Ombudsman
SASKATCHEWAN

Recommendations 2011

Fourth Quarter Update

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October - December 2011

Overview

At Ombudsman Saskatchewan, we promote and protect fairness in the design and delivery of government services. One of the ways our office does this is by taking complaints from citizens about unfairness in government services.

We assess each complaint we receive to determine whether it is within our jurisdiction and if so, what is the most appropriate method of service: coaching, negotiation, mediation or investigation. For those complaints that require investigation, several outcomes are possible. For example:

- We may determine that the government office was fair and that no further action is needed.
- The government office may discover and voluntarily correct an error.
- We may recommend that the government office make a change or do something differently.

An Ombudsman recommendation is different from a suggestion and is a much more formalized process. Each recommendation is the result of thoughtful research and investigation. It may be specific to the individual that brought the complaint or it may be broader, impacting policy, processes and future interactions for many people.

Although government is not obligated to accept our recommendations, it usually does - and so it should. Recommendations are not made lightly and the applicable government office always has an opportunity to review and comment on a recommendation before it is finalized. This step, which is mandated by *The Ombudsman and Children's Advocate Act,* is part of a fair process and provides an opportunity for government to state any objections they may have or challenges they may face in implementing the recommendation.

Unless there is some good reason to withdraw or change the recommendation, it remains as it is. It is then up to the ministry or government agency to determine whether it will comply with the recommendation and respond accordingly.

For files that were closed in the fourth quarter of 2011, Ombudsman Saskatchewan's recommendations statistics are:

Recommendations Made: 10
Accepted: 9
Partially Accepted: 1
Not Accepted: 0

Recommendations

Following is a brief description ot the complaints that resulted in recommendations and were closed during the fourth quarter of 2011. The names of those involved have been changed to protect their privacy.

Questions from Grieving Parents

Ministry of Justice and Attorney General – Saskatchewan Coroner's Service (SCS)

Danielle and Don's daughter was under 18 when she died in a motor vehicle accident (MVA). After the accident, they learned from the community coroner that, because their daughter had been the driver of one of the vehicles involved in the accident, a complete post-mortem, also known as an autopsy, would be required. As parents, they did not want the autopsy to be performed and did not consent to it, but would have consented to an external examination and toxicology tests. They were told that it was policy that complete post-mortems are required on all drivers who die in a MVA. Danielle and Don believed that they were also not informed of any appeal process to have this decision reviewed.

The parents also questioned why they were not allowed access to their daughter's body before the autopsy, why it took several days to complete the autopsy and why they were not informed that the body had been released to the funeral director until after she was returned to their home community. They felt that their wishes as parents had not been considered, and that the delayed access had made their final goodbyes more difficult.

Danielle and Don also learned that they would be permitted to see the community coroner's report and when it came out they noticed several errors. They were concerned that these errors might affect the outcome of a related court case and asked to have them corrected. They still wanted to know why the autopsy had been done and whether it was really necessary. They wrote to the Chief Coroner about these concerns, but were not satisfied with the response. Still grieving, and with many questions, they contacted our office.

Our investigation encompassed several areas, including the contents and application of policy, the role of the parents, the appeal process, the alleged delays, access to the body, the coroner's investigation, the report, communication and transparency.

Ordering of the Post-Mortem Examination
The Coroner's Act allows the Coroner to "order" a post-mortem and the regulations allow for two types of exams: a complete post-mortem (or autopsy) and a less intrusive external examination. In this case, it was well within the community coroner's legislative authority to order a complete post-mortem. In addition, Saskatchewan Coroner's Service (SCS) policies direct, without exception, that the all MVA driver fatalities undergo a complete post-mortem examination. The policy is based on the need to document, retain and preserve evidence, with respect to the manner and cause of death, should the matter proceed to criminal or civil court or for other civil purposes.

Our review did not question the Coroner's authority under the Act to the order a post-mortem examination. We did, however, question the strict application of the SCS policy requiring that all MVA driver fatalities receive a complete post-mortem examination - both in the general sense and, more specifically, in this case.

Our office understood the need for post-mortem examinations, particularly in matters proceeding through the criminal or civil courts; the time limitations Community Coroners are under to make these decisions; and the serious repercussions of making the wrong decision. We questioned, however, the value of such an intrusive procedure in all but only the necessary cases if other less intrusive means of inquiry are available and would serve the same purpose and meet the same need. In this case it would appear that the less intrusive option could have yielded the same information.

We found that the SCS policy restricts the ability of community coroners to use their discretion in choosing the type of examination ordered in MVA driver fatality cases. It is the Ombudsman position that "policy should never be rigidly applied or interpreted, and decisions must still be made based on the individual circumstances of each situation." The SCS policy requiring all MVA driver fatalities to undergo complete post mortems unduly limits the community coroners' discretion and therefore their ability to make the necessary administrative decisions based on the specific case circumstance.

