Manitoba Ombudsman

2006

Annual Report

Manitoba Ombudsman

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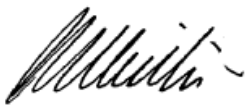
March 31, 2007

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*, subsections 58(1) and 37(1) of *The Freedom of Information and Protection of Privacy* Act and *The Personal Health Information Act respectively*. I am pleased to submit the Annual Report of the Ombudsman for the calendar year January 1, 2006 to December 31, 2006.

Yours truly,



Irene A. Hamilton
Manitoba Ombudsman

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A MESSAGE FROM THE OMBUDSMAN – 2006 A YEAR OF CHANGE

In my 2005 Annual Report I described the beginnings of a change process designed to enhance our operating procedures and to make the office more relevant to the public, government, and public sector bodies. That process resulted in significant changes in 2006; changes in how we communicate with and respond to the public, and changes in our complaints intake and investigation processes. We have also changed our reporting format and this will be the first combined annual report encompassing our activities under *The Ombudsman Act, The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

The changes made or begun in 2006 will increase the effectiveness of our office within our existing resource allocation and statutory mandate. The value of the office to both government and the public should reflect the powers and responsibilities vested in the office in *The Ombudsman Act,* FIPPA and PHIA, each of which clearly sets an expectation that the office will do more than investigate individual complaints.

RAISING AWARENESS

In order for the office to be relevant, its role as an impartial office charged with monitoring administrative accountability and its responsibility in the framework of parliamentary democracy must be understood by the public. A significant challenge, and a priority for us, is to reach all Manitobans to ensure that they are aware of the office and what it can do.

The jurisdiction of the office is very broad and the powers of investigation and reporting are extensive. But that is meaningless to the public if it is unaware that the office exists to allow them access to an independent review of the actions or omissions of government. I believe that the responsibility for ensuring awareness of the office rests with the office. To accomplish this, a number of organizational changes were made in 2006 to enhance our capacity for public education, and a number of educational initiatives commenced.

In March 2006, an existing position in the office was reallocated to create the Manager, Research and Education. The manager is responsible to promote public education and awareness of our office, and for research and policy analysis on existing and emerging issues relevant to our office. The manager reports directly to the Ombudsman and serves both the Ombudsman and Access and Privacy Divisions.

INFORMING STUDENTS

The best place to start educating the public about the Ombudsman's role and function in the democratic process is the school system, where information can be provided to students who are learning about government and participatory democracy as part of their curriculum. Adapting an idea shared with us by my colleague the Chief Electoral Officer we developed a program for students to inform them of how the Ombudsman can play a part in the exercise of democratic rights by ensuring government accountability. This initiative involved the drafting of learning activities on government and the Manitoba Ombudsman for use with the Manitoba Social Studies curriculum for Grades 6, 9 and 11. These grades were chosen due to the curriculum content on Canada and Canadian government. The learning experiences overviews for teachers, and student activities are compiled in a module entitled "Joining the Herd, A Handbook on Participating in Manitoba's Government". The module will be delivered to every English language school in Manitoba having Grades 6, 9 and 11, in the spring of 2007. Teachers using the materials can invite us to their classrooms for "Ask the Ombudsman" talks, which can also be conducted in French.

INFORMING THE PUBLIC

In 2006, we continued our efforts to reach segments of the Manitoba public that may not be aware of our office or see it as a resource. Our efforts included targeting groups that rarely contact us and making more Manitobans aware of the serious and evolving issues arising in the realm of access and privacy. Our attempts to reach more Manitobans from groups that do not contact the office is a work in progress. In access and privacy, the challenge will continue to be to educate people and respond to complaints within our mandate in an environment of constant change driven by technological advances.

Holding government accountable in a parliamentary democracy is the job of all citizens, not just the role of specialized offices like Ombudsman and Information and Privacy Commissioners. Because the Ombudsman is and should be an office of last resort, our public education role must include informing people about existing government processes and procedures that should first be used to deal with their concerns. Of course, if other avenues of appeal or complaint have been pursued unsuccessfully or if the person is not capable of pursuing them, we could become involved in a complaint within our jurisdiction. The Ombudsman is not a complainant's advocate but we can and should provide complainants with information about processes available to them when acting as their own advocate. Our intake services team can advise callers about appeal rights that exist and how to exercise those rights. We are trying to ensure that even if a matter is not appropriate for investigation by our office, no one is turned away without receiving advice or assistance to deal with government directly.

RIGHT TO KNOW WEEK

Since 2002, September 28th has been observed around the world as Right to Know Day by countries that enjoy or seek the benefits of access to information laws. In 2006, our office participated with colleagues across the country in Canada's first celebration of Right to Know Week.

The Government of Manitoba and the cities of Dauphin, Selkirk and Thompson declared September 25 to 29, 2006 as Right to Know Week in their jurisdictions. The Canadian Association of Journalists (Manitoba), Canadian Taxpayers Association (Manitoba), Manitoba Bar Association and Provincial Council of Women of Manitoba participated with us in organizing a public information panel about Manitoba's access to information laws. I participated on the panel with representatives from the Canadian Taxpayers Association, CBC, Manitoba Health and the Winnipeg Sun.

COMMUNICATING WITH PUBLIC SECTOR BODIES AND TRUSTEES

It is essential for the effective functioning of the office that the bodies over which the Ombudsman has oversight understand the role and function of the office.

In access and privacy matters, public sector bodies and trustees play a critical role in investigations by supplying information, background, perspective, opinions and responsive records, all of which are key components to an investigation. Obtaining all the information we need quickly and concisely has a positive impact on the speed with which a complaint can be resolved and an investigation concluded.

During 2006, the Access and Privacy Division undertook a review of how we do our work to find ways to provide better service to complainants and public sector bodies and trustees. We have been implementing changes to make our investigation processes more efficient and our reports timely. We have implemented policies to streamline our process of investigating complaints. We recently wrote to public sector bodies and trustees across the province to make them aware of these changes and policies.

BROWN BAG TALKS

In 2006, monthly Brown Bag Talks were introduced as an ongoing outreach program for access and privacy coordinators and officers to provide them with information about the responses we require to conduct our investigations. Over the year, there were eight 50 minute discussions at our Winnipeg office led by divisional staff on practical, pre-selected topics of interest. These sessions are also available by request outside our office. Our Brown Bag Talks were presented to access and privacy personnel in Brandon and Thompson, and in Beausejour where coordinators from 12 Eastman communities attended.

To complement the Brown Bag Talks, twelve Practice Notes related to the topics under discussion were issued. After each Winnipeg Brown Bag Talk, the Practice Notes were emailed to access and privacy personnel around Manitoba and placed on our web site. These are included on the CD format of this Annual Report in *Other Publications* and are also available on our web site at www.ombudsman.mb.ca.

PRIVACY CONFERENCE PRESENTATIONS

As noted in last year's Annual Report, our office provided financial and human resources in organizing the conference, "Privacy in the Public Sector: Challenges and Solutions". The event

was held in Winnipeg on May 4, 2006. About 325 individuals attended from around and outside the province. Staff from our office presented a practical session on approaches for handling access requests from the Ombudsman's perspective. Intensive post conference workshops were offered the following day, including a half day interactive workshop led by our office on implementing privacy in organizations. Demand for this session resulted in a second workshop being scheduled. Power point slides from our conference presentation and privacy workshop are posted on our web site. Upon request, our staff is available to make these presentations to interested groups in Manitoba.

CONFERENCE ATTENDANCE

In 2006, we began the process of communicating with government in a more organized and comprehensive way, outside the context of complaints investigation. Traditionally, our office responds to requests and invitations for presentations, such as requests to speak to correctional staff as a group. I believe we can work with government in a more proactive way by participating in government and government-sponsored initiatives such as training seminars for municipal officials and government-appointed bodies that exercise delegated decision making authority. For example, in 2006 a number of my colleagues and I attended the 1st annual Manitoba Council of Administrative Tribunals conference dealing with administrative decision making. The conference included a session on the role and function of the Ombudsman. This was an important opportunity to introduce our office to many of the people who make decisions affecting the lives of countless Manitobans. We look forward to participating in this initiative annually. We hope to achieve similar results by cooperating with Intergovernmental Affairs in its efforts to educate local decision makers in their capacity as overseers of municipal planning.

INTAKE AND INVESTIGATION

In March 2006, the Intake Services Team in Winnipeg was created to enhance our initial contacts with the public. Existing positions from the office were reallocated to improve the linkage between the public, intake services and the complaint investigation process of the office. Three Complaints Analysts and a Manager comprise the team that is the first point of contact with our office for members of the public. In addition to providing information about

dealing directly with government, the team provides information about the role, function and jurisdiction of the Ombudsman, explains how to file a complaint and provides basic information about administrative and access and privacy matters.

Inquiries are reviewed to determine how our office can provide assistance. This involves determining jurisdiction, obtaining clarifying information about complaints, explaining the complaint investigation process and opening cases for investigation. The team performs a "triage" type function in which it obtains all the necessary information to clarify a complaint or establish jurisdiction and in specific circumstances, attempts to achieve a quick and satisfactory resolution to a complaint while it is still at the "Inquiry" stage. Matters that cannot be resolved by Intake Services are then opened as complaint investigation files, with all of the necessary initial information provided to the assigned investigator.

The enhanced role of Intake Services reduced the number of cases opened for complaint investigation in 2006. The change in our complaints process is reflected in the manner in which we record and report our statistics. This investment of resources at the intake stage is a significant organizational change. The goals achieved include better issue identification, quick resolution of some issues where appropriate, enhanced referral capacity and more time for investigators to work on complex and difficult files.

Another function of the Intake Services Team is to identify issues that may require review or investigation beyond the parameters of an individual complaint, and might require the review of an administrative system. In 2006, our office gained considerable experience and insight into systemic investigations through the external review of the child welfare system.

CHILD WELFARE REVIEW

In March 2006, I was named with the Children's Advocate and the Executive Director of a Northern Ontario Aboriginal child welfare agency as a co-chair of a review to recommend changes in "the standards around the opening, closing and transfer" of cases in the child welfare system, as well as any other issues identified by the co-chairs. In order to understand and analyze those standards it was necessary to understand the child welfare system as a whole.

Only then could the decision-making process that would lead to a case being opened, closed or transferred be properly understood.

The review was conducted over the course of the next six months. The review team was composed of ten people: six from my office, two people seconded from the First Nations Child and Family Services Authorities, one from the Office of the Children's Advocate and one from the Office of the Auditor General.

Focus groups and interviews were conducted in 32 communities around the province including First Nations communities. The team received information from over 760 individuals. The 148 page report, containing over 100 recommendations, was forwarded to the Minister of Family Services and Housing at the end of September, within the 6 month time frame set for the review. All of the recommendations were accepted by the government.

The magnitude of the child welfare review, larger than any undertaken previously by our office, presented numerous logistical and resource challenges. I am pleased to report that we were able to meet those challenges. Six of our investigative staff worked full time on the review and their positions were not "back filled". Their participation required the redistribution of management functions, investigator caseloads, and administrative support functions. Every member of the staff contributed to our ability to complete a thorough review in a timely and cost effective way.

The report entitled, "Strengthen the Commitment" has significant implications for children and families involved with the child welfare system, and for the governments responsible for the administration of the system. The provincial government has committed to fully implementing the recommendations of the report and if this is achieved, the face of child welfare in this province will be significantly improved for the future.

An additional benefit of the 2006 Child Welfare Review was the opportunity for investigators from our office to visit many rural, northern and First Nations communities. Further information relating to the Child Welfare Review is set out separately in this report under the activities of the Ombudsman Division.

SYSTEMIC INVESTIGATIONS

It is not unusual for our office to receive complaints from numerous people about the same issue or to receive repeat complaints about the actions or decisions of a particular department or agency. In some instances, a single complaint can identify significant issues affecting many Manitobans. If a matter appears to require a review of the system from which the individual complaint arose, the office should be able to deal with that through an intensive investigation that will quickly get to the heart of the matter.

I have the authority under *The Ombudsman Act* to initiate an investigation on my own initiative. This power can and has been used to investigate the cause of an issue rather than focusing on a particular decision or action. This kind of systemic investigation can highlight concerns that affect large numbers of people at one time and benefit government by identifying gaps or deficiencies in programs and services that result from imperfections in the policies and systems under which they operate. Reports of such systemic investigations can be issued to inform the public of our findings and the recommendations for changes that we believe will correct the problem.

The child welfare review proved to be of significant assistance to our office in understanding the resources needed to undertake and plan a review of this magnitude. An analysis of the review process identified planning for systemic investigations as a critical step, both in terms of ensuring that the work is done effectively and within a short time frame, and in analyzing whether the information generated from such work is of importance to a large segment of the public.

In our 2006 planning exercise, a process for this kind of investigation was developed as one of the tools available to assist in meeting our statutory obligations and to ensure that these comprehensive reviews are focused and completed in a timely manner. To achieve this goal, teams will be assigned to systemic investigations, with specific investigative plans and time frames.

In our 2005 Annual Report we identified the provincial response to unlicensed drainage as an "emerging issue" and we notified the Department of Water Stewardship that we were opening an investigation file. In 2006, we determined that because of the magnitude and complexity of the issue and the multiple jurisdictions involved, a more comprehensive investigation was required. Accordingly, in late 2006, a team was assigned to expand and continue this review as a systemic investigation.

AUDITS

Access and privacy legislation also gives the Ombudsman the authority to conduct audits and make recommendations to monitor and ensure compliance with the law. In 2006, because of increasing evidence of a failure to respond to requests within the 30 day time limit prescribed in *The Freedom of Information and Protection of Privacy Act*, we undertook an audit of a provincial department. The audit disclosed several areas where improvements can and should be made, to benefit both the department and the public. A summary of the audit is set out in this report under the activities of the Access and Privacy Division.

RECOMMENDATION OR ORDER - OMBUDSMAN OR COMMISSIONER

In 2006, there was renewed discussion by government officials and the media about the merits of appointing a commissioner to oversee access to information and privacy legislation. Based on our own experience and information from our colleagues across the country we are in a position to contribute to that discussion by providing factual information about the oversight models for access to information and protection of privacy in Canada, and the acknowledged merits of both. I hope this information can assist in addressing two key issues:

- the differences between a commissioner and an ombudsman; and
- the differences between the order model and the recommendation model.

Commissioner or Ombudsman

There are 15 parliamentary offices in Canada responsible for the oversight of access to information and privacy matters: ten provincial, three territorial and two federal. The term "parliamentary" is used to denote that the office is independent of government and reports to the elected representatives, through the Speaker.

In three jurisdictions - Manitoba, New Brunswick and Yukon Territory - the provincial Ombudsman is responsible for access and privacy, as well as the duties set out in their provincial ombudsman acts. The rest of the oversight officers are called Commissioners, except Nova Scotia which has a Review Officer.

At the federal level the responsibilities are divided generally between access to information and privacy. The Information Commissioner deals with complaints about access to government-held information that is not personal information. The Privacy Commissioner deals with complaints about access to and protection of personal information.

