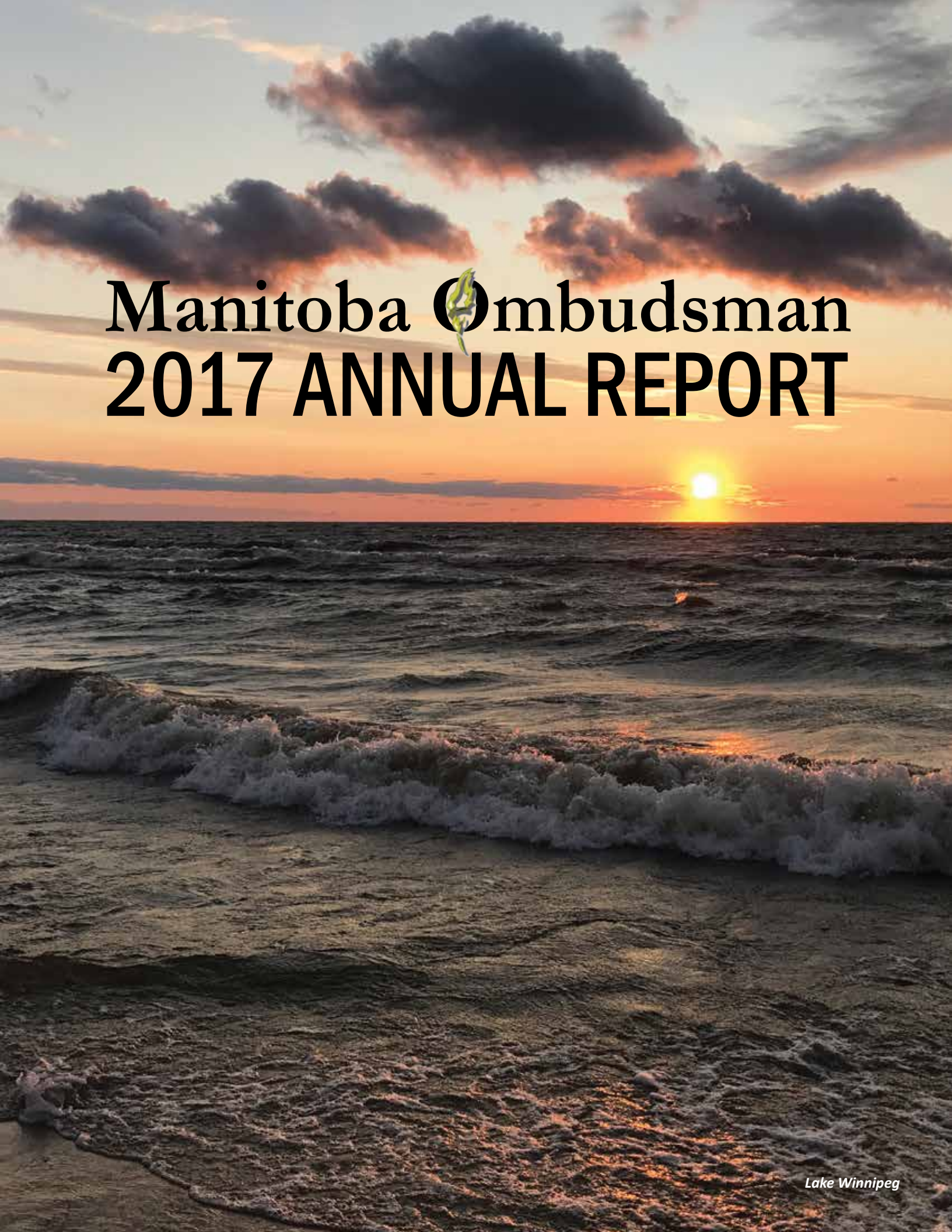

Manitoba Ombudsman
2017 ANNUAL REPORT

Lake Winnipeg

Manitoba Ombudsman

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May 28, 2018

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 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, 2017 to December 31, 2017.

Yours truly,

Charlene Paquin
Manitoba Ombudsman

Contents

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Ombudsman's Message

Charlene Paquin, Manitoba Ombudsman

I am pleased to present Manitoba Ombudsman's 2017 Annual Report, which highlights the work and accomplishments of the office.

2017 was a very busy year for the office. We saw an increase in inquiries, complaints and investigations, began a restructuring of the organization and continued to work on new initiatives.

We investigate complaints made under the Ombudsman Act, the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Health Information Act (PHIA) and the Public Interest Disclosure (Whistleblower Protection) Act (PIDA). This year, we saw a five per cent increase in the number of inquiries and complaints made to the office, and in total, we opened 432 formal investigations, which is a 27 per cent increase compared to last year, primarily due to more access and privacy complaints. Some of the investigations concluded in 2017 are highlighted later in this report. We also posted 24 of our investigation reports on our website.

Our work is primarily driven by complaints from the public and we are committed to providing efficient and timely service while ensuring that all our investigations are thorough, fair and impartial. In 2017, we continued with our efforts to address delayed cases, which have been an ongoing challenge for the office for many years. Delays in the conclusion of investigations can be due to complexity and can be cyclical and cumulative. However, we made significant strides in addressing our backlog and the work we have undertaken should set the stage for continued successes in this area.

Specific actions we have taken included creating and filling two new deputy ombudsman positions for the office – one dedicated to overseeing the Access and Privacy Division (FIPPA and PHIA) and one for the Ombudsman Division (the Ombudsman Act and PIDA). Changing the office's structure to include deputies has strengthened our ability to move forward effectively in meeting our core mandates and to lead focused change in the two divisions.

In early 2017, we undertook an internal review of our processes in the Access and Privacy Division. The outcome of this review has already helped to identify process changes and resulted in a dedicated plan to address the more significantly backlogged files, particularly under FIPPA where we have seen the most significant increases in complaints.

The office as a whole has also been engaged in reviewing and documenting our internal business processes. As our new organizational structure continues to evolve, this work will continue to help us identify areas where we can be more effective. We also reviewed our software needs to make sure we have a functional information technology system that allows us to manage our caseloads as well as support consistent and high quality data.

2017 marked the 20-year anniversary of PHIA and the 10-year anniversary of PIDA. This year, we also continued to work with the now named Manitoba Advocate for Children and Youth on developing a plan to open a joint office in Thompson. As well, this marks the last year that our office monitored and reported on recommendations made by the advocate under section 16.1 of the Ombudsman Act, as this function transferred to the Manitoba Advocate for Children and Youth in 2018.

