2004 Annual Report

Ombudsman Manitoba

Administrative
Accountability

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 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

Ombudsman Manitoba

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May 31, 2005

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

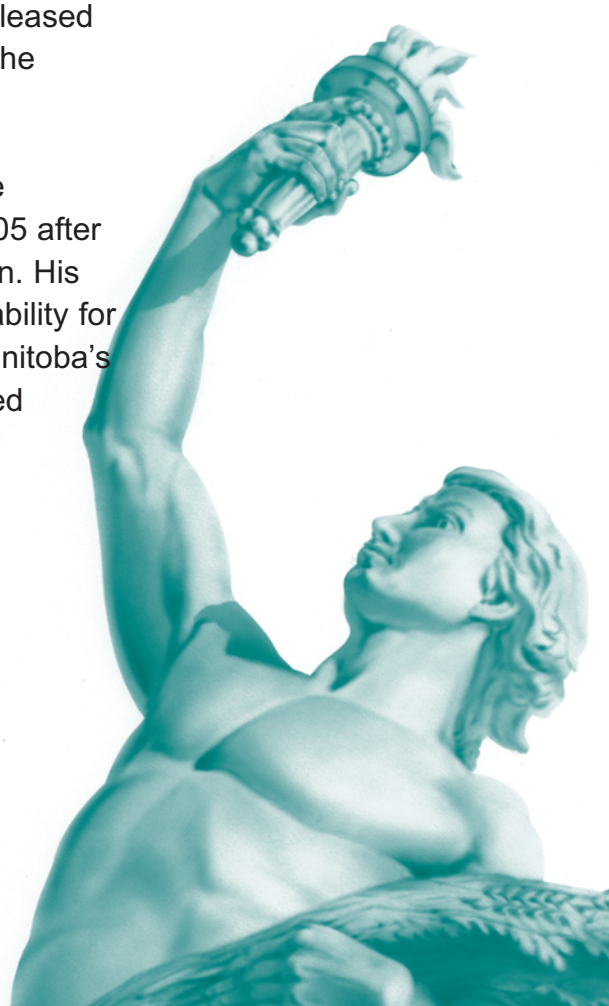
Dear Mr. Speaker:

In accordance with Section 42 of *The Ombudsman Act*, I am pleased to submit the thirty-fifth Annual Report of the Ombudsman for the calendar year January 1, 2004 to December 31, 2004.

This report covers a period during which Barry Tuckett was the Manitoba Ombudsman. Mr. Tuckett retired on February 11, 2005 after serving twenty-six years with this office, eleven as Ombudsman. His commitment to promoting fairness and administrative accountability for all Manitobans was demonstrated throughout his tenure as Manitoba's third Ombudsman. I wish to thank him for his years of dedicated service.

Yours truly,
Original signed by

Irene A. Hamilton
Manitoba Ombudsman



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Personnel at December 2004

Ombudsman Division:

Donna M. Drever
Deputy Ombudsman

Corinne Caron
Senior Investigator

Cheryl Ritlbauer
Senior Investigator

Robert Baker
Investigator

Debra DeGraeve
Investigator

Robert W. Gates
Investigator

Kris Ramchandar
Investigator

Wanda Slomiany
Investigator

Marni Yasumatsu
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

Patricia Cox
Compliance Investigator

Carol Markusoff
Compliance Investigator

Darren Osadchuk
Compliance Investigator

Kim Riddell
Compliance Investigator

Candace Russell
Compliance Investigator

Aurele Teffaine
Compliance Investigator

Administration:

Laura Foster
Office Manager

Helen Hicks
Administrative Support Clerk

Jacquie Laberge
Intake Assistant

Felicia Palmer
Administrative Support Clerk

Year 2004 in Review

In addition to the departure of Ombudsman Barry Tuckett, 2004 saw the departure of Deputy Ombudsman Donna Drever. We would like to thank her for her many dedicated years of service to this office.

In 2004 the office continued its outreach activities, and in particular, we visited mental health and correctional facilities. As well, we offered group presentations on the role and function of our office and in 2004 participated in several training sessions for new staff in Manitoba Justice.

Our goal continues to be the pursuit of excellence in investigating individual and systemic complaints with a view to improving the processes by which members of the public interact with their governments, both provincial and municipal.

In 2004 we were contacted over 4500 times by members of the public.Eight hundred and nine formal complaints and 3,713 telephone calls were received regarding actions and decisions of boards, corporations, departments and agencies of the provincial and municipal governments. A number of the complaints related to entities over which we have no jurisdiction. In those cases referrals were made, or the individual was advised of alternative appeal routes.

Statistics

The contacts with our office were as follows:

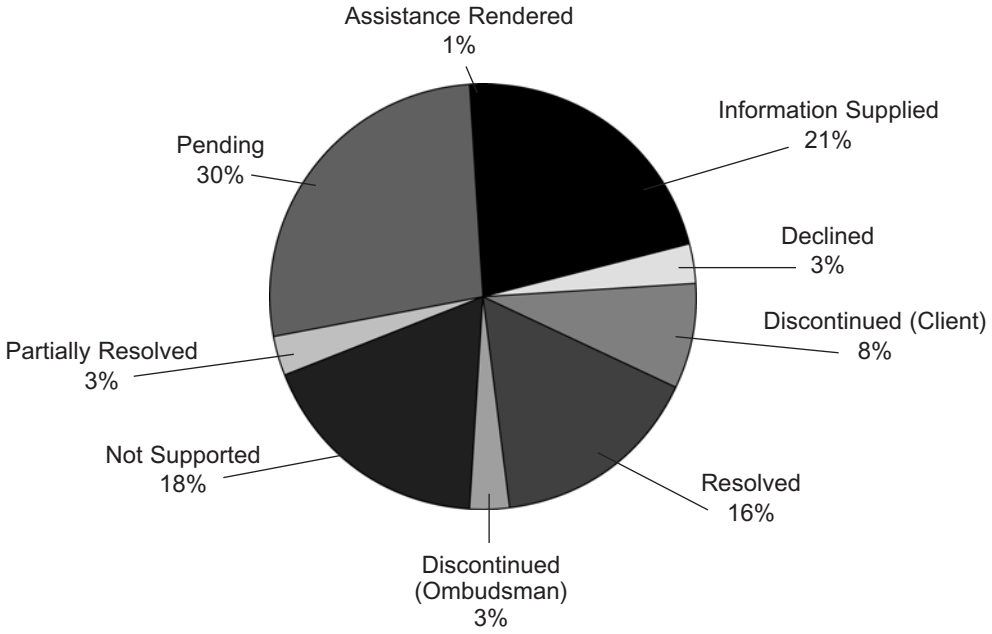
Open files January 1, 2004	354
Files opened 2004	809
Files closed 2004	860
Open files December 31, 2004	303
Telephone Inquiries in 2004	3713

Of the 860 complaint files closed in 2004:

- 22% were resolved;
- 6% were partially resolved;
- 2% were concluded after assistance was given;
- 26% were concluded after information was supplied;
- 26% were not supported;
- 15% were discontinued either by the Ombudsman (4%) or the client (11%);
- 3% were declined.

Status of Files Received in 2004

The graphic below represents the status of the 809 new complaint files received by the Office of the Ombudsman in 2004.



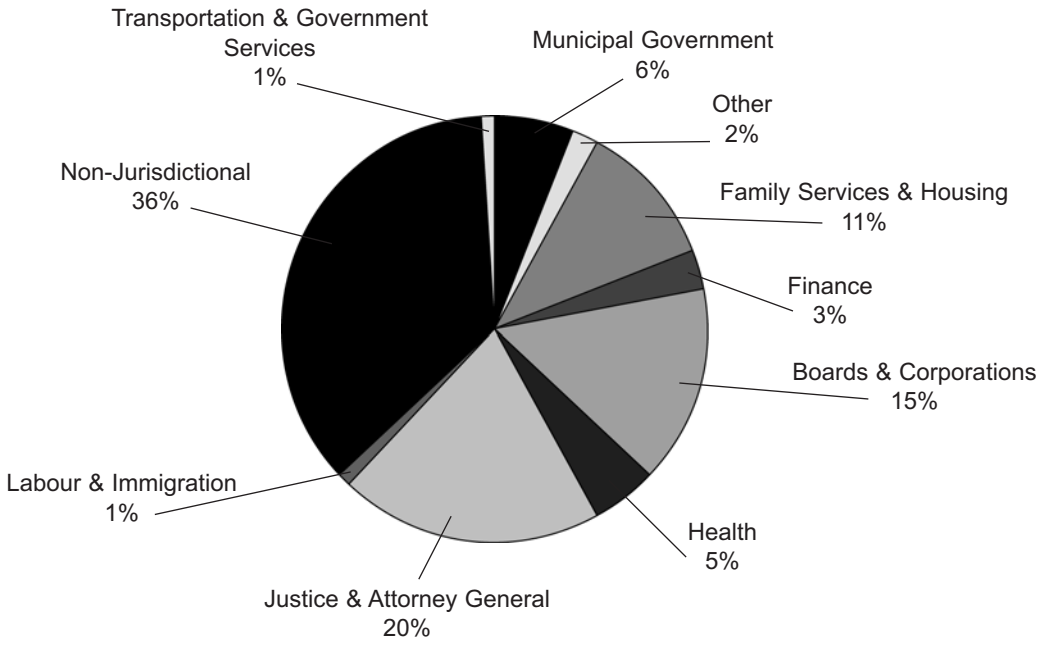
What People PHONED us about in 2004

When a person calls, they speak to an intake officer. The intake function is to explain the role and jurisdiction of the Ombudsman and provide information and referrals. Inquiries are confidential. Individuals are usually asked if they have tried to resolve their concerns with the public body involved. Our office will assist individuals in determining any avenues of appeal available to them and we suggest that they exhaust all avenues of appeal before we become involved.

The Ombudsman's office receives many calls throughout the year regarding complaints about government departments and agencies at all levels of government, private businesses and other private matters. Some of the complaints are from people who feel they did not receive enough information about decisions.Often their concerns result from a lack of communication. They do not know where to go and, consequently, by the time they reach our office they are frequently frustrated and angry.