A common misunderstanding is that all Commissioners have order making power. This is not the case. In fact, 10 of the 15 oversight offices use the recommendation model - the two federal offices and eight provincial/territorial jurisdictions. The jurisdictions with order making power are British Columbia, Alberta, Ontario, Quebec and Prince Edward Island.

The chart below illustrates the model in each jurisdiction. In the recommendation model, either the term Ombudsman or Commissioner may be used to describe the oversight authority. In the order model, the term Commissioner is used.

Office Name	**Responsibility**	**Power**
Information Commissioner of Canada	Access to information	Recommendation
Privacy Commissioner of Canada	Protection of privacy	Recommendation
Information and Privacy Commissioner, BC	Access to information and protection of privacy	Order
Information and Privacy Commissioner, Alberta	Access to information and protection of privacy	Order
Information and Privacy Commissioner, Sask.	Access to information and protection of privacy	Recommendation

Manitoba Ombudsman	Access to information, protection of privacy, and ombudsman	Recommendation
Information and Privacy Commissioner, Ontario	Access to information and protection of privacy	Order
Commission d'accès à l'information du Québec	Access to information and protection of privacy	Order
Ombudsman New Brunswick	Access to information, protection of privacy, and ombudsman	Recommendation
Information and Privacy Commissioner, NL	Access to information and protection of privacy	Recommendation
Freedom of Information and Privacy Review Officer, NS	Access to information and protection of privacy	Recommendation
Information and Privacy Commissioner, PEI	Access to information and protection of privacy	Order
Ombudsman and Commissioner,Yukon	Access to information, protection of privacy, and ombudsman	Recommendation
Information and Privacy Commissioner North West Territories, Nunavut (one commissioner serves both jurisdictions)	Access to information and protection of privacy	Recommendation

Order or Recommendation

It should be noted that in both models, access and privacy complaints are more often than not, resolved informally. In both models, matters may ultimately be heard in court.

Order model

The order model means that a formal inquiry process may be used and at its conclusion, the oversight officer issues an order with which a public body must comply.

If a complaint investigation reaches the inquiry stage, the inquiry is quasi-judicial. Parties will often, but not always, be represented by legal counsel. The Commissioner's office will normally be represented by counsel. Formal representations are made to the Commissioner, who then issues a binding order. However, it is important to note that even in order-making jurisdictions, a significant percentage of complaints are resolved without the matter proceeding to the inquiry stage.

Because of the power of the Commissioner to make an order, he or she must function like a judge and not be involved in the preliminary discussions leading up to the point at which the matter may come before the Commissioner at inquiry.

A benefit of order making power is that generally there is no need to go to court to require a public body to comply with an order. The matter may still go to court if the order is appealed on a question of law or fact. The orders of the Commissioner set precedent for the way in which matters are resolved and future decisions on similar facts will be decided in the same way.

Recommendation model

The recommendation process is not quasi-judicial in nature. In the recommendation model, access to information and protection of privacy is an administrative function. At the conclusion of an investigation, if a matter cannot be resolved informally, the oversight officer may make recommendations to the public sector body that he or she believes are appropriate in the circumstances of the case. It is unusual for legal counsel to become involved in the process. Responsibility for accepting or rejecting the recommendation of the Ombudsman or Commissioner rests with the public body.

Offices with recommendation power do not have to keep the Commissioner or Ombudsman removed from the discussions and he or she often participates to try to resolve the matter informally.

The legislation in the recommendation jurisdictions allows that a matter relating to a refusal of access may be taken to court for an order. For example, in Manitoba if the Ombudsman's recommendation is not followed in a refusal of access case, the Ombudsman may make an application to the Court of Queen's Bench or the person who initially filed the complaint with the Ombudsman may make an application. In Manitoba, if it is alleged that an offence has been committed under either Act, the matter may be prosecuted in court.

The informality of the process, and particularly the fact that people can use the process without the need for legal counsel, is seen as a benefit in the recommendation model.

ANTICIPATED CHANGES

In addition to the changes made in 2006, events occurred that will dictate further change in 2007. One of those was the passage of *The Public Interest Disclosure Act*, referred to as "whistleblower" legislation. The legislation identifies the Ombudsman as one of the parties to whom a disclosure may be made. The Ombudsman is authorized to take steps to resolve a matter within the department or government body in which it arises, to investigate disclosures for the purposes of bringing them to the attention of government and to recommend corrective measures. The Ombudsman may also require that government advise of the steps it has taken or proposes to take in response to recommendations, and this act contains reporting provisions including the right to publish a special report in respect of a particular matter. Until the legislation is proclaimed we will not be in a position to assess the impact it may have on our resource requirements and operating procedures.

Another anticipated change arises from legislation introduced as a result of the child welfare review. One of the recommendations was that responsibility for reviewing the circumstances surrounding the deaths of children in care be transferred from the Office of the Chief Medical Examiner to the Office of the Children's Advocate. The objective of these reviews is to identify improvements and make recommendations that may help prevent future child deaths. It is proposed that the task of following up with the child welfare system to determine if those recommendations have been complied with will rest with my office. We anticipate that this compliance monitoring will have resource implications for our office.

IN CONCLUSION

Even though many of the planned changes in the office to improve our services were delayed to accommodate the requirements of the child welfare review, I am pleased to be able to report on the significant progress that we have made in 2006. I wish to thank all of my colleagues for their dedication to the work of the office of the Ombudsman and their service to the public of Manitoba.

THE OFFICE OF THE OMBUDSMAN

The Ombudsman is an independent officer of the Legislative Assembly with the power to conduct investigations under *The Ombudsman Act*, *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*.

The office has a combined intake team and two operational divisions.

- **The Intake Services Team** which responds to inquiries from the public by providing information about making complaints under *The Ombudsman Act*, *The Freedom of Information and Protection of Privacy Act*, and *The Personal Health Information Act*, advises callers of referral and appeal options, analyzes complaints to determine jurisdiction, gathers information to start an investigation or, where appropriate, attempts early resolution.

- **The 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.

- **The Access and Privacy Division**, which investigates access to information and protection of privacy complaints and reviews compliance under *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*.

More information about the Ombudsman's Office can be found on our web site at www.ombudsman.mb.ca.

A copy of the Acts mentioned above can be found on the statutory publications web site at www.gov.mb.ca/chc/statpub/.

THE INTAKE SERVICES TEAM

Intake Services responds to inquiries from the public by providing information about the right of complaint under *The Ombudsman Act, The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. Intake Services analyzes complaint issues on a case by case basis to determine jurisdiction and discuss referral and appeal options. Information is provided on how to submit a complaint to the Ombudsman. Intake Services determines with callers whether they may have another avenue of appeal available to them and if so provides them with the information necessary to further the process themselves. If the matter cannot be resolved, the individual may contact Intake Services again for assistance. The office will continue to monitor and review the services we provide with regard to matters that are within our jurisdiction, as well as provide referral information where we cannot investigate.

In 2006, Intake Services responded to inquiries and opened files for investigation by the Ombudsman Division and the Access and Privacy Division as follows:

Inquiries responded to by Intake Services (information supplied or assistance provided)	2647
Cases resolved by Intake Services	112
Cases opened for the Ombudsman Division	313
Cases opened for the Access and Privacy Division	255
Total contacts	**3327**

In addition, the office received 2100 general telephone inquiries, where the caller was assisted or provided with information by administration staff, without referral to Intake Services or investigations.

The enhanced role and increased resources in Intake Services has reduced the number of files opened for investigation by resolving many issues at the intake stage. This reduction in investigation files has enabled the office to complete investigations more quickly, initiate outreach and education activities and focus efforts and resources on systemic investigations.

THE OMBUDSMAN DIVISION

The Ombudsman investigates complaints from people who feel that they have been treated unfairly by government. The Ombudsman is not a part of any government department or agency, and reports directly to the Legislative Assembly.

The Ombudsman can investigate the actions and decisions of municipal and provincial civil servants, and others who implement and administer government programs and policies, but cannot investigate decisions made by the Legislative Assembly, Executive Council, the Courts or decisions reflected in Municipal policy by-laws.

The Ombudsman is responsible for reporting her findings, after conducting a thorough and impartial investigation, to both the government and the complainant. Elected officials are responsible for accepting or rejecting those findings and are accountable to the public.

There must be a balance between the responsibility of government to enact and administer laws and policies of its choosing and the power given to the Ombudsman to investigate a complaint thoroughly and at arms length. That balance has been achieved in *The Ombudsman Act* by giving the Ombudsman the power to make recommendations, but not to issue orders.

Because the Ombudsman is an independent officer of the Legislative Assembly and accountable to the Assembly, people can be assured that her investigations will be neutral. Broad and substantial powers of investigation ensure that her investigations will be thorough.

The Ombudsman's investigative powers include the authority to require people to provide information or documents upon request, to require people to give evidence under oath and to enter into any premises, with notice, for the purpose of conducting an investigation. Provincial laws governing privacy and the release of information do not apply to Ombudsman investigations. It is against the law to interfere with an Ombudsman investigation.

The Ombudsman has a wide range of options available in making recommendations the government may use to correct a problem. After completing an investigation, the Ombudsman

can find that the action or decision complained about is contrary to law, unreasonable, unjust, oppressive, discriminatory or wrong. She can find that something has been done for an improper reason or based on irrelevant considerations. If she makes such a finding, she can recommend that a decision be reconsidered, cancelled or varied, that a practice be changed or reviewed, that reasons for a decision be given or that an error or omission be corrected.

In addition to investigating complaints from the public, the Ombudsman can start her own investigations. She can investigate system wide issues to identify underlying problems that need to be corrected by government, with the hope of eliminating or reducing the public's need to complain about those issues.

The Ombudsman can investigate complaints about any agency of government. This includes provincial government departments, crown corporations, and other government entities such as regional health authorities, planning districts and conservation districts. As well, the Ombudsman has jurisdiction over all municipalities.

The Ombudsman may investigate any matter of administration. While *The Ombudsman Act* does not say what "matter of administration" means, the Supreme Court of Canada has defined it as "…everything done by governmental authorities in the implementation of government policy...".

Most citizens' everyday interaction with government will be with its administrative departments and agencies, rather than with the legislative or judicial branches. Experience tells us that it is in the administration of government programs and benefits and in the enforcement of laws, policies, and rules where the public encounters most problems or face decisions they feel are unfair or unreasonable. These are the "matters of administration" that a person who feels aggrieved can complain about to the Ombudsman.

The Ombudsman Act imposes restrictions on accepting complaints when there is an existing right of review or appeal, unless she concludes that it would be unreasonable to expect the complainant to pursue such an appeal. This can occur in situations when the appeal is not

available in an appropriate time frame or when the cost of an appeal would outweigh any possible benefit.

The Ombudsman may decline to investigate complaints which the complainant has known about for more than one year, complaints that are frivolous or vexatious or not made in good faith and complaints that are not in the public interest or do not require investigation.

THE ACCESS AND PRIVACY DIVISION

Under the provisions of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act,* the Ombudsman investigates complaints from people who have concerns about any decision, act or failure to act that relates to their requests for information from public sector bodies or trustees, or a privacy concern about the way their personal information has been handled. The access and privacy legislation also gives the Ombudsman the power to initiate her own investigation where there are reasonable grounds to do so.

The Ombudsman has additional duties and powers with respect to access and privacy legislation and these include:

- conducting audits to monitor and ensure compliance with the law;
- informing the public about access and privacy laws and receiving public comments;
- commenting on the implications of proposed legislative schemes or programs affecting access and privacy rights; and
- commenting on the implications of record linkage or the use of information technology in the collection, storage, use or transfer of personal and personal health information.

The protection of individuals' privacy and the public's ability to gain access to and control information held by others about them, are matters of increasing public concern. Different rules for public and private institutions, the flow of information electronically across international borders, and different levels of legislated protection around the world can all have an impact on personal privacy in Manitoba.

Governments face a growing demand by the public for access to their personal information, and a constantly changing technological environment in which they must protect the privacy of individuals' personal information. Access and privacy are also areas where education and broad public input into government policy are essential. Meeting these challenges is achieved, in part, by legislating fundamental rights and protections and ensuring that those who administer access and privacy laws receive the training and support needed to do their jobs.

The additional oversight powers granted to the Ombudsman in relation to access and privacy matters are both useful and necessary in monitoring the adequacy of the complex legislative and policy framework in a way that could not be done by individual complaints investigation alone. These powers permit the Ombudsman to go beyond pointing out that something has been done wrong, and allow her to bring to the attention of the public sector, policies and programs that have not kept pace with the changing public expectations and technological advances.

Manitoba's Access and Privacy Legislation

Our access and privacy laws, like many others around the world, are based on two fundamental principles:

- the right to have access to information held by public institutions including information about oneself, subject to limited and specific exceptions; and,
- the obligation of public institutions to protect the privacy of personal information collected, maintained, used and disclosed.

The Freedom of Information and Protection of Privacy Act governs access to general information and personal information held by "public bodies" and sets out requirements that they must follow to protect the privacy of personal information contained in the records they maintain.

The Personal Health Information Act provides people with a right of access to their personal health information held by "trustees" and requires trustees to protect the privacy of personal health information contained in their records.

The gatekeepers and guardians of personal and personal health information are the public bodies and trustees identified in the legislation.

Under *The Freedom of Information and Protection of Privacy Act* public bodies include:

- provincial government departments, offices of the ministers of government, the Executive Council Office, and agencies including certain boards, commissions or other bodies;
- local government bodies such as the City of Winnipeg, municipalities, local government districts, planning districts and conservation districts;
- educational bodies such as school divisions, universities and colleges; and
- health care bodies such as hospitals and regional health authorities.

Under *The Personal Health Information Act* trustees include:

- public bodies (as set out above);
- health professionals such as doctors, dentists, physiotherapists and chiropractors;
- health care facilities such as hospitals, medical clinics, personal care homes, community health centres and laboratories; and
- health services agencies that provide health care under an agreement with a trustee.

Public bodies and trustees are effectively the administrators of personal and personal health information, responsible for its collection, use, privacy, maintenance and disclosure in accordance with the law. It is these administrators, and their application of the access and privacy laws, over which the Ombudsman has jurisdiction.

The Freedom of Information and Protection of Privacy Act establishes a right of access to records held by public bodies, sets out the limitations on such access and requires that public bodies protect the privacy of personal information as defined by law. People using the Act to obtain access to records, including their own, must apply in writing on the form designed for that purpose, and specify the information they are seeking. Public bodies have access coordinators to process requests from the public. A person is entitled to receive a response within a fixed period of time, either providing access or explaining why access is being denied.

Sometimes there is a fee charged for access, but it must be authorized and reasonable. If a person believes a public body has information about him or her that is wrong, she or he can request that it be changed. The public body must either agree to change the information or explain why it is refusing to do so, and if it refuses, the person can have their position added to their record.

The Personal Health Information Act establishes a right of access to personal health information held by trustees, spells out the basis on which access can be denied and requires that trustees protect the privacy of personal health information over which they have control. Personal health information includes a person's health, health care history, genetic information, payment information and more general information such as address, gender, and birth date if it is collected in relation to health care services.