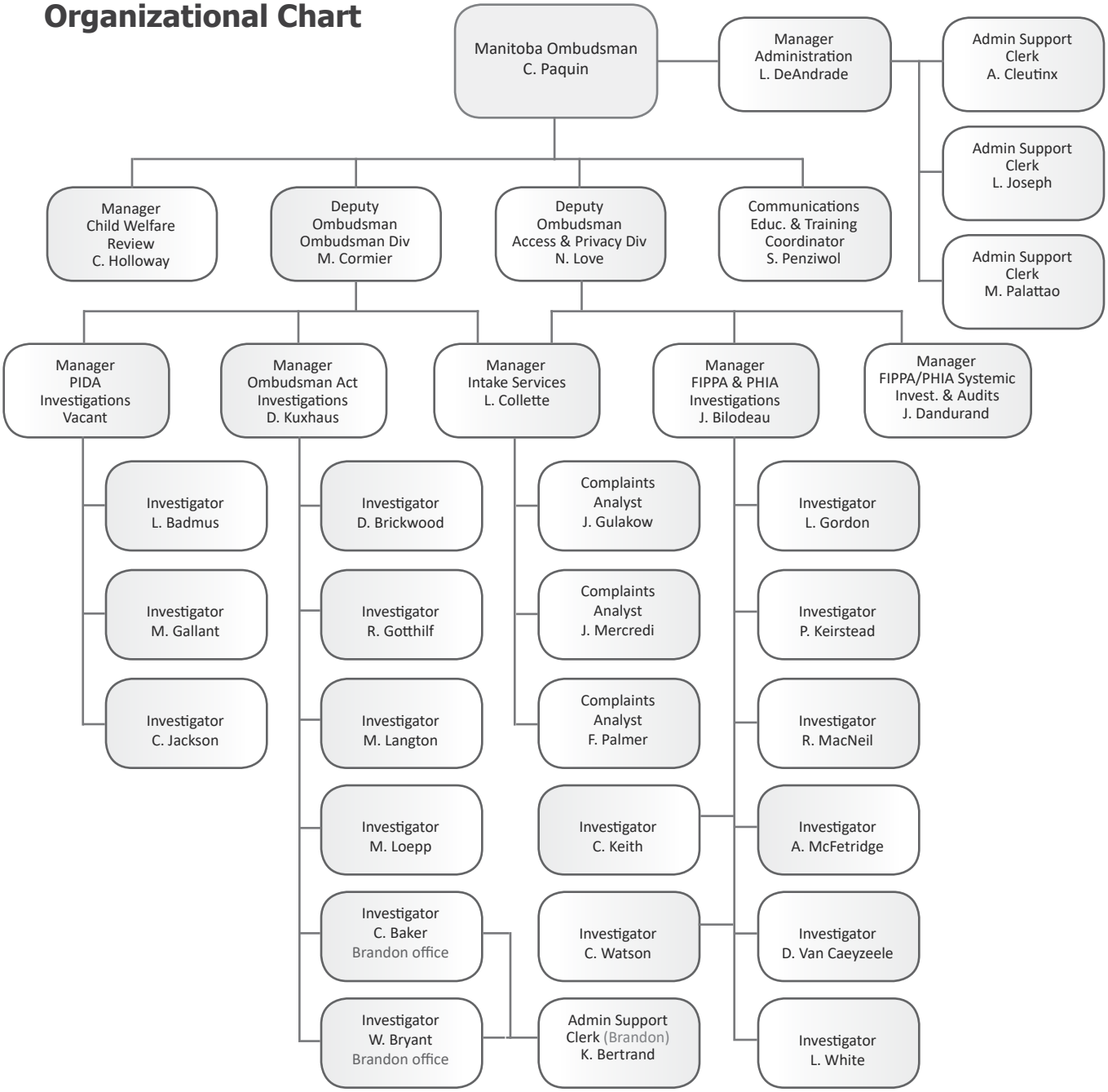
We also developed a number of new privacy-related resources for public bodies and trustees subject to Manitoba's privacy legislation. These are mentioned later in this report and can be found on our website.

continued on next page

Finally, throughout the year I also met with my ombudsman, information and privacy commissioner and public interest disclosure commissioner counterparts from across the country to discuss common areas of interest. We highlight two initiatives – a joint resolution related to solicitor-client privilege and a joint letter about privacy education – later in this report.

The work of Manitoba Ombudsman is important. We continue to try to help address the concerns of citizens, public bodies and trustees in a variety of ways, including consultation, referral, resolution and formal investigations and recommendations. Our work offers opportunity for improvements in accountability, transparency, fairness, privacy protection and good governance, which are important for all Manitobans.

Organizational Chart



About the Office

Manitoba Ombudsman is an independent office of the Legislative Assembly of Manitoba. The office has two divisions with an 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), the ombudsman investigates complaints from people about any decision, act or failure to act relating to their requests for information from public bodies, and privacy concerns about the way their personal information has been handled. The ombudsman has additional powers and duties under FIPPA, including auditing to monitor and ensure compliance with the act, informing the public about the act and commenting on the access and privacy implications of proposed legislation, programs or practices of public bodies.

Under 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 personal health information from trustees, and privacy concerns about the way their personal health information has been handled. The ombudsman also has the same additional powers and duties under PHIA as under FIPPA.

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.

Under the **Public Interest Disclosure (Whistleblower Protection) Act** (PIDA), the ombudsman investigates disclosures of wrongdoing. 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.

2017/18 Office Budget	
Total salaries and employee benefits	$2,994,238
Other expenditures	$665,000
Total budget	**$3,659,238**

2017 Overview

4,270	**INQUIRIES AND COMPLAINTS**
3,336	The intake services team handled 3336 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
48	The PIDA investigation team handled 15 inquiries and 33 disclosures related to the Public Interest Disclosure (Whistleblower Protection) Act (PIDA)
886	The administration team also handled 886 general inquiries
432	**INVESTIGATIONS OPENED**
318	FIPPA (parts 4 and 5)
62	PHIA (parts 4 and 5)
49	Ombudsman Act
3	PIDA
42	**RECOMMENDATIONS MONITORED**
20	3 inquest reports with 20 recommendations were received from the Provincial Court of Manitoba
22	40 special investigation reports with 22 recommendations were received from the Office of the Children's Advocate
24	**INVESTIGATION REPORTS POSTED ON WEBSITE**
13	FIPPA
2	PHIA
9	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.

Presentations

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

- What is (and isn't) personal information under FIPPA
- Requirements for exercising the rights of others under FIPPA and PHIA

"Overcoming Privacy Paralysis" session at the Southern Health-Santé Sud annual PHIA Day

Presentations at the 2017 Recreation Connections Conference, the Association of Manitoba Municipalities' Municipal Officials Seminar, Manitoba Centre for Health Policy's Evidence to Action Workshop, the Manitoba Association of Chiefs of Police training day and a Manitoba Community Health Association workshop

Seven presentations to community groups in Brandon, Winnipeg and Selkirk

Three presentations to students at the University of Manitoba and University of Winnipeg

A presentation to teachers participating in "Learning at the Leg!"

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

Five presentations to Manitoba government employees

Events

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

- Law Day and the Law Courts Open House, Winnipeg and Brandon
- Canada Summer Games, Duckworth Centre venue, Winnipeg, in collaboration with the Office of the Privacy Commissioner of Canada
- Manitoba Social Science Teachers Association SAGE conference, Winnipeg
- Brandon Teachers' Association LIFT conference, Brandon

LIFT Conference, Brandon

New Student Activities and Teacher's Notes

In 2017 we continued to develop a new web-based collection of learning activities designed to support the Manitoba curriculum for social studies in grades six and nine and grade 12 law and global issues. Our collection is divided into four main themes – government and the ombudsman, fair decision making, access to information and information privacy. Activities and teacher's notes are available on our "teachers and students" page at www.ombudsman.mb.ca/info/teachers-and-students.html

See the Access and Privacy section for information on new publications for public bodies and trustees subject to FIPPA and PHIA.

