Manitoba Ombudsman
2016 ANNUAL REPORT

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near St. Lazare, Manitoba

Manitoba Ombudsman

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May 29, 2017

The Honourable Myrna Driedger
Speaker of the Legislative Assembly
Room 244 Legislative Building
Winnipeg MB R3C 0V8

Dear Madam Speaker:

In accordance with section 42 of the Ombudsman Act, subsection 58(1) of the Freedom of Information and Protection of Privacy Act, subsection 37(1) of the Personal Health Information Act and subsection 26(1) of the Public Interest Disclosure (Whistleblower Protection) Act, I am pleased to submit the annual report of Manitoba Ombudsman for the calendar year January 1, 2016 to December 31, 2016.

Yours truly,

Charlene Paquin
Manitoba Ombudsman

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Some information in this annual report is presented differently than in previous reports. Please contact our office if you have questions – other information may be available on request.

OMBUDSMAN'S MESSAGE

Charlene Paquin, Manitoba Ombudsman

I am pleased to present the Manitoba Ombudsman 2016 Annual Report, which highlights the work and accomplishments of the office this past year.

In 2016, we continued to investigate complaints made to our office 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. In total, the office opened 339 formal investigations and posted 18 investigation reports on our website. Some of the investigations we concluded in 2016 are highlighted later in this report.

We had the privilege of hosting the 2016 Manitoba Connections: Access, Privacy, Security and Information Management Conference during Right to Know Week, which brought together almost two hundred participants to hear from a variety of speakers and panelists who presented many perspectives and insights into the importance of the conference's themes.

We also conducted our own research into privacy breach practices in Manitoba through a survey to 238 public-sector organizations. This was the first survey done by the office in this way. In December we published our survey report that includes our findings and analysis and also highlights areas where we felt we could offer further assistance and guidance. As a result of this work we also created a new page on our website, which has specific privacy breach related materials. Our office will continue to update and add to this resource over time.

In 2016, we also had several opportunities to work collaboratively with others. For example, we contributed to and endorsed publications produced by the Office of the Privacy Commissioner of Canada and we partnered with the Office of the Children's Advocate to produce an online safety poster for young people. All of these publications relate to online youth privacy. Coordinating our efforts has helped to better reach our intended audience, namely young people who will benefit from understanding how to reduce privacy risks when using the internet.

Over the course of the year, I also met with my ombudsman, information and privacy commissioner and public interest disclosure commissioner counterparts from across the country to discuss areas of common interest. We highlight one of our joint initiatives – a submission on the federal government's review of national security laws and policies – later in this report.

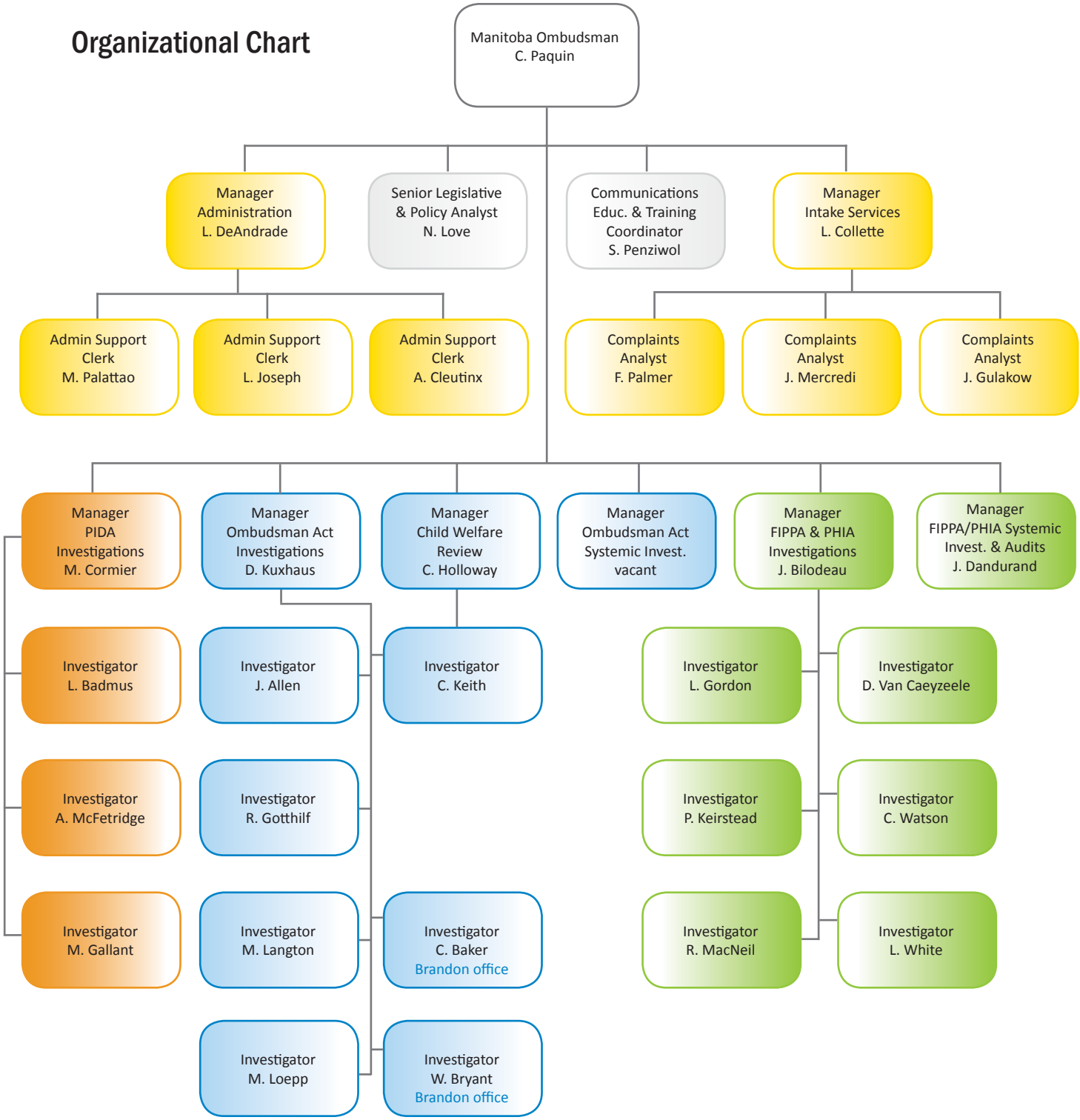
As well, early in 2016, we welcomed a colleague from the Ombudsman of South Australia who was researching perceptions of privacy and practice around disclosure of personal information in circumstances where failure to share information can have serious consequences for individuals.

2016 represented my first full year as ombudsman. It continues to be a privilege for me to serve Manitoba in this role.

Budget and Staff

2016/17 Office Budget	
Total salaries and employee benefits	$2,969,000
Other expenditures	$581,000
Total budget	**$3,550,000**

Organizational Chart



About the Office

Manitoba Ombudsman is an independent office of the Legislative Assembly of Manitoba. The office has a combined intake services team and three investigation teams – access and privacy, ombudsman and public interest disclosure (whistleblower).

Under the **Freedom of Information and Protection of Privacy Act** (FIPPA) and the **Personal Health Information Act** (PHIA), the ombudsman investigates complaints from people about any decision, act or failure to act relating to their requests for information from public bodies or trustees, and privacy concerns about the way their personal information or personal health information has been handled. The ombudsman has additional powers and duties under FIPPA and PHIA, including auditing to monitor and ensure compliance with these acts, informing the public about the acts and commenting on the access and privacy implications of proposed legislation, programs or practices of public bodies and trustees.

Under the **Ombudsman Act**, the ombudsman investigates complaints from people who feel they have been treated unfairly by government, including provincial government departments, crown corporations, municipalities, and other government bodies such as regional health authorities, planning districts and conservation districts.

