Manitoba Ombudsman

2007 Annual Report

Manitoba Ombudsman

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March 31, 2008

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, and subsection 26(1) of *The Public Interest Disclosure Act*, I am pleased to submit the Annual Report of the Ombudsman for the calendar year January 1, 2007 to December 31, 2007.

Yours truly,

Original signed by

Irene A. Hamilton
Manitoba Ombudsman

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A Message From the Ombudsman – 2007

In my last two annual reports, I described changes occurring in our office that included how we communicate with and respond to the public, how we respond to complaints at intake, and our investigation processes. I am pleased to report that in 2007, those changes have been substantially implemented and have had a positive effect on our capacity to respond to the public and the public sector.

More complaints are being resolved quickly at the intake stage, allowing us to devote more time to individual complaint files opened for investigation, and to broader systemic reviews of matters affecting larger numbers of people.

Our outreach efforts were expanded to include people in northern Manitoba, and significant progress was made in increasing awareness of privacy matters among both the general public and professional organizations whose members need to be informed of access and privacy legislation.

Although public awareness of privacy issues is increasing, opportunities for public input into policy decisions on access and privacy are limited. As well, rapid technological change continues to make it difficult for the public to keep pace with privacy issues. This is an area in which we will devote increasing efforts.

While we have streamlined our intake and investigation processes, our resources were taxed in 2007 by new responsibilities under *The Public Interest Disclosure (Whistleblower Protection) Act* and the significant efforts required to follow up on our 2006 report on the child welfare system.

With the proclamation of *The Children's Advocate Enhanced Mandate Act*, anticipated in 2008, our resources will be further stretched as we assume responsibility to monitor the implementation of recommendations made by the Office of the Children's Advocate after her review of the deaths of children involved with the child welfare system.

EDUCATION AND OUTREACH ACTIVITIES

Northern Outreach

It is important to me that, as much as possible, my office meets with people in their own communities. I believe that meeting personally to hear people's concerns, to explain what we do and to exchange ideas, remains the most effective means of outreach.

In 2007, my office undertook our first public outreach tour. Three of my colleagues and I visited Dauphin, Flin Flon and The Pas, and in November, one of our investigation managers visited Churchill.

In the course of thirteen presentations, we spoke to members of the general public, high school students, and college students and staff. We also spoke with representatives of provincial government departments, municipal governments, health care workers and staff from child and family services agencies and youth services agencies. A frequent topic of discussion was the ongoing implementation of the recommendations contained in our 2006 report on the child welfare system, *Strengthen the Commitment.*

We discussed the role of our office in promoting administrative accountability and compliance with access and privacy laws, and we also discussed situations where concerns can arise in multi-jurisdictional environments, such as in First Nations communities.

Right to Know Week

Right to Know Week is celebrated in Canada in conjunction with International Right to Know Day, September 28. It is an opportunity to promote openness and transparency in the public sector. The theme for 2007 was encouraging routine and pro-active disclosure of information as the norm.

The Government of Manitoba and the cities of Brandon and Thompson joined other progressive communities across Canada in declaring October 1 to 5, 2007, as Right to Know Week. The highlight of Manitoba's Right to Know activities was the participation of

Canada's former Information Commissioner, John Reid. Mr. Reid shared his vast experience as a public servant and advocate of government openness at public speaking events in Brandon and Winnipeg.

I was pleased to participate on a public panel about routine disclosure of information with representatives from Manitoba Culture, Heritage, Tourism and Sport, The Canadian Press and Manitoba Wildlands.

These events were organized by the Manitoba Right to Know Committee, a working group with representatives from my office, the Canadian Association of Journalists (Manitoba), Canadian Taxpayers Association (Manitoba), Manitoba Bar Association and Provincial Council of Women.

Manitoba OmbudsNews Newsletter

To more regularly share information with the public and public sector bodies on our projects, activities and upcoming events, we introduced a quarterly newsletter. *Manitoba OmbudsNews* debuted in December 2006, and in 2007, it was published quarterly, in English and French.

New editions are announced on the "What's New" portion of our web site. We also email new editions upon request. To be added to our distribution list, individuals and organization can send us their email address, directed to ldeandrade@ombudsman.mb.ca. Editions of *Manitoba OmbudsNews* 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.

In the Schools

Last year, I reported on our completion of *Joining the Herd: A Handbook on Participating in Manitoba's Government*, for students and teachers in Grades 6, 9 and 11 Social Studies. The curriculum for Social Studies in these grades concerns Canadian government.

In March 2007, Manitoba Education and Training delivered a copy of our *Joining the Herd* to the approximately 900 English schools in Manitoba having Grades 6, 9 or 11. The students'

exercises and puzzles and teachers' learning experiences overviews are available on our web site at www.ombudsman.mb.ca and in disk and hard copy format from the Manitoba Text Book Bureau (stock order 80564). *Joining the Herd* is also included on the CD format of this Annual Report in *Other Publications*.

Teachers answered our invitation in *Joining the Herd* to have staff from my office meet with their students. We had the pleasure of speaking with students at Elm Creek School, Winnipeg Beach School, Dauphin Regional Comprehensive Secondary School and Winnipeg's Stanley Knowles School. I was also pleased to address Social Studies teachers who were meeting in Winnipeg at the 2007 S.A.G. (Special Area Groups) Conference and at the first Teachers' Institute on Parliamentary Democracy, hosted and coordinated by the Office of the Speaker of the Legislative Assembly.

Corrections Outreach

Life in jail is highly regulated and strictly controlled. There are rules governing almost every aspect of inmates' daily routines, including their interactions with correctional staff. The number of contacts between inmates and staff, combined with the numerous rules necessary to maintain order, results in a high volume of complaints to our office.

To assist in ensuring that Corrections staff understand our role and responsibilities in investigating complaints, my office has been involved in the educational training offered to correctional officer recruit classes for the past several years. In 2007, my staff provided presentations to eight separate correctional officer recruit classes. These sessions have been well received by Manitoba Corrections and provide an excellent opportunity to share our experiences within the context of corrections.

In 2007, we presented eighteen sessions to the youth at the Manitoba Youth Centre and Agassiz Youth Centre. We make these presentations every year which gives both staff and residents an opportunity to identify issues and discuss the process by which issues/complaints can be resolved.

Also in 2007, at the request of Portage Correctional Centre, we made four presentations on the role and function of the Ombudsman to the women incarcerated there.

Outreach to Health Professionals through Health Regulatory Bodies

Over the past two years, we have provided access and privacy sessions for health professionals working in regional health authorities, hospitals, clinics and provincial government departments. It has been more difficult, however, to share information with the thousands of health professionals who work in independent practices dispersed throughout Manitoba who also work with *The Personal Health Information Act* (PHIA).

In 2007, our office partnered with Manitoba Health in an interactive presentation to the professional colleges and associations responsible for twenty-one groups of regulated health professions in Manitoba. While these regulatory bodies are not subject to the rules of PHIA, they play a pivotal role in keeping their members up-to-date on how information privacy relates to their patients. Our office and Manitoba Health have been asked by the health regulatory bodies to provide additional presentations to help them assist their members in being informed on PHIA.

Crossjurisdictional Initiatives in Privacy Protection

Neither public interest in privacy, nor the laws designed to protect our privacy, can keep up with advances in technology that may jeopardize that privacy. Monitoring and responding to privacy concerns is largely the task of privacy commissioners, who effectively stand in place of the public on privacy issues. As Manitoba Ombudsman, I have the responsibilities of a privacy commissioner.

Information flows rapidly across borders, necessitating the cooperation of access and privacy professionals across Canada and around the world. It is vital that Manitobans be informed and vigilant about information privacy issues. Personal privacy protection is particularly challenging when new, dynamic technologies are raising unprecedented risks and opportunities. Several privacy developments and activities in 2007 are worthy of note.

The Provincial Privacy and Security Council

Like other jurisdictions in Canada, Manitoba is developing an electronic health information system that will be capable of providing needed health information across disciplines by linking provincial data bases. The system will enable health professionals to compile a relevant, up-to-date electronic health record on a patient. This has such advantages as timeliness, currency and clarity. This approach, however, also raises privacy questions. For example, who will have access to this personal health information? How will that access be controlled? If an individual's personal health information is placed on the system by one health care provider and obtained by another health care provider, who will be responsible for it? Who, for example, will be responsible for any corrections of the information?

In 2007, our office was invited to sit on the newly formed Provincial Privacy and Security Council, with membership from various Manitoba health organizations and disciplines. The Council is responsible for identifying the privacy and security requirements that an interoperable electronic health record, must meet to protect individuals' privacy. I accepted the invitation and sit as a non-voting member of the Council to maintain the independence of our office. I am pleased that our office will have an ongoing opportunity to comment on the privacy considerations of this initiative that is important to all Manitobans.

The Privacy Forum on Electronic Health Records

Nationally, there is an initiative to build a common framework for federal, provincial and territorial electronic health information systems that will enable these data bases to communicate with each other. This will make possible a Canada-wide interoperable electronic health record. This is related to, and has similar advantages and challenges as the provincial model described above. The Canada-wide model raises further issues of accountability for personal health information that travels across provincial or territorial borders.

In 2007, Canada Health Infoway, which is leading this national initiative, invited the participation of the federal, provincial and territorial health ministries and Privacy Commissioner offices, to jointly consider the privacy issues raised by the project. Our office is participating in the ongoing discussions with our colleagues from across Canada.

Federal No-Fly List Program

The federal Passenger Protect Program, also known as the no-fly list, came into effect on June 18, 2007. This initiative prevents individuals who have been deemed an immediate threat to aviation security from boarding a domestic or international flight in Canada or boarding a flight destined for Canada. The program raises several privacy concerns. For example, Transport Canada has not provided assurances that the names of individuals on the list will not be shared with other countries. There is a very real risk that people will be stopped from flying because they have been incorrectly listed or have the same name as someone on the list. If that happens, there is no right of appeal.

Federal, provincial and territorial Privacy Commissioners have jointly called on the federal government to suspend the no-fly list or, alternatively, ensure that the program functions under strict ministerial scrutiny with regular public reports until a comprehensive Parliamentary review is completed and necessary reforms are made.

SYSTEMIC INVESTIGATIONS AND AUDITS

In our 2006 Annual Report, I reported on the development of our systemic investigation tool, an expedited team investigation model to address concerns that affect large numbers of people at one time. In July 2007, an existing staff position was converted to the position of Senior Investigator, responsible for systemic investigations. This senior investigator position reports directly to the Ombudsman and is responsible for working with managers to plan, conduct, and report on systemic investigations.

Last year, I reported on *Strengthen the Commitment*, the September 2006 report on a systemic investigation of the child welfare system. The provincial government committed to fully implementing the recommendations of the report and I indicated that my office would monitor and report on its implementation efforts and results. Because of the extensive work needed to implement the recommendations in *Strengthen the Commitment,* I will issue a separate report on the government's efforts to March 31, 2008.

I also reported last year on an audit of Manitoba Conservation conducted under our access and privacy legislation, which gives the Ombudsman the authority to conduct audits and make recommendations to monitor and ensure compliance with the law. The audit identified several areas where improvements were needed to benefit both the department and the public. The department accepted my recommendations. In 2007, my office monitored the department's efforts to implement those recommendations and a summary of our observations is contained in the Access and Privacy Division section of this report.

In late 2007, we completed our systemic investigation of the licensing and enforcement practices of Manitoba Water Stewardship. During the investigation, we noted that the department was undergoing a significant restructuring and received a substantial increase in the resources available for staff for licensing and enforcement. As well, the department has undertaken a review of critical licensing and enforcement policies. I provided the department with a draft report in December 2007 and invited a response reflecting any changes that might affect our investigative findings and conclusions. The final report of that investigation was issued in April 2008.

In 2007, with the agreement of the Chief Judge of the Provincial Court, we revised our practice for reporting on the implementation of recommendations made by provincial judges in reports on inquests conducted pursuant to *The Fatality Inquiries Act.*

At the end of an inquest, the judge submits a report that may contain recommendations for changes in government programs, policies and practices where, in his or her opinion, such changes would reduce the likelihood of a death in circumstances similar to those that resulted in the death that is the subject of the inquest. Because many of these recommendations are systemic in nature, it is important that our reporting on the government's efforts to implement those recommendations be made public.

In 2008, our reports to the Chief Judge on the implementation of inquest recommendations will be publicly available on our web site. This new practice is intended to better inform the public about the results of inquests and to enhance governmental accountability.

THE PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT

The Public Interest Disclosure (Whistleblower Protection) Act was proclaimed in April 2, 2007. The Act 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 and to investigate disclosures for the purpose of bringing them to the attention of government and to recommend corrective measures.

I am pleased to include in this annual report, our first report on the activities of my office arising from *The Public Interest Disclosure (Whistleblower Protection) Act.*

ONGOING CONCERNS

The Ombudsman Act provides a broad mandate for making recommendations to effect change, including recommendations that laws or policies be reviewed. In my view, this includes identifying administrative issues that require a coordinated response across two or more government departments for effective solutions to be achieved. I have commented on two such issues in the report on the activities of the Ombudsman Division. However, one long outstanding issue that requires resolution immediately is the detention of intoxicated youth under *The Intoxicated Persons Detention Act* in a correctional facility.

Inappropriate Detention of Youth

Police frequently have to detain adults and young people who are intoxicated, but are not being charged with an offence. They are in need of care and a safe place where they can be supervised until they sober up or "detox" to the point where they may safely be released.

While some adults are held in police holding cells, others are detained in community facilities. No such facilities exist for youth. Youth are detained in at the Manitoba Youth Centre, a correctional centre.

