2001 Annual Report

Ombudsman Manitoba

Administrative Accountability

Ombudsman Manitoba

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December 2002

The Honourable George Hickes
Speaker of the Legislative Assembly
Province of Manitoba
Room 244 Legislative Building
Winnipeg MB R3C 0V8

Dear Mr. Speaker:

In accordance with Section 42 of *The Ombudsman Act*, I am pleased to submit the thirty-second Annual Report of the Ombudsman for the calendar year January 1, 2001 to December 31, 2001.

Yours very truly,

Original signed by

Barry E. Tuckett
Manitoba Ombudsman

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Personnel at December 2001

Ombudsman Division:

Donna M. Drever
Deputy Ombudsman

Corinne Caron
Senior Investigator

Cheryl Ritlbauer
Senior Investigator

Linda Barker
Investigator

Robert W. Gates
Investigator

Kris Ramchandar
Investigator

Wanda Slomiany
Investigator

Jack Mercredi
Intake Office/Investigator

Brandon Office:

Janet Wood
Senior Investigator

Mel Holley
Investigator

Sharon Krakowka
Intake/Office Manager

Access & Privacy Division:

Peter Bower
Executive Director

Gail Perry
Manager, Compliance Review

Nancy Love
Manager, Compliance Investigation

Valerie Gural
Compliance Investigator

Debbie Haddad
Compliance Investigator

Carol Markusoff
Compliance Investigator

Darren Osadchuk
Compliance Investigator

Aurele Teffaine
Compliance Investigator

Katherine Wong
Compliance Investigator

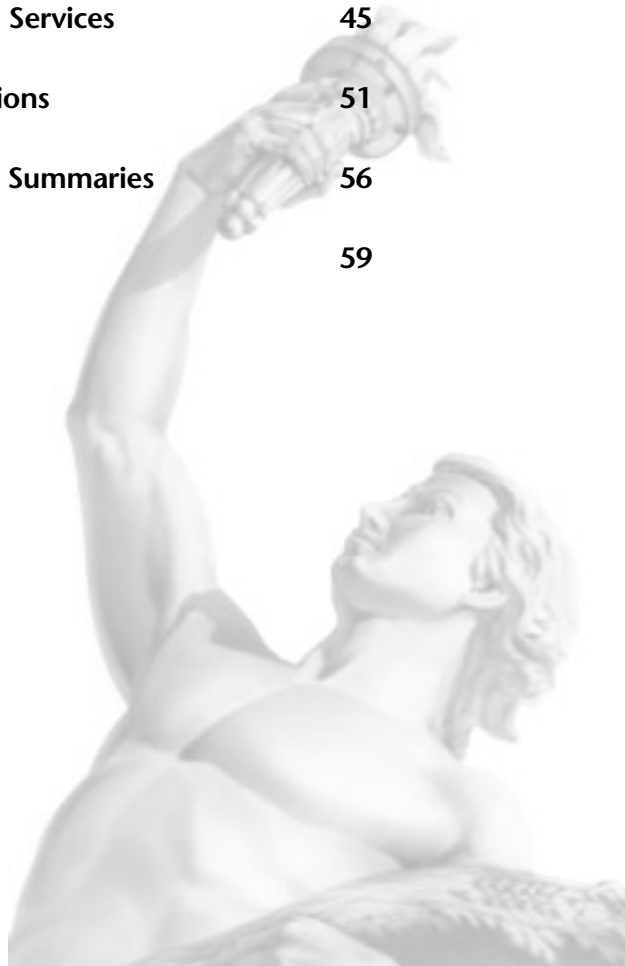
Administration:

Laura Foster
Office Manager

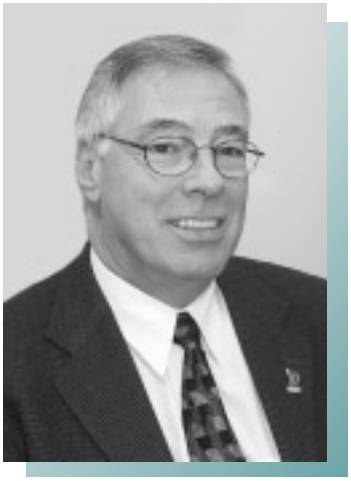
Helen Hicks
Administrative Support Clerk

Jacquie Laberge
Intake Assistant

Felicia Palmer
Administrative Support Clerk



A Message From the Manitoba Ombudsman



Barry E. Tuckett
Manitoba Ombudsman

During the preparation of the 2001 Annual Report of the Ombudsman, I became aware that the Standing Committee of the Assembly on Privileges and Elections had recommended my reappointment as Ombudsman for a further six-year term. The recommendation by this All-Party Committee of the Legislative Assembly was accepted and I was appointed effective March 2, 2002.

The appointment process is not just symbolic. It captures the very essence of the Office. Through it, the Legislative Assembly expresses confidence that the person they recommend for appointment as Ombudsman is, and is seen to be impartial, objective and non-partisan in carrying out the duties and responsibilities under *The Ombudsman Act*. These are fundamental characteristics of the Ombudsman because the level of confidence and commitment received from the Legislative Assembly, the government, and the public has a critical impact on the effectiveness of the Office and its staff.

As an independent Officer of the Assembly, the Ombudsman investigates complaints received against public bodies relating to matters of government administration. On behalf of the Assembly, the Ombudsman seeks to resolve disputes in an informal, non-adversarial and non-legalistic way, using the powers of persuasion, investigation, and recommendation. The role of the Ombudsman is one that promotes open and accountable government and enhances the public's confidence that our public institutions are respecting principles of fairness and equity.

The Office has helped bring resolution to many thousands of disputes over the years. This in itself should not be viewed as an indication that Manitoba does not have a dedicated and professional public service. To the contrary, my experience over the years suggests that we are fortunate to have such a hard working and qualified civil service. It should not be a surprise, however, that at times there are breakdowns in some aspects of the delivery of government services. No system is perfect. The Government is subject to fiscal restraints, growing technical and legal complexities, political and public pressures, and increasing service demands that can be very difficult if not impossible to meet. Under these conditions, one can expect some mistakes, some exercise of poor judgement, some unnecessary delays, and some human error. Within these realities, it is how an organization deals with its mistakes that is a true measure of its commitment to principles of fairness.

Demonstrating commitment to fairness is not always easy

There is reluctance at times to acknowledge mistakes for fear of embarrassment or consequences. There may be time or cost commitments implicated by rectifying an error. There are concerns sometimes that the acknowledgement and resolution of an error can set a precedent.

The Office of the Ombudsman was created to ensure that the Government's commitment to fairness is visible, respected, and upheld. The Ombudsman role imparts to the system a thorough review of administrative actions, decisions or omissions, and brings to the table an objective finding, independent opinion, and impartial recommendation based on reasonableness and standards of fairness, and that is not in itself precedent setting. A public body committed to fairness, equity, and accountability should value and be committed to the role of the Ombudsman.

As I have said before, for the most part civil servants and the public recognize the fundamental and essentially democratic value of independent scrutiny of administrative actions and the

decisions of government. I am pleased to say that most have demonstrated a respect for the role. I must also say, however, that this is not always the case and that I have a concern with what I feel is at times a lack of regard, or at least a very scant regard, for this independent Office of the Legislature.

Some departments and agencies seem to view our Office as being an advocate for a complainant or in an adversarial position. In such situations, we are placed in conflict with government when I feel we should not and need not be.

It seems at times that some departments and agencies don't understand or appreciate the role of the Ombudsman. This is demonstrated when our Office is subjected to long delays in receiving responses to our enquiries, when recommendations are rejected with little or no explanation, and when it takes public scrutiny rather than a recommendation of the Ombudsman to resolve a dispute. These difficulties in resolving disputes are frustrating not only for our office, but also for the public we serve on behalf of the Legislative Assembly. They contribute to backlogs, which are frustrating to the public, as well as to our Office.

The degree to which these factors impact on the public's confidence in our ability to assist in resolving disputes against Government is difficult to measure. However, the fact remains: If our office cannot resolve a valid grievance in a timely manner with our powers of investigation and reporting and our objectivity, what chance does the ordinary person have?

In the case summaries of this Annual Report, we provide details on two cases involving Manitoba Agriculture where our recommendations were rejected. The Department did not dispute the facts we had presented. It did not argue that our findings and conclusions were wrong or unreasonable. It seems to me that the Department simply did not want to accept the recommendations and it did not give appropriate consideration to the matter. I believe the Department viewed our recommendations as just another opinion and it did not give these recommendations the serious consideration and respect that an independent Office of the Legislative Assembly has the right to expect.

Unfortunately, these cases are not isolated incidents. There are several cases in process where I believe a department or agency has shown a misunderstanding of the role or a lack of regard for this Office. I cannot report to the Legislative Assembly on these cases at this time as our Office is still attempting to resolve the issues informally.

While it is discouraging at times to be involved in unnecessary disputes with government, it is important to note that the Legislative Assembly has shown confidence in the Office through the years. In 1997, existing legislation was amended to expand the Ombudsman's independent oversight role to all municipalities except the City of Winnipeg. The mandate of the Office was further expanded significantly in 1997 and 1998 with oversight responsibilities under access and privacy statutes, which cover a wide range of public bodies and personal health information trustees including various health care facilities, agencies, and professionals. At the time of writing this Annual Report, the mandate of the Ombudsman under *The Ombudsman Act* was extended again, this time to the City of Winnipeg, effective January 2003.

While I appreciate the confidence shown by the Legislative Assembly in expanding the role of this Office, I feel I must repeat what I stated in the 2000 Annual Report of the Ombudsman;

> Commitment to open and accountable government has many undisputed benefits for our society. Commitment to these principles has its costs. However, I believe that a lack of commitment to these principles has an even higher cost for Manitobans. Our Office's effectiveness has been hampered by a lack of resources, a lack of jurisdiction in some areas and, at times, a lack of visible commitment by government decision-makers.

I hope that by reiterating my concerns in the 2001 Annual Report, I will draw attention unequivocally to what I believe is a pressing need for a visible and practical commitment by the government and Legislative Assembly to the purpose and value of the Ombudsman role.

Year 2001 In Review

We received approximately 3800 enquiries and formal complaints from the public, a large majority relating to actions and decisions of provincial and municipal governments.

In 2001, we received 719 formal complaints and we responded to approximately 3100 enquiries from the public. With a backlog of 226 files carried forward from previous years, our Office handled 945 files over the year, closing 687. We also carried 258 complaint files into 2002.

Of the complaint files handled in 2001:

- 16% were resolved;
- 2% were partially resolved;
- 13% were not supported;
- 24% were concluded as information supplied;
- 11% were discontinued either by the Ombudsman (3%) or the client (8%);
- 4% were closed as assistance rendered;
- 3% were declined;
- 27% were carried over to 2002.

Numerous Ombudsman's Own Initiative Files were Opened

Under *The Ombudsman Act*, administrative actions and decisions may be investigated on a written complaint or on the Ombudsman's Own Initiative (OOI). For example, when an inquest is held and recommendations are made to a government department or agency relating to a matter of administration, an OOI file is opened to follow-up on the implementation of these recommendations. In addition, an OOI file is opened where an individual complaint identifies a need for a more systemic review of the administrative policies or procedures of a public body.

In 2001, four OOI files were opened to monitor the administrative actions and decisions undertaken as a result of recommendations arising from inquests. In addition, OOIs were opened to review:

- The use of administrative segregation and the use of restraint chairs in correctional facilities;
- The designation of the Manitoba Youth Centre as a place of safety for youth apprehended under *The Child and Family Services Act* and as a detoxification centre for youth under *The Intoxicated Persons Detention Act*;
- The administrative process involved in placing names on the Child Abuse Registry;
- The policies and procedures followed by the Public Trustee to identify inactive client bank accounts, which have been transferred to the Bank of Canada dormant accounts.

While OOI files may be complex and time consuming, the benefit of these initiatives are justified by their value in avoiding unnecessary complaints and bringing assurance that government practices, procedures and policies meet standards of fairness.

Speaking Engagements

As usual, in 2001 we continued to be available to make presentations on the role of the Ombudsman to many groups and organizations. Our staff spoke to supervisory and management staff at the Psychiatric Health Centre at the Health Sciences Centre. Staff made presentations to correctional officers and staff from Employment and Income Security as well as presentations to youth at the Manitoba Youth Centre and the Agassiz Youth Centre. Staff toured various government institutions, including correctional facilities, meeting with directors or managers of departments and agencies to discuss our role and function. We have participated in annual meetings, open houses or other special functions on request and participated in Law Day, held annually at the Law Courts Building.

I also receive many personal invitations from public bodies and other organizations to speak about the Ombudsman role, which I am happy to accept. These include presentations to classes at the University of Winnipeg, the University of Manitoba, the Orientation Program for Management Interns within the Civil Service and the Manitoba Legislative Internship Program.

While I consider outreach and public education an important activity of the Office, we remain committed to reducing our backlog while maintaining a professional and courteous relationship with public bodies and the people whom we serve. We are continually looking for ways to improve and streamline our investigative and complaint resolution process with the emphasis on informality and a non-adversarial and non-legalistic approach.

We find it necessary and important to spend many hours over a year listening to complainants and public bodies, explaining our role and our process, clarifying and providing reasons for our findings and opinions and considering further representations received from those who may disagree with our actions and decision. In many cases a thorough impartial review is not enough. A good ear is necessary along with time, patience and sensitivity to bring closure to disputes that have a history of conflict.

The professional staff of our Office are not only required to fact find, analyze, educate and interpret legislation, but they seek to resolve complaints informally using facilitation, conciliation and mediation skills. I believe the government, the Legislative Assembly and the public are well served by staff of this Office who daily exemplify the dedication and character required to fulfill the important role they play in promoting fairness and equity in government.

Statistics

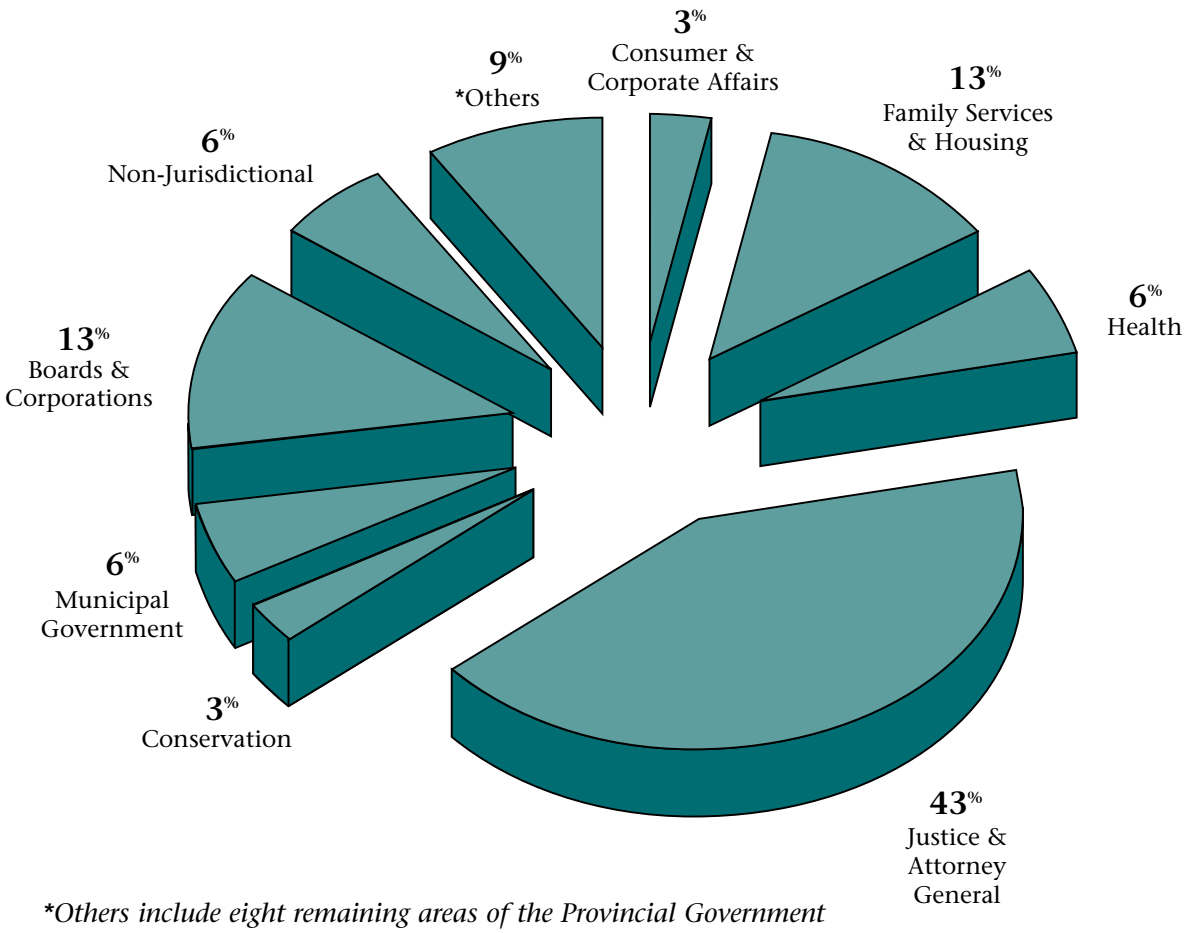
The Office of the Ombudsman opened 719 new complaint files this year. Of these we closed 523 complaint files and fielded 3,108 telephone enquiries. We also closed 164 of the 226 files carried forward from previous years.