The ombudsman also investigates disclosures of wrongdoing under the **Public Interest Disclosure (Whistleblower Protection) Act** (PIDA). Under PIDA, a wrongdoing is a very serious act or omission that is an offence under another law, an act that creates a specific and substantial danger to the life, health, or safety of persons or the environment, or gross mismanagement, including the mismanagement of public funds or government property.

2016 Overview

4048 INQUIRIES AND COMPLAINTS

3227 The intake services team handled 3227 inquiries and complaints related to the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Health Information Act (PHIA) and the Ombudsman Act

44 The PIDA investigation team handled 21 inquiries and 23 disclosures related to the Public Interest Disclosure (Whistleblower Protection) Act (PIDA)

777 The administration team also handled 777 general inquiries

339 INVESTIGATIONS OPENED

237 FIPPA (parts 4 and 5)

42 PHIA (parts 4 and 5)

56 Ombudsman Act

4 PIDA

37 RECOMMENDATIONS MONITORED

9 3 inquest reports with 9 recommendations were received from the Provincial Court of Manitoba

28 47 special investigation reports with 28 recommendations were received from the Office of the Children's Advocate

18 INVESTIGATION REPORTS POSTED ON WEBSITE

6 FIPPA

2 PHIA

10 Ombudsman Act

OUTREACH AND OTHER ACTIVITIES

The ombudsman and staff further the work of the office by attending and hosting meetings and events, delivering presentations and training sessions and developing publications and reports, sometimes collaboratively with other offices.

2016 Conference

We hosted the Manitoba Connections: Access, Privacy, Security and Information Management Conference from September 27-28, 2016 during national Right to Know Week. The conference's "connections" theme recognized the interconnectedness of these disciplines and the role of good information management practices and information security in supporting access to information and privacy of personal and personal health information in the Manitoba public service.

The conference highlighted the latest trends and emerging issues, and offered practical guidance and solutions to meet the information challenges faced by public bodies and trustees subject to FIPPA and PHIA. It featured experts in the field including several speakers from Manitoba who shared their experiences, challenges and successes. The agenda included five plenary speakers and 15 breakout sessions. There were three optional half-day workshops to enable in-depth exploration of key issues.

Almost two hundred attendees from provincial and municipal governments, school divisions, universities, colleges and health-care bodies attended the conference. The success of the conference was due in large part to the valued input from an advisory committee of representatives from public bodies and trustees who assisted us in planning the conference.

Presentations

Brown Bag Talk series for access and privacy coordinators and officers:

- Dealing with access requests involving employee information
- Considerations for disregarding a request for access under FIPPA
- Privacy breach reporting under PHIA
- Fees and fee estimates (with reference to recent investigation reports)

PHIA: Back to the Basics session at the Southern Health-Santé Sud annual PHIA Day

FIPPA training session for public bodies in conjunction with the Information and Privacy Policy Secretariat

Presentations at Sanford Collegiate and "Seniors for Seniors" in Brandon

Presentations at the Manitoba Youth Centre

Seven sessions to correctional officer recruits as part of their regular training program

Events

Ombudsman employees hosted display tables or exhibitor booths at the following events:

- Law Day and the Law Courts Open House, Winnipeg
- Manitoba Social Science Teachers Association SAGE conference, Winnipeg
- Brandon Teachers' Association LIFT conference, Brandon
- Association of Manitoba Municipalities Annual Convention, Winnipeg

Ombudsman staff also attended powwows at the Agassiz Youth Centre and Manitoba Youth Centre

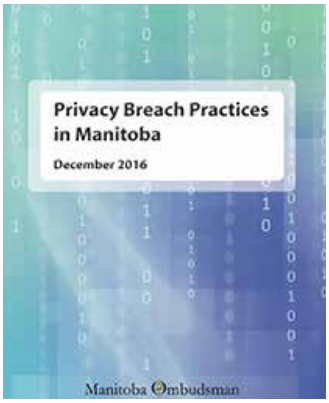
New Publications

- During Fraud Prevention Month in 2016, we partnered with the Office of the Privacy Commissioner of Canada (OPC) on an initiative to make seniors and others aware of risks to their personal information. This involved the distribution of an identity theft guide, *Identity Theft and You*, and bookmarks through public libraries across Manitoba.

- We also contributed to an article by the OPC, *Practice privacy-safe surfing: How 21st Century parents can set an example for their kids,* which appeared in the October/November 2016 issue of *Winnipeg Parent Magazine*.

- To help young people engage about privacy, the OPC produced a graphic novel, *Social Smarts: Privacy, the Internet, and You*, which was endorsed by Manitoba Ombudsman and other information and privacy commissioner offices across the country.

- We produced a poster in partnership with the Office of the Children's Advocate to give young people some simple reminders for staying safe and secure online.



We released *Privacy Breach Practices in Manitoba*, a report that summarizes findings and analysis from a survey distributed to 238 public-sector organizations across the province. More information about the survey and report is on page 17.

Manitoba OmbudsNews

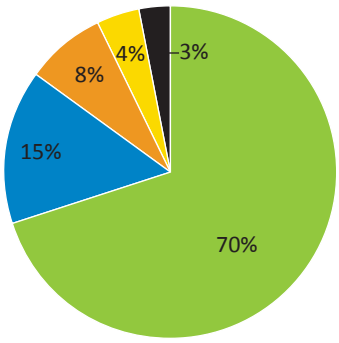
2016 marked the 10th anniversary of our quarterly newsletter, *Manitoba OmbudsNews*. The publication, available on our website, continues to be an effective means of sharing information about initiatives and events with an audience that includes all civil servants, other public-sector organizations and members of the public who choose to subscribe.

INTAKE SERVICES

All inquiries and complaints received under the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Health Information Act (PHIA) and the Ombudsman Act are initially reviewed by Intake Services. Inquiries and disclosures related to the Public Interest Disclosure (Whistleblower Protection) Act (PIDA) are handled by the PIDA investigation team (see pages 23-24).

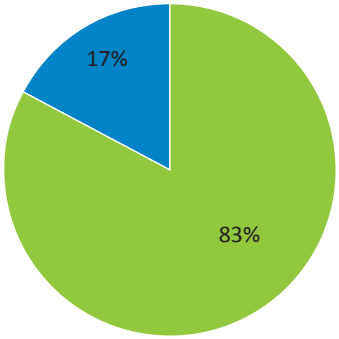
Intake staff accept calls from the public, meet with clients who attend the office and respond to email and written inquiries and complaints. Intake staff are responsible for identifying the specific nature of complaints, explaining the role and function of the office, assessing jurisdiction, explaining avenues of review or appeal, making appropriate referrals for non-jurisdictional concerns, reviewing documentation and conducting research. Intake Services can sometimes initiate and achieve early resolution of concerns raised to the office, before they go to a formal investigation.

In 2016, Intake Services handled 3227 inquiries and complaints:



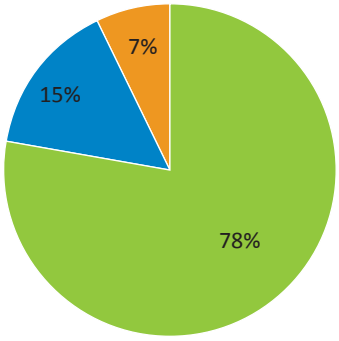
COMMUNICATION METHOD

- Telephone
- Complaint form/letter by mail or fax
- Email
- Website
- In person (walk-in)



JURISDICTION

- Within our jurisdiction
- Not within our jurisdiction



ACT

- Ombudsman Act
- FIPPA
- PHIA

For the number of cases opened for formal investigation, see specific sections by act later in this report.

