished pending the court date, while the regular maintenance order payments would continue to be garnished. This information was communicated to the complainant who planned to discuss the non-garnishment of arrears with the Enforcement Officer and was proceeding to address these concerns through the courts and the internal complaint process.

This office was satisfied that the MEP was acting within its legislated authority to enforce the maintenance order. There are criteria in place for the Director to not enforce an order under exceptional and limited circumstances.

Case Study – Own-Motion

In the past year, the Office of the Ombudsman completed its recent own-motion investigation, a review of the circumstances surrounding the death of a child whose family had been receiving government services. The following is a summary of our key findings and one of the major recommendations, taken from an overview released to the public in July of 2014.

Review of Child's Death Finds Services Fragmented

(Excerpts from Ombudsman's Press Release of July 29, 2014)

The death of a child who was receiving government services highlights a "fragmented" government approach and "communications issues and in some instances vague standards."

The investigation did not turn up evidence of government agents or public servants acting in "an uncaring or indifferent manner," or any specific actions or inactions by them that caused the child's death.

"Rather it revealed a series of disconnects, issues related to standards, and uncertainty of approach. What emerged from our investigation might best be described as system fragmentation."

The Ombudsman's review was administrative. It included the roles and responsibilities of provincial government agencies and their approach to decision-making.

The Child Protection Services Division of the Department of Community Services was periodically involved in the child's case for several months prior to the death, and was extensively involved with the family during the three months leading up to the child's death.

There was a series of five referrals or complaints to Child Protection Services expressing concerns about the child's well-being. Two separate investigations remained open when the child died.

The child died at home. An autopsy found that death was caused by blunt abdominal trauma. A person close to the family was charged with manslaughter and was acquitted.

The investigation involved the departments of Community Services, Health and Wellness, and Justice. While the major focus was on Community Services, a key recommendation was to the Justice Department which was asked to lead an initiative to create a standing team to examine all child deaths and serious injuries where government services are involved.

(The complete report is available online at www.gov.ns.ca/ombu).

Implications of the Case

The report of the Child Death Review was received positively by the three departments involved in the case. The departments had 30 days to respond to the many recommendations. All did so within that time frame, and all recommendations were accepted.

Such a review was deemed necessary in the absence of automatic government reviews of all deaths and critical injuries of children receiving government services or in care and custody. This office also was aware of its obligations to children at risk, and of its broader child advocacy role.

The recommendations arising from the Child Death Review are provided earlier in this report in Figure 8, page 14. Implementation of the recommendations is being monitored by this office.

•••

A review of Nova Scotia's Residential Child Care Facilities (RCCFs) launched two years ago was largely completed in 2013 and recommendations were issued.

The authority to launch such investigations under the Ombudsman Act is an important prerogative of an independent Office of the Ombudsman.

V - Where Complaints Originate

Complaints can come to the Ombudsman's Office from anywhere that provincial and municipal services impact citizens. They also can relate to other agencies and entities that are beyond our jurisdiction, such as federal government departments and the courts.

Many complaints are about the services that affect people most, such as those provided by the provincial departments of Health and Wellness, Justice, and Community Services, or from circumstances such as correctional facilities where individuals are extensively regulated and their freedom limited.

This office recognizes that the volume of complaints concerning a public body does not necessarily reflect the quality of services provided by that body. In fact it more often reflects the volume and the nature of the services provided.

The following tables provide statistical snapshots of both the main sources and the types of complaints. Tables 13 to 18 enumerate the kinds of complaints received for the six provincial bodies about which the majority of issues are raised. To the extent possible, the complaints are broken down by the departmental divisions to which they apply.

This office recognizes that the volume of complaints concerning a public body does not necessarily reflect the quality of services provided by that body. In fact it more often reflects the volume and the nature of the services provided.