If a concern is within the Ombudsman's jurisdiction, the intake officer will explain how to file a complaint with our office. If it is determined that we have no jurisdiction, the intake officer may refer the complainant to the appropriate avenue to try to resolve the issue.

The graphic below represents the 3,713 telephone inquiries in 2004 by department or agency.



Telephone Inquiries 2004

PROVINCIAL GOVERNMENT DEPARTMENTS (1,450)

Advanced Education &Training	**9**
Agriculture, Food and Rural Initiatives	**12**
Civil Service Commission	**4**
Conservation	**22**
Culture, Heritage & Tourism	**1**
Education, Citizenship & Youth	**7**
Family Services & Housing (398)	
General	44
Child & Family Services	78
Employment & Income Assistance	218
Manitoba Housing Authority	44
Social Services Advisory Board	14
Finance (120)	
General	11
Automobile Injury Compensation Appeal Commission	1
Consumers Bureau	17
Financial Institutions Regulation Branch	4
Residential Tenancies Branch	76
Residential Tenancies Commission	9
Securities Commission	2
Health (183)	
General	34
Addictions Foundation of Manitoba	1
Mental Health	91
Regional Health Authorities	57
Intergovernmental Affairs & Trade	**1**
Justice (747)	
General	51
Agassiz Youth Centre	3
Dauphin Correctional Centre	4
Brandon Correctional Centre	92
Headingley Correctional Centre	204
Milner Ridge Correctional Centre	22
Portage Correctional Centre	13
The Pas Correctional Centre	13
Winnipeg Remand Centre	158
Maintenance Enforcement	57
Human Rights Commission	20
Legal Aid Manitoba	29
Public Trustee	52
Manitoba Youth Centre	11
Courts	18
Labour & Immigration (34)	
General	8
Employment Standards	5
Manitoba Labour Board	21
Transportation & Government Services	**33**

BOARDS & CORPORATIONS (566)

Workers Compensation Board	**107**
Centra Gas	**2**
Manitoba Hydro	**50**
Manitoba Lotteries Corporation	**5**
Manitoba Public Insurance	**370**
Driver & Vehicle Licencing	32

MUNICIPAL GOVERNMENTS (233)

City of Winnipeg (138)	
General	11
The Board of Trustees of the Winnipeg Civic Employees' Benefits Program	1
City Clerk's Office	1
Community Services	4
Corporate Finance	3
Corporate Services	4
Fire Paramedic Service	9
Planning, Property & Development	21
Property Assessment	11
Public Works	21
Transit	4
Water & Waste	7
Winnipeg Police Service	41
Other Municipal Governments	**95**

NON-JURISDICTIONAL (1,343)

Federal Departments & Agencies (170)	
General	162
RCMP	8
Private Matters (1,173)	
General	1022
Consumer	48
Doctors	43
Lawyers	30
Schools	30

Total number of telephone calls	**3,713**

Where do the people making formal complaints in 2004 live?

Altona	1
Anola	3
Arborg	2
Ashern	1
Beausejour	7
Brandon	61
Carman	2
Cayer	1
Churchill	1
Carlowrie	1
Cormorant	1
Cranberry Portage	1
Dauphin	6
Dominion City	1
Douglas	1
Dugald	2
Eden	2
Erickson	1
Ethelbert	1
Fisher Branch	2
Flin Flon	1
Garson	1
Gimli	5
Glenboro	1
Grand Marais	1
Grand Rapids	1
Grandview	2
Grosse Isle	1
Gunton	2
Headingley	130
Inwood	1
Keelfeld	1
Kelwood	1
La Riviere	1
La Broquerie	1
Lac du Bonnet	6
Landmark	1
Letellier	1
Libau	1
Lorette	3
Mariapolis	1
Marius	1
Middlebro	2
Minitonas	1
Minnesdosa	1
Minto	1
Morden	3
Morris	1
Neepawa	2
Newdale	1
Niverville	2
Oak Bluff	1
Oakbank	1
Ochre River	1
Otterburne	1
Pine Falls	2
Portage la Prairie	34
Powerview	1
Rennie	3
Riverton	1
Rivers	2
Roblin	1
Russell	1
St. Andrews	2
St. Claude	1
St. Francois Xavier	2
St. Jean Baptiste	1
St. Martin	1
St. Pierre-Jolys	1
Ste. Agathe	1
Ste. Anne	1
Sandy Lake	2
Selkirk	12
Sherridon	1
Shilo	1
Skownan	1
Sprague	1
Springfield	1
Steinbach	2
Stonewall	2
Somerset	1
Souris	2
Swan River	5
Teulon	1
The Pas	1
Thompson	7
Threherne	1
Waskada	1
Winkler	4
Winnipeg	411
Winnipegosis	2
Zhoda	1
Subtotal	**793**
Alberta	3
British Columbia	1
Nova Scotia	1
Ontario	7
Saskatchewan	3
South America	1
Subtotal	**16**
Total	**809**

New Complaint Files Opened in 2004 by Department or Agency

PROVINCIAL GOVERNMENT DEPARTMENTS (566)

Aboriginal & Northern Affairs	**1**
Advanced Education & Training	**6**
Agriculture, Food and Rural Initiatives	**9**
Civil Service Commission	**1**
Conservation(25)	
General	20
Water Stewardship	5
Culture, Heritage & Tourism	**2**
Education, Citizenship & Youth	**1**
Family Services & Housing (85)	
General	16
Child & Family Services	24
Employment & Income Assistance	28
Manitoba Housing Authority	14
Social Services Advisory Committee	1
Ombudsman's Own Initiative (OOI)	1
Finance (27)	
General	3
Automobile Injury Compensation Appeal Commission	3
Residential Tenancies Branch	13
Residential Tenancies Commission	5
Securities Commission	3
Health (57)	
General	18
Mental Health	18
Regional Health Authorities	20
Ombudsman's Own Initiative (OOI)	1
Intergovernmental Affairs & Trade(6)	
General	5
Ombudsman's Own Initiative (OOI)	1
Justice (331)	
General	17
Agassiz Youth Centre	15
Brandon Correctional Centre	36
Dauphin Correctional Centre	1
Headingley Correctional Centre	125
Milner Ridge Correctional Centre	7
Portage Correctional Centre	12
The Pas Correctional Centre	4
Winnipeg Remand Centre	63
Maintenance Enforcement	15
Human Rights Commission	6
Legal Aid Manitoba	3
Public Trustee	19
Manitoba Youth Centre	3
Courts	3
Ombudsman's Own Initiative (OOI)	2
Labour & Immigration (6)	
General	3
Manitoba Labour Board	2
Ombudsman's Own Initiative (OOI)	1
Transportation & Government Services	**10**

BOARDS & CORPORATIONS (129)

Workers Compensation Board	**24**
The Appeal Commission	**10**
Civil Service Superannuation Board	**1**
Manitoba Hydro	**17**
Manitoba Lotteries Corporation	**4**
Manitoba Public Insurance (73)	
General	63
Driver & Vehicle Licencing	10

MUNICIPAL GOVERNMENTS (76)

City of Winnipeg (30)	
General	1
Community Services	2
Corporate Finance	6
Fire Paramedic Service	2
Planning, Property & Development	9
Property Assessment	1
Public Works	2
Transit	1
Water & Waste	1
Winnipeg Police Service	5
Other Municipalities	**46**

NON-JURISDICTIONAL (38)

Federal Departments & Agencies	**5**
Private Matters	**32**
Schools	**1**

Total Complaint Files	**809**

New Complaint Files Opened in 2004 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) Recom-mendation (A)(NA)	Pending
Provincial Government Departments	**566**										
Aboriginal & Northern Affairs	**1**	-	1	-	-	-	-	-	-	-	-
Advanced Education & Training	**6**	-	1	-	1	-	2	-	1	-	1
Agriculture Food & Rural Initiatives	**9**	1	-	1	-	1	2	-	1	-	3
Civil Service Commission	**1**	-	-	-	-	-	1	-	-	-	-
Conservation	**25**										
General	20	-	-	1	3	5	2	-	1	-	8
Water Stewardship	5	-	-	-	-	1	-	-	-	-	4
Culture, Heritage & Tourism	**2**	-	-	-	-	-	-	-	-	-	2
Education, Citizenship & Youth	**1**	-	-	-	-	-	-	-	-	-	1
Family Services & Housing	**84**										
General	16	-	-	3	-	4	3	-	5	-	1
Child & Family Services	24	-	-	-	2	3	5	1	2	-	11
Employment & Income Assistance	28	2	-	3	-	5	5	1	7	-	5
Manitoba Housing Authority	14	-	-	1	1	5	2	-	2	-	3
Social Services Advisory Board	1	-	-	1	-	-	-	-	-	-	-
Ombudsman's Own Initiative (OOI)	1	-	-	-	-	1	-	-	-	-	-
Finance	**27**										
General	3	-	-	1	-	-	-	-	1	-	1
Automobile Injury Compensation Appeal Commission	3	-	-	-	-	-	1	-	-	-	2
Residential Tenancies Branch	13	-	-	-	-	4	3	-	2	-	4
Residential Tenancies Commission	5	1	-	1	-	2	-	-	-	-	1
Securities Commission	3	-	-	1	-	-	1	-	1	-	1
Health	**57**										
General	18	-	-	2	1	2	5	-	1	-	7
Mental Health	18	-	-	1	-	3	7	1	1	-	5
Regional Health Authority	20	-	1	2	-	11	5	-	1	-	-
Ombudsman's Own Initiative (OOI)	1	-	-	-	-	-	-	-	1	-	-
Intergovernmental Affairs	**6**										
General	5	-	1	-	-	1	1	1	-	-	1
Ombudsman's Own Initiative (OOI)	1	-	-	-	-	-	-	-	-	-	1
Justice & Attorney General	**331**										
General	17	-	4	-	-	5	-	1	-	-	7
Agassiz Youth Centre	15	2	-	1	-	2	3	1	6	-	-
Brandon Correctional Centre	36	-	-	1	-	12	8	4	9	-	2
Dauphin Correctional Centre	1	-	-	-	-	-	1	-	-	-	-
Headingley Correctional Centre	125	-	-	16	1	8	31	7	51	-	11

