Ombudsman Saskatchewan

Promoting Fairness

2021

Annual Report

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Ombudsman Saskatchewan
Promoting Fairness

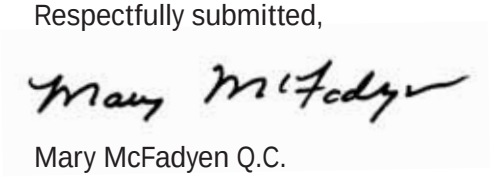
April 2022

The Honourable Randy Weekes
Speaker of the Legislative Assembly
Province of Saskatchewan
Room 129, Legislative Building
2405 Legislative Drive
Regina, Saskatchewan S4S 0B3

Dear Mr. Speaker:

In accordance with subsection 38(1) of *The Ombudsman Act, 2012*, it is my duty and privilege to submit to you the annual report of Ombudsman Saskatchewan for 2021.

Respectfully submitted,



Mary McFadyen Q.C.
OMBUDSMAN

Vision, Mission, Values and **Goals**

Vision

Our vision is that government is always accountable, acts with integrity, and treats people fairly.

Mission

Our mission is to promote and protect fairness and integrity in the design and delivery of government services.

Values

We will demonstrate in our work and workplace:

- fairness, integrity and accountability
- independence and impartiality
- confidentiality
- respect
- competence and consistency

Goals

Our goals are to:

- Provide effective, timely and appropriate service.
- Assess and respond to issues from a system-wide perspective.
- Undertake work that is important to the people of Saskatchewan.
- Demonstrate value to the people of Saskatchewan by making recommendations that are evidence-based, relevant and achievable.
- Be experts on fairness and integrity.
- Educate the public and public sector employees about fairness and integrity.
- Have a safe, healthy, respectful and supportive work environment.

Ombudsman's Message

Mary McFadyen, Q.C.
Ombudsman

I am pleased to present Ombudsman Saskatchewan's *2021 Annual Report*, highlighting our progress and activities during the year.

In January 2021, after receiving a request from the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health, we conducted an own-motion investigation into the COVID-19 outbreak at Extendicare Parkside that was declared in November 2020. We reviewed Extendicare's handling of the pandemic and the Parkside outbreak, including whether it followed provincial standards and requirements. We also investigated the Ministry of Health's and the Saskatchewan Health Authority's oversight and support of Extendicare Parkside. We publicly reported on our investigation, making four recommendations to Extendicare (Canada) Inc., and four recommendations to the Saskatchewan Health Authority aimed at improving the way long-term care is managed and overseen within the province. This report includes an update on implementation of those recommendations.

While the Extendicare Parkside investigation revealed unsettling issues, it was not the first time we have reported publicly on the need for changes in the long-term care sector and not the only investigation into the sector we completed in 2021. The Health section of this report includes, for example, a summary of an investigation into the fall and death of a long-term care resident. We looked into whether her care met the required standards, and whether the Saskatchewan Health Authority investigated the incident in accordance with the law and established rules and policies.

In all, we made 19 recommendations in 2021 aimed at improving administrative decisions in Saskatchewan's public sector. There were many other cases in which we were able to achieve change informally. Some of these early resolution success stories are included in this annual report.

Overall, complaints from the public increased in 2021 returning to pre-pandemic levels. We received 3,811 complaints, 2,825 of which were within our jurisdiction. About 11% of the complaints we received were focused on COVID-19 in some way.

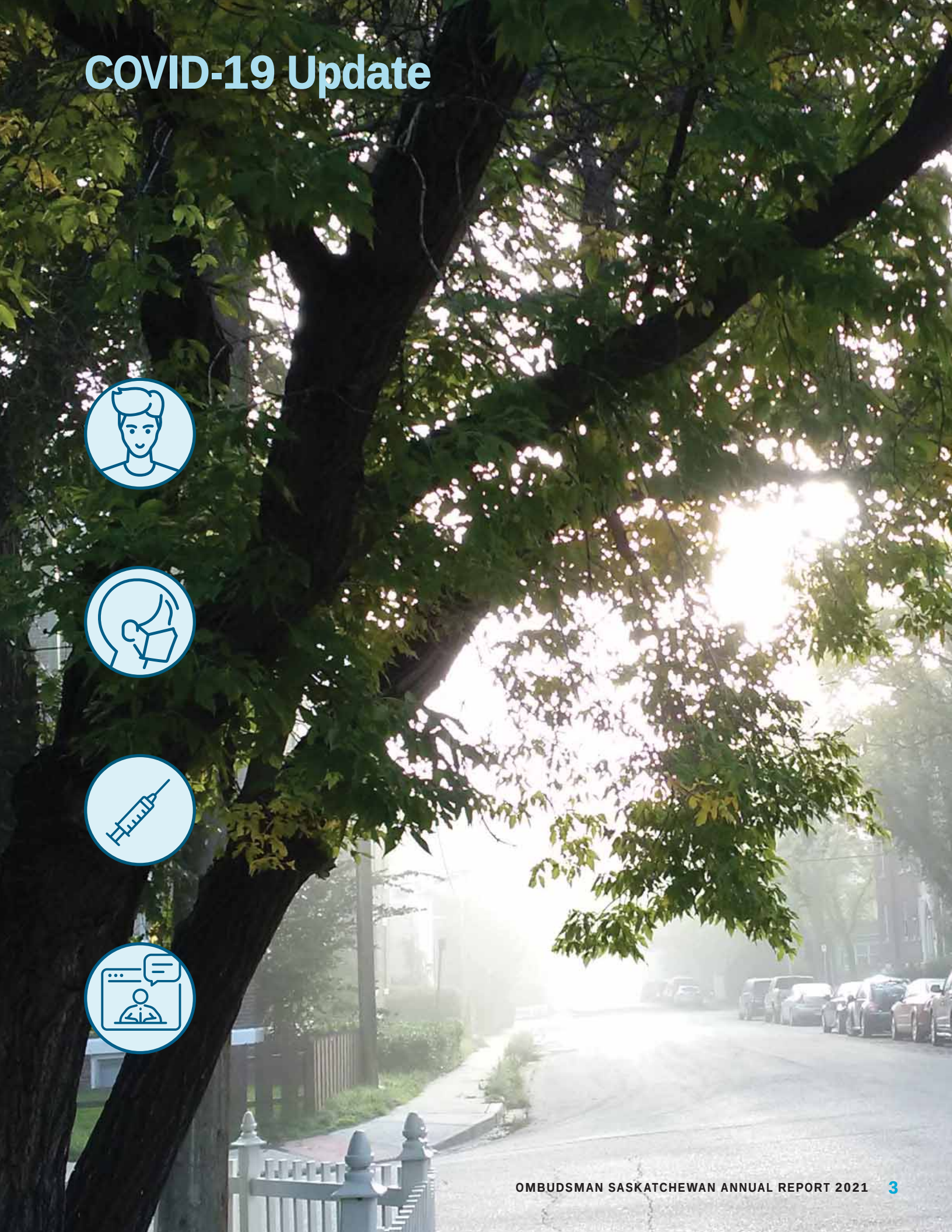
As in 2020, the pandemic required us to adapt the way we worked. We followed public health orders and directions. Most of our staff continued to work remotely for part of the year. Despite

these adjustments, we continued to fulfil our mandate which, as an Ombudsman's Office, is to investigate or informally address complaints about matters of government administration, make findings and recommendations, issue reports, and educate the public and public servants about administrative fairness and the role of the Ombudsman.

Under *The Ombudsman Act, 2012*, we can review the administrative decision-making processes of provincial ministries, Crown corporations, most provincial agencies, boards, commissions, publicly-funded health entities, and municipalities, as well as complaints about the conduct of municipal council members under their codes of ethics. We carry out our role independently from the entities within our jurisdiction. The Act gives us wide powers of investigation, ensures our independence, and supports the integrity of our investigation process.

In closing, I take this opportunity to thank everyone at Ombudsman Saskatchewan for their hard work, for helping ensure that no one who contacted our Office slipped through the cracks and that we responded to complaints honestly, quickly and efficiently. Most of the time, it is our investigations that attract the most attention, and I am proud of the work our investigations team has produced this year. However, most of our complaints are resolved informally without the need for an investigation. Therefore, I also want to especially thank and acknowledge the great work done by our administrative staff and complaint analysts. You are the first point of contact someone has with our Office, and first impressions are important. You listen, inform, and help the people who come to us, who are often frustrated and have turned to us because they feel they have been mistreated by a government institution. This is not an easy job! I appreciate you and your work very much, so thanks to all of you.

COVID-19 Update



How the Pandemic Affected Complaints in 2021

In 2021, the pandemic continued to affect complaints, though the nature and number of some of them shifted compared with 2020. In the first year of the pandemic, we received fewer complaints than usual about some government programs and organizations when they adapted their services and people's activities temporarily changed. For example, income assistance requirements were less strictly enforced, and there were fewer evictions, fewer utility cut-offs, and fewer vehicles on the roads.