Intake Services

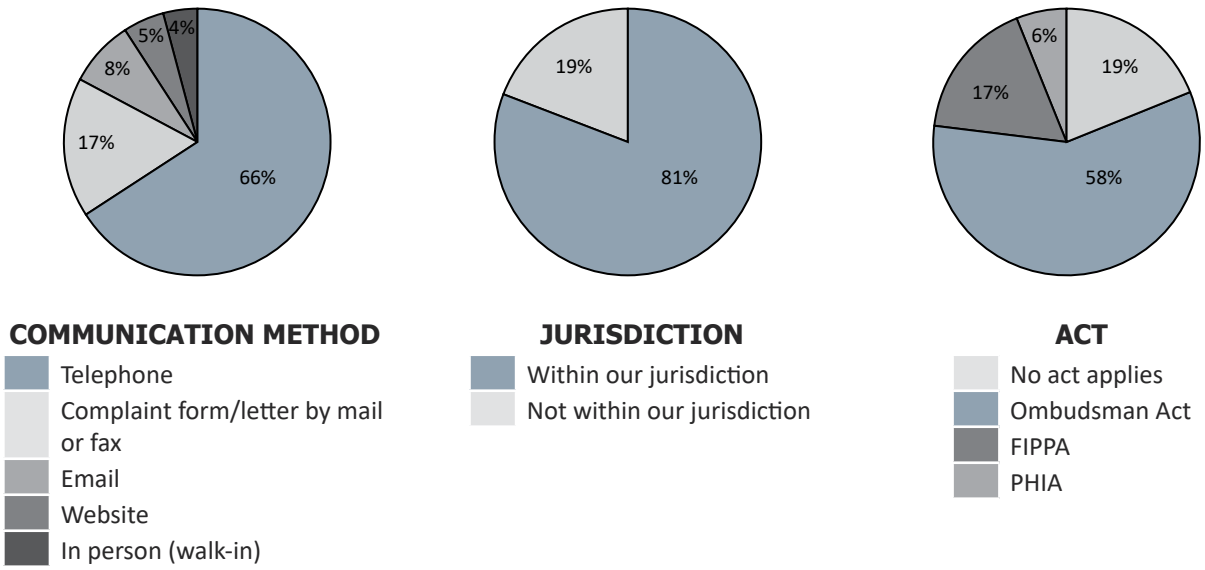
All inquiries and complaints received under the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Health Information Act (PHIA) and the Ombudsman Act are initially reviewed by Intake Services. Inquiries and disclosures related to the Public Interest Disclosure (Whistleblower Protection) Act (PIDA) are handled by the PIDA investigation team (see pages 24-26).

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 achieve early resolution of concerns, before they go to a formal investigation.

Intake Service's early resolution process sometimes involves facilitating communication between an individual and the right person at the organization being complained about. For example, an inmate at a correctional facility contacted our office because he believed he did not receive a response from a public body after submitting a FIPPA application to them. Intake staff called the public body and determined that information had been sent to the inmate. When intake staff called the correctional facility, it was determined that information for the inmate had arrived, but correctional staff had not told the inmate of its arrival and that he could make arrangements to see the information. Intake staff spoke to the inmate, explaining to the steps he needed to take in order to see the information, and also reminded staff at the correctional facility that the FIPPA process is time sensitive.

In another case, a City of Winnipeg resident contacted our office after he received an unusually high water bill and the water in his residence had been turned off. Communication between the resident and the city's Water and Waste Department did occur, but for several reasons including miscommunication, the issue had not been resolved. Intake staff contacted the Water and Waste Department and were given information about the city's new water leak credit policy and the application process. Intake staff shared this information with the resident.

In 2017, Intake Services handled 3,336 inquiries and complaints:



Access and Privacy Division

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

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

2017 Access and Privacy Division Overview

This year saw a significant increase to our work under FIPPA and PHIA and we made a number of changes to address this increase. In addition to the new deputy ombudsman position, in January 2017, we also permanently reallocated an investigator position from within the office to the division and in September, we temporarily reassigned a second investigator to the division.

In addition, after an office-wide planning session held in late 2016, the division began an internal review in early 2017 to examine investigation processes, identify challenges and develop solutions to increase timeliness and efficiency of investigations. We also developed a plan to address a backlog in cases.

Investigations were the main priority for the division in 2017 and we made significant progress in completing investigations and reducing our backlog during the year. Overall, the division handled 626 cases under Parts 4 and 5 of FIPPA and PHIA, including 380 new cases opened in 2017. Of these 626 cases, 482 cases were closed in 2017 and 144 cases were carried over into 2018.

The bulk of the division's work involves the investigation of complaints under Part 5 of the acts. We opened 338 new complaints, which when combined with our pre-existing cases, brought our total to 547 cases. We concluded 406 of these cases in 2017.

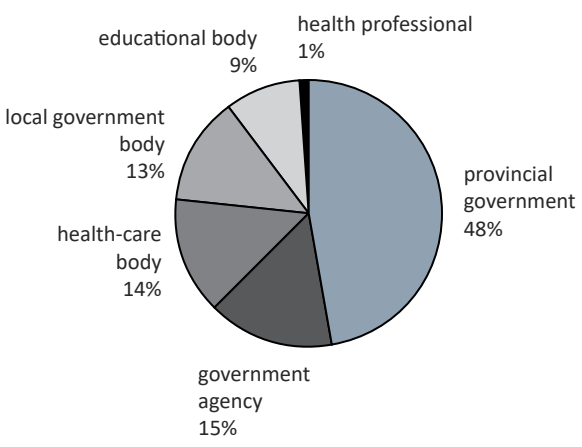
The majority of our work under Part 4 of the acts involves addressing privacy breaches voluntarily reported to our office by public bodies and trustees. In 2017, we opened 26 new cases, which when combined with our pre-existing cases, brought our total to 52 cases. We concluded 50 of these cases, all of which related to privacy breaches.

Public bodies and trustees play a critical role in the work of the division by providing information and documentation to our office to explain and support their decisions in a thorough and timely manner. We heard from several public bodies that they had experienced an increase in access to information requests under FIPPA in 2017. Our office also experienced a 41 per cent increase in FIPPA access complaints, from 189 in 2016 to 266 in 2017.

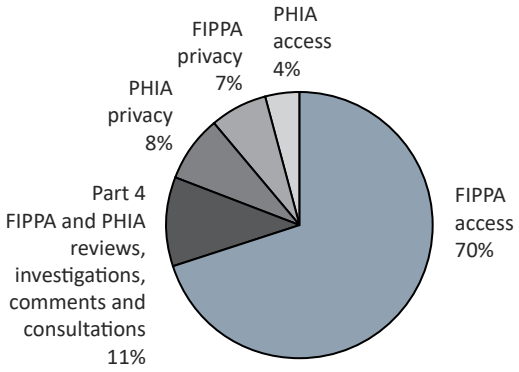
An increase in the volume of both access to information and privacy complaints can pose challenges for public bodies, trustees and our office. We will continue to work toward finding ways to make our investigation processes more efficient for our office and for public bodies and trustees, and our reports timelier for complainants.

Our outreach activities and presentations relating to FIPPA and PHIA are important in supporting the work of access and privacy personnel in public bodies and trustees, fostering common understandings, and promoting compliance with the acts. We will be assessing our outreach activities and obtaining input from public bodies and trustees to help us target our activities in the most effective way.

Distribution of Complaints Opened Under Part 5 of FIPPA and PHIA in 2017



Types of Cases Opened Under Parts 4 and 5 of FIPPA and PHIA in 2017



Investigations

PHIA Privacy Breach

Our office initiated an investigation under PHIA related to incidents of an employee's unauthorized access to personal health information in the databases of the Provincial Drug Program branch within Manitoba Health, Seniors and Active Living. Improperly accessing or snooping into the personal health information of others is a very serious matter that constitutes an offence under PHIA. Organizations that hold personal health information must have policies, procedures and safeguards in place to ensure that this information is only accessed by employees who have a legitimate work-related purpose for doing so.