Requests for access can be made directly to a trustee such as a doctor or dentist, or in the case of larger facilities such as hospitals to a person identified as the privacy officer for that facility. A person is entitled to receive a response within a fixed period of time, either providing access to their personal health record or explaining why access is being denied. Sometimes there is a fee charged for access, but it must be authorized and reasonable. If a person believes their personal health record contains information that is wrong he or she can request that it be changed. The trustee must either agree to change the information or explain why it is refusing to do so and if it refuses, the person can have a statement of disagreement added to their record.

Complaints to the Ombudsman

Under *The Freedom of Information and Protection of Privacy Act* there are specified time limits for making complaints about access, but not about breaches of privacy. All complaints must be in writing on a prescribed form for making a complaint, which can be found on our web site at www.ombudsman.mb.ca.

Under *The Personal Health Information Act*, complaints to the Ombudsman must be in writing but can be in the form of a letter, or a person can complete our Questionnaire for a Privacy Complaint which is also on our web site. There is no time limit for filing a complaint, but the

Ombudsman can decline to investigate if too much time has elapsed to make an investigation practical. There are time limits on the investigation by the Ombudsman and reporting requirements set out in law.

Under *The Freedom of Information and Protection of Privacy Act* or *The Personal Health Information Act*, a person can complain to the Ombudsman about various matters, including if she or he believes a public body or trustee:

- has not responded to a request for access within the legislated time limit;
- has refused access to recorded information that was requested;
- has charged an unreasonable or unauthorized fee related to the access request;
- has refused to correct the personal or personal health information as requested; or
- has collected, used or disclosed personal or personal health information that is believed to be contrary to law.

When the Ombudsman has not supported an access complaint, or when she has supported a complaint but the public body or trustee has failed to act on the Ombudsman's recommendation, an access applicant may appeal to the Manitoba Court of Queen's Bench. The Ombudsman can also appeal a refusal of access to the Court in place of the applicant and with the applicant's consent. However, when appealing under *The Freedom of Information and Protection of Privacy Act*, the Ombudsman must be of the opinion that the decision raises a significant issue of statutory interpretation or that the appeal is otherwise clearly in the public interest.

If the Ombudsman believes an offence has been committed, she may disclose information relating to the offence to the Minister of Justice. Manitoba Justice then determines if any charges will be pursued through prosecution in Court.

Since 1998, the Court of Queen's Bench has ruled on four access appeals under *The Freedom of Information and Protection of Privacy Act*. There has been only one privacy prosecution to date launched under *The Personal Health Information Act*. For details on these cases please consult www.ombudsman.mb.ca or previous annual reports.

Further Information

Access and privacy matters are complicated. Manitoba Culture, Heritage and Tourism provides information on *The Freedom of Information and Protection of Privacy Act*, including instructions on how to apply for access to information, how to request a correction to personal information, how to complain to our office and appealing to court at www.gov.mb.ca/chc/fippa/index.html.

Manitoba Health provides information on *The Personal Health Information Act*, including an informative Question and Answer piece that addresses most of the issues a person might raise when first inquiring about their rights under the Act at www.gov.mb.ca/health/phia.

BUDGET AND STAFFING

Budget for 2006/2007

Our budget of $2,513,900 for salaries and other expenditures is broken down as follows:

Total salaries and employee benefits for 30 positions	$2,054,300

Positions allocated by division are:

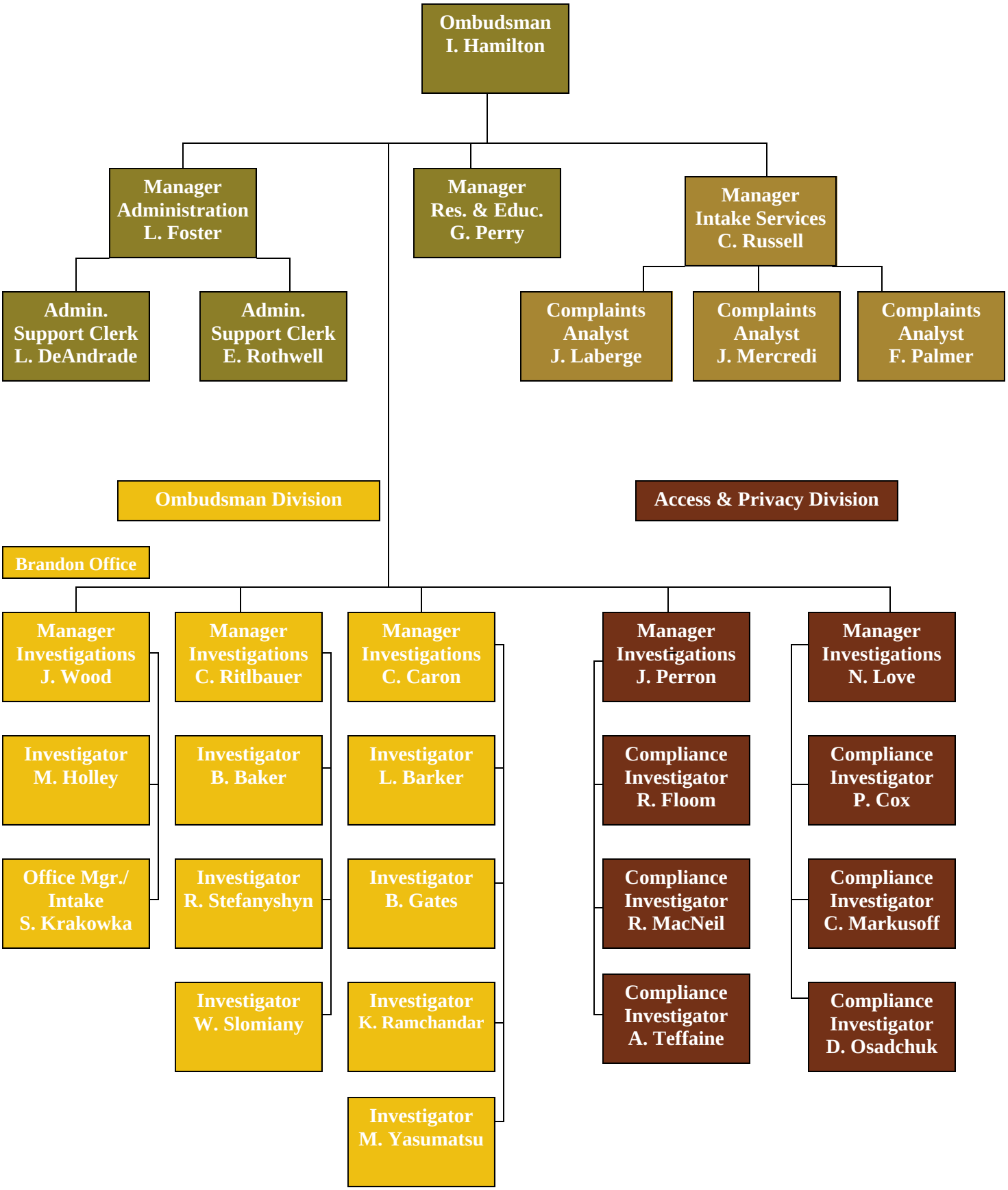
- Ombudsman Division 12
- Access and Privacy Division 8
- General 10

Other expenditures	$459,600

Staffing

The following chart details the organization of positions and staff in the office:

ORGANIZATIONAL CHART



Report on the Activities of the Ombudsman Division

SYSTEMIC REVIEW

REVIEW OF THE CHILD WELFARE SYSTEM

Manitoba has an extensive child welfare system dedicated to the protection of children and preservation of families. At any given time the child welfare system can have over 5000 children in care and provide other services to another 5000 families. The system includes traditional child welfare agencies as well as large numbers of foster parents, shelter providers and support workers. The system interacts in a significant way with the health care system, the education system, law enforcement and the courts. It operates through public or private agencies in every corner of the province.

In early 2006, Manitobans heard horrifying reports of the death of a child who at one point had been in the child welfare system. In March 2006, the Minister of Family Services and Housing called for two reviews to be conducted of cases of children in care. Billie Schibler, Children's Advocate, Michael Hardy, Executive Director of Tikinagan Child and Family Services of Sioux Lookout, Ontario and I co-chaired the administrative review of the child welfare system. The administrative review requested by the Minister provided a broad mandate to examine standards, processes and protocols related to the opening, closing, and transfer of child welfare files, as well as any other issues identified by the co-chairs. The review was to be completed within six months, with the full cooperation of people working at all levels of the system.

The review team was established with members from the Office of the Children's Advocate, the First Nations Child and Family Services Authorities, the Ombudsman's Office and the Office of the Auditor General. The members had experience in the child welfare system and external investigations.

The review team developed a plan to review the legislative and financial framework in which the system operates, previous internal and external reports about the system, existing policies and standards and to interview stakeholders throughout the province.

Team members met with people working in the department, the child and family services authorities and child welfare agencies. They traveled throughout the province and conducted interviews in all regions, in First Nations communities and in urban centres including Winnipeg. In order to hear from as many people as possible in the time available, it was decided that interviews would be conducted in focus group settings. Groups of people working in child welfare with the same or similar levels of responsibility were brought together to discuss their experience and recommendations about how the system could be improved.

Members of the team met separately with people who wished to express their views in private. They also spoke privately with children, youth and foster families in the system. In the course of the review we consulted with people in 32 communities across the province. Over 700 people who work within or are affected by the system provided input to the review. We heard from children and youth in the system whose perspectives were critical to understand how child welfare has affected them. We also heard from care providers, and direct and collateral service providers. The review team found that although expressed from different perspectives, the concerns that were voiced about the system were generally consistent throughout the province.

The review disclosed that the existing governance structure of the child welfare system was inadequate to meet its stated goals and that parts of the statutory mandate were not being met. There were significant problems with both provincial case management standards and information systems. The legislative provisions for reviewing the circumstances surrounding the deaths of children in care and making the necessary improvements in the system were inadequate. In many cases the problems identified related to inadequate funding, while in others the source of the problem was a gap in communication between the people designing the systems and those delivering services on the front lines, or between the system and collateral service providers.

Critical Findings

Authority Structure

Our review occurred at a turning point in the Manitoba child welfare system. Over the past 25 years the system had been reviewed and redesigned on numerous occasions. The most recent

restructuring of the system, which was not yet fully implemented at the time of our review, saw the creation of four child welfare "authorities" responsible for governance, including two First Nations authorities and a Metis authority. This structure was designed in part to restore control of Aboriginal child welfare to Aboriginal peoples, to address the inequities and inadequacies of the child welfare system for the Aboriginal community, and to provide child and family services to Aboriginal people in a manner which respects their unique status and their cultural and linguistic heritage.

The authority system was created to foster an environment of cross cultural understanding and to ensure that the interpretation of child welfare legislation did not create barriers to appropriate service in and for the Aboriginal community.

Each child welfare agency reports to one of the four authorities. When the authorities were created, they were given many of the responsibilities of the Director of Child Welfare and the Child Protection Branch (the branch) including governance responsibilities related to their agencies. This required that authority staff were primarily responsible for financial management, quality assurance and compliance functions. Authorities were not resourced to assume policy and planning functions.

Each authority was given responsibility only for those children and families receiving service from one of their agencies. Because children and families in the province who are in contact with the child welfare system move frequently, the authority model needed flexibility to respond to ensure seamless service for these children and families. A standing committee was created to facilitate communication among the authorities and the branch and to allow the system to consider the needs of child welfare in the province as a whole. However, there were no staff positions allocated to the standing committee and it was designed as an advisory body to the authorities and government.

We found that without sufficient operational capacity the new authorities could not address existing systemic problems, nor hope to move the system forward in a way that would fulfill the promise made to Aboriginal peoples. We concluded that there must be an appropriately

resourced mechanism to develop and implement the goals of re-structuring, to meet the needs of the authorities and the branch both individually and collectively. This is essential if these separate entities are to provide a child welfare system without gaps into which children and families may fall.

Based on our findings we recommended the creation of a Child Welfare Secretariat to be responsible for the research, design, training, and development of programs, policies and standards in accordance with the direction of the authorities and the branch.

Services to Children and Families

Child and family services legislation sets out the rights of children and families. These include the right of families to receive prevention and support services directed to preserving the family unit, and the right of both families and children to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society. The legislation also calls for the provision of services to families in a way that respects their cultural and linguistic heritage and states that communities have a responsibility to promote the best interests of their children and families, and a right to participate in services to their families and children.

We found that families in Manitoba often do not receive prevention or support services consistent with these principles, that the rights enshrined in the legislation were for the most part ignored and that the child welfare system was based on child protection being its first and often only response. This situation had developed despite a consensus that the prevention and support services enshrined in legislation were essential in creating the healthier environments necessary to allow children and families to thrive.

The review found that funding for prevention and support services was grossly inadequate to assist families in becoming healthy and able to parent. The absence of prevention and support programs led to circumstances where workers were able to provide services to children only through the protection process of apprehending them.

We found that new resources were needed to provide the support that is referenced as a principle upon which the child welfare system is based. We recommended that funding be provided immediately to begin the process of planning and implementing prevention and support programs throughout the province, using new methods of service delivery to not only protect children, but to also build on the strengths of families and communities and promote the use of best practices in the delivery of child welfare services in Manitoba.

Service Delivery Models

Funding tied to protection runs counter to the principles espoused in the acts. Prevention and support funding should be the first response with protection a critical component of the system, but not its sole response. Families need the opportunity and assistance to provide appropriate parenting. We found that a new service delivery model was required, with a focus on intervention measures that would allow support to be provided to families to reinforce the benefits of keeping children in their family and communities. Programs needed to be created using community development models to reinforce a child's sense of belonging in a community and the need for families to look after one another.

One such program model identified during the review was the "Alberta Response Model", the implementation of several complex activities that address short term and long term needs of children, youth and families who come into contact with the child welfare system. It is family centered practice with child centered outcomes. It focuses on enhancing community-based partnerships and enriching natural family supports. This is a "differential response" model intended to ensure that children and youth at high risk of physical or emotional harm are protected and, whenever possible, that parents are supported to be responsible for the safety and well being of their children. It also involved permanency planning to improve the outcomes for children and youth, and the evaluation of outcomes for the children, youth, and families that come into contact with the child welfare system.

Differential response is an approach to case management that provides a mechanism for identifying vulnerable children and families early and mobilizes the necessary support services before a crisis occurs. This will help parents fulfill their natural role and responsibilities as

caregivers for their children. Through a differential response using community or neighborhood networks, families can be connected to the services they need to cope with their challenges and meet their children's need for a stable and nurturing home. Providing early support will strengthen vulnerable families, reducing the possibility of child maltreatment and the need for protection services.

Because of the failure of the current system and its focus on apprehension as a primary intervention tool, a new model was required. The differential response model appeared consistent with the principles espoused and rights afforded families in Manitoba legislation. Accordingly, we recommended that the government immediately begin the research and planning necessary for the implementation of a differential response model of service commencing in 2007/08 and that the Alberta response model be studied for this purpose.