Intake Services: Case Studies

Intake staff communicate with complainants on a daily basis. In most instances, intake staff assist complainants by explaining referral and appeal options that might be helpful as a first step in solving their issues and concerns. Sometimes, complainants may have tried to resolve their concerns, but have not been able to do so for a variety of reasons. In some circumstances, intake staff will attempt to informally resolve an issue if it appears that it may be relatively straightforward to do so. Sometimes facilitating communication between an individual and the right person at the organization being complained about is all that is required to achieve a resolution. At other times, making some preliminary inquiries to obtain more information about the matter being complained about can prompt an organization to revisit and sometimes amend its initial decision.

Intake staff were able to informally resolve 114 such cases in 2016, including in the following case examples:

Case 1 A tenant contacted our office after hydroelectricity in his apartment was disconnected because of arrears on an account with Manitoba Hydro. The individual had moved into a new apartment where hydroelectricity was included in the lease; however, there was some confusion over billing. After putting the individual in contact with Hydro, the two parties were able to sort out the issue, service was reconnected and the individual was reimbursed some money.

Case 2 A tenant in a Manitoba Housing unit wanted the lock on her apartment door changed because of security concerns. Initially, she was told that changing the lock without approval could result in eviction, and she called our office for assistance. We were able to contact Manitoba Housing to clarify the policy on changing locks and we requested that they contact the individual to explain the process. They did so, and the individual was able to have her concerns addressed.

Case 3 A new Manitoba resident was living in a trailer on a vacant property while making plans to build a home. As the municipality only allowed trailers on vacant lots after a building permit had been obtained and the individual in this case had not yet applied for a permit, a by-law enforcement officer ordered the trailer be removed. The individual appealed the order to the municipal council but was not successful – council upheld the order to remove the trailer. The individual contacted our office for assistance. After we contacted the municipality, they set up a meeting with the individual, who in the end, was allowed to keep the trailer for a longer period, which gave her the necessary time to apply for a building permit.

Case 4 An individual was unable to get reimbursement for prescription drugs from the provincial Pharmacare program due to insufficient documentation to verify his income. We contacted the Provincial Drug Program to see what documentation is required to determine a person's income. In the end, the department decided to revisit their decision and the individual received a Pharmacare reimbursement.

Case 5 An inmate in a correctional facility had concerns about his ability to privately contact his lawyer. Within the correctional facility, the inmate was allowed to contact his lawyer from a phone in a staff office while being supervised by a correctional officer, which meant the inmate was not afforded privacy during his calls. We contacted the facility for more information and asked if there was a private setting where the calls could be made. After exploring some options, the facility was able to arrive at a solution to allow private calls between the inmate and his lawyer in this specific case.

ACCESS AND PRIVACY

The Freedom of Information and Protection of Privacy Act (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 Personal Health Information Act (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.

FIPPA applies to:

- provincial government departments, offices of the ministers of government, the office of the executive council, 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
- health-care bodies such as hospitals and regional health authorities

PHIA applies to:

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

The Ombudsman's Role Under FIPPA and PHIA

Under FIPPA and 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 bodies or trustees, or a privacy concern about the way their personal information has been handled. For example, a person can make a complaint if he or she believes a public body or trustee has:

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

The ombudsman has additional duties and powers under FIPPA and PHIA, 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 legislation or programs affecting access and privacy rights, and
- commenting on the implications of the use of information technology in the collection, storage, use or transfer of personal and personal health information

Complaint Investigations

Every year, there are complaint investigations that illustrate the significant time and effort expended to try to address complaints about access under FIPPA. The following two case examples from 2016 illustrate these efforts.

Assiniboine River Maps

In 2016, our office concluded an investigation of a refusal of access complaint for copies of maps of dykes on the lower Assiniboine River that were believed to have been transferred to the provincial government from the federal government under the Prairie Farm Rehabilitation Administration (PFRA) agreement. Manitoba Infrastructure and Transportation (since renamed Manitoba Infrastructure) took numerous steps to try and locate these records, which were believed to have been transferred in 1996. Staff with current responsibilities for Assiniboine River dykes were consulted; however, they identified only textual records, and not maps. A search was also made of the Keystone Database (Archives of Manitoba), with the same result. In addition, senior staff were consulted in various areas of the department, such as hydrologic forecasting and water management, operations and maintenance, policy development and planning and standards to determine the potential whereabouts of the records. These employees did not have copies of the requested records, and moreover, did not remember ever seeing PFRA maps of Assiniboine River dykes. The department also made inquiries with two other departments that might be expected to have these types of records, and confirmed that the maps were not in the possession of these other departments either. During our investigation, the department continued its search, including reviewing over 50 boxes of materials transferred from PFRA, but did not locate the requested maps. Manitoba Infrastructure and Transportation explained that additional PFRA records may be transferred by the federal government in the future; however, it concluded that the records that have been transferred to date do not include the requested maps. On the basis of these search efforts, our office found that it was reasonable for the department to conclude that the requested records did not exist or could not be found. Our report on case 2015-0349 is posted on our website.

Employment and Income Assistance (EIA)

An individual complained under FIPPA that he had not received access to his complete EIA file, despite making three requests for the same information in as many months. Following several discussions with the complainant, our office came to understand that the complainant believed that there were additional records in his file that he had not been provided.

Further contact with the complainant identified that the records he believed to be missing were letters and medical information contained in correspondence between himself and his EIA caseworker. He thought these records had not been considered in an appeal hearing he had before the Social Services Appeal Board and that this could only be explained by the absence of these records from his EIA case file. The complainant also believed that there were discrepancies in the number of records he received in response to his three separate FIPPA requests for his EIA file, which led him to believe that the responses were not thorough.

Our investigation included attending the public body's office to review the complainant's entire EIA file (about 900 pages) in comparison to the records released in each of his requests and the records he believed were missing. We were able to verify that the records the complainant believed were missing had in fact been included in the package released to him, and that the reason for the different numbers of records being released in response to his three requests were that two requests encompassed only parts of his file and that only the third request encompassed the entire file. We reviewed the allegedly missing records with the complainant and were able to confirm that he did in fact have these records. However, he identified additional records that he now also believed had not been provided. We made further inquiries with the public body and verified that these records had also been provided to the complainant, which we subsequently were able to confirm with the complainant. We ultimately found that the public body had made every reasonable effort to identify and provide the requested records, and while we did not support the individual's complaint, our investigation addressed all of the issues raised in the complaint and those that arose during the investigation. Our report on case 2015-0200 is posted on our website.

In addition to complaints about access, our office concluded a number of privacy investigations in 2016. The following two case summaries highlight issues with collection, use and/or disclosure of personal health information.

Disclosure by the Appeal Commission

Our office investigated a complaint regarding the alleged unauthorized disclosure of personal health information by the Appeal Commission appointed under the Workers Compensation Act. The complainant's personal health information was contained in a written decision (with reasons), which was issued to both the complainant and his former employer. The complainant, who had not worked for this employer for approximately 16 years, questioned why his personal health information would be disclosed to his former employer, who had not even participated in the appeal.

The commission explained that it was required to give all parties who have a direct interest in a matter the opportunity to make representations, including the employer of the worker at the time of the accident. The commission was also required to give written notice of a decision to any person with a direct interest in a matter.

Our office agreed that the commission was authorized under PHIA to disclose the complainant's personal health information to the former employer on the basis that the disclosure was authorized or required by the Workers Compensation Act. However, we found that the commission did not limit its disclosure to the minimum amount of personal health information necessary to accomplish the purpose for which it was disclosed. While the commission was required to give written notice of its decision, giving reasons was required only when requested by a person with a direct interest in the matter. In this case, the employer had not requested written reasons for the commission's decision (and did not even participate in the appeal), and therefore we found that the commission was not authorized to disclose the detailed personal health information described in the written reasons for the decision.