My office has reported on this issue since 1998. Government has been discussing the issue for at least that long. In 2005, my office made a formal recommendation to the Minister of Justice

that the practice cease. In 2006, in writing to the Deputy Ministers of Justice, Family Services and Housing and Health, we advised that this has been a long-standing issue, the successful resolution of which will need to involve several departments. We were advised that the matter had been referred to the Healthy Child Manitoba Deputy Ministers' Committee, that the committee continues to meet to study this issue, and that …*all of the departments have indicated that the situation constitutes a shared responsibility and requires a willingness to work together to find creative options and solutions.*

The issue does not require continued study or analysis and is one that the authorities responsible have been aware of for over a decade. It is an issue on which there is consensus: intoxicated youth should not be detained in jails. It is clear that a resolution will not be achieved unless the ministers responsible impose a deadline to end this inappropriate practice.

THE OFFICE OF THE OMBUDSMAN

The Ombudsman is an independent officer of the Legislative Assembly and is not part of any government department, board or agency. The Ombudsman has the power to conduct investigations under *The Ombudsman Act*, *The Freedom of Information and Protection of Privacy Act, The Personal Health Information Act,* and *The Public Interest Disclosure (Whistleblower Protection) Act*.

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

The Intake Services Team

The Ombudsman Division

The Access and Privacy Division

THE INTAKE SERVICES TEAM

Intake Services responds to inquiries from the public and provides information about making complaints under *The Ombudsman Act*, *The Freedom of Information and Protection of Privacy Act*, *The Personal Health Information Act* and *The Public Interest Disclosure (Whistleblower Protection) Act*. Intake Services analyzes each complaint to determine jurisdiction and provides information after review of referral and appeal options. Information is provided about how to address concerns informally and how to submit a complaint to the Ombudsman. Individuals may contact Intake Services for additional assistance if matters cannot be resolved or if additional information is needed. The team also gathers information to start an investigation.

The number of issues resolved at the intake stage has continued to increase. Intake staff are often able to contact a respondent department or agency to clarify or expand upon the reasons for an action or decision, and then convey that information to a complainant. Intake staff can clarify the authority for an action or decision, based upon their experience and knowledge of statutes, regulations and government policies. In other instances, intake staff can review information a complainant has already received to ensure that he or she understands it. Information provided by Intake Services about problem solving can be a valuable tool to assist individuals in resolving issues on their own. The ability to resolve concerns informally and

quickly reduces the need for formal investigation.

When a complaint cannot be resolved, Intake Services is responsible for gathering and analyzing information in preparation for the complaint investigation process. This can involve gathering documents, researching applicable policy and preparing background reports on the history of a complaint or issue. In 2007, an investigator was transferred into this unit from the Ombudsman Division to enhance the capacity of the Intake Services Team.

In 2007, 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)	2264
Cases resolved by Intake Services	141
Cases opened for the Ombudsman Division	175
Cases opened under *The Public Interest Disclosure (Whistleblower Protection) Act*	1
Cases opened for the Access and Privacy Division	401
Total Contacts	**2982**

In addition to the inquiries and activities described above, administrative staff in the office received 2100 general telephone inquiries where the caller was assisted or provided with information, without referral to Intake Services or investigators.

THE OMBUDSMAN DIVISION

The Ombudsman investigates complaints from people who feel that they have been treated unfairly by government. "Government" includes provincial government departments, crown corporations, and other government entities such as regional health authorities, planning districts and conservation districts. It also includes all municipalities. The Ombudsman cannot investigate decisions made by the Legislative Assembly, Executive Council (Cabinet), the

Courts or decisions reflected in municipal policy by-laws.

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 of the public's everyday interactions 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 through the application of laws, policies, and rules where the public encounters most problems or faces decisions they feel are unfair or unreasonable. These are the "matters of administration" about which a person who feels aggrieved can complain to the Ombudsman.

In addition to investigating complaints from the public, the Ombudsman can initiate 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 any gap between government policy and the administrative actions and decisions intended to implement those policies.

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 that 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 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 that 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 is 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.

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 investigations ensure that her investigations will be thorough.

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

THE ACCESS AND PRIVACY DIVISION

Under the provisions of *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA), 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.

FIPPA 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 Ombudsman has jurisdiction over public bodies, which 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.

PHIA 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 Ombudsman has jurisdiction over trustees, which 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.

Under FIPPA or PHIA, a person can complain to the Ombudsman about various matters, including if he or she 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.

After completing an investigation, if the Ombudsman finds that the action or decision complained about is contrary to FIPPA or PHIA, she can make recommendations to the public body or trustee to address the complaint-related issues.

When the Ombudsman has not supported a refusal of 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 FIPPA, 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 under the Acts, she may disclose information to the Minister of Justice, who is responsible for determining if any charges will be pursued through prosecution in Court.

Access and privacy matters are complicated. Manitoba Culture, Heritage, Tourism and Sport provides information on FIPPA, 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 appeal to court at www.gov.mb.ca/chc/fippa/index.html.

Manitoba Health provides information on PHIA, including an informative Question and Answer section 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.

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 PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT

The Public Interest Disclosure (Whistleblower Protection) Act was proclaimed as law in Manitoba on April 2, 2007. The Act identifies the Ombudsman as one of the parties to whom a disclosure may be made, and sets out other specific duties in responding to disclosures, investigating allegations of wrongdoing, and reporting on activities arising from the Act.

The Act applies to provincial public sector bodies such as departments, Crown corporations, regional health authorities, statutory child and family services agencies and authorities, and independent offices of the legislative assembly. As of October 1, 2007, the Act also applies to designated bodies, where at least 50% of the funding of the organization is provided by the government. This includes universities, child-care centres, agencies that provide support services to adults and children, social housing services, family violence crisis shelters and licensed or approved residential-care facilities.

The Act gives government employees and others a clear process for disclosing significant and serious wrongdoing in the Manitoba public service, and provides protection from reprisal. The Act defines wrongdoing as:

- an act or omission that is an offence under an Act or regulation (breaking the law);
- an act or omission that creates a substantial and specific danger to the life, health or safety of persons or the environment (not including dangers that are normally part of an employee's job);
- gross mismanagement, including mismanaging public funds or a public asset (government property); and

- knowingly directing or advising someone to commit any wrongdoing described above.

The Ombudsman is responsible for responding to requests for advice, responding to and investigating disclosures of wrongdoing, referring matters to the Auditor General where appropriate and reporting annually to the Legislative Assembly. Although each government department must have a designated officer to deal with disclosures, smaller bodies for whom this would not be practical can request an exemption from this requirement. Those requests are made to the Ombudsman, who can either approve or deny an exemption. In 2007, 99 of 107 contacts about the Act related to this provision.

The Ombudsman also has the authority to arrange for legal advice for employees and others involved in a disclosure or investigation under the Act, if she considers it to be necessary to further its purposes.

The following table provides a summary of activities for 2007 under *The Public Interest Disclosure (Whistleblower Protection) Act*.

Inquiries Received	5
Disclosures received and not investigated	2
Disclosure received and opened for investigation	1
Exemption Requests approved	39
Exemption Requests denied	60
Total Contacts	**107**

The office received five inquiries about the Act that resulted in information being provided. In one of those instances, a referral was made to the Manitoba Labour Board regarding an allegation of reprisal.

Three disclosures of wrongdoing were received, one of which was opened for investigation under *The Public Interest Disclosure (Whistleblower Protection) Act*. The other two disclosures related to matters of administration and were investigated under *The Ombudsman Act*.

Information about *The Public Interest Disclosure (Whistleblower Protection) Act* can be obtained at: http://www.gov.mb.ca/csc/whistle/links.html

BUDGET AND STAFFING FOR 2007/08

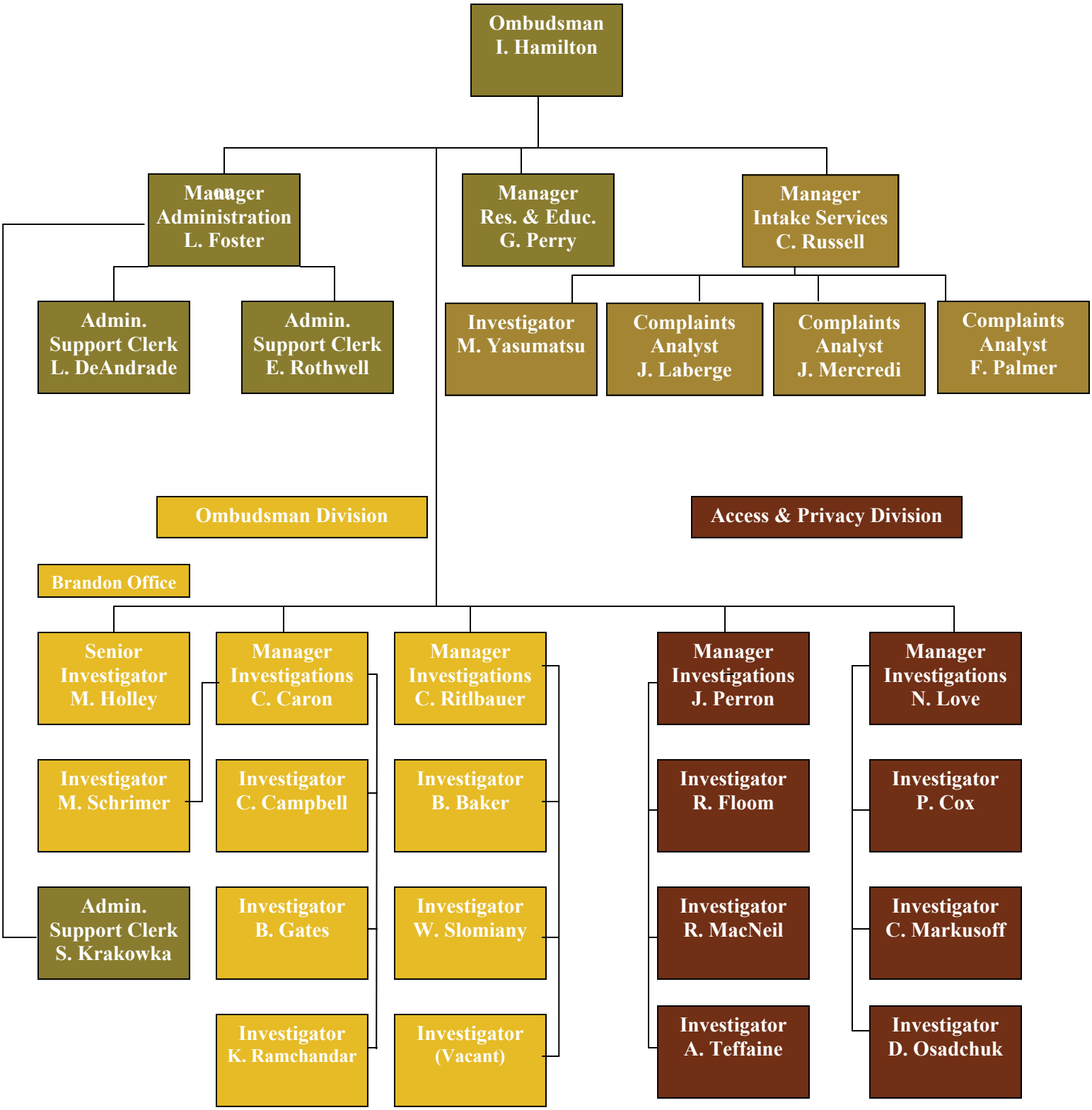
Our budget of $2,622,000 for salaries and other expenditures is broken down as follows:

Total salaries and employee benefits for 30 positions		$2,160,600
Positions allocated by division are:		
Ombudsman Division	11	
Access and Privacy Division	8	
General	11	
Other expenditures		$461,400

Staffing

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

ORGANIZATIONAL CHART



Report on the Activities of the Ombudsman Division

OVERVIEW OF 2007

In 2007, significant resources were devoted to following up on the implementation of recommendations made in *Strengthen the Commitment*, our 2006 report on the child welfare system. As well, my office completed a comprehensive review of the licensing and enforcement practices of Manitoba Water Stewardship.

We have reviewed and strengthened our process for reporting on the implementation of recommendations made by provincial judges after inquests under *The Fatality Inquiries Act.* These changes will allow us to provide more information to the public, and make it easier to track progress in areas where judges have identified a need for improvement.

The ongoing restructuring of our Intake Services team has continued to enhance our capacity to provide information to the public and quickly resolve complaints where full scale investigations are not required. This transition has provided investigators with more time for difficult cases that are opened for investigation.

As well, I am publicly reporting on cases where recommendations made have not been accepted or adopted, with the goal of making these matters subject to further discussion by those interested in and responsible for administration in these areas.

For the same purpose, I have commented on a number of issues where deficiencies have been identified in the delivery of government programs, but the solutions are beyond the capacity of the department responsible alone. Effective solutions to these issues require coordination and collaboration across two or more government departments.

UPDATE ON THE CHILD WELFARE REVIEW

Implementation of the Recommendations *Strengthen the Commitment* 2007

In March 2006, the Minister of Family Services and Housing asked the Ombudsman, the Children's Advocate and the Executive Director of Tikinagan Child and Family Services to

conduct a review of the opening, closing and transfer of cases in the child welfare system.

The report of that review, *Strengthen the Commitment*, was submitted to the Minister on September 29, 2006 and contained over 100 recommendations designed to improve the administration of the child welfare system in Manitoba. On October 12, 2006, the Minister announced that the government would work with the Métis and First Nations Authorities towards the implementation of the recommendations in the report and two other reports related to child welfare, and committed $42 million over the course of the next three years to do so.