Our investigation reviewed the incidents of unauthorized access and the department's response to these incidents, which included examining the measures in place to prevent, detect and respond to the privacy breach. We found instances where the department did not respond in a timely way to address and mitigate the risks of the privacy breach and we identified a need to improve policies and procedures. At the conclusion of the investigation, we made 11 recommendations to the department to assist in ensuring that it complies with PHIA.

This investigation was initiated in 2014 and in April 2016, the ombudsman charged the former employee of the department with an offence under PHIA. We held the finalization and release of our investigation report in abeyance pending the conclusion of the prosecution. In 2017, the former employee was found guilty and fined $7,500.

Our report into this matter is available on our website at:
www.ombudsman.mb.ca/uploads/document/files/case-2014-0500-en.pdf

Recommendation About Refused Access

In another case, an individual submitted an application for access under FIPPA to the City of Winnipeg – Winnipeg Police Service (WPS) for information about mobile photo radar enforcement locations. After the WPS denied access on the basis that the requested records were not in its custody or control, the individual made a complaint to our office.

During our investigation, the WPS revised its access decision and provided access to the requested information in part with some information severed, relying on an exception in FIPPA that allows a public body to deny access if disclosure could reasonably be expected to endanger the life or safety of a law enforcement officer. As a result of further investigation, the ombudsman found that the WPS did not establish a clear and direct connection between knowledge of all potential photo enforcement locations and the risk of the harm to photo enforcement operators, and therefore the cited exception did not apply to most of the information in the record at issue, particularly information about photo radar enforcement at public locations.

The ombudsman recommended release of the remaining information at issue, while continuing to sever information relating to photo radar enforcement on private property. The WPS accepted the ombudsman's recommendation and implemented it.

This report is available on our website at:
www.ombudsman.mb.ca/uploads/document/files/case-2015-0338-en.pdf

Social Media in the Workplace

Social media platforms such as Facebook, Twitter, YouTube, Snapchat, and others play a significant role in some individuals' lives; however, they also pose a substantial risk to privacy, including privacy in the workplace. In 2017, our office investigated a complaint regarding an incident where personal health information was posted to a social media platform. An employee of a trustee was testing a new application on her personal mobile device and recorded a video that included patient records. When the video was shared online, viewers could see the personal health information of others.

In addition to investigating the complaint, we initiated a broader review examining the steps taken by the trustee to contain the breach, evaluate the potential risks, consider notification, and to prevent future similar breaches.

This case highlights the need for public bodies and trustees to consider the use of social media and personal devices in the workplace. Many public bodies and trustees have policies in place for Internet use; however, using social media and/or personal devices poses different privacy challenges, which should be addressed in conjunction with other workplace privacy policies.

Clear policies and procedures should specifically address the use of social media and/or personal devices including establishing best practices, outlining expectations for acceptable use in the workplace and setting out the consequences of misuse. Public bodies and trustees are encouraged to speak with their employees on a regular basis about the policy and discuss the privacy implications of using social media and/or personal devices in the workplace.

Over-Collection of Information

FIPPA and PHIA place restrictions on the collection of personal and personal health information to ensure that the information being collected is

- for a lawful purpose connected with a function or activity of the public body or trustee
- necessary for that purpose, and
- limited to the amount of information that is necessary for that purpose

These restrictions protect the privacy of individuals' personal and personal health information by preventing the "over collection" of information not reasonably needed by public bodies and trustees.

In 2017, we investigated a complaint under PHIA from an individual who was asked to indicate her religion for the admissions record as part of the check-in procedure at an adult day surgery clinic at a hospital. The individual believed that the collection of this information was unnecessary for the provision of health care to her as an outpatient who was having a minor procedure.

We found that the collection of information about the complainant's religion was not authorized under PHIA as it was not necessary for the purpose of health care, as spiritual care would not be provided in this type of situation. This finding would also be applicable to the collection of this information from other outpatients.

We discussed our finding with the hospital and it agreed to implement procedures to limit the collection of information about religion to circumstances that may reasonably involve the provision of spiritual care to patients.

This report is available on our website at:
www.ombudsman.mb.ca/uploads/document/files/case-2017-0297-en.pdf

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 2017, we initiated 42 reviews and investigations – 25 under part 4 of FIPPA and 17 under part 4 of PHIA. Including the 37 cases carried over from 2016, we worked on a total of 79 cases and concluded 76 of them. These included consideration of longer extension requests under FIPPA, reviews of privacy breaches voluntarily reported to our office under both FIPPA and PHIA, and formal consultations and comments.

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 2017, we were formally consulted in five matters. Additionally, we publicly commented and made recommendations to amend sections of FIPPA and PHIA (see side panel).

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.

FIPPA and PHIA Reviews

FIPPA and PHIA require that a comprehensive review of the acts be conducted. Periodic reviews of the acts are essential to examine if they are operating as intended and to ensure that they are updated. After a public review in 2004, the acts were significantly amended in 2010 and 2011. The Manitoba government initiated a public review of FIPPA and PHIA in 2017.

Since the acts were last reviewed in 2004, many changes have occurred to the way in which information is collected, stored, used, disclosed and managed. In response to the government's review, we made 68 comments and recommendations to amend both acts. Our recommendations addressed key areas, such as:

- Balancing the need to ensure that exceptions to the right of access are specific and clear in their intent, and do not infringe on the right of access any further than necessary.
- Balancing the discretion to refuse access under FIPPA with the public's right to know with a "public interest override," which would enable consideration of whether the disclosure of information that could be withheld would serve a broader public interest.
- The need for security safeguards to ensure that electronic personal and personal health information is protected, to reflect the increasing use of new and innovative technologies to manage and share citizens' information.

Our comments and recommendations are available on our website at:
www.ombudsman.mb.ca/info/fippa-and-phia-review.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 addition to the 24 privacy breach investigations carried into 2017, our office initiated 26 privacy breach investigations in 2017. We concluded all 50 of these investigations.

Interjurisdictional Collaboration

As part of a federal, provincial and territorial community of access and privacy commissioner offices across Canada, we often work together on issues of mutual interest and concern.

In 2017, Canada's information and privacy commissioners, including our office, issued a joint resolution calling on governments to ensure that access to information and privacy legislation in every jurisdiction empowers oversight offices to compel the production of records over which solicitor-client privilege has been claimed by public bodies to enable our office to review and verify whether these claims are properly asserted when responding to requests for access to information.

Also in 2017, commissioners sent a joint letter to the Council of Ministers of Education encouraging them to make privacy education a greater priority in order to equip young people with the skills and knowledge to navigate our complex digital environment.

Documents related to these joint initiatives are on our website at:
www.ombudsman.mb.ca/info/federal-provincial-territorial.html

New Privacy-Related Resources

We recognize that public bodies and trustees hold significant amounts of personal and personal health information about Manitobans in order to provide various services, programs and benefits. To increase compliance with access and privacy legislation, to encourage the implementation of best practices and to help employees protect and manage personal and personal health information on a daily basis, we developed a number of privacy-related resources.

Our **Guidelines for Implementing a Privacy Management Program for Privacy Accountability in Manitoba's Public Sector** outline a step-by-step process that can help organizations of any size develop an effective, accountable and transparent privacy management program.
www.ombudsman.mb.ca/uploads/document/files/privacy-management-program-guidelines-en-1.pdf

Ten Tips for Addressing Employee Snooping sets out guidance to specifically prevent, detect and respond to employee snooping, which is the common term for deliberate, unauthorized access to personal and personal health information in contravention of FIPPA and PHIA.
www.ombudsman.mb.ca/uploads/document/files/ten-tips-for-addressing-employee-snooping-en.pdf

Our updated practice note **Key Steps in Responding to Privacy Breaches under FIPPA and PHIA** sets out four key steps for public bodies to take when responding to a suspected or actual privacy breach.
www.ombudsman.mb.ca/uploads/document/files/key-steps-in-responding-to-privacy-breaches-en.pdf

To bring together all materials related to privacy breaches, we created a **privacy breach resources** page on our website at
www.ombudsman.mb.ca/info/privacy-breaches.html

Complaint dispositions used in the tables on pages 19-22:

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, 2017.