In this particular case, we felt the primary issue was that although the former employer took no interest whatsoever in the proceedings, the term "person who has a direct interest," had such a broad definition that the commission could not exercise any discretion in determining whether the former employer was indeed affected by the decision regarding the complainant's appeal. The commission advised our office that it was prepared to recommend to the WCB Board of Directors that a revision of this definition be considered in the next legislative review. The report on this case (2015-0142) is available on our website. It includes discussion about the importance of giving written reasons as part of the rules of natural justice.

Collection, use and disclosure of personal health information for disability accommodation

Trustees (including public bodies) across Manitoba collect, use and disclose personal health information for the purpose of providing accommodations for employees with disabilities (as well as administering employee sick leaves). In 2016, we posted a report (cases 2015-0352, 2015-0353 and 2015-0354) on our website that touches on these issues.

The complaints about collection, use and disclosure were united by a common thread, which was that the actions of the trustee were not consistent with the complainant's expectations. While our office found that the trustee had complied with the requirements of PHIA regarding the collection, use and disclosure of the complainant's personal health information, the complaints highlighted the importance of open communication between trustees and individuals in the administration of disability accommodations (and sick leave as well). In particular, the collection of personal health information from an individual's physician (or other health-care professional) without the individual's knowledge and authorization was not consistent with the intent of PHIA, which indicates that collection of information directly from the individual is always preferable, whenever possible. We also observed that involving individuals in the process by collecting the information through the individual, gives them an opportunity to ask questions and avoids surprising them at a later date about what and how much information has been collected. Our report also discusses considerations relevant to limiting use of personal health information to those employees who need to know the information.

Ombudsman-Initiated Activities Under FIPPA and PHIA

In addition to the investigation of complaints, FIPPA and PHIA enable our office to undertake other activities including consultation and providing advice.

In 2016, we initiated 35 reviews and investigations – 21 under part 4 of FIPPA and 14 under part 4 of PHIA. Including the 21 cases carried over from 2015, we worked on a total of 56 cases and concluded 33 of them. These included consideration of longer extension requests under FIPPA and reviews of privacy breaches voluntarily reported to our office under both FIPPA and PHIA.

Consultation and Comments

New initiatives, proposed legislation, programs or practices of public bodies and trustees often have privacy or access to information implications. Our role under FIPPA and PHIA enables us to reach out or respond to requests for consultation about access or privacy implications and provide comments about these matters. We generally do not report publicly about these matters, unless there is a public interest in doing so, due to their confidential nature. During 2016, we were formally consulted in seven matters.

In addition to formal comments, public bodies and trustees also seek informal guidance from us to assist them in dealing with challenging access and privacy issues under FIPPA and PHIA. These inquiries indicate a commitment to ensuring compliance with the acts and following best practices. Although we cannot provide any kind of advance ruling, we can offer guidance and general advice. In responding to these inquiries, we may discuss factors to consider in interpreting and applying provisions of FIPPA and PHIA, provide guidance on best practices to follow, or refer them to investigation reports, practice notes or other resources on our website.

Privacy Breach Practices Survey and Report

Public-sector organizations collect, use and disclose information about Manitobans in order to deliver various programs, services and benefits. Although organizations may strive to handle personal and personal health information in accordance with FIPPA and PHIA, privacy breaches can occur due to human error, use of technology or malicious actions. A privacy breach can have significant consequences for the affected individuals including identity theft, damage to reputation and relationships, or loss of employment. Those individuals, as well as our office, may not be aware of privacy breaches that have occurred as in Manitoba there is no requirement to notify affected individuals of a breach of their information or report a breach to our office.

In order to gain a better understanding of how prepared organizations are to respond effectively to privacy breaches, we distributed a survey about privacy breach practices to 238 public-sector organizations. Our report, *Privacy Breach Practices in Manitoba*, provides a summary of our findings and our analysis of some of the issues raised by the survey responses. In response to the survey findings, we created a privacy breach resources page on our website as a place to bring together useful material to assist public bodies and trustees in preparing for and managing privacy breaches. The page is at https://www.ombudsman.mb.ca/info/privacy-breaches.html

Privacy Breach Reports

In addition to our investigation of privacy complaints from individuals about their own personal or personal health information, we also initiate investigations of privacy breaches that come to our attention in other ways. We may hear about breaches through the media or from a member of the public contacting our office. Most come to our attention through voluntary reports made to our office by public bodies and trustees. Privacy breach reports are not mandatory in Manitoba.

During these privacy breach investigations, we assist public bodies and trustees by making suggestions about actions to take to respond quickly and effectively to the breach. We may provide guidance on containing the breach and on providing notice to affected individuals. We will also review the circumstances of the privacy breach in order to identify opportunities to prevent similar future breaches by strengthening practices for protecting personal information and personal health information. Suggested improvements could include implementing measures to safeguard information, such as requiring password protection and encryption of electronic devices. We may also suggest developing new policies, providing training, or creating and implementing a program to audit user access to personal (health) information in electronic form.

In 2016, our office initiated 14 privacy breach investigations and five investigations were completed.

Interjurisdictional Collaboration

As part of a federal, provincial and territorial community of access and privacy oversight offices across Canada, we often work together on issues of mutual interest and concern. To highlight this interjurisdictional work, we created a page on our website at https://www.ombudsman.mb.ca/info/federal-provincial-territorial.html

In 2016, the federal privacy commissioner, along with provincial and territorial counterparts including our office, provided a submission on the federal government's review of national security laws and policies. The submission stressed the importance of considering the impact of surveillance measures and the need to address privacy risks related to information sharing by government and collection of metadata by national security agencies and law enforcement bodies. Metadata is generated constantly by digital devices and it can reveal sensitive personal information, such as medical conditions, personal interests, and many other elements of personal information. For example, the metadata created when you browse on the internet includes your search queries, the results that appeared in your searches and the pages visited and when. The metadata generated from sending an email message includes the sender and recipient's names and email addresses, the subject of the email, the date and the time.

Snooping Charge Laid Under PHIA

In 2016, our office laid a charge for the first time under a new offence provision in PHIA against a former employee of Manitoba Health, Healthy Living and Seniors (now Manitoba Health, Seniors and Active Living) for deliberately accessing another person's personal health information inappropriately. PHIA was amended on December 5, 2013, to make it an offence for an employee to willfully use, gain access to, or attempt to gain access to another person's personal health information contrary to the act. This amendment was requested by our office as a result of a previous snooping incident.

SUMMARY OF 2016 FIPPA AND PHIA COMPLAINTS OPENED AND CLOSED

FIPPA

FIPPA Complaints Opened	
Type of Access Complaint	
Refused access	102
No response	39
Request was disregarded	4
Extension	10
Fees	14
Fee waiver	4
Correction	1
Other access matters	15
Sub-total	**189**
Type of Privacy Complaint	
Collection	6
Use	6
Disclosure	15
Sub-total	**27**
Other	
Third party contests access	-
Complaint by relative of deceased	-
Sub-total	-
Total FIPPA complaints opened	**216**

FIPPA Complaints Closed	Total	Declined or discontinued	Supported in part or in whole	Not supported	Resolved	Recommendation made
Type of Access Complaint						
Refused access	92	9	27	51	5	-
No response	32	8	24	-	-	-
Request was disregarded	2	1	-	1	-	-
Extension	11	2	5	3	1	-
Fees	8	-	1	4	3	-
Fee waiver	2	1	-	1	-	-
Correction	1	1	-	-	-	-
Other access matters	14	1	8	2	3	-
Sub-total	**162**	**23**	**65**	**62**	**12**	**-**
Type of Privacy Complaint						
Collection	6	1	2	3	-	-
Use	4	1	2	1	-	-
Disclosure	6	1	2	2	1	-
Sub-total	**16**	**3**	**6**	**6**	**1**	**-**
Other						
Third party contests access	-	-	-	-	-	-
Complaint by relative of deceased	-	-	-	-	-	-
Sub-total	-	-	-	-	-	-
Total FIPPA complaints closed	**178**	**26**	**71**	**68**	**13**	**-**