On October 13, 2006, the Minister announced the launch of *Changes for Children*, an action plan to implement more than 220 recommendations made in the reviews of the child welfare system, including those made in *Strengthen the Commitment*.

He also announced that *…public accountability for the action on the recommendations will be enhanced with report cards on action taken to be released by…the ombudsman on the review of the child welfare system for the fiscal years 2007/08 and 2008/09*. My 2007/08 report will be submitted separately from this annual report, and will note the progress to March 31, 2008 towards the implementation of the recommendations in *Strengthen the Commitment*.

In our 2007/08 report, we will not comment on the impact of the actions to date as it will take longer for many of the changes to have a measurable impact at the front lines for children and families.

THOMPSON HOLDING CELLS

Background

The Thompson Holding Cells (THC) is a lock up operated by the RCMP. Pursuant to an agreement with the province, provincial remand prisoners awaiting court appearances in Thompson are held there.

After investigating a number of complaints from prisoners about health, food, transportation, hygiene and safety issues, my office opened a general investigation of the THC to look into concerns about prisoner treatment and well-being. The investigation included a review of individual complaint files, discussions with departmental staff and the RCMP, a review of statistical information regarding the number and length of stay of inmates, and site visits to observe existing conditions and practices.

Interim Report

In September 2005, I submitted an interim report to the Deputy Minister of Justice providing an overview of areas of concern relating to inmates generally and to youth in particular. We reported our conclusion that:

> *It is our understanding that this facility was never intended to be a remand facility for youth or adults. While all parties involved seem to be trying to make the best of a difficult situation, based on our review and findings, we feel alternative solutions need to be found.*
>
> *The conditions under which inmates are transported to and from, and housed at, the THC, are by all accounts cause for concern. An urgent matter which needs attention is the housing of remanded youth with adults. The inappropriateness of this situation is exacerbated by housing remanded youth with intoxicated adults detained by the RCMP at the THC.*
>
> *The practice of holding remanded youth at the THC needs to be addressed immediately.*

The areas of concern identified in the report which we have continued to monitor are:

Housing Male and Female Youth and Adults

The THC houses youth and adult, male and female prisoners in the same area. Although they are separated by cells, male and female adults can verbally communicate with each other, as well as with youth housed in nearby cells.

Remand and Transport

Prisoners required to appear in court in Thompson are moved back and forth from The Pas Correctional Centre, or if they are a young person, between the Manitoba Youth Centre in Winnipeg and Thompson. They are sometimes transported together and are often held in the THC for two or more days waiting for court.

Physical Structure

The Thompson Holding Cells are a block of eleven cells and three intoxicated persons' detention cells, on either side of a long hallway. At one end of the hall is the sally port – the garage that allows Sheriff's vans to drive into the cell area through garage doors. Due to the access of the garage to the holding cell area, heating in the winter and cooling in the summer can be difficult to control. Also poor ventilation often results in lack of air movement and an oppressive odor.

Health and Well-Being

Prisoners are allowed to shower only on Monday, Wednesday or Friday nights. Prisoners are not allowed to have soap, a comb or toothbrush, toilet paper or feminine hygiene products in their cells, as are permitted in cells in correctional centres. This results in some prisoners appearing in court after up to two days in the cells without having had any opportunity to shower, brush their teeth, comb their hair or change out of dirty or soiled clothing.

Under a contractual arrangement, food is provided by a local restaurant. However, there is no provision for meals that will meet medical and religious requirements of inmates. If prisoners being transported into Thompson arrive after lunches have been given to the inmates in the cells, they may not eat until supper.

Telephone Contact

Prisoners do not appear to be receiving adequate telephone access for the purpose of remaining connected to their families or their communities, to contact their lawyers, or to raise concerns with outside bodies such as our office.

Short Term Solutions

Justice has implemented some interim measures to attempt to alleviate some of the concerns at the THC. These involve moving remanded prisoners to Thompson less frequently, keeping remand prisoners in Thompson for the shortest time possible, and making some improvements in the conditions in THC. These efforts are a step in the right direction. We continue to investigate complaints and observe conditions at the THC, and to communicate with the department to monitor its efforts to resolve these issues. Given the seriousness of these issues and the lengthy period of time these concerns have existed, I have asked the department for a status report on these improvement efforts, and will continue to do so on a regular basis.

Long Term Solutions

While the department's efforts are commendable in attempting to reduce the negative impacts of the conditions at the THC, they are not a substitute for the long term solutions that are needed, and should not deflect the pursuit of such solutions.

It is my understanding that Justice may be considering whether the construction of a correctional facility in the Thompson area is feasible. This would require a significant capital expenditure for construction, followed by significant annual operating costs.

Our review of this matter confirms that the conclusions and recommendations of the Aboriginal Justice Inquiry are as valid today as they were in 1991. The recommendations of the AJI included:

> ***5.6*** *Aboriginal communities be provided with resources to develop bail supervision and other programs that will serve as alternatives to detention.*
>
> ***5.7*** *Young offenders be removed from their community only as a last resort and only when the youth poses a danger to some individual or to the community.*

There may also be merit for Justice, in collaboration with all stakeholders in the north, to consider community-based solutions that include community programs designed to address the root causes of conflict with the law, in combination with community bail management.

Justice should also consider the establishment of a separate and secure place to house youth awaiting trial in the Thompson region. Holding and transporting youth with adults should not be an option.

INQUEST RECOMMENDATIONS

The Fatality Inquiries Act provides that the Chief Medical Examiner may direct that an inquest be held into the death of a person. Those inquests are presided over by provincial judges.

Subsection 19(3) of *The Fatality Inquiries Act* provides that inquests are mandatory where there are reasonable grounds to believe:

> *(a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility defined in the Mental health Act, or while a resident in a developmental centre as defined in The Vulnerable Persons Living with a Mental Disability Act died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or*

(b) that the person died as a result of an act or omission of a peace officer in the course of duty.

In recent years, the majority of the inquests have been mandatory pursuant to this provision.

Following an inquest, the judge submits a report and may recommend changes in the programs, policies and practices of government where in his or her opinion such changes would reduce the likelihood of a death in circumstances similar to those that resulted in the death that is the subject of the inquest.

Many of the deaths into which an inquest is held occur in circumstances that could also be the subject of an investigation by the Ombudsman. In 1985, in order to avoid duplicate investigations, the Chief Medical Examiner and the Ombudsman developed a protocol by which they agreed that if a death were the subject of an inquest, the role of the Ombudsman would be to follow up with the provincial government department, agency, board or commission to which inquest recommendations were directed.

Following receipt of the inquest report, the Ombudsman contacts each public sector body to which a recommendation is directed to determine what action is being taken. When a satisfactory response has been received from each entity involved, a letter is sent to the Chief Judge of the Provincial Court advising him of the responses to the recommendations made in the inquest report.

The inquest reports are published on the Manitoba Courts web site. To date, the reports of the Ombudsman to the Chief Judge have not been published and the public has not been able to see the departments' responses to the recommendations.

In order to provide greater transparency to this process, the Chief Judge has agreed that the Ombudsman may publish the letters that are written to him reporting on the responses of the departments to the recommendations contained in inquest reports. It is my intention to publish these letters on the Ombudsman web site.

In order to provide some context for the public, the web site will also provide information about the deceased, the inquest and the recommendations made. The web site will also include links to the full text of the inquest report.

This system of reporting will commence in 2008, and will initially include all inquests where the response from the Ombudsman to the Chief Judge is pending. It will not include inquests where the response has been sent and the Ombudsman file is closed. As reports are received, they will be added to the web site.

CASES OF INTEREST

MANITOBA JUSTICE

Each year we receive hundreds of telephone calls and dozens of written complaints from inmates, both youth and adults, alleging that they have been treated unfairly in provincial jails.

Jail populations are growing. The average daily adult custody population in Manitoba in 2004/05 was 1147, in 2005/06 it was 1348 and in 2006/07 it increased to 1497. This is a 31% cumulative increase in the average adult custody population in two years. In youth corrections, the cumulative two year increase was 22%.

These numbers include both sentenced prisoners and inmates who are awaiting trial and are presumed innocent. In 2005/06, the percentage of the total custody population awaiting trial was 64%. In 2006/07 it was 66%.

The importance of a healthy correctional system is most apparent when one considers the broad purposes and mandate of that system. *The Correctional Services Act* espouses three purposes in furtherance of a *…safe, just and peaceful society…*

- *the appropriate degree of custody, supervision and control essential for public safety;*
- *the safe, secure and humane accommodation of persons in lawful custody; and*
- *appropriate programs, services and encouragement to assist offenders to lead law-abiding and useful lives.*

The task of meeting these purposes is the responsibility of the Corrections Division of Manitoba Justice. This task is becoming more difficult with the increasing complexity of the inmate population and an aging infrastructure.

We investigate each corrections complaint within our jurisdiction by examining the facts of the complaint in an effort to determine if the inmate has been treated fairly. In most cases, this involves making a determination of whether the inmate has been treated in accordance with existing rules.

Our investigations of individual complaints sometimes result in the identification of broader issues that relate to the fairness of those rules, and of the administration of the correctional system as a whole. The cases that follow represent our findings in relation to some of those issues.

In 2007, my office identified a number of cases involving Manitoba Justice where our investigations had disclosed serious concerns that have been raised in past investigations and have not been resolved. The difficulty lies in the fact that the solutions require the collaborative action of other departments with Justice to fully address the issues identified.

High Risk- High Needs Inmates

Inmates who are living with mental illnesses or mental disabilities can be at high risk when they are incarcerated, and have higher needs than the general custody population. A correctional centre does not have the capacity to meet the needs of inmates who fall into this category. For a number of years, my office has been concerned with what happens to high risk, high needs inmates when they are incarcerated.

Manitoba Justice alone cannot address all the issues arising from the detention of vulnerable and mentally ill people in correctional facilities. It is both unrealistic and unreasonable to expect them to do so. Solutions must be achieved through a planning and implementation process that includes Manitoba Justice, Manitoba Health, and Manitoba Family Services and Housing (FSH).

Vulnerable Persons in Correctional Facilities

Many people who are living with a mental disability receive services from FSH when they are in the community. If they are in conflict with the justice system and are remanded into

custody in a provincial correctional centre, their essential community services can be lost, with devastating consequences for the individual.

The Vulnerable Persons Living With a Mental Disability Act acknowledges that vulnerable people who may be at risk in society require protection. A vulnerable person's risk is heightened in correctional facilities, both because of the environment itself and because of behavioral issues that may arise from or be exacerbated by their incarceration.

Correctional staff have acknowledged the difficulty of identifying a vulnerable person within the inmate population, and of dealing with the often complex issues and behaviors that may arise from their disability. They acknowledge that because their responsibility is for custody and control of inmates, they lack the specialized knowledge and training to deal with inmates who are vulnerable persons. It does not seem appropriate that correctional officers are placed in the position of delivering long-term care for individuals who would be more appropriately served by community services workers who have the necessary expertise to address the special needs of these individuals.

Resulting from our investigation of an individual complaint, the Winnipeg Remand Centre and FSH have developed a protocol that will allow correctional staff to determine if an individual is in fact a client of the Supported Living Program of FSH. If so, FSH staff can provide information to assist correctional staff in addressing challenging behaviours. The protocol states that if the individual is to be in custody for an extended period, the assigned community services worker should arrange to visit the vulnerable person on a regular basis to ensure their well-being and to support correctional staff in dealing with the individual appropriately.

However, a greater concern is the often protracted detention of a vulnerable person in a correctional centre. When a vulnerable person is incarcerated, he or she often has lost or loses their placement in the community. Therefore, there is nowhere to which he or she may be released, resulting in their continued detention in a correctional facility. The protocol does not provide guidance on how to obtain community placements for vulnerable persons to which they could be released.

Because the issue remains unresolved, I wrote to the Deputy Minister, FSH at the end of 2007 to advise him of my position that finding community placements needs to be a high priority. I advised the Deputy Minister that we have reviewed cases where vulnerable inmates appear to have deteriorated within the correctional setting. These inmates were potentially vulnerable to the predatory behavior of other inmates with whom they may come in contact. They were often in isolation for 23 hours a day and force was needed to manage problematic behavior.

We have recently been advised by the department that this matter continues to be studied, with a further report expected in the fall of 2008. My office will continue to investigate any complaint relating to a vulnerable person in custody as a priority. While the department continues to work towards a solution, I have suggested to the department that the existing protocol between FSH and the Winnipeg Remand Centre be applied province wide.

Our discussions with FSH and Corrections about this issue began in 2005, and while we understand that there are relatively few people in this situation, the fact that any vulnerable person must remain in custody because they have nowhere else to go is unacceptable.

Mental Health Services in Correctional Facilities

People who are living with mental illnesses have access to a broad range of services in the community through Manitoba Health. When individuals living with mental illness are incarcerated, they are in an environment where the community services are no longer available to them.

Our investigation of individual complaints identified concerns that inmates whose mental health had deteriorated and who required hospitalization in a psychiatric facility remained in correctional facilities on a waiting list for admission to hospital. Because they are in custody, the only acceptable hospital setting for inmates is the secure Forensic Unit at the Health Sciences Centre in Winnipeg.

In 2005, we raised this matter with the Director of Forensic Services and the Executive Director of Adult Corrections. We were advised that demands on the fourteen-bed forensic unit had on

occasion resulted in extended waiting periods. There is ongoing pressure on the unit from a number of sources. This unit treats approximately two hundred and fifty outpatients, most of whom suffer from severe mental illnesses. At any point in time, persons from this group may require admission to hospital because of a deterioration in their condition. Admissions of people from the community usually have priority because their own safety or the safety of others could be compromised by a delay in admission. Priority is also given to people from the community waiting in the emergency ward of the hospital. Admissions may also occur where assessments are ordered by the Courts, or where the Criminal Code Review Board orders a person under its jurisdiction into hospital.