An Overview of Complaint Files Ombudsman Staff Worked on in 2001

Disposition of Complaint Files

New complaint files opened in 2001	719
Complaint files carried into 2001 from previous years	226
Total complaint files worked on in 2001	**945**
Complaint files closed in 2001 that were opened in 2001	523
Complaint files closed in 2001 from previous years	164
Total complaint files closed in 2001	**687**
Total complaint files carried over into 2002	**258**

719 New Complaints



**Others include eight remaining areas of the Provincial Government*

New Complaint Files Opened in 2001 by Department or Agency

PROVINCIAL GOVERNMENT DEPARTMENTS (545)

Advanced Education (2)	
Agriculture & Food (2)	
General	1
Manitoba Crop Insurance Corporation	2
Conservation (19)	
General	1
Ombudsman's Own Initiative (OOI)	1
Consumer & Corporate Affairs (22)	
General	5
Consumers' Bureau	1
Residential Tenancies Branch	11
Residential Tenancies Commission	5
Culture, Heritage & Tourism(2)	
Education,Training & Youth (11)	
General	10
Student Financial Assistance	1
Family Services & Housing (91)	
General	17
Child & Family Services	19
Employment & Income Assistance	39
Manitoba Housing Authority	8
Social Services Advisory Committee	5
Ombudsman's Own Initiative (OOI)	3
Finance (3)	
Health (40)	
General	12
Addictions Foundation of Manitoba	1
Health Sciences Centre	2
Manitoba Adolescent Treatment Centre	1
Mental Health	3
Selkirk Mental Health Centre	7
Regional Health Authorities	13
Ombudsman's Own Initiative (OOI)	1
Intergovernmental Affairs (4)	
Justice & Attorney General (308)	
General	23
Agassiz Youth Centre	14
Brandon Correctional Centre	27
Headingley Correctional Centre	114
Milner Ridge Correctional Centre	7
Portage Correctional Centre	15
The Pas Correctional Centre	3
Winnipeg Remand Centre	38
Maintenance Enforcement	18
Human Rights Commission	2
Legal Aid Manitoba	8
Public Trustee	15
Manitoba Youth Centre	9
Courts	8
Ombudsman's Own Initiative (OOI)	7
Labour & Immigration (16)	
General	3
Employment Standards	10
Manitoba Labour Board	3
Transportation & Government Services (25)	
General	14
Driver & Vehicle Licencing	11

BOARDS & CORPORATIONS (95)

Workers Compensation Board (26)	
Corporations and Extra Departmental (69)	
Centra Gas	3
Manitoba Hydro	7
Manitoba Lotteries Corporation	1
Manitoba Public Insurance	58

MUNICIPAL GOVERNMENT (36)

NON-JURISDICTIONAL (43)

City of Winnipeg (2)
Federal Departments & Agencies (5)
Private Matters (35)
Legislative Assembly (1)

Total Complaint Files	**719**

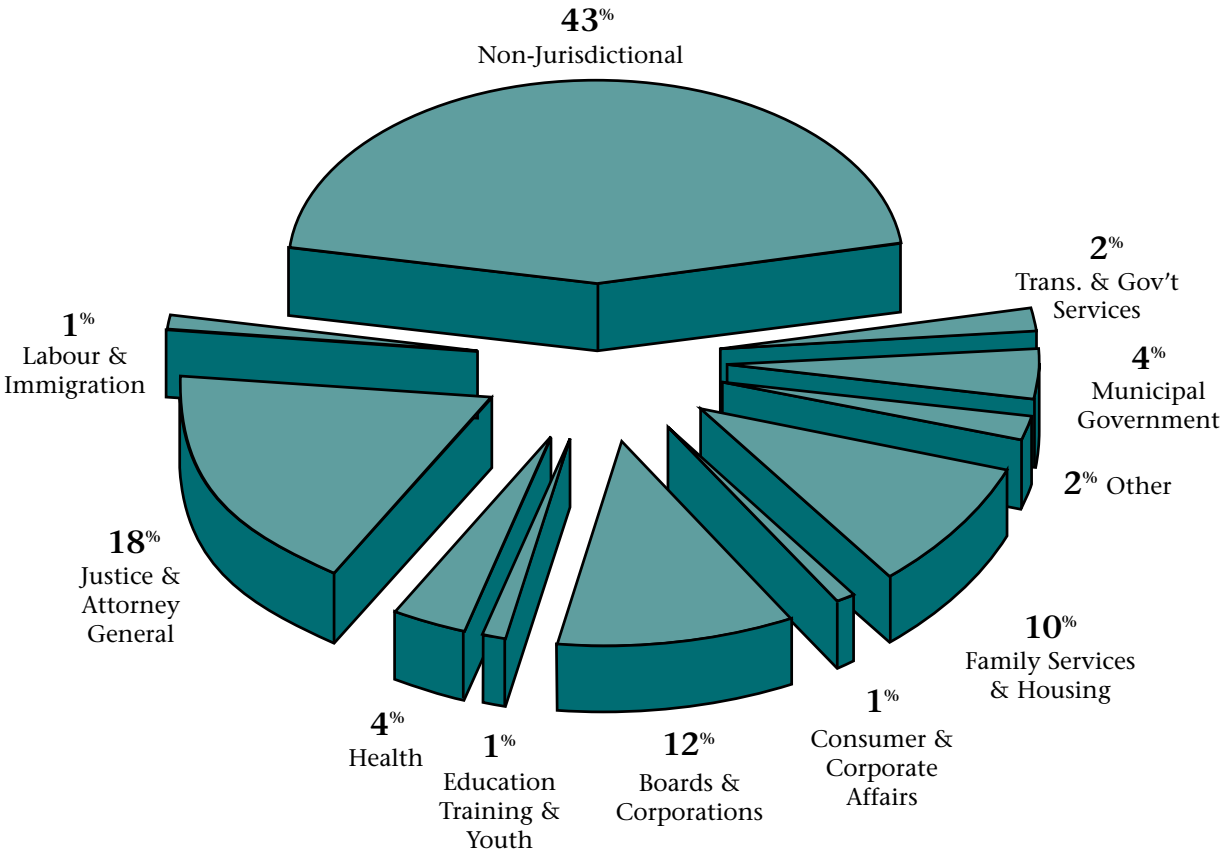
What people PHONED us about in 2001

The past year has shown very little has changed in terms of the type of enquiries our Winnipeg and Brandon office receive, either by phone or when people stop by the Office to discuss a complaint. These are all listed under telephone enquiries.

The complainants may be new but the problems are the same. Lack of effective communication and understanding between the public and the government officials remains a consistent theme in the calls we receive. We are still being told by callers that they are not being informed of appeal avenues if they are dissatisfied with the service received or the decisions made. A certain level of frustration is also expressed with automated telephone systems and sometimes waiting for two or three days to have a call returned.

We continue to play an important role as a source of referral information. Of the total telephone calls and personal contacts handled by our support staff and intake officers, 44% related to complaints that we have no authority to investigate. Some examples are complaints about schools, court decisions, federal departments and agencies, consumer complaints, or private disputes.

The graph below represents the 3,108 enquiries received in the year 2001. These numbers reflect enquiries where no formal intervention is required by our Office. The individual has either received a referral or contact number to the appropriate resource or appeal body; often the information provided at the intake level addresses the concern and no further action is required.



PROVINCIAL GOVERNMENT (1,110)

Aboriginal & Northern Affairs (1)	
Agriculture & Food (9)	
General	5
Manitoba Crop Insurance Corporation	4
Civil Service Commission (1)	
Conservation(31)	
Consumer & Corporate Affairs (51)	
General	8
Residential Tenancies Branch	39
Residential Tenancies Commission	4
Culture, Heritage & Tourism(1)	
Education,Training & Youth (20)	
General	22
Child & Family Services	69
Employment & Income Assistance	206
Manitoba Housing Authority	33
Executive Council(1)	
Family Services & Housing (330)	
General	22
Child & Family Services	69
Employment & Income Assistance	206
Manitoba Housing Authority	33
Finance (4)	
Health (130)	
General	34
Health Sciences Centre	6
Mental Health	59
Selkirk Mental Health Centre	8
Regional Health Authorities	23
Intergovernmental Affairs (4)	
Justice & Attorney General (467)	
General	45
Agassiz Youth Centre	2
Dauphin Correctional Centre	8
Brandon Correctional Centre	81
Headingley Correctional Centre	109
Milner Ridge Correctional Centre	8
Portage Correctional Centre	31
The Pas Correctional Centre	31
Winnipeg Remand Centre	32
Maintenance Enforcement	20
Human Rights Commission	10
Legal Aid Manitoba	16
Public Trustee	34
Manitoba Youth Centre	6
Courts	34
Labour & Immigration (15)	
General	5
Employment Standards	15
Manitoba Labour Board	5
Transportation & Government Services (45)	
General	25
Driver & Vehicle Licencing	20

BOARDS & CORPORATIONS (518)

Workers Compensation Board (107)	
Corporations and Extra Departmental (411)	
General	1
Manitoba Hydro	31
Centra Gas	30
Manitoba Lotteries Corporation	1
Manitoba Public Insurance	347

MUNICIPAL GOVERNMENT (110)

NON-JURISDICTIONAL (1,370)

City of Winnipeg	**35**
Federal Departments & Agencies (182)	
General	162
Employment Insurance	12
RCMP	3
Revenue Canada	5
Private Matters (1,153)	
General	1,052
Consumer	49
Doctors	12
Hospitals	8
Lawyers	7
Schools	25

Total number of telephone calls	**3,108**

Complaint Files Carried into 2001 from Previous Years

Department or Category	Total	Assist. Rendered	Declined	Discont'd (client)	Discont'd (omb.)	Info. Supplied	Not Supported	Partially Resolved	Recom-endation	Resolved	Pending
Provincial Government Departments	**154**										
Agriculture & Food	**10**										
General	8	-	-	-	-	-	3	-	-	-	5
Manitoba Crop Insurance Corporation	2	-	-	-	-	-	1	-	-	-	1
Civil Service Commission	**1**	-	-	-	-	-	-	-	-	-	**1**
Conservation	**22**	1	-	2	2	-	1	-	-	3	13
Consumer & Corporate Affairs	**10**										
General	1	-	-	-	-	-	1	-	-	-	-
Securities Commission	4	-	-	-	-	1	3	-	-	-	-
Residential Tenancies Branch	3	-	-	-	1	1	1	-	-	-	-
Residential Tenancies Commission	2	-	-	-	-	1	1	-	-	-	-
Culture, Heritage & Tourism	**1**	-	-	-	-	-	-	-	-	-	1
Education, Training & Youth	**3**										
General	1	-	-	-	1	-	-	-	-	-	-
Student Financial Assistance	2	-	-	1	-	-	1	-	-	-	-
Family Services & Housing	**12**										
General	1	-	-	-	1	-	-	-	-	-	-
Child & Family Services	7	-	-	1	-	-	-	-	-	1	5
Employment & Income Assistance	1	-	-	-	-	-	-	-	-	-	1
Manitoba Housing Authority	3	-	-	-	1	-	2	-	-	-	-
Health	**10**										
General	6	-	-	-	-	-	3	-	-	2	1
Health Sciences Centre	1	-	-	-	-	-	-	-	-	-	1
Regional Health Authority	3	-	-	-	-	1	-	-	-	-	2
Intergovernmental Affairs	**2**	-	-	-	-	-	2	-	-	-	-
Justice & Attorney General	**71**										
General	15	-	-	1	4	1	2	1	-	2	4
Agassiz Youth Centre	1	-	-	-	1	-	-	-	-	-	-
Brandon Correctional Centre	1	-	-	-	-	-	-	-	-	1	-
Headingley Correctional Centre	16	-	-	2	-	5	5	3	-	1	-
Portage Correctional Centre	9	-	-	2	-	-	5	1	-	-	1
The Pas Correctional Centre	5	-	-	-	-	1	-	-	-	4	-
Winnipeg Remand Centre	8	-	-	-	-	-	4	-	-	2	2
Maintenance Enforcement	4	-	-	-	-	1	1	-	-	2	-
Human Rights Commission	4	1	-	1	-	-	1	-	-	-	1
Legal Aid Manitoba	3	-	-	-	-	-	3	-	-	-	-
Public Trustee	5	1	-	-	1	-	1	-	-	1	1
Labour & Immigration	**3**										
General	1	-	-	-	-	-	-	1	-	-	-
Employment Standards	1	-	-	-	-	-	-	-	-	-	1
Manitoba Labour Board	1	-	-	-	-	-	1	-	-	-	-
Transportation & Government Services	**9**										
General	7	1	-	-	-	1	3	-	-	-	2
Driver & Vehicle Licencing	2	1	-	-	-	-	1	-	-	-	-
Boards & Corporations	**71**										
Workers Compensation Board	**16**	-	-	1	-	-	7	-	-	1	7
Corp. & Extra Departmental	**26**										
Manitoba Hydro	1	-	-	-	-	-	-	-	-	-	1
Manitoba Lotteries Corporation	1	-	-	-	-	-	1	-	-	-	-
Manitoba Public Insurance	24	-	-	1	-	5	11	2	-	3	2
Municipal Government	**34**										
Non-Jurisdictional	**1**										
Private Matters	**1**	-	-	-	-	**1**	-	-	-	-	-
Total Complaints	**226**	**5**	**-**	**14**	**12**	**23**	**74**	**9**	**-**	**27**	**62**

At the close of 2000, there were 226 complaint cases still pending:

- 181 were carried over from 2000
- 33 originated in 1999
- 10 originated in 1998
- 1 originated in 1997
- 1 originated in 1996

We closed 164 or 73% of these pending cases. Of the 62 complaints still pending:

- 39 originated in 2000
- 16 originated in1999
- 5 originated in1998
- 1 originated in1997
- 1 originated in1996