We recommended specific funding allocations for 2007/08 and that the model be fully implemented in 2008/09 with funding allocated in the amount of $15,000,000 and that ongoing funding in that amount plus price and volume increases be provided in following years. Finally, we recommended that any savings achieved elsewhere in the system as a result of the differential response model be reinvested in the system.

Child Centered Service Delivery

Families receiving services in the child welfare system are often the recipients of a number of other services from government including employment and income assistance, housing, justice and other social programs aimed at those living in poverty. Each program has its own policies and requirements and knows what outcomes it wishes to achieve. This model has not served the interests of children or families well.

Government should consider the child as the client and use a client focused service model. The inputs that the child receives from government should be calculated from all sources such as Education, Health, Housing, Employment and Income Assistance, and Child Welfare, and potentially Justice.

A child focused service delivery model requires a coordinated government wide effort for the effective and efficient support of children, youth and their families. The larger service delivery system should work collaboratively with the mandated services to ensure best practice occurs. A concerted effort by all is necessary to ensure a coordinated investment of resources to achieve what is in the best interests of the child. This concept is consistent with the principle in *The Child and Family Services Act* that declares "*The best interests of children are a fundamental responsibility of society*".

Accordingly, we recommended that government programs designed to enhance the well-being of children and promote their development be coordinated horizontally, and include child welfare investment to ensure a rational approach to providing government services even in times of family crisis.

Child and Family Services Information System (CFSIS)

There was general agreement that a province wide tracking system is necessary. This is especially important due to the transience of a high number of families in the system. CFSIS was designed as a province wide electronic system that could be consulted to obtain information about children and families within the system.

However we found that agencies do not have the ability to get access to information about families who have been involved with other agencies, beyond some basic demographic information. Because there is no ability to obtain information on files in another agency on the electronic system, workers have to call the agency that "owns the file". This is very time consuming for intake workers who need to have quick access to information about the family.

Numerous agencies and individual workers told the review team that CFSIS no longer meets the purpose for which it was intended and in many cases it operates as an impediment to communication between workers and to workers providing direct services to children and families. Many agencies are not using the system because their community does not have the technological capacity to allow its use, the agency does not have the necessary equipment to run the system or the agency has developed its own system. Regardless of the reason, CFSIS is

lacking significant amounts of information. Workers are relying on the system to contain the information they need. Unfortunately, it is not always available and if it is available, it may not be accurate.

If CFSIS is to be the province wide electronic system, then the province needs to ensure that all agencies and sub-offices across the province are funded for hardware and operating costs, and staff must be trained in utilizing the system.

Because of the cost of the system and the difficulty of replacing it province wide, we did not recommend that CFSIS be replaced. However, we did recommend that the issues with CFSIS be addressed and that staff have access to cases across the Province.

Intake

Intake is a critical function in any service delivery system. It is the front door to a system. In child welfare it is the point at which children are identified as being in need of protection, or families in crisis contact the system for help. Mistakes at intake can lead to services not being provided, with potentially disastrous results.

We found that the current intake structure, in which a "designated intake agency" provides intake services for all agencies in the same geographic area and serves as the public's front door to the system, requires refinement to ensure that transfers from intake to service delivery agencies are timely and appropriate. Intake standards need to be consistent and critical information must be available for sharing between agencies.

In order to ensure that the information necessary to make decisions is available to designated intake agencies, we recommended that funding be provided for additional staff in each child and family services agency to answer questions that may come from intake.

Provincial Program Standards

The Director of Child Welfare is required to develop standards for child welfare service and practice in Manitoba. These provincial standards are the minimum requirements that all

agencies must meet in providing services. The provincial standards regulate the manner in which each agency administers the provision of service, but are not entrenched in legislation. The authorities are responsible for the development of culturally appropriate standards for their respective agencies which are to be consistent with or surpass the provincial standards. When established, these standards will apply to the agencies under each authority.

Based on information received from agencies in the course of the review, there are at minimum three formats of standards which may be in use in whole or part by agencies across the province, causing inconsistency in service delivery, administration, compliance and training. Most workers and supervisors advised us that they had not received training or orientation with regard to the current required standards. In our site reviews with staff of agencies, relatively few frontline workers had copies of the printed standards manual and many did not have access to the standards available on the internet. In many First Nations communities we were advised that the program standards were either culturally inappropriate or impossible to meet because of geographic or economic limitations, or both.

The majority of workers we spoke to identified significant barriers to meeting the provincial standards resulting from the varied formats of standards, limited access to the manuals, as well as the absence of training and orientation to the standards.

To address these concerns we recommended that the provincial standards (foundational standards) intended to ensure the safety of children be applicable throughout the province and be completed as a priority. We recommended that every worker in the province receive training on the foundational standards. We recommended that the foundational standards be published online and that every agency office and sub-office receive a manual containing the standards as well.

Because of comments about a lack of consultation in the development of standards, and concerns about their cultural appropriateness, we recommended that no standard be implemented without the opportunity for meaningful comment from front line protection workers representing each authority.

Oversight

There are currently both internal and external oversight mechanisms in place to examine the circumstances surrounding the death of a child who is, or has recently been, in the care of a child welfare agency in Manitoba. By far the most comprehensive oversight mechanism with respect to the deaths of children in care rests with the Office of the Chief Medical Examiner.

When the Chief Medical Examiner receives a report of the death of a child who, at the time of death or within a year before the death, was in the care of a child welfare agency (or had a parent or guardian receiving services from a child welfare agency) he conducts a review under section 10 of *The Fatality Inquiries Act* to:

" …assess the quality or standard of care and service provided by the agency by;

(c) examining the records of the agency respecting the child and the parent or guardian; and

(d) reviewing the actions taken by the agency in relation to the child and the parent or guardian".

Upon the completion of such an examination or a review, the Chief Medical Examiner immediately submits a confidential written report to the Minister of Family Services and Housing.

The scope of the review is an assessment of the quality or standard of care and service provided by the agency and allows the Office of the Chief Medical Examiner to identify both individual and systemic concerns and to make recommendations to address these concerns. We reviewed all reports completed and recommendations made by the Chief Medical Examiner for the last five years. The issues and concerns identified in those reports result from larger systemic issues such as inadequate resources and excessive workloads. Inadequate resources for staff training or excessive workloads may result in inadequate assessments and an inability to meet the provincial standards. Concerns about inadequate file documentation are related to workload but are also directly related to the problems with the automated information systems described elsewhere in this report.

Addressing these concerns promptly can help reduce the risk to children in the system. Resolving the larger systemic issues is essential to creating the solid foundation necessary to prevent the deterioration of the system feared by people working in the field throughout the province.

Although the Office of the Chief Medical Examiner is external to the child welfare system, once the review is complete and the recommendations are made, the oversight process becomes internal. The branch, sometimes in consultation with the authority or agency, determines whether the response is adequate. The problem lies in the fact that the branch's analysis is done within the context of existing problems such as inadequate resources and excessive workloads. As well, the branch is in the difficult position of being the oversight mechanism for the system with respect to compliance, while at the same time being a system partner and a resource for authorities and agencies alike. No response to the report is made to the Chief Medical Examiner and there is no external scrutiny to ensure that his recommendations are implemented.

We recommended that there be a compliance mechanism external to the child welfare system. All reports on the death of a child should receive independent scrutiny to ensure that the recommendations made are implemented, or are given due consideration and the appropriate action taken.

A second concern identified was the location of the review process. The Office of the Chief Medical Examiner was chosen for this role because he has the authority and expertise to investigate deaths and is objective and independent of the system. However, the scope and focus of the review is not typically a matter for a medical examiner. Although the reviews are required upon the death of a child, the review itself is more about the practical workings of and identifiable deficiencies in the child welfare system, more a matter for the Office of the Children's Advocate which is also independent of the child welfare system.

Although the Office of the Chief Medical Examiner conducts its reviews with professionalism and independence, it has done so under increasingly difficult circumstances. A lack of

resources has often prevented the reviews from being completed in a timely manner. More recently, agencies have expressed concern that the review staff is unable to do on-site investigations that would allow them to fully appreciate and report on the context in which agencies provide services. This context includes the harsh realities of service delivery in isolated communities suffering from tremendous individual poverty and staggering social and physical infrastructure deficits. It also includes the very real gap between the realities of service delivery and the requirements of provincial regulations and standards that are seen in many communities as unattainable and in others as culturally inappropriate.

Staff of many agencies expressed a concern that the review was restricted to examining the services provided by child welfare agencies. The inability to evaluate the impact of collateral resources, or their absence, was seen as a missing piece that resulted in unfair judgment of an agency.

To address concerns about this process we recommended that the responsibility for reviewing the deaths of children in care be transferred to the Office of the Children's Advocate; that additional staff and resources be provided to conduct the reviews; and that the Office of the Children's Advocate be given access to all records held by government that relate to collateral services provided by government, regardless of department.

Recommendations intended to prevent similar deaths in future will still be sent to government. However, to have the same body issuing recommendations and monitoring compliance with those recommendations would be unfair to the bodies, agencies, authorities, branch or department required to respond to the recommendations and make and justify decisions about implementing those recommendations. Accordingly, we recommended that the compliance monitoring role be assigned to the Ombudsman and reported on annually to make the system's handling of its identified problems a more transparent process.

Conclusion

The child welfare review examined the child welfare system with the goal of identifying improvements to its administrative structure. We made over one hundred recommendations,

some calling for significant expenditures and system wide changes. Because our findings and conclusions were based in large part on the experiences of people in or affected by the system, we believe that the implementation of these recommendations can directly improve the lives of children and families touched by that system.

Our report was submitted to the Minister of Family Services and Housing at the end of September 2006. After reviewing the report and recommendations the Minister advised that his government would accept all of our recommendations. The department and the authorities have formed a team to oversee the changes needed to implement the recommendations. Our office has committed to producing the annual "report card" announced by the Minister for the next 2 fiscal years. The team we have formed to monitor implementation will continue its work until all the recommendations have been implemented.

CASES OF INTEREST

Each year many Manitobans contact us when they have been unable to resolve their concerns with government despite having used all existing complaint and appeal mechanisms. Our involvement in some of these cases is described below.

MANITOBA PUBLIC INSURANCE

A complainant asked us to help resolve his dispute with Manitoba Public Insurance Corporation (the Corporation), which found him 75% responsible for an accident. He felt that the Corporation was not giving full consideration to several additional factors relevant to the case.

The complainant was turning left off a two lane provincial highway when he was struck by a vehicle passing him on the left. Generally, the Corporation places the onus on the driver making the turn to ensure that it is safe to do so. This was the basis upon which our complainant was found 75% at fault. We received the Corporation's explanation for the decision, including court decisions finding a left-turning driver 75% liable. However, the corporation also noted that there were cases supporting the opposite conclusion. After receiving and reviewing those cases, we were able to point to similar circumstances where the overtaking driver was found liable for the accident.

We reviewed the Corporation's file regarding our complainant's accident. We pointed to several factors contributing to the accident that we felt should also be taken into consideration. For instance, in this case witnesses traveling behind the vehicles involved reported that the driver of the overtaking vehicle was driving erratically and at excessive speeds. They witnessed him attempt to pass two vehicles at one time when his vehicle struck the rear panel of our complainant's vehicle after he had completed his turn off the highway and onto the gravel road. The damage to the two vehicles supported this version of events. We asked that the Corporation review our complainant's case bearing in mind these factors.

Upon further review, the Corporation concluded that our complainant's liability would be lowered from 75% to 25%. Our complainant had the merit points on his licence returned, the

surcharge on his licence reversed, his deductible payment returned and a larger percentage of personal property damage was covered by his insurance.

TREASURY BOARD SECRETARIAT

The Compensation Services program in the Labour Relations Division of the Treasury Board Secretariat is involved in matters related to compensation for employees of the provincial government.

In 2004, the Department of Family Services and Housing compensated a group of directors for extraordinary work done during a difficult period of transition from 2000 to 2002. Four retired directors had done the same work during the same period, but had left the civil service before the additional compensation was approved. They complained to our office that they had not received the additional compensation. They felt they were equally deserving of the compensation and did not understand why they were being treated differently just because they were no longer working for government.

They had pursued their argument with Family Services and Housing which was responsible for reviewing their request. Their position was that all of the extraordinary work had been done at the same time, while they were in the same job positions, prior to their retirement and therefore retirement should not disentitle them to the compensation. Despite the logic of their position, they had been unable to persuade government they were being treated unfairly. Our office carefully considered the position of both parties to see if there were any logical, legal or technical reasons for the differential treatment of the complainants. We found none and agreed that they were being treated unfairly. No formal recommendation was necessary because during our investigation we had discussions with Family Services and Housing as well as Compensation Services and they agreed to pay the complainants the compensation to which they felt they were entitled.

Although this should have ended the matter, compensation was delayed when the complainants were asked, as a condition of payment, to sign a release form far different than the one signed by the directors still working for the department. Their concern was that the release form

required by Compensation Services was much broader, relating to any current or future claim the complainants might have against government for any reason. The complainants felt it should be the same as the release signed by their counterparts, relating specifically to the retroactive compensation package. Compensation Services appeared to require the broader release on the basis that the individuals had retired. We agreed with the complainants' position and suggested a more appropriate release, specifically related to the claim for compensation. Ultimately Compensation Services agreed that the complainants would receive their compensation upon signing the same form of release as current civil servants who had received the compensation package.

In a second case involving Compensation Services, a retired government employee with 32 years of service complained to our office that he had been short changed financially as a result of a departmental reorganization.

Prior to his retirement in 2000, our complainant was one of a group of professional employees who in 1990 applied for a reclassification of their position. A decision was reached in 1995 approving the reclassification to a higher position with higher pay for our complainant and his colleagues. However, the department had been re-organized and the position to which the employees were ultimately upgraded had been eliminated on March 31, 1993. The employees were awarded retroactive wages at their new classification level for the 3 years between their application date and the date that the position was eliminated. Our complainant felt that he was also entitled to the application of a policy known as "over grade pay protection", which stipulated that during a re-organization any employee downgraded by the re-organization, through no fault of their own, may be paid at the previous rate of pay for a two year transition period. In our complainant's opinion, he should have received this over-grade pay for the 2 year period from April 1, 1993 to March 31, 1995.

The complainant had attempted to resolve his concerns directly with the department and while there was some acknowledgment of the merits of his position, the matter was referred to Compensation Services which took the position that these individuals were not actually "reclassified" as the position they had won no longer existed. This meant they could not

benefit from the over-grade policy because they were not actually in the new position prior to its elimination.

We reviewed the facts of the case, as well as all of the applicable departmental policies and the appeal decision granting the reclassification appeal. We concluded that the position taken by Compensation Services effectively re-interpreted the appeal decision and was inconsistent with the actual wording of the decision. We advised Compensation Services that we supported the complaint and were prepared to make a formal recommendation to that effect but wanted to provide them an opportunity to review the matter and report back.

Although Compensation Services continued to disagree with our position, the department felt that the complainant's request was fair and agreed to pay a settlement equivalent to the amount of over-grade for the period requested as provided in the departmental policy.