Manitoba Justice, as well as correctional officials across Canada and North America, have acknowledged that there is a problem with incarcerating people whose principal issue is mental illness. In acknowledging that prisons are poor placements for mentally ill people, Corrections advised:

> *The environment and the surrounding population, of which a significant number are sociopathic and sometimes predatory, tend to aggravate the mentally ill person's condition. Our medical and other staff make every effort to mitigate these circumstances but, for the most part, are not specifically trained in this area. Besides, their energies and efforts are diverted to the much greater number of criminal offenders - our purpose for being. We lack the facilities, specialists and pharmaceutical means to adequately address the mentally ill ... Our intervention methods for acting out individuals may not be appropriate for the acutely mentally ill but they are all we have at our disposal.*
>
> *We have, and will continue to improve our capacities but you must understand that our resources are statutorily directed toward public safety and criminal rehabilitation. Given the demands on us and our current overcrowding, our resources are stretched very tight just to maintain basic living and safety standards.*

Manitoba Justice has taken steps to deal with this situation by improving staff capacity to deal with such inmates, and by continuing to identify and raise issues of inmates suffering from mental illness as a cross-departmental concern.

We have been advised that for an individual with an acute mental illness, waiting for treatment can lead to further impairment, delayed recovery and increased residual symptoms. This may also increase the risk of self-harm and self-neglecting behaviour. In addition to the significant consequences for the individual whose mental illness remains untreated while in custody awaiting admission to a hospital, there are also safety concerns for them, for other inmates and correctional staff.

Resolution of this issue requires collaboration between Manitoba Health and Manitoba Justice. These departments must work together to achieve a solution to the critical issues faced by inmates who are mentally ill. We will monitor progress towards this goal and will continue to investigate complaints from individuals in these circumstances as a priority.

MANITOBA PUBLIC INSURANCE

Theft Investigation

Manitoba Public Insurance (MPI) statistics for the year ending February 28, 2007, indicate that of the 269,000 Autopac claims made in the year, over 9,000 were "total theft claims" relating to stolen vehicles.

MPI employs numerous strategies to combat auto theft, including making immobilizers mandatory in most at risk vehicles. It also supports the Winnipeg auto theft suppression strategy (WATSS) which, in 2006, resulted in 964 arrests and 1156 auto theft charges.

On occasion MPI suspects that a stolen vehicle claim is fraudulent. Over the past few years we have received a number of complaints about MPI files that began as auto theft claims by policy holders, but ended up as fraud investigations.

When MPI suspects an auto theft claim is fraudulent it will often be referred to the Special

Investigations Unit (SIU) for further investigation. The SIU works in *...detecting and recovering costs from fraudulent claims*. It consists of more than a dozen specially trained investigators who work with a prosecutor to prosecute those who would commit fraud against the MPI. As far back as 2002, MPI noted that it … *is committed to protecting honest rate payers. While the vast majority of claims are legitimate, we will vigorously investigate potentially fraudulent claims*.

Over the past few years, a number of individuals whose theft claims have been subjected to such vigorous investigations have complained to our office. One wrote that at the end of her experience she felt she had been *...Victimized twice, once by the thieves and [a second time] by Autopac.*

In a number of cases reviewed by our office, MPI became suspicious because they were unable to find obvious physical evidence of theft, such as significant damage to the steering column or ignition mechanism. MPI retains an independent locksmith to verify this and then looks for motive for a fraudulent claim, such as significant mechanical problems.

While this may not be unreasonable, it can place honest claimants in the untenable position of having to explain a theft they have no knowledge about or risk having their claim denied.

As a result of the issues raised by complaints about the handling of theft claims, I wrote to MPI at the end of November 2006 to advise that our office had opened an Ombudsman's Own Initiative investigation to consider the way in which MPI responded to theft claims. That investigation ended in 2007 when MPI advised us that they had *...initiated a review to ensure we are doing all we can to protect Manitobans from this risk and to ensure they receive all benefits to which they are entitled. Accordingly, following meetings with various staff from affected departments we have enhanced our process for theft claims.*

The enhancements included the establishment of a theft claim review committee. We were advised that the committee is a review panel with representatives from claims division, legal department, SIU, training and research department and the auto theft unit. This committee

will be responsible for reviewing theft claims prior to denial, to ensure their handling and recommended decisions are consistent with established procedures.

MPI also advised that they are working on designing an expert investigation outline *...to be used in cases where decisions are heavily based on precise information which technical experts can verify. Consultations with such experts will be useful in the investigation of theft claims involving vehicles equipped with devices such as immobilizers and remote starters.*

MPI Premium Refunds

In 2005, an MPI customer went to an agent to renew the insurance on his vehicle and was told that he had been overpaying premiums, because his vehicle was registered in the incorrect classification. He was told he would be paying a lower premium, but when he enquired about a refund for the previous year's overpayment he was told that no refund would be provided.

This error was discovered because MPI's agent was using the new "VinLink" system that identified registration classes according to the unique vehicle identification number, rather than the former system that used a vehicle description. In response to our inquiries regarding how many vehicle owners MPI was now aware of that had overpaid in the past, we were told:

> *In September 2004 the Corporation examined all of our customers' accounts to determine how many policies had vehicles that were not declared properly at that point in time. We were pleased to learn that almost 90% of our customers had properly declared their vehicles. Of the remaining 10%, only half paid more premium than they would have had they declared their vehicles properly.*
>
> *Not only does this tell us that the vast majority of our customers take care in describing their vehicles, only a small number of those who didn't were negatively affected.*

The number of vehicles represented by the percentages, where the owner had overpaid premiums is approximately 2,000. The overpayments would seem to be based on inadvertent mistakes made during many customer transactions, and that as many as 2,000 people, who as

MPI stated, provided their "best information" to their agents when the system did not provide a correct match, ended up with an incorrect rating.

In response to our inquiries about how the premium prior to 2004 was assessed for our complainant, MPI advised us that:

> *To allow the system to rate a vehicle correctly, Manitoba Public Insurance relies solely on the information customers provide us and verify as accurate. The vehicle description entered on the system is clearly stated on the application that prints at the end of the transaction giving the customer one last opportunity to verify the accuracy of the information that he or she provided. The customer verifies this information as correct by signing the application.*
>
> *Manitoba Public Insurance takes the position that it is the customer's obligation to ensure the description on the application for registration insurance that he or she signs is correct. If it is not correct, the broker should be advised at the time of the transaction, and a correction will be initiated by MPI at that very moment.*
>
> *Mr. (complainant) had the opportunity to point out the discrepancy at the time of the original transaction and each subsequent year upon renewal. Because he did not, his vehicle was rated based on the incorrect information he had provided and verified as correct until the last insurance year. This was not an MPI or broker error, and as such, he is not entitled to a refund*.

MPI had implemented a policy that premium overpayments would not be refunded and premium underpayments would not be pursued.

In light of information from both the complainant and from MPI, we had difficulty accepting MPI's assertion that responsibility for this error rested entirely with the complainant. MPI indicated that when the complainant originally registered and insured his vehicle he *would have been asked to provide further information…* to clarify which insurance class was the one

appropriate for his vehicle. The complainant had no recollection of having such a discussion with the agent. The specific inaccuracy that led to the incorrect registration was that the vehicle was described as a 1991 Toyota-long bed-2 wheel drive rather than a 1991 Toyota-pickup-2 wheel drive.

We advised MPI that while it is difficult to assess the extent of the role played by MPI's agents in transactions resulting in incorrect classifications, one must allow for the fact that agents are an integral part of this process. In response, the MPI advised that:

> *The technology that we used in the past helped our customers when describing their vehicles. However, the full responsibility for ensuring their vehicles were correctly described was, and remains, with the customer. That's why prior to signing the declaration on the registration and insurance certificate, customers are required to check the information and verify its accuracy*.

As a result of the investigation and the exchange of information with MPI, I asked MPI to reconsider its position regarding this policy which I viewed as unfair. Although it has sometimes provided refunds to vehicle owners in its discretion, MPI pointed out that there was no statutory requirement that premium overpayments be refunded.

MPI indicated that it would not be fair or reasonable to all ratepayers, more particularly, those who had taken care to properly describe their vehicles, to issue refunds to those who did not. MPI explained that to provide a refund to all owners who had overpaid would require a labour intensive process that would take dozens of staff many months to complete. It also pointed out that any decision to limit the analysis and recalculation to a period other than when a vehicle was first registered would be arbitrary and significantly more labour intensive, expensive, and time consuming. MPI felt that its ability to pursue critical improvement initiatives that would benefit all Manitoban motorists would be compromised. MPI concluded by stating its belief that the decision was fair, reasonable and balanced in the interest of all policy holders.

However, if the owner who had overpaid were to suffer a total loss of his or her vehicle, the

coverage would have been paid not based on the premium that was paid, but rather based on the vehicle that was owned. The insurance coverage at the higher rate would not be provided. I believe that for the MPI to keep unearned premiums is inappropriate and that the overpayments should have been refunded.

At the end of 2007, I recommended that MPI provide refunds to vehicle owners who have overpaid premiums. MPI refused to accept my recommendation.

CONSENT TO MENTAL HEALTH TREATMENT

The Mental Health Act (the Act) sets out circumstances where people suffering from mental illnesses may be detained and treated without their consent. Appropriately, such treatment is a last resort. For people who suffer from mental illness, losing control over decision making about their health care can be a traumatic experience. It is an issue of personal choice and dignity.

Even when an individual has been found in need of involuntary admission to a mental health centre, consent to treatment must be sought from the patient, or his or her substitute decision maker, unless that treatment is deemed necessary because of emergency circumstances.

In 2007, our office conducted an investigation into the question of whether consent had been obtained for the seclusion of inpatients. A fundamental issue was whether seclusion was a treatment decision for which consent was required. This issue arose at the Selkirk Mental Health Centre, which cooperated with our office in attempting to answer this difficult question.

An inpatient at the Centre had complained to our office about being placed in seclusion. His treating physician had included seclusion in his overall treatment plan. The complainant had been deemed incompetent to make treatment decisions, and therefore was unable to give consent. Consent for treatment had in the past been given by his substitute decision maker; however, such consent had not been sought for the use of seclusion.

The Centre's existing policy indicated that the use of seclusion required only an order by the attending physician. We were advised that no other consent was required for the use of seclusion and that, in fact, seclusion was a standing order for all patients at the Centre.

Our review of the Act suggested that even when the use of seclusion was deemed part of treatment, consent was required unless it was used in an emergency. The Centre initiated a review of its policy. At the same time it adopted an interim procedure that required that consent be obtained, except in emergencies. We were subsequently advised that the Centre's policy has been amended to always require consent for seclusion, except in emergency circumstances.

We expect that because the policy is based on the requirements of *The Mental Health Act* for consent to treatment, and the definition of seclusion as treatment, the policy will be adopted province wide.

Taxicab Board

The taxicab industry in Winnipeg is regulated by provincial statute, *The Taxicab Act.* The provincial Taxicab Board has jurisdiction over matters such as the number of taxicab licences issued and taxicab rates. Anyone wishing to own or operate a taxicab in Winnipeg, or to drive one, requires a licence from the Board.

Although the Board has the sole jurisdiction to grant licences, one of the requirements for obtaining a licence from the board is the production of a Certificate of Good Character from a different body, the City of Winnipeg Record Review Board.

In 2007, an applicant for such a certificate complained to our office after he was advised that *your application for a [certificate] to enable you to obtain a Taxi license has been set aside at this time as our records indicate there are charges pending before the court*.

The existence of the charge effectively precluded the applicant from pursuing employment as a taxicab driver. This scenario appeared to violate the applicant's right to be presumed innocent of a charge until proven guilty.

Because there was no appeal to any higher civic authority, or to the Taxicab Board itself, the decision of the Record Review Board effectively pre-empted any decision by the Taxicab Board on whether the applicant should be granted a licence.

The matter was compounded by the fact that neither *The Taxicab Act* nor the Board provides criteria to be used in determining whether to issue a Certificate of Good Character.

Through no fault of any of the parties involved, this was clearly a case of a gap in the licensing process. That gap, the absence of any established criteria or appeal mechanism, resulted in the applicant being treated unfairly.

When we raised this matter with the Taxicab Board, they agreed that there should be an appeal provision in a situation where the certificate was denied because of pending charges. In implementing a new process which would address these types of situations, they advised;

> *In the situation where a Record Review has been denied by the Record Review Board, the applicant will be advised that a criminal record check and a criminal record transcript can be requested from the Winnipeg Police Service. The applicant can also provide additional supporting documents with respect to his character such as letters of reference. The applicant can then make application to the Taxicab Board to make a decision with respect to the suitability of the applicant to obtain a taxicab driver's licence, pursuant to section 11(2)(a)(ii) of the Taxicab Act.*
>
> *The Taxicab Board will implement this procedure immediately. Information on the alternative method of providing a certificate of good character will be provided to all new taxicab driver licence applicants.*

I believe the Taxicab Board's response achieves the degree of fairness required in this circumstance. While an applicant's pending charges may still be considered, applicants will have an opportunity to make their best case before the body that is ultimately responsible for the decision to grant or deny a licence.

MUNICIPAL CASES OF INTEREST

In 2007, my office concluded investigations concerning complaints about municipalities, two of which are discussed below; the first about the actions of a municipal council and the second about a planning district.