New Complaint Files Received in 2001 by Category and Disposition

Department or Category	Total	Assist. Rendered	Declined	Discont'd (Client)	Discont'd (Omb.)	Info. Supplied	Not Supported	Partially Resolved	Resolved	(1) Reco-mendation (A) (NA)	Pending
Provincial Government Departments	**545**										
Advanced Education	**2**	-	-	-	-	-	-	-	**2**	-	-
Agriculture & Food	**2**										
General	1	-	-	-	-	-	-	-	-	-	1
Manitoba Crop Insurance Corporation	1	-	-	-	-	-	-	-	-	-	1
Conservation	**19**										
General	17	-	1	1	-	3	-	-	1	-	11
Ombudsman's Own Initiative (OOI)	2	-	-	-	-	-	-	-	-	-	2
Consumer & Corporate Affairs	**22**										
General	5	-	-	1	-	-	-	-	-	-	4
Consumers' Bureau	1	-	-	-	-	-	1	-	-	-	-
Residential Tenancies Branch	11	-	-	1	-	5	-	-	1	-	4
Residential Tenancies Commission	5	-	-	-	1	1	-	-	1	-	2
Culture, Heritage & Tourism	**2**	-	-	-	**1**	-	-	-	-	-	**1**
Education, Training & Youth	**11**										
General	10	-	2	-	1	2	-	-	1	-	4
Student Financial Assistance	1	1	-	-	-	-	-	-	-	-	-
Family Services & Housing	**91**										
General	17	-	2	1	1	6	1	-	2	-	4
Child & Family Services	19	1	-	1	1	6	2	-	-	-	8
Employment & Income Assistance	39	-	2	3	-	8	5	2	14	-	5
Manitoba Housing Authority	8	-	-	-	-	4	1	-	2	-	1
Social Services Advisory Committee	5	-	-	-	-	2	3	-	-	-	-
Ombudsman's Own Initiative (OOI)	3	-	-	-	-	-	-	1	-	-	2
Finance	**3**	-	**1**	-	-	**1**	-	-	-	-	**1**
Health	**40**										
General	12	3	-	1	1	-	1	-	4	-	2
Addictions Foundation of Manitoba	1	-	-	-	-	-	-	-	-	-	1
Health Sciences Centre	2	-	-	1	-	-	-	1	-	-	-
Manitoba Adolescent Treatment Centre	1	-	-	-	-	-	-	-	-	-	1
Mental Health	3	-	-	2	-	1	-	-	-	-	-
Selkirk Mental Health Centre	7	-	-	1	1	1	1	1	-	-	2
Regional Health Authority	13	1	-	-	-	3	2	-	3	-	4
Ombudsman's Own Initiative (OOI)	1	-	-	-	-	-	-	-	-	-	1
Intergovernmental Affairs	**4**	-	-	-	-	**1**	-	-	**1**	-	**2**

(1) Recommendation (A) = Accepted, (NA) = Not Accepted

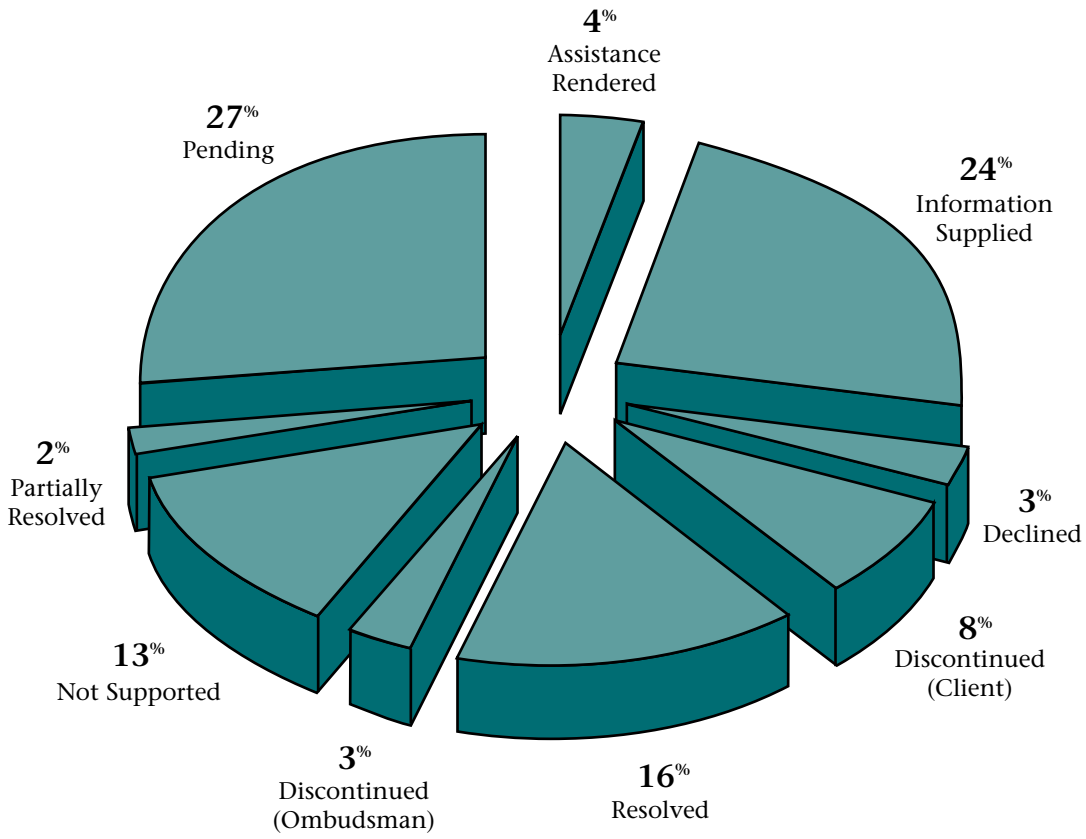
Department or Category	Total	Assist. Rendered	Declined	Discont'd (Client)	Discont'd (Omb.)	Info. Supplied	Not Supported	Partially Resolved	Resolved	(1) Recommendation (A) (NA)	Pending
Justice & Attorney General	**308**										
General	23	-	3	1	-	7	3	-	3	-	6
Agassiz Youth Centre	14	-	-	2	-	1	4	-	3	-	4
Brandon Correctional Centre	27	1	-	1	-	6	8	-	3	-	8
Headingley Correctional Centre	114	3	-	14	3	21	18	3	34	-	18
Milner Ridge Correctional Centre	7	-	-	1	-	-	2	-	2	-	2
Portage Correctional Centre	15	-	-	-	-	6	3	-	5	-	1
The Pas Correctional Centre	3	-	-	1	-	-	-	-	2	-	-
Winnipeg Remand Centre	38	1	-	6	-	8	8	1	7	-	7
Maintenance Enforcement	18	1	1	-	-	8	1	-	2	-	5
Human Rights Commission	2	-	-	-	-	-	1	-	-	-	1
Legal Aid Manitoba	8	1	-	-	-	2	2	-	1	-	2
Public Trustee	15	2	-	-	1	4	3	-	1	-	4
Manitoba Youth Centre	9	1	-	3	-	2	-	-	1	-	2
Courts	8	-	1	1	2	1	-	1	2	-	-
Ombudsman's Own Initiative (OOI)	7	-	-	-	-	-	-	1	-	-	6
Labour & Immigration	**16**										
General	3	-	-	-	-	1	-	-	-	-	2
Employment Standards	10	-	1	-	-	2	-	1	1	-	5
Manitoba Labour Board	3	-	-	-	-	3	-	-	-	-	-
Transportation & Government Services	**25**										
General	14	-	-	1	1	2	2	-	1	-	7
Driver & Vehicle Licencing	11	1	1	-	-	3	4	-	-	-	2
Boards & Corporations	**95**										
Workers Compensation Board	**26**	**3**	**2**	**2**	**2**	**3**	**2**	-	**1**	-	**11**
Corp. & Extra Departmental	**69**										
Centra Gas	3	-	-	1	-	1	-	-	-	-	1
Manitoba Hydro	7	-	-	-	-	4	-	-	-	-	3
Manitoba Lotteries Corporation	1	-	-	-	-	-	1	-	-	-	-
Manitoba Public Insurance	58	3	-	3	3	11	8	2	10	-	18
Municipalities	**36**										
Non-Jurisdictional	**43**										
City of Winnipeg	**2**	**2**	-	-	-	-	-	-	-	-	-
Federal Departments & Agencies	**5**	-	**1**	-	**1**	**3**	-	-	-	-	-
Private Matters	**35**	**1**	**1**	**4**	**3**	**25**	-	-	-	-	**1**
Legislative Assembly	**1**	-	-	-	-	**1**	-	-	-	-	-
Total Complaints	**719**	**29**	**20**	**56**	**23**	**173**	**93**	**16**	**113**	-	**196**

Where do the people making formal complaints in 2001 live?

Altona	1
Anola	1
Arborg	1
Arnaud	1
Arnes	1
Beaconia	1
Beausejour	14
Binscarth	1
Bowsman	1
Brandon	61
Brunkild	2
Carberry	1
Cartier	1
Carman	1
Carroll	2
Churchill	3
Cranberry Portage	1
Cromer	3
Cross Lake	1
Dauphin	6
Deloraine	6
Dugald	3
East St. Paul	3
Flin Flon	2
Gimli	1
Gladstone	1
Grand Beach	1
Grandview	1
Grunthal	1
Harding	1
Headingley	113
Ile des Chênes	1
Inwood	1
Kelwood	1
Kola	1
La Riviere	1
Lac du Bonnet	3
Laurier	2
Little Saskatchewan First Nation	1
Lorette	1
Lowe Farm	1
McCreary	1
Minitonas	1
Minnedosa	7
Morden	2
Morris	1
Neepawa	2
Niverville	1
Oakville	1
Ochre River	2
Onanole	2
Petersfield	1
Pinawa	1
Plumas	2
Portage la Prairie	36
Pukatawagan	1
Rathwell	2
Reston	1
Richer	1
Rossburn	2
San Clara	1
Selkirk	15
Shoal Lake	1
Sifton	1
Souris	2
St. Adolphe	1
St. Andrews	3
St. Claude	1
St. Jean Baptiste	1
St. Malo	1
Ste. Anne	3
Stockton	1
Swan River	1
Teulon	1
The Pas	5
Thompson	2
Tyndall	2
Vermette	1
Virden	1
Waskada	1
West St. Paul	1
Winnipeg	337
Winnipeg Beach	1
Woodridge	1
Subtotal	**702**
Alberta	4
British Columbia	5
New Brunswick	1
Ontario	2
Saskatchewan	2
USA	3
Subtotal	**17**
Total	**719**

Disposition of Files Received in 2001

The graphic below represents the 719 new complaint files received by the Office of the Ombudsman in 2001.

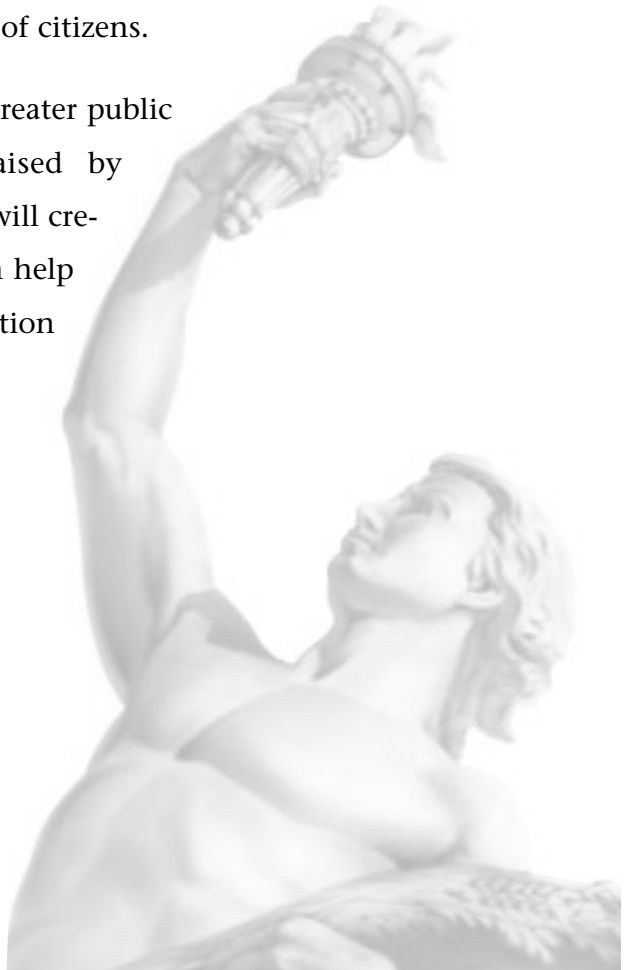


Selected Overviews of Organizations and Case Summaries

Being included in, or excluded from this section of the Annual Report is not intended to indicate any particular organization's level of commitment to the principles of fairness and equity and administrative accountability.

This section of the Annual Report is intended to profile some of the cases that my staff and I worked on in 2001. These cases are indicative of some of the issues and challenges that people brought forward for our help. They are here to put a human face to the problems that many people face in dealing with government and its agencies as well as some of the challenges that government bodies face in trying to meet the expectations of citizens.

We hope that their inclusion will help to facilitate greater public awareness and discussion about the issues raised by Manitobans in 2001. Furthermore, we hope that it will create more opportunities for positive changes that can help alleviate some of the challenges identified in this section of the report.



Provincial Government Case Summaries

154 Complaint Files Carried into 2001

545 New Complaint Files Received against Provincial Government Departments and Agencies in 2001

1,110 Telephone Enquiries Received in 2001

503 Complaint Files Closed in 2001

76% of our total number of formal complaints received in 2001 involved the provincial government. Of the new complaint files we received about the provincial government:

- 56% involved Manitoba Justice and Attorney General
- 17% involved Family Services and Housing
- 7% involved Manitoba Health
- 5% involved Manitoba Transportation and Government Services
- 4% involved Manitoba Consumer and Corporate Affairs
- 3% involved Manitoba Conservation
- 3% involved Manitoba Labour and Immigration
- The remaining 5% of new complaint files were spread amongst Advanced Education; Agriculture and Food; Culture, Heritage and Tourism; Education, Training and Youth; Finance; Intergovernmental Affairs and the Legislative Assembly.

Manitoba Advanced Education

0 Complaint Files Carried into 2001
2 New Complaint Files Received in 2001
0 Telephone Enquiries Received in 2001
2 Complaint Files Closed in 2001

The Department of Advanced Education was created on January 17, 2001. The Manitoba Ombudsman received two complaints concerning this Department:

CASE SUMMARY

Going the Extra Mile

A student contacted our Office alleging that mishandling of his second term disbursement funds by Student Loans had been costly both financially and in terms of aggravation with creditors. He was requesting $125 to recover his costs for NSF cheques and other penalties. Enquiries with the Student Financial Assistance Program suggested that the fault was not theirs but the problem arose as a result of computer "glitches" with the University of Manitoba. Nevertheless, at the student's request, the Investigator spoke with his bank and the University to discuss the financial problems that had resulted through no fault of his own. We have no jurisdiction over either institution, but after explaining the situation the bank agreed to reverse the NSF charges. The University was also prepared to discuss reimbursement of other penalties directly with the student.

CASE SUMMARY

Putting it Right

The second complaint was from a former resident in Flin Flon who had graduated from the Health Care Aide course offered by Keewatin Community College (KCC) to prepare herself for a move and career in Saskatchewan. She could have attended a college right across the border in Saskatchewan but was a proud Manitoban. She had also been assured that the certificate from Manitoba would be valid in Saskatchewan. She graduated, obtained a job in a Saskatchewan hospital and then discovered that two of the courses she had taken at the KCC were not recognized in that province. She contacted our Office for help. We wrote to the President of the KCC and received an immediate response back with the promise of contacting us the following week with a proposed solution. The President was good to his word. He agreed to reimburse the expenses incurred by the Health Care Aide in attempting to have her credentials approved in Saskatchewan and to pay any tuition fees if she had to take any further courses to earn accreditation. The immediate and practical response by the President brought this to a successful conclusion.

Manitoba Agriculture and Food

10	**Complaint Files Carried into 2001**
2	**New Complaint Files Received in 2001**
9	**Telephone Enquiries Received in 2001**
4	**Complaint Files Closed in 2001**

This year our Office opened only 2 new complaint files against Agriculture and Food, as compared to the 18 we opened in 2000. While the complaints have dropped significantly, we continued to spend considerable time and effort on 2 cases from pervious years where formal recommendations were made to the Minister and these were not accepted.

Recommendations are made to a Minister only after an unbiased, independent, thorough investigation and after all attempts at informal resolution have failed. In the following cases, it seems to me that the Department has not given adequate regard to the role the Ombudsman plays on behalf of the Legislative Assembly, in terms of the impartiality when investigating citizen complaints and fighting for citizen's rights to fair treatment and accountability.

It is troubling that in rejecting the recommendations, the Department did not dispute the substantial factual information that supported our findings and conclusions, nor did it provide any rebuttal to support that the recommendations were wrong, unreasonable or could not be implemented. It is unfortunate that situations like this arise as they serve no interest and tend to diminish the public's credibility of the Department and of this Office of the Legislature, in terms of promoting fair treatment and accountability.