MANITOBA HEALTH APPEAL BOARD

In 2005, a complainant had received treatment at a hospital outside Manitoba and had made a claim to the Insured Benefits Branch of Manitoba Health for his expenses. The Insured Benefits Branch denied his application and he appealed the matter to the Manitoba Health Appeal Board. His hearing took place in January 2006, with the written decision provided to all parties the same month. In their decision, the Manitoba Health Appeal Board unanimously agreed that the complainant's expenses met the criteria for funding set out by the Health Services Insurance Act and regulation and that he should be reimbursed accordingly.

Legal counsel for Manitoba Health wrote to our complainant and advised that they would be asking the Manitoba Health Appeal Board to reconsider its decision and therefore, a cheque would not be issued pending the Manitoba Health Appeal Board's response to that request. The Co-Chair of the Manitoba Health Appeal Board advised that they had no jurisdiction to reconsider the decision further and that the Insured Benefits Branch was free to ask the courts for a judicial review of their decision.

The matter went on for months without any reimbursement to the complainant from the Insured Benefits Branch in compliance with the appeal decision, and without any application for a judicial review. The complainant contacted our office alleging that the Insured Benefits Branch was unreasonably delaying any action on the decision.

Our office contacted the Insured Benefits Branch and discussed the complainant's concerns, acknowledging that the delay seemed unreasonable in light of the fact that no further action regarding an application for judicial review had been taken. Following this contact, the Insured Benefits Branch reconsidered their position on the matter and decided to pay the award as provided in the appeal decision. As this decision resolved the matter for the complainant, no formal recommendation from the Ombudsman was necessary.

REVIEW OF DISCRETIONARY DECISIONS

In our last annual report we commented on complaints about decisions of administrative and quasi-judicial boards and tribunals that have the power to hear evidence and make decisions on appeals from members of the public. We noted that while complainants may disagree with such decisions, the threshold for an investigation by the Ombudsman is an allegation of some procedural defect or flaw that prevented the complainant from getting a fair hearing.

In 2006 our office examined complaints about three different bodies not always thought of as administrative tribunals: a municipal council, a cabinet minister and a community college grades appeal panel.

Under *The Planning Act*, municipal councils can hear applications from citizens seeking to vary specific provisions of zoning by-laws which they feel adversely affect their property rights. Under some provincial statutes there is provision for a final or near final level of appeal to the minister responsible for the department. Most community colleges have a review process whereby a student who fails a course can seek to have their grade or performance reviewed. In each of these cases the person or body making the decision is under an obligation to provide a fair hearing.

A fundamental requirement for a fair hearing is that the person or body making the decision be impartial. Bias or the perception of bias, was an issue raised by the complainants in each of the cases discussed below.

MUNICIPAL ZONING VARIATION

In our 2005 annual report we identified municipal planning as an "emerging issue," particularly in light of the fact there would be a new planning act as of January 1, 2006. In the fall of 2006, a couple from a town in western Manitoba complained that their municipal council had denied them a fair hearing when they objected to a variation sought by a neighbour who had built a large outdoor fireplace inches from the wooden fence between their respective properties. They were concerned about possible impact on their fire insurance and about the nuisance of smoke

in their backyard. The "bias" complained of was an assertion that the council had refused to consider the impact on their property of the non-conforming structure.

Complaints that a tribunal has failed to consider a party's position are often resolved by confirming that the tribunal has heard and considered the complainant's position, and clarifying for a complainant that because a tribunal has not accepted their position this does not mean it has not listened to or considered that position.

Our investigation of this complaint began with a review of documentation provided by the town and a video tape of the hearing. *The Planning Act* allows an individual to seek a variation if he or she "…believes that a zoning by-law adversely affects his or her property rights…". In this hearing there was no indication from the applicant nor any inquiry on the part of council, about how the applicant was adversely affected. Instead, his neighbours were required to explain their objection. They felt as though they were placed on the defensive and this contributed in large part to their assertion that council was biased against them. While we found no evidence of actual bias we understood how the complainants had reached their conclusion.

The Planning Act clearly sets out the conditions that must be met for a variance to be granted. Among the criteria is that the variance "is the minimum modification of a zoning by-law required to relieve the injurious effect of the zoning by-law on the applicant's property…". Other criteria include compatibility with the surrounding area and the health and general welfare of people in the surrounding area. In this case there was no evidence about or inquiry into the minimum modification required to relieve the injurious effect of the zoning by-law because injurious effect had never been raised.

Further issues identified were the appropriateness of a councillor voting on the matter at the re-convened hearing although she had not been present for the first part of the hearing before it had been adjourned a month earlier; and apparent confusion about whether the construction had proceeded with a building permit or simply on the basis of an application having been made for a permit pending the granting of a variance.

This was a case where the issues identified by the investigation went beyond the specific concerns expressed by the complainants. When this happens, our office determines if there is the basis for a recommendation in favour of the complainants and advises the respondent department or municipality of all of the issues identified so that they may consider the need for any changes or improvements to administrative process.

In this case, the complainants' concerns about the impact of their neighbour's fireplace on their home insurance was addressed to their satisfaction by their insurance carrier. Their concerns about smoke were based on a canopy of trees above the fireplace. Their concern was speculative because at the time of their complaint the fireplace had not been used. The town's fire chief had determined that the fireplace itself was safe and the question of whether the canopy of trees would cause smoke to accumulate above the complainant's property would not be answered until the fireplace had been used in various weather conditions. The town took the position that if in the future the complainants were aggrieved by smoke, their concern could be addressed when it arose by requiring the neighbour to take remedial action at that point. We agreed with that position and concluded that no formal recommendation was necessary. The complainants were advised of our conclusions, including the fact that we had identified and raised with the municipal council the very concerns that had led them to feel that they had not been treated fairly.

The matter was concluded with the town after an investigator met first with the chief administrative officer and then with the municipal council to review all of the procedural concerns identified by the investigation. Council was receptive to the report and the matter was concluded.

Because municipal planning was identified as an emerging issue in our 2005 Annual Report, we followed up on this case by contacting the planning division of Manitoba Intergovernmental Affairs to determine what assistance was available to municipalities when holding hearings under *The Planning Act*. Information from the department confirmed that all municipalities had received numerous notices about the changes to the legislation, that there had been training opportunities for municipal officials and that training activities and staff support are available on an ongoing basis.

APPEAL TO CABINET MINISTER

Our office was contacted by a couple who raised several concerns regarding a wastewater treatment project undertaken by their local Rural Municipality, including the issuance of an Environmental Licence by Manitoba Conservation. The couple and others from the area, had appealed the issuance of the licence, but their appeals were dismissed by the Minister.

The complaint identified several administrative issues relating to both the licensing process and the statutory appeal to the Minister. Our office received reasonable responses from the Environmental Assessment and Licensing Branch which were relayed to the complainants. We also explained to the complainants that once the dismissal of their appeal was approved by the Lieutenant Governor in Council, our office had no jurisdiction to review that decision as *The Ombudsman Act* does not allow a review of decisions made by the Lieutenant Governor in Council or Cabinet.

As part of their complaint the couple indicated that the Minister who rendered the decision with respect to their appeal had previously appeared as a proponent for the project at an informational meeting earlier in the process. Apparently at the time of this meeting, the Minister was a Member of the Legislative Assembly for that area and was later appointed Minister of Conservation. We wrote to the Deputy Minister to express concern about an appeal process where the legislation gives the Minister decision making power on a subject where he has in another capacity expressed an opinion on the matter, leaving a potential perception of bias in the public's mind. We queried whether in such circumstances it would be better to have another Minister decide the appeal.

In December 2006, the Deputy Minister advised that they had reviewed the concerns raised. He pointed out that under *The Environment Act* the underlying intent of the appeal to the Minister (as opposed to a separate, independent decision maker) in respect of licensing decisions of the Director, is to reflect *The Environment Act's* philosophy which mandates licensing decisions be made in light of relevant government priorities and policy considerations. The Minister's proposed disposition of an appeal of a licence must be referred to the Lieutenant Governor in Council for approval. The Deputy Minister pointed out that this step ensures that the Minister's

decision is not final or effective until such time as it has been vetted with and received an approval from Cabinet, confirming that the Minister's decision is not unilateral.

The Deputy Minister acknowledged that there may be in some instances, a perception of conflict or unfair appeal process if the Minister has, in some earlier context, taken a position on a specific issue. The Deputy Minister agreed to discuss with senior staff, the need as part of the appeal processing criteria, to review the Minister's role relative to any matter that comes before him by way of appeal, thereby considering the possibility of a perception of bias in future appeals. He indicated that in these situations, staff should determine whether the Minister's appellate role has been compromised or subject to a perception of bias and if so, the suggestion of having a different Minister review the appeal in these situations would be considered as one possible alternative.

STUDENT APPEAL

A community college student contacted us to complain about a grades appeal process he felt was unfair. The student had been enrolled in a technical course where grades were assessed not only on academic performance but also on an instructor's evaluation of applied practical skills.

The student felt he had not had a full opportunity to respond to the evaluation because he had not been provided with the instructor's observations, on which the evaluation was based. He was also concerned that staff involved in the first level of appeal had participated in the second level appeal, making it impossible for him to get a truly impartial review at that level.

The first issue, how to achieve a fair review of a grade that is based in part on personal observation by an instructor, related to the specific circumstances under which the appeal arose. The extent, if any, to which people involved at one level of an appeal process should then be involved at a subsequent level is a question relevant to any multi-layered appeal process.

The community college acknowledged that the participation of the same staff at the different levels of appeal was inconsistent with their existing policy. It had occurred because the particular program in which the student was enrolled was structured and staffed in a way not

contemplated by the existing policy. After we had brought the student's concerns to the attention of the college, the college advised that it would review the policy.

Subsequently, the college advised us that it had implemented a new appeals policy in which any person making a decision on a grade would not be part of any appeal or review panel, and any person making a decision at one stage of the appeal process would not be involved at a subsequent stage. With respect to the question of reviewing grades based on personal observations and evaluations of applied skill competencies, the college set up a multi-disciplinary panel comprised of a non-voting chair, a dean or dean's designate, along with representatives of students, instructors and practitioners who had no involvement with the student or the assignment of the initial grade.

Our complainant was granted a new appeal, under the provisions of the improved appeals policy.

STATISICAL REVIEW OF 2006

The following table provides a summary for 2006 of the work done by the Ombudsman Division by tracking cases opened and the disposition of cases closed.

Cases carried over into 2006	247
New cases in 2006	314
Total cases in 2006	561
Total cases closed 2006	417
Pending at December 31, 2006	144

Of the 417 cases closed in 2006:

20% were resolved;

5% were partly resolved;

29% were not supported;

.5% were completed;

26.5% were concluded after assistance or information was provided;

15% were discontinued either by the Ombudsman or the client;

4% were declined.

CASES OPEN IN 2006 AND DISPOSITION OF CLOSED CASES

Department or Category	Carried over into 2006	New cases in 2006	Total cases in 2006	Pending at Dec. 31, 2006	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
PROVINCIAL GOVERNMENT DEPARTMENTS	**178**	**197**	**375**	**108**									
Aboriginal & Northern Affairs	**3**	**-**	**3**	**2**									
General	2	-	2	1	-	-	1	-	-	-	-	-	-
Ombudsman's Own Initiative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-
Advanced Education & Literacy	**3**	**1**	**4**	**1**									
General	2	1	3	-	-	-	1	1	-	-	1	-	-
Ombudsman's Own Initiative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-
Agriculture, Food & Rural Initiatives	**3**	**2**	**5**	**1**									
Manitoba Crop Insurance Corporation	3	2	5	1	-	1	2	-	1	-	-	-	-
Civil Service Commission	**1**	**-**	**1**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	1	**-**	**-**
Conservation	**25**	**6**	**31**	**16**									
General	17	2	19	7	-	-	1	4	4	1	2	-	-
Water Stewardship	7	4	11	8	-	-	-	-	2	-	1	-	-
Ombudsman's Own Initiative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-
Culture, Heritage & Tourism	**2**	**-**	**2**	**-**	**-**	**-**	**-**	**-**	1	**-**	1	**-**	**-**
Education, Citizenship & Youth	**2**	**-**	**2**	**1**									
General	1	-	1	-	-	-	-	1	-	-	-	-	-
Ombudsman's Own Initiative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-
Family Services & Housing	**29**	**34**	**63**	**25**									
General	3	4	7	6	-	-	-	-	-	-	1	-	-
Child & Family Services	8	7	15	5	-	-	3	1	1	1	4	-	-
Employment & Income Assistance	9	14	23	4	-	-	5	6	5	-	3	-	-
Manitoba Housing Authority	4	4	8	-	-	-	-	3	3	-	2	-	-
Social Services Advisory Brd.	1	1	2	2	-	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative-OOI	4	4	8	8	-	-	-	-	-	-	-	-	-
Finance	**9**	**11**	**20**	**4**									
General	1	3	4	2	-	-	1	-	1	-	-	-	-
Automobile Injury Compensation Appeal Com.	2	2	4	-	-	1	-	-	3	-	-	-	-
Residential Tenancies Branch	5	4	9	-	1	-	1	4	1	-	2	-	-
Residential Tenancies Commission	-	2	2	2	-	-	-	-	-	-	-	-	-
Securities Commission	1	-	1	-	-	-	1	-	-	-	-	-	-

CASES OPEN IN 2006 AND DISPOSITION OF CLOSED CASES

Department or Category	Carried over into 2006	New cases in 2006	Total cases in 2006	Pending at Dec. 31, 2006	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
Health	**15**	**20**	**35**	**17**									
General	5	7	12	4	1	-	-	2	2	1	2	-	-
Mental Health	2	7	9	3	-	-	2	3	1	-	-	-	-
Regional Health Authority	3	3	6	2	1	-	1	1	1	-	-	-	-
Ombudsman's Own Initiative-OOI	5	3	8	8	-	-	-	-	-	-	-	-	-
Infrastructure & Transportation	**6**	**2**	**8**	4									
General	5	2	7	3	-	1	-	-	3	-	-	-	-
Ombudsman's Own Initiative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-
Intergovernmental Affairs & Trade	**2**	**5**	**7**	**3**									
General	1	4	5	1	-	-	2	-	2	-	-	-	-
Ombudsman's Own Imitative-OOI	1	1	2	2	-	-	-	-	-	-	-	-	-
Justice	**75**	**114**	**189**	**32**									
General	9	5	14	1	-	-	4	3	1	2	3	-	-
Agassiz Youth Centre	-	4	4	-	-	-	-	-	-	-	4	-	-
Brandon Correctional Centre	13	12	25	-	-	-	4	1	15	1	4	-	-
Headingley Correctional Centre	8	19	27	1	1	1	1	4	5	2	12	-	-
Milner Ridge Correctional Centre	-	4	4	-	-	-	1	1	-	-	2	-	-
The Pas Correctional Centre	4	3	7	-	-	-	1	2	2	-	2	-	-
Portage Correctional Centre	3	16	19	1	1	1	-	2	3	5	6	-	-
Winnipeg Remand Centre	3	15	18	1	1	-	1	3	7	1	4	-	-
Maintenance Enforcement	7	3	10	-	-	-	4	2	1	1	2	-	-
Human Rights Commission	4	11	15	6	-	1	2	3	3	-	-	-	-
Legal Aid Manitoba	-	9	9	5	-	-	-	3	1	-	-	-	-
Public Trustee	3	4	7	1	-	-	-	1	1	-	4	-	-
Manitoba Youth Centre	4	4	8	-	-	-	2	-	-	-	6	-	-
Ombudsman's Own Initiative-OOI	17	5	22	16	-	-	1	1	-	-	3	-	1
Labour & Immigration	**3**	**2**	**5**	2									
General	2	1	3	-	-	-	1	1	1	-	-	-	-
Manitoba Labour Board	-	1	1	1	-	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-