By comparison, in 2021, as people returned to some of their usual activities and many government programs resumed their regular processes, our overall complaint numbers returned to pre-pandemic levels. In 2021, we received 3,811 complaints, which is about the same as in 2019. Of those, 431 or 11% were related to COVID-19, compared with 14% in 2020.

Here is an overview of some of the ways in which the pandemic affected complaints this past year.

Health

About half (160) of the 321 complaints we received about the health sector were related to the pandemic. Forty-five of these were complaints about public health measures: more than half of these (28) were from people who thought the measures were too stringent, while others thought they weren't stringent enough or wanted more information about them. We referred many of these complaints back to the Ministry of Health. We also received around 30 complaints about the vaccine rollout process and access to vaccine passport records.

In addition, we received complaints from people concerned about the way public health measures were being implemented in specific circumstances, and how they affected them and their families. These included complaints about delays in treatments and surgeries, and the wait time in emergency rooms.

As in 2020, people continued to be concerned about family members in long-term care. Some worried about whether facilities had the capacity to provide quality care during the pandemic. Families wanted to know when they could resume visiting so they could see the quality of care for themselves, and to help with activities such as feeding, exercise, and social interactions. Almost half (27) of the 56 complaints we received

about long-term care in 2021 were related to COVID-19. We completed three investigations into long-term care, including the aforementioned report about Extendicare Parkside.

Corrections

In 2021, 83 complaints from provincial correctional centres were related to COVID-19, compared with 100 in 2020. As in 2020, we heard some concerns about whether sufficient precautions were being taken, and also about COVID-19 protocols limiting the time inmates had outside their cells for phone calls, exercise, programming, and other activities. We responded to these complaints individually and continued to flag broader issues with management.

Social Services

We continued to receive complaints from people whose eligibility for provincial income support benefits had been affected by the funds they received under the Canadian Emergency Response Benefit (CERB). This amounted to about 40 complaints in 2020 and almost as many again in 2021. We completed an investigation into this issue in 2021. While we did not make recommendations to the Ministry of Social Services, we did point out that it could have improved the way it communicated with its clients. A summary of this investigation is provided in the Social Services section of this report.

Municipalities

Most of the municipal complaints that came in were not related to COVID-19, but the 17 we did receive were mainly about vaccine requirements and COVID-19 protocols for public meetings.

Outreach

In 2021, we continued to give online presentations to community groups, the public sector, and other Canadian ombudsman offices. These included Ombudsman 101 presentations to new corrections workers, as well as virtual events with the Saskatchewan Urban Municipalities Association, the Institute of Public Administration (IPAC), Radius Community Centre for Education and Employment Training, the Regina Open Door Society, and the Saskatchewan Seniors Mechanism, to name a few.

Complaints

This section provides an overview of the volume and types of complaints we received in 2021. It includes summaries of our investigations and examples of other cases we resolved. We have changed the names of complainants to protect their identities.

Social Services

Complaints Received

MINISTRY OF SOCIAL SERVICES	2021	2020	2019
Child & Family Service Delivery	118	90	132
Housing Programs and Finance	58	60	66
Community Living Service Delivery	7	6	11
Income Assistance Service Delivery - Saskatchewan Assured Income for Disability	206	157	183
Income Assistance Service Delivery - Saskatchewan Assistance Program	54	99	279
Income Assistance Service Delivery - Saskatchewan Income Support	168	92	75
Income Assistance Service Delivery - Transitional Employment Allowance	9	28	93
Income Assistance Service Delivery - Income Supplement Programs - Other	7	12	34
Social Services - Other	18	10	11
TOTAL	**645**	**554**	**884**

Case Examples

RECEIVING BENEFITS UNDER CERB AND INCOME ASSISTANCE

We received several complaints from recipients of the Saskatchewan Assistance Program (SAP), Saskatchewan Income Support (SIS), and Saskatchewan Assured Income for Disability (SAID) programs, who had also received the Canada Emergency Response Benefit (CERB). They thought it was unfair that Social Services considered their CERB payments to be income, which affected their eligibility for and the amount of their SAP, SIS and SAID benefits. We initiated an Ombudsman's own-motion investigation to review the matter.

The Saskatchewan Assistance Act empowers the government to create income-tested assistance programs for eligible persons in need. If a person's income is over a certain threshold, they are not eligible for benefits. People who are eligible and receive benefits to start with, but later receive other income that puts them over the threshold, are no longer eligible. If they continue to receive provincial benefits while not eligible, they are assessed an overpayment, which they must pay back.

The SAP, SIS and SAID regulations automatically exclude a list of income sources from being used to calculate a recipient's or applicant's income. The Minister has the discretion to order other sources of income to be put on the exclusion list.

Social Services told us it began considering whether the CERB benefit would be considered income for the purposes of its income assistance programs as soon as the federal government announced it. This included reviewing the purpose of CERB and who it was intended for. Social Services also contacted other provinces to learn how they intended to handle CERB. After being briefed by officials, the Minister decided that CERB was income, that it would not be exempt from the calculation of entitlements. The Minister had the right under legislation to make this decision. It was communicated to front line staff by April 9, 2020, three days after the federal government began accepting CERB applications.

However, Social Services did not consider proactively advising clients of what would happen to their income assistance if they received the CERB benefit. Officials told us they felt it was not their place to advise clients about CERB. While this may be true, it would have been reasonable for Social Services to advise clients of the potential consequences of receiving CERB benefits so they could make informed decisions about whether to apply for it.

Despite non-exempt sources of income usually being deducted dollar for dollar from entitlements, Social Services exercised discretion to reduce the amount of CERB that would be considered as income on a case-by-case basis in recognition of the unprecedented nature of the pandemic. For example, it allowed recipients to make purchases with CERB that it normally would not allow. At times, it also kept benefits files open longer than normal to assist recipients.

In summary, we found Social Services had the legal authority to make the decision it did, and exercised discretion on specific files, but it should have proactively communicated with clients about the potential consequences of receiving CERB.

Status: No Recommendations Made

FURNISHING A ROOM IN A PERSONAL CARE HOME

The Social Services Appeal Board (SSAB) decided to uphold Social Services' denial of Sydney's request for funding for furniture. Sydney thought these decisions were unreasonable.

This was a unique situation. As a young adult in university who needed assistance to meet their needs, Sydney lived in a personal care home and received funding under the Saskatchewan Assured Income for Disability (SAID) program. Sydney's little apartment in the personal care home was unfurnished, so Sydney asked Social Services for an allowance for specialized furniture. Social Services decided the personal care home should provide certain furnishings as set out in *The Personal Care Home Regulations, 1996*, (PCH regulations) and, otherwise, Sydney was supposed to cover these expenses from the benefits they already received. SAID denied Sydney's request for furniture on this basis. The SSAB upheld the denial.

We considered whether the denial was based on a reasonable interpretation of *The Saskatchewan Assured Income for Disability Regulations, 2012* (SAID regulations), the PCH regulations, and the Social Services Saskatchewan Assured Income for Disability Policy Manual (SAID policy).

The SSAB found that, under the SAID regulations and SAID policy, recipients are responsible to save for household furnishings from a "living income benefit" they receive. However, since Sydney lived in a personal care home, they were not entitled to, and did not receive a living income benefit. Instead, Sydney received a "residential support" benefit, almost all of which went to the personal care home, and none of which was intended to pay for furnishings. Further, the SAID policy allowed Social Services the discretion to provide benefits for basic household furnishings in certain circumstances, notably in cases like Sydney's where a recipient has never owned them before. However, Social Services decided that it could not use this discretion because the SAID policy prohibited it from providing furnishings if a recipient received "room and board" – which Sydney did. Lastly, the denial was also based on Social Services' and the SSAB's reading of the PCH regulations, which state that personal care homes are required to ensure residents' bedrooms have certain furnishings.

We found, however, that neither the PCH regulations, the SAID regulations, nor the SAID policy addressed Sydney's unique living arrangements. Sydney did not live in a traditional personal care home, which would typically provide each resident with only a bedroom. Instead, Sydney had a tiny apartment with a bedroom and a separate living area. The PCH regulations did not provide for Sydney's living

room to be furnished. Further, since the SAID regulations did not prohibit Social Services from providing furniture grants to people living in personal care homes, we found that Social Services had a duty to consider providing Sydney with benefits for basic furnishings. We found that it had fettered its regulatory discretion by relying on the rigid rules in the SAID policy, which did not specially address Sydney's situation. Therefore, we found that it would have been reasonable for the SSAB to expect Social Services to revisit whether to provide benefits to furnish Sydney's living area.

We provided Social Services and the SSAB with a draft of our investigation report, recommending that the SSAB reconsider its decision. After reviewing the draft report, Social Services advised us that due to the exceptional circumstances of Sydney's living arrangements, it reversed its decision to deny benefits for furnishings. Since the matter was resolved, it was unnecessary for us to formally make the recommendation.