PHIA

PHIA Complaints Opened	
Type of Access Complaint	
Refused access	4
No response	1
Fees	1
Fee waiver	-
Correction	1
Other access matters	1
Sub-total	**8**
Type of Privacy Complaint	
Collection	1
Use	8
Disclosure	11
Failure to protect	-
Sub-total	**20**
Total PHIA complaints opened	**28**

PHIA Complaints Closed	Total	Declined or discontinued	Supported in part or in whole	Not supported	Resolved	Recommendation made
Type of Access Complaint						
Refused access	-	-	-	-	-	-
No response	1	1	-	-	-	-
Fees	-	-	-	-	-	-
Fee waiver	-	-	-	-	-	-
Correction	1	-	-	-	1	-
Other access matters	1	-	-	1	-	-
Sub-total	**3**	**1**	**-**	**1**	**1**	**-**
Type of Privacy Complaint						
Collection	3	1	-	2	-	-
Use	8	-	4	4	-	-
Disclosure	9	2	4	1	2	-
Failure to protect	1	-	-	1	-	-
Sub-total	**21**	**3**	**8**	**8**	**2**	-
Total PHIA complaints closed	**24**	**4**	**8**	**9**	**3**	**-**

FIPPA INVESTIGATIONS OF INDIVIDUAL COMPLAINTS (UNDER PART 5)

Some Manitoba government departments were restructured in 2016. Our statistics reflect the new structure. Former names are included in brackets below.	Case Numbers			Case Dispositions							
	Carried over into 2016	New cases in 2016	Total cases in 2016	Pending at 12/31/2016	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Provincial department											
Agriculture (Agriculture, Food & Rural Development)	1	2	3	2	-	-	-	-	-	1	-
Civil Service Commission	-	3	3	2	1	-	-	-	-	-	-
Education & Training	-	3	3	-	-	2	1	-	-	-	-
Executive Council	9	3	12	7	-	-	3	-	2	-	-
Families (Family Services)	16	9	25	14	-	2	1	3	4	1	-
Finance	5	3	8	4	-	-	4	-	-	-	-
Growth, Enterprise & Trade (Jobs & the Economy; Labour & Immigration)	5	9	14	8	-	-	4	1	-	1	-
Indigenous & Municipal Relations	-	1	1	1	-	-	-	-	-	-	-
Infrastructure (Infrastructure & Transportation)	7	11	18	5	-	3	6	3	-	1	-
Justice & Attorney General	9	6	15	4	-	2	7	1	-	1	-
Sport, Culture & Heritage (Tourism, Culture, Sport & Consumer Protection)	-	2	2	-	-	-	-	2	-	-	-
Sustainable Development (Conservation & Water Stewardship)	11	40	51	23	-	2	2	3	21	-	-
Crown corporation and government agency											
CFS Agency/Authority	-	4	4	4	-	-	-	-	-	-	-
East Side Road Authority	2	-	2	-	-	-	-	1	1	-	-
Manitoba Liquor & Gaming Authority	1	-	1	-	-	-	1	-	-	-	-
Manitoba Housing Authority	-	1	1	1	-	-	-	-	-	-	-
Manitoba Hydro	5	6	11	9	-	-	1	-	1	-	-
Manitoba Public Insurance	1	7	8	5	1	1	-	1	-	-	-
Taxicab Board	-	1	1	-	-	1	-	-	-	-	-
Workers Compensation Board	2	16	18	8	-	-	6	3	1	-	-
Local government body											
City of Brandon	-	3	3	2	-	1	-	-	-	-	-
City of Winnipeg	44	40	84	44	-	3	21	6	6	4	-
Eastern Interlake Planning District	1	-	1	1	-	-	-	-	-	-	-
Municipality of Bifrost-Riverton	-	2	2	-	-	1	-	1	-	-	-
Municipality of Brenda-Waskada	-	2	2	2	-	-	-	-	-	-	-
Municipality of Clanwilliam-Erickson	-	1	1	1	-	-	-	-	-	-	-
Municipality of Norfolk-Treherne	-	1	1	1	-	-	-	-	-	-	-
Municipality of Swan Valley West	-	4	4	3	-	1	-	-	-	-	-
Municipality of West Interlake (RM of Siglunes)	3	-	3	3	-	-	-	-	-	-	-
Red River Planning District	-	1	1	1	-	-	-	-	-	-	-

FIPPA INVESTIGATIONS OF INDIVIDUAL COMPLAINTS (UNDER PART 5), continued

	Case Numbers			Case Dispositions							
	Carried over into 2016	New cases in 2016	Total cases in 2016	Pending at 12/31/2016	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Local government body, continued											
RM of De Salaberry	2	3	5	1	-	-	1	1	2	-	-
RM of East St. Paul	-	3	3	-	-	-	-	-	3	-	-
RM of Gimli	2	-	2	-	-	-	1	-	-	1	-
RM of Lac du Bonnet	-	9	9	6	-	-	-	-	2	1	-
RM of Riding Mountain West	-	1	1	1	-	-	-	-	-	-	-
RM of Rosedale	1	-	1	1	-	-	-	-	-	-	-
RM of St. Clements	2	-	2	-	-	-	2	-	-	-	-
RM of Ste. Rose	-	3	3	1	-	1	-	1	-	-	-
Town of Beausejour	2	-	2	2	-	-	-	-	-	-	-
Town of Virden	-	1	1	-	-	-	-	-	-	1	-
Educational body											
Manitoba Institute of Trades & Technology	-	1	1	1	-	-	-	-	-	-	-
Mystery Lake School Division	1	-	1	1	-	-	-	-	-	-	-
Southwest Horizon School Division	-	1	1	-	-	-	1	-	-	-	-
St. James Assiniboia School Division	-	3	3	-	1	-	2	-	-	-	-
Western School Division	-	1	1	-	-	1	-	-	-	-	-
Universite de Saint-Boniface	1	-	1	1	-	-	-	-	-	-	-
University College of the North	1	-	1	-	-	-	1	-	-	-	-
University of Manitoba	-	4	4	2	-	1	1	-	-	-	-
University of Winnipeg	1	-	1	-	-	-	1	-	-	-	-
Health-care body											
Misericordia General Hospital	1	-	1	-	-	-	-	1	-	-	-
Prairie Mountain Health	2	-	2	1	-	-	-	-	-	1	-
St. Boniface General Hospital	-	1	1	-	-	-	1	-	-	-	-
Winnipeg Regional Health Authority	1	3	4	4	-	-	-	-	-	-	-
TOTAL											
	139	**216**	**355**	**177**	**4**	**22**	**68**	**28**	**43**	**13**	**0**

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: Decision by ombudsman not to investigate complaint, usually based on a determination that the circumstances do not require investigation.

Pending: Complaint still under investigation as of December 31, 2016.