CASES OPEN IN 2006 AND DISPOSITION OF CLOSED CASES

Department or Category	Carried over into 2006	New cases in 2006	Total cases in 2006	Pending at Dec. 31, 2006	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
BOARDS & CORPORATIONS	**37**	**66**	**103**	**17**									
Workers Compensation Board	**7**	9	16	1	-	3	2	4	6	-	-	-	-
WCB Appeal Commission	**5**	7	12	-	-	-	-	2	10	-	-	-	-
Corp. & Extra Departmental	**1**	**7**	**8**	1									
Manitoba Hydro	1	6	7	1	-	-	2	1	3	-	-	-	-
Manitoba Lotteries Corporation	-	1	1	-	-	-	-	1	-	-	-	-	-
Manitoba Public Insurance	24	**43**	**67**	**15**									
General	23	42	65	14	1	3	3	19	12	4	9	-	-
Driver & Vehicle Licencing	1	-	1	-	-	-	-	1	-	-	-	-	-
Ombudsman's Own Initiative-OOI	-	1	1	1	-	-	-	-	-	-	-	-	-
MUNICIPALITIES	**30**	**42**	**72**	**19**									
General	17	17	34	11	-	-	5	7	8	1	2	-	-
City of Brandon	1	4	5	2	-	-	1	-	2	-	-	-	-
City of Winnipeg	12	19	31	4	-	3	4	7	9	1	2	-	1
Ombudsman's Own Initiative-OOI	-	2	2	2	-	-	-	-	-	-	-	-	-
NON-JURISDICTIONAL	**2**	**9**	**11**	**-**									
Federal Departments & Agencies	2	4	6	-	-	1	1	4	-	-	-	-	-
Private Matters	-	5	5	-	-	-	-	5	-	-	-	-	-
TOTAL CASES	**247**	**314**	**561**	**144**	7	16	61	104	121	21	85	-	2

At December 31, 2005 there were 247 cases still pending:

- 189 cases were carried into 2006 from 2005
- 32 originated in 2004
- 11 originated in 2003
- 5 originated in 2002
- 5 originated in 2001
- 4 originated in 2000
- 1 originated in 1999

We closed 189 or 77% in the year 2006.
At December 31, 2006 there were 58 cases still pending:

- 41 originated in 2005
- 7 originated in 2004
- 2 originated in 2003
- 2 originated in 2002
- 1 originated in 2001
- 4 originated in 2000
- 1 originated in 1999

DEFINITION OF DISPOSITIONS

Not Supported
Complaint not supported at all.

Supported
Complaint fully supported because the decision was not compliant with the legislation.

Recommendation Made
All or part of complaint supported and recommendation made after informal procedures prove unsuccessful.

Resolved
Complaint is resolved informally.

Partly Resolved
Complaint is partly resolved informally.

Discontinued
Investigation of complaint stopped by Ombudsman or Client.

Declined
Complaint not accepted for investigation by Ombudsman, usually for reason of non-jurisdiction or premature complaint.

Completed
Case or inquiry where the task of auditing, monitoring, informing, or commenting has been concluded.

Pending
Complaint still under investigation as of January 1, 2007.

Report on the Activities of the Access and Privacy Division

STREAMLINING THE INVESTIGATION PROCESS

As an oversight office we monitor and comment on the ability of public sector bodies and trustees to meet their statutory obligations in a timely manner. It is important that we continue to monitor and assess our own ability to meet our obligations and our institutional goals. One of the goals we strive for is conducting thorough investigations in a timely manner. In 2006, in addition to improving communication with trustees, the public sector and the public, we restructured the Access and Privacy Division to streamline our investigation process.

Our statutory mandate includes both responding to complaints from the public and initiating our own compliance investigations and audits. Until 2006, separate teams performed these functions. Now both teams in the Access and Privacy Division have responsibility for complaints received and Ombudsman initiated investigations. Each team is assigned to particular public sector bodies and trustees, to allow them to become familiar with their practices and to foster better working relationships.

This reorganization has resulted in a more balanced allocation of staff and has improved the work flow of the two teams.

REQUIREMENT OF THE PUBLIC SECTOR TO PROVIDE COMPLETE RESPONSES – UPDATE ON COMPLIANCE WITH FIPPA

When access to information is refused, a public body must inform the applicant of the basis for the refusal, provide contact information for an employee who can answer the applicant's questions about the refusal, and inform the applicant that he or she can complain to the Ombudsman about the refusal. Other required information is specific to the reason for the refusal.

In previous Annual Reports we outlined the findings of our *Evaluation of Compliance with Section 12 of The Freedom of Information and Protection of Privacy Act*, released in June 2005. Since July 2005 we have routinely reviewed the contents of response letters received by applicants and provided to us during an investigation, and returned to the public body any

response letters that do not contain all the information required by law. A revised response is required to be sent to the applicant within 14 days, and copied to our office.

In 2006, we reviewed 98 response letters where access was refused in whole or in part. Of these, 60 (61%) contained all of the information required by law. In comparison, our initial study found that only 16% were fully compliant.

We reviewed 26 response letters where access was refused because the record being sought did not exist or could not be located. Fifteen of those letters (58%) contained all of the required information and were found to be compliant. In our initial study 26% were compliant.

We reviewed 72 letters where access was refused because the public body determined that the record was exempt from disclosure and found that 45 (63%) of these were fully compliant. This was a significant improvement from our initial study in which only 13% were compliant.

COMMUNICATING WITH PUBLIC SECTOR BODIES AND TRUSTEES

The goals of our Brown Bag Talks and Practice Notes include providing public bodies and trustees with information to assist them in responding appropriately to the public and in dealing with our office when we investigate complaints from the public. In 2006, our Practice Note topics included providing reasons, documenting decisions and seeking extensions. All of our Practice Notes are included on the CD format of this Annual Report in *Other Publications* and are also available on our web site.

Providing Reasons

The most problematic issue for public bodies continues to be providing applicants with reasons to explain decisions refusing access. We believe a response should identify the specific statutory provision relied upon to deny a request for access, and explain why it applies to the requested information. While it may help to quote from the legislation, explanations in plain language need to be provided as well. Our Practice Note on providing reasons contains some examples to assist public bodies in complying with the requirement to give reasons when refusing access.

Documenting Decisions

Keeping track of how, why and by whom a decision was made is a critical part of responding to access requests. In responding to our inquiries about a complaint, a public body or trustee must be able to explain and support the basis for the decision. Thorough documentation enables access and privacy personnel to accurately recall the details of specific decisions, such as extending the time limit for responding, charging certain fees or refusing access. When decisions have not been properly documented, investigations can be prolonged as a public body reconstructs the details surrounding the decision.

This has been an ongoing issue of considerable concern to us and in 2006 we discussed it at a Brown Bag Talk and issued a Practice Note.

Seeking an Extension of Time

Under *The Freedom of Information and Protection of Privacy Act,* a public body may extend the 30 day time limit to respond to an access application for up to an additional 30 days, or longer if the Ombudsman agrees. Cases where a longer extension was sought have been rare. However in 2006, we received four requests for longer extensions, which were granted.

Our Practice Note on seeking a longer extension provides direction to public bodies when making a submission to our office. Where a longer extension is sought, it is preferable for a public body to contact our office within the first 30 days of receiving the application, allowing sufficient time for our office to consider and respond to the submission.

QUESTIONNAIRES FOR USE IN PRIVACY COMPLAINTS

Unlike access to information requests and complaints, there are no standard forms for providing details of complaints about a breach of privacy. To assist people who wish to complain to our office, we developed a series of questionnaires on which they can provide enough information to start the complaint process. If a person chooses to write us a letter, the questionnaire can be used as a guide to the information that should be contained in the letter.

The questionnaires are included on the CD format of this Annual Report in *Other Publications* and are also available on our web site.

FAILURE TO RESPOND TO AN OMBUDSMAN'S RECOMMENDATION

When the Ombudsman makes a recommendation to a public body under *The Freedom of Information and Protection of Privacy Act*, the law requires a response to that recommendation within fifteen days. The response must indicate either that the recommendation has been accepted, or explain why the recommendation has not been accepted. If the Ombudsman's recommendation has not been accepted and the complainant has still not been granted access, he or she then has a right to appeal the refusal of access to the Court of Queen's Bench.

In our 2005 Annual Report, we reported that Manitoba Conservation failed to provide the Ombudsman with a response to our recommendation within the 15 day time limit set out in the Act. In 2006, the department continued in its failure to respond and had neither granted the applicant access to the requested record nor provided a response explaining its decision, as required by law.

Therefore, we advised the department that our position is that when a recommendation to respond to an access application has been made and the public body does not respond, the failure to respond will be treated in the same way as a decision to refuse access. Manitoba Conservation was advised that its continued failure to respond was treated as a decision to refuse access, and the applicant was advised of his right to appeal the refusal to the Court of Queen's Bench.

SYSTEMIC REVIEW

AUDITING TO ENSURE COMPLIANCE WITH FIPPA

In 2006, we conducted an audit of Manitoba Conservation's compliance with the 30 day time limit for responding to access applications, as required by *The Freedom of Information and Protection of Privacy Act*.

The audit was undertaken because of concerns about the volume of complaints we received about failures to respond within the time limit and the increasing frequency with which those complaints were found to be supported. Relative to other departments which also receive a high volume of requests, we were receiving more complaints about Manitoba Conservation failing to respond. As well, our office was experiencing ongoing difficulties in obtaining the information we needed from the department during investigations. We had discussed our concerns with the department a number of times in recent years.

Early in 2006 we received an unprecedented number of complaints against Conservation for failing to respond. The volume of complaints underscored the department's growing backlog of overdue requests which had built up over time.

The audit reviewed the department's procedures for processing access requests to identify where the delays were occurring, to determine what was causing the delays and to identify changes that could be made to improve the department's response times. The audit occurred over a period of several months and was conducted with the full cooperation of the department. We reviewed the department's requests and complaints history and conducted interviews and job shadowing with the Access and Privacy Coordinator, to consider the following issues:

- workload of the Coordinator and Officer
- job responsibilities in addition to access matters, the time allotted to these responsibilities and how priorities in multiple program areas were dealt with
- responsibilities of other access and privacy personnel in the department
- how access requests are processed from receipt to completion
- how access complaints are processed from receipt to completion

- the tracking system for access requests and complaints
- observing the Coordinator's day-to-day job

There were ongoing meetings with the Coordinator and the Assistant Deputy Minister responsible to discuss issues, our observations and ultimately our audit findings.

The audit identified key factors that contributed to the department's delays which we grouped into three categories: workload, resources and support.

Workload

The Access and Privacy Coordinator for Conservation also serves as an Access and Privacy Officer for *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. She has the same responsibilities for Water Stewardship. In addition to access and privacy responsibilities, the Coordinator also served Conservation in several other roles including Records Officer, French Language Services Coordinator and Claims Coordinator for Insurance and Risk Management, and had responsibilities for warehouse support and lease renewals.

Over time, the volume of *The Freedom of Information and Protection of Privacy Act* requests made to Manitoba Conservation had increased, as had the backlog of overdue access requests. Between 2000 and 2005, requests had increased from 65 to 111 per year, and the backlog had increased from 7 to 66. As the backlog of overdue requests grew, more complaints were being made to us about the department not providing timely responses and as a result, more time was spent dealing with the complaints while new access requests were being received and needed to be processed in a timely manner.

We observed during the job shadowing that the Coordinator was only able to devote a small portion of the workday to access and privacy responsibilities due to all of her other job responsibilities. Moreover, when the Coordinator was absent, no one else took over those responsibilities.

It was clear that given the volume of requests received by the department in combination with workload and time requirements of the legislation, insufficient human resources were dedicated to access and privacy responsibilities. Based on the volume of work in access and privacy matters, and the time limits set in the legislation, it was our view that access and privacy responsibilities constituted a full-time job in the department.

Resources for Access and Privacy

We found that while the volume of requests had increased over time and backlogs of unanswered requests had risen, the level of resources allocated to access and privacy appeared to have decreased.

In any public body, there should be additional staff trained to handle access matters and devote the time necessary to provide assistance when it is required. Our analysis of the workload and process indicated that a dedicated administrative support position would be an enormous asset. This position could assume responsibility for logging requests, photocopying, obtaining the requested records, creating the indexes, filing, and doing any follow up with field staff as needed. This would alleviate some of the pressure on the Coordinator and free her up to deal with substantive access matters. It was our view that there should also be at least one other departmental employee trained and available to do access work when there is a spike in volume of requests, or when the Coordinator is absent. This would also be useful in terms of succession planning. Finally, we noted the absence of certain basic workplace tools such as an electronic tracking system and storage space.

In 2003 and 2004 a high percentage of access requests to Manitoba Conservation were fully granted. This indicated that there may be types of information that could be released without the need to make a request under the Act. We suggested that one way of proactively releasing public information is to make it available on the department's web site. Another way is to identify documents that can be routinely released when someone asks for them. Although these strategies would take time initially to set up and maintain, they would save time in the future if fewer access requests were made. It was our opinion that strengthening *The Freedom of Information and Protection of Privacy Act* resources in these ways would greatly improve the situation.

Support

Responsibility for access and privacy matters rests with the entire department, not just with the Coordinator. For Manitoba Conservation, this meant that program staff should be able to review records and provide meaningful feedback to the Coordinator. This would support the Coordinator in her review of the records and determination of whether the information can be released.

Everyone involved in processing a request has a responsibility to meet statutory timelines. Within the 30 day limit for responding to a request, there are approximately 20 working days. Upon review of the steps the department followed when responding to a request, we concluded that shorter turnaround times were needed for each step in the process. This resulted in the development of a guideline for processing a request within the time limit.

In order for a guideline to be effective, we noted that full cooperation and dedication is needed from all staff who may be involved in processing a request, regardless of position in the department.

Recommendations

At the conclusion of the audit, we made 15 recommendations to the Deputy Minister of Conservation. The following recommendations were structured to propose a realignment of responsibilities and resources, and to reinforce the point that access is a department wide responsibility:

1. The Minister reinforce to all staff that the cooperation of the entire department is required for the department to meet its responsibilities under FIPPA.
2. The department take steps to immediately bring in additional and sufficient human resources to eliminate the current FIPPA backlog where responses have not been made to requests.
3. The department target October 16, 2006 as the date that the backlog of overdue requests is eliminated.