Status: No Recommendations Made

WAITING FOR CONFIRMATION

Ariel contacted us because she felt her Saskatchewan Assured Income for Disability (SAID) benefits had been unfairly held and would soon be terminated.

Ariel told us she had started receiving SAID benefits, but still needed to transfer her RRSPs into a Registered Disability Savings Program (RDSP). This was necessary because RRSPs would be considered an asset, making her ineligible to receive benefits, but RDSPs are exempt. Ariel said she was waiting to hear back from the Canada Revenue Agency about the RDSP. She had inquired about the delay, but felt the process was out of her hands. In the meantime, Social Services advised her that her benefits were being withheld and would be terminated unless she could show that the RRSPs had been converted to RDSPs. She told us she had tried to contact Social Services but could not get through.

We reached out to Social Services to ask about Ariel's file. Given the circumstances, she was provided an additional four months to get documentation to show that the transfer to RDSPs had taken place. She was assigned a worker, who called her and explained what sort of documentation she would need to provide. In the interim, a supervisor also reviewed the file and agreed to release the previously held benefits.

Status: Resolved

WAITING FOR BABY

Simone contacted us because Social Services told her there were no Saskatchewan Income Support (SIS) program benefits to help her stay closer to medical services as she neared the end of a high-risk pregnancy.

Simone was from a remote community. She told us she and her mother had come to Saskatoon so she could have better access to the care she needed leading up to delivery. They needed help with the costs for food and a place to stay if they were to remain in Saskatoon until she gave birth. She told us she had recently made the change from the former Saskatchewan Assistance Program to SIS, but was now receiving less money. She was concerned about how she would be able to support her baby once it was born. She said she contacted Social Services but was told that there was nothing available to her under SIS.

We contacted Social Services to ask about Simone's concerns. Social Services then called Simone and her mom. She was provided the $400 Children's Basic Benefit for Newborns, which would enable her to buy a car seat and other supplies she might need for bringing the baby home. Upon confirmation of medical necessity, she and her mom would be provided a place to stay and receive funding for meals while waiting for the baby to arrive.

Status: Resolved

Corrections

Complaints Received

MINISTRY OF CORRECTIONS, POLICING AND PUBLIC SAFETY	2021	2020	2019
Pine Grove Correctional Centre	104	87	51
Prince Albert Correctional Centre	61	89	90
Regina Correctional Centre	211	189	172
Saskatoon Correctional Centre	155	220	241
Saskatchewan Hospital North Battleford (Corrections)	15	13	4
White Birch Female Remand Unit	2	2	0
Whitespruce Provincial Training Centre	13	3	2
Adult Corrections - Other	10	8	14
Corrections, Policing and Public Safety - Other	9	8	5
TOTAL	**580**	**619**	**579**

Case Examples

UPDATE: INMATE DISCIPLINARY SYSTEM

In our *2019 Annual Report*, we published the results of an investigation into the inmate disciplinary system. Under legislation, inmates are entitled to a full and fair hearing if they are charged with disciplinary offences such as fighting, engaging in gang activity, threatening people, or trying to escape. When charged, they are brought before a panel to determine whether they are guilty and if so, what sanctions will be applied. We found, among other things, that inmates were often not given enough information about the charges beforehand to adequately prepare for the hearing, they could not call other inmates to testify on their behalf, and they could not question staff witnesses. Also, the discipline panels were composed of staff members of the correctional facility, who often had to decide between the testimony of inmates and their own co-workers and supervisors, making it difficult to be objective. In addition, even though inmates could appeal the panel's decisions, the sanctions were applied as soon as the decisions were made, so by the time an appeal could be heard, it would be irrelevant. We made nine recommendations to improve the process.

An update from Corrections informed us that seven of the recommendations had been implemented. For example, it has made policy changes which will enable inmates to be represented by someone other than a lawyer, for inmates and their representatives to view relevant evidence in advance (including video evidence), and for inmates to call witnesses. Corrections also told us it created a Disciplinary Hearing Manual to provide guidance to discipline panels on several of the issues referenced in our recommendations. As for the remaining recommendations (#5 and #9), Corrections indicated it is still evaluating options for increasing the independence of discipline panel chairpersons and is working on a new training curriculum for discipline panels.

UPDATE: PEPPER SPRAY USE, DECONTAMINATION, AND DOCUMENTATION

In our *2020 Annual Report*, we published the results of an investigation into an inmate's complaint that pepper spray was used on him unjustifiably and that he was not properly decontaminated afterwards. We found that, although his behaviour was disruptive, destructive, and often disgusting, the use of pepper spray did not comply with *The Correctional Services Act, 2012* or Corrections' policies. We also found that Corrections failed to comply with its decontamination procedures, did not properly document the incident, and did not explain his right to appeal to the head of Corrections when his formal complaint to the director was dismissed.

We made six recommendations to improve documentation of the use of organic/chemical agents or spray irritants, to ensure appropriate decontamination of the inmate and the surrounding area, and to ensure that decision letters issued in response to a complaint clearly inform the inmate of the right to appeal, to whom, and the applicable timelines. The recommendations were accepted.

In 2021, Corrections sent us an update, stating it has implemented all our recommendations: that it updated policies related to the use of inflammatory or chemical agents and the documentation of such events, that it added appeals information to inmate complaint and appeal forms and that it advised correctional centre directors of the appropriate wording to use when advising inmates of their right to appeal.

THE MISSING ARTWORK

Shae contacted us because he was having trouble finding out what happened to some artwork he made when he was at the Saskatoon Correctional Centre (SCC).

He told us he had made some beaded artwork, which he wanted to send to his mom as a gift. He explained that a corrections officer helped him fill out a form so his inmate trust account could be charged for the cost of mailing. The envelope with the artwork was placed in the staff basket ready for mail. His mom never got the package.

He said he had talked with the corrections officer who had helped him earlier. She checked his inmate trust account. It had never been charged for the mail cost, so they assumed it was either lost or stolen. The officer encouraged him to submit a formal complaint, which he did, but he was not satisfied with the response. He was then transferred to the Regina Correctional Centre, which made it more difficult for him to contact SCC to address the issue. He called us.

SCC investigated the matter and told us nobody had found the artwork, so there wasn't much they could do. They suggested it may have been lost in the mail. We thought that was unlikely since the mail costs had not been charged to Shae's inmate trust account. We asked if SCC could have lost it, in which case, Shae would be entitled to replacement of the materials used for his artwork. SCC was reluctant to accept this possibility and pointed out that it didn't have the paperwork on file to prove that Shae had submitted the package for mailing – but Shae was able to retrieve his copy, which had been signed by staff. Fortunately, at that point, five months after it went missing, SCC found the artwork and Shae was able to send it to his mom after all. Given all that had happened, Corrections offered to pay the mailing costs.

Status: Resolved

DOUBLE TROUBLE

Silas contacted us because he thought he was charged an unfair restitution fee for damaging a window at the Prince Albert Correctional Centre (PACC).

Silas had been sharing a cell with another inmate when damage to their window was discovered. They were both required to pay restitution for the damage and $400 was removed from each of their inmate trust accounts.

Corrections policy says that inmates who damage institutional property can be charged up to a maximum of $400 restitution. Correctional centres are also able to set up a schedule of restitution fees based on the types of items damaged. While working on a previous file, we had found that Saskatchewan correctional centres were not all using the same restitution schedule and we had requested they do so. They had agreed and created a revised restitution schedule for facilities to follow.

According to the restitution schedule, a cell window was listed at $350. We questioned why this was not applied and why both inmates had to pay the maximum restitution for the same window. We sought clarification from the Ministry's Offender Services Branch, which agreed with us. PACC split the cost between Silas and his former cellmate so they would only pay $175 each. They were reimbursed for the difference.

Status: Resolved

Municipalities

Complaints Received

MUNICIPALITIES	2021	2020	2019
Cities	136	127	87
Towns	113	103	65
Villages	92	58	62
Resort Villages	23	13	18
Rural Municipalities	161	126	128
Northern Municipalities	15	24	35
Other / Not Disclosed	6	8	8
TOTAL	**546**	**459**	**403**

Case Examples

CONFLICT OF INTEREST ALLEGATIONS AGAINST A COUNCILLOR OF THE R.M. OF ENNISKILLEN NO. 3

Following a previous conflict-of-interest investigation into the RM of Enniskillen, we received another complaint that a council member had participated in the RM council's discussions and decisions about matters in which they had conflicts of interest.

After reviewing the complaint, we found that the council member contravened the conflict of interest rules four times in the same council meeting. The council member participated in discussions and votes in three matters that benefitted people with whom the council member had a personal relationship. In the fourth matter, the council member did declare a conflict of interest in the council's decision about whether to accept a proposal prepared by one of their family members to hire the company the family member worked for, but the council member stayed in the council chamber during the discussions and advocated for the proposal, only leaving the chamber while they voted on the proposal. In response to our findings, the council member did not agree that they had a conflict of interest in the matters, because the persons involved were not "closely connected persons" as defined in *The Municipalities Act*.