PHIA INVESTIGATIONS OF INDIVIDUAL COMPLAINTS (UNDER PART 5)

Some Manitoba government departments were restructured in 2016. Our statistics reflect the new structure. Former names are included in brackets below.	Case Numbers			Case Dispositions							
	Carried over into 2016	New cases in 2016	Total cases in 2016	Pending at 12/31/2016	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Provincial departments											
Civil Service Commission	-	1	1	1	-	-	-	-	-	-	-
Families (Family Services)	1	1	2	-	-	-	1	1	-	-	-
Health, Seniors & Active Living (Healthy Living & Seniors)	9	1	10	9	-	-	1	-	-	-	-
Growth Enterprise & Trade (Jobs & the Economy)	2	-	2	2	-	-	-	-	-	-	-
Crown corporation and government agency											
CFS Agency	1	-	1	-	-	-	-	-	-	1	-
Manitoba Housing Authority	-	2	2	1	1	-	-	-	-	-	-
Manitoba Public Insurance	1	-	1	-	-	-	1	-	-	-	-
Workers Compensation Board	-	3	3	2	-	-	-	-	1	-	-
WCB Appeal Commission	1	-	1	-	-	-	-	1	-	-	-
Local government body											
City of Winnipeg	-	2	2	1	1	-	-	-	-	-	-
RM of Victoria Beach	-	1	1	1	-	-	-	-	-	-	-
Educational body											
Université de Saint-Boniface	1	-	1	-	-	-	-	-	1	-	-
University of Manitoba	-	1	1	1	-	-	-	-	-	-	-
Winnipeg School Division	1	-	1	1	-	-	-	-	-	-	-
Health-care body											
CancerCare Manitoba	1	-	1	1	-	-	-	-	-	-	-
Designated Health-Care Facility	4	-	4	-	-	-	3	-	1	-	-
Diagnostic Services of Manitoba	-	1	1	1	-	-	-	-	-	-	-
Grace Hospital	1	1	2	1	-	-	-	1	-	-	-
Medical Clinic	-	1	1	-	-	-	-	-	-	1	-
Northern Regional Health Authority	1	-	1	1	-	-	-	-	-	-	-
Prairie Mountain Regional Health	2	3	5	3	-	-	1	-	-	1	-
St. Boniface Hospital	-	1	1	1	-	-	-	-	-	-	-
Southern Health-Santé Sud	-	1	1	1	-	-	-	-	-	-	-
Winnipeg Regional Health Authority	4	2	6	3	-	-	2	-	1	-	-
Health-care practitioner											
Occupational therapist	-	1	1	-	-	1	-	-	-	-	-
Pharmacist	-	1	1	1	-	-	-	-	-	-	-
Physician	-	4	4	2	-	1	-	-	1	-	-
TOTAL											
	30	**28**	**58**	**34**	**2**	**2**	**9**	**3**	**5**	**3**	**-**

PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER)

Under the Public Interest Disclosure (Whistleblower Protection) Act (PIDA), our office investigates disclosures of wrongdoing. A wrongdoing under PIDA is a very serious act or omission that is an offence under another law, an act or omission that creates a specific and substantial danger to the life, health, or safety of persons or to the environment, or gross mismanagement, including the mismanagement of public funds or government property.

2016 Investigations and Reports

In 2016, we initiated four PIDA investigations into allegations of wrongdoing. Additionally, four PIDA reports were finalized. The subjects of the finalized reports were:

- an alleged danger to health, life and safety regarding the use of specific equipment at a hospital
- alleged dangers to the health and safety of patients at a hospital
- alleged danger to the health and life of inmates at a correctional centre
- alleged dangers to health and life of residents at a personal care home

None of the investigations resulted in findings of wrongdoing. However, in three of the four reports, we made some recommendations for administrative improvement including improved care. All recommendations were accepted by the respective public bodies and prior to the end of 2016, all public bodies had also implemented the recommendations.

When our office declines to investigate disclosures

In 2016, we declined to investigate 15 disclosures of wrongdoing. In most cases, disclosures were declined because they were outside our mandate to investigate as a wrongdoing under PIDA.

Before declining a disclosure, considerable work is put into assessing it. All disclosures are assessed using the same procedure. First, an analysis is conducted to identify the details and nature of the allegations. An investigator then meets with the discloser to fully determine the scope and seriousness of the allegations. Evidence provided by the discloser and applicable law and policies are also reviewed.

An assessment is then completed. If the allegations do not describe matters that are serious or significant enough, we cannot investigate under PIDA. However, our involvement in the matter may not cease at this point.

In most cases, we try to identify an alternate solution for the discloser. Sometimes, this may be to advise the discloser on other potential avenues for dealing with the matter (perhaps through a union or another public office). In other cases, we may bring the matter to the attention of the public body, often by meeting with senior staff to inform them of the allegations. Once they become aware of the matter, public bodies may initiate their own internal investigation.

In some cases, public bodies also inform us about the outcome of their investigations, so that we can then share that information with the discloser. In this way, the discloser, while remaining anonymous to the public body, is made aware of the outcome of the internal investigation into their concerns.

PIDA INQUIRIES AND INVESTIGATIONS

	Case Numbers			Case Status							Recommendations	
	Assistance provided	PIDA case files carried over into 2016	New PIDA case files opened in 2016	Total PIDA case files pending at 12/31/2016	Declined investigation	Discontinued investigation	Referred investigation	Disclosure resolved	Investigation completed – wrongdoing found	Investigation completed – wrongdoing not found	Recommendations made	Follow-up on recommendations completed
Government department		1	5	3	3	-	-	-	-	-	-	-
Health-care facility		2	1	1	-	-	-	-	-	2	1	1
Personal care home		2	2	1	2	-	-	-	-	1	1	2
Regional health authority		1	1	1	1	-	-	-	-	-	-	-
Child and Family Services agency/authority		3	4	1	4	-	-	2	-	-	-	-
Corrections facility		1	1	-	1	-	-	-	-	1	1	1
University/college		-	-	-		-	-	-	-	-	-	-
Crown corporation		2	1	1		1	1	-	-	-	-	-
Other government body or publicly funded organization		3	4	3	3	-	-	1	-	-	-	-
Non-jurisdictional public body		-	1	-	1	-	-	-	-	-	-	-
TOTAL	**21**	**15**	**20**	**11**	**15**	**1**	**1**	**3**	**-**	**4**	**3**	**4**

Assistance provided: Assistance or information supplied to public body or to individual upon being contacted regarding PIDA issues. These contacts with our office did not result in a disclosure being submitted.

PIDA case files carried over into 2016: Case files that were pending resolution at the beginning of 2016. Case files can contain more than one disclosure.

New PIDA case files opened in 2016: A case file is opened when a written disclosure is received. Some case files may contain more than one disclosure regarding the same matter.

Total PIDA case files pending at 12/31/2016: PIDA case files pending resolution as of January 1, 2017. These may be ongoing investigations or pending assessment to determine if investigation is required.

Declined investigation: Disclosure not accepted for investigation by the ombudsman, for reason of non-jurisdiction, but more often in cases when the allegations did not pertain to wrongdoings as defined by PIDA. In many of these cases, the matter was instead referred to the applicable public body for internal review and action.

Discontinued investigation: Investigation of disclosure ceased by the ombudsman.

Referred investigation: Disclosure referred to another public body to be investigated using a procedure provided for under an act other than PIDA.

Disclosure resolved: Disclosure was resolved informally without completing an investigation.

Investigation completed – Wrongdoing found: Upon completion of investigation, one or more wrongdoings, as defined by PIDA, were found.

Investigation completed – Wrongdoing not found: Upon completion of investigation, no wrongdoing, as defined by PIDA, was found.

Recommendations made: As a result of an investigation, recommendations were made to one or more public bodies, whether wrongdoing was found or not.

Follow-up on recommendations completed: Monitoring the completion of a public body's commitment to our recommendations has concluded. Completion of the monitoring can be for recommendations made in the previous year.

OMBUDSMAN

Under the Ombudsman Act, our office investigates administrative actions and decisions made by government departments and agencies, and municipalities, and their officers and employees.

Our investigations typically assess actions taken or decisions made against a benchmark established by government. Sometimes that benchmark is provincial legislation or a municipal by-law. In cases concerning an impact on individual rights or benefits, we also examine the fairness of the action or decision. If a complaint is supported, we may make recommendations. Administrative investigations can also identify areas where improvements may be suggested to a government body.

We continued our work in monitoring and reporting on the status of inquest recommendations made by provincial court judges under the Fatality Inquiries Act. We also tracked the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate.

Municipal Cases: By-Law Enforcement

In 2016, we concluded several municipal investigations related to by-law enforcement. In some we made recommendations related to the cancellation of fees or fines, and in others our recommendations were related to policies and recordkeeping.