4. The responsibilities of the Access and Privacy Coordinator position under FIPPA and PHIA be done on a full time basis.
5. The department dedicate sufficient administrative support to the Access and Privacy Coordinator.
6. The department ensure that back-up coverage for any absences by the Coordinator or when there are spikes in volumes of requests, is provided by departmental staff fully trained in FIPPA, when necessary.
7. The department implement an electronic system to track FIPPA requests.
8. The department adopt and communicate to appropriate staff FIPPA processing time lines that will facilitate the completion of processing a request within 30 calendar days (approximately 20 working days).
9. Staff involved in the processing of FIPPA requests receive education and training semi-annually, so that they can contribute constructively on whether or not exceptions apply to responsive records that are located in their program areas.
10. The department ensure that the office of the Access and Privacy Coordinator contains sufficient functional storage so that files and records can be easily stored and quickly located.
11. The department implement an active disclosure program on its web site.
12. The department identify and create a list of types of records that can be routinely released if requested informally or formally under FIPPA, and update this list on an annual basis.
13. Copies of the Ombudsman's report be provided to the Executive Management Committee, each regional director, and appropriate managers, for information.
14. The Deputy Minister provide a response to the Ombudsman concerning these recommendations, within two weeks, indicating whether the recommendations are accepted and describing any proposed action to be taken to implement them, or the reasons why the department chooses not to take action to implement the recommendations.
15. The Deputy Minister provide the Ombudsman with a report on the progress of the implementation of each of the recommendations numbered 1 to 13, by November 1, 2006.

Conclusion

The department accepted our recommendations and most have been implemented. Our office continues to monitor the situation and provide our assistance in support of the department's efforts to improve its compliance with the legislation.

CASES OF INTEREST

In 2006, formal recommendations were made in response to three access to information complaints under *The Freedom of Information and Protection of Privacy Act.*

ACCESS TO POLLING INFORMATION

One of the purposes of FIPPA is to allow the public access to records held by public sector bodies, subject to the limited and specific exceptions to disclosure set out in the Act. When a public body claims that information is withheld because of an exception, the onus is on it to demonstrate how the claimed exception applies to the withheld information.

There are mandatory exceptions to disclosure, relating to information a public body shall not disclose, and discretionary exceptions relating to information a public body may choose not to disclose for various reasons. Both types of exceptions are spelled out in the Act. When applying a discretionary exception, public bodies must take a second step and decide whether to release all, part or none of the information requested. If part of a record is subject to an exception and other parts are not, then the non-excepted parts must be released.

In two complaints about refused access to polling related information, we found that the City of Winnipeg's (the City) application of discretionary exceptions to disclosure was not in compliance with the Act.

In the first case, the applicant had requested access to all poll questions and responses commissioned by the Mayor's office for a particular time period. The City refused access, asserting that the information could reveal advice, opinions, proposals, recommendations or analyses prepared for the City. If that were correct, the City could in fact exercise discretion to refuse access to the information.

At the outset of our investigation the complainant advised that he was no longer seeking the responses to the poll questions, but still wanted access to the questions asked. Despite this, the City then claimed additional discretionary exceptions: that the poll questions could reveal

consultations or deliberations involving its employees and could harm the City's economic or financial interests or negotiating position.

We reviewed each poll question in light of the legislation and the information provided to us by the City. We concluded that none of the polling questions might reveal the types of information the City could except from disclosure under the exceptions claimed. We pointed out that the City often posts on its web site actual poll or survey questions in its Bid Opportunities when tendering for survey research services, and additionally, that it has in the past released other poll information (the gas tax poll) which is information of a class similar to that requested but in this case withheld. In this case, the poll questions would be no secret to the many individuals who were polled. We pointed out as well that it is common practice at all levels of government to release poll information (questions and responses) and we provided examples of polls that have been released by the Federal Government and the Manitoba Government.

In the course of the investigation, the City took the position that *The Freedom of Information and Protection of Privacy Act* does not require the compulsory release of poll information. This interpretation is contrary to the spirit and intent of the Act, which is designed to give the public a right of access to information held by public sector bodies unless it is subject to one of the exceptions specified by the legislation.

In the second case, an applicant had requested access to polling information pertaining to a specific issue. The request included the cost of the poll, the name of the company that conducted the poll, the results of the poll, and the research methodology for the poll. Initially, the City refused access on the basis of the same discretionary exceptions it had cited in the first case.

We reviewed the requested records in light of the legislation and the information provided by the City. We did not agree with its assertion that the cost, the research methodology, the questions asked of the public and the responses revealed any advice, opinions, proposals, recommendations, analyses or policy options being developed by or for the City. We concluded that the claimed exceptions did not apply and recommended the release of the records identified as being responsive to the request.

Each of these cases related to requests for information obtained by the City from the public at public expense. The City relied upon similar discretionary exceptions to deny access to the information sought.

In the first case, a formal recommendation was made that the City release the information sought by the applicant. The City declined to follow the recommendation, as is their right in law. In the second case, the City advised us that it would release the withheld information to the applicant. Our office remains unable to reconcile why in one case the City refused to release poll questions, but in the other case, released the poll questions and the responses.

In both of these cases, the investigations were hampered by incomplete and delayed responses to our office by the City. This protracted the process, and was not in keeping with the spirit and intent of the legislation. We will continue to work with the City to improve our relationship and to ensure that the City meets its statutory obligations under *The Freedom of Information and Protection of Privacy Act.*

ACCESS TO PUBLISHED MATERIALS

Under *The Freedom of Information and Protection of Privacy Act*, a public body has the discretion to refuse access to records where the disclosure could reasonably be expected to result in harm to law enforcement or legal proceedings. When a public body relies upon this discretionary exception, it must be able to demonstrate how or why the disclosure of the information could result in harm.

Our office received a complaint from an applicant who had been refused access to specific materials contained within a course manual held by Manitoba Culture, Heritage and Tourism. In the course of processing the access request, the department learned that the applicant had civil litigation pending against another organization. In denying the applicant's request, the department relied on the discretionary exception allowing it to refuse to disclose information that could be injurious to the conduct of existing or anticipated legal proceedings.

Our investigation revealed that Manitoba Culture, Heritage and Tourism had not been named in the civil suit and was not a party to the legal proceeding. We asked the department to explain its position that the disclosure could injure the conduct of the legal proceeding. The department responded that if both parties did not have the information at the same time, the disclosure of the information could result in potential harm to one of the parties to the litigation.

The discovery process in litigation and the access process under *The Freedom of Information and Protection of Privacy Act* are distinct and unrelated. Initiating a civil suit does not preclude a person from exercising their right to request access to records under *The Freedom of Information and Protection of Privacy Act* .

We advised the department that in our view it had not been able to demonstrate how legal proceedings would be harmed by releasing the course material and we requested that it reconsider its decision to deny the applicant's request. Subsequently, a recommendation was made to Manitoba Culture, Heritage and Tourism to release the requested records to the applicant. The department accepted the recommendation and released the records sought by the applicant.

At the outset of our investigation we learned that the information requested by the applicant was already publicly available for a fee, as the manual was part of a training course offered to the public by the department. However, because the applicant chose to make a request under the Act and the department refused access under the Act, this became a complaint.

The Freedom of Information and Protection of Privacy Act does not and should not replace existing procedures for obtaining access to records that are normally available to the public. If information is normally available to the public, efforts should be made to provide that information taking into account legitimate cost and other applicable considerations.

UNSUPPORTED COMPLAINT ABOUT THE MANITOBA LOTTERIES CORPORATION

The Freedom of Information and Protection of Privacy Act sets out rules to protect individuals against unauthorized disclosure of their personal information by public bodies.

During 2006, we investigated a case where it was alleged that employees' personal information in the custody and control of Manitoba Lotteries Corporation (MLC) had been disclosed. Employees complained to our office that they had received unsolicited mail addressed to their home addresses from a third party. They alleged that the information could only have been received by the third party from the employer, a public body under *The Freedom of Information and Protection of Privacy Act*. They also said that the information had been disclosed without their authorization.

Our investigation determined that the personal information of the employees had been disclosed, but we were unable to determine the source of the disclosure other than to conclude that the MLC had not been responsible for the disclosure.

In the course of the investigation we reviewed MLC's policies and procedures relating to the handling of personal information in its human resources and technology areas, its internal review of the alleged disclosure and the information provided to employees on privacy. We determined that MLC had taken appropriate measures to protect personal information in its custody and control by making reasonable security arrangements against such risks as unauthorized access, use, disclosure or destruction. Furthermore, we were of the opinion that employee personal information is maintained by MLC in a secure environment and managed in a confidential manner.

We were pleased to report that Manitoba Lotteries Corporation had in place those kinds of protection of personal information that are needed to comply with the Act. Section 41 of *The Freedom of Information and Protection of Privacy Act* sets out the obligation of a public body to protect personal information by making reasonable security arrangements against such risks as unauthorized access, use, disclosure or destruction. This case serves as a good example of a situation where a public body had developed comprehensive policies and procedures in order to meet this obligation.

A JOINT COMMENTARY WITH THE MANITOBA PHARMACEUTICAL ASSOCIATION

Pharmacists are "trustees" of personal health information under *The Personal Health Information Act*, and are therefore subject to the requirements of the Act. As the oversight authority, the Ombudsman may comment on the privacy implications of programs or practices of trustees. Early in 2006, our office worked cooperatively with the Manitoba Pharmaceutical Association to address a privacy concern related to the purchase of levonorgestrel, an emergency contraception for women, commonly referred to as Plan B.

Beginning in the spring of 2005, it became possible to buy emergency contraception without a prescription, but it was not sold on display shelves and therefore a woman wishing to purchase it had to ask at the pharmacy counter. In 2006, media reports suggested that some Manitoba pharmacists were asking personally sensitive questions at the point of purchase.

Pharmacists have a professional responsibility to ensure that the medication they dispense is appropriate. They need information to do this. However, under *The Personal Health Information Act*, personal health information must not be collected unless it is necessary and then only the minimum amount of personal health information that is required should be collected.

The joint commentary with the Manitoba Pharmaceutical Association was an opportunity to quickly and efficiently clarify for the public how this medication would be provided, in a way that allowed pharmacists to meet their professional obligations and standards, while respecting the principles of privacy set out in Manitoba law.

Our joint commentary noted that documenting that a person received emergency contraception is only necessary when the individual wishes to have a third party pay for the medication, or when the individual wants the information recorded on her patient profile. Therefore, information identifying the purchaser should be recorded only where the individual requests or agrees with the recording.

It was also noted that any consultations between a pharmacist and a purchaser should be conducted in an area where confidentiality can be ensured.

In addition to the joint commentary, the Manitoba Pharmaceutical Association clarified its practice guideline on emergency contraception and issued a notice to the profession on the subject.

The joint commentary is posted on our web site.

STATISTICAL REVIEW OF 2006

The following table provides a summary for 2006 of the work done by the Access and Privacy Division by tracking cases opened and the disposition of cases closed.

Cases carried over into 2006	106
New cases in 2006	255
Total cases in 2006	361
Total cases closed 2006	254
Pending at December 31, 2006	107

Of the 254 cases closed in 2006:

34% were supported;

10% were partly supported;

1% were resolved;

1% were concluded by recommendation;

34% were not supported;

8% were completed;

8% were discontinued either by the Ombudsman or the complainant;

4% were declined.

OVERVIEW OF ACCESS COMPLAINTS OPENED IN 2006

In 2006, 224 new complaints about access matters were opened under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. The following chart provides a breakdown of the access complaints.

Type of Access Complaint	Total	FIPPA	PHIA
No Response	115*	115	-
Extension	10	10	NA**
Fees	4	4	-
Correction	1	-	1
Refused Access	94	93	1
Total	**224**	**222**	**2**

*92 were made against one department

**NA: Not Applicable as extensions cannot be taken under PHIA

OVERVIEW OF ACCESS COMPLAINTS CLOSED IN 2006

During 2006, 205 complaints under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* about access matters were closed. The following chart provides a breakdown of the dispositions of these access complaints.

Type of Access Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or whole	Not Supported	Resolved
Refused Access	98	1	99	15	30	50	4
No Response	89	0	89	11	67	11	0
Fees	5	0	5	1	1	3	0
Correction	0	1	1	0	1	0	0
Extension	10	0	10	1	8	1	0
Other	1	0	1	0	0	1	0
Total	**203**	**2**	**205**	**28**	**107**	**66**	**4**

OVERVIEW OF PRIVACY COMPLAINTS OPENED IN 2006

In 2006, 12 new complaints about privacy matters were opened under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. The following chart provides a breakdown of the privacy complaints.

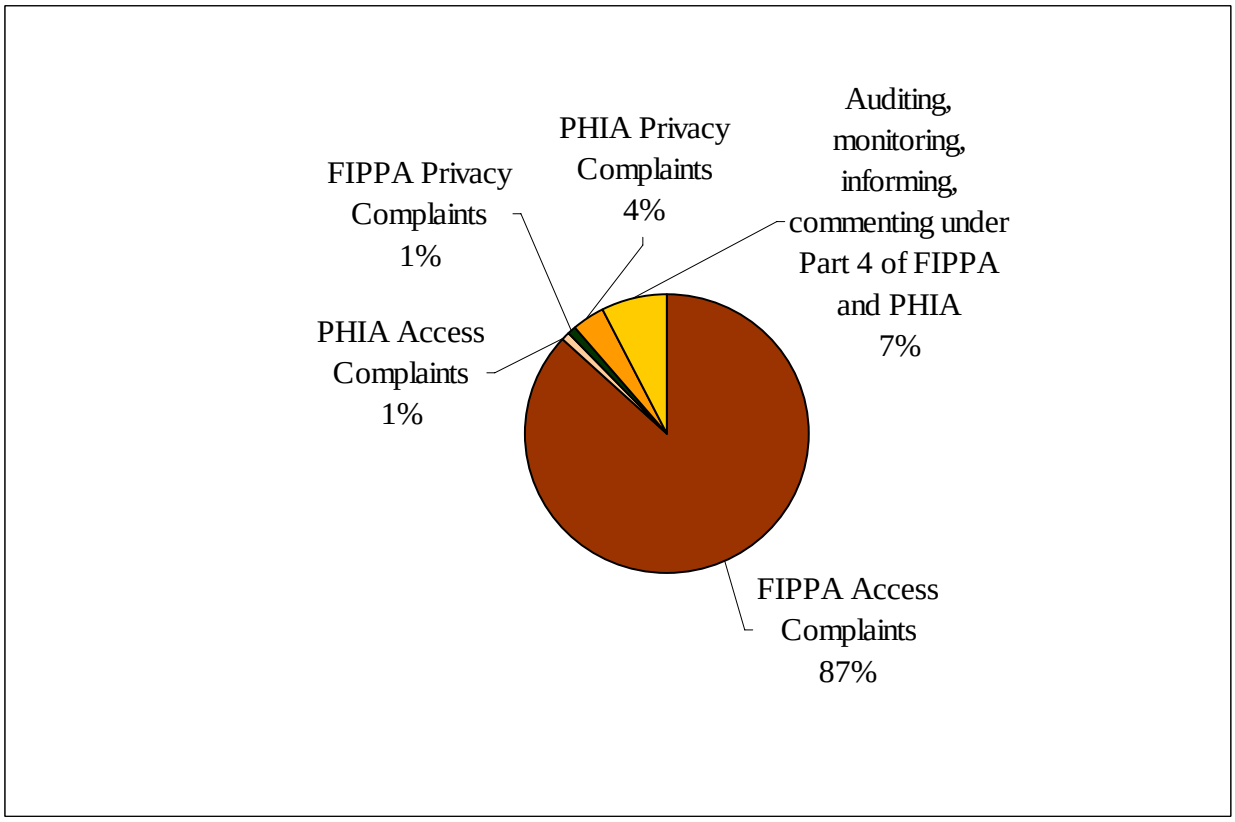
Type of Privacy Complaint	Total	FIPPA	PHIA
Collection	0	0	0
Use	1	1	0
Disclosure	10	2	8
Security	1	0	1
Total	**12**	**3**	**9**