Municipality of Killarney-Turtle Mountain

A local improvement plan is a means by which municipalities can borrow money for large capital projects and then raise the funds through municipal taxes to repay that money.

This investigation involved a municipality that was required by statute to give the public specific information in a notice about a proposed "local improvement plan". The requirement was not met. When members of the public obtained information about the proposed plan through the media and attempted to state their case as a delegation to their municipal council, they were turned away on a technicality.

In early 2007, the Municipality of Killarney-Turtle Mountain (KTM) was in the final stages of approving a new multi-use recreational facility. The project had been initiated years earlier, before the Town of Killarney and the R.M. of Turtle Mountain had amalgamated to form the Municipality of Killarney-Turtle Mountain. Prior to amalgamation, each municipal body had approved a local improvement plan to cover part of the project's financing.

The estimated cost of the project had risen from just over $6 million in 2005, to $10 million. Because of increasing costs, it became necessary for the amalgamated municipality to approve a third local improvement plan, for an additional $2.5 million, bringing the total borrowing to $6.5 million.

For many residents of Killarney-Turtle Mountain, an article published in the "Killarney Guide" on the afternoon of Thursday, April 5, 2007, was the first indication that the cost of the proposed new facility had dramatically increased. It was also when they learned that their municipal council would be meeting the following Wednesday morning to give final approval to this third local improvement plan.

On the morning of Wednesday, April 11, 2007, between fifty and one hundred people attended the council meeting, some in the council chamber itself and others outside in the hallway or on the sidewalk in front of the building. They wanted to speak to their elected representatives. One of the delegation present also wanted to present Council with one hundred copies of a letter asking council to *...re-consider the financial cost…of the proposed New Facility complex and the* ***total burden*** *it will place on the taxpayers of the Rural Municipality of Killarney-Turtle Mountain for many years to come*.

Because the municipal office had been closed on Friday and Monday, for Easter, a motion was required to dispense with the rule stating that delegations to council must give 5 days notice of their intention to appear. The Mayor proposed such a motion. It was defeated.

Moments later, councillors voted to give second and the third (final) reading to the local improvement plan, authorizing the additional borrowing. Immediately following that vote, the Mayor resigned and left the table.

Residents complained to our office that they had not been made aware of the increase in cost, and the associated increase in their property tax burden, and that they had been denied an opportunity to speak to their municipal council when the true cost of the project was finally made public.

Our review concluded that the notice of the public hearing concerning the local improvement plan contained no information about: the estimated costs of the local improvement and the period of the years over which it was to be spread; the anticipated sources of funding to pay for the local improvements and the portion of estimated costs to be paid by each source; the estimated amount of money to be borrowed, the maximum rate of interest and the terms of repayment of the borrowing; or how the annual operation or maintenance of the local improvement was to be funded. Provincial law requires that all of this information be provided.

While it was suggested that most residents were aware of the cost of the project, we concluded that that the missing information was critical, particularly at that stage, because the cost of the

project had escalated well beyond the cost that was stated by the municipality in 2005. We concluded as well that the absence of the information had impeded the ability of taxpayers to decide if they should attend the public hearing or make efforts to find out more about the local improvement plan.

On that basis, we recommended to KTM that they hold a public meeting to provide the residents with information about the cost and financing of the facility and to hear residents' views on the costs and benefits before proceeding to give final approval to the construction contract.

Our investigation also found that there had been a breakdown in the oversight mechanism through which local improvement plans are reviewed by Manitoba Intergovernmental Affairs before being submitted to the Municipal Board for final approval. Accordingly, I recommended to Intergovernmental Affairs that it review and alter its practice when processing proposed local improvement plans, specifically to include standard requirements for public notices.

Both the municipality and Intergovernmental Affairs accepted my recommendations. Immediately following, KTM held a public meeting to provide full disclosure of the financial implications of the local improvement plan. We were subsequently advised that over one hundred people attended the meeting to hear the information provided and to express their views. While the municipal council ultimately decided to proceed with the contract to complete the project, the meeting and airing of public concerns met the intention of the statutory requirements imposed upon the municipality and served to restore transparency and accountability to the process.

In accepting my recommendations, Intergovernmental Affairs concluded that the recommendations would enhance their due diligence process. Prior to the end of 2007 the department had given effect to the recommendation by including the enhanced notice requirements in the Municipal Act Procedures Manual it distributes to all municipalities.

Selkirk and Area Planning District Board

Municipalities and their Planning Districts are the stewards of municipal land use, responsible for overseeing development in an orderly fashion that fosters necessary growth, while protecting existing public rights. Private developers perform an essential function in municipal growth, and can assume significant financial risk in developing new projects. Clear ground rules and effective communication are essential to a successful relationship between these parties.

In the case below, inadequate communication proved to be the source of a complaint about the Selkirk and Area Planning District Board (known as Selplan).

Depending on the location, size and nature of a proposed development, that development may require various municipal actions or approvals. These can include a zoning by-law amendment, a variance or conditional use approval or a sub-division approval. The requirements for each are set out in *The Planning Act,* as are the respective roles of municipal councils and planning districts, either of which may be an "approving authority" under the Act.

Typically, the action or approval required from an approving authority by a developer is initiated by a formal written application, with supporting documentation demonstrating the merits of the application. Planning district staff review the information and prepare a report, which can include recommendations to the approving authority. Depending on the nature of the specific application, there may be input from various interested parties followed by a public hearing. It is not unusual during the early stages of this process for the developer and the planning district staff to communicate for the purpose of clarifying information.

In this case, the developer wanted access to the report by planning district staff to the authority before the public hearing. The developer felt that fairness dictated that he receive a copy beforehand in order to properly prepare for the hearing. Selplan's normal practice was to share reports with the applicants (developers) when the reports were presented at the public hearings.

Selplan advised that in some cases formally providing the report to the applicant prior to the hearing is not possible because it has not received all of the information requested from other sources in time to permit this. However, Selplan advised that once it submits a report to an authority, any interested party may ask to review it.

Based on our review, our opinion was that Selplan should review its procedure for providing timely information, such as its reports and recommendations to Council, to applicants prior to the commencement of public hearings to ensure fairness, openness and transparency, as well as the perception that these principles are being applied.

Selplan responded that they would *…follow through on your recommendation that we should review our information disclosure procedure.* We received a copy of their new policy on Planning Report Disclosure, which requires that reports in respect of zoning by-law amendments, conditional use uses and variances, development plan amendments and sub-division applications be sent to applicants when they are sent to the respective municipality.

It should be noted that this was not a case where we found that the planning district had treated the applicant unfairly, considering all of the circumstances, but one in which the principle of best practices required that a procedure be written and adopted as organizational policy.

STATISTICAL REVIEW OF 2007

The following table provides a summary for 2007 of the work done by the Ombudsman Division by tracking cases opened and the disposition of cases closed.

Cases carried over into 2007	144
New cases in 2007	175
Total cases in 2007	319
Total cases closed 2007	203
Pending at December 31, 2007	116

Of the 203 cases closed in 2007:

22% were resolved;

7% were partly resolved;

1.5% were concluded by recommendation;

32% were not supported;

8% were completed;

17% were concluded after information was provided;

11% were discontinued either by the Ombudsman or the complainant;

1.5% were declined.

CASES OPEN IN 2007 AND DISPOSITION OF CLOSED CASES

Department or Category	Carried over into 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
PROVINCIAL GOVERNMENT DEPARTMENTS	**108**	**115**	**223**	**84**									
Aboriginal & Northern Affairs	**2**	**1**	**3**	**2**									
General	1	1	2	1	-	-	-	-	-	-	1	-	-
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	-	1
Advanced Education & Literacy	**1**	**1**	**2**	**-**									
General	-	1	1	-	-	-	-	-	-	-	1	-	-
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	-	1
Agriculture, Food & Rural Initiatives	**1**	**3**	**4**	**1**									
Manitoba Crop Insurance Corporation	1	3	4	1	-	-	-	3	-	-	-	-	-
Conservation	**16**	**6**	**22**	**4**									
General	7	2	9	2	-	1	-	-	5	-	1	-	-
Water Stewardship	8	4	12	1	-	-	5	-	1	1	4	-	-
Ombudsman's Own Initiative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-
Education, Citizenship & Youth	**1**	**-**	**1**	**-**									
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	-	1
Family Services & Housing	**25**	**11**	**36**	**17**									
General	6	1	7	2	-	-	-	1	1	-	3	-	-
Child & Family Services	5	2	7	1	-	-	2	-	2	2	-	-	-
Employment & Income Assistance	4	2	6	5	-	-	-	-	-	-	1	-	-
Manitoba Housing Authority	-	2	2	-	-	-	-	1	-	-	1	-	-
Social Services Advisory Board	2	-	2	1	-	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative-OOI	8	4	12	8	-	-	-	-	-	-	1	-	3
Finance	**4**	**9**	**13**	**3**									
General	2	-	2	-	-	-	-	2	-	-	-	-	-
Automobile Injury Compensation Appeal Commission	-	3	3	1	-	-	-	2	-	-	-	-	-
Residential Tenancies Branch	-	2	2	-	-	-	-	1	1	-	-	-	-
Residential Tenancies Commission	2	2	4	-	-	-	-	1	3	-	-	-	-
Securities Commission	-	1	1	1	-	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative-OOI	-	1	1	1	-	-	-	-	-	-	-	-	-

CASES OPEN IN 2007 AND DISPOSITION OF CLOSED CASES

Department or Category	Carried over into 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
Health	**17**	**12**	**29**	**16**									
General	4	4	8	4	-	-	-	1	1	1	1	-	-
Mental Health	3	1	4	-	-	-	-	1	2	1	-	-	-
Regional Health Authority	2	2	4	2	-	-	-	1	-	-	1	-	-
Ombudsman's Own Initiative-OOI	8	5	13	10	-	-	-	-	-	-	1	-	2
Infrastructure & Transportation	**4**	**4**	**8**	**2**									
General	3	4	7	2	-	-	1	-	3	-	1	-	-
Ombudsman's Own Imitative-OOI	1	-	1	1	-	-	-	-	-	-	-	-	-
Intergovernmental Affairs & Trade	**3**	**1**	**4**	**1**									
General	1	1	2	-	-	-	-	-	2	-	-	-	-
Ombudsman's Own Imitative-OOI	2	-	2	1	-	-	-	-	-	-	-	-	1
Justice	**32**	**65**	**97**	**35**									
General	1	4	5	3	-	-	-	-	2	-	-	-	-
Brandon Correctional Centre	-	7	7	4	-	-	2	-	-	-	1	-	-
Headingley Correctional Centre	1	12	13	-	-	-	-	-	5	2	6	-	-
The Pas Correctional Centre	-	1	1	1	-	-	-	-	-	-	-	-	-
Portage Correctional Centre	1	3	4	1	-	-	1	1	-	-	1	-	-
Thompson Holding Cells	-	1	1	1	-	-	-	-	-	-	-	-	-
Winnipeg Remand Centre	1	7	8	2	-	-	-	1	3	1	1	-	-
Maintenance Enforcement	-	3	3	1	-	-	-	-	1	-	1	-	-
Human Rights Commission	6	6	12	3	-	-	-	1	7	1	-	-	-
Law Enforcement Review Agency	-	2	2	-	-	-	-	1	-	-	1	-	-
Legal Aid Manitoba	5	2	7	-	-	-	2	2	2	1	-	-	-
Public Trustee	1	2	3	-	-	-	-	2	-	1	-	-	-
Manitoba Youth Centre	-	3	3	-	-	-	-	-	-	1	2	-	-
Ombudsman's Own Initiative-OOI	16	12	28	19	-	-	-	1	-	1	3	-	4
Labour & Immigration	**2**	**2**	**4**	**3**									
General	-	1	1	1	-	-	-	-	-	-	-	-	-
Manitoba Labour Board	1	-	1	1	-	-	-	-	-	-	-	-	-
Pension Commission	-	1	1	1	-	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	-	1

CASES OPEN IN 2007 AND DISPOSITION OF CLOSED CASES

Department or Category	Carried over into 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
BOARDS & CORPORATIONS	**17**	**36**	**53**	**18**									
Workers Compensation Board	1	5	6	3	-	-	1	-	1	-	1	-	-
WCB Appeal Commission	-	3	3	1	-	-	-	1	1	-	-	-	-
Corp. & Extra Departmental	**1**	**4**	**5**	4									
Manitoba Hydro	1	2	3	2	-	-	-	-	1	-	-	-	-
Manitoba Lotteries Corporation	-	1	1	1	-	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative-OOI	-	1	1	1	-	-	-	-	-	-	-	-	-
Manitoba Public Insurance	**15**	**24**	**39**	**10**									
General	14	24	38	10	-	-	-	3	15	2	6	2	-
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	1	-	-	-	-
MUNICIPALITIES	**19**	**23**	**42**	**14**									
General	10	10	20	4	-	-	4	7	2	-	2	1	-
City of Brandon	2	3	5	2	-	2	1	-	-	-	-	-	-
City of Dauphin	-	1	1	1	-	-	-	-	-	-	-	-	-
City of Winnipeg	4	6	10	3	-	-	1	1	2	-	2	-	1
Conservation District	-	1	1	1	-	-	-	-	-	-	-	-	-
Local Planning District	1*	2	3	3	-	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative-OOI	2	-	2	-	-	-	1	-	-	-	-	-	1
NON-JURISDICTIONAL	**-**	**1**	**1**	**-**									
Private Matters	-	1	1	-	-	-	1	-	-	-	-	-	-
TOTAL CASES	**144**	**175**	**319**	**116**	-	3	22	35	65	15	44	3	16

* In 2006 this case was reported under Municipalities - General

At December 31, 2006 there were 144 cases still pending:

- 86 cases were carried into 2007 from 2006
- 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

We closed 203 or 64% in the year 2007.
At December 31, 2007 there were 116 cases still pending:

- 77 originated in 2007
- 18 originated in 2006
- 17 originated in 2005
- 1 originated in 2003
- 1 originated in 2002
- 1 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, 2008.