Major Sources of Complaints

Table 13

Community Services							
Year	**Total**	Employment Support and Income Assistance	Children, Youth and Families	Affordable Housing and Repairs	Service Issues	Services for Persons with Disabilities	Other
2013-14	**266**	90	56	34	50	18	18
2012-13	**241**	118	45	28	37	9	4
2011-12	**260**	123	49	39	28	10	11

Table 14

Justice					
Year	**Total**	Correctional Services	Maintenance Enforcement Program	Court Services	Other
2013-14	**242**	181	25	24	12
2012-13	**346**	292	31	17	6
2011-12	**427**	360	44	14	9

Table 15

Health and Wellness							
Year	**Total**	Inmate Medical	Continuing Care	Capital District Health Authority	Other DHAs and Hospitals	Pharmacare	Other
2013-14	**161**	87	23	10	13	3	25
2012-13	**215**	128	19	20	27	6	15
2011-12	**219**	129	34	15	15	8	18

Table 16

Service Nova Scotia and Municipal Relations						
Year	**Total**	Registry of Motor Vehicles	Residential Tenancies	Debtor Assistance and Student Loans	Land Title Registry	Other
2013-14	**64**	22	13	2	2	25
2012-13	**49**	22	7	3	2	15
2011-12	**58**	30	10	3	3	12

Table 17

Halifax Regional Municipality					
Year	**Total**	Planning and Development Services	Halifax Regional Police	Transportation and Public Works	Other
2013-14	**52**	5	17	11	19
2012-13	**38**	4	19	5	10
2011-12	**34**	5	13	7	9

Table 18

Workers' Compensation Board					
Year	**Total**	Administrative Service	Benefits	Claims Process	Other
2013-14	**31**	7	10	7	7
2012-13	**53**	16	16	17	4
2011-12	**52**	14	18	11	9

Respondents to Complaints – All Entities

Table 19 below provides a complete list of entities that were the subjects of jurisdictional complaints in the year under review, as well as the categories of non-jurisdictional complaints.

Non-jurisdictional inquiries are referred by our office to their appropriate oversight bodies, usually with contact information such as telephone numbers and names of officials.

Table 19

Department/Agency/ Commission/Non-Jurisdictional Entity	Number of Complaints
Agriculture	3
Annapolis County Municipality	3
Annapolis Valley Health Authority	1
Annapolis Valley Regional School Board	2
Antigonish County Municipality	1
Aylesford Village Commission	1
Bridgetown (Town)	3
Bridgewater (Town)	1
Cape Breton District Health Authority	2
Cape Breton Regional Municipality	12
Cape Breton/Victoria Regional School Board	5
Capital District Health Authority (CDHA)	10
CDHA Offender Health	87
Chester District Municipality	1
Chignecto Central Regional School Board	3
Colchester-East Hants Health Authority	1
Community Services Department	266
Conseil scolaire acadien	1
Courts/Judges*	22
Cumberland County Municipality	1
Cumberland Health Authority	2
East Hants District Municipality	1
Economic and Rural Development and Tourism	9
Education and Early Childhood Development	9
Efficiency Nova Scotia	2
Emergency Management Office	1
Energy Department	2
Environment Department	8
Federal Government*	122
Finance and Treasury Board Department	2
Guysborough District Municipality	1
Halifax Regional Municipality	52
Halifax Regional School Board	4
Health and Wellness Department	54
Human Rights Commission	10
Inverness County Municipality	1
IWK Health Centre	1
Justice Department	61
Justice (Corrections)	181
Kentville (Town)	4
King's County Municipality	5
Kingston Village Commission	1
Labour and Advanced Education Department	19
Labour Relations Board	2
Lawrencetown Village Commission	1
Legal Aid Commission	14
Liquor Commission (NSLC)	2
Lunenburg District Municipality	1
Medical Services Insurance (MSI)	6
Middleton (Town)	1
Natural Resources Department	7
New Glasgow (Town)	1
Non-Jurisdictional Assistance*	20
Nova Scotia Community College	2
Nova Scotia Gaming Corporation	1
Nova Scotia Legislature	1
Other*	121

Parrsboro Town	1
Pictou County Health Authority	1
Pictou County Municipality	1
Pictou Town	1
Police Commission	4
Private*	251
Property Valuation Services Corporation	4
Public Prosecution Service	2
Public Service Commission	6
Public Trustee	2
Queen's Municipality (Region of Queen's Municipality)	2
Richmond County Municipality	2
Securities Commission	1
Self-Regulating Body/Process	5
Service Nova Scotia and Municipal Relations	64
Shelburne Town	1
South Shore Health Authority	1
South Shore Regional School Board	1
Southwest Nova Health Authority	1
Springhill Town	2
Strait Regional School Board	1
Transportation and Infrastructure Renewal	15
Tri-County Regional School Board	2
Truro (Town)	2
Waterfront Development Corporation	1
West Hants District Municipality	6
Westville Town	1
Windsor Town	1
Workers' Compensation Appeals Tribunal	5
Workers' Compensation Board	31
Yarmouth District Municipality	1
Total	**1577**

Note: *Asterisks (*) denote non-jurisdictional inquiries and complaints that are referred by this office to their appropriate oversight entities.*

Month at a Glance

In a given month the Office of the Ombudsman can receive as many as 200 complaints, on a wide variety of topics.