Summary of 2017 FIPPA and PHIA Complaints Opened and Closed

FIPPA

FIPPA Complaints Opened	
Type of Access Complaint	
Refused access	139
No response	49
Request was disregarded	6
Extension	13
Fees	25
Fee waiver	2
Correction	-
Other access matters	32
Sub-total	**266**
Type of Privacy Complaint	
Collection	4
Use	5
Disclosure	16
Sub-total	**25**
Other	
Third party contests access	2
Complaint by relative of deceased	-
Sub-total	**2**
Total FIPPA complaints opened	**293**

FIPPA Complaints Closed	Total	Declined or discontinued	Supported in part or in whole	Not supported	Resolved	Recommendation made
Type of Access Complaint						
Refused access	163	27	28	79	28	1
No response	47	3	40	3	-	1
Request was disregarded	6	-	2	2	2	-
Extension	19	8	4	6	1	-
Fees	29	1	5	21	2	-
Fee waiver	2	-	-	2	-	-
Correction	-	-	-	-	-	-
Other access matters	29	9	2	9	9	-
Sub-total	**295**	**48**	**81**	**122**	**42**	**2**
Type of Privacy Complaint						
Collection	8	-	2	6	-	-
Use	10	2	3	5	-	-
Disclosure	29	3	14	11	1	-
Sub-total	**47**	**5**	**19**	**22**	**1**	**-**
Other						
Third party contests access	2	1	-	1	-	-
Complaint by relative of deceased	-	-	-	-	-	-
Sub-total	**2**	**1**	-	**1**	-	-
Total FIPPA complaints closed	**344**	**54**	**100**	**145**	**43**	**2**

PHIA

PHIA Complaints Opened	
Type of Access Complaint	
Refused access	4
No response	2
Fees	2
Fee waiver	-
Correction	2
Other access matters	5
Sub-total	**15**
Type of Privacy Complaint	
Collection	5
Use	10
Disclosure	14
Failure to protect	1
Sub-total	**30**
Total PHIA complaints opened	**45**

PHIA Complaints Closed	Total	Declined or discontinued	Supported in part or in whole	Not supported	Resolved	Recommendation made
Type of Access Complaint						
Refused access	6	-	-	3	3	-
No response	2	1	-	-	1	-
Fees	3	-	1	1	1	-
Fee waiver	-	-	-	-	-	-
Correction	3	1	-	2	-	-
Other access matters	3	-	2	1	-	-
Sub-total	**17**	**2**	**3**	**7**	**5**	**-**
Type of Privacy Complaint						
Collection	5	1	2	2	-	-
Use	18	-	12	5	-	1
Disclosure	21	5	13	3	-	-
Failure to protect	1	-	1	-	-	-
Sub-total	**45**	**6**	**28**	**10**	**-**	1
Total PHIA complaints closed	**62**	**8**	**31**	**17**	**5**	**1**

FIPPA Investigations of Individual Complaints (Under Part 5)

	Case Numbers			Case Dispositions							
	Carried over into 2017	New cases in 2017	Total cases in 2017	Pending at 12/31/2017	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Provincial government											
Agriculture	2	1	3	-	-	-	2	-	-	1	-
Civil Service Commission	2	7	9	4	-	1	-	3	1	-	-
Education & Training	-	5	5	4	-	-	-	-	-	1	-
Executive Council	7	10	17	2	-	2	5	3	3	2	-
Families	14	6	20	2	-	3	9	1	3	2	-
Finance	4	11	15	2	-	4	6	-	1	2	-
Growth, Enterprise & Trade	8	8	16	5	-	-	4	2	4	1	-
Health, Seniors & Active Living	-	11	11	4	-	1	5	-	-	1	-
Indigenous & Municipal Relations (department restructured in 2017 to Indigenous & Northern Relations and Municipal Relations)	1	1	2	-	-	-	2	-	-	-	-
Infrastructure	5	12	17	4	1	1	8	3	-	-	-
Justice & Attorney General	4	13	17	9	1	1	5	-	-	1	-
Sustainable Development	23	71	94	22	5	8	12	3	37	7	-
Government agency											
Addictions Foundation of Manitoba	-	1	1	-	-	-	1	-	-	-	-
CFS Agency/Authority	4	4	8	2	-	1	2	1	2	-	-
Manitoba Housing	1	5	6	1	-	-	5	-	-	-	-
Manitoba Hydro	9	3	12	5	-	-	4	2	-	1	-
Manitoba Liquor & Lotteries	-	4	4	2	-	-	1	1	-	-	-
Manitoba Public Insurance	5	2	7	-	-	-	3	2	2	-	-
Workers Compensation Board	8	25	33	12	1	-	14	2	1	3	-
Local government body											
City of Brandon	2	1	3	-	-	-	2	1	-	-	-
City of Portage la Prairie	-	4	4	-	-	-	4	-	-	-	-
City of Thompson	-	1	1	1	-	-	-	-	-	-	-
City of Winnipeg	44	19	63	16	-	9	24	5	2	6	1
Dallas/Red Rose Community Council	-	1	1	1	-	-	-	-	-	-	-
Eastern Interlake Planning District	1	-	1	-	-	-	-	-	1	-	-
Municipality of Bifrost-Riverton	-	2	2	-	-	-	1	-	-	1	-
Municipality of Brenda-Waskada	2	-	2	-	-	-	1	1	-	-	-
Municipality of Clanwilliam-Erickson	1	1	2	-	-	-	-	-	1	1	-
Municipality of Norfolk-Treherne	1	-	1	1	-	-	-	-	-	-	-
Municipality of Ste. Rose	1	-	1	-	-	-	-	1	-	-	-
Municipality of Swan Valley West	3	-	3	-	-	-	-	1	2	-	-
Municipality of West Interlake (formerly RM of Siglunes)	3	-	3	-	-	1	1	-	-	-	1
Municipality of Westlake-Gladstone	-	1	1	-	-	-	1	-	-	-	-

FIPPA Investigations of Individual Complaints (Under Part 5)