Report on the Activities of the Access and Privacy Division

OVERVIEW OF 2007

Access and privacy issues are matters of increasing importance to the public. There is a recognized need to move from a compliance model of access, to a model where proactive disclosure of information becomes routine. With the heightened importance of access and privacy matters, it is essential that governments and other public sector bodies move to adopt best practices.

In addition to a number of new cases of interest in 2007, we continued to monitor compliance by the public sector with the requirement to provide complete responses to access applicants under FIPPA. As well, we monitored the ongoing implementation of recommendations made after a 2006 audit of the access practices of Manitoba Conservation.

During 2007, I made formal recommendations in eighteen cases, a record number, some of which are summarized below. Of these, seventeen concerned access complaints under FIPPA and one concerned a privacy complaint under PHIA.

BROWN BAG TALKS AND PRACTICE NOTES

In 2007, our office continued our outreach activities for access and privacy coordinators and officers with the delivery of monthly Brown Bag Talks. These sessions consisted of discussions on practical issues including what to do if a privacy breach occurs, what to expect from an investigation by our office of either an access or a privacy complaint, protecting personal and personal health information when working outside the office, dealing with access requests for publicly available information and use of personal and personal health information under FIPPA and PHIA.

Our Brown Bag Talks were also presented outside of Winnipeg. This included presentations to staff of Regional Health Authorities and other health trustees in Portage la Prairie, Brandon, The Pas and Flin Flon.

In combination with the Brown Bag Talks, Practice Notes related to the issues discussed were completed and given to those who attended the talks. The Practice Notes were provided to access and privacy personnel in the province and posted 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. Of particular note in 2007 was our Practice Note *Privacy Considerations for Faxing Personal and Personal Health Information.*

Privacy Considerations for Faxing Personal and Personal Health Information

During 2007, the media reported on several incidents where faxes containing personal health information were sent by various trustees to unintended recipients, including to an individual's home. The result of these incidents was a breach of the privacy of the individual whose health information was contained in the faxes, through the unauthorized disclosure of that personal health information.

A breach of privacy under FIPPA or PHIA cannot be undone and can have significant consequences for the individual whose personal health information has been disclosed. A misdirected fax of sensitive information concerning an individual's health status, diagnosis or care and financial or employment information can expose an individual to harm. This harm may include damage to reputation, loss of business or employment opportunities, physical harm, fraud and identity theft.

A privacy breach can also harm the public sector body or trustee. This harm may include damage to reputation, loss of public trust, as well as financial and other resource costs incurred when dealing with the breach and notifying the affected parties. Public sector bodies and trustees have a duty under FIPPA and PHIA to adopt reasonable security measures to protect the privacy of personal and personal health information. Given the risks and consequences, before faxing personal and personal health information, a public sector body or trustee should first determine if there is an immediate requirement that demonstrates the need to send the information by fax. If there is no immediacy, the information should be sent by courier or mail.

In situations where the information is required immediately and is being sent by fax, the public sector body or trustee should have steps in place to mitigate the risk of faxing to an unintended recipient. These steps should be outlined in a workplace policy and employees should be made aware of them.

REQUIREMENT OF THE PUBLIC SECTOR TO PROVIDE COMPLETE RESPONSES TO ACCESS APPLICANTS – 2007 UPDATE ON COMPLIANCE WITH FIPPA

In an ongoing effort to improve public sector accountability we have, since 2005, monitored compliance with the requirement under section 12 of FIPPA for providing complete responses to applicants when access to information is refused.

The contents of response letters received by our office during an investigation are reviewed and any response letters that do not contain all the elements required by the Act are returned to the public sector body for revision. A revised response is required to be sent to the applicant, and copied to our office, within 14 days.

Our *Evaluation of Compliance with Section 12 of FIPPA* released in June 2005, which was based on response letters concerning complaints from 2002 to 2004, revealed that applicants were infrequently receiving the full responses to which they were entitled. Only 16% of the response letters reviewed were compliant with FIPPA.

We are pleased to report that the rate of compliance has steadily improved. In 2006, 61% of the response letters were compliant. In 2007, the rate of compliance increased to 85%. This improvement demonstrates that not only are public sector bodies more frequently meeting their obligations to provide full responses, but also that applicants are being better informed about refusal of access decisions.

Where responses are not compliant, we have observed that the information most frequently missing from letters continues to be reasons explaining the refusal of access and the specific provision of the Act on which the refusal is based. The specific provision should identify the clause or sub clause. For example, "subsection 18(1)" is not a specific provision but subclause

18(1)(c)(i) is. Providing reasons requires an explanation of why the specific provision applies to the withheld information.

Our Practice Notes to assist public sector bodies in complying with FIPPA, *Checklist: Contents of a Complete Response under FIPPA* and *Providing Reasons to an Applicant When Refusing Access under FIPPA*, are available on our web site.

TIME FRAMES FOR INVESTIGATION OF COMPLAINTS

As noted in our 2006 Annual Report, the Access and Privacy Division continues to seek ways to streamline our investigation process and ensure that thorough investigations are conducted in a timely manner. In 2007, our office adopted a policy on time frames for access and privacy complaint investigations.

This policy sets time lines for opening and assigning files to investigators; initiating contact with complainants and public bodies and trustees; reviewing and analyzing responses and preparing written reports. This policy will assist us in completing investigations within the time limits set out in FIPPA and PHIA.

We have distributed our policy to access and privacy coordinators and requested their cooperation and support in meeting this goal.

SYSTEMIC REVIEW

CONSERVATION AUDIT: ONE YEAR LATER

In our 2006 annual report, we provided a summary of our audit of Manitoba Conservation's non-compliance with the requirement to respond to FIPPA access applications. The need for the audit was based on our experience that Conservation was frequently not meeting its obligation to respond to access applications within the statutory time limit.

The audit had two objectives: to improve the department's timeliness in responding to applications and its timeliness in responding to my office in relation to complaints investigations.

Summary of 2006 Audit Findings and Recommendations

The audit was conducted with the full cooperation of the department. The key factors identified in the audit as contributing to the department's delays were grouped into three categories: workload of the Access and Privacy Coordinator, resources allocated for access and privacy, and support within the department. Following the audit, we made fifteen recommendations to the department to address these key factors, with the intent of improving the department's responsiveness. The department accepted all of the recommendations, which were detailed in our 2006 annual report. During 2007, we monitored the performance of the department to determine whether improvements occurred.

Our Observations One Year Later

When the audit began, our office had eighty-three pending complaints against Conservation, almost all of them about the department's failure to respond to applications. The department indicated that it would be able to eliminate the backlog by December 31, 2006. At the end of 2007, eleven of the original backlog of eighty-three complaints remained unresolved.

Conservation's efforts to address the backlog and respond to access applications in a timely manner have been affected by an unprecedented volume of applications received in late 2006 and in 2007.

Longer extensions were granted by our office to enable the department to respond to the influx of applications while still meeting its obligations to respond to the backlogged applications.

In February 2007, we implemented a time frames policy concerning our investigations of complaints. Due to the backlog of applications and complaints that Conservation was still attempting to address in early 2007, and the unprecedented influx of applications, our office's time frames policy was not applied to the department until late 2007.

We have continued to receive a significant number of complaints about Conservation's failure to respond to applications. In 2006, we received ninety-one complaints, many of which remained unresolved and were carried into 2007. In 2007, we received twenty-eight new complaints. Twenty-six of these new complaints were determined to be well founded.

To assist the department in 2007, we identified priority cases for the department to address. However, after efforts to resolve priority complaints informally were unsuccessful, we made formal recommendations in thirteen cases. Despite the recommendations, many of these cases have not been concluded.

Investigations of complaints against Conservation are protracted because the department is often unable to provide a detailed explanation for refusing access. Inadequate documentation of decisions on the FIPPA files appears to be a contributing factor to delay. The importance of documenting access decisions has been emphasized with the department and a Practice Note on this subject is available on our web site.

Despite some progress as a result of measures taken by the department to respond in a timely manner, chronic problems have persisted. The department has been unable to implement many of the recommendations arising from our audit, and in some situations continues to be unable to meet statutory timelines for responding to new access applications. The department does not appear to have a plan to address these issues.

CASES OF INTEREST

As Ombudsman, I may make any recommendations to a public sector body or trustee that I consider to be appropriate about a complaint. A written response must be provided to the Ombudsman within 15 days under FIPPA and 14 days under PHIA. The response must indicate that either the recommendations are accepted and what action will be taken to implement them, or the reasons why action will not be taken to implement the recommendations. We then notify the complainant in writing about the response to the recommendations. The Acts require that the Ombudsman report annually on recommendations made.

Most of our recommendations in 2007 were made after considerable efforts to informally resolve long-standing complaints proved to be unsuccessful. Thirteen such cases involved Manitoba Conservation and two cases involved Manitoba Water Stewardship.

In two of the thirteen cases involving Conservation, recommendations were made after we were unable to obtain the information required for our investigations from the department. Conservation did not respond to our recommendations within the time limit under FIPPA. Eleven of the thirteen cases concerning Conservation, which are summarized in this section, related to Conservation's failure to respond to applications received in 2003.

We also made recommendations to release information in two refusal of access cases involving Manitoba Competitiveness, Training and Trade and the Rural Municipality of St. Andrews. Recommendations were made in one privacy case concerning a disclosure of personal health information by the Workers Compensation Appeal Commission. These three cases are summarized below.

In addition to the investigation of complaints under Part 5 of the Acts, the Ombudsman has other duties under Part 4, including commenting on the privacy implications of proposed programs of public sector bodies and trustees. In 2007, Manitoba Lotteries Corporation requested our comments on the privacy implications of using facial recognition software in its

Winnipeg casinos. A summary of this case appears in this section.

FAILURE TO RESPOND TO LONG-STANDING APPLICATIONS

FIPPA requires that a written response be provided to an applicant within 30 days of receiving an application, indicating whether or not access is being granted. In 2006, we received 46 complaints from an applicant concerning access applications submitted to Manitoba Conservation in 2003.

Prior to complaining to our office, the applicant tried to resolve these matters with the department. The applicant corresponded with the department and received assurances from the Minister in early 2005, that the applications would be processed on a priority basis. When the applications were not processed during the next year, the applicant submitted complaints to the Ombudsman.

All except eleven of these complaints were informally resolved in 2006/07. Ten of these complaints concerned the department's failure to respond to the applications. In four of the ten cases, the department had collected search and preparation fees from the applicant in 2004 but still had not provided responses to the applicant. In the remaining case, the department had responded to the applicant in 2006, two years after collecting search and preparation fees. In total, the applicant had paid $840 to the department concerning the five applications.

We recommended that the department respond to the ten unanswered applications within one month. The department responded to two of the ten applications within the recommended one month time frame. Eight of these cases remained unresolved because the department had not responded to the applicant at the end of 2007.

The amount of time that the applicant waited for a response from the department was by any standard, so wrong and unfair that it warranted that the department bear the cost of the fees. We recommended that the department refund the search and preparation fees for each of the five applications for a total refund of $840. We also advised the department that it would be appropriate for the department to apologize in writing to the applicant for its failure to carry out

its responsibilities under FIPPA. The department refunded the fees as recommended and apologized to the applicant.

ACCESS TO FOCUS GROUP REPORTS ABOUT "SPIRITED ENERGY "

FIPPA sets out mandatory exceptions to disclosure relating to information a public sector body must not disclose, and discretionary exceptions relating to information a public sector body may choose not to disclose for various reasons. When a public sector body claims that information is withheld because of an exception, the onus is on the public sector body to demonstrate how the exception claimed applies to the withheld information.

When applying a discretionary exception, a public sector body must take a second step and decide whether to release all, part or none of the information requested. If part of the record is subject to an exception and other parts are not, then those parts not subject to an exception must be released.

In a complaint about refused access to information from focus group studies relating to "Spirited Energy", a provincial marketing and promotional campaign, we found that Manitoba Competitiveness, Training and Trade's (the department) application of discretionary exceptions to disclosure was not in compliance with the Act.

The applicant had requested access to all focus group studies conducted about the Spirited Energy campaign. The department refused access, asserting that the information could reveal advice, opinions, proposals, recommendations, analyses or policy options developed for the department. If that were correct, the department could in fact exercise discretion to refuse access to the information.

After our investigation began, the department claimed a mandatory exception of which it had not advised the applicant. It stated that the information would reveal a third party's commercial information that had been provided on a confidential basis to the department, and was treated as confidential information by the third party.

We reviewed the requested records in view of the legislation and the information provided by the department. We did not agree with the department's assertion that the focus group studies revealed any advice or opinions developed for the department. Furthermore, when a discretionary exception applies, our office reviews the reasonableness of a public sector body's exercise of discretion to withhold information. The department did not provide any explanation to support its exercise of discretion to withhold the records. We concluded that the discretionary exception did not apply and that the decision to withhold the information under that exception was not reasonable.

We agreed with the department's position that the focus group studies would reveal commercial information of a third party, provided in confidence to the department, but were of the opinion that this mandatory exception applied to only some of the information withheld.

We recommended the release of all information to which the mandatory exception did not apply. The department accepted our recommendation and released the information to the applicant.

Following receipt of the department's response to our recommendations, we were advised by the department that there were two additional focus group reports which the department had not previously considered to be responsive to the applicant's request.