CASE SUMMARY

Manitoba Agricultural Credit Corporation (MACC)

MACC Makes a 29% Profit on Land Settlement at Farmer's Expense

This case began in 1996 when a farmer contacted us because he felt that MACC had unfairly assessed the value of his land. Our investigation supported the farmer's position and recommendations to resolve the matter were made to the Deputy Minister and the Ministers of Agriculture under both the Progressive Conservative and the current New Democratic Government administrations. I had hoped for a positive resolution in 2001 but that was not to be.

Ombudsman recommendations based on unbiased thorough review of facts

While I continue to believe that the farmer has a valid complaint, our file was closed as the Minister responsible for Manitoba Agriculture and Food refused to accept the recommendation of the Ombudsman. This is particularly disturbing, as the Ombudsman is an independent Officer of the Legislative Assembly, appointed to provide unbiased, independent and thorough investigations into complaints received from Manitobans who believe they have been treated unfairly. Recommendations are not made lightly, and are made only after all attempts at informal resolution have failed.

When the Legislature appoints an Ombudsman for the purpose of rendering impartial decisions it should be incumbent on the Department to give serious consideration to the matter with a view to accepting the Ombudsman's recommendation unless it can be shown that the premise on which the recommendation is made, is wrong or not based on fact. In this case, the Department did not dispute the factual information that supported our findings and conclusions, nor did it argue that the recommendation was wrong or unreasonable or could not be implemented.

Here are the Facts:

In order to satisfy a debt owed to MACC a farmer entered into an agreement in March 1996, through his lawyer, with MACC to pay a sum of cash and transfer two parcels of land to MACC. MACC had appraised the land in December 1995 and January 1996. At that time, the farmer had advised MACC that he disagreed with the appraised amount believing it to be too low. He had made MACC aware of an accepted Offer to Purchase he had received in January 1996 on a parcel of comparable land, which showed a much higher value for land than the MACC appraisal. He felt MACC should have taken this accepted Offer to Purchase into consideration when establishing their values. However, MACC would not consider it, as it was not what they deemed to be a completed sale. The farmer felt he had no other option but to accept MACC's appraised values when MACC indicated that it would take possession of his land within days by means of foreclosure proceedings.

A few months later, when the farmer exercised his option to buy back the two parcels of land, MACC conducted a new appraisal. This appraisal of August 1996 established values of approximately 29% and 18% higher on the respective parcels of land than when the farmer had transferred them to MACC.

Our investigation supports complaint

The farmer, again through his lawyer, objected to the increase in value and expressed the opinion that land values had not increased that much in such a short period of time. Rather, he argued the higher appraisal in August supported his belief that MACC had originally undervalued the land at the time of its transfer to MACC. MACC, however, remained confident that its appraisal values accurately reflected market conditions.

When the farmer could not resolve the matter by dealing directly with MACC, he approached our Office and requested that we review his concerns. Our Office conducted a lengthy and extensive investigation into the complaint. As well as meeting with the farmer and his legal counsel, there were numerous letters, meetings and discussions with officials of both MACC and Manitoba Agriculture and Food regarding their position and how the appraisals were conducted.

Our investigation revealed that:

- the values placed on the lands the farmer originally transferred to MACC were too low and
- MACC had used two different sets of criteria to assess the value of the land when it had been purchased and then sold back to the farmer.

MACC had repeatedly advised us of its policy/practice that it used only "completed sales" when establishing a value on property, whereas our review showed that for the August 1996 appraisal, MACC had contacted other sources for recent sales and that some of the sales that

were considered in that appraisal were not, in fact, "completed sales". MACC had advised our Office that it did not consider potential sales in establishing its appraisal values. This was repeated to us on numerous occasions. In June 2000 MACC wrote:

> *MACC does not enter into hearsay by asking realtors, parties to sales, or market commentators for value indications. An informed and defendable opinion can be best stated from sale confirmation data obtained from the Assessment Branch.*
>
> Registration dates reported to the Assessment Branch are the accepted and uniform date used by MACC in order to establish relevancy and accuracy. These records provide certainty and are readily available. MACC consistently uses this approach.

Our investigation revealed, however, that in the August appraisal, MACC had contacted other sources for other recent sales not confirmed with the Assessment Branch and had also considered sales that were not "completed sales".

We also noted that MACC's August 1996 appraisal included sales of comparable land, which had not been used in the December/January appraisals. The information regarding these sales was available at the time of the first appraisals and MACC should have been aware of them. In my opinion, these sales were relevant to the assessment of the value of the land that had been transferred.

Conclusion

For over four years our Office received contradictory information from MACC and Manitoba Agriculture and Food that necessitated further enquiries and prolonged resolution of this matter. Numerous attempts to resolve the matter, including recommendations to the Minister of Agriculture in January 1999 and again in January 2001 were not accepted.

In a final attempt to resolve this issue, I met with the Minister and the Deputy Minister in November 2001. No arguments were put forward to dispute my findings but their position remained unchanged. I feel this is a case where a farmer has a valid grievance that has gone unresolved.

CASE SUMMARY

Manitoba Agriculture and Food

Buyer Beware when purchasing from Manitoba Agriculture and Food!
Department Ignores Ombudsman's Recommendation to Pay for Diseased Elk

In January 2000 our Office received a letter from Mr. G who felt that he had been treated unfairly by the Provincial Government. In his correspondence, Mr. G advised that in September 1997 he had purchased six cows and one bull elk from the Province under the 1997 Elk Dispersal Draw. In December 1997, he noticed that the bull that cost $4,000 was limping badly. In January 1998, a veterinarian treated the bull, but the animal subsequently died in April 1998. The dead bull was re-examined by the veterinarian who reported a non-responsive narcotizing footrot of the left hind and a large number of abscesses distributed throughout the body.

Mr. G felt that he should be compensated for the elk. He contacted our Office when his efforts to resolve the matter with Manitoba Agriculture and Food were not successful. He acknowledged that he had signed an offer to purchase contract that specified that the elk were sold on an "as is, where is basis." Nevertheless, he felt that it was unfair that his request

for compensation was denied. He explained that the veterinarian's report supported that the bull had a pre-existing health problem. In addition, he was of the view that he had every right to expect that he had been sold a healthy animal.

Information on the Department's file indicated that:

- Necrobacillosis is a common disease in farmed elk, with a variable time between the initial injury (allowing access to the infective bacteria) and the development of clinical symptoms. The disease is refractory to treatment and many infected elk proceed to die as the infection spreads to various organs in the body. Hoof problems due to bacterial invasion appear to be of long duration, as noted in post-mortem reports.
- Three elk were shipped from Crane River for dispersal. These three elk developed hoof problems (necrobacillosis).
- Prior to the dispersal, the Department was aware of hoof problems involving one of the elk that was being shipped from Crane River. This elk was pulled from the dispersal as it showed signs of lameness. The other two elk subsequently died of the disease.
- At the time of the dispersal, staff noticed another lame elk in a group of older velveting males assembled for the draw. When the male elks were brought in for the dispersal, all appeared to be walking normally and the lame elk could not be identified. In a departmental report, it was acknowledged that it was quite conceivable that the elk in question were harboring the infection at the time of the dispersal and that the lame elk noticed at the dispersal may have been one of the elk that subsequently died. The departmental report recommended that consideration be given to replacing the two elk from Crane River that subsequently died.
- After considering the matter, the Department decided not to provide compensation because of the precedent it would set. It was noted that there was a disclaimer in the package of material that producers received and that prices were set well below market prices because of the risk associated with animals from the wild. It was our understanding that the waiver of responsibility was based on the fact that the Department had no history of the condition of animals from the wild and, accordingly, the animals could not be guaranteed.

Recommendation to Minister

Following a thorough review of Mr. G's concern, and numerous dealings with departmental staff, including the Deputy Minister of Manitoba Agriculture and Food, no resolution could be reached. I was not prepared to accept the rationale used by the Department for refusing to compensate our complainant. Accordingly, I reported my findings to the Minister of Agriculture and Food supporting Mr. G's request for compensation. Included in our report was a recommendation that compensation be provided to the elk farmer, Mr. Q, who had purchased the other elk from Crane River which subsequently died.

Minister Rejects Recommendation

The Minister responded to my recommendation by assuring our Office that the facts and circumstances of the case had been completely and accurately described through the various reports, letters and oral communications that had taken place between our Office and the Department. The Minister further advised:

"The salient features of this case, as I see them, are as follows:

1. *It is conceivable that a pre-existing condition of hoof infection was present at the time of dispersal, but that this was not evident.*
2. *Recognizing the inherent risk in dealing with wild animals the price of elk in the dispersal program was set at less than the market price in Alberta and Saskatchewan.*
3. *The draw rules for the elk program were clear as to lack of any warranty respecting quality, fitness, health etc.*
4. *Purchasers signed an offer to purchase which stated the lack of warranty provisions and also that the elk were purchased on an "as is" basis and "where is" basis.*
5. *Department veterinarians were at the sale and prepared to sign a form, which would allow purchasers to obtain mortality insurance. The industry was instrumental in ensuring this service was available because they recognized the inherent risk in dealing with wild animals.*

While I appreciate the loss suffered by Mr. G and Mr. Q, and the recommendation you made in this regard, I believe the Department set up a program, which properly mitigated against such losses. This included ensuring that an insurance program was available to producers. Therefore, I support the decision of the Department to not provide compensation as requested."

Follow-up and Unsatisfactory Conclusion

In a further letter to the Minister, I referred to the Minister's statement that: "It is conceivable that a pre-existing condition of hoof infection was present at the time of dispersal, but that this was not evident." I commented:

Aside from this statement, the Department provided no rebuttal to our contention that the Department was aware of possible pre-existing health problems with elk dispersed at the draw and that no further precautionary steps were taken. I am at a loss to understand how the Department can support that statement.

I noted that the concept of inherent risk when dealing with wild animals and that purchases are on an "as is" basis with "no warranty" was understood by our Office, and I suggested this would apply in cases where there is no knowledge, indication or evidence of any pre-existing condition. I expressed my belief that the Department had knowledge of a pre-existing condition of hoof infection at the time of possession by the purchasers and the decision to deny compensation as recommended in our report was unjust.

I indicated that I felt due diligence was not exercised to identify and isolate the lame elk observed prior to dispersal, and there was no doubt in my mind that on the balance of probability, either Mr. G or Mr. Q was the purchaser of that elk.

A further meeting on the subject was held with the Minister and senior government officials, following which I was advised that the Department was not prepared to change its position in the matter.

In reporting to our complainants I explained that the Department was not required to accept a recommendation from the Ombudsman, and that there was no further action our Office could take to resolve this matter. To date, this injustice has not been corrected.

Manitoba Family Services and Housing

12 Complaint Files Carried into 2001
91 New Complaint Files Received in 2001
330 Telephone Enquiries Received in 2001
77 Complaint Files Closed in 2001

In the year 2001, we received 91 new complaints from individuals who had concerns relating to their dealings with Family Services and Housing. This was an increase from the 80 complaints received during the previous year. Our telephone enquiries, on the other hand, showed a slight decrease, from 351 to 330.

The concerns received by our Office involved Child and Family Services; Employment and Income Assistance (EIA); Manitoba Housing Authority (MHA); and the Social Services Appeal Board (previously referred to as the Social Services Advisory Committee).

Of the 91 complaints received by our Office against this Department, 43% were directly related to issues involving EIA. Most complainants consider their concerns to be of an urgent nature. In all cases, we review the urgency described by the individual to determine the appropriate action.

We find that many of the social assistance recipients who contact us at intake level simply are not aware that avenues of appeal exist, and may not have exercised their right to appeal. However, we may make enquiries with the social allowance Office to get some clarification and by doing so, the situation sometimes gets resolved or the complainant receives more information to help them understand what is happening, alleviating the need for an investigation.

In one case, an individual received financial assistance that appeared to be less than the assistance provided for the previous month. The explanation provided by staff from the EIA office did not satisfy our complainant's enquiry. However, with the same information conveyed in, perhaps, a different way by our Office, we were able to clarify the complainant's concerns.

Another individual contacted our Office and advised that he was acting on the instructions of his case coordinator when he paid for cleaning of his septic field with the understanding that he could submit his receipts for reimbursement. On submitting the receipt, however, he learned that the company was also paid directly by the social assistance office, resulting in having been paid twice for the same services.

A refund cheque was offered to the complainant, but he felt that the delay of a week to process the cheque was not acceptable, as he needed the money to pay for medical services. Our staff phoned the office of EIA and the case coordinator agreed to contact the company to arrange for an immediate refund. The complainant later contacted us and thanked us for the resulting immediate resolution of his concerns.

In our dealings with staff at EIA, we have found that they are knowledgeable and co-operative to Ombudsman staff when responding to our enquiries. We have developed similar working relationships with most departments and agencies that have statutory rights of appeal in an effort to avoid unnecessary appeals or allow the agency to take another look at the case, perhaps at a higher level, to consider whether a decision should stand. If complainants still disagree with the decision, we advise them of their right to pursue an appeal to the Social Services Appeal Board.

A section on issues and Ombudsman cases involving the Child and Family Services Division are contained later in this Annual Report in the Child and Adolescent Services section.

Manitoba Health

10 **Complaint Files Carried into 2001**
40 **New Complaint Files Received in 2001**
130 **Telephone Enquiries Received in 2001**
35 **Complaint Files Closed in 2001**

During the year 2001 we received 40 new complaints, which is only one less than the previous year; we received 18 fewer telephone enquiries than in 2000. Of the 40 formal complaints received 13 or 33% related to actions or decisions of Regional Health Authorities (RHA); 13 or 33% were complaints received from patients in mental health facilities; 13 or 33% were complaints related to services received from, or decisions made by, programs or branches of Manitoba Health (the Department) (for example the Addictions Foundation of Manitoba; Insured Benefits etc.); 1 file was opened on the Ombudsman's Own Initiative to monitor an inquest.

While our primary function is to investigate complaints as they relate to matters of administration, from time to time we receive a number of health-related concerns which are not within our jurisdiction; for example, medical or therapeutic decisions by physicians. We continue to provide the appropriate referral information about internal appeal mechanisms or to agencies such as the College of Physicians and Surgeons.

We try to meet as often as possible with staff from the regional health authorities, hospitals or other branches and agencies of Health to discuss individual complaints. This also provides an opportunity for us to explain our process for receiving and investigating complaints.

At times we may not directly investigate the complaint, but have a role to play in monitoring the Department's review of the issues raised. Our involvement may be at the initiation of a department if it feels that the circumstances warrant independent scrutiny. For example, the issue may be publicly or politically sensitive; there may be some perceived conflict if a department investigates itself; it may be anticipated that the complainants will not accept the findings of the Department; or the Department has reviewed the complaint and reported its position, to no avail.

CASE SUMMARY

Regional Health Authority

In one case, a family had been very concerned about the services and care their father had received in a rural hospital in southeastern Manitoba, prior to his death by suicide. The family had raised questions with the Minister of Health, requesting a review into the death. Initially, the Minister requested that our Office investigate the circumstances surrounding the death. Upon further discussion with the Department and the family, it was determined that the Department would assume responsibility for the investigation and we would monitor the situation. The Department appointed a psychiatrist and a registered nurse to conduct a review of the clinical issues.

We maintained an open file and the assigned senior investigator was accessible to the family members and department officials, effectively acting as a conduit for conveying issues and concerns.

The Department's review resulted in two general recommendations. The South Eastman Regional Health Authority (SERHA) considered the Department's report and reviewed their services with a view to determining the need for any operational or other improvements to services and/or care. The Department also committed to looking at an action plan as to how the recommendations could be implemented in the region, as well as with other regional health authorities.

Since the death, the SERHA made a number of changes to their programs and a number of initiatives were in progress. This information was shared with the family.

Our Role

Throughout the review process our Office had ongoing communication with the family as well as the Department. The family was pleased with the action taken to address the concerns they had raised and felt that the system was in fact changing because of the review.

With the Family

The family advised that they couldn't have achieved closure without our assistance. The family indicated that when they came to our Office they felt listened to and heard. They appreciated our neutral and independent position, which provided a supportive and calming effect. They felt that this helped them get through their anger, sadness and frustration and thus allowed them to work through their issues with the Department.