About a third of all complaints are outside the jurisdiction of the Ombudsman Act. As well, the majority of complaints received this year under the Public Interest Disclosure of Wrongdoing Act had other and more appropriate avenues of review or appeal.

The following list of subjects from August 2013 is indicative of the scope and diversity of complaints and inquiries received.

It should be noted that the existence of a complaint or an inquiry does not automatically implicate the respondent department and agency. Figure 20 reflects complaints as received, not as resolved. While many complaints eventually are shown to have merit, the majority are either sorted out readily with the assistance of this office, or are beyond its jurisdiction.

Figure 20

August 2013 – All Complaints

Correctional Services/Courts
- inmate medical issues (11)
- inmates' canteen accounts (3)
- complaint process (2)
- inmates' property (1)
- laundry conditions (1)
- injury during transfer (1)
- discipline (2)
- food - diet mix-up (1)
- lockdown - duration/reasons (5)
- communications with staff (1)
- recreation denied (1)
- safety/confidentiality (1)
- staff conduct - facilities (2)
- release date (1)
- legal representation (1)
- dispute with court (1)
- missed court date (2)
- probation officer (1)
- court staff (1)

Justice – Victim Services
- no response from serious incident response team (1)

Municipal – Halifax Regional (HRM)
- monitoring of construction debris + Environment Department (1)
- rats and bad smells from a business + Environment Department (1)
- councillor conflict of interest (1)
- allegation of assault by police + Halifax Regional Police (1)
- allegation of wrongful offense charge + Halifax Regional Police (1)
- housing development (1)
- flooding of property (1)

Municipal – Cape Breton Regional (CBRM)
- tax-sale of property (1)
- workplace harassment (1)

Municipal – Cumberland County
- abuse of elected position (1)

Municipal – Inverness County
- tax procedures (1)

Municipal – County of Kings
- conflict around rezoning (1)

Municipal – West Hants
- fire services and property purchase (1)

Municipal – Village of Kingston
- by-law enforcement (1)

Non-Jurisdictional
- courts/judges (1)
- federal (13)
- RCMP (4)
- other - various referrals (11)
- private - mainly businesses (30)

Health/Medical – General
- alleged botched surgery (1)
- infection control issue (1)
- surgery said unnecessary (1)
- alleged patient malnourished (1)

Health – Continuing Care
- family health information denied (1)

Health – Emergency Services
- ambulance bills (2)

Community Services – Family
- false claims by staff (1)
- not following policy (1)
- travel allowance reduced (1)
- breach of confidentiality (1)
- child's safety ignored (1)
- troubled youth (1)
- children removed (1)
- child welfare issue (1)

Community Services – Housing
- bedbugs (1)
- unsolicited information (1)
- compensation for temporary housing (1)
- contractor law-suit notice (1)
- denial of housing grants for home repairs (1)

Community Services – Income Assistance
- benefits decreased (3)
- denied bus pass (1)
- calculation of benefits (1)
- return to school assistance (1)
- delayed assistance (1)
- landlord seeks rental payment (1)
- complainant with several issues (1)
- no benefits for firewood (1)
- income assistance (1)
- termination of benefits (1)
- special needs denied (1)
- taxi funds denied (1)

Economic Development
- government loan denied (1)

Education
- alleged abuse by teacher (1)
- bullying (2)

Maintenance Enforcement
- arrears not collected (1)

Public Trustee
- communications (1)

Motor Vehicle Registration
- license revocation (2)

Transportation
- maintenance of a gravel road (1)
- road maintenance and hiking trail misuse (1)

Workers' Compensation/Labor Relations
- staff mistreatment (1)
- coverage reduced (1)
- fair representation delay (1)

Miscellaneous
- denial of agriculture assistance (1)
- conduct of a civil servant (1)
- denial of legal aid (1)
- disagreement about a government decision (1)

VI - Transition and Looking Ahead

Dwight Bishop

Former Ombudsman Dwight Bishop retired at the end of 2013, and it is fitting that the staff of this office acknowledge his substantial contribution over the past decade.