This case demonstrates the responsibility of the public sector body to search for all records prior to issuing a response to the applicant. While the department indicated that they were prepared to release these reports with severing under the same mandatory exception previously noted, it is worth noting that the department has an obligation to consider all records that fall under the request. This obligation is highlighted as part of their duty to assist an applicant and respond accurately and completely.

REQUIREMENT TO LIMIT DISCLOSURE OF PERSONAL HEALTH INFORMATION

We received a breach of privacy complaint from a Workers Compensation Board claimant about the disclosure of his personal health information to his employer. PHIA requires that every disclosure be authorized under the Act and also that every disclosure be limited to the minimum amount of information necessary for the purpose for which it is being disclosed. Our investigation considered both of these aspects of the disclosure.

The claimant had appealed a decision of the Workers Compensation Board to the Appeal Commission. The disclosure occurred in a letter the Appeal Commission sent to the employer, as well as to the claimant, about the Appeal Commission's decision. The personal health information disclosed was detailed psychological and psychiatric information from a five-year period.

The position of the Commission was that the disclosure was authorized under PHIA, which permits a disclosure if it is authorized or required under other laws of Manitoba or Canada. The Manitoba *Workers Compensation Act* and *The Appeal Commission Rules of Procedure Regulation* require the Commission to provide written reasons for its decision to any person who has a direct interest in the matter being heard in the appeal. *The Appeal Commission Rules of Procedure Regulation* defines the employer of a worker at the time of an accident as a person who has a direct interest in the matter.

The Commission's written reasons for its decision included the mental health factors that were considered in the appeal. Accordingly, providing reasons for the decision would require a disclosure of personal health information to the employer. We concluded that PHIA permitted a disclosure of personal health information in these circumstances.

However, PHIA requires that a disclosure of personal health information be limited to the minimum amount necessary. We considered whether the written decision contained the minimum amount of personal health information necessary to explain the Commission's decision. The personal health information contained in the reasons for its decision was detailed psychological and psychiatric information including the claimant's symptoms,

prescribed medications, and diagnosed and suspected behavioral and/or personality issues. We concluded that the volume and detail of the personal health information disclosed in the written decision of the Commission was unnecessary and excessive for the purpose of providing reasons for its decision.

We found that the disclosure was not in compliance with PHIA regarding the requirement to limit the amount of personal information to the minimum amount necessary to accomplish the purpose for which it was disclosed.

Two recommendations were made concerning this breach of privacy: to send a letter of apology to the claimant for the breach of privacy resulting from the excessive disclosure of his personal health information, and to take steps to ensure that all commissioners are aware of their privacy responsibilities under PHIA. The Ombudsman's recommendations were accepted and implemented. Subsequently, our office accepted an invitation to participate in an educational session on privacy for appeal commissioners.

ACCESS TO PERSONAL INFORMATION OF A THIRD PARTY

The public's right of access to information must be balanced against the unreasonable invasion of personal privacy. Determining whether a disclosure of personal information about a third party under FIPPA would be an unreasonable invasion of that person's privacy is a complex and multi-layered exercise. It can be made easier by reading and considering all of the relevant provisions of the legislation before coming to a conclusion.

Under FIPPA, there is a requirement to refuse access when disclosure of personal information about a third party would be an unreasonable invasion of privacy of that individual. However, the Act limits the circumstances to which this requirement applies. FIPPA permits the disclosure of personal information if the record is publicly available. In addition, when the personal information is about the employment responsibilities of employees, officers or elected or appointed council members of a public sector body, the requirement to refuse access does not apply.

In this case, the applicant had requested access to a consultant's report prepared for the Rural Municipality of St. Andrews (R.M.). The R.M. refused access on the basis that the disclosure of personal information would be an unreasonable invasion of the privacy rights of a third parties; its employees and councillors.

In his complaint to our office, the applicant questioned the decision given his knowledge that details of the report were reported by a newspaper and that the report had also been provided to another applicant under FIPPA.

Our review determined that the Reeve, who was designated as head of the public body for the purposes of FIPPA, had personally given an unsevered copy of the report to the editor of a newspaper. Two articles were subsequently published in which details of the report were revealed.

Our review determined that some of the information in the report related to employment responsibilities of staff and elected representatives of the R.M. Other information in the report was subject to an exception because it included personal information of a third party; information that could harm a third party's business interests and information that could be expected to threaten the security of property.

We advised the R.M. that we considered that when information in the report, provided to a newspaper, was disclosed in published articles, it had been made publicly available. We further advised that giving access to information about employment responsibilities is not considered to be an unreasonable invasion of privacy. We recommended that the record be released to the applicant, with the excepted information severed. The R.M. accepted our recommendation and released the severed report to the applicant.

Depending on circumstances, information contained in records may no longer be subject to the exceptions to disclosure found in the legislation when an authorized official releases information that is later published.

COMMENTING ON PRIVACY IMPLICATIONS OF USING FACIAL RECOGNITION SOFTWARE

In addition to the investigation of complaints under PHIA and FIPPA, the Ombudsman has other duties, including the ability to comment on the implications for protection of privacy of proposed legislative schemes or programs of public sector bodies and trustees. Requesting comments from the Ombudsman at an early stage in the planning process for new initiatives, enables a public sector body or trustee to better identify and address any privacy-related issues and/or concerns that might arise.

In 2007, Manitoba Lotteries Corporation (MLC) requested our comments on the privacy implications of using facial recognition software in its Winnipeg casinos. MLC proposed to implement Facial Recognition Technology (FRT) at the Casinos of Winnipeg as a surveillance tool to assist in the management of the exclusion programs under the corporation's Responsible Gaming and Corporate Securities Policies. Under these exclusion programs an individual is restricted, either voluntarily or involuntarily, from entering the casinos for a variety of reasons.

In this case, MLC had prepared a privacy impact assessment, which is a best practice tool and process to ensure compliance with privacy protection responsibilities under FIPPA and PHIA. A privacy impact assessment requires a broad analysis of the program's potential impact on privacy and identification of measures to mitigate any such impact.

Based on our review of MLC's Privacy Impact Assessment and communications materials including public information brochures, we were of the opinion that the collection, use and disclosure of personal information related to the FRT and the policies and procedures of MLC in relation to that technology were generally in compliance with FIPPA. We indicated to MLC that increasing the amount of information available to the public, ensuring staff education about FRT and providing notification to the public about collection practices promotes openness and transparency.

We recognized that upon the implementation of FRT, as with any new electronic program or surveillance tool, modifications or enhancements to the existing program or the introduction of new surveillance tools or software are likely to occur. Our office suggested that a privacy impact assessment be completed annually to assist MLC in fulfilling its obligations under FIPPA to ensure the enhancements or modifications to the technology or the exclusion programs are compliant with the Act.

STATISTICAL REVIEW OF 2007

The following table provides a summary for 2007 of the work done by the Access and Privacy Division by tracking cases opened and the disposition of cases closed.

Cases carried over into 2007	107
New cases in 2007	401
Total cases in 2007	508
Total cases closed 2007	396
Pending at December 31, 2007	112

Of the 396 cases closed in 2007:

38% were supported;

5% were partly supported;

1% were resolved;

2% were concluded by recommendation;

24% were not supported;

6% were completed;

6% were discontinued either by the Ombudsman or the complainant;

18% were declined.

OVERVIEW OF ACCESS COMPLAINTS OPENED IN 2007

In 2007, 351 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	133	127	6
Extension	4	4	NA*
Fees	21	21	-
Correction	1	1	-
Refused Access	186	184	2
Other	6	6	-
Total	**351**	**343**	**8**

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

OVERVIEW OF ACCESS COMPLAINTS CLOSED IN 2007

During 2007, 359 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	164	-	164	75	29	56	4
No Response	163	5	168	15	130	23	-
Fees	20	-	20	1	19	-	-
Correction	1	-	1	-	-	-	1
Extension	3	-	3	2	-	1	-
Other	3	-	3	-	-	2	1
Total	**354**	**5**	**359**	**93**	**178**	**82**	**6**

OVERVIEW OF PRIVACY COMPLAINTS OPENED IN 2007

In 2007, 20 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.

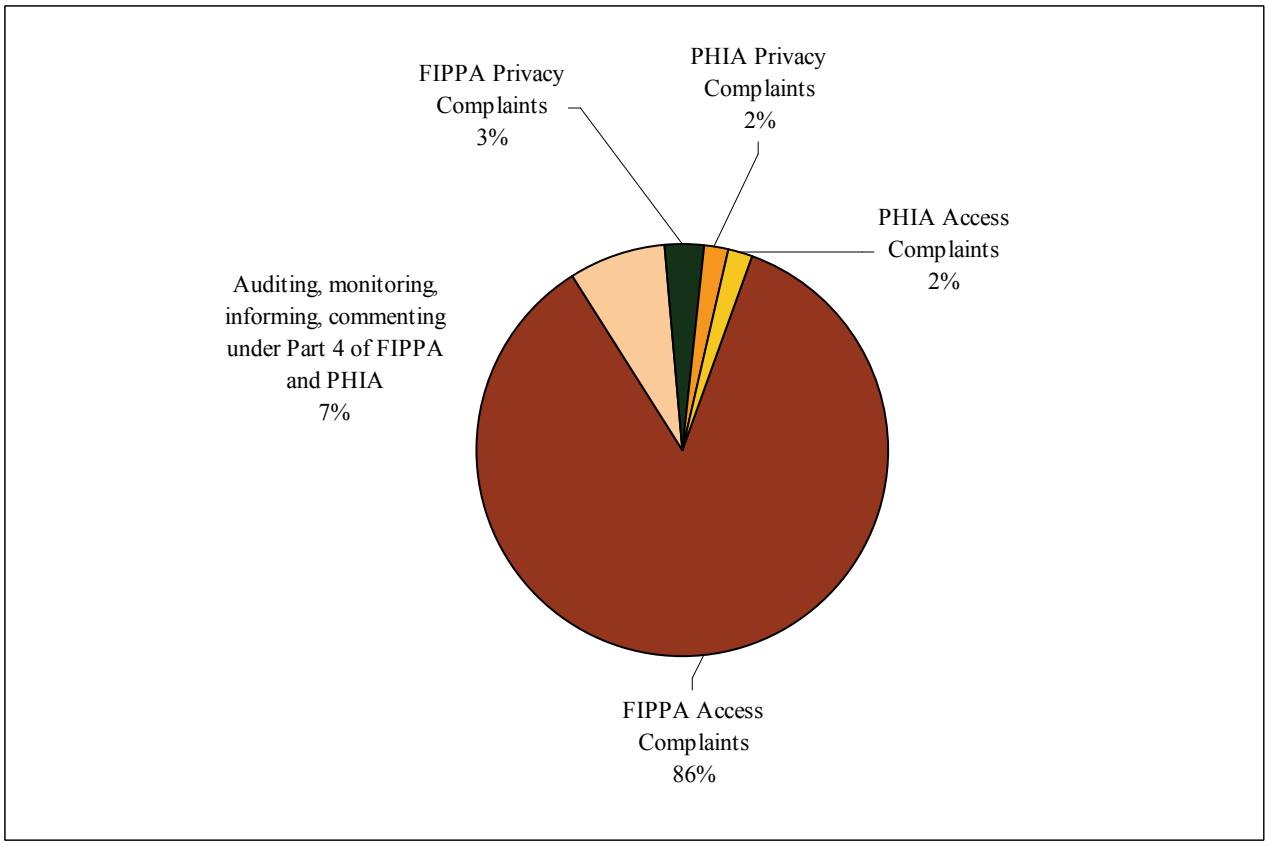
Type of Privacy Complaint	Total	FIPPA	PHIA
Collection	3	2	1
Use	4	1	3
Disclosure	13	9	4
Total	**20**	**12**	**8**

OVERVIEW OF PRIVACY COMPLAINTS CLOSED IN 2007

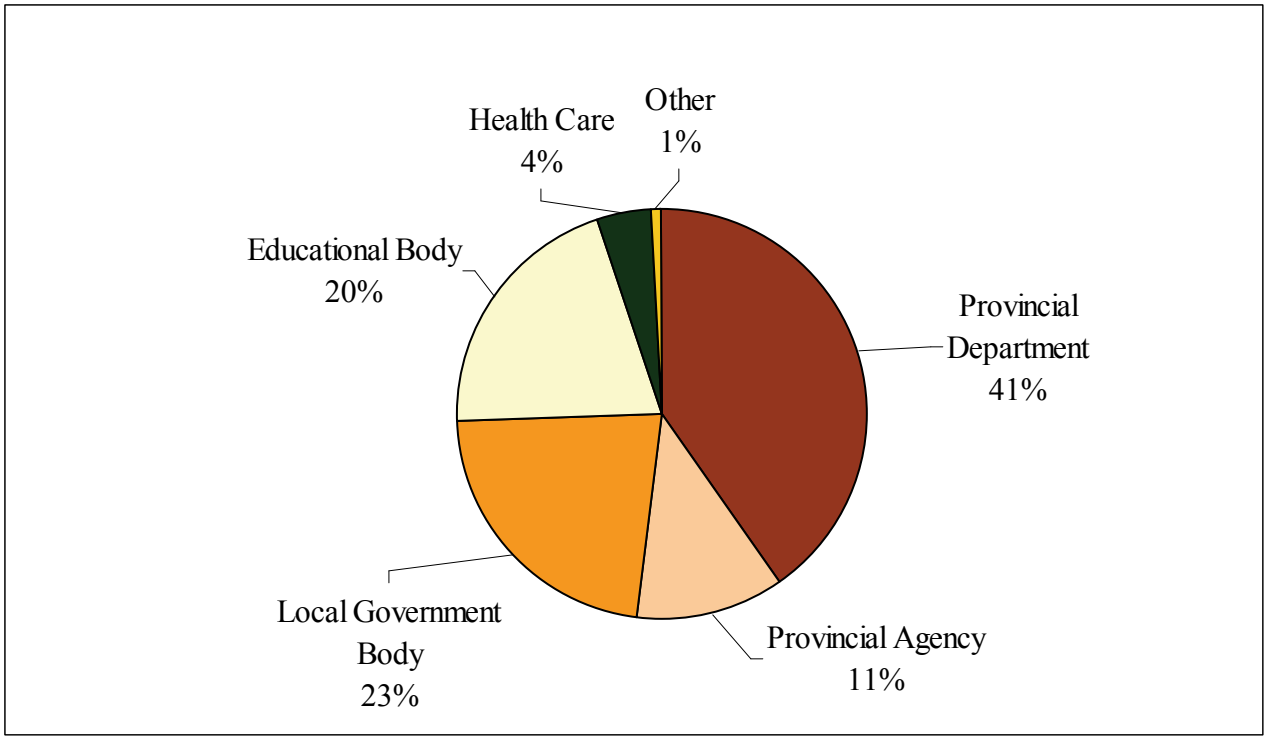
During 2007, 12 privacy complaints under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* were closed. The following chart provides a breakdown of the dispositions of these privacy complaints.