With the Department

By providing the Department impartial feedback and facilitating the communication between the family and the Department, the Department was able to do their job and use their expertise to address the concerns that had been raised. By being a buffer between the family and the Department, the Department was able to respond sensitively to the family. The Department did not become defensive as we were monitoring the situation and from our feedback they too felt supported.

CASE SUMMARY

Regional Health Authority
Reconsideration Results in Compensation

The Concern

A residential care facility operator who provided accommodation for Winnipeg Regional Health Authority (WRHA) clients of the Mental Health Program believed that he should be reimbursed by the Department for a $1,500 veterinarian bill that had been incurred when one of the clients placed in his home injured the family's pet dog.

While the WRHA sympathized with the circumstances surrounding Mr. N's claim, they felt that this type of risk was part of the overall costs of doing business and could possibly have been covered by some form of insurance had the operator decided to arrange it. Residential care providers are given information during the licensing process regarding the expectation that insurance requirements are the responsibility of the operator.

Reconsideration

Departments and agencies are often concerned about setting a precedent.

We believe that each case should be reviewed on its own merit.

After giving the matter further thought, the WRHA reimbursed $1,000 to the operator as a gesture of goodwill in light of the unusual circumstances of the situation. The payment was made on a without prejudice, without precedent basis and was not in any way to be construed as an admission of any liability on the part of the WRHA. We believed that the reconsideration provided by the WRHA was fair and Mr. N expressed his appreciation for our involvement in resolving the issue.

CASE SUMMARY

Midwifery Services

The Complaint

A woman from a rural community in western Manitoba complained to our Office that Manitoba Health was failing to ensure the provision of province wide midwifery services, and that she had been unable to receive a commitment to have midwifery support for her planned home birth.

It became apparent shortly after receiving the complaint that the investigation would take some time to complete and in all likelihood the complainant would have given birth prior to the conclusion of the investigation. We discussed this with the complainant who indicated that she understood this and still wished the investigation to proceed.

Our investigation found that provincial policy did not require regional health authorities to provide midwifery as a "mandated service". A significant factor in the Department's decisions to make implementation voluntary at that point was a shortage of midwives. We were advised 100 midwives would be required to provide midwifery to all areas of the province and only about 30 were available at the time of the investigation. Another issue that had to be addressed was the travel distance to hospitals in the event of emergencies. Integration of midwives into existing delivery models would also present other varying challenges to regional health authorities.

The Department's Position

The Department advised us that the development of midwifery in Manitoba had been a lengthy and complex process, beginning in 1994 with the appointment of a council to make recommendations on policy and propose legislation. To demonstrate the complexity of the issues which needed to be addressed the Department advised us that the development of midwifery included the establishment of a governing body, the College of Midwives of Manitoba; the development of a midwifery model of practice; the integration of a new service into existing health care models delivered by regional health authorities; and appropriate levels of compensation for midwives.

In light of all of the issues identified, the Department felt it was more useful to begin implementation by working with regional health authorities willing and interested in midwifery, to ensure an effective model of integration. It also hoped that existing services would demonstrate the effectiveness and value of providing midwifery services. It was noted that the current approach did not preclude the Department from eventually declaring midwifery as a core service.

Our Analysis

As only about seven months had elapsed between the time that the legislation had been proclaimed in June 2000 and the complaint was received, the Ombudsman could not conclude that the Department had been tardy or deficient in its efforts to make midwifery available.

The Ombudsman recognizes the importance of the issue raised to both the complainant and to all women who see midwifery as an essential and long overdue health care service. However, the effective implementation of a complex program to be delivered in various parts of the province requires planning and support to ensure that the service is effectively delivered in a manner intended to ensure its ongoing strength and success, therefore, we advised the complainant that we would be unable to support her complaint.

71 **Complaint Files Carried into 2001**
308 **New Complaint Files Received in 2001**
467 **Telephone Enquiries Received in 2001**
304 **Complaint Files Closed in 2001**

Complaints and enquiries during the past year concerned the Public Trustee, the Legal Aid Services Society, the Maintenance Enforcement Program, Court Services, the Corrections Division and, the Prosecutions Division.

Individuals incarcerated in provincial correctional facilities generated 74% of the complaints and 66% of the enquiries related to Manitoba Justice. The specific breakdown by centre can be found in the Statistics section of this Report. Manitoba Justice case summaries relating to youth are contained in the Child and Adolescent Services section of this Annual Report.

Adult Correctional Services

Overview

As correctional facilities house individuals who are in conflict with the law and subsequently incarcerated, they are, of necessity, strictly regulated and operate on highly regimented routines to ensure order. Over the years, it has become apparent that our Office is of tremendous importance to individuals in correctional facilities who are unable to resolve their problems through the internal mechanisms available to them. The Office is also of importance to the Department in its efforts to maintain the order and good management of correctional facilities. We can provide the impartial and balanced perspective necessary to ensure compliance with the rules by both parties.

The Office receives complaints from inmates based on their individual circumstance as well as complaints about broader systemic or policy issues.

It is important that inmates have and maintain access to our Office so that concerns can be addressed expeditiously.

Sometimes a complaint of a very minor nature or an unresolved problem can have a significant impact on an incarcerated individual. In one such case, an individual at the Winnipeg Remand Centre (WRC) required assistance bathing, because of a physical disability. As a result of our enquiries arrangements were made for the inmate to be allowed to bathe daily, a practice that all of us would normally take for granted. In another instance, an inmate from Headingley Correctional Centre (HCC) complained that he was in segregation and did not know why. Our investigation revealed that he had been segregated by mistake. After contact by our Office he was released from segregation and given a written apology.

The consistent application of regulation, policy and institutional standing orders are critical to the good order of institutions. The Office occasionally receives complaints about arbitrary decisions, which do not appear to follow or be based on any established policy criteria. For example, in 2001 my Office received a complaint from an individual at the Portage Correctional Centre (PCC) who indicated that PCC had severely limited her smoking privileges. The PCC had based this decision on the inmate's medical conditions, which included diabetes and chronic obstructive lung disease. The individual felt that this treatment was unfair, arbitrary, and interfered with her right to choose. Our investigation disclosed that there was no regulation or policy dealing with the denial of smoking privileges nor was there

any substantive reason other than the potential ill effect to the individual. As a result of our inquiry the decision was reviewed. The PCC concluded that they could not limit the individual's choice unless and until it became an operational issue with some impact on the PCC, as opposed to the potential impact on the individual.

A second complaint about arbitrary decision making was the denial of visitation by an individual who was a former staff member in a correctional centre. HCC's decision to deny a visit was based on their feeling that the visit could be a threat to the security of HCC. However through discussions it became apparent that the decision seemed to be based on the belief that it would not be in the former officer's best interest to visit a particular inmate. After discussions with various officials from Adult Corrections, the Superintendent decided to grant a visit.

In both of the cases noted above, correctional officials were acting in what they believed to be the best interests of others. Unfortunately those views did not correspond with the views of the individuals in question, nor were their actions justified on the basis of any existing statute law, regulation, policy, or standing order. It's clear that such decisions can be seen as arbitrary and inappropriate. In at least these two cases, we agreed with the complainants.

Despite the Correctional Services Regulation and the extensive written policies that govern correctional facilities, we often find individual complaints that speak to the need for the further development of policy or the refinement of existing policy.

In 2001 individual complaints from inmates resulted in a new policy at HCC to deal with how inmate property is to be handled and what to do if it is lost or destroyed; development of a Notice form at HCC to advise inmates of decisions of Disciplinary Boards, consistent with the requirements of the Correctional Services Regulation; and a rewriting and clarification of the BCC's policy regarding inmate job pay rates.

In 2001, our Office received a number of complaints from various correctional facilities about what inmates felt was unfair process relating to segregation. In 2000, the Ombudsman had reported on a number of cases involving segregation at the Winnipeg Remand Centre.

Staff from our Office visited some of the facilities and, as a result of the issues identified, wrote to both the Superintendent of one of the facilities and to the Director of Adult Corrections setting out a number of concerns. As a result of this, Adult Corrections undertook a systemic review of the procedures for dealing with periodic status reviews for inmates in segregation to ensure that institutional practices were in compliance with the Correctional Services Regulation. We were advised that the review was to be system wide and result in the development of an Adult Correctional Services policy, which would then be the basis for revised correctional centre standing orders. It is our understanding that the review is ongoing.

Medical care is another potentially contentious area. Inmates lack control over medical care; they have to rely on others to get it. Inmates receive their medical care through medical units staffed by nurses at the correctional facilities. These nurses assess inmate requests for medical services and determine who needs to see the doctor or dentist. The nursing staff also controls inmate access to medication. Our Office frequently receives complaints from inmates who feel they are being unfairly denied access to proper medical treatment or have received the wrong treatment.

CASE SUMMARY

Portage Correctional Centre

Follow Up Report on Portage Correctional Centre

In our 2000 report I noted that our Office had completed the investigative phase of a review of medical services at the Portage Correctional Centre (PCC). The review was based upon a complaint initially made by an advocacy group directly to the Department, which asked my Office to investigate allegations of "medical negligence". In 2001 our Office presented the Department with an interim report setting out our investigative findings and conclusions. At the same time investigators from our Office met with Elizabeth Fry Society to advise them of the substantive findings of the investigation.

The Complaint

The complaint presented to our Office identified issues related to specific incidents or individuals at PCC suggesting that women's health was at risk, as well as some more general concerns. After the investigation began we were able to categorize the larger issues into the adequacy and sufficiency of medical service available; medication issues; and communication.

The Investigation

During the investigation of the complaint investigators interviewed staff of PCC, inmates, staff of the Elizabeth Fry Society, and medical professionals providing service to the Centre. Individual medical files were reviewed, as were the numerous and varied policies relating to the provision of medical service at PCC.

It became apparent during the course of the investigation that complaints about medical service were reflective of inmate frustration with other issues. Among the issues affecting the provision of medical care, as well as inmate frustration was overcrowding. During the period covered by the investigation the women's unit at the Winnipeg Remand Centre was closed and women on remand were housed at PCC. This proved a strain on the physical facility as well as on staff resources, including medical resources. This bulge in population caused by the influx of remand inmates to a certain extent was alleviated with the opening of an expanded facility at Headingley Correctional Centre and the re-opening of the female unit at the Winnipeg Remand Centre. We noted however that the circumstances that gave rise to the problem, the increase in the number of individuals being remanded by the court system was beyond the Department's control. We noted as well that inmate concerns about medical care were exacerbated by other institutional circumstances; such as reduced employment and programming opportunities and increased security measures imposed because of a more transient population.

Early on in the investigation we reached a point where we were in a position to report to the Department that our review had found no basis of support for the proposition that women's health was at risk, alleviating some concern for both the Department and the Elizabeth Fry Society. Notwithstanding this, our interim report to the Department provided 17 recommendations for their consideration and response. The proposed recommendations related, for the most part, to procedures and safeguards intended to enhance the administration of medical service at PCC. They were based on principles relevant to the relationship between staff and inmates of any correctional facility; inmates opportunity to be aware of the rules; ease of access to institutional services; consistent application of policy based decisions; clarity of communication; certainty of result; and, prompt access to an appeal mechanism. We noted as well, that while the recommendations were based on findings specific to PCC, they could be applicable to any provincial correctional centre.

Women's Health Found Not At Risk

Reporting and Follow Up

Subsequent to the provision of the interim report the Department responded in detail, both verbally and in writing, advising of some of the actions taken in respect of the recommendations, proposed actions, and issues which they saw as arising from the proposed recommendations.

The Department indicated that their review of the report provided them with direction toward developing policy and procedures but noted that their plan to improve and reorganize the management of medical services would take some time. They indicated that we would be advised of the progress and provided with a copy of any policy and procedural changes that might occur as a result of implementing the recommendations.

After reviewing their response, I felt that the Department had given consideration to the concerns expressed and responded reasonably to the majority of those recommendations. Based on the Department's response, I concluded that it would not be necessary to proceed to formal recommendations. Nevertheless, some issues remain outstanding and I have advised the Department that our Office will continue to monitor the Department's actions in response to the report and propose recommendations.

Throughout the course of the investigation our Office received the full cooperation of the departmental staff, as well as the staff from the Elizabeth Fry Society and we have expressed our appreciation to both.

CASE SUMMARY

Headingley Correctional Centre

Medical Unit

In 2001, we noted a 50% increase in telephone enquiries and complaint files about medical care for inmates at Headingley Correctional Centre (HCC).

In 2001, inmates from HCC contacted us about medical concerns 91 times, and our Office opened 54 complaint files. Roughly one-half of these HCC contacts over the last two years were dealt with at the initial telephone inquiry level, indicating that they could be addressed by providing information or by making a referral.

When we find a problem, sometimes a simple change in procedure is all that is needed.

Lack of documentation and communication issues identified as problems at HCC

For example, a diabetic inmate at HCC complained that because no nurse was on duty until 8 a.m., he was given his insulin after the 7:30 am breakfast, not before, contrary to how insulin ought to be administered. When our Office raised the issue, HCC arranged for Mr. G to be delivered his breakfast after his morning insulin injection.

In another case, an inmate complained that the medical unit at HCC was not adequately treating his chronic back pain. He also complained that when he had suffered an acutely painful migraine headache, his requests for treatment were denied. Our investigation revealed that, while the nursing staff reported that Mr. H's pain was being, and had been, properly treated, there was no documentation to show that it had been assessed, or that any nursing care had been provided at all for his migraine headache. As a result of our enquiries, HCC now requires that nursing staff document all nursing care and conduct a nursing assessment for all continued complaints of pain. HCC also began a review of ways to increase access to a physician.

Sometimes, a clarification of policy settles the matter

Mr. P called to complain that the nurses at HCC were not making their rounds and he had not received his medication. The Superintendent responded to our inquiry by issuing an order that nurses must make rounds once a day and setting out exactly how medications are to be delivered.

Sometimes, re-thinking the matter leads to a change in policy

Mr. S. had routinely received a flu shot while on the "outside". He was denied a flu shot at HCC because he did not fit Manitoba Health's criteria to receive a free injection. No other correctional facility was allowing inmates to get flu shots unless it was medically necessary. After our Office opened its investigation, HCC changed its policy to allow an inmate who did not qualify for free coverage, yet wanted the shot, to be given one, provided the inmate paid for it.

Better communication needed between medical staff and patients

A common thread running through the telephone enquiries and the complaint files seems to be poor communication between the medical staff at HCC and their patients. Often, my staff found it necessary to explain to an inmate why a particular medication or treatment had been prescribed, what a nurse could or could not do without a doctor's order, and what were the relevant HCC medical unit policies and procedures. It would appear that improved patient education might substantially reduce the number of complaints.

CASE SUMMARY

Winnipeg Remand Centre

Ombudsman's Own Initiative Use of Restraint Chair

Last year, the Ombudsman reported that Adult Corrections had undertaken a review of their policy regarding the use of Emergency Restraint Chairs after the Ombudsman reported on a case where, contrary to Winnipeg Remand Centre (WRC) policy/standing orders and chair manufacturer's instructions, an inmate at the WRC was confined in a restraint chair for over nine hours. There was no documentation explaining why the inmate was confined beyond the recommended two-hour maximum or that required checks on the inmate at 20-minute intervals had occurred.

Improper use of restraint chair can result in serious injury or death

Update – New Policy Developed regarding the Use of Emergency Restraint Chairs

As a result, The Custodial Policy on Restraint Equipment was updated with an appendix on the Use of Emergency Restraint Chair. The policy states that an offender shall not be confined for longer than a 2-hour period unless the officer in charge is of the belief that due to the offender's behavior and/or apparent emotional state, releasing the offender would place the offender or a staff member at risk of serious harm. It is mandatory to check at least every 15 minutes. Continued confinement beyond 2 hours is subject to 8 specified conditions, as well as detailed documentation requirements. Upon approval, it is our understanding this policy will be sent to all provincial correctional facilities (youth and adult) with the expectation that their standing orders will be updated so they are in line with the policy.

CASE SUMMARY

Community & Youth Correctional Services

How do I know when I've done my time?