In one case, a town removed a trailer it deemed to be unsafe from the property of a resident and had it demolished. The town added the cost of the removal and destruction of the trailer to the resident's property tax bill. Although it was within the jurisdiction of the town to take steps to remove the trailer and bill the resident for the associated costs, we determined some of the expenses should not have been charged to the resident, specifically expenses the municipality had incurred during its first failed attempt to remove the trailer. As a result, the town reimbursed the resident for some of the costs billed.

In another case, a property owner complained to us about a municipality's decision to enforce an emergency clean up of her property and bill her for the cost. Debris had been piled on the municipal road by a landscaping company hired by the property owner. The municipality considered the debris a hazard that needed to be immediately removed, and as such, it was authorized to charge the property owner for removal of the debris. However, under the municipality's litter by-law an individual was only liable to a fine upon a summary conviction. In this case, the time frame to take such legal action had expired. Following our investigation, we recommended that the municipality rescind the offence notice fine, which it agreed to do.

We also had a complaint from a resident after she cleaned up her property in response to an order from the municipality. Several months after the compliance deadline, the municipality returned to the property, conducted a clean up and billed the owner for it. There was no record of the municipality ever inspecting the property to see if it had been cleaned by the owner by the deadline. We recommended that the municipality amend its unsightly property policy by adding a reasonable time frame for the enforcement of a compliance order once a deadline had elapsed. The municipality also cancelled the bill it issued to the property owner.

A complaint was also made to us that a business located in a residential building was contravening home occupation requirements set out in the local zoning by-law. The local government district (LGD) was aware the home-based business was not complying with the by-law and was trying to resolve the matter with the business owner. However, there were no records of discussions between the LGD and the business or any other records of the LGD's decision making in this matter. We recommended that the LGD establish a policy for how it addresses by-law non-compliance and clarify how it will keep records of its investigations, inspections and decisions regarding such matters. The LGD agreed to develop a policy concerning how to address by-law non-compliance and agreed to maintain written records for site inspections that arise following allegations of unlawful activity.

Provincial Cases: Policies and Procedures

In 2016, we also concluded several provincial investigations in which we made recommendations for changes in law, policy or procedures.

In one case, a homeowner's basement was damaged by water seepage and subsequently by sewer backup during the 2011 flood. The Disaster Assistance Appeal Board denied the homeowner's appeal of an Emergency Measures Organization (EMO) decision to reject his application for disaster financial assistance. In denying his application, EMO and the board relied on the "principle of concurrent causation," explaining that because some of the damage was caused by sewer backup, which is insurable, assistance was not available through the Disaster Financial Assistance program. As a result of our investigation, EMO agreed to review how it applies concurrent causation and set out circumstances under which uninsurable damages are deemed to be insurable.

In another case, a rural taxicab operator alleged that Winnipeg taxicab drivers were operating illegally outside the City of Winnipeg. We found there were gaps with respect to the enforcement of certain regulations concerning the operation of taxicabs and a lack of clarity as to the enforcement responsibilities between the Motor Transport Board and the Taxicab Board. We also determined that the regulatory framework appears to be inequitable, providing advantages to Winnipeg taxicab drivers over rural taxicab drivers. We recommended that the departments responsible for the boards look at legislative and regulatory changes that would address any unfairness. The departments involved indicated that our recommendations will be taken into account in any future policy or regulatory considerations.

We were also contacted by an individual who believed the Manitoba Housing and Renewal Corporation (MHRC) had retained architectural services for a project without a competitive bidding process. MHRC explained to us that rather than using a competitive bidding process, it expanded the scope of existing contracts it had awarded after a public tendering process. We found that while MHRC's decision deviated from existing procedure, MHRC's rationale for its approach in this case was reasonable. However, we recommended that when tendering contracts that may be extended, MHRC should look at opportunities to clearly communicate this intent to potential bidders at the outset of the process. Our investigation also revealed the agreement to expand the scope of the work was initially done without putting the details in writing. We recommended that MHRC formally document its commitments of public funds in exchange for goods and services. MHRC accepted our recommendations.

Inquest Reporting

Under the Fatality Inquiries Act, the chief medical examiner may direct that an inquest be held into the death of a person. Inquests are presided over by provincial court judges. Following the inquest, the judge submits a report and may recommend changes in the programs, policies and practices of government that in his or her opinion would reduce the likelihood of a death in similar circumstances.

Since 1985, Manitoba Ombudsman has been responsible by way of an agreement with the chief medical examiner for following up with the provincial government department, agency, board, commission or municipality to which inquest recommendations are directed, to determine what action has been taken. The status of the responses to the recommendations by the public bodies are available on our website.

In 2016, we opened nine files relating to three inquests (one file may be related to multiple departments). Since 2008, we have publicly reported on 48 inquests.

OMBUDSMAN ACT INVESTIGATIONS

Some Manitoba government departments were restructured in 2016. Our statistics reflect the new structure. Former names are included in brackets below.	Case Numbers			Case Dispositions							
	Carried over into 2016	New cases in 2016	Total cases in 2016	Pending at 12/31/2016	Case resolved early	Declined or discontinued	Not supported	Partly resolved	Resolved	Recommendation(s) made	Other
Manitoba government departments											
Agriculture (Agriculture, Food & Rural Development)	2	1	3	2	-	1	-	-	-	-	-
Education & Training	-	1	1	-	-	1	-	-	-	-	-
Families (Family Services; Housing & Community Development)	2	4	6	2	-	2	1	-	-	1	-
Finance	5	1	6	-	-	1	4	1	-	-	-
Growth, Enterprise & Trade	-	1	1	-	-	1		-	-	-	-
Health, Seniors & Active Living (Health, Healthy Living & Seniors)	2	1	3	1	-	-	1	-	-	-	1
Indigenous & Municipal Relations (Municipal Government)	14	1	15	14	-	-	-	-	-	1	-
Infrastructure (Infrastructure & Transportation)	5	3	8	2	-	2	1	1	-	2	-
Justice & Attorney General (Justice)	8	9	17	11	1	3	1	1	-	-	-
Sport, Culture & Heritage	-	2	2	-	-	2	-	-	-	-	-
Sustainable Development (Conservation & Water Stewardship)	4	3	7	4	-	1	1	-	-	1	-
Other Manitoba government bodies											
Assiniboine Community College	-	1	1	1	-	-	-	-	-	-	-
Manitoba Hydro	1	-	1	1	-	-	-	-	-	-	-
Manitoba Public Insurance	2	-	2	1	-	-	-	1	-	-	-
WCB Appeal Commission	1	-	1	-	-	-	1	-	-	-	-
Workers Compensation Board	-	2	2	-	-	1	1	-	-	-	-
Municipalities											
City of Winnipeg	8	3	11	5	-	2	2	1	1	-	-
Other cities, RMs, towns, villages	24	20	44	13	4	13	7	1	3	3	-
Planning districts	5	2	7	2	-	1	2	1	1	-	-
Community council	-	1	1	-	-	1	-	-	-	-	-
TOTAL											
	83	**56**	**139**	**59**	**5**	**32**	**22**	**7**	**5**	**8**	**1**

Pending: Complaint still under investigation as of December 31, 2016.

Case resolved early: Case resolved before proceeding through a full formal investigation process.

Declined or discontinued: Investigation ceased as complaint was withdrawn or due to issues of jurisdiction or the existence of other avenues of appeal or resolution.

Not Supported: Complaint not supported at all.

Partly Resolved or Resolved: Complaint is partly or fully resolved through investigation.

Recommendation(s) made: All or part of complaint supported and recommendation(s) made after informal procedures prove unsuccessful.

Other: Monitoring and follow-up in previous cases where recommendations had been made, has been concluded.