New Complaint Files Opened in 2004 by Category and Disposition *cont'd*

Department or Category	Total	Assist. Rendered	Declined	Discont'd (Client)	Discont'd (Omb.)	Info. Supplied	Not Supported	Partially Resolved	Resolved	Recom-mendation (A)(NA)	Pending
The Pas Correctional Centre	4	-	-	-	-	3	-	-	1	-	-
Winnipeg Remand Centre	63	1	-	11	-	5	21	2	17	-	6
Maintenance Enforcement	15	-	-	3	-	3	1	1	3	-	4
Human Rights Commission	6	-	-	-	-	-	3	-	-	-	3
Legal Aid Manitoba	3	-	-	-	1	1	1	-	-	-	-
Public Trustee	19	-	-	-	2	5	2	-	1	-	9
Manitoba Youth Centre	3	1	-	-	-	-	1	-	1	-	-
Courts	3	-	2	-	-	1	-	-	-	-	-
Ombudsman's Own Initiative (OOI)	2	-	-	-	-	-	-	-	1	-	1
Labour & Immigration	**6**										
General	3	-	-	-	1	1	-	-	-	-	1
Manitoba Labour Board	2	-	-	-	-	-	-	-	-	-	2
Ombudsman's Own Initiative (OOI)	1	-	-	-	-	-	-	-	-	-	1
Transportation & Government Services	**10**	**-**	**-**	**-**	**1**	**-**	**1**	**-**	**-**	**-**	**8**
Boards & Corporations	**129**										
Workers Compensation Board	24	-	2	1	-	9	3	2	1	-	6
The Appeal Commission	10	-	1	1	2	4	-	-	-	-	2
Corp. & Extra Departmental	95										
General	1	-	-	-	-	-	-	-	-	-	1
Manitoba Hydro	17	-	-	-	-	7	1	-	1	-	8
Manitoba Lotteries Corporation	4	-	-	1	-	-	1	-	1	-	1
Manitoba Public Insurance	**73**										
General	63	2	2	3	4	10	3	1	4	-	34
Driver & Vehicle Licencing	10	-	-	-	-	4	3	-	1	-	2
Municipalities	**76**										
City of Winnipeg	**30**										
General	1	-	-	-	-	-	-	-	-	-	1
Community Service	2	-	-	-	-	-	1	-	-	-	1
Corporate Finance	6	-	-	1	-	-	1	-	-	-	4
Fire Paramedic Service	2	-	-	-	-	1	-	-	-	-	1
Planning, Property & Development	9	-	-	1	-	1	1	-	-	-	6
Property Assessment	1	-	-	-	-	-	-	-	-	-	1
Public Works	2	-	-	-	-	-	-	-	1	-	1
Transit	1	-	-	-	-	1	-	-	-	-	-
Water & Waste	1	-	-	-	-	-	-	-	-	-	1
Winnipeg Police Service	5	-	-	1	-	1	1	-	-	-	2
Other Municipalities	**46**	**-**	**3**	**3**	**-**	**7**	**8**	**-**	**3**	**-**	**22**
Non-Jurisdictional	**38**										
Federal Departments & Agencies	**5**	**-**	**-**	**1**	**-**	**4**	**-**	**-**	**-**	**-**	**-**
Private Matters	**32**	**1**	**6**	**-**	**3**	**21**	**-**	**-**	**-**	**-**	**1**
Schools	**1**	**-**	**1**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total Complaints	**809**	**11**	**25**	**66**	**23**	**166**	**147**	**24**	**132**	**-**	**215**

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

Complaint Files Carried over into 2004

Department or Category	Total	Assist. Rendered	Declined	Discont'd (Client)	Discont'd (Omb.)	Info. Supplied	Not Supported	Partially Resolved	Resolved	Recom-mendation (A)(NA)	Pending
Provincial Government Departments	**243**										
Advanced Education & Training	**1**	-	-	-	-	-	1	-	-	-	-
Agriculture, Food and Rural Initiatives	**3**										
General	2	-	-	-	-	1	1	-	-	-	-
Manitoba Crop Insurance Corporation	1	-	-	-	-	-	-	-	-	-	1
Civil Service Commission	**1**	-	-	-	-	-	-	-	-	-	1
Conservation	**23**	1	-	1	2	1	4	1	-	-	13
Education, Citizenship & Youth	**3**										
General	1	-	-	1	-	-	-	-	-	-	-
Ombudsman's Own Initiative (OOI)	2	-	-	-		-	-	-	-	-	2
Family Services & Housing	**34**										
General	3	-	-	1	-	-	2	-	-	-	-
Child & Family Services	11	1	-	-	-	1	3	3	1	-	2
Employment & Income Assistance	6	-	-	1	-	2	-	1	2	-	-
Manitoba Housing Authority	8	-	-	2	-	2	-	1	2	-	1
Ombudsman's Own Initiative (OOI)	6	-	-	-	1	-	-	-	1	-	4
Finance	**14**										
General	1	-	-	-		-	-	-	-	-	1
Automobile Injury Compensation Appeal Commission	4	-	-	-	1	1	2	-	-	-	-
Residential Tenancies Branch	6	-	-	1	-	3	2	-	-	-	-
Residential Tenancies Commission	3	-	-	-	-	1	-	1	-	-	1
Health	**27**										
General	3	-	-	-	-	-	1	1	-	-	1
Mental Health	10	-	-	-	-	-	1	3	6	-	-
Regional Health Authority	8	-	-	-	-	1	3	-	2	-	2
Ombudsman's Own Initiative (OOI)	6	-	-	-	-	-	-	-	-	-	6
Justice	**123**										
General	7	-	-	-	-	5	1	1	-	-	-
Agassiz Youth Centre	3	-	-	1	-	-	-	1	1	-	-
Brandon Correctional Centre	3	-	-	-	-	2	1	-	-	-	-
Dauphin Correctional Centre	2	-	-	2	-	-	-	-	-	-	-
Headingley Correctional Centre	30	-	-	2	-	7	9	3	9	-	-
Milner Ridge Correctional Centre	2	-	-	1	-	-	1	-	-	-	-
Portage Correctional Centre	7	-	-	-	-		7	-		-	-
Winnipeg Remand Centre	15	-	-	1	-	-	5	2	6	-	1
Maintenance Enforcement	11	-	-	-	-	2	1	3	-	-	3
Human Rights Commission	4	-	-	1	-	-	3	-	-	-	-
Legal Aid Manitoba	3	-	-	-	-	-	2	-	1	-	-
Public Trustee	8	-	-	1	-	-	2	1	2	-	2
Ombudsman's Own Initiative (OOI)	28	-	-	-	3	-	-	1	7	-	17

Complaint Files Carried over into 2004 *cont'd*

Department or Category	Total	Assist. Rendered	Declined	Discont'd (Client)	Discont'd (Omb.)	Info. Supplied	Not Supported	Partially Resolved	Resolved	Recom-mendation (A)(NA)	Pending
Labour & Immigration	**6**										
General	2	-	-	1	-	1	-	-	-	-	-
Labour Board	2	-	-	-	-	-	1	-	-	-	1
Ombudsman's Own Initiative (OOI)	2	-	-	-	-	-	-	-	-	-	2
Transportation & Government Services	**8**	2	-	1	-	-	2	1	1	-	1
Boards & Corporations	**55**										
Workers Compensation Board	**11**	-	-	-	1	4	2	1	-	-	3
The Appeal Commission	**2**	-	-	-	-	1	1	-	-	-	-
Corp. & Extra Departmental	**42**										
Centra Gas	1	-	-	-	-	-		-	1	-	-
Manitoba Hydro	4	-	-	-	-	2	1	-	1	-	-
Manitoba Lotteries	2	-	-	-	-	-	1	1	-	-	-
Manitoba Public Insurance	30	2	-	2	-	8	8	-	4	-	5
Driver and Vehicle Licencing	5	-	-	-	-	2	2	-	-	-	1
Municipalities	**19**										
City of Winnipeg	**28**										
The Board of Trustees of the Winnipeg Civic Employees' Benefits Program	1	-	-	-	-	-	1	-	-	-	-
City Clerk	1	-	-	-	-	1	-	-	-	-	-
Community Service	3	-	1	1	-	-	-	-	-	-	1
Corporate Finance	7	-	-	2	-	-	3	-	-	-	2
Planning, Property & Development	7	-	-	-	-	3	1	1	-	-	2
Public Works	1	-	-	-	-	1	-	-	-	-	-
Water & Waste	3	1	-	-	-	1	-	1	-	-	-
Winnipeg Police Service	2	-	-	-	-	-	-	1	-	-	1
Ombudsman's Own Initiative (OOI)	3	-	-	-	-	-	-	-	-	-	3
Other Municipalities	**24**										
General	23	1	-	-	-	5	5	1	7	-	4
Ombudsman's Own Initiative (OOI)	1	-	-	-	-	-	-	-	-	-	1
Non-Jurisdictional	**4**										
Federal Depts. & Agencies	**1**	-	-	-	-	1	-	-	-	-	-
Private Matters	**3**	-	-	2	-	-	1	-	-	-	-
Total Complaints	**354**	**8**	**1**	**25**	**8**	**59**	**81**	**30**	**54**	**-**	**88**

At the close of 2003, there were 354 complaint cases still pending:

- 269 were carried over from 2003
- 50 were carried over from 2002
- 18 originated in 2001
- 14 originated in 2000
- 2 originated in 1999
- 1 originated in 1997

We closed 266 or 75% of these pending cases in 2004. Of the 88 complaints still pending:

- 52 originated in 2003
- 18 originated in 2002
- 7 originated in 2001
- 9 originated in 2000
- 2 originated in 1999

Selected Case Summaries

This section of the Annual Report is intended to profile some of the cases the office worked on in 2004. These are examples of the issues and challenges that people brought forward for our help. They are intended to relate some of the problems encountered by people dealing with government and its agencies, as well as some of the challenges that these bodies face in trying to meet the expectations of the public.

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

We hope that the case summaries will help to facilitate greater public awareness and discussion about some of the issues raised by Manitobans in 2004. 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.

Special Investigations

OMBUDSMAN'S OWN INITIATIVE

In addition to investigating complaints received from members of the public, *The Ombudsman Act* authorizes the Ombudsman to initiate her own investigation of government actions or decisions by which members of the public may be aggrieved.