This result echoed the response to our previous investigation into allegations of conflict of interest by members of this RM's council. In 2019, we found two council members were in a conflict of interest when they participated in the council's discussions and decision to pay one of them for clay that was used by the RM for a road project. Based on that investigation, it was apparent to us that the council did not understand the conflict of interest rules. We recommended they take training to get a better understanding, so they could comply with the rules, and that they fully comply with *The Municipalities Act*, by declaring and disclosing conflicts of interest, removing themselves from the meeting room during the discussion and vote on the matter, and that those declarations be properly recorded in meeting minutes. In that case, the council rejected our recommendations.

At the end of this year's investigation, we again urged the council to accept and follow our previous recommendations. It refused.

The Municipalities Act has now been amended to clarify that council members have a conflict of interest if they make decisions or participate in making decisions in the execution of their office when they know or ought reasonably to know that there is an opportunity to improperly further any other person's private interests, whether they are a "closely connected person" or not.

Health

Complaints Received

HEALTH ORGANIZATIONS	2021	2020	2019
MINISTRY OF HEALTH	86	65	21
eHEALTH SASKATCHEWAN	19	9	14
SASKATCHEWAN CANCER AGENCY	1	1	1
SASKATCHEWAN HEALTH AUTHORITY	188	156	141
OTHER HEALTH ENTITIES	27	26	16
TOTAL	**321**	**257**	**193**

Case Examples

UPDATE: *CARING IN CRISIS*

Following a request from the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health, we investigated Extendicare (Canada) Inc.'s handling and response to the COVID-19 outbreak at Extendicare Parkside, declared on November 20, 2020. One hundred ninety-four of Parkside's 198 residents and 132 of its staff got COVID-19 during the outbreak. Forty-two residents who got COVID-19 died during the outbreak. It was the cause of death for 39 of them.

We investigated whether Extendicare's response to the pandemic and outbreak was reasonable and met provincial requirements. We also investigated whether the Ministry and the Authority provided Extendicare reasonable governance, oversight and support during the pandemic and outbreak. We focused on five key areas that exemplified the challenges and opportunities they had to prevent Parkside's residents and staff from getting COVID-19 and to respond effectively to the outbreak. A full copy of the report is available on our website.

In the report, we made the following recommendations to Extendicare (Canada) Inc.:

1. Extendicare (Canada) Inc. issue a formal, written apology to each of the families of the Extendicare Parkside residents who passed away as a result of the COVID-19 outbreak, and to all other Extendicare Parkside residents whose lives were disrupted because they got COVID-19, because they were displaced from their home to other facilities, and because they had to live through the outbreak.

2. Extendicare (Canada) Inc. conduct, in collaboration with the Saskatchewan Health Authority, a comprehensive critical incident review of the COVID-19 outbreak at Parkside Extendicare as required by *The Provincial Health Authority Act* and *The Critical Incident Regulations, 2016.*

3. Extendicare (Canada) Inc. develop and implement effective administrative and management processes to ensure its Saskatchewan special-care home administrators and staff comply with both its own corporate policies, procedures, plans and standards, and any Saskatchewan Ministry of Health or Saskatchewan Health Authority policies, procedures, plans, practices and standards that it either has agreed to comply with, or is required to comply with under any Act or regulation.

4. Extendicare (Canada) Inc. ensure that Extendicare Parkside has on-site, sustainable resources to effectively support its staff's compliance with all relevant infection prevention and control management processes, standards and practices, including good quality education, auditing and managerial oversight.

Extendicare (Canada) Inc. has not accepted these recommendations. We gave it several opportunities to confirm with us whether it had accepted them, and whether it intended to implement them. It did not respond.

We made the following recommendations to the Saskatchewan Health Authority:

1. The Saskatchewan Health Authority immediately stop the practice of having four special-care home residents share a bedroom.

2. The Saskatchewan Health Authority update its standard written agreement (Principles and Services Agreement) for special-care home operators without delay, and ensure all operators it enters into agreements with to provide services, are required to comply with care-related policies, standards and practices, including

infection prevention and control measures, that are acceptable to the Authority.

3. The Saskatchewan Health Authority establish and implement a detailed annual review and reporting process to ensure that all special-care homes in Saskatchewan are following all required care-related policies, standards and practices, including infection prevention and control measures, and that it publicize information indicating each home's level of compliance at least annually.

4. The Saskatchewan Health Authority ensure its communicable disease prevention and control management standards and practices are consistently applied in all special-care homes in Saskatchewan, including completing comprehensive infection prevention and control inspections of all special-care homes at least annually.

The Saskatchewan Health Authority accepted these recommendations. It advised us it has implemented the first recommendation and implementation of the other three recommendations is in process.

BEFORE AND AFTER A DEADLY FALL

Sophia was admitted to a long-term care facility. She had a high risk of falling so her initial care plan required safeguards to be put in place. On her first night, she fell out of bed. Because her bed alarm went off, staff found her right away and helped her. Her care plan was updated with more fall prevention safeguards. Despite this, a few days later, she was found on the floor in her bathroom at 7:30 in the morning, seriously injured, bleeding and unresponsive. Based on the information we were provided, she could have been lying there for up to an hour and 45 minutes. She was taken to the hospital and passed away three days later.

Sophia's family questioned how she could have fallen since so many safeguards had been put in place to protect her. They were also concerned that her fall and death were not properly investigated. We investigated whether Sophia's care leading up to and after her fall met required standards, and whether the Authority investigated her fall and death in accordance with the law and established rules and policies.

Sophia's Care

The Ministry of Health's *Program Guidelines for Special-care Homes* requires every long-term care resident to have a care plan to meet their

needs. Care plans must include appropriate fall prevention safeguards. Long-term care homes must also have a program for continuously monitoring and assessing residents' fall risks, reviewing fall incidents, implementing fall reduction strategies, and minimizing the severity of falls. In Sophia's case, the facility manager was required to ensure that the fall reduction program was fully implemented.

Sophia's care plan appropriately assessed her risk of falling. Her initial care plan required her to have a walker (and a wheelchair). Staff were to observe her frequently and intervene appropriately. After she fell the first time, her updated care plan required further interventions: use of a bed alarm while she was in bed, use of a hip protector during the day, the call bell was to be within reach, and "intentional night owl rounding" (staff were to engage Sophia in purposeful interactions or 'rounding' hourly – at a minimum every two hours – throughout the night). Whiteboards in her room reminded staff to ensure they set her bed alarm, and helped her to the toilet twice during the night (at midnight and between 4 and 5 a.m.).

Despite appropriately assessing Sophia and developing a care plan that met her needs, we found the Authority failed to properly implement it. Her caregivers were unclear whether her bed alarm had gone off, was not working, or even whether it had been activated when she went to bed. No one confirmed that it was working or turned on. They were also not clear about when or how many times she was checked on during the night. This was partly because staff involved were not asked to recall this until weeks after Sophia died. We found no indication that she was checked after 8:30 p.m. until 3:00 a.m. – a 6 ½ hour gap. We considered that this might be why her bed alarm never went off: since no one checked on her from before she went to bed until the middle of the night, perhaps the alarm was never set. The gap also meant no one helped her to the toilet at midnight as planned. Further, though staff said they checked on her twice between 5:00 a.m. and 6:15 a.m., they did not report helping her to the toilet. Though there is no way of knowing for sure, she likely fell because she got up to go to the bathroom by herself. Had the bed alarm gone off and a staff member responded to it immediately, she may not have fallen at all. Even if she had, she would have been found, and her injuries would have been assessed and attended to much earlier.

We found that the Authority failed to provide Sophia with the minimum standard of care required by the Ministry's *Guidelines*. Despite all its planning and detailed rules and forms designed to ensure Sophia's specific needs were safely met, she still fell, was seriously injured, was not discovered for up to an hour and 45 minutes, and subsequently died.

The Authority's Investigation of Sophia's Fall and Death

After Sophia was found injured on the bathroom floor, staff completed an 'incident report' as required, but it was not completed properly. It noted things that were irrelevant. For example, it said Sophia's bed was in the lowest position and its wheels were locked, but since she was found in the bathroom and not by her bed, this was not relevant. It also failed to note things that were relevant. For example, it said that whether the bed alarm was activated was not applicable, when it was obvious that whether it was properly set or went off was relevant.

Even though the report noted that Sophia was at a high risk of falling, it indicated she fell because she had a stroke. However, there was no way of knowing what caused her fall: whether a stroke caused her to fall, or she lost her footing (as she was known to do), fell and hit her head, and then had a stroke while on the floor. In any event, she fell because she was out of bed on her own and heading towards or away from the bathroom without any help – precisely the situation her care plan was designed to avoid. By noting a stroke as a possible contributing factor but not noting the potential failure of the alarm to go off, or the failure to have followed the toileting schedule, the report was, in our view, misleading.