An Ombudsman investigation into a complaint from a person who did not know when his conditional sentence would end, identified a lapse in process regarding Warrant Expiry Dates (WED) for conditional sentences.

When a person is ordered by the court to serve a 'conditional sentence', the offender doesn't have to go to jail, but must adhere to certain rules, or 'conditions' such as abstaining from drugs and alcohol or avoiding certain people. A conditional sentence ends on the WED. If the offender breaches a condition, the WED can change. The calculation of the new WED is complicated, and is the responsibility of the Manager of the Probation Intake and Fine Option Program.

It's all a question of time

Oops – a Gap in the Process

The trouble was there was nothing in place to make sure that someone told the offender the new WED. Nor was there any formal acknowledgment the offender had to sign to show that she or he knew and understood when the WED would now expire.

Quick Action Solves the Problem

We brought the lapse to the attention of Community and Youth Correctional Services on June 27, 2001 and on July 12, 2001, the director of Adult Probation Services sent out a revised policy to all probation officers, requiring them to inform the offender of any change in the WED of his or her conditional sentence, and to document this.

CASE SUMMARY

Maintenance Enforcement

In 2001, our Office opened 25 complaint files involving the Maintenance Enforcement Program (MEP). Frequently, the concerns involved problems in communication. Complainants can be confused about enforcement actions. Payors may not understand how and why their income sources can be garnished; payees may be concerned that the money obtained through garnishment does not seem to be coming in quickly enough. The court processes used to enforce Court Orders can be frustrating and confusing for both parties.

Court processes can be confusing and frustrating

In one instance, a payor complained that the MEP had garnished more in one month than allowed by law. Our investigation showed that a mistake had been made and the MEP issued a refund.

Investigations into two other complaints revealed that payors who had made payments to payees when they were not enrolled in the MEP were vulnerable if, and when, payees opted back into MEP, as payees could claim they had not received support payments during the period when they were not enrolled in the MEP. When they enrolled, MEP would set the arrears based on this denial. MEP did not have a history of examining evidence of payment, referring all disagreements to the courts. Payors were forced to foot the expense of going to court, or to pay again.

Policies and guidelines are being revised as a result of our reviews

Meetings with the director of MEP resulted in a review of MEP's practice and policy. In both cases, the Director examined the proofs of payment our complainants provided, and in one case, she reduced the amount of arrears by nearly $1000. At the time of writing, the MEP is revising its policy and developing guidelines for determining the amount of arrears, including what may be considered as an acceptable proof of a payment made outside of the MEP.

Courts Division

Following are two cases where complaints were resolved through the excellent cooperation and efforts of Courts administrators.

Administrative Inconsistencies Across Manitoba Create Inequity of Garnishment Procedures and Fees

Mr. M runs a business, which leads him to make frequent use of garnishment procedures to collect debts owed to him. He wrote us to complain that different Court administrative offices throughout the province gave him differing information and allowed him to charge the garnishee fees (called 'costs') in differing amounts in different parts of the province when he issued Notice of Garnishment.

Responsive action not excuses resolves problems …

Our inquiry prompted the Courts Division to survey all the Court of Queen's Bench Centres in Manitoba to ask about their procedures when issuing Notices of Garnishment; information provided, advice given, fees charged and costs allowed. The survey confirmed the practices were inconsistent. The Courts Division responded by standardizing the fees and costs throughout the province.

Court Services Won't Give Bail Money Back

Mr. O wrote us to ask for help in getting back the $2000 cash he had given to the Court as bail money. Even though he had not breached his bail conditions and a judge had assured him he would get his money back, he could not get it released. He and three others had all tried and failed, and Court Services had given three different explanations for why it didn't owe him the money. He had been trying for five months. Could we help? Christmas was coming and he needed the money to buy presents for his children.

We spoke to the Manager of Revenue Accounting/Collections. She did what it seemed others had not done – some digging. First, she found that they (Court Services) had a trust account in Mr. O's name. That meant there had to be some money, although it might have been entered into the system incorrectly. She kept looking and found there was an entry error right at the beginning, when Mr. O first paid his money into the Court. Three weeks after we received Mr. O's letter, he got his cheque for the full amount, with 12 shopping days left before Christmas.

CASE SUMMARY

Public Trustee

Background

Concern had been raised as to whether the Public Trustee's office was doing their job on behalf of their clients who cannot tend to their own affairs and trust the Public Trustee to do it for them. This concern particularly involved possible unclaimed money through bank accounts with the Bank of Canada. We investigated a particular individual's situation and, based on our belief that it was in the public interest to pursue this matter, a file on the Ombudsman's Own Initiative was opened to review the broader systemic issue as to whether the Public Trustee takes sufficient action to ensure that inactive bank accounts of their clients are claimed.

File opened on Ombudsman's Own Initiative

What We Found

Based on our review, we are satisfied that reasonable procedures are in place to locate assets once the Public Trustee is appointed as a person's committee.

It is our understanding that, generally, when the Public Trustee is appointed as a person's committee, requests for information about assets are directed to the client if he or she is in a position to provide assistance; to family members; to the Bank of Canada; and, to any other financial institution identified by a review of the client's income tax returns, a search and inventory of the client's premises and possessions, or through information obtained from community members or those such as social workers at the hospital, personal care home or other place where the client resides.

The Public Trustee's internal auditor reviews 50% of files six months after opening. This may identify assets that were not located when the file was first opened. In addition, their Legal Department does a random file review of 5% of all files. We were also advised that, if, through the course of administering a client's affairs, new information should come to light, it is expected that staff would pursue the information.

Our Office did note that there was no policy requiring officers to follow-up with the Bank of Canada 10 years after a person becomes a client of the Public Trustee. It was our understanding that banks do not forward account proceeds until the expiration of 10 years after the last transaction, so it is possible that accounts may be transferred to the Bank of Canada after the initial inquiry letter is sent by the Public Trustee. This issue was raised with the Public Trustee. She agreed that further checks should be done with the Bank of Canada to locate dormant accounts shortly after the 10-year anniversary of the date a person becomes a client of the Public Trustee. We were advised that this procedure would be incorporated into their Procedure Manual and would become part of the Internal Auditor's file review process.

A further improvement

CASE SUMMARY

Public Trustee
How Much is too Much?

The Complaint

A woman complained to our Office that the Public Trustee would not respond to a letter she had written her, nor provide any specific reasons why her Power of Attorney had been revoked for an older gentleman with whom the complainant had resided for a number of years. The Public Trustee had allowed her to remain in the home, but froze all of his bank accounts and assets, and was in the process of trying to arrange suitable housing for him in a personal care setting as he had recently become too ill to remain at home and was hospitalized.

The complainant described her situation with the gentleman as mutually advantageous as she provided care for him with respect to all of his daily living activities and he provided her with a home.

The complainant felt that the Public Trustee did not have good reason to appoint herself committee for the individual and was simply doing so because the man's family was putting pressure on the Public Trustee to do so.

The Investigation

Through our investigation, we found that the Public Trustee had noted that the complainant had purchased an expensive new vehicle very shortly after being appointed Power of Attorney, yet the man did not drive and had no obvious reason to own such a vehicle. Further, the complainant had been charged with fraud in the past, although it was not clear whether those charges had resulted in a conviction. Finally, the man's children had serious concerns about the complainant's control of their father's affairs and felt that he was not able to make sound decisions when it came to the complainant's spending or care. Based on this information, the Public Trustee felt that she had the grounds to take the control of Mr. N's affairs out of the complainant's hands.

It was also confirmed that this information was never relayed to the complainant as a Client Services Manager at the Public Trustee felt that the information was very sensitive and that it might serve to make the situation even more volatile.

Giving reasons for decisions ensures an opportunity to respond

Our Office suggested that if the information was significant enough to use as the basis for their decision to revoke the complainant's Power of Attorney, it should be available to her for her edification. The Client Services Manager wrote to the complainant and outlined clearly the specific issues that had caused concern about the management of Mr. N's finances and resulted in the decision.

As the complainant's questions were answered, our Office closed our file advising her that if she had concerns about their reasons for action she could contact our Office again or challenge the decision of the Public Trustee through the Courts. Upon receiving her answers from the Public Trustee, she did not contact us for any further assistance.

Scrutiny Withstood

Sometimes information used to make decisions will be sensitive. Disclosing such information may even lead to conflict. It is important, however, that the individuals be informed of the basis on which decisions affecting them are made. Disclosing the reasons for decisions ensures that individuals have an opportunity to fully respond to any information that they dispute. As well, I feel it is important that any information relied upon by a government department or agency affecting the rights, privileges, benefits or interests of an individual should be able to withstand scrutiny by the individual.

Providing reasons for decisions, and standing behind them, ensures maintenance of the important principles of transparency and accountability.

Manitoba Labour and Immigration

3	**Complaint Files Carried into 2001**
16	**New Complaint Files Received in 2001**
15	**Telephone Enquiries Received in 2001**
11	**Complaint Files Closed in 2001**

The complaints received against Labour and Immigration involved the actions or decisions of branches such as Employment Standards (10); the Manitoba Labour Board (3); the Office of the Fire Commissioner (2); and Mechanical Engineering (1).

For example, a restaurant owner sought clarification about the application of fire code requirements that pertained to her establishment. She believed similar businesses did not have to meet what she felt were the strict requirements imposed on her.

We contacted the Office of the Fire Commissioner and received information that clarified the requirements specific to her restaurant, as well as the general requirements for compliance with the Manitoba Fire Code. The information provided addressed her questions and indicated that she was being treated equitably. As a result of our discussions with her, she had a better understanding of both the role of the Office of the Fire Commissioner and how to pursue a complaint if she felt an establishment was in violation of the Fire Code.

Sometimes our Office receives complaints because individuals do not understand or are not advised of why a decision affecting them was made. That was why an employer contacted our Office expressing concerns with a decision of the Manitoba Labour Board (MLB) not to provide reasons for upholding a payment of wages order issued against her. She felt it was unfair and that she was entitled to know the basis for the decision.

Our Office made enquiries with the MLB. We believed that the reasons for decision would be informative for the complainant to understand why the MLB upheld an order for payment of wages against her. We discussed this with the MLB and it agreed to provide the reasons to the employer. However, that solution led to a new problem.

Over 4 months went by after we were told the MLB would provide reasons. The Ombudsman wrote to the chair of the MLB in an effort to determine when the reasons could be anticipated. Within a month of that letter, the reasons for the MLB's decision were made available to the complainant and our Office. Once she received and understood the reasons for the decision she accepted it and did not pursue the issue further.

Providing reasons for decisions demonstrates openness and accountability

This case highlights the importance for any administrative decision-making body to provide either written reasons, or at the very least, some indication of the basis for their decisions. The provision of reasons is a critical piece of the administrative fairness process and in the Ombudsman's opinion, demonstrates a government authority's commitment to openness and accountability. While our Office has had some success in convincing boards and tribunals of the benefits of providing reasons for their decisions, this is one aspect of the administrative process on which our Office continues to focus.

Manitoba Transportation and Government Services

9	**Complaint Files Carried into 2001**
25	**New Complaint Files Received in 2001**
45	**Telephone Enquiries Received in 2001**
23	**Complaint Files Closed in 2001**

New complaint files increased 39% this year, and included the Manitoba Emergency Management Organization, Land Management Services and the Driver and Vehicle Licencing Division.

Sometimes our involvement can be as simple as making the inquiry. Once presented with the concern the Department takes remedial action without the need for our Office to do an in-depth investigation.

For example, an individual returning to Manitoba from another province complained that Driver and Vehicle Licencing had imposed restrictions on his Manitoba Drivers Licence based on stale dated information related to his physical condition. He felt that the provincial policy on restrictions, relative to physical disabilities was out-dated and discriminatory.

Having raised his concerns with the Department, he then filed a complaint with our Office and the Manitoba Human Rights Commission. Upon inquiry, we were advised the Department would review its policy. We were subsequently advised that the Department completed a policy review and that changes were made that resolved our complainant's concern.

CASE SUMMARY

Manitoba Emergency Management Organization

Court is not the only Avenue of Appeal

The Complaint

In November 1998, a gentleman contacted the Ombudsman's Office about the Manitoba Emergency Management Organization's (MEMO) handling of a 1997 claim for Disaster Financial Assistance (DFA) that was filed jointly by his brother and another individual.

Information supported his claim that while he co-owned the property with his brother, MEMO had paid the compensation to his brother, without his knowledge. He questioned the process followed by MEMO and believed that he was entitled to a portion of the $37,000 compensation ($32,000 building and $5,000 demolition fee) that MEMO awarded to his brother and the other party. He indicated that he had not received any money from his brother and efforts to try and resolve the matter directly with his brother and the other individual were not successful. He felt that MEMO should be held accountable.

The Initial Response

Enquiries with MEMO revealed that the complainant's brother and the other party had specified they were the registered owners of the property when they submitted their request for DFA. MEMO relied on this information as being factual and truthful in basing entitlement. As a result of the new information presented to them by this particular complaint, MEMO would be taking steps to modify their application assessment process so that similar situations would not arise in future.

However, as the complainant had never made a claim with MEMO, he also could not pursue the matter further through MEMO's appeal process. Numerous conversations and meetings with MEMO staff, including the Executive Coordinator, ensued, but MEMO was not prepared to do anything for the complainant. If Mr. S felt that he was entitled to a share or interest in the subject property, MEMO was of the view that this would be a matter between our complainant and his brother (or his representative) to determine and resolve, including any resolution of the DFA that had been previously granted in respect of the claim submitted in June 1997.

While the Department seemed to be prepared to accept some responsibility for what had happened, they felt that the Court would have to clarify any entitlement the complainant might have to the monies that MEMO had paid out on the claim. They also had secured a legal opinion that supported their position.

Our View

One of the considerations in establishing the Office of the Ombudsman was to provide a non-adversarial avenue as a remedy to disputes, and as an alternative to costly or lengthy Court battles. Once we had determined there was a legitimate grievance due to an administrative error, I did not consider the Courts a reasonable alternative in this case.

Our Office was established as an alternative to costly court action

After carefully considering MEMO's position and reviewing its guidelines, it was our opinion that Mr. S was entitled to a portion of the monies awarded on the claim. It was apparent that MEMO should have taken steps to ensure that the claimants were the registered owners of the property and entitled to DFA. Further, it did not seem fair that our complainant should be expected to pursue the matter legally because of errors or omissions by MEMO staff.

Further discussions were held with the departmental officials but their position did not change. Therefore, in March 2001, the Ombudsman met with the Deputy Minister and senior departmental officials to discuss the case. As a result of this meeting, the Department agreed to take further action. We were advised that MEMO staff would endeavor to deal directly with the claimants in an effort to resolve matters.

Resolution At Last

Finally, in the fall of 2001, MEMO processed a payment to our complainant for $16,000.00 (50% of $37,000 - $5,000) to offset damages to the subject property.

While this matter took a long time to resolve, we were pleased that our complainant did not have to take legal action to obtain compensation as MEMO made the error that resulted in the payment not being made to the proper parties.

CASE SUMMARY

No Trespassing Please!

Request for Assistance

A complainant asked us a simple question, "Can the government trespass over private property without permission?"

She explained that her land completely surrounded a house and several buildings that had been bought out by the provincial government. She indicated that a 30 foot wide building on the property was likely going to be sold and removed along a 16 foot wide legal right-of-way running through her property. She expressed her concern to the Department about the restricted access and the ecological and physical damage that would surely result if the building was removed through the right-of-way. When she discussed this matter with the Department she got the impression that the Department had the authority to do whatever it wanted. We advised her that we would contact the Department to clarify matters.

Clarification Obtained

Land Management Services (LMS) advised our Office that the Department had no specific right that would allow them to come onto the complainant's land without her consent. They acknowledged that their Title did not grant sufficient access to allow the building to be removed without causing some damage, as she feared. The Department withdrew the buildings from sale until the matter of physical access could be resolved. LMS stated that they were exploring alternatives to protect the area and had contacted the Parks Branch to advise them of the significance of the area. Parks Branch had indicated that they would be reviewing the designation of the area.

Question Answered / Fears Ease

What we were told was dramatically different than what the complainant understood. The problem seemed to stem from a communication issue, either in how information was conveyed or how it was interpreted. Our complainant was grateful for the assistance and clarification we provided and she was no longer worried about the building being moved through her property without her consent.