Type of Privacy Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or whole	Not Supported	Resolved
Collection	-	1	1	-	-	1	-
Use	1	-	1	1	-	-	-
Disclosure	5	5	9	1	3	6	-
Total	**6**	**6**	**12**	**2**	**3**	**7**	**-**

TYPES OF CASES OPENED IN 2007



DISTRIBUTION OF CASES OPENED IN 2007



CASES IN 2007 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

This chart shows the disposition of the 508 access and privacy cases investigated in 2007 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 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
***Part 5 of The Freedom of Information and Protection of Privacy Act* (FIPPA)**												
PUBLIC BODY												
Provincial Department	**76**	**147**	**223**									
Aboriginal & Northern Affairs	-	2	**2**	2	-	-	-	-	-	-	-	-
Agriculture, Food & Rural Initiatives	-	2	**2**	1	-	-	-	-	1	-	-	-
Competitiveness, Training & Trade	-	4	**4**	1	-	-	1	1	-	-	1	-
Conservation	56	66*	**122**	29	-	1	9	2	79	-	2	-
Culture, Heritage & Tourism	2	4	**6**	-	-	-	3	2	-	-	1	-
Education, Citizenship & Youth	5	-	**5**	-	-	-	5	-	-	-	-	-
Executive Council	-	3	**3**	-	-	-	1	-	2	-	-	-
Family Services & Housing	6	16	**22**	-	-	5	6	3	8	-	-	-
Health	-	3	**3**	1	-	-	2	-	-	-	-	-
Infrastructure & Transportation	1	2	**3**	2	-	-	1	-	-	-	-	-
Justice	3	6	**9**	3	-	-	6	-	-	-	-	-
Labour & Immigration	-	2	**2**	-	-	-	1	-	1	-	-	-
Science, Technology, Energy & Mines	-	1	**1**	1	-	-	-	-	-	-	-	-
Water Stewardship	3	36	**39**	17	-	4	5	-	11	-	2	-
Crown Corporation and Government Agency	**6**	**37**	**43**									
Agriculture Services Corporation	-	1	**1**	-	-	-	1	-	-	-	-	-
Boxing Commission	2	2	**4**	-	1	-	2	-	-	1	-	-
Credit Union Deposit Guarantee Corp.	-	1	**1**	-	-	-	1	-	-	-	-	-
Human Rights Commission	-	3	**3**	-	-	-	1	1	1	-	-	-
Hydro	-	10	**10**	2	-	-	1	2	5	-	-	-
Lotteries Corporation	1	1	**2**	-	-	-	1	-	1	-	-	-
Manitoba Housing Authority	-	1	**1**	1	-	-	-	-	-	-	-	-
Manitoba Public Insurance	3	12	**15**	-	2	5	5	-	-	3	-	-
Sport Manitoba	-	1	**1**	-	-	-	-	-	1	-	-	-
Winnipeg Child & Family Services	-	1	**1**	1	-	-	-	-	-	-	-	-

CASES IN 2007 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
West Region Child & Family Services	-	1	**1**	1	-	-	-	-	-	-	-	-
Workers Compensation Board	-	3	**3**	-	-	-	1	2	-	-	-	-
LOCAL PUBLIC BODY												
Local Government Body	**5**	**89**	**94**									
City of Winnipeg	2	20	**22**	8	-	4	7	1	1	1	-	-
Town of Beausejour	-	1	**1**	-	-	1	-	-	-	-	-	-
Town of Leaf Rapids	-	1	**1**	-	-	-	-	1	-	-	-	-
Town of Lac du Bonnet	-	1	**1**	-	-	-	1	-	-	-	-	-
R.M. of Archie	1	-	**1**	-	-	-	1	-	-	-	-	-
R.M. of Arthur	-	1	**1**	-	-	-	-	-	1	-	-	-
R.M. of Brokenhead	-	5	**5**	-	-	-	-	-	5	-	-	-
R.M. of Dauphin	1	1	**2**	-	1	-	-	1	-	-	-	-
R.M. of East St. Paul	-	2	**2**	1	-	-	-	-	1	-	-	-
R.M. of Ethelbert	-	2	**2**	-	-	-	-	-	2	-	-	-
R.M. of Gilbert Plains	-	1	**1**	-	-	-	-	-	1	-	-	-
R.M. of Grahamdale	-	1	**1**	-	-	-	1	-	-	-	-	-
R.M. of Grey	-	6	**6**	-	-	-	6	-	-	-	-	-
R.M. of Hamiota	-	1	**1**	-	-	-	-	-	1	-	-	-
R.M. of Kelsey	-	1	**1**	1	-	-	-	-	-	-	-	-
R.M. of Lac du Bonnet	-	3	**3**	3	-	-	-	-	-	-	-	-
R.M. of Morton	-	2	**2**	-	-	1	-	-	1	-	-	-
R.M. of Portage la Prairie	-	1	**1**	-	-	-	-	1	-	-	-	-
R.M. of St. Andrews	1	-	**1**	-	-	-	-	-	-	-	1	-
R.M. of St. Laurent	-	1	**1**	-	-	-	-	-	1	-	-	-
R.M. of South Norfolk	-	8	**8**	-	-	-	8	-	-	-	-	-
R.M. of Springfield	-	11	**11**	-	-	-	-	-	11	-	-	-
R.M. of Stanley	-	1	**1**	-	-	-	-	-	1	-	-	-
R.M. of Strathclair	-	3	**3**	-	-	-	-	-	3	-	-	-
R.M. of Whitehead	-	1	**1**	-	-	-	-	-	1	-	-	-
La Salle Redboine Conservation District	-	11	**11**	-	-	-	11	-	-	-	-	-
South Riding Mountain Planning District	-	3	**3**	-	-	-	-	-	3	-	-	-

CASES IN 2007 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
Educational Body	**2**	**76**	**78**									
Interlake School Division	-	1	**1**	1	-	-	-	-	-	-	-	-
Louis Riel School Division	-	1	**1**	1	-	-	-	-	-	-	-	-
Mountain View School Division	-	1	**1**	-	-	1	-	-	-	-	-	-
Red River College	-	65**	**65**	-	65	-	-	-	-	-	-	-
University of Manitoba	2	7	**9**	5	-	-	3	-	1	-	-	-
University of Winnipeg	-	1	**1**	1	-	-	-	-	-	-	-	-
Health Care Body	**1**	**4**	**5**									
Burntwood Regional Health Authority	-	1	**1**	1	-	-	-	-	-	-	-	-
Winnipeg Regional Health Authority	1	3	**4**	1	-	-	1	-	1	1	-	-
Other	**-**	**2**	**2**									
Leaf Rapids Community Development Corporation	-	2	**2**	-	2	-	-	-	-	-	-	-
***Part 5 of The Personal Health Information Act* (PHIA)**												
PUBLIC BODY												
Provincial Department	**-**	**2**	**2**									
Justice	-	2	**2**	1	-	-	1	-	-	-	-	-
Crown Corporation and Government Agency	**2**	**4**	**6**									
Hydro	-	1	**1**	1	-	-	-	-	-	-	-	-
Manitoba Public Insurance	-	1	**1**	1	-	-	-	-	-	-	-	-
Winnipeg Child & Family Services	-	1	**1**	-	-	-	1	-	-	-	-	-
Workers Compensation Appeal Commission	2	-	**2**	-	-	-	-	1	-	-	1	-
Workers Compensation Board	-	1	**1**	-	-	-	-	-	1	-	-	-
LOCAL PUBLIC BODY												
Educational Body	**-**	**2**	**2**									
University of Manitoba	-	2	**2**	2	-	-	-	-	-	-	-	-
Health Care Body	**2**	**2**	**4**									
Brandon Regional Health Authority	1	1	**2**	2	-	-	-	-	-	-	-	-
North Eastman Health Association	-	1	**1**	1	-	-	-	-	-	-	-	-
Winnipeg Regional Health Authority	1	-	**1**	1	-	-	-	-	-	-	-	-

CASES IN 2007 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
Health Professional	**-**	**4**	**4**									
Physician	-	1	**1**	-	-	-	-	-	1	-	-	-
Psychiatrist	-	1	**1**	-	-	-	-	-	1	-	-	-
Psychologist	-	2	**2**	-	2	-	-	-	-	-	-	-
Health Care Facility	**1**	**2**	**3**									
Assiniboine Clinic	-	1	**1**	-	-	-	-	-	1	-	-	-
Prairie Trails Medical Centre	1	-	**1**	-	-	-	1	-	-	-	-	-
Middlechurch Personal Care Home	-	1	**1**	1	-	-	-	-	-	-	-	-
Part 4 under FIPPA and PHIA												
PUBLIC BODY												
Provincial Department	**4**	**13**	**17**									
Advanced Education & Training	1	-	**1**	1	-	-	-	-	-	-	-	-
Competitiveness, Training & Trade	-	1	**1**	1	-	-	-	-	-	-	-	-
Conservation	1	5	**6**	2	-	-	-	-	-	-	-	4
Family Services & Housing	-	1	**1**	-	-	-	-	-	-	-	-	1
Finance	-	1	**1**	-	-	-	-	-	-	-	-	1
Health	1	2	**3**	1	-	-	-	-	-	-	-	2
Justice	-	1	**1**	1	-	-	-	-	-	-	-	-
Infrastructure & Transportation	1	-	**1**	-	-	-	-	-	-	-	-	1
Water Stewardship	-	2	**2**	-	-	-	-	-	-	-	-	2
Crown Corporation and Government Agency	**1**	**5**	**6**									
Manitoba Housing Authority	-	1	**1**	1	-	-	-	-	-	-	-	-
Lotteries Corporation	-	1	**1**	-	-	-	-	-	-	-	-	1
Manitoba Public Insurance	1	2	**3**	2	-	-	-	-	-	-	-	1
Workers Compensation Board	-	1	**1**	-	-	-	-	-	-	-	-	1
LOCAL PUBLIC BODY												
Local Government Body	**3**	**2**	**5**									
City of Brandon	1	-	**1**	1	-	-	-	-	-	-	-	-
City of Winnipeg	2	1	**3**	2	-	-	-	-	-	-	-	1
R.M. of Dauphin	-	1	**1**	-	-	-	-	-	-	-	-	1

CASES IN 2007 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2007	New cases in 2007	Total cases in 2007	Pending at Dec. 31, 2007	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
Educational Body	**-**	**4**	**4**									
Red River College	-	1	1	-	-	-	-	-	-	-	-	1
University of Winnipeg	-	2	2	-	-	-	-	-	-	-	-	2
University of Manitoba	-	1	1	1	-	-	-	-	-	-	-	-
Health Care Body	**1**	**1**	**2**									
Interlake Regional Health Authority	1	-	**1**	-	-	-	-	-	-	-	-	1
Winnipeg Regional Health Authority	-	1	**1**	-	-	-	-	-	-	-	-	1
Health Care Facility	**1**	**2**	**3**									
Canadian Blood Services	1	1	**2**	-	-	-	-	-	-	-	-	2
Wong Medical Clinic	-	1	**1**	1	-	-	-	-	-	-	-	-
Health Professional	**2**	**2**	**4**									
Massage Therapist	-	1	**1**	-	-	-	-	-	-	-	-	1
Orthodontist	1	-	**1**	1	-	-	-	-	-	-	-	-
Pharmacist	1	1	**2**	2	-	-	-	-	-	-	-	-
Other	**-**	**1**	**1**									
Elections Manitoba	-	1	**1**	-	-	-	-	-	-	-	-	1
Total	**107**	**401**	**508**	**112**	**73**	**22**	**95**	**18**	**149**	**6**	**8 †**	**25**

At December 31, 2006, there were 107 cases pending:

- 94 were carried over from 2006
- 11 were carried over from 2005
- 2 were carried over from 2004

In 2007, 82 of these 107 carried over cases were closed. Of the 25 cases still pending at December 31, 2007:

- 22 originated in 2006
- 2 originated in 2005
- 1 originated in 2004

*** Note: Of the 66 complaints, 22 were filed by one individual, 16 by a second individual.**
****Note: All of the 65 complaints were filed by one individual.**

† Recommendations were made in 10 other cases still pending at December 31, 2007.

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, 2008.