The Authority was also required by law to give the Ministry of Health notice of Sophia's fall and death within three business days, conduct a critical incident review, and then report on it to the Ministry of Health within 60 days. A critical incident review is to focus on the circumstances that led to a critical incident – when a long-term care resident suffers an adverse health event while in care – and the factors that contributed to it. It is intended to uncover what caused the critical incident and what the Authority should do to prevent similar incidents from happening.

Despite the Authority having policies, guidelines and rules specifically setting out which incidents are critical incidents and requiring they be reported to the Minister of Health and investigated, it was only after Sophia's family contacted the Authority, 10 days after her death, that it took steps to confirm it was a critical incident. It did not classify it as a critical incident and give the Ministry the required notice until 15 days after she passed away – 12 days late.

As good as regulations, policies and procedures are, if the people actually doing the work are not aware of them, do not understand them, or do not follow them, they are of no value at all. The difficulty with the critical incident reporting system is that it places the onus on facility staff and management to self-report incidents that were potentially the result of their own mistakes or misconduct. In Sophia's case, the critical incident notification and review process was late getting started because local staff did not follow the Authority's internal rules for reporting it.

In Sophia's case, the investigation did not get underway for weeks after the incident, proper interviews were not completed until many days after she fell, and her room was not secured. Information was lost as a result. For example, the whiteboards in her room were wiped clean because a new resident had already moved in. Also, no one checked whether the bed alarm had been set or malfunctioned.

In addition, an official working in a local quality services department was assigned to conduct the review. They told us they had little experience investigating critical incidents and had never been trained to do them. They were also uncomfortable with having to interview their local managers and directors, and the people they worked with every day. As well, they were responsible for taking and responding to questions and concerns from Sophia's family who was grieving and, at times, upset. This meant they were tasked with reviewing Sophia's fall and death, while also managing the Authority's relationship with her family during the process.

As a result, the review was not as timely or thorough as expected. The Ministry of Health rejected the first draft of the report and reported not being highly satisfied with the final report, but accepted it anyway because it "was likely the best they would get."

Critical incident reviews fulfil an important function. By getting to the root causes of incidents, they help ensure that preventable failures – whether specific to one resident's care or systemic in nature – can be addressed and avoided in the future. They are specifically designed not to focus on blame or assigning guilt. The information gathered from staff involved is protected under statute from disclosure and being used in other proceedings. This is so they can have full and frank discussions, and be open and honest without fear that what they say will be used against them or the Authority. The necessity of these protections highlights the basic truth that critical incident reviews, by their nature, focus on potential staff errors. The individuals whose decisions, actions or failures may have caused the serious injury or death of a resident might naturally be expected to feel nervous or even struggle with fully disclosing their involvement. In our view, this means whoever is tasked with gathering information from them must be sufficiently removed to maintain objectivity, to help them be forthright, and to ensure the review is based on a full understanding of the events leading to the incident.

While incident investigators do not have to be completely independent from the Authority, they should not be placed in a position of having to interview their co-workers and superiors about what are always tragic incidents. They should also not have to manage the Authority's relationship with the family and to attempt to meet their expectations for full disclosure, while simultaneously having to gather and review detailed, legally-privileged information for the incident review which they cannot divulge to the family.

Sophia's case demonstrates that even though there are Acts, regulations, guidelines, policies, procedures and standards aimed at ensuring all adverse health incidents are investigated and reported on in a timely manner, this does not always happen. The Authority needs better administrative processes to ensure incidents such as Sophia's fall are immediately and properly documented and reported to officials who are appropriately trained, reasonably independent from the staff and managers involved, and appropriately resourced to efficiently and effectively determine whether an incident is a critical incident, and, if so, to properly notify the Ministry of Health, carry out the required critical incident review, and complete the required report.

We recommended:

1. The Saskatchewan Health Authority develop and implement a single, comprehensive, province-wide, adverse health event reporting and investigation process that clearly identifies the notification, reporting and investigative requirements and processes for all special-care homes and other facilities operated by the Authority.

   Status: Accepted

2. The Saskatchewan Health Authority ensure anyone assigned to investigate an adverse health event, including critical incidents, is: (a) sufficiently independent so that a reasonably informed person would not be concerned about their impartiality; and (b) appropriately trained to carry out investigations professionally, comprehensively, and in a timely manner.

   Status: Accepted

DECIDING ON THE DECISION-MAKER

Anna's mother Sadie lived in a long-term care home operated by the Saskatchewan Health Authority. After Sadie was admitted, Anna made all decisions about her care, including which medications she would be given, and the home shared all her health information with Anna. When Anna learned that someone she did not approve of had been visiting Sadie, she made a complaint, alleging that the person posed a risk to Sadie's health and well-being, and she accused the home of not keeping her mother safe. Once Anna complained, the Authority quit sharing Sadie's health information with Anna and did not let her make any decisions about Sadie's health care. Anna thought this was a form of retaliation.

We looked at whether the Authority reasonably investigated Anna's allegations. Under the *Program Guidelines for Special-care Homes*, the Authority must take reasonable steps to provide residents an environment free from all forms of abuse, and have procedures for reporting and investigating suspected abuse. Investigations are to be procedurally fair and done promptly. If there is any potential risk to a resident, appropriate interventions are to be taken immediately to ensure their safety.

We found that although the Authority did not document or investigate Anna's allegations exactly as required by the *Guidelines* and its own policies, its response to the complaint was, overall, reasonable:

- When the complaint was made, the Authority took immediate steps to not admit the visitor until it determined Sadie was not in any danger and had the capacity to decide for herself who she associated with.
- Within days, multiple Authority officials were involved in discussing whether more testing was needed to determine Sadie's competency, and whether the visitor should be banned.
- It took reasonable steps to confirm Sadie's mental capacity. Her physician indicated that Sadie had the capacity to make informed decisions about who she associated with and should be free to do so. When Anna did not accept the physician's assessment, the Authority took further steps, including cognitive and mental health assessments.

Once Anna complained, it became evident to some Authority staff that Anna's personal interests in the situation might be in direct conflict with Sadie's. At this time the Authority began to question whether Anna had the legal authority to make decisions on behalf of Sadie. Upon reviewing the power of attorney Sadie signed as well as the health care directive concerning Sadie, it realized Anna did not have the authority to direct Sadie's health care. The health care directive did not comply with *The Health Care Directives and Substitute Health Care Decision Makers Act, 2015.*

Once it realized its mistake, it stopped providing Anna with Sadie's health information and stopped taking her instructions. While this was appropriate, given the context in which it was done, we found that the Authority did not give Anna a proper explanation for its decision. In our view, Anna could not be blamed for feeling the Authority was being obstructive rather than forthright.

We found the Authority's guidelines, rules, Acts and regulations used several terms that were not clearly defined when referring to a person having authority over another person's health care decisions. It was clear that not all Authority staff dealing with Sadie and Anna

understood the definitions of “capacity,” “proxy,” “power of attorney,” “responsible person,” “substitute decision-maker,” “personal guardian,” “health care directive,” “advanced health care directive,” and other terms and phrases found in these documents. These terms became further complicated when used with other terms commonly associated with long-term care, such as “family,” “next-of-kin,” and “key contact.” In our view, Authority staff whose primary role is to actively care for residents could be forgiven for thinking terms such as “responsible person”, “next-of-kin”, “power of attorney” and “proxy” are interchangeable, even though they are not.

We recommended:

1. The Saskatchewan Health Authority develop clear instructions for inclusion in its special-care homes admission procedures for staff to determine:
    a. whether a resident has the capacity to make their own care-related decisions;
    b. whether a resident has appointed a proxy in a health care directive that complies with *The Health Care Directives and Substitute Health Care Decision Makers Act, 2015* and, if so, the circumstances in which the proxy is entitled to make decisions for them;
    c. whether a person has been appointed as a personal decision-maker and/or a property decision-maker for the resident under *The Adult Guardianship and Co-decision-making Act,* and if so, the extent of the person’s authority to make decisions respecting the care and provision of services to the resident in a special-care home; and
    d. if the resident does not have capacity, has not appointed a proxy, and a personal-decision maker has not been appointed, the resident’s nearest relative who is willing and able to make decisions for them as a substitute health care decision maker under *The Health Care Directives and Substitute Health Care Decision Makers Act, 2015*.

    Status: Accepted

2. The Saskatchewan Health Authority ensure that it does not take instructions or directions from anyone who has not been identified as having the authority to make decisions on behalf of the resident.

    Status: Accepted

3. That the Saskatchewan Health Authority ensure that wording and terms used in any Health Care Directive policies and procedures is consistent with the terms used in *The Health Care Directives and Substitute Health Care Decision Makers Act, 2015*.