Implementation of Recommendations Resulting from Special Investigations of Child Deaths by the Office of the Children's Advocate

Manitoba Ombudsman monitors and reports annually on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA). The recommendations are directed at entities and organizations involved with the child welfare system or any publicly funded social service in Manitoba.

When a child dies in Manitoba, the Office of the Chief Medical Examiner determines the manner of death and notifies the OCA of the death. The OCA is responsible for conducting a special investigation review of services that were delivered in the life of a child or youth if that young person or the family received child welfare services in the year before the death of the child.

In their special investigation reviews, the OCA may make recommendations to improve services, enhance the safety and well-being of children and prevent deaths in similar circumstances in the future.

Our office follows up with the entity or entities to which the recommendations have been made to determine what action has been taken in response to the recommendations, and to report publicly on those actions to ensure accountability.

Since the OCA received its mandate to perform reviews on September 15, 2008, to the end of our reporting period December 31, 2016, the OCA has made 524 recommendations. To date, 449 recommendations have been implemented (86 per cent).

Through our mandate to monitor and report annually on the implementation of the OCA'S recommendations, we have noted that while all the recommendations within the special investigation reviews are intended to improve services and enhance the safety and well-being of children and prevent future similar deaths, the recommendations range from specific, single-agency improvements to complex, multi-organizational system changes, even legislative changes. It is clear that some recommendations lend themselves to immediate implementation; others may require intensive consultation, coordination and collaboration.

The child welfare system in Manitoba is a large and complex network of entities that has evolved over time. Recommendations made by the OCA resulting from special investigations of child deaths often reflect this complexity, providing an avenue to examine the larger issues that impact the child welfare system and to make administrative improvements that help the system work together to implement larger systemic changes.

In preparation for this annual report, our office engaged in a new approach with the authorities who have the largest volume of pending and in progress recommendations. We undertook an extensive review of all outstanding recommendations made by the OCA since receiving its mandate in September 2008. This information was compiled and presented to the authorities as a means to assist them in the tracking and implementation of their recommendations, particularly those recommendations that were very longstanding. This process created additional consultation with our office and we also note that a large volume of fully implemented recommendations resulted.

Aggregate Investigations

In 2011 – 2012, the OCA began grouping some special investigation reviews together thematically into one special investigation report (SIR). Called an aggregate report, this type of SIR groups together a number of child death investigations according to service delivery from particular agencies, or examinations of certain issues linking multiple agencies. Some of the systemic themes explored involve staff training, recordkeeping, inter-organizational communication, the ability of agencies to respond to the needs of older youth and gang interference in the lives of children.

Table 1 illustrates the number of special investigation reports received by our office from the OCA by fiscal year from September 15, 2008 to December 31, 2016. Table 2 illustrates the status of special investigation report recommendations by calendar year.

Table 1: Special Investigation Reports Received by the Ombudsman from the OCA by Fiscal Year – September 15, 2008 to December 31, 2016

Fiscal Year	Child Deaths Investigated	Special Investigation Reports Received	SIRs Received with Recommendations	Recommendations Received
2008 - 2009	7	7	7	40
2009 - 2010	21	21	19	141
2010 - 2011	27	26	16	63
2011 - 2012	154*	147	15	44
2012 - 2013	89	76	22	72
2013 - 2014	82	69	24	60
2014 - 2015	55	53	12	49
2015 - 2016	49	49	16	45
2016 - Dec 31, 2016	27	27	3	10
Total	**511***	**475***	**134**	**524**

Table 2: Special Investigation Reports Received by the Ombudsman from the OCA by Calendar Year – September 15, 2008 to December 31, 2016

Calendar Year	Child Deaths Investigated	Special Investigation Reports Received	SIRs Received with Recommendations	Recommendations Received
2008	3	3	3	17
2009	19	19	17	83
2010	23	22	18	135
2011	148*	141	17	43
2012	78	65	20	69
2013	68	68	15	43
2014	72	59	21	63
2015	53	51	13	43
2016	47	47	10	28
Total	**511***	**475***	**134**	**524**

* Note: The number of child deaths investigated in 2011-2012 is significantly higher than other years due to cases carried from previous years, and is not reflective of the number of child deaths referred to the OCA by the OCME in that year. The number of Child Deaths Investigated and the number of Special Investigation Reports Received differ because some special investigation reports, called aggregate reports, group together a number of child death investigations into one report to address systemic issues.

Table 3 encompasses the recommendations within the special investigation reports received by our office from the OCA since September 15, 2008. The table illustrates the status of the recommendations as reported to us by the entities to which the recommendations were made using the status definitions as per the CFS Standing Committee, listed below:

CFS – Child and Family Services
CFSSC – Child and Family Services Standing Committee
CPB – Child Protection Branch/Division
FS – Department of Families
GA – General Child and Family Services Authority
MA – Metis Child and Family Services Authority
NA – First Nations of Northern Manitoba Child and Family Services Authority
OCA – Office of the Children's Advocate
SA – Southern First Nations Network of Care Child and Family Services Authority

Status Definitions Used in Table 3:

Complete – The organization to which the recommendation is directed has demonstrated that it has taken all necessary steps to respond to the recommendation.

Complete-Alternate Solution – The organization to which the recommendation is directed has developed an alternate solution which addresses the concern. The organization has formulated an implementation plan to fully respond to the issue underlying the recommendation and has demonstrated that it has taken all necessary steps to respond to the recommendation.

In Progress – The organization to which the recommendation is directed has formulated an implementation plan to fully respond to the recommendation.

Pending – The organization to which the recommendation is directed has not yet completed an implementation plan to fully respond to the recommendation.

Not Accepted (unachievable) ¬ The organization to which the recommendation is directed agrees with the recommendation but cannot implement the recommendation based on existing resources, legislation, or governance structure.

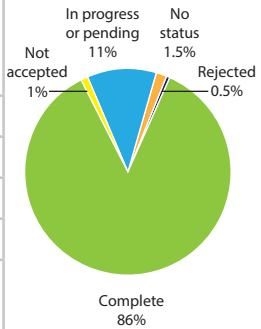
Rejected – The organization to which the recommendation is directed disagrees with both the foundation and substance of the recommendation.

Response Under Review – Manitoba Ombudsman has received information from the organization to which the recommendation is directed and is currently reviewing the information.

No Status Reported – The organization to which the recommendation is directed has not yet reported to Manitoba Ombudsman. Note that it is expected that entities would not report on recently issued recommendations.

Table 3: September 15, 2008 to December 31, 2016

	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NOT ACCEPTED	REJECTED	NO STATUS REPORTED TO THE OMBUDSMAN	STATUS OF RECOMMENDATIONS
Child Protection Branch	59	54	2	0	3	0	0	
CFS Standing Committee	1	1	0	0	0	0	0	
CPB & CFS Standing Committee	4	4	0	0	0	0	0	
Department of Families*	26	23	3	0	0	0	0	
Multiples – FS, CPB, NA, MA, SA, GA (more than one authority/ agency/entity)	19	14	4	0	1	0	0	
Southern Authority	167	145	14	0	1	2	5	
Northern Authority	162	129	31	0	0	0	2	
General Authority	32	32	0	0	0	0	0	
Metis Authority	21	17	4	0	0	0	0	
External organizations (other departments, private service providers)	33	30	2	0	0	0	1	
TOTAL NUMBER	**524**	**449**	**60**	**0**	**5**	**2**	**8**	
TOTAL PERCENTAGE		**86%**	**11%**	**0%**	**1%**	**0.5%**	**1.5%**	



* Note: Includes former department names of Family Services, Family Services & Labour and Family Services & Consumer Affairs.

Detailed statistics by year on the status of special investigation report recommendations received by our office from the OCA by entity are available on our website at:

https://www.ombudsman.mb.ca/documents_and_files/annual-reports.html