OVERVIEW OF PRIVACY COMPLAINTS CLOSED IN 2006

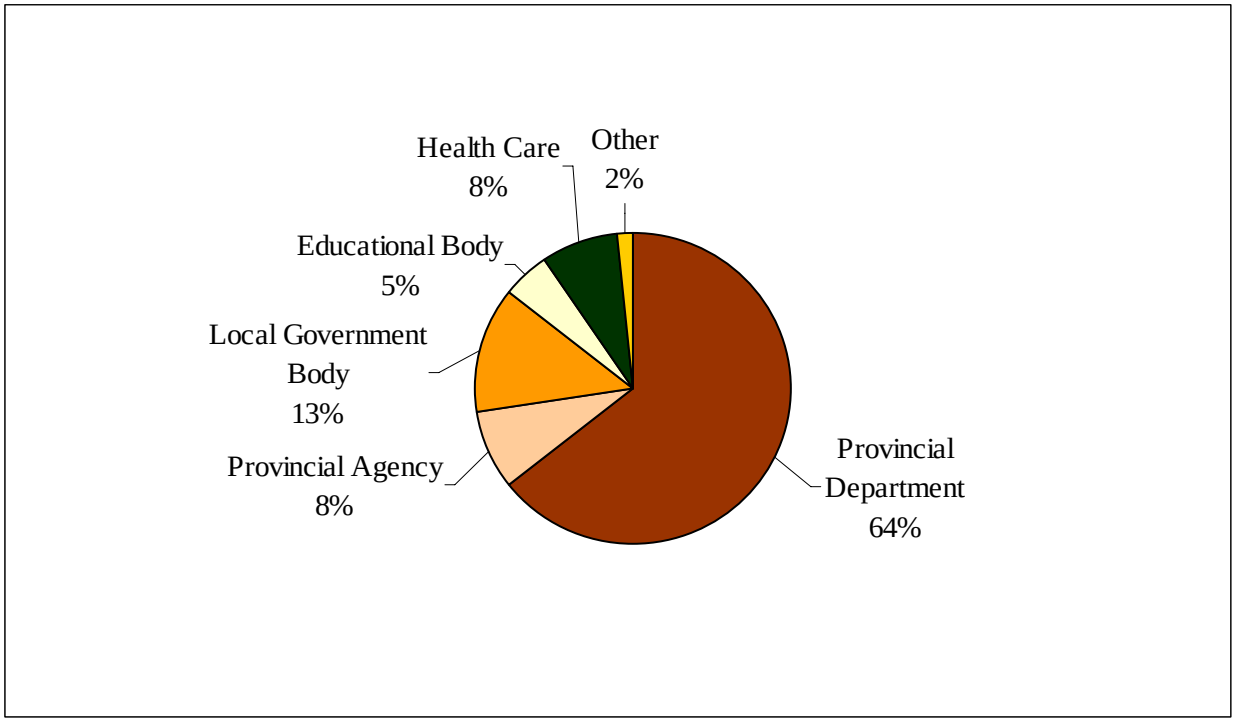
During 2006, 32 privacy complaints under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* were closed. The following chart provides a breakdown of the dispositions of these privacy complaints.

Type of Privacy Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or whole	Not Supported	Resolved
Collection	3	1	4	0	1	3	0
Use	2	2	4	0	2	2	0
Disclosure	8	7	15	3	2	10	0
Security	1	2	3	0	0	1	2
Other	3	3	6	0	1	4	1
Total	**17**	**15**	**32**	**3**	**6**	**20**	**3**

TYPES OF CASES OPENED IN 2006



DISTRIBUTION OF CASES OPENED IN 2006



CASES IN 2006 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

This chart shows the disposition of the 361 access and privacy cases investigated in 2006 under Part 4 and 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*.

Act/Department or Category	Carried over into 2006	New cases in 2006	Total cases in 2006	Pending at Dec. 31, 2006	Declined	Discontinued	Resolved	Not Supported	Partly Supported	Supported	Recommendation	Completed
***Part 5 of The Freedom of Information and Protection of Privacy Act* (FIPPA)**												
PUBLIC BODY												
Provincial Department	**48**	**158**	**206**									
Advanced Education & Training	-	1	**1**	-	-	-	-	1	-	-	-	-
Agriculture, Food & Rural Initiatives	1	2	**3**	-	-	-	-	1	1	1	-	-
Conservation	13	107*	**120**	56	-	4	-	6	-	54	-	-
Culture, Heritage & Tourism	1	1	**2**	2	-	-	-	-	-	-	-	-
Education, Citizenship & Youth	-	6	**6**	5	-	-	-	1	-	-	-	-
Energy Science & Technology	1	-	**1**	-	-	-	-	-	-	-	-	1
Executive Council	-	1	**1**	-	-	-	-	1	-	-	-	-
Family Services & Housing	6	17	**23**	6	-	-	1	12	4	-	-	-
Finance	2	2	**4**	-	-	1	-	2	1	-	-	-
Health	2	1	**3**	-	-	-	-	3	-	-	-	-
Industry, Economic Development & Mines	1	3	**4**	-	-	-	-	3	1	-	-	-
Infrastructure & Transportation	-	1	**1**	1	-	-	-	-	-	-	-	-
Intergovernmental Affairs & Trade	1	7	**8**	-	6	-	-	-	2	-	-	-
Justice	5	6	**11**	3	-	1	-	5	1	1	-	-
Labour & Immigration	1	-	**1**	-	-	-	-	1	-	-	-	-
Transportation & Government	3	1	**4**	-	-	-	-	2	2	-	-	-
Water Stewardship	11	2	**13**	3	-	-	-	1	-	9	-	-
Crown Corporation and Government Agency	**17**	**16**	**33**									
Boxing Commission	8	1	**9**	2	-	-	2	3	2	-	-	-
Cattle Enhancement Council	-	1	**1**	-	-	1	-	-	-	-	-	-
Dakota Ojibway Child & Family	1	-	**1**	-	-	1	-	-	-	-	-	-
Floodway Expansion Authority	-	1	**1**	-	-	-	-	1	-	-	-	-
Housing & Renewal Corporation	-	1	**1**	-	-	-	-	1	-	-	-	-
Legal Aid Services	1	-	**1**	-	-	-	-	1	-	-	-	-
Lotteries Corporation	-	1	**1**	1	-	-	-	-	-	-	-	-
Manitoba Public Insurance	6	11	**17**	3	2	2	-	10	-	-	-	-
Workers Compensation Board	1	-	**1**	-	-	-	-	-	1	-	-	-
LOCAL PUBLIC BODY												
Local Government Body	**14**	**29**	**43**									
City of Brandon	-	1	**1**	-	-	-	-	-	-	1	-	-
City of Winnipeg	13	17	**30**	2	2	2	-	15	3	4	2	-
Town of Minnedosa	-	1	**1**	-	-	-	-	-	-	1	-	-
R.M. of Archie	-	8	**8**	1	-	6	-	-	-	1	-	-

CASES IN 2005 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2006	New cases in 2006	Total cases in 2006	Pending at Dec. 31, 2006	Declined	Discontinued	Resolved	Not Supported	Partly Supported	Supported	Recommendation	Completed
R.M. of Dauphin	1	-	**1**	1	-	-	-	-	-	-	-	-
R.M. of Rockwood	-	1	**1**	-	-	-	-	1	-	-	-	-
R.M. of St. Andrews	-	1	**1**	1	-	-	-	-	-	-	-	-
Educational Body	**5**	**13**	**18**									
Evergreen School Division	1	-	**1**	-	-	-	-	1	-	-	-	-
River East Transcona School	1	-	**1**	-	-	-	-	-	1	-	-	-
Red River College	-	9	**9**	-	-	-	-	6	2	-	-	1
University of Manitoba	3	3	**6**	2	-	1	-	1	2	-	-	-
University of Winnipeg	-	1	**1**	-	-	-	-	1	-	-	-	-
Health Care Body	**1**	**9**	**10**									
Winnipeg Regional Health	-	9	**9**	1	-	-	-	-	-	8	-	-
Seven Oaks General Hospital	1	-	**1**	-	-	-	-	-	-	1	-	-
***Part 5 of The Personal Health Information Act* (PHIA)**												
Crown Corporation and Government Agency	**2**	**3**	**5**									
Workers Compensation Appeal Commission	-	2	**2**	2	-	-	-	-	-	-	-	-
Workers Compensation Board	2	1	**3**	-	-	-	-	2	1	-	-	-
LOCAL PUBLIC BODY												
Local Government Body	**3**	**-**	**3**									
City of Winnipeg	3	-	**3**	-	-	-	-	3	-	-	-	-
Educational Body	**1**	**-**	**1**									
Brandon School Division	1	-	**1**	-	-	-	-	-	-	-	-	1
Health Care Body	**-**	**4**	**4**									
Brandon Regional Health	-	1	**1**	-	1	-	-	-	-	-	-	-
Interlake Regional Health	-	1	**1**	-	1	-	-	-	-	-	-	-
Regional Health Authority - Central Manitoba Inc.	-	1	**1**	-	-	-	-	-	-	1	-	
Winnipeg Regional Health	-	1	**1**	1	-	-	-	-	-	-	-	-
Health Professional	**3**	**-**	**3**									
Physician	3	-	**3**	-	-	-	-	-	1	1	-	1
Health Care Facility	**2**	**1**	**3**									
Seven Oaks General Hospital	2	1	**3**	-	-	-	-	3	-	-	-	-
Medical Clinic	**-**	**2**	**2**									
Family Matters Medical Clinic	-	1	**1**	1	-	-	-	-	-	-	-	-
Prairie Trails Medical Centre	-	1	**1**	1	-	-	-	-	-	-	-	-
Personal Care Home	**-**	**1**	**1**									
Charleswood Care Centre	-	1	**1**	-	-	1	-	-	-	-	-	-
Part 4 under FIPPA and PHIA												
PUBLIC BODY												
Provincial Department	**4**	**6**	**10**									
Advanced Education & Training	1	-	**1**	1	-	-	-	-	-	-	-	-

CASES IN 2005 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2006	New cases in 2006	Total cases in 2006	Pending at Dec. 31, 2006	Declined	Discontinued	Resolved	Not Supported	Partly Supported	Supported	Recommendation	Completed
Competitiveness, Training & Trade	-	1	**1**	-	-	-	-	-	-	-	-	1
Conservation	-	2	**2**	1	-	-	-	-	-	-	-	1
Education, Citizenship & Youth	1	-	**1**	-	-	-	-	-	-	-	-	1
Family Services & Housing	1	2	**-**	-	-	-	-	-	-	-	-	2
Health	-	1	**1**	1	-	-	-	-	-	-	-	-
Transportation & Government	1	-	**1**	1	-	-	-	-	-	-	-	-
Water Stewardship	-	1	**1**	-	-	-	-	-	-	-	-	1
Crown Corporation and Government Agency	**2**	**2**	**4**									
Addictions Foundation of Manitoba	1	-	**1**	-	-	-	-	-	-	-	-	1
Manitoba Film & Sound Development Corporation	-	1	**1**	-	-	-	-	-	-	-	-	1
Manitoba Public Insurance	1	1	**2**	1	-	-	-	-	-	-	-	1
LOCAL PUBLIC BODY												
Local Government Body	**2**	**4**	**6**									
City of Brandon	1	-	**1**	1	-	-	-	-	-	-	-	-
City of Winnipeg	1	4	**5**	2	-	-	-	-	-	-	-	3
Educational Body	**1**	**-**	**1**									
Brandon School Division	1	-	**1**	-	-	-	-	-	-	-	-	1
Health Care Body	**-**	**1**	**1**									
Interlake Regional Health	**-**	**1**	**1**	1	-	-	-	-	-	-	-	-
Health Care Facility	**-**	**1**	**2**									
Canadian Blood Services	-	1	**1**	1	-	-	-	-	-	-	-	-
Crossing Medical Clinic	1	-	**1**	-	-	-	-	-	-	-	-	1
Health Professional	**-**	**2**	**2**									
Orthodontist	-	1	**1**	1	-	-	-	-	-	-	-	-
Pharmacist	-	1	**1**	1	-	-	-	-	-	-	-	-
Other	-	3	**3**									
Dental Laboratory	-	1	**1**	-	-	-	-	-	-	-	-	1
MB Pharmaceutical Association	-	1	**1**	-	-	-	-	-	-	-	-	1
MB Municipal Admin. Assoc.	-	1	**1**	-	-	-	-	-	-	-	-	1
Total	**106**	**255**	**361**	**107**	**11**	**20**	**3**	**86**	**26**	**85**	**2+**	**21**

At December 31, 2005, there were 106 cases pending:

- 80 were carried over from 2005
- 20 were carried over from 2004
- 2 were carried over from 2003
- 4 were carried over from 2001

In 2006, 93 of these 106 carried over cases were closed. Of the 13 cases still pending at December 31, 2006:

- 11 originated in 2005
- 2 originated in 2004

***Note: Of the 107 complaints, 10 were filed by one individual, 42 by a second individual and 46 by a third individual.**
+Two additional recommendations were made in 2006 but the files were pending at December 31, 2006.

DEFINITION OF DISPOSITIONS

Supported
Complaint fully supported because the decision was not compliant with the legislation.

Partly Supported
Complaint partly supported because the decision was partly compliant with the legislation.

Not Supported
Complaint not supported at all.

Recommendation Made
All or part of complaint supported and recommendation made after informal procedures prove unsuccessful.

Resolved
Complaint is resolved informally before a finding is reached.

Discontinued
Investigation of complaint stopped by Ombudsman or Client.

Declined
Upon making enquiries, complaint not accepted for investigation by Ombudsman, usually for reason of non-jurisdiction or premature complaint.

Completed
Cases conducted since 2002, under Part 4 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* where the task of auditing, monitoring, informing, or commenting has been concluded.

Pending
Complaint still under investigation as of January 1, 2007.