	Case Numbers			Case Dispositions							
	Carried over into 2017	New cases in 2017	Total cases in 2017	Pending at 12/31/2017	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Local government body, continued											
Red River Planning District	1	-	1	-	-	1	-	-	-	-	-
RM of De Salaberry	1	-	1	-	-	-	1	-	-	-	-
RM of East St. Paul	-	3	3	-	-	-	2	-	-	1	-
RM of Grey	-	3	3	-	-	-	3	-	-	-	-
RM of Headingley	-	1	1	-	-	-	-	-	1	-	-
RM of Lac du Bonnet	6	-	6	-	-	-	1	3	-	2	-
RM of Riding Mountain West	1	-	1	-	-	-	-	1	-	-	-
RM of Rosedale	1	-	1	-	-	-	-	-	1	-	-
RM of St. Andrews	-	1	1	1	-	-	-	-	-	-	-
RM of St. Clements	-	1	1	-	-	-	1	-	-	-	-
RM of Tache	-	2	2	2	-	-	-	-	-	-	-
RM of Whitehead	-	2	2	2	-	-	-	-	-	-	-
South Interlake Planning District	-	1	1	1	-	-	-	-	-	-	-
Town of Beausejour	2	-	2	-	-	-	-	-	-	2	-
Educational body											
Manitoba Institute of Trades & Technology	1	-	1	-	-	-	1	-	-	-	-
Hanover School Division	-	1	1	1	-	-	-	-	-	-	-
Mountain View School Division	-	1	1	-	-	-	-	-	-	1	-
Mystery Lake School Division	1	-	1	-	-	1	-	-	-	-	-
Prairie Spirit School Division	-	1	1	1	-	-	-	-	-	-	-
River East Transcona School Division	-	4	4	2	-	-	-	-	-	2	-
Seven Oaks School Division	-	8	8	-	-	-	4	-	-	4	-
Université de Saint-Boniface	1	-	1	-	-	1	-	-	-	-	-
University of Manitoba	2	9	11	2	-	6	3	-	-	-	-
University of Winnipeg	-	1	1	-	-	-	1	-	-	-	-
Health-care body											
CancerCare Manitoba	-	1	1	-	-	-	1	-	-	-	-
Diagnostic Services of Manitoba	-	2	2	-	-	-	2	-	-	-	-
Interlake Eastern Regional Health Authority	-	2	2	1	1	-	-	-	-	-	-
Prairie Mountain Health	1	1	2	1	-	1	-	-	-	-	-
St. Boniface Hospital	-	1	1	1	-	-	-	-	-	-	-
Winnipeg Regional Health Authority	4	17	21	12	-	3	3	1	1	1	-
TOTAL											
	177	**293**	**470**	**126**	**9**	**45**	**145**	**37**	**63**	**43**	**2**

PHIA Investigations of Individual Complaints (Under Part 5)

	Case Numbers			Case Dispositions							
	Carried over into 2017	New cases in 2017	Total cases in 2017	Pending at 12/31/2017	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Provincial government											
Civil Service Commission	1	-	1	-	-	-	-	1	-	-	-
Families	-	1	1	-	1	-	-	-	-	-	-
Health, Seniors & Active Living	9	1	10	-	-	1	-	-	8	-	1
Growth, Enterprise & Trade	2	-	2	-	-	-	2	-	-	-	-
Infrastructure	-	1	1	1	-	-	-	-	-	-	-
Justice & Attorney General	-	2	2	-	-	1	-	-	-	1	-
Government agency											
Manitoba Housing	1	-	1	1	-	-	-	-	-	-	-
Manitoba Public Insurance	-	4	4	-	-	1	-	1	2	-	-
Workers Compensation Board	2	1	3	-	-	-	1	1	1	-	-
Local government body											
City of Winnipeg	1	-	1	-	-	1	-	-	-	-	-
RM of Victoria Beach	1	-	1	-	-	-	-	1	-	-	-
Educational body											
University of Manitoba	1	6	7	4	-	-	2	1	-	-	-
Health-care body											
Deer Lodge Centre	-	1	1	1	-	-	-	-	-	-	-
Designated health-care facility	-	2	2	-	-	-	1	1	-	-	-
Diagnostic Services of Manitoba	1	-	1	1	-	-	-	-	-	-	-
Grace Hospital	1	-	1	-	-	-	1	-	-	-	-
Interlake-Eastern Regional Health Authority	-	2	2	-	-	-	2	-	-	-	-
Medical clinic	-	4	4	-	-	-	2	1	1	-	-
Northern Regional Health Authority	1	1	2	1	-	-	1	-	-	-	-
Personal care home	-	1	1	-	-	-	1	-	-	-	-
Prairie Mountain Health	3	2	5	-	-	2	2	-	-	1	-
St. Boniface Hospital	1	1	2	-	-	-	1	-	1	-	-
Southern Health-Santé Sud	1	1	2	-	-	-	-	-	2	-	-
Victoria General Hospital	-	1	1	1	-	-	-	-	-	-	-
Winnipeg Regional Health Authority	3	9	12	3	-	1	1	1	5	1	-
Health professional											
Occupational therapist	-	1	1	-	-	-	-	-	-	1	-
Pharmacist	1	-	1	-	-	-	-	-	1	-	-
Physician	2	2	4	1	-	-	-	1	1	1	-
Physiotherapist	-	1	1	1	-	-	-	-	-	-	-
TOTAL											
	32*	**45**	**77**	**15**	**1**	**7**	**17**	**9**	**22**	**5**	**1**

* In our 2016 annual report we reported in error that 34 PHIA cases were carried into 2017.

Ombudsman Division

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.

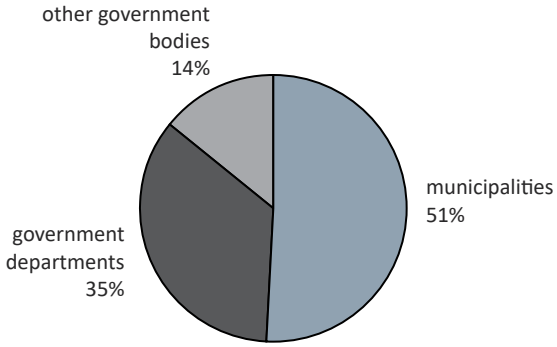
Under the **Ombudsman Act**, our office investigates administrative actions and decisions made by provincial government departments and agencies, municipalities, and their officers and employees. Our office also monitors and reports on the status of inquest recommendations made by provincial court judges under the Fatality Inquiries Act, and tracks the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate.

2017 Ombudsman Division Overview

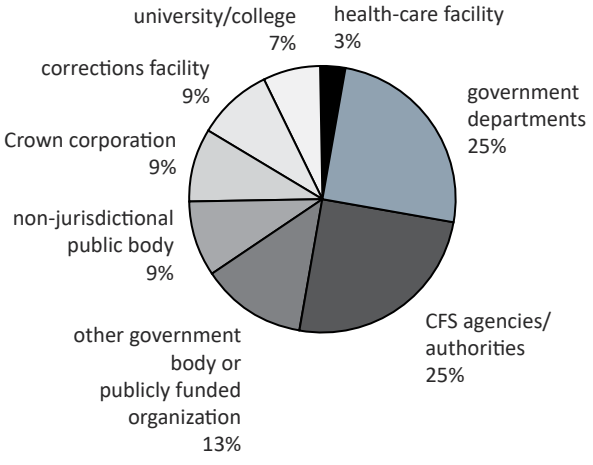
In 2017, the Ombudsman Act investigative team and PIDA investigative team were brought together under a newly appointed deputy ombudsman for the Ombudsman Division. This restructuring allowed for better use of investigative resources that could be coordinated at a divisional level.

The priority of the Ombudsman Division was investigating and reporting on complaints received under both the Ombudsman Act and PIDA. The division balanced the need to handle new cases with the need to complete older cases. In addition, the division began two new ombudsman-initiated investigations ("ombudsman's own initiative" or OOI) and carried on investigative efforts in ongoing OOIs. Of 108 total investigations in 2017, four of them were ombudsman-initiated. The division also revised investigative business processes across its teams.

Distribution of Cases Opened Under the Ombudsman Act in 2017



Distribution of Cases Opened Under PIDA in 2017



PIDA Investigations

In 2017, we initiated three new PIDA investigations into allegations of wrongdoing and nine PIDA reports were finalized.

Two of our concluded investigations in 2017 resulted in findings of wrongdoing and we made recommendations in these two cases. In five additional cases where we did not find wrongdoing, we made some recommendations for administrative improvement. All recommendations were accepted by the respective public bodies.