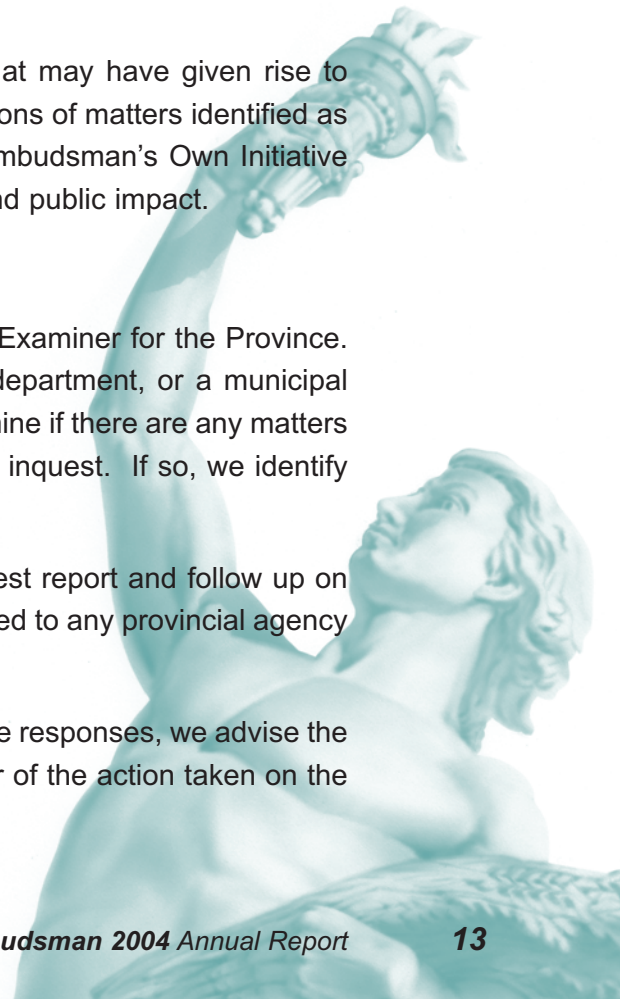
This allows the Ombudsman to investigate underlying concerns that may have given rise to numerous individual complaints, and to conduct systemic investigations of matters identified as having broad public interest. Such investigations are known as Ombudsman's Own Initiative (OOI) and typically involve a review of legislation, policy, practice and public impact.

MONITORING INQUESTS

Our office receives notices of inquests called by the Chief Medical Examiner for the Province. If a pending inquest involves a provincial government agency or department, or a municipal authority under our jurisdiction, we generally review the file to determine if there are any matters of administration which we believe should be addressed during the inquest. If so, we identify these matters for the inquest.

Following completion of the inquest, we receive a copy of the inquest report and follow up on the action taken in response to any recommendations that are directed to any provincial agency or department, or municipality.

Once we are satisfied that there have been adequate and appropriate responses, we advise the Chief Judge of the Provincial Court and the Chief Medical Examiner of the action taken on the various recommendations.



Over the years we have found our process for monitoring inquests to be useful and effective. It has provided an opportunity for provincial and municipal entities to establish that they have carried out their statutory responsibilities and responded appropriately to recommendations flowing from inquests conducted under *The Fatality Inquiries Act*. The involvement of our office ensures that due consideration is given to the recommendations following publication of the inquest report.

Provincial Government Case Summaries

70% of the of formal complaints received in 2004 involved the provincial government.

Of the new complaint files we received about the provincial government:

- 58% involved Manitoba Justice
- 15% involved Family Services and Housing
- 10% involved Manitoba Health
- 5% involved Manitoba Finance
- 4% involved Manitoba Conservation
- 2% involved Manitoba Transportation and Government Services
- 2% involved Manitoba Agriculture, Food and Rural Initiatives

The remaining 4% of new complaint files were spread amongst Aboriginal and Northern Affairs; Advanced Education and Training; the Civil Service Commission; Education, Citizenship and Youth; Intergovernmental Affairs; and, Labour and Immigration.

Manitoba Agriculture, Food and Rural Initiatives

Manitoba Agriculture, Food and Rural Initiatives is a large department that includes the Manitoba Crop Insurance Corporation and Appeal Tribunal, the Agricultural Crown Lands Branch and Appeal Board, the Manitoba Agriculture Credit Corporation, and the Food Development Centre.

This year, our office is reporting on one case involving both the Agricultural Crown Lands Branch and their Appeal Board. Although this investigation was very detailed and complex, there was a need for expediency as the viability of the complainant's recently purchased farming operation was hanging in the balance. The branch understood this urgency and cooperated fully with our office in our efforts to complete the investigation promptly.

Manitoba Agriculture, Food and Rural Initiatives

Crown Lands Branch

Ms L complained that the Agricultural Crown Lands Branch (branch) had denied a request to transfer a crown lease to her when she bought a farm operation and private land from the existing lessee. Such transfers are known as "unit transfers" and the purchaser is the only eligible applicant.

Ms L felt that she had been misinformed by the branch about the documentation required to process the transfer; that there had been undue delay; and that both she and her lawyer had relied on statements by departmental staff that the lease transfer had been approved when in fact it had not.

Ms L had appealed the branch denial to the Crown Lands Appeal Board (appeal board), but her appeal had been dismissed. She complained to our office about that decision as well. Because the complainant had identified different administrative concerns about the initial denial and the appeal board process, we investigated both.

With the full cooperation of the branch we conducted an extensive review of the relevant statutory provisions, departmental policies and documentation related to this transfer and met with the Director to review the transfer approval process.

The Director's decision to deny the transfer was based upon a staff recommendation and an analysis of the applicant's eligibility. This analysis, the rationale for the refusal, was not supported by the information contained in the file. As well, part of the analysis dealt with matters that were irrelevant to the policy under which the application was considered.

The investigation disclosed that the decision to deny the unit transfer was based, at least in part, on a factor that Ms L was not made aware of: a concern that she was applying for the land lease on behalf of another person. Ms L did not have full knowledge of the case she had to meet, and she was not given an opportunity to respond. It could not be said that she was treated fairly.

Finally, it appeared that in considering the application the branch had applied the wrong test of eligibility. Instead of the test for new applicant lessees, the branch appeared to have applied the

more stringent test applicable to existing lessees being investigated to determine ongoing eligibility. In applying that test, it would be difficult, if not impossible, for new applicants to qualify for crown land leases.

The Ombudsman noted that although the complaint had come from the prospective lessee, the branch decision also had a negative impact on the existing lessee, who had sold his private land to the complainant. We set out our investigative findings in detail for the Director and invited him to respond before proceeding any further.

The Director indicated he did not take issue with our investigative findings, and was prepared to reconsider the matter.

We were subsequently advised by the Director that, after consultation with departmental staff, the decision had been reversed and the unit transfer approved.

Although the Director's decision to allow the unit transfer resolved Ms L's complaint, the investigation of her concerns about the appeal board process continued, and a number of issues were referred back to the board to canvass with legal counsel.

Manitoba Conservation

In our 2003 Annual Report we summarized a four-year investigation into the construction of an unlicensed drainage project which led to formal recommendations to the Minister of Conservation. We were advised by the Minister in 2003 that the recommendations had been accepted. Responsibility for implementing the recommendations was assigned to Manitoba Water Stewardship.

We reported that at the time of writing the 2003 Annual Report the recommendations had not been implemented and that we would continue to monitor the situation. At the end of 2004, those recommendations had not been implemented and our complainants continued to report that little progress was being made. They reported that department's efforts to address their concerns were discouragingly similar to efforts that failed to produce results in the past. We have no reason to take issue with their analysis.

The department's failure to give effect to recommendations they accepted in 2003 is a matter of significant concern. It raises serious issues that go beyond the delays and the resulting frustration described in our 2003 Annual Report, and speaks to the department's ability to act in a reasonable and timely manner.

As well, the Ombudsman noted in his 2003 Annual Report that our office had received complaints during the past four years regarding the department's handling of the resettlement of Hecla Island. The Ombudsman expressed the view that Manitoba Conservation had not responded adequately or in a timely manner to complaints, but he remained optimistic that the department's efforts would improve.

Unfortunately, despite the Ombudsman's efforts to persuade the department to bring outstanding matters to a fair and reasonable conclusion, a number of those concerns had not been addressed by the end of 2004.

Manitoba Family Services and Housing

The range of services provided by this department is varied and the complaints we receive tend to reflect a wide variety of issues. In 2004, we received complaints related to Employment and Income Assistance (EIA), the Manitoba Housing Authority and the Residential Tenancies Branch and Commission. A breakdown of the numbers of complaints received and the specific divisions and agencies affected can be found in the statistics section of this report.

Cases regarding concerns about agencies of Child and Family Services are reported in the Child and Adolescent Services section of this report.

In 2004, the office toured the Manitoba Developmental Centre (MDC) in Portage La Prairie and visited with residents, families and staff. We hope to continue to work on outreach activities with MDC in an effort to improve services for vulnerable persons living with a mental disability.

As in previous years, the majority of complaints about this department related to EIA. There is often urgency in reviewing benefit entitlement concerns, and staff sometimes have to deal with understandably emotional complainants. Investigators handling these cases have responded with sensitivity and understanding, and because of the cooperation from staff at EIA, many of these issues have been resolved informally and quickly.

Manitoba Family Services and Housing

Manitoba Housing Authority

A former tenant of the Manitoba Housing Authority (MHA) complained about efforts to collect a debt from her. The MHA notified the complainant that she owed $999.97 for damage it was alleged that she caused to MHA property while a tenant. The complainant denied responsibility for any damage and disputed the debt. The MHA attempted to recover the debt through a lien against her GST Rebate. She questioned the authority for recovering money from her without first having obtained an order from the Residential Tenancies Branch (RTB).

We inquired of the MHA as to the authority for the lien and were advised that in some cases claims against tenants were not vetted through the RTB. We discussed this matter with the Director of the RTB, who subsequently made contact with the Director of MHA to review the manner by which debts may be collected from tenants.

We were advised that the RTB and the MHA would work out a process for addressing existing disputes where there is no order by the RTB. Measures to address the manner by which the MHA will attempt to collect arrears or debts from tenants were put in place.