Child and Adolescent Services

Provincial Government Cases Involving Children and Youth

Each year in the Annual Report, the Ombudsman provides an overview of our activities relating to our role with youth in the Province of Manitoba. In 2001, we received:

103	**telephone enquiries**	**55**	**formal complaints**
69	**Family Services and Housing**	**27**	**Justice and Attorney General**
25	**Schools**	**25**	**Family Services and Housing**
8	**Justice and Attorney General**	**2**	**Manitoba Public Insurance**
1	**Manitoba Public Insurance**	**1**	**Conservation**

In addition to responding to telephone enquiries and investigating complaints, over the past year staff from my Office have been working with the Manitoba Human Rights Commission and the Children's Advocate on a booklet, which would provide information to youth on children's and youth's rights in Manitoba.

An investigator from my Office attended a meeting in Toronto with the Canadian Council of Provincial Child and Youth Advocates. The meeting pertained to youth in the young offender system. A tour of a youth custody facility in Ontario also was arranged. Senior Counsel for the Federal Department of Justice made a presentation on the new *Youth Criminal Justice Act* and the group attended the 2nd Annual Grant Lowery Memorial Lecture given by Senator Landon Pearson, entitled A World Fit For Children: What Can Canada Do?

Ombudsman staff continued to be involved in the training program for new correctional officers in Manitoba Justice. Staff from my Office provide information on our role and jurisdiction and advise on the process involved in our investigations. We believe that this is very valuable as when we investigate complaints the staff know and understand our role and can provide us with the information we need to address the complainant's situation.

We met with residents in each cottage at the Manitoba Youth Centre (MYC) and at the Agassiz Youth Centre (AYC) to talk about issues that residents might have.

We also met with an individual from the Aboriginal Public Administration Program who was doing a placement with the Children's Advocate to discuss our role and function and distinctions between the two Offices.

A meeting was arranged with the new A/Director, Child, Protection and Support Services and the Assistant Deputy Minister of Child and Family Services to discuss our roles and expectations with respect to investigations. Other meetings were arranged with the new Interim Director of Winnipeg Child and Family Services and the Provincial Training Coordinator, Child, Protection and Support Services, to discuss our role and function.

Staff from my Office attended the Winnipeg Child and Family Services Annual General Meeting, the Ian Logan Memorial Award Presentation and the Manitoba Aboriginal Youth Achievement Awards. The Manitoba Adolescent Treatment Centre's Annual Meeting was also attended.

Family Services and Housing Cases

The Ombudsman responded to 69 telephone enquiries involving Family Services and Housing and formally opened 25 cases. Most of the concerns related to Child and Family Services agencies, and pertained to the actions of agencies in apprehending children; denying access; and, not providing adequate information or not providing adequate intervention. Concerns were also raised relating to the post adoption registry; a release form required by an agency; the conduct of a social worker and the possible abuse of a child in care.

In 2001, we opened a total of three new Ombudsman Own Initiative (OOI) files to monitor systemic issues that we believed could have a negative impact, or be improved upon, regarding services for children and youth. One related to concerns that had been raised about the child abuse committee review process; the second pertained to the holding of a child welfare ward in a correctional facility designated as a place of safety; and the third related to the designation of youth correctional facilities as places of safety by Child and Family Services.

CASE SUMMARY

Concerns about Child Abuse Registry Processes

Systemic Issue (OOI)

Over the years our Office has received a number of calls from individuals expressing concern regarding the administrative process involved in placing their names on the Child Abuse Registry. Following allegations of child abuse, there may be a police investigation, criminal court and then the Child and Family Services child abuse committee review and registry process. We have been informed that the child abuse committee will often reserve its decision until all criminal proceedings pertaining to a case are disposed of and all information relating to the criminal aspect of the case is provided.

When does a name go on the registry?

Under *The Child and Family Services Act* each agency is required to establish a child abuse committee to review cases of suspected abuse of a child. When a child abuse committee suspects a person of having abused a child, the committee gives the suspect an opportunity to provide information. The committee is charged with the responsibility to form an opinion as to whether the person in question abused a child, and whether the person's name should be entered on the Child Abuse Registry. The committee reports its opinions and, where it has formed the opinion that the person has abused the child, it provides the circumstances of the abuse to the agency.

Sometimes, when more than one child abuse committee have been involved, delays have occurred due to an apparent lack of coordination and accountability.

Although *The Child and Family Services Act* has time lines which come into effect following the decision to enter a name on the Registry, it is our understanding that there are no time frames placed upon the child abuse committee's deliberations regarding whether the name will be placed on the Registry.

Individuals or their families that have contacted the Ombudsman have felt that the process is exceptionally long and stressful. Also, it is our understanding that individuals may not even be aware the situation will be reviewed under *The Child and Family Services Act* until

after the criminal matter has been dealt with. They feel that it is unfair that after they have completed the criminal investigation and court proceeding, they now must endure the probing and sometimes lengthy review of a child abuse committee that can result in further difficulties for them if their name is placed on the Registry. This is compounded by the fact that removal of identifying information regarding an abuser has specified time lines that do not begin to elapse until the name is placed on the Registry.

Our Office has addressed on a case by case basis, concerns raised to the Ombudsman. The similarities in the issues suggested that there could be some systemic issues relating to the child abuse committee review process. Our Office opened a OOI file and wrote to Child, Protection and Support Services regarding this issue. We were informed that this matter had been forwarded to the Divisional Manager, Legislation and Regulations where it will be added to a list of possible amendments to both *The Child and Family Services Act* and the Child Abuse Regulation. We were advised these amendments would be reviewed prior to March 14, 2004.

CASE SUMMARY

Access Rights for Non-Custodial Parents

Systemic Issue (OOI)

This issue came to our attention through an investigation of a specific complaint. While the specific complaint has been addressed, the Ombudsman continued to investigate the broader systemic issue.

A Discrepancy

The Ombudsman's Office questioned the Child, Protection and Support Services Branch, on how an agency could sign a Voluntary Placement Agreement (VPA) with one parent, placing a child in care without notifying and obtaining the consent of the other parent.

It is our understanding that the spirit and intent of *The Child and Family Services Act* is to encourage and support contact between a child in care and their family. Yet, there appears to be a discrepancy between two Acts regarding the rights of non-custodial parents.

The Child and Family Services Act

Under Section 14 of *The Child and Family Services Act*, an agency may enter into an agreement with a parent, guardian or other person who has actual care and control of a child, for the placing of the child without transfer of guardianship.

The Family Maintenance Act

Under Section 39(1) of *The Family Maintenance Act*, the rights of parents in the custody and control of their children are joint except under certain conditions. It is our understanding that if parents have cohabited after the birth of their child, the custodial rights of the parents remain joint in the absence of a Court order or agreement to the contrary. Therefore, it appears that each parent retains the right to be consulted regarding the decisions affecting the child.

The Outcome

The Branch's Counsel agreed that it appeared that Section 14(1) of *The Child and Family Services Act* did conflict with Section 39(1) of *The Family Maintenance Act*.

The Child and Family Services Act to be amended

It was their feeling, at the very least, that it appeared that a joint custodial parent who does not have actual care and control of a child should receive notice of the intention to enter into a VPA with an agency. It is understood that in some situations, the whereabouts of the other joint custodial parent may not be known. However, it was counsel's view that at the very least, attempts should be made to notify that person if his/her whereabouts are known.

They felt the issue of a joint non-custodial parent, who does not have actual care and control of a child receiving notice of the intention to enter into a VPA with an agency, should be mentioned in Section 14(1) of *The Child and Family Services Act* to make it consistent with Section 39(1) of *The Family Maintenance Act*. Therefore, the apparent conflict between these two sections will be entered in the Department's list of proposed amendments to *The Child and Family Services Act*.

Youth Corrections Cases

Almost all of the complaints involving Manitoba Justice and the Attorney General pertained to youth correctional facilities. They related to the denial of eyeglasses; attitude of staff; use of force in restraint; use of restraint methods; missing personal property; denial of dental services; placement of a name on a gang list; the condition and cleanliness of bedding, pillows and mattresses; and the quantity and quality of food being served.

We opened a new Ombudsman's Own Initiative (OOI) involving Manitoba Justice and the Attorney General to monitor recommendations made by the Chief Medical Examiner to Child, Protection and Support Services under Section 20 of *The Fatality Inquiries Act*. We continued to monitor and work on the files opened on the OOI relating to the use of Lakewood Unit, the maximum security facility at the Agassiz Youth Centre as well as the holding of youth in correctional facilities under *The Intoxicated Persons Detention Act*. Details of these OOI cases follow:

Intensive Custody

Systemic Issue (OOI)

Over the years, the Ombudsman has monitored the development of the Lakewood Unit (Unit) at Agassiz Youth Centre. This high security, 20 cell facility opened in December 1999 and accepts transfers from all institutions in the province that hold young offenders in custody.

Our Office's interest began when we opened a file under the Ombudsman's Own Initiative regarding the now-defunct Intensive Custody Unit (ICU) at Brandon Correctional Institution (BCI) and reported on it in our 1997 Annual Report. Questions had been raised whether the conditions of confinement constituted cruel and unusual punishment. The ICU had become an isolation unit for non-compliant youths with problem behaviors. The programs designed to help these youths and decrease their negative behaviors were not being delivered as planned.

In 1998 the ICU at BCI was shut down and the decision was made to develop the Lakewood Unit at AYC.

It would appear that the Unit has moved from being primarily an isolation unit to a unit that provides opportunities to residents who respond positively, allowing them to participate in a full range of activities in conjunction with other residents.

We understand that attempts are now being made to work with residents on the underlying causes of their behavior. We have been advised that negative behavior is confronted and dealt with rather than resulting in punishment in the form of cell lockup or loss of privileges. As well, it would appear that the conditions of confinement have been normalized and residents are out of their cells most of the day participating in a number of activities, chores, recreation, work projects, school and programs.

From isolation to intervention

Manitoba Justice has indicated that the unit has undergone a significant transition and a very meaningful, focused intervention program has been developed. We were in fact provided with a copy of a letter that the Department received from a resident thanking them for setting up the unit. We are pleased that this would seem to indicate the positive effect the program is having on the residents.

CASE SUMMARY

Improper Use Of Manitoba Youth Centre

Systemic Issue (OOI)

Youth Correctional Facilities being used as Places of Safety

This year we worked on a case involving B, a seventeen year old permanent ward of Winnipeg Child and Family Services who became involved with the Manitoba Youth Centre (MYC) following the breakdown of his placement through Child and Family Services.

Initially he was housed at the MYC under two charges of mischief and assault. Approximately four months after his placement at MYC the Court stayed B's charges. The Acting Executive Director of Child, Protection and Support Services designated the MYC as a "place of safety" for B until further notice. The MYC was designated as a place of safety for B in light of the very difficult behavioral management issues he presented with respect to his physical aggression.

B had been diagnosed as having a mental disability in the borderline range, as well as a Conduct Disorder and a Developmental Language Disorder. B was considered to be very active, highly distractible, exhibited attention-seeking behavior and had been known to be physically aggressive without discernible provocation. Significant concerns had been expressed by the agency regarding the rate of recidivism and the capability of existing resources to effectively control and manage B's behavior in the community.

Our Office was very concerned about the length of time that this special needs youth had been confined at the MYC. B had consistently expressed his desire to leave the MYC and had indicated that he would like to be placed "anywhere else". We were also concerned about the length of time taken to locate a suitable placement and that the MYC, a youth correctional facility was designated as a "place of safety".

B is Released

After three weeks of voicing our concerns regarding this situation to staff from the Justice Department, as well as Family Services and Housing, the Ombudsman wrote to the Deputy Minister of Family Services and Housing, with a copy to the Minister, outlining our concerns

regarding this situation. By the end of the fourth week of our involvement B was moved out of MYC. B had been placed in the MYC for a total of 22 weeks. Seven of those weeks were after criminal charges were stayed.

The Broader Systemic Issue

Use of correctional facilities as places of safety questioned

In 1989/1990 our Office had reviewed the issue of correctional facilities being used as places of safety for child welfare agencies. We became aware that police holding cells and jail cells were to be designated as places of safety. The Ombudsman at the time expressed his opinion that the use of correctional facilities as a place of safety for children was not acceptable.

It was our understanding that this designation was subsequently deleted from the standards. In our 1990 Annual Report we reported that in the standards: "It was clearly stated that no child is to be placed or left in a correctional facility as a place of safety."

Revised Standards

Assurances given but standards changed

We were surprised and disappointed that, despite the assurances given our Office in the past, we were only informed in 2001 that these standards were revised in 1994 allowing the Director to authorize a correctional facility as a place of safety. The Department advised that when the standards were developed in 1990, the intent was to exclude only adult correctional facilities or police holding cells as a place of safety and not the MYC. They advised that the description of a correctional facility in the program standards was not intended to include the MYC, which had historically been used as a place of safety.

Further Investigation Required

We remain of the opinion that it is not acceptable to use correctional facilities (youth or adult) as a place of safety for children. It is also questionable in terms of a child's constitutional rights and we will be following up on this issue in 2002.

CASE SUMMARY

Youth Held Under *The Intoxicated Persons Detention Act*

Systemic Issue (OOI)

Change is not coming fast enough

In reviewing a complaint from a young woman, our Office discovered that youth detained under the non-criminal nature of *The Intoxicated Persons Detention Act* (IPDA) were routinely held at the MYC. At the time of writing the 1999 Annual Report, we had been advised that representatives from the Departments of Justice; Health; and Family Services had met and were working together to locate an alternate placement for youths being held under the IPDA.

In 2000, representatives from the Departments of Justice; Health; and Family Services and Housing requested proposals from organizations that would be willing to take on the responsibility for holding youth detained under the IPDA. It was our understanding that a joint submission to Treasury Board was being discussed.

What is the Department's intention?

In 2001, the situation remains unresolved. It is our understanding that the majority of other Canadian jurisdictions do not detain youth in a young offender facility. The Ombudsman remains of the opinion that a correctional facility is not an appropriate detoxification centre for youth.

Boards and Corporations

42 Complaint Files Carried into 2001
95 New Complaint Files Received in 2001
518 Telephone Enquiries Received in 2001
94 Complaint Files Closed in 2001

Complaints about corporations and boards accounted for just over 13% of the formal complaint cases our Office received in 2001. The types of complaints were varied and often complex.

Of the 95 formal complaints received about Boards and Corporations this year:

- 61% involved Manitoba Public Insurance
- 27% involved the Workers Compensation Board
- Almost 8% involved Manitoba Hydro
- 4% were of a general nature

Manitoba Public Insurance (MPI)

The year 2001 marks the second consecutive year where there was a reduction in formal complaints against MPI. Formal complaints were down 19% from last year's total of 72. However, telephone enquiries increased 31% from last year's total of 264.

The increase in the telephone enquiries may well account for the decrease in formal complaints. Often, the people who call us ask what they can do to resolve problems that they might be having with their claim. Where appropriate, we refer these individuals to the MPI's Fair Practices Office (FPO). In several cases, the opportunity for our complainants to submit additional information to MPI, in support of their claim was sufficient to resolve the complaint or bring speedy resolutions. However, our referrals to the FPO come with the understanding that individuals have the option to bring their issue back to our Office, and ask that we review their concern further.

The number of formal complaints that we receive regarding service-related issues is very small considering that MPI processed 248,563 claims in 2001. The concerns brought to us this year covered a broad range of issues, including: liability assessments for traffic accidents, denials of coverage, payment of deductibles, as well as general issues regarding the manner in which claims were handled. The following are examples of the various issues that our Office dealt with this year.

- Mr. T contacted us because he felt MPI had unfairly held him 70% responsible for a traffic accident. He had appealed the 70% finding through MPI's appeal process. However, the independent reviewer confirmed MPI's finding.

Our review of the assessment supported that the 70% finding was not unreasonable. Nevertheless, MPI acknowledged that there were some procedural problems with the way the claim and subsequent appeal was handled. However, for the most part, these occurred after the assessment of liability had been made. These problems caused some confusion and led to incorrect information being provided to our complainant. Accordingly, MPI agreed to refund the $25 fee our complainant paid for the independent review.