The following three case summaries illustrate some of our investigative work under PIDA.

Gross mismanagement of public funds or a public asset

Our office investigated a disclosure alleging that a professional employed by a government department was using government office space and time to provide services to private clients, thereby creating a conflict of interest with the professional's obligations to the department. We confirmed that the professional had used government office space to provide services to private clients with management approval, although this practice was discontinued during our investigation.

We found no wrongdoing but recommended that if a situation like this were to occur again, the department should develop a mechanism for independently verifying the number of private clients and the allocation of time to these clients in the professional's schedule. We further recommended that professionals of this nature who see private clients on-site sign an agreement establishing the appropriate boundaries of the private practice, thereby mitigating the risk of an actual, potential or perceived conflict of interest. The department accepted these recommendations.

The disclosure also contained an allegation that a staff member used improper procurement methods to purchase office supplies and directed other staff to fabricate documentation in support of a purchase order after a purchase had been made. We confirmed that an error had been made with respect to a purchase but found no evidence of a fraudulent act or deliberate intent to bypass government procurement policies. We also did not find evidence that direction was given to staff to fabricate documentation.

While we found no wrongdoing, we noted that the department had deviated from government procurement guidelines in its day-to-day spending practices within a particular program, and therefore recommended that the department create an internal policy, to be approved by the appropriate financial authority, setting out the permissible spending practices to be used by the program. The department accepted this recommendation and completed implementation.

Unauthorized use of public assets and appropriation of public funds

Our office investigated a disclosure alleging unauthorized private use of government equipment, misappropriation of government resources, abuse of overtime and improper use of staff time at a provincial department. In the course of our investigation, we found evidence of larger systemic issues, which increased the scope of the investigation to include lack of proper accountability for government assets, as well as insufficient asset and inventory management and control by the provincial department.

During our investigation, it was necessary to inspect private property to view government equipment that we believed was at the premises without direct authority. In inspecting the private property, Manitoba Ombudsman exercised its legal authority pursuant to the Ombudsman Act and the Manitoba Evidence Act, to enter private premises for the purpose of conducting the inspection. We preserved the charter rights of the owner of the personal property, while exercising our authority to obtain evidence.

Our investigation confirmed that government equipment had been improperly used for private purposes; that there had been appropriation of government resources; that there were significant lapses of management oversight and accountability for government assets and as a result, there existed a vulnerability for abuse. We also confirmed that inventory management and control were inadequate. As a result, we found that wrongdoing had occurred.

We made 13 recommendations to the provincial department, including that the department undertake a province-wide review of its asset and inventory management in all units of the relevant division of the department. We also recommended that the department review their overall purchase and asset management procedures, and enhance their processes for monitoring the use of government procurement cards. The department accepted all of our recommendations and has put in place an action plan to address them.

Risk to patient health, life and safety

Our office investigated a disclosure alleging that a health-care facility was using respiratory equipment which did not alarm if failure occurred, putting patient health and safety at risk. It was also alleged that problems with this equipment had been ongoing and not appropriately documented.

We confirmed that the facility was using unalarmed equipment. We consulted with an expert to confirm the level of potential risk from unnoticed equipment failure, as well as practices in place at other facilities using similar (but alarmed) equipment. We interviewed various levels of staff to determine what was understood about the risk this equipment presented, whether actions were taken to mitigate the risk, and whether problems were properly documented. We noted that a patient incident in summer 2015 should have alerted the facility to the severity of the risk.

When we received the disclosure, the facility was in the process of upgrading their equipment to fully alarmed units. However, this process took several months and we found that the steps taken to mitigate risk in the interim were not sufficient for all patients. As a result, we assessed that in the time between the patient incident and the roll-out of new equipment, there was a specific and substantial risk to life, health and safety for some patients, and wrongdoing had occurred. We recommended that the facility make policy changes to meet the monitoring requirements in place at other facilities for high-risk patients using similar equipment, and that staffing levels be reviewed to ensure they were appropriate, especially at night.

In addition, we found that staff had not been properly documenting equipment problems despite expressing their discomfort with the equipment. We recommended that the facility develop a strategy to improve charting and reporting by the relevant staff.

The facility accepted our recommendations and we confirmed that implementation has been completed.

PIDA Inquiries and Investigations

	Case Numbers			Case Status							Recommendations	
	Assistance provided	PIDA case files carried over into 2017	New PIDA case files opened in 2017	Total PIDA case files pending at 12/31/2017	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		2	8	1	7	-	-	-	1	1	2	1
Health-care facility		1	1	-	1	-	-	-	1	-	1	1
Personal care home		1	-	-	-	-	-	-	-	1	1	1
Regional health authority		1	-	-	-	-	-	-	-	1	-	-
Child and Family Services agency/authority		1	8	3	5	-	-	-	-	1	1	1
Corrections facility		-	3	1	2	-	-	-	-	-	-	-
University/college		-	2	2	-	-	-	-	-	-	-	-
Crown corporation		-	3	-	3	-	-	-	-	-	-	-
Other government body or publicly funded organization		4	4	3	2	-	-	-	-	3	2	2
Non-jurisdictional public body		-	3	-	3	-	-	-	-	-	-	-
TOTAL	**15**	**10**	**32**	**10**	**23**	**-**	**-**	**-**	**2**	**7**	**7**	**6**

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 2017: Case files that were pending resolution at the beginning of 2017. Case files can contain more than one disclosure.

New PIDA case files opened in 2017: 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 December 31, 2017: PIDA case files pending resolution as of January 1, 2018. 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 Act Investigations

Administrative 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.

Below are some summaries of investigations our office conducted after receiving complaints against provincial government departments/agencies and municipal governments.

Provincial Cases

- Seven in-custody patients from unit PX3, a 15-bed adult forensic mental health unit located at Health Sciences Centre (HSC), alleged that they were confined to their locked ward 24 hours per day without any outside fresh-air time, which violated basic human rights and impeded recovery from illness. Shortly after we began our investigation, access to the forensic courtyard for non-acute security risk patients on PX3 was reinstated. While we concluded that the decision to suspend access to the courtyard pending a review of security concerns was reasonable, the amount of time taken to resolve this matter and resume courtyard access was not. We recommended that Manitoba Health, Seniors and Active Living and Manitoba Justice collaborate to develop a protocol to assist in the timely identification and resolution of security issues on PX3 in order to help prevent similar delays in the future. The departments accepted the recommendation.

- We received complaints from ten individuals and the chief administrative officer of the Rural Municipality of Argyle, who alleged they were not provided with adequate notification about a proposed water project by the Town of Pilot Mound and therefore were unable to formally register their concerns with Manitoba Sustainable Development's Environmental Approvals Branch. We determined that the public bodies involved with the implementation of the water project met legislative and regulatory requirements regarding public notification of the project. However, we were of the view that improvements could be made to ensure a more comprehensive notification process to allow individuals to fully participate in the review process. In addition, we suggested improvements to the communication and administrative coordination between Sustainable Development and the Manitoba Water Services Board with respect to providing information about projects.

- We received a complaint from an individual about the amount of time (33 months) it took the Crown Lands and Property Agency (CLPA) to assess his application to purchase Crown land , and the amount of time the Corporate Crown Lands Policy office (CCLP) took to review that decision (27 months at the time our report was issued). Our investigation focused on the application process of CLPA and the review process of CCLP, and whether the organizations communicated with the applicant throughout those processes. In the end, we concluded that a lack of communication throughout the lengthy application and review processes was unfair to the applicant and we made several administrative suggestions. CLPA and CCLP have taken steps to shorten the processing time and improve communications with applicants.