The actions taken by both the MHA and the RTB seemed to be reasonable and as a result, we concluded our involvement. Subsequently, our complainant had the matter vetted through the RTB and then the Residential Tenancies Commission and received a favorable decision.

Manitoba Health

During 2004, the office completed a presentation on the role of the office to the staff and patients of the forensic unit at the Selkirk Mental Health Centre. We toured the PsycHealth Centre (Health Sciences Centre), McEwen Building (St. Boniface General Hospital), and the Mental Health Program at the Seven Oaks General Hospital. An increase in the number of cases involving mental health issues in 2004 may have resulted from the increased visibility of the office in the community.

In an effort to educate the office on various mental health related topics, we invited three distinguished guests from the mental health field to present information at a two-day office seminar. As well, we invited a guest speaker from the Winnipeg Regional Health Authority Client Relations Office to educate staff on its role and function. It was a welcome opportunity to understand and appreciate services offered to a variety of WRHA clients and to learn about their client-driven complaint process. Once we had established contact with the Client Relations Office, we were able to refer individuals to them with their concerns. This initiative should assist individuals who contact us with concerns related to the health care system.

It is important to note that when investigating complaints related to the health care profession, our office investigates matters of administration, but does not review complaints related to the diagnosis, prognosis or medical decisions of physicians. Should a member of the public be dissatisfied with a treatment plan, diagnosis or related issues, they have the right to report those concerns to the College of Physicians and Surgeons.

Case Summary

MANITOBA HEALTH

Regional Health Authority

In 2004 our office concluded a lengthy investigation into the concerns of Mrs. A, whose son's mental health had deteriorated dramatically after being released from a mental health facility on a Certificate of Leave.

Mrs. A felt that her son had not received adequate follow-up care in the community, and that more should have been done to monitor his compliance with the conditions imposed on him by the Certificate of Leave.

She also had concerns about the obligations and responsibilities placed upon her as her son's "nearest relative" under *The Mental Health Act*. In accordance with the Act, she was the person eligible to make treatment decisions on behalf of her son when he was not competent to do so. Shortly after admission to hospital as an involuntary patient, Mrs. A's son was found not competent to make treatment decisions. She had ongoing contact with her son and hospital staff, and participated in discharge planning.

Our investigation revealed that discharge planning is a critical issue in the successful transition from institution to community, and it is addressed in Regional Health Authority (RHA) policy,

provincial standards, and *The Mental Health Act. The Mental Health Act* states that a Certificate of Leave may be issued only if the patient, his representative, the attending psychiatrist and other health professionals and persons involved in the patient's care and treatment develop a treatment plan for the patient to adhere to while in the community on the Certificate.

In this case, the plan called for the patient to have contact with a community mental health worker, to receive proctor service, to continue with prescribed medication, and to be treated by a psychiatrist. These were conditions imposed by the Certificate of Leave. The patient indicated that he would be living in his home community, although this was not a condition imposed by the Certificate of Leave.

With the full cooperation of the RHA in our investigation, we found that a series of events had resulted in the discharge plan breaking down almost immediately.

The community mental health worker who was to be involved with Mrs. A's son in the community was not involved in the development of the discharge plan. She was not provided with a copy of the Certificate, nor did she receive a written referral until several days after the patient was discharged. Although she called the patient immediately after receiving the plan and made an appointment, he did not attend. The first meeting between the worker and the client occurred fourteen days after he left the hospital.

Records indicated the worker had concerns about whether or not the patient was taking his medication, and that he stated he would not accept proctor services beyond driving him to appointments. He also stated that he was moving to Winnipeg. The worker conveyed this information to the patient's psychiatrist immediately.

The patient had no further contact with Community Mental Health (CMH) before leaving the area. He returned three months later, at which point there seemed to be consensus that his mental health had deteriorated. Upon being informed of his return, the community mental health worker passed on the concerns to the psychiatrist and was instructed to discuss the matter with Mrs. A, as the nearest relative.

Mrs. A was angry and felt that her son should be in the hospital, but also felt it was up to the psychiatrist and the worker to facilitate this. In the course of this lengthy investigation, we learned that the complainant's dilemma was common among family members who want to support and maintain a bond with a loved one who has become ill, but often are called upon to make difficult and emotional decisions resulting in involuntary admission or medication the patient does not want.

While there are no easy answers to such a dilemma, our investigation did confirm that responsibility for determining that a patient is noncompliant with a Certificate of Leave, and should be re-admitted to hospital, rests solely with the psychiatrist, notwithstanding the existence of a nearest relative.

In this case, the investigation disclosed little about the interaction between the patient and psychiatrist, because after the patient was discharged, visits with the psychiatrist were at a private clinic. The RHA could not confirm whether any assessment of the patient's compliance with the conditions of the Certificate of Leave was made until immediately prior to his re-admission, approximately six weeks after his return to the community.

Upon further inquiry we were advised that people who are now discharged on a Certificate of Leave and required to see a psychiatrist, are seen at an RHA facility, and the records of their follow-up treatment are part of their institutional file.

At the end of the investigation we had to report to Mrs. A that we could not support her complaint about the role of CMH. We reported in detail the efforts made by the worker, the limitations and constraints placed upon the worker by the system that existed at the time, and the significant factors beyond the worker's control. We also reported on some significant and positive systemic changes implemented by the RHA.

The discharge planning process changed to include the involvement of the community mental health worker, or a representative from CMH. The importance of clarity and timeliness in providing information in support of referrals to CMH was discussed with staff of the psychiatric unit, and responsibility for making specific referrals was assigned to a staff social worker. To assist workers in the field, the RHA had hired a clinical supervisor for community mental health workers.

To assist persons called upon to make treatment decisions for others, the RHA developed an information sheet that included information about the role and function of a person making treatment decisions for others, the criteria and test to be applied by them when granting consent to treatment, and identifying a means by which a person can cease to be called upon to make treatment decisions. The development of this information sheet addressed Mrs. A's concerns about her experience as the decision maker for treatment of her son.

Our office commends the efforts of the RHA to address the concerns raised by Mrs. A's complaint in a meaningful way on a systemic basis.

The majority of complaints to our office about Manitoba Justice relate to concerns about decisions made and services provided by Manitoba Corrections to individuals incarcerated in the seven provincial adult correctional facilities. Information relating to youth in the correctional system is reported in the Child and Adolescent Services section of this report.

Complaints about other branches of Manitoba Justice related to the Maintenance Enforcement Program, the Public Trustee, Legal Aid Manitoba, and the Manitoba Human Rights Commission. Please refer to the statistics section of this report for a breakdown of the number of complaints pertaining to the specific divisions within Manitoba Justice.

Incarcerated persons depend on the Corrections Division for the provision of basic necessities: food, shelter, clothing and medical care. Many complaints reflect concerns about the provision of the basic necessities. Other issues raised in 2004 related to missing property, institutional placement and segregation, discipline and visits.

Given the limited resources of many individuals in correctional facilities and the importance of their concerns in terms of their daily well-being, the independent and impartial review of those concerns by our office continues to be of vital importance.

Our relationship with Adult Corrections goes beyond the investigation of individual complaints. We continue to tour facilities to examine the conditions that exist and to ensure that both staff and inmates remain aware of our role and function and are able to communicate with us when the need arises. In 2004 we spoke to new recruits in the correctional officer training program and visited correctional facilities to speak with unit managers, healthcare providers, line staff and groups of inmates. These presentations are valuable in explaining the role and function of the Ombudsman.

Many inmate complaints are seen as urgent. Our office attempts to resolve complaints informally and in the most expeditious manner possible. We continue to have an excellent working relationship with the Corrections Division of Manitoba Justice and the heads of the adult correctional facilities.

In addition to individual complaints, our office continues to monitor and receive updates on systemic concerns such as the mental health care provided to inmates, the use of preventative segregation in corrections facilities and the placement of remand inmates in the police lock-up in Thompson, Manitoba.

Thompson Holding Cells (OOI)

In 2003, we identified concerns relating to the use of the Thompson Holding Cells (THC) to house provincial inmates. This facility is a police lock-up operated by the Royal Canadian Mounted Police (RCMP), but, by contract, it also houses provincial inmates who are attending court in Thompson.

Specific concerns raised included a complaint from a male inmate who alleged he observed a strip search of a female prisoner housed in the same area of the facility; and a young person being placed in proximity to an adult he was to testify against in court. The youth alleged that while in the THC he had been threatened by the adult.

More general concerns from provincial inmates include: expired frozen meal products; lack of medical services; lack of hygiene products; inadequate showers; lack of clean clothing; lack of bedding, and an inability to contact outside resources such as legal counsel or the Ombudsman.

Our office continues to have discussions with the Corrections Division regarding the THC, and we continue to monitor the situation. We have been advised that sheriffs employed by Manitoba Justice are now in place at the THC and are assisting with some of the prisoner care. We hope this change will allow the Corrections Division to monitor the situation more closely and will result in improvements to living conditions. Our file on this matter remains open.

Systemic Medical Review (OOI)

In 1999, the Elizabeth Fry Society (Society) wrote to the Minister of Justice expressing concerns related to the medical care of inmates at the Portage Correctional Centre (PCC). At the request of the Executive Director of Adult Corrections, and with the agreement of the Society, the office of the Manitoba Ombudsman undertook an investigation of the issues raised.

In February 2001, the Ombudsman issued an "Interim Report on Investigation into Elizabeth Fry Society Complaint Regarding Medical Services at Portage Correctional Centre". The report contained a number of proposed recommendations. The A/Assistant Deputy Minister responded to the report advising that "many of the concerns highlighted in the report had been identified as issues within the division for some time and were issues relating to the entire system of health care services and not confined to any single institution."

In January 2002, our office issued a further "Report on Investigation into Elizabeth Fry Society Complaint Regarding Medical Services at Portage Correctional Centre" containing information relating to our proposed recommendations and the department's response. At that time we felt that the department had given consideration to the concerns expressed and had responded reasonably to the majority of the proposed recommendations. Concurrently, our office was engaged in a number of investigations related to medical care in other provincial correctional facilities. Several of these investigations highlighted medical issues that appeared to be systemic to most of the Adult Corrections medical units. On the basis of these concerns an Ombudsman Own Initiative (OOI) file had been opened to review these medical concerns.