A great deal of information gathered by the coroner can provide data that may help prevent future accidents. When we reviewed the information in this case and required for these purposes, however, we found that it can all be gathered by means other than a complete post-mortem.

Involvement of the Deceased Person's Parents
Parents are accustomed to being asked for their consent for their children's medical and dental procedures, so learning that they have no say in the kind of examination to be performed on a deceased child can be disconcerting. Don and Danielle believed that they should have been asked for their consent in this situation as well. On the other hand, there is an obligation on the part of government to determine the cause and manner of death in order to prevent future deaths and to assign responsibility for the accident. A policy that provides room for discretion and affords parents a role in the decision-making process would help to balance these two important aspects.

Appeal Limitations
Parents or family members who disagree with a community coroner's decision can contact the Chief Coroner, who will review the case and make a final determination. If families still disagree, they can apply for a review to the Court of Queen's Bench. This step is very technical, however, and is limited to a judicial review of the administrative decision of the Chief Coroner. The community coroner had provided Don and Danielle with a pamphlet, but it did not describe these appeal routes.

Timing of the Post-Mortem
We reviewed the time taken to conduct the autopsy and release the body and found that this was reasonable. In our opinion, information to the contrary that had been given to Don and Danielle was not accurate.

Access to the Body
The parents also believed that they were denied access to their daughter's body because of the post-mortem exam. This does not appear to be the case and we found that this concern could have been better addressed with better communication.

The Coroner's Investigation and Report
Danielle and Don noted several errors in the Final Coroner's Report and Final Autopsy Report

and were concerned that these errors would impact any future court proceedings. We found the errors to be minor and that the report itself was not part of the subsequent court proceedings.

Danielle believed that the community coroner's investigation was incomplete and biased. She thought it would be more like a police investigation and assign blame. The report indicated that the manner of death was accidental, which she believed meant that nobody was at fault. It meant that the cause of death was an accident, rather than a homicide or suicide, for example. The report did not determine fault and would actually have been biased if it did.

The Importance of Communication
Most people learn about what a coroner does from TV or the Internet. Much of this information is incorrect. Other families, like this one, who encounter the coroner in very difficult circumstances, need more clear and detailed information. In this case the family was provided a single pamphlet on the night their daughter died. The pamphlet, though helpful, does not adequately explain the coroner's process prior to autopsy, the need for and purpose of a post-mortem and any available appeal routes. Accessible, clear and concise information is needed to help families make decisions.

The Coroner's Files
In reviewing the community coroner's files, we found that much of the work was hand-written. The electronic templates available for reporting were not compatible with the community coroner's computer and the Office of the Chief Coroner did not provide laptop computers to its community coroners. This paper-based system extends to the Office of the Chief Coroner and hampers the office's ability to gather and analyze information – information that can and should be used to prevent future deaths.

Recommendations

1. The Ministry of Justice and Attorney General and the Office of the Chief Coroner, in conjunction with policing agencies and other affected stakeholders, undertake a comprehensive review of the current Saskatchewan Coroner's Service (SCS) policies requiring that all MVA fatalities undergo a complete post-mortem examination. They should determine if and under what circumstances such examinations are required and develop criteria that would specify the circumstances under which an MVA fatality would undergo a post-mortem examination and of those, which cases require a complete post-mortem and which cases require an external post-mortem examination.

   Status: Accepted

2. The Ministry of Justice and Attorney General and the Office of the Chief Coroner consider the issues of parental involvement when a post-mortem examination (either external or complete) of a deceased minor child is contemplated or ordered by a community coroner. The Ministry and the Office of the Chief Coroner should consider the nature of parental involvement from both a legal and a best practices perspective and develop program policies and practice guidelines that speak to the issue of parental involvement.

   Status: Accepted

3. The Ministry of Justice and Attorney General and the Office of the Chief Coroner develop and implement a review process consistent with the principles of procedural fairness and best practices. The process would look at decisions of the community coroner reviewable by the Chief Coroner, identify what administrative decisions are reviewable, what the appeal process entails, the scope of the review and the timeline for review. This process should then be articulated in OCC policy and produced in information material available to the public both in print and electronically.

   Status: Accepted

4. The Office of the Chief Coroner develop program policies and best practice guidelines that assist the community coroners in determining when a complete post mortem examination would and should be ordered and in what circumstances an external post-mortem examination would and should be ordered.

   Status: Accepted

5. The Office of the Chief Coroner review and if necessary develop information materials directed to family members including parents and guardians of deceased children who may be subject to a post-mortem examination. This material should be made public and easily available.

   Status: Partially Accepted
   The Chief Coroner says that the information provided to parents in the pamphlet "Saskatchewan Office of the Chief Coroner, The Coroner's Investigation" is adequate, that he remains committed to regular reviews of the pamphlet and if additional information is required, changes will be made.

6. The Office of the Chief Coroner acquire and adopt data and case management capability that would allow for greater oversight, support and communication between the Office of the Chief Coroner and community coroners.