- A condominium owner subject to multiple fines from her condominium board complained to our office after the Residential Tenancies Branch (RTB) upheld the board's decision to impose the fines. The condominium owner raised concerns about the fairness and impartiality of the RTB appeal process. We were of the view that RTB acted in accordance with relevant legislation and policies and that the decision of the appeal commissioner was not clearly wrong or unreasonable.

- Manitoba Housing, a division of Manitoba Families, manages a Homeowners Renovation Assistance Program (HRAP) that provides funding for household repairs to low income homeowners. We received a complaint from a homeowner who applied for financial assistance for repairs but was refused. While we determined that the decision was made in accordance with the eligibility criteria for HRAP, we made several suggestions for administrative improvements to the program, particularly with respect to ensuring the terms and conditions of the program are clearly communicated to applicants.

Municipal Cases

- A group of citizens in the Rural Municipality of Whitemouth complained about the RM's decision to rebuild the Water Street Bridge. Specifically, the complainants alleged that there was a lack of public consultation regarding the project and inadequate information for ratepayers. They also alleged that the RM did not follow its purchasing/procurement policy, did not have the authority to reallocate Disaster Financial Assistance (DFA) funds and that a councillor was in a conflict of interest situation. Our office found that the RM did undertake the proper procedures in approving the project and providing public consultation opportunities. We did not find maladministration with respect to conflict of interest in a vote by a specific councillor. However, we did conclude there were issues related to following the purchasing/procurement policies and a lack of clarity in the use of DFA funding for the bridge. Our office made four recommendations to the RM of Whitemouth, which the RM accepted. Our office was also advised by Manitoba Infrastructure that administration of the DFA program was being reviewed and that some changes had already occurred.

- The City of Flin Flon billed a property owner over $10,000 for waterline repairs and later adjusted the amount owing to approximately $2,700. The property owner made a complaint to our office about the city's authority to assess costs and the amount billed to him. While the City of Flin Flon has the authority to bill property owners for repairs to waterlines, we found that the city did not communicate changes it made to its waterline repair billing policy to citizens. It also did not provide the property owner with sufficient information about how the invoice amount was determined or about the extent and location of waterline repairs. We made a number of recommendations to improve administrative practices and to ensure citizens are treated fairly. The City of Flin Flon advised our office that it will implement our recommendations.

- A resident from the Rural Municipality of Lac du Bonnet complained to our office after the RM cancelled their appearance before council to contest a municipal enforcement order and refused to reschedule it to a later council meeting. Over the course of our investigation, the RM gave several reasons for its decision, including that it believed the complainant was planning to take legal action against the RM and that the complainant had acted in threatening manner toward staff. Our office determined that the RM did not have the legal authority to cancel the delegation and the complainant was ultimately allowed to appear before council to state their case.

Ombudsman Act Investigations

	Case Numbers			Case Dispositions									
	Carried over into 2017	New cases in 2017	Total cases in 2017	Pending at 12/31/2017	Case resolved early	Declined or discontinued	Not supported	Partly resolved or resolved	Partly supported or supported	Other	Administrative suggestions made*	Recommendations made*	Both administrative suggestions and recommendations made*
Manitoba government departments													
Agriculture	2	-	2	-	-	-	1	1	-	-	1	-	-
Crown Services	-	1	1	1	-	-	-	-	-	-	-	-	-
Families	2	2	4	2	-	1	1	-	-	-	1	-	-
Growth, Enterprise & Trade	-	1	1	-	-	1	-	-	-	-	-	-	-
Health, Seniors & Active Living	1	-	1	1	-	-	-	-	-	-	-	-	-
Infrastructure	2	1	3	1	-	-	2	-	-	-	-	-	-
Justice & Attorney General	11	8	19	5	-	3	3	2	1	5	-	1	-
Municipal Relations	14	-	14	1	-	-	12	-	-	1	12	-	-
Sport, Culture & Heritage	-	1	1	-	-	1	-	-	-	-	-	-	-
Sustainable Development	4	3	7	1	-	3	-	2	1	-	2	-	-
Other Manitoba government bodies													
Assiniboine Community College	1	-	1	1	-	-	-	-	-	-	-	-	-
Interlake-Eastern Regional Health Authority	-	1	1	-	1	-	-	-	-	-	-	-	-
Manitoba Hydro	1	1	2	1	-	-	1	-	-	-	1	-	-
Manitoba Public Insurance	1	3	4	2	-	1	-	1	-	-	1	-	-
Winnipeg Regional Health Authority		1	1	-	-	1	-	-	-	-	-	-	-
Workers Compensation Board	-	1	1	1	-	-	-	-	-	-	-	-	-
Municipalities													
City of Winnipeg	5	4	9	6	-	-	3	-	-	-	-	-	-
Other cities, RMs, towns, villages	13	19	32	12	1	7	4	2	6	-	6	1	4
Planning districts	2	1	3	2	-	-	-	-	1	-	1	-	-
Ombudsman's Own Initiative (OOI) -- municipal (general)	-	1	1	1	-	-	-	-	-	-	-	-	-
TOTAL													
	59	**49**	**108**	**38**	**2**	**18**	**27**	**8**	**9**	**6**	**25**	**2**	**4**

Pending: Complaint still under investigation as of December 31, 2017.

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.

Partly Supported or Supported: Investigation found administrative issues that needed to be addressed.

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

* At the conclusion of some investigations, the ombudsman may make informal administrative suggestions and/or formal recommendations to support and help achieve better administration. The cases in these columns are included in the case disposition numbers this table.

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 2017, we opened five files relating to three inquests. Since 2008, we have publicly reported on 51 inquests.

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

Manitoba Ombudsman has been responsible for the monitoring and reporting annually on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA). These recommendations have been directed at entities and organizations involved with the child welfare system or any publicly funded social service in the province of Manitoba.

Since the OCA received its mandate to perform special investigation reviews on September 15, 2008, to the end of our reporting period December 31, 2017, the OCA has made 546 recommendations. To date 481 recommendations have been implemented (88 per cent).

Our office has followed up with the entity or entities to which recommendations have been made to determine what actions have been taken in response to the recommendations, and to report publicly on those actions to ensure accountability. 2017 marks the final year that our office will be responsible for monitoring and reporting on these recommendations as the new Advocate for Children and Youth Act has been proclaimed and includes a transfer of this responsibility to the now named Manitoba Advocate for Children and Youth as part of that office's mandate.

Throughout our mandate to monitor and report annually on the implementation of the advocate's recommendations, we have noted over time that recommendations within the special investigation reviews have ranged from specific, single-agency improvements to complex multi-organizational system changes, and at times legislative changes. It is clear that some recommendations have lent themselves to immediate implementation; others have required intensive consultation, coordination and collaboration.

We wish our colleagues at the Manitoba Advocate for Children and Youth success in their continued representation of the rights, interests and viewpoints of children and youth throughout the province of Manitoba.

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

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, 2017. 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, 2017

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 - 2017	47	47	10	28
2017 - Dec 31, 2017	20	20	2	4
Total	**551***	**515***	**143**	**546**

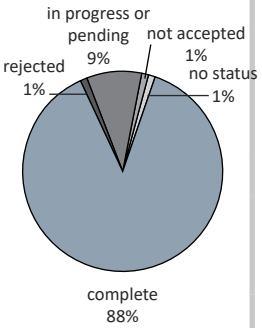
Table 2: Special Investigation Reports Received by