   Status: Accepted

BETTER INVESTIGATIONS

Sam contacted the Ministry of Health with concerns about the care of a resident in a personal care home. The Ministry investigated Sam's concerns, but Sam felt its investigation was incomplete and did not address all the issues they raised, so they contacted our Office.

According to personalcarehomes.saskatchewan.ca, there are 247 personal care homes licensed in Saskatchewan under *The Personal Care Homes Act.* The Act gives the Ministry the authority to conduct investigations necessary for ensuring the well-being of residents in personal care homes. While the Ombudsman does not have jurisdiction over the homes, we were able to review the Ministry of Health's investigation.

The Ministry's *Guidelines for Conducting Complaint Investigations, Personal Care Homes Program* establish procedures for investigating concerns raised by residents, supporters, and others. We considered whether these *Guidelines* were appropriate for the type of investigation that was conducted, whether they were followed in this case, whether the Ministry addressed all the issues outlined in the complaint, and whether it provided Sam with meaningful reasons for its decisions.

We found that:

- The *Guidelines* were based on reliable investigative and fairness principles but could be improved to provide more guidance to investigators, particularly about how to review and analyze information, how to determine whether complaints are substantiated, how to provide an opportunity for complainants and licensees to review tentative findings, and about ensuring appeals/review processes are available.
- It was inappropriate for the *Guidelines* to enable the Ministry's investigators to share their conclusions with licensees during the interview process (that is, before the investigation is completed).
- It was unclear whether the investigator of Sam's complaint had followed all the applicable steps in the *Guidelines* because some steps were documented while others were not.
- The decision letter the Ministry sent Sam after completing its investigation did not explain how the Ministry arrived at its conclusion.

It is essential that anyone having concerns about the care of a loved one residing in a personal care home has confidence that their concerns are reviewed and investigated fairly and thoroughly.

Therefore, we made the following recommendations:

1. The Ministry of Health update its *Guidelines for Conducting Complaint Investigations, Personal Care Homes Program* so that it provides instructions to investigators:
    a. on how to analyze information gathered during an investigation in order to assess its relevance, reliability, and credibility;
    b. clarifying that both the complainant and licensee have an opportunity to be heard before a final investigation report and conclusion is reached, and to explain when this should occur during the investigation process;
    c. clarifying that it is not appropriate to provide the complainant and/or the licensee with the conclusions of the investigation before the information gathering and assessment stage of the investigation is complete; and
    d. on how to properly document all steps of the investigation.

    Status: Accepted

2. The Ministry of Health take steps to ensure that all decision letters setting out the outcome of a complaint investigation provide more detailed information so that the complainant and the licensee have sufficient reasons for why decisions were made.

    Status: Accepted

3. The Ministry of Health ensure that all decision letters clearly set out the appeal or review process that is available to the licensee and/or the complainant.

    Status: Accepted

THE MISSING DENTURES

Sarah contacted us because she thought the Saskatchewan Health Authority should have taken some responsibility for her mother's dentures going missing during a hospital transfer.

Sarah told us that when her mother, Sonja, was admitted to her local hospital, staff removed her dentures and placed them with her other personal property. Sonja saw the nurse put the dentures into a bag containing her other belongings. Soon after admission, Sonja was transferred to a different hospital and the property bag was placed next to her in the ambulance. When she got to her room in the other hospital, the dentures weren't in the bag. Sarah contacted the Authority. She was told the Authority would not reimburse Sonja for the dentures as it was not possible to say how or where they were lost. Fortunately, the dentures were insured, but Sonja still had to pay a deductible of $500 to get new ones.

The Authority has a policy stating that a patient's personal property is their own responsibility. When we reviewed the situation, however, we determined the circumstances merited further consideration. Medical records indicated that Sonja was not well enough to care for her items herself, and further, there was documentation showing staff had placed the dentures in the property bag prior to transport. We found this placed the responsibility on the Authority to ensure her personal belongings arrived with her. We raised these points with an official at the Authority who agreed with our assessment and subsequently agreed to reimburse Sonja for the $500 deductible.

Status: Resolved

Crown Corporations

Complaints Received

CROWN CORPORATIONS	2021	2020	2019
CROWN INVESTMENTS CORPORATION	1	0	0
FINANCIAL & CONSUMER AFFAIRS AUTHORITY	1	4	1
SASKATCHEWAN CROP INSURANCE CORPORATION	4	4	6
SASKATCHEWAN GOVERNMENT INSURANCE			
Auto Fund	45	35	60
Claims Division - Auto Claims	51	49	68
Claims Division - No Fault Insurance	27	31	32
Claims Division - Other / SGI Canada	23	22	31
Other	8	2	13
TOTAL - SGI	154	139	204
SASKATCHEWAN LIQUOR AND GAMING AUTHORITY	1	2	3
SASKATCHEWAN RESEARCH COUNCIL	0	0	1
SASKENERGY	41	21	34
SASKPOWER	94	79	134
SASKTEL	38	23	37
WATER SECURITY AGENCY	3	2	6
TOTAL	**337**	**274**	**426**

NOTE: Crown corporations about whom we received no complaints in the last three years are not listed in this table.

NOTE: eHealth complaints are reported under the Health section.

Case Examples

CONFIRMING IDENTITY

Steve contacted us because SaskPower refused to provide him with power and did not believe him when he said that previous unpaid bills were due to a relative fraudulently using power in his name.

Steve was moving. When he contacted SaskPower to set up power, he was told he was $6,000 in arrears from a previous account, which would have to be paid first. In addition, there was an older unpaid account of about $500. He admitted owing the $500 but said the $6,000 was not his debt; that a relative had fraudulently set up an account in his name and did not pay the bills.

We contacted SaskPower and asked if it could check its records to determine the facts. Steve had previously told SaskPower that a relative had set up the account using Steve's name and that he had reported this to the police. SaskPower had a record of the police file number. SaskPower also found that the mother's maiden name on the account was not Steve's but the relative's mother's maiden name. In addition, SaskPower found that the voice on a recording of the phone call that was made to set up the account did not match Steve's voice; that it was "definitely different."

SaskPower believed Steve was telling the truth and decided to open an account for him. He would not owe the $6,000, but would have to pay a security deposit, since his $500 debt was too old to collect.

Status: Resolved

HELP FROM SGI'S FAIR PRACTICES OFFICE

Note: We are an office of last resort, which means that people should first try any other options and appeals available to them. When people have not done this yet, we usually refer them back to complete the process. SGI, for example, has a Fair Practices Office to help resolve issues where customers may have hit a roadblock.

Scarlett contacted us because delays in processing her SGI claim were causing problems with her ability to repay her vehicle loan.

Scarlett told us she was driving home from work when she hit a porcupine. She stopped and checked for damage, decided her car was drivable, and continued driving, but did not make it home and had to call a tow truck. When she submitted her claim to SGI, its decision about her claim was delayed while it determined whether her driving the vehicle after the accident would disqualify her claim. She also had trouble reaching her adjuster and then learned he had taken some time away from work. In the meantime, she lost her job because she didn't have a vehicle to drive to work.

When SGI decided to pay out the claim, Scarlett asked that the payment go directly on her vehicle loan. Given the financial difficulties she was in, money deposited to her account could be garnisheed for other debts and she wanted to make sure the claim money was paid to the vehicle loan. Unfortunately, the money was transferred directly to her account, which resulted in several holds and restricted her ability to use the money to pay the vehicle loan. She was struggling to resolve these matters and contacted our Office. She had not taken her concerns to SGI's Fair Practices Office, so we encouraged her to do so. With their help, she was able to withdraw the money from her bank and return it to SGI, which in turn, made the payment directly on her vehicle loan, as she had originally requested.

Status: Information Provided

Other Ministries

Complaints Received

MINISTRIES & EXECUTIVE COUNCIL	2021	2020	2019
ADVANCED EDUCATION*	6	7	6
AGRICULTURE	1	2	7
CENTRAL SERVICES**	n/a	5	3
EDUCATION	5	2	3
ENVIRONMENT	10	8	14
EXECUTIVE COUNCIL	1	0	0
FINANCE	4	6	8
GOVERNMENT RELATIONS	6	4	6
HIGHWAYS AND INFRASTRUCTURE	4	8	12
IMMIGRATION AND CAREER TRAINING	3	3	7
JUSTICE			
Court Services	19	13	10
Maintenance Enforcement Branch	25	37	23
Public Guardian and Trustee	39	19	21
Office of the Public Registry Administration	3	5	2
Justice - Other	17	15	22
TOTAL - JUSTICE	103	89	78
LABOUR RELATIONS AND WORKPLACE SAFETY	11	9	24
PARKS, CULTURE AND SPORT	2	5	5
SASKBUILDS AND PROCUREMENT**	2	0	n/a
TRADE AND EXPORT DEVELOPMENT	0	2	0
MINISTRY NOT DISCLOSED	2	0	0
TOTAL	**160**	**150**	**173**

*Complaints about regional colleges are now reported separately under Other Entities.