- Ms. H called our Office about a dispute she was having with MPI about the coverage she received for damage that was done to her vehicle as a result of it being stolen. Information provided to us by MPI revealed that the dispute had to do with depreciation that our complainant's repair shop had charged her. While the dispute seemed to have more to do with her repair shop than it did with MPI; they took an active role in dealing with the shop and refunded her the depreciation she had incorrectly been charged.

- Mr. E was involved in a dispute with MPI regarding the value of his motorcycle that was written off as a result of damage it sustained in an accident. MPI provided our Office with a detailed explanation of the basis for its offer of settlement. We discussed MPI's position with Mr. E. In addition, a more general discussion took place about the factors that MPI considers when they assess a vehicle's value. Our complainant then obtained additional information that MPI ultimately accepted as proof that his motorcycle was worth more than what had been offered originally and the claim was resolved.

- Mr. A contacted us to express concern about an administrative fee charged by MPI when he changed his lay-up policy (for stored vehicles) to a road policy. He felt that this charge was unnecessary and furthermore, was not listed in the schedule of administrative fees that MPI published in their 1999 Guide to Autopac. Having reviewed the matter, MPI at first only updated the information contained in their Guide and the corrected version appeared in 2000. Upon further review, MPI decided effective February 2001, to no longer charge the fee for this transaction. While not retroactive, our complainant was satisfied that MPI had considered this matter further and took steps to revise their policy.

- Ms. J advised that MPI had taken steps against her to collect on arrears in the form of a "refuse to renew" placed on her Driver's Licence. The arrears resulted from surcharges assessed as being at fault in an accident. Ms. J advised that because of a threat of domestic violence, she was forced to lie about her involvement in this accident and stated that the fault for the accident actually lay with her former domestic partner. She indicated that she had evidence to support her position and our Office was able to convince MPI that this case merited further investigation. Arrangements were made for Ms. J to provide MPI with documents she felt could support her case. MPI agreed to consider this additional information in relation to the arrears on her account. Ms. J. was satisfied with having an opportunity to further discuss the particulars of her situation with MPI.

Workers Compensation Board of Manitoba

Several cases that we reviewed in 2001 were successfully and quickly resolved for our complainants after we notified the Worker's Compensation Board's (WCB) Service Quality Division of the complaint.

Appeal Submission for Medial Review Lost

Mr. T contacted us with regard to his WCB claim. He disputed the findings by a Medical Review Panel. He advised that he had provided a submission on his case to the WCB but had not yet heard anything back. As this claim was still active, our Office enquired as to a status report on the file. By virtue of that contact, WCB's Service Quality reviewed the claim, and found that the appeal submission had been misplaced; it was located and forwarded to the Review Office (RO). While our involvement ended since we had served to clarify an oversight and final decisions were yet to be made, our complainant felt that we helped to get his appeal back on track.

Processing Error Creates Delay in Benefits

Ms. W experienced a lengthy delay in receiving benefits for which she was owed by WCB. Our inquiry prompted the Service Quality Division to review her claim and it was determined that an error had occurred in the way the claim was processed. Information should have been acted upon earlier in order to have facilitated completing the claim for benefits. Ms. W received her outstanding cheques as well as a letter of apology from the WCB.

Processing Error in Review Office Leads to Delay for Client

Mr. Y felt that the WCB was unnecessarily delaying an appeal decision on his claim. Our Office contacted WCB to determine the status of this matter. This prompted a review by WCB's Service Quality Division who discovered an error that contravened the WCB's revised protocol for the handling of incoming correspondence for appeals.

In the past, when the RO reviewed correspondence relating to appeals the Administrative Assistant would date stamp and place the correspondence on file awaiting an initial screening. Sometimes the file was required in another sector and pulled before being reviewed by a screener. This would result in delays in the appeal process.

To alleviate that possibility, the WCB had instituted a new protocol. When an appeal letter is received, it is date stamped and added to a list for screeners. That way, even if the file is pulled, the screeners know an appeal has been received. In Mr. Y's case, the new protocol was not followed. His appeal was stamped as being received in December 27 but for some reason, it didn't get noted on the screener's list. It was not dealt with in the RO until January 19. The WCB took full responsibility for the delay and apologized for it. Our complainant was satisfied with the explanation and apology.

Other cases like the one below are not as straightforward and require a more formal review.

CASE SUMMARY

Long Time Pain – Long Term Gain

Ms. X's case was the subject of investigation by our Office in 1995, which we believed had been resolved. In January 2000, she contacted us and raised a number of issues regarding the ongoing management of her claim with the Workers Compensation Board of Manitoba.

Background

Ms. X had injured herself in 1991 while employed as a registered nurse and received WCB benefits while recovering from her injury. In March 1993, the WCB advised Ms. X that her benefits would end on March 15th. Ms. X appealed the WCB's decision. The Appeal Commission heard the case in 1994 and the majority "reluctantly" concluded that Ms. X had no entitlement to WCB benefits and services beyond March 15, 1993.

Our Office reviewed this matter and felt that the WCB had not applied its policies appropriately. The Board of Directors agreed to our request to reconsider the matter. The previous decision was stayed and the case was sent back to the Appeal Commission for a new hearing. In 1997, the Appeal Commission found that Ms. X was entitled to further benefits and services.

Problems Continue

In July 1998, Ms. X contacted the Ombudsman's Office again, indicating she had waited until March 1998 to receive her first payment and was still waiting to receive further benefits. However, Ms. X felt she was receiving good service from the WCB Vocational Rehabilitation Consultant (VRC) who was assisting her in exploring vocations more in line with her pre-accident earnings. She advised that she preferred to deal with the WCB on her own for the time being.

In October 1998, Ms. X advised our Office that she had received further payments relating to her award. The WCB had also advised her by letter in June 1998 that restrictions on her workplace capabilities were permanent. She was seeking clarification about the effect permanent restrictions had on her WCB benefits.

We made enquiries with the WCB and we were advised that permanent restrictions were placed on Ms. X's work capabilities. The VRC had outlined specific actions to be taken relating to Ms. X's benefit entitlement as detailed on their file. The VRC would be contacting Ms. X in the near future to begin the vocational rehabilitation plan formulation. No further involvement was needed by our Office at this point.

Back Again

Then, in January 2000, Ms. X contacted our Office again because the WCB was of the opinion that restrictions were now no longer required as a direct result of her 1991 injury. As such, it was the WCB's opinion that she should be able to return to her pre-accident employment.

Trust compromised because of continued errors

This opinion was contrary to one expressed in a signed memo from a WCB medical advisor. The return to pre-employment also did not take into account that the complainant's nursing registration had expired three year's before. Ms. X would not be eligible to work as a registered nurse until she took a refresher course, and she had already begun pursuing other options. Then, in February 2000, she was notified that the WCB was unable to reimburse her for costs associated with her participation in the Bachelor of Psychiatric Nursing program as her claim "was officially ceased in August 1999".

She retained the right to appeal this decision and any decision of the WCB or the Appeal Commission that affected her entitlement to benefits. Our Office does not usually become involved if there is an avenue of appeal or review still available, however, we sought clarification from the WCB as we found their decision to lift Ms. X's permanent workplace restrictions somewhat puzzling.

A Positive Conclusion

In July 2000, our Office was advised that WCB staff had reviewed Ms. X's case and determined that the decision to terminate her benefits was made in error. A case manager did not note earlier documentation on the claim file from the unit supervisor recommending that permanent restrictions be imposed relative to Ms X's claim.

We were advised that retroactive payment of her benefits was being processed immediately; her benefits would be reinstated; and a VRC would be assigned once again. Ms. X received a letter of apology from the WCB for the error, as well as a $5,000.00 advance while her full entitlement to benefits was being calculated.

In December 2000, Ms. X contacted out Office and advised us that she had received an additional payment from the WCB to cover her tuition and related costs. She reported her studies were going very well and she was pleased with the outcome of the WCB's review. Decisions relating to her benefits claim had likely been delayed as Ms. X now insisted in having everything in writing. She expressed a loss of trust over errors made in regards to her injury claim, which had affected her relationship with the WCB. We raised Ms. X's concern with the WCB representative who acknowledged that extra efforts would have to be made by WCB staff in mending their relationship with her.

In early 2001, Ms. X received cheques amounting to more than $30,000 in retroactive benefits. As well, she was advised that she would receive regular benefit payments while participating in her vocational training plan. While she still had some reservations relating to her relationship with the WCB, our complainant was very pleased that her benefits and her retraining plan were back on track.

Our Office was impressed with the sincerity of both our complainant and the representative from the WCB in working towards resolving the concerns raised as a result of a very unfortunate error. Our recent experience in dealing with the WCB has reflected a genuine willingness to consider issues we raise on behalf of aggrieved parties.

Municipal Government Case Summaries

29 Complaint Files Carried into 2001

36 New Complaint Files Received in 2001

110 Telephone Enquiries Received in 2001

40 Complaint Files Closed in 2001

Although complaints received about municipal issues represented just over 5% of the total formal complaints our Office received in 2001, the types of complaints we receive usually deal with complex issues and often necessitate making enquiries with other government departments and agencies to get all the information required.

In 2001, our Office was involved with municipalities that had never had contact with our Office before. As well as trying to resolve the complaints, we attempted to take advantage of those opportunities to inform and educate municipal governments on the role and function of the Manitoba Ombudsman.

Communication remains the key to positive working relationships. It goes a long way towards minimizing disputes and conflict. We believe that if people were routinely provided with information on the basis and reasons for decisions that it would further reduce the number of complaints our Office receives about provincial and municipal government administration.

For example, our Office conducted a detailed investigation into the denial of a permit that would have allowed an individual to operate a business. Council of the municipality involved did not provide reasons for their denial. We attempted to obtain additional information from the municipality that would assist us in understanding whether such a denial was reasonable. After considerable effort and consideration by our Office, we were satisfied that there had been a basis for the decision. While it was determined that Council is not obligated by legislation to provide reasons for such decisions, we felt that more effort could have gone into explaining to the complainant the basis on which that decision was made to demonstrate that it was not made for improper, frivolous or vexatious reasons.

The following case summaries are examples of some of the issues that were raised with our Office relating to municipalities.

CASE SUMMARY

City of Brandon

The Issue

The year 2001 saw the resolution of a long standing complaint by a Brandon landlord about the City of Brandon's practice of collecting delinquent tenant water bills by adding the outstanding bills to the landlord's property tax bill.

The City's View

The City took the position that it was the responsibility of the landlord who rented the premises to a tenant and to whose property the water was provided. The City also pointed out that there were a number of options available to landlords, such as relying upon early notice from the City that an account was delinquent, or having the water bill in the landlord's name so that they would be in a position to monitor tenant payments.

The Landlord's View

The landlord felt that the practice, while permitted by law, was unfair because it was the tenant who had contracted with the City for the provision of water, used the water, and defaulted on the payment. The landlord felt that the City could be taking more constructive action, such as requiring deposits from tenants who sought to set up water bill accounts or refusing to provide service to tenants with a previous history of delinquency.

Ombudsman's View

The Ombudsman felt that there was considerable merit to both sides of the argument. As the investigative process continued for a period of time we noted that there were significant improvements in the City's practices. As well, a similar complaint in Winnipeg had resulted in the City of Winnipeg making a decision to refer delinquent tenant accounts to a collection agency for collection prior to adding such delinquent accounts to a landlord's property tax bill.

The Resolution

After further discussions, the City made amendments to by-laws as well as sought and gained approval from the Public Utilities Board for a "collection referral fee" that would be added to each delinquent account in an amount sufficient to cover the cost of collection so that all water utility ratepayers or taxpayers would not have to bear the cost of collections. At that point, the delinquent amount would be referred to a collection agency for a two month period and monies collected, credited to the account. In the event that the collection process was unsuccessful the City would then continue with the lawful practice of adding the delinquent amount to the property tax bill.

The landlord indicated that he saw the proposed solution as an improvement; however, he still felt that the issue of delinquent water bills was one between the City and its tenant customers.

The Ombudsman felt that the City's actions were reasonable and that they had put significant effort into resolving the matter. The complainant was advised that the Ombudsman would not be making a recommendation in respect of his complaint. Although not completely satisfied, he expressed his appreciation for the effort extended to come up with a solution.

CASE SUMMARY

Special Report on Municipal Policing

When the Ombudsman's jurisdiction was expanded in 1997 to include municipalities, excluding the City of Winnipeg, the new responsibility included the investigation of complaints regarding municipal policing.

The investigation of administrative decisions, acts, errors and omissions on the part of the police service was a new layer of civilian scrutiny for these municipal police services, as well as a new area of responsibility for the Ombudsman. Matters of the conduct of individual police officers are not the subject of investigations by the Ombudsman but may be raised with the Manitoba Justice Law Enforcement Review Agency.

As the largest municipal police force in the province outside the City of Winnipeg is the 75 member police force of the City of Brandon, the Deputy Ombudsman and an Investigator from our Brandon Office met with the Chief Executive Officer of the City of Brandon and the Chief of Police, when the Ombudsman initially began investigating municipal policing. We explained the role and function of the Ombudsman and established a protocol for the handling of police complaints by direct communication with the chief.

In 2001, the majority of complaints in respect of municipal policing come from individuals in Brandon. This year, for example, individuals complained to the Ombudsman's Brandon-based Office that the Brandon Police Service (BPS) was not adequately addressing complaints of noise under a Nuisance By-law; not adequately responding to complaints about by-law infractions and was handling these particular complaints differently than calls from other individuals; and that BPS had treated a husband's complaints differently than the complaints of his estranged wife during the course of divorce proceedings.

So Far, So Good

In each instance, review by the Ombudsman found no basis to conclude that the BPS had been inconsistent with existing and approved policy or that the complaints had not been handled properly. The BPS has unfailingly responded in a prompt and sufficient manner, providing our investigators with access to documentation and personnel as required. For our part, the experience in dealing with the BPS has provided us with a foundation that will be invaluable in investigating municipal policing complaints from jurisdictions outside the City of Brandon. Our experience in investigating municipal policing both in Brandon and elsewhere has been positive.

CASE SUMMARY

RM of St. Andrews

A Road Paved with Good Intentions

In the latter part of August 2001, we were contacted by a woman regarding the conditions of the roads in her subdivision. She felt that the RM had failed to take action to bring the roads up to municipal standards and explained that this matter had been ongoing since May 1999. However, her efforts to deal directly with the RM had met with little in the way of results.

The Municipality Advises

When we contacted the RM it was apparent that they had been working with the developer of the sub-division in an effort to resolve outstanding issues relating to the condition of the roads. On September 10th, the RM advised our office that an arrangement had just been negotiated with the developer whereby the RM would assume responsibility for the work that was required to bring the roads in the subdivision up to standards. The RM also provided a chronology to explain what had transpired since the previous council had approved the sub-division in 1993. On September 17, the RM confirmed that the road works had been started and that it should be completed in a matter of days. On September 24, we were advised that the work had been completed and inspected.

Conclusion

In our report to the complainant, we advised her of the information the RM had provided regarding the events covering the period May 1999 to August 2001, when the RM successfully negotiated a resolution with the developer. We agreed that it was unfortunate that the matter had been ongoing since 1999 but indicated that as action had been taken to resolve her concern, there was no recommendation that the Ombudsman could make respecting this matter.

This case again illustrates the power of positive communication. The complainant had very appropriately been pursing the issues directly with the RM, however, she either did not know or understand what action was being taken to address the situation. Our involvement and enquiries led to confirmation of what action would be taken, within a specified time frame. Sharing this information with the woman resolved her concerns.

Legislation

The purpose of the Ombudsman's Office is to promote fairness, equity and administrative accountability through independent and impartial investigation of complaints and legislative compliance reviews. The basic structure reflects the two operational divisions of the Office:

- Ombudsman's Division, which investigates complaints under *The Ombudsman Act* concerning any act, decision, recommendation or omission related to a matter of administration, by any department or agency of the provincial government or a municipal government.
- Access and Privacy Division, which investigates complaints and reviews compliance under *The Freedom of Information and Protection of Privacy Act and The Personal Health Information Act*.

A copy of the Acts mentioned above can be found on our web site at www.ombudsman.mb.ca