Further discussions occurred with the department on all the issues that had been raised, which resulted in the resolution of many of the concerns. This was largely due to the fact that over the past several years, the department has undertaken a number of initiatives. Some of the initiatives were intended to address particular concerns, related to PCC or another correctional facility; others dealt with system wide policies and practices.

Medical Director

Initially, it appeared there was agreement that there could be a benefit in the appointment of a Medical Director to oversee medical care within the Corrections Division. With the passage of time, the department's focus shifted to developing the permanent position of Coordinator of Health Services. While not a medical doctor, the Coordinator will be charged with overseeing medical services within youth and adult correctional facilities to ensure adequate care is available to inmates. Duties will include reviewing and developing policy, functional supervision

on all professional practice and standards of care, and implementing a system to collect relevant statistical information. This position has now been filled on an acting basis.

PCC Medical Services

Many of the medical treatment concerns at PCC have been addressed through an increase in nursing staff and the adjustment of physician hours, which has allowed the doctor to increase the number of patients seen during clinic hours. Fewer inmates are now transferred to PCC as a result of increased unit space for female inmates at the Winnipeg Remand Centre (WRC) and this has resulted in a decrease in the number of requests to see the doctor. Overall, our office has observed a reduction in complaints from PCC inmates.

Systemic Changes

In terms of systemic changes, the department has made revisions to its divisional policy regarding inmate health services. In particular, the new policies on psychiatric/forensic services, dental services, optometry services, hospital transfers, information release, medical transfer sheet, medications, self-administered medications and communicable disease control directly address issues which, in the past, have led to complaints to our office.

As well, the department has initiated a process whereby each inmate will have a single medical file, rather than separate files at each institution where he or she has been housed. The file will follow the inmate when he or she is transferred. This is expected to facilitate continuity of care and may prevent errors that may be attributable to insufficient clinical information. The inmate's file will be stored at the WRC upon the inmate's release and it is our understanding that a medical office assistant has been hired to serve at the WRC to facilitate this new process.

HCC Medical Unit

The department has responded to concerns particularly pertaining to the Headingley Correctional Centre (HCC) Medical Unit by hiring an independent medical consultant to conduct an audit of HCC's Medical Unit. It is our understanding that the audit and recommendations were positively received and consideration is being given to conduct similar audits in other correctional centres.

The department is currently studying the recommendations relating to the HCC report. Although most deal with HCC's Medical Unit, a few have implications for the provincial system as a whole.

We remain interested in the work the department has undertaken to improve its health care services and have invited ongoing updates and information relating to this issue. We appreciate the cooperation the department and the various institutions have provided with respect to the concerns raised by our office.

Case Summary

MANITOBA JUSTICE

Headingley Correctional Centre

PROBLEM

Mr. W contacted our office and alleged that correctional officers at the Headingley Correctional Centre (HCC) had used excessive force while responding to a fight between him and another inmate. He claimed that correctional officers secured his hands behind his back with handcuffs and then carried him by the handcuffs, causing him to suffer a fractured wrist.

He also felt that his concern about excessive force was not appropriately addressed by HCC and requested an investigation by our office. Mr. W advised our office that the incident giving rise to his complaint was recorded on videotape and that this might prove useful in substantiating his allegation that excessive force had been used.

OUR REVIEW

HCC confirmed that Mr. W was fighting with another inmate and after being pepper sprayed, both inmates were restrained and escorted to different areas of the institution. Following the incident Mr. W was escorted to a hospital emergency ward where x-rays were completed and his wrist placed in a cast.

HCC documentation suggested that Mr. W had on two previous occasions reported an injury to the same wrist.

The videotape was seized by the correctional officer who had used the pepper spray in his capacity as the officer in charge. However, HCC was unable to provide information regarding the whereabouts of the videotape. There was no mention of video evidence in a letter sent to the RCMP the following day when they were contacted by HCC at the complainant's request.

HCC advised us that they could not conclusively substantiate or dismiss the allegation made by Mr. W as they had not maintained continuity of the video evidence.

We raised with HCC their failure to mention the videotape evidence in their correspondence to the RCMP. Subsequent to that discussion, HCC notified the RCMP of the missing video evidence.

OUTCOME

HCC acknowledged the shortcomings of their review of the situation, specifically with respect to the continuity of evidence and the lack of an internal investigation. In an effort to address this matter, HCC reviewed and clarified with staff their respective roles in the investigation of inmate complaints and the handling and storage of videotape evidence. Our office has been assured that future incidents of this nature will be fully investigated by HCC.

Because of the seriousness of the allegations made by the complainant, and because our investigation concluded that procedures which could have prevented this incident were already in place and should have been followed, we reported our findings to the Deputy Minister of Justice and the Assistant Deputy Minister for Corrections. Our office received a response from the Deputy Minister of Justice, who confirmed that this was a serious situation and acknowledged the deficiencies in the investigative process.

Case Summary

MANITOBA JUSTICE

Headingley Correctional Centre

Mr. A complained that the Headingley Correctional Centre (HCC) abruptly ceased dispensing medication for his anxiety disorder, and that as a result of the abrupt cessation he was experiencing withdrawal.

Mr. A advised our office that he was suspected of supplying and/or exchanging medication with other inmates. He denied the allegations.

In reviewing Mr. A's medical records, we learned that he was not placed on a step-down program, nor did he have contact with a physician or psychiatrist for assessment purposes. It appeared that his medication was abruptly discontinued on the direction from a psychiatric nurse at HCC.

The individual who discontinued the medication believed Mr. A was interchanging medication with other inmates, and that the medication should be discontinued for the safety of other inmates. We learned that Mr. A had been charged institutionally for exchanging medication, but had been found not guilty by a discipline board.

Our review also confirmed that normally an inmate would be placed on a step-down program before ending the medication regime but that this did not happen in Mr. A's case.

As a result of our investigation, Mr. A's medication regime was restored. The staff person responsible for the discontinuation of the medication was advised verbally and in writing by management that the decision to discontinue the medication was beyond his authority and that such decisions were the responsibility of doctors. HCC apologized to the inmate for the actions that occurred. Our office felt that the matter was appropriately resolved. Mr. A appreciated the outcome of the investigation.

Case Summary

MANITOBA JUSTICE

Maintenance Enforcement Program

Mr. D's court order required him to make monthly support payments between $0 and $400 depending upon his gross income for the previous month. In order to determine the amount of the payments, he had to provide the Maintenance Enforcement Program (MEP) with proof of his earnings on a monthly basis. If he earned less than $1,000 in the previous month, then he would not have to pay support for the current month. Mr. D advised that he lost his employment in the summer of 1998 and did not have any income to report. As a result, he began to file statutory declarations with MEP stating that his income was "nil". MEP accepted these declarations for approximately four years, during which time Mr. D was not required to pay support and no arrears accumulated on his account.

According to Mr. D, in the summer of 2002, MEP refused to continue accepting his statutory declarations so he did not file any declarations after that time. In the summer of 2003, MEP

commenced garnishment proceedings to collect arrears that had subsequently accumulated on Mr. D's account. Mr. D complained to our office about both the calculation of the arrears and the garnishment.

MEP'S Position

We were advised by MEP that Mr. D had attended their office on various occasions wishing to swear a declaration that his income was nil. On two occasions, MEP refused to accept these declarations. MEP advised that when a client is required to report his income to MEP and that report is not forthcoming, is inaccurate or incomplete, the maximum amount of support is to be paid. In Mr. D's case, this meant that when he stopped filing statutory declarations in 2002, MEP set his monthly support at the highest amount payable under the court order and arrears accumulated on his account. MEP began garnishment proceedings to collect the arrears.

MEP further advised that they had information that Mr. D had some form of monthly income, and therefore, his declarations of "nil" income were false. Since MEP questioned the accuracy of the declarations, they requested Mr. D provide information in support of the income he was claiming. Mr. D refused to provide any information. MEP took the position that they should not accept his declarations as they had reason to believe that he had income.

Our Review

We appreciated MEP's concern that Mr. D might be making false statutory declarations. However, it was not clear that this authorized MEP to refuse to accept the declarations altogether, which resulted in Mr. D's support payments accruing at the highest amount under the order. We noted that the Act provided a process to address potentially false declarations.

MEP explained that there were two issues: the first was whether or not MEP may refuse to accept statutory declarations they suspect may be false for the purpose of establishing income pursuant to a court order, and the second is whether or not MEP must adjust an account based on information they believe to be false.

With respect to the first issue, MEP advised that in the future, if a client swears what MEP believes to be a false declaration, MEP will not refuse to accept the declaration altogether. MEP will follow the process set out in the Act for charging the client with the offence of swearing a false declaration, which is punishable by a fine or imprisonment or both.

With respect to the second issue, adjusting the account, MEP advised that there is no requirement to accept a declaration from a client as proof of their income on a final basis. As such, MEP is not bound to adjust account records unless satisfied that the evidence presented reflects the order and is accurate. MEP is at liberty to substantiate any information provided by a client and there are provisions in the Act to address this.

Conclusion

In this case, MEP wrote to Mr. D in February of 2004 and advised that they would be prepared to accept his statutory declarations dating back to the summer of 2002. However, they would not adjust his account record unless he provided sufficient verification of the income he was claiming. If he was able to substantiate his income, MEP would reduce or eliminate his support payments accordingly and adjust his account. Mr. D would be required to pay any arrears

remaining after the adjustments had been made. Mr. D was also warned that if MEP discovered income that was not declared, MEP would pursue a charge under the Act.

Our office was satisfied that this approach reflected the process outlined in the Act for addressing potentially false declarations. We felt MEP's offer to accept Mr. D's declarations and supporting information for past months was a fair resolution to the matter.

Child and Adolescent Services

In addition to reviewing complaints from youth, or involving concerns about youth, our office undertook several outreach activities to inform youth about the role of this office and to support the services and programs that assist youth.

The office gave presentations about the role and jurisdiction of the Ombudsman to residents of the Agassiz Youth Centre (AYC) and Manitoba Youth Centre (MYC), and toured these facilities. The office also attended the facilities when necessary to meet with residents to discuss particular issues of concern.

Our office was represented at the MYC Pow-Wow as well as the Ian Logan Memorial Award presentation. As well, we attended the ceremony honouring recipients of the Manitoba Aboriginal Youth Achievement Awards, and had representation at the Manitoba Adolescent Treatment Centre's Annual General Meeting.