** On November 9, 2020, SaskBuilds and the Ministry of Central Services were replaced by the Ministry of SaskBuilds and Procurement.

NOTE: Ministries about whom we received no complaints in the last the last three years are not listed.

Other Entities

Complaints Received

AGENCIES, BOARDS, COMMISSIONS & COLLEGES	2021	2020	2019
ANIMAL PROTECTION SERVICES OF SASKATCHEWAN	3	3	0
APPRENTICESHIP AND TRADES CERTIFICATION COMMISSION	0	0	3
AUTOMOBILE INJURY APPEAL COMMISSION	2	1	2
HIGHWAY TRAFFIC BOARD	5	1	8
OFFICE OF RESIDENTIAL TENANCIES	83	64	105
PRAIRIE AGRICULTURE MACHINERY INSTITUTE (PAMI)	0	0	1
PROVINCIAL CAPITAL COMMISSION	0	1	2
PROVINCIAL MEDIATION BOARD	0	1	2
PUBLIC SERVICE COMMISSION	3	1	2
REGIONAL COLLEGES	2	0	1
SASKATCHEWAN ASSESSMENT MANAGEMENT AGENCY	2	1	0
SASKATCHEWAN EMPLOYMENT ACT ADJUDICATORS	1	1	2
SASKATCHEWAN HUMAN RIGHTS COMMISSION	12	9	14
SASKATCHEWAN LABOUR RELATIONS BOARD	2	0	1
SASKATCHEWAN LEGAL AID COMMISSION	27	23	42
SASKATCHEWAN MUNICIPAL BOARD	1	0	3
SASKATCHEWAN POLYTECHNIC	5	2	3
SASKATCHEWAN PUBLIC COMPLAINTS COMMISSION	11	9	7
SASKATCHEWAN SOCIAL SERVICES APPEAL BOARD	4	3	5
WORKERS' COMPENSATION BOARD	73	59	76
TOTAL	**236**	**179**	**279**

NOTE: Entities about whom we received no complaints in the last three years are not listed.

Complaint Examples

TRYING TO FIX A MISTAKE

Sally contacted us because she thought the Office of Residential Tenancies (ORT) treated her unfairly when, contrary to its communications with her, it did not adjourn a hearing after she provided documentation that she was sick, and it refused to re-hear the matter.

Sally was a landlord. When her tenants ended the lease, Sally believed there was damage done and she served them notice that she intended to keep the security deposit. The tenants disputed this, and the matter was set for a hearing.

Sally became quite ill. She was still recovering when she received notice of the hearing date. She contacted the ORT and asked to have the hearing rescheduled. The ORT told her that if she provided a doctor's note before the hearing date, her rescheduling request would be granted. Sally emailed the doctor's note the same day.

Sally assumed that, since she did what was requested, the hearing would be adjourned. However, the email was not read and was not put on the ORT's hearing file. Since there was nothing about her adjournment request on the file, and she did not answer the hearing officer's call to her, the hearing went ahead as scheduled in her absence, and her request to keep the security deposit was denied.

A few weeks later, Sally contacted the ORT to ask for the date of the rescheduled hearing. The ORT then realized its mistake: that the email had not been dealt with. Staff asked the hearing officer what to do. The hearing officer said that Sally should be told she needed to appeal to the court. Sally was not advised that under *The Residential Tenancies Act, 2006* she had the right to apply to have the hearing officer re-hear the claim.

We found that the ORT treated Sally unfairly in two ways. It failed to follow through on its commitment to process her adjournment request once she submitted the doctor's note in advance of the hearing. It also failed to advise her that it had made the error and that, as a result, she needed to apply to the hearing officer to have the claim re-heard.

We recommended:

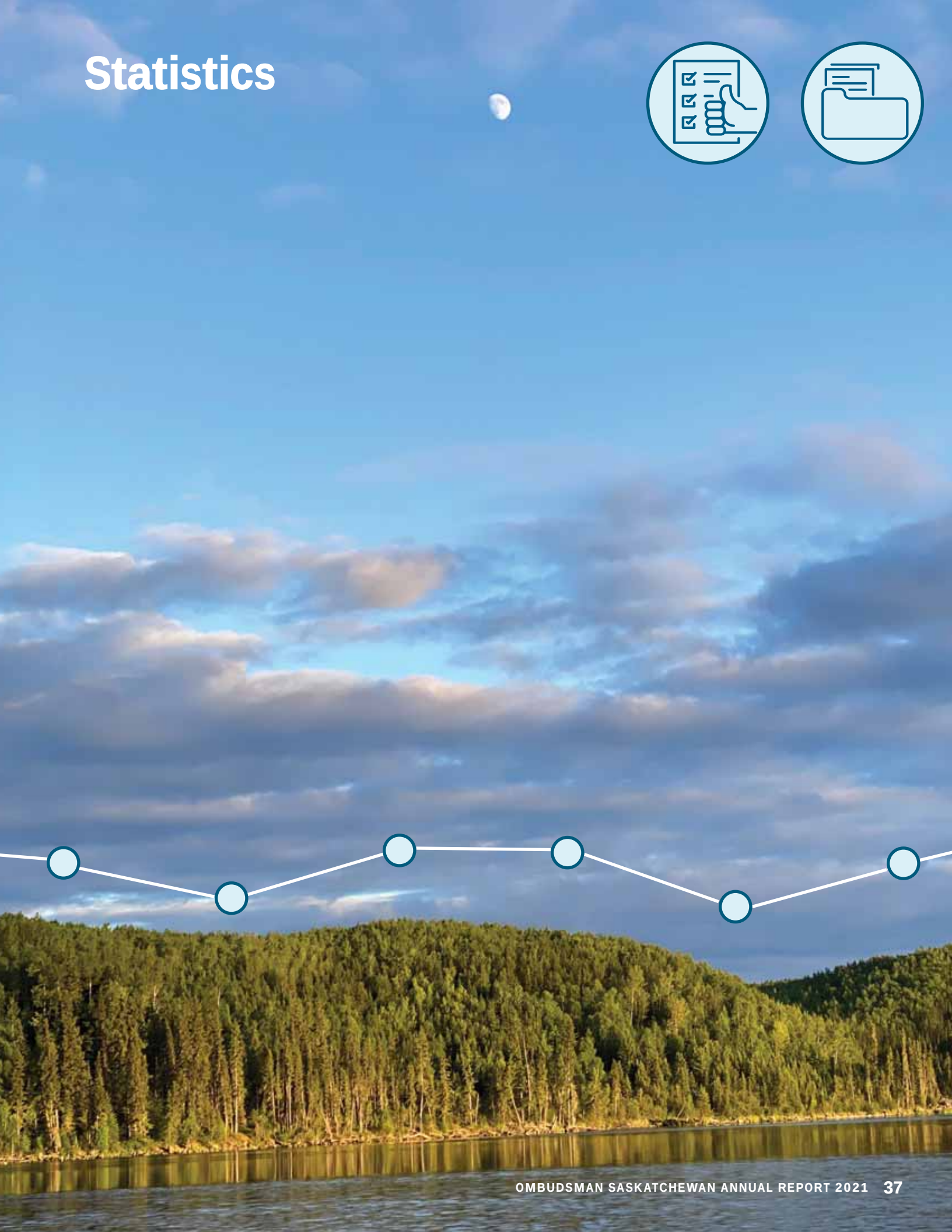
1. The Office of Residential Tenancies clarify the process for adjournments in advance of hearings in its Rules for Procedure, including who has the authority to approve the request, and when the request must be heard by a hearing officer.

   Status: Accepted

2. The Office of Residential Tenancies clarify and explain on its website in what circumstances and how a party may apply for a rehearing.

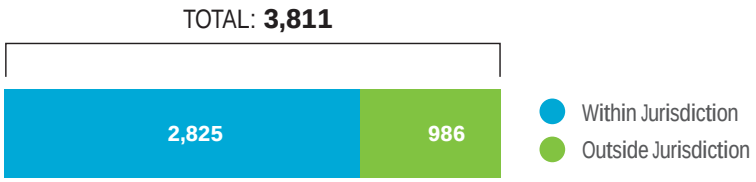
   Status: Accepted

Statistics



Receiving Complaints

Most complaints we receive fall within our jurisdiction, but a significant number do not. In those instances, we take the time to redirect the person to the most appropriate office or service. In 2021, we received 3,811 complaints: 2,825 that were within jurisdiction and 986 that were not.