"I have enjoyed a unique privilege," Mr. Bishop said at the time of his retirement, "an opportunity to both serve the public and to influence how the public should be served. My cause has been integrity and fairness in government service."

Appointed in 2004, Mr. Bishop served two five-year terms as Ombudsman. He also served as Acting Review Officer, Freedom of Information and Protection of Privacy, from January 2006 to February 2007.

A native of Cambridge, Kings County, Mr. Bishop is a lawyer and was a member of the RCMP for 34 years, retiring as an Assistant Commissioner and Commanding Officer for Nova Scotia. He led the Nova Scotia RCMP through the Swissair disaster in 1998 and 9/11 in 2001.

Mr. Bishop has been a consistent proponent of effective oversight. In recent years his particular interest has been oversight programs geared towards vulnerable groups such as youth, First Nations people, new residents, and persons with multiple or complex health needs.

In the past year, the Office of the Ombudsman received significant attention for three major investigations initiated under Mr. Bishop's tenure.

There were two reports on spending practices and administrative issues in regional development authorities, the South West Shore Development Authority (SWSDA) and the Cumberland Regional Development Authority (CRDA). The former resulted in criminal charges and the latter currently is the subject of an RCMP investigation which followed a forensic audit, initiatives recommended by the Ombudsman.

Dwight Bishop

In July of 2014 the office released a public report on the death of a child whose family had been receiving government services. That investigation was initiated under Mr. Bishop, and was completed shortly after his departure. Mr. Bishop had promised to make the report public, and he was pleased to see that happen.

One of Mr. Bishop's last duties on the job was to apply to the Nova Scotia Court of Appeal to resolve a difference of opinion between the office and the Department of Agriculture regarding the jurisdiction of the Ombudsman. The office had met with resistance in what Mr. Bishop regarded a routine Ombudsman case. The Nova Scotia Court of Appeal is expected to hear the application in the spring of 2015.

The current staff of the Office of the Ombudsman acknowledges Mr. Bishop's leadership and mentorship, and we thank him for his contribution and his continuing encouragement and support.

Ongoing Activities

Looking ahead, the Office of the Ombudsman is charting a pragmatic course of continuing initiatives and approaches that have proved their value over many years, while at the same time identifying and responding to evolving needs.

Newer initiatives include an in-depth review of a government commission, and ongoing preparation for the Nova Scotia Court of Appeal case.

We look forward to the result of this case as a possible first step in clarifying a number of Ombudsman jurisdictional issues that currently loom. Among those issues is access to information in cases where government legislation requiring confidentiality is invoked to deny the Ombudsman access to information we believe is both contemplated and authorized by the Ombudsman Act.

Emerging Issues

The factors that will influence our service in the years ahead include an aging population, financial and organizational stresses in the health care system, increasing environmental concerns, and matters related to integrity and responsiveness in government. Nova Scotians and all Canadians are displaying increased concerns about those matters.

At the operational level, those forces will increase the need for more in-depth research and more complex investigations. Our objective will be to manage our resources strategically to meet public expectations in those areas, while at the same time remaining responsive to the many everyday issues that Nova Scotians bring to this office.

VII - Let's Talk

Ombudsman Representatives are available to meet your group or organization to talk about the services the office provides.

The office also has communication materials to distribute, such as brochures and posters. Additional reference documents supplementing our Annual Report, including our Statement of Mandate and our Accountability Report, may be found on our website, or by contacting the office.

There are a number of easy ways to contact the Office of the Ombudsman:

Public Inquiries/Complaints: (902) 424-6780
Toll free: 1-800-670-1111
Youth Inquiries: 1-888-839-6884

Disclosure of Wrongdoing Inquiries: 1-877-670-1100

Fax: (902) 424-6675

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5670 Spring Garden Road, Suite 700
PO Box 2152
Halifax, Nova Scotia B3J 3B7

Website: www.gov.ns.ca/ombu
E-mail: ombudsman@gov.ns.ca

Facebook: Nova Scotia Ombudsman - Youth Services

Twitter: @NS_Ombudsman

Staff of the Office of the Ombudsman during 2013 - 2014