Two files were opened in 2004 under the Ombudsman's Own Initiative (OOI) relating to inquests involving youth and government departments. Six OOI files relating to the deaths of children and youth remain pending from previous years.

Our office has been working with the Children's Advocate and the Executive Director of the Manitoba Human Rights Commission on the development of a series of "Youth Rights" pamphlets. Each pamphlet covers a different subject area; Criminal Justice, Special Family Matters (adoption), Employment, On the Job, You and School, Youth in Care, Neglect and Abuse, Family Matters (separation/divorce/custody) and Human Rights. It is our hope that these pamphlets will be completed and published in 2005.

Youth Corrections

Intoxicated persons Detention Act (IPDA) Concerns (OOI)

Over the past seven years, our office has raised concerns about the designation of the Manitoba Youth Centre (MYC) as a holding centre for youth detained under The Intoxicated Persons Detention Act (IPDA). While we have been advised that the department has been attempting to address these concerns, the practice continues.

Background

It is our understanding that intoxicated youth have regularly been detained at the MYC since the early 1970's and this practice has been of concern to correctional officials for many years. It would appear that the concerns relate to the non-criminal nature of the detention under IPDA, and to overcrowding and safety issues.

We were advised that in 1996/97 the Corrections Division had raised concerns about the practice with the Winnipeg Police Services; however, the issue was not resolved.

In 1997 we wrote to the A/Executive Director, Community and Youth Correctional Services and copied the A/Assistant Deputy Minister of Corrections regarding concerns our office had with this practice. We were advised that the department was looking at possible alternatives, as the longstanding overcrowding at the MYC had been exacerbated by this practice.

The practice continued and in 1999 we wrote to the Assistant Deputy Minister indicating that this has been an ongoing issue for several years and it was our view that this situation should be addressed. The department continued in their efforts to find an alternative, but the situation remained unresolved.

In 2002 we wrote to the Deputy Minister of Justice and Deputy Attorney General regarding this matter. In response he advised that a number of steps had been taken to resolve the problem, but no solution had been found. He informed our office that a meeting had been planned with representatives of the City of Winnipeg to discuss the issue of housing intoxicated youth. He indicated that the department's objective was to find a suitable solution, with the participation of the City, and stated, "We remain firm in our determination to find an alternative."

In 2003 the Assistant Deputy Minister, Corrections Division wrote to the Chief of the Winnipeg Police Service and advised that beginning on June 1, 2002, he had directed the MYC to limit the number of intoxicated youth held under the IPDA to two at any one time. He also stated that this was an interim measure pending arrangements for alternative accommodation. He stated, "We will continue to work with WPS in supporting an alternative community-based option for IPDA youth with the view to delisting MYC within a one-year period."

At the end of 2003 we reviewed this matter and were informed that the MYC had not been delisted. We were advised by the Deputy Minister of Justice and Deputy Attorney General that the department had been reviewing the situation carefully, that there had been discussions with the City and with various agencies, and that the legalities of the situation had been assessed. The Deputy advised that this is a very complex issue with no easy solution, but the department was making every effort to resolve the issue.

While we could appreciate that the solution to this may be complex, and we have been advised that corrections officials have made an effort to address this issue, it has remained unresolved for seven years.

It is the opinion of the Ombudsman that a correctional facility is not an appropriate detoxification centre for youth. It is our understanding that intoxicated adults are generally not detained in correctional facilities and that the majority of other Canadian jurisdictions do not detain youth in a youth correctional facility.

RECOMMENDATION

As the Ombudsman was of the opinion that it is wrong to hold youth detained under The Intoxicated Persons Detention Act in a correctional facility, he recommended on January 21, 2005 to the Minister of Justice that the MYC no longer be used as a detoxification centre for youth. At the time of this report we are awaiting a response.

Case Summary

Child and Adolescent Services

Agassiz Youth Centre

We received a letter from a young person at the Agassiz Youth Centre (AYC) expressing concerns about Positive Peer Culture, a program in which a young person who is acting out can be restrained by other members of his group. In the letter he spoke of past instances, unrelated to AYC, where he had been the victim of abuse which related to his reaction to being restrained. AYC staff had seen the letter. In the course of our investigation, it became apparent that due to a communication breakdown his disclosure had not been reported to the proper authorities.

AYC confirmed that the abuse should have been reported. Staff are aware it is not the responsibility of AYC to determine if an alleged abuse disclosure is worthy of investigation, but rather that of the proper authorities (RCMP and/or Child and Family Services). It is the usual practice of AYC to report allegations of abuse to the proper authorities in accordance with their policy.

We raised with AYC a question about Positive Peer Culture and its impact on young persons who have experienced abuse.

We were advised that the guidelines for confinement under the Positive Peer Culture were reiterated with staff. The expectation is that if needed, the young person will be physically confined for a twenty-minute period. If they are unable to manage their behavior after a twenty-minute confinement, they will be placed in the quiet room.

It is our understanding, as well, that AYC is implementing an alternative to the Positive Peer Culture program and that training for the new program is already underway.

Family Services and Housing

Place of Safety (OOI)

The issue of designating a correctional facility as a "Place of Safety" under the provisions of *The Child and Family Services Act* dates back to 1989. In our Annual Report for 1990 we reported that it was not acceptable to utilize jail and police cells to house children who need assistance because of child welfare concerns. In 2001 we became aware that a 17-year-old youth was being housed without charge or sentence at the Manitoba Youth Centre (MYC) pursuant to a "Place of Safety" designation. Out of concern we opened an Ombudsman's Own Initiative file and wrote to the Departments of Justice and Family Services and Housing condemning the practice. Our investigation of the practice continued even after the youth in question was released. We reported on the progress of our investigation in our annual reports for 2001, 2002 and 2003.

In 2004 we had further discussions with the department, and they requested that their legal counsel review the issue to assist them in determining what future action might be required. We expect to receive a further response once that review has been completed.

Manitoba Public Insurance (MPI)

This year our office continued to receive complaints related to a wide range of issues, including liability assessments for traffic accidents, denials of coverage, and other general issues related to the handling of claims.

In 2004, a restructuring occurred resulting in the Division of Driver and Vehicle Licencing (DDVL) of Manitoba Transportation and Government Services becoming a department of MPI. The DDVL deals with all aspects of driver and vehicle licensing, including issuing licences, managing driver examinations and maintaining driver extracts. It is anticipated that the merger will not have any impact on the relationship between DDVL and our office, or the investigation of complaints.

Boards and Corporations

Driver and Vehicle Licencing

A woman complained to our office about the quality of a safety inspection completed on a recently purchased vehicle, and about her interaction with the Division of Driver and Vehicle Licencing (DDVL), the branch of government responsible for administering the vehicle safety inspection program.

The complainant advised that when she had purchased the vehicle from a small used car dealership she received a Certificate of Inspection confirming the vehicle had passed a safety inspection. Shortly after purchasing the vehicle she began experiencing many problems, including a serious one with the steering. Prior to returning to the dealer, the complainant obtained a Certificate of Inspection from a local repair firm, which identified several deficiencies. She contacted the dealer and asked if she could return the vehicle for a refund as she felt the vehicle was not safe, despite their valid Certificate of Inspection. The dealer refused.

The complainant contacted DDVL which conducted its own inspection of the vehicle and identified several different deficiencies. The DDVL contacted the dealer on behalf of the owner to determine if he was prepared to negotiate a refund or cancel the contract. The dealer refused.

The Highway Traffic Act does not provide the DDVL with the authority to cancel a contract of sale, but it does allow the Registrar of Motor Vehicles to issue a Notice to Repair to a dealer if a vehicle is not in the condition identified in the Certificate of Inspection. After the DDVL inspection, the Registrar issued a "Notice to Repair" to the dealer advising that the vehicle was not in compliance with the minimum standards at the time of sale. The dealer was required to bring the vehicle into compliance with the standards set out by the Vehicle Inspections Handbook. The owner was referred back to the dealer to arrange for specified repairs identified in the Notice, after which DDVL would reinspect the vehicle.

The complainant also wanted DDVL to explore the possibility of having the repairs completed at a different repair shop, as she no longer had confidence in the dealer who sold her the vehicle. The dealer was prepared to repair the vehicle in accordance with the Notice issued by the Registrar, but would not pay for another shop to repair the vehicle. The vehicle was repaired by the dealer and inspected again by the DDVL, which then issued a Certificate of Inspection certifying that the vehicle had passed.

Despite the Certificate of Inspection provided by the DDVL, on reinspection of the vehicle, the complainant was not satisfied with the repairs completed by the dealer and still felt the vehicle was unsafe. She subsequently went to several repair firms and obtained Certificates of Inspection indicating the vehicle remained unsafe and had failed inspection. The DDVL was advised of the independent inspections, but declined further action on the basis that the vehicle met the minimum standards required by the Vehicle Inspections Handbook and could be registered for use on the road.

After reviewing the DDVL position we advised the complainant that because the DDVL had required the dealer to bring the vehicle into compliance with the standards set out by the Vehicle Inspections Handbook, meeting the requirements of *The Highway Traffic Act*, there was no basis for a recommendation by the Ombudsman.

In the course of reviewing this complaint, we noted that there were at least seven different Certificates of Inspection on the vehicle in question. No two reports were exactly the same, and there were inconsistencies in the two Certificates of Inspection completed by the DDVL. From further discussions with staff at DDVL, we learned that the program was under review and proposed changes were being considered.

We wrote to the Deputy Minister of Transportation and Government Services and asked to be advised of any changes made by the Department on completion of its review of the program

In the meantime, our complainant was not happy with our findings and pursued the matter in Small Claims Court. We understand her claim was dismissed.

Boards and Corporations

Manitoba Public Insurance

Ms D was involved in a collision at an uncontrolled intersection in a parking lot. MPI assessed Ms D 100% responsible for the accident. Upon her application, the liability assessment was reviewed by MPI's Independent Review, who agreed with MPI and upheld the assessment. Ms D was not satisfied with the explanation she received from MPI and brought her concerns regarding the liability assessment to our office.