HOW COMPLAINTS WERE RECEIVED

3,277 Phone Calls

439 Internet Forms

52 Emails

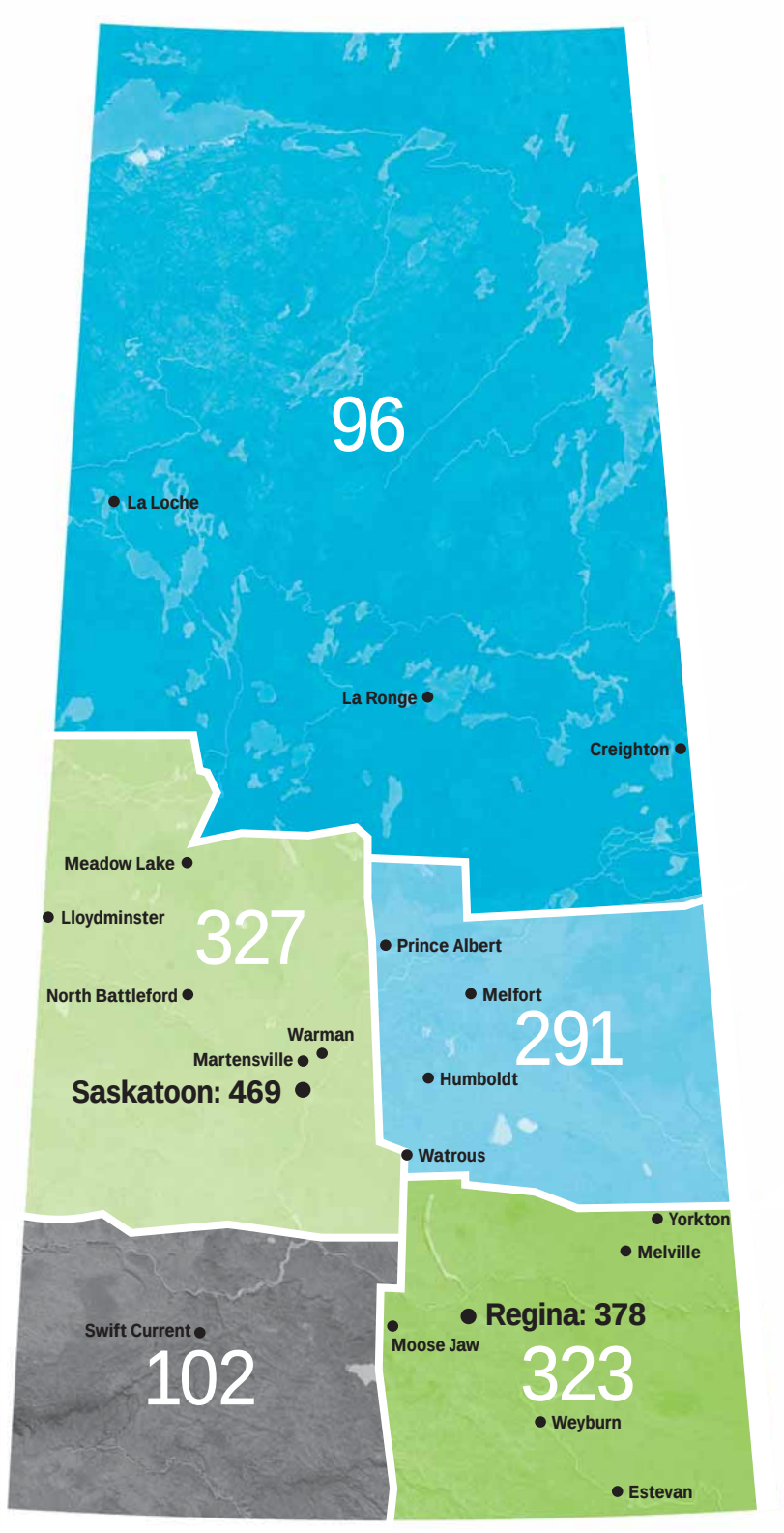
37 Letters

6 Walk-ins

COMPLAINTS RECEIVED OUTSIDE JURISDICTION

TOPIC	COMPLAINTS RECEIVED
Courts/Legal	52
Education	16
Federal Government	142
First Nations Government	18
Health Entities Outside Our Jurisdiction	41
Private Company	235
Private Landlord/Tenant	229
Private Matter	88
Professional	51
RCMP	48
Other	66
TOTALS	**986**

COMPLAINTS RECEIVED BY REGION



This map provides an overview of the complaints we received within our jurisdiction, separated into five regions, plus Regina and Saskatoon. Complaints received from inmates in correctional centres have been counted separately since they do not necessarily represent the home communities of those complainants.

Regions & Larger Cities

North	96
West Central	327
East Central	291
Southwest	102
Southeast	323
Regina	378
Saskatoon	469

Other Locations

Correctional Centres	561
Out of Province	43
Unknown	235

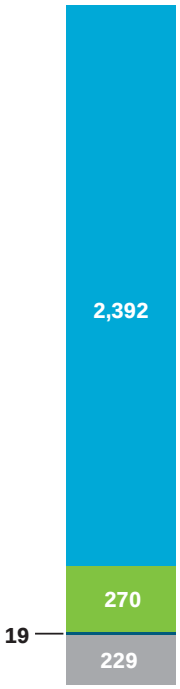
TOTAL Complaints

TOTAL	2,825

Closing Complaints

Each complaint is unique and there are many possible outcomes. However, we have grouped outcomes into the four categories defined below. Please note that not all complaints are closed in the year they are received, so the number received in a year will not necessarily be the same as the number closed. Also, some complaints contain multiple issues, each of which may be closed with a different outcome.

OUTCOMES OF COMPLAINTS WITHIN JURISDICTION



Initial Support
We provided basic support, such as a referral to an appeal process, an advocacy service, or an internal complaints process. At this stage, we encourage people to call us back if their attempts to resolve the matter do not work out.

Resolved
These complaints were resolved in some manner. For example, an appropriate remedy may have been reached or a better explanation provided for a decision.

Recommendations Made
This represents the total number of recommendations made on closed files.

No Further Action
There was no further action required on these files. For example: there was no reason to request the government entity to act, there was no appropriate remedy available, or the complainant discontinued contact with our Office.

TIME TO PROCESS CASES

The time it takes to complete and close a case varies, depending on the circumstances and the amount of work required. Many can be closed within a few days, while others may take several months. Overall, our goal is to complete most cases within six months.

	TARGET	ACTUAL
Files Closed Within 90 Days	90%	96%
Files Closed Within 180 Days	95%	98%

Staff and **Budget**

Staff

Christy Bell
Assistant Ombudsman

Leila Dueck
Director of Communications

Karin Dupeyron
Complaints Analyst

Renée Gavigan
Assistant Deputy Ombudsman

Stacey Giroux
Executive Administrative Assistant

Mike Halayka
Deputy Ombudsman

Jennifer Hall
Assistant Ombudsman

Adrienne Jacques
Complaints Analyst

Yinka Jarikre
Assistant Ombudsman

Ryan Kennedy
Executive Administrative Assistant

Pat Lyon
Assistant Ombudsman

Lindsay Mitchell
Assistant Ombudsman

Sherry Pelletier
Assistant Ombudsman

Nicole Protz
Complaints Analyst

Shelley Rissling
Administrative Assistant

Andrea Smandych
Director of Corporate Services

Niki Smith
Complaints Analyst

Jason Stamm
Complaints Analyst

Greg Sykes
General Counsel

Laurie Taylor
Administrative Assistant

Kathy Upton
Complaints Analyst

Harry Walker
Complaints Analyst

Rob Walton
Assistant Ombudsman

Budget

	2019–2020 AUDITED FINANCIAL STATEMENT*	2020–2021 AUDITED FINANCIAL STATEMENT*	2021–2022 BUDGET**
REVENUE			
General Revenue Fund Appropriation	**$3,714,071**	**$3,213,318**	**$4,354,000**
Miscellaneous	**$990**	**$739**	**-**
TOTAL REVENUE	**$3,715,061**	**$3,214,057**	**$4,354,000**
EXPENSES			
Salaries & Benefits	**$2,383,693**	**$2,310,034**	**$3,280,000**
Office Space & Equipment Rental	**$504,245**	**$562,933**	**$573,400**
Communication	**$33,462**	**$34,104**	**$34,200**
Miscellaneous Services	**$87,659**	**$79,997**	**$135,600**
Office Supplies & Expenses	**$14,671**	**$20,049**	**$16,800**
Advertising, Promotion & Events	**$34,931**	**$60,719**	**$76,300**
Travel	**$52,766**	**$14,339**	**$32,000**
Amortization	**$121,359**	**$121,358**	**-**
Dues & Fees	**$31,507**	**$65,265**	**$82,200**
Repairs & Maintenance	**$93,242**	**$65,869**	**$123,500**
TOTAL EXPENSES	**$3,357,535**	**$3,334,667**	**$4,354,000**
ANNUAL (DEFICIT) SURPLUS	**$357,526**	**($120,610)**	**$0**

*These columns are based on our audited financial statements, which follow our fiscal year (April - March) and our annual report follows the calendar year. The audited financial statements are available on our website at www.ombudsman.sk.ca.

**Due to the timing of this report, 2021–2022 numbers reflect the budgeted amount rather than the actual.