   Status: Accepted

7. The Office of the Chief Coroner produce an annual report that provides information concerning their activities and data about the number, type of deaths and findings and recommendations in relation to investigations and inquests.

   Status: Accepted

8. The Office of the Chief Coroner provides opportunities for community coroners who have limited experience to follow or be mentored by more experienced and or skilled coroners.

   Status: Accepted

Towards a Better Understanding

Ministry of Social Services, Income Assistance and Disability Services
Saskatchewan Social Services Appeal Board

Doris was a mother of three children who was living with and caring for an elderly father. A Canadian citizen, she had emigrated from a country where English was not her first language. Doris had a limited understanding of English. Though she could carry on a conversation she had a limited ability to read or write English. Doris was not employed outside the home and received limited support from family. Her father, a senior, was ill did not have the additional income to support Doris and her three children, so she applied for social assistance with the help of her teenage son as a translator, and was placed on assistance.

While Doris and her children were on assistance, her sister had given them money to visit her ailing mother back in her country of origin. Doris did not understand she had to tell her social worker and cancel her social assistance benefits when out of the country. When their social worker learned of the trip, Doris was charged with an overpayment for the social assistance benefits she had received while she was out of country. The money from her sister was determined to be a gift and after subtracting the $200 allowable gift deduction the rest was considered money she had available to support her family and calculated as support for a specified number of months in accordance with the applicable policy. She was now not on assistance, with no income and with a large debt to Social Services to be repaid.

When Doris reapplied for assistance at the end of the calculated time period, Social Services reviewed her financial assets and discovered that Doris's name was on some joint bank accounts with her father. When Social Services confronted Doris about the accounts, she told them she did not know about the accounts and this was the first time she had heard of them.

She was again refused assistance and all the assistance she had been paid since her original application was now deemed to be an overpayment. She and her three children then had to live off of her father's senior income, the Child Tax Benefit and a rental supplement for all their needs.

Her father, who also had a limited ability to communicate in English, met with the Ministry to explain why Doris' name was on the accounts. He explained that the money was to be an inheritance to be left to his entire family should he die. His understanding was that this action replaced the necessity of having a will. He told Social Services she did not know about the accounts. In order to try and resolve the situation, Doris had to show that her name was removed from the accounts. When her father understood the impact, he removed her name from the accounts and verification was provided to Social Services. Social Services placed Doris and her children back on assistance but the overpayment for all previous assistance was still to be paid.

Doris tried to discuss the situation further with Social Services, but English was not her first language and she had trouble communicating. Social Services would not change the decision, so

she appealed to the regional committee and then the Appeal Board, but was denied. At the appeals she was not provided an interpreter to ensure she clearly understood the process, the questions asked and the policies that were being discussed. The advocate who presented her case was not fluent or knowledgeable in Doris's first language so could not ensure Doris clearly understood the information. After the appeal, Doris obtained an adult friend as an interpreter and contacted our office.

Our investigation found that Social Services was following policy when it assessed Doris an over-payment for the assistance money received while she was out of the country and when they considered the funds from her sister as available money to support her family.

We found, however, that Social Services could not demonstrate that Doris actually knew about the joint accounts or that she had accessed them. In reality, the money in the accounts had not been available to her.

We found that, in both instances, the situation was made more difficult because of a language barrier. It was not appropriate for the Ministry and Appeal Board to assume that Doris understood all the rules when she had difficulty communicating in English, nor was it appropriate to rely on a minor to interpret the obligations under the social assistance policy and program. Doris needed to understand the reasons for the decisions and she needed to be able to communicate clearly in return. She needed the services of an interpreter and translator in her first language, but she could not afford to pay for this.

Recommendations

To the Ministry of Social Services

1. That the Ministry of Social Services provide interpreter services at no cost to income assistance applicants and or recipients where:

    a. it appears to ministry staff that the applicant is unable to reasonably appreciate and understand their obligations with respect to receiving social assistance, or

    b. the applicant or recipient has declared that language will serve as a barrier to their ability to appreciate and understand their obligations required to receive social assistance and that assertion appears to be reasonable.

    Status: Accepted

2. That the Ministry remove the overpayment assessed to Doris based on the decision that she had access to funds in any account held jointly with her father.

    Status: Accepted

To the Social Services Appeal Board

1. That the Social Services Appeal Board consult with the Ministry of Social Services to develop and implement a plan of action that will allow the appropriate appeal panels, both at the regional appeal committee level and at the board level, at their discretion or upon request of a respondent, to provide interpreter services at no cost to an income assistance applicant and or recipient where:

    a. the applicant is unable to reasonably appreciate and understand the hearing process and requires the assistance of an interpreter to adequately make presentation to the appeal panel and to actively participate in the appeal hearing, or

    b. the applicant or recipient has declared that language will serve as a barrier to adequately make presentation to the appeal panel and to actively participate in the appeal hearing.

    Status: Accepted