In its decision letter, MPI advised that Ms D was travelling through a parking lot when a collision occurred with a vehicle that was travelling in a "back lane". MPI concluded that since the other car was on the "main roadway", Ms D was responsible for the accident. The Reviewer also found that the other driver was on the main roadway.

Ms D felt that the rules of the road as set out in *The Highway Traffic Act* (HTA) should apply to parking lots. These rules of the road include the general right-of-way rule, which requires the vehicle on the left to yield the right-of-way to the vehicle on the right. She felt the other driver should have yielded the right-of-way to her, as she was the driver to the right. She questioned whether this was taken into consideration by MPI or the Reviewer in making their decisions. She also questioned how it was determined that the other vehicle was travelling in a "back lane" or a "main roadway."

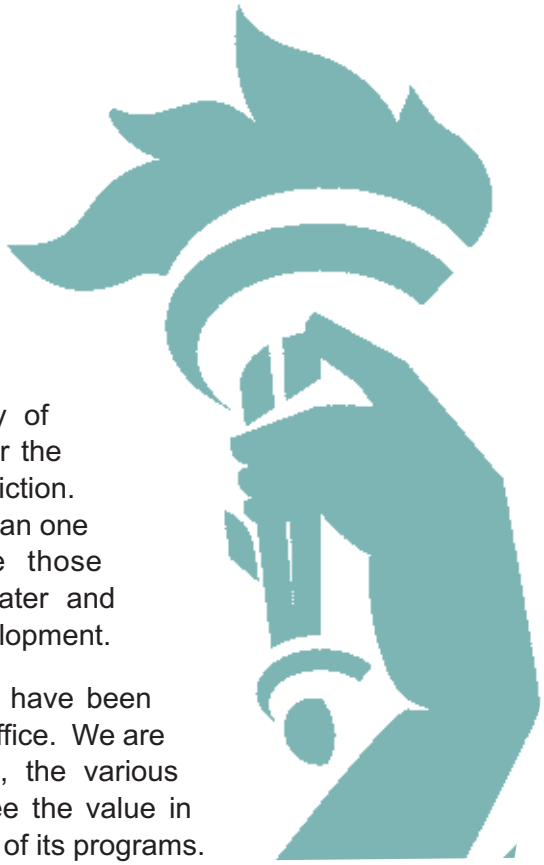
Upon inquiry we were advised that MPI agreed that the HTA applies to parking lots, but advised that it uses a combination of court precedent and the rules of the road to determine liability. MPI provided our office with a court decision, which set out the following principles:

- The definition of "highway" as found in the HTA does not include parking lots and as a result, the right-of-way rules in the HTA do not necessarily apply to parking lots.
- Where a driver on the main thoroughfare in a parking lot is travelling at a reasonable speed, that driver has the right to expect that the vehicles travelling on feeder lanes will yield the right-of-way, or at least not enter when it is unsafe to do so.

While these principles supported MPI's assessment of liability, Ms D felt it was not clear which lanes in this parking lot were main thoroughfares and which were feeder lanes. She provided sketches and diagrams of the parking lot in support of her position. We made further inquiries with MPI as to how it was determined that the other vehicle was on the main thoroughfare and Ms D was on a feeder lane.

MPI's Claims Division reviewed the matter again. As it was not clear which lane was the main thoroughfare, a decision was made to reverse the liability decision in this matter. Neither Ms D nor the other driver were found at fault.

Municipal Government Case Summaries



Our office received 30 new complaints against the City of Winnipeg in 2004 compared with 78 in 2003, the first year the City of Winnipeg came under the Ombudsman's jurisdiction. Some complaints required us to make inquiries with more than one department, increasing the time it took to complete those investigations. One complaint involved contact with Water and Waste, Public Works and Planning, and Property and Development.

Our relationship with the City continues to evolve. There have been some cases where there is confusion about the role of our office. We are optimistic that in time and with more frequent contacts, the various departments will better understand our jurisdiction and see the value in having our office review issues relating to the City's delivery of its programs.

Outside Winnipeg, our office continues to receive complaints about municipalities that have never dealt with us, and we welcome the opportunity meet with each one to discuss our role and jurisdiction. Informing municipal governments about the Office of the Ombudsman is an important function. Equally important are the lessons we continue to learn about regional issues and perspectives.

Case Summary

City of Winnipeg

In the spring of 2003 we were approached by an individual who sought compensation from the City of Winnipeg for damage caused when she struck a large "pothole." She filed a claim with the City, which denied liability.

The City explained that it had investigated her claim, but was unable to find any evidence of liability on its part. The City advised that potholes are common hazards on Winnipeg streets and that they had no prior knowledge that this particular pothole existed.

We asked the City to provide the details regarding its investigation as well as its policy respecting pothole claims in general. The City advised our office that it follows a general practice with respect to pothole complaints, which is summarized below:

- Motorists are responsible for the care and control of their vehicles and must adjust their driving to suit road conditions. The City will only pay claims where it can be established that it was aware of the situation and failed to take corrective action in a reasonable period of time.

- Each pothole claim is considered on its own merits. When a claim is filed, the Risk Management Division obtains a report from the Public Works Division. This report provides information on the pothole and includes the action that was taken to address the problem.

- In this case, reports obtained by Risk Management indicated that the City was not aware of the pothole in question until our complainant contacted them on February 23, 2003. The City acknowledged that it received two other contacts about this pothole on February 24 and February 25. The City's records reflect that the pothole was "patched" on February 27, 2003.

In cases such as this, our role is not to determine or rule on matters relating to liability, but rather to assess whether the basis for denying the claim is reasonable. This was a good example of the efforts made by the City when it investigates a claim. We advised the complainant that, based on its existing practice, the City had reasonable grounds for denying her claim. We explained that while our office was unable to determine to what extent, if any, the City may have been liable for her losses, we had determined that the City had taken reasonable steps to investigate her claim.

The initial response that our complainant received from the City did not detail the steps it took to assess her claim. While our complainant was not pleased that her vehicle had been damaged and she had been denied compensation, she at least understood from our investigation that the decision to deny her claim was not arbitrary.

Rural Municipality of Rosedale

Our office received a complaint from Mr. R. that a rural municipality (RM) had ordered him to demolish a house. He felt the order was unreasonable because he thought the building could be repaired. He also alleged that he was denied the opportunity to present his case on appeal to the municipal council and that he had been treated differently from other property owners.

Upon being advised of the complaint, the municipality decided to delay demolition until our investigation was complete. Because of the urgency of the situation and because council welcomed an independent review of the issues raised, the Chief Administrative Officer (CAO) suggested a meeting with the municipal council to discuss our findings prior to issuing any report.

At a meeting with council, we identified the following issues:

WERE THE STATUTORY REQUIREMENTS MET?

It was acknowledged that the owner had not received notice of inspection prior to the issuance of an order, as required by *The Municipal Act*. This appeared to have been a deficiency in the process.

Under *The Municipal Act* a by-law does not come into force and effect until the day after it has been passed. In this case, a notice citing a violation under the by-law was issued on the day it

received third reading. Therefore, it was unclear whether the by-law was in force and effect at the time the notice was issued.

Was the Notice too Vague?

The notice stated that the building was in violation of the by-law. It did not explain why.

The complainant had requested in writing a copy of the "criteria" used by the municipality to determine that his building was unsafe and also what he would have to do to make his building fit the municipal definition of "safe". He did not get a reply.

The building inspector had not produced a written report identifying any specific concerns; however, when we interviewed the building inspector he cited a number of safety issues with the building. The difficulty is that while the building inspector was able to clearly identify these issues for us during an interview, he did not identify them for the complainant, either in the order or subsequently when the complainant requested that he do so.

In light of the documentation reviewed and the information provided, there appeared to be some merit to the assertion that the complainant had no way of bringing his premises into compliance with the by-law because he did not know what was required of him.

Did the Penalty Fit the Violation?

Central to the complainant's position was his assertion that the building could be repaired rather than demolished.

While it is not appropriate for us to second-guess the technical expertise of the building inspector, we did raise the simple question of whether or not the concerns he identified could be remedied without demolition. In plain language, if something can be fixed, why does it need to be torn down?

Did the Complainant Receive Adequate Notice of the Appeal hearing/Decision?

The complainant stated that he only received the notice one day before the Appeal Hearing. The documentation provided by the RM supported this. The by-law required that the complainant be given five day's notice of the hearing date. Notice was sent by registered mail and is deemed to have been delivered three days later, more than five days before the hearing. This indicated that notice had been legally served; however, the complainant stated that he did not receive the notice until the day before the hearing. His mailing address is a rural postal box in a different community than his residence. Additionally, he did not have a car and could only pick up mail when he could get a ride. As well, he was working as a farm labourer and it was his busy time of the year at work. We asked Council to consider whether the notice, although legally sufficient, was fair and reasonable in the circumstances.

Was the Complainant Treated Differently?

The complaint that led to the initial inspection of the complainant's property was made verbally by a municipal councillor to the CAO, who referred it to the building inspector. Subsequently, the complainant himself filed three complaints about properties owned by municipal councillors. Only one of those properties was referred by the CAO to the building inspector. On the other

two, the CAO wrote back to the complainant and asked him for more details. The complainant felt that this was differential treatment.

Upon inquiry, we were advised that it is not unusual for municipal councillors to advise the CAO of verbal complaints received from municipal residents. We were told that this is what had occurred in our complainant's case. We were also advised that the CAO had not referred two of Mr. R's complaints to the building inspector because they had identified properties with multiple buildings without identifying a particular building he thought might be in violation of the by-law. We felt the explanations provided were reasonable.

We advised council that, although it did not appear to us that Mr. R.'s complaints were handled unreasonably, his concerns were understandable because at first glance his complaints appeared to have been handled differently at a time when he was in the midst of an already acrimonious dispute.

We presented our preliminary investigative findings to the municipal council with the understanding that in the normal course of events they would be sent out in writing to the CAO with an invitation to provide any further information or response they felt appropriate.

The Reeve indicated that council appreciated the promptness of our investigation and that our comments were welcomed and would be helpful to council in determining an appropriate course of action.

We were subsequently provided with a copy of a resolution passed by Council rescinding the demolition order. We advised Mr. R. that the matter appeared to have been resolved and concluded the file by writing to the CAO to confirm the matters discussed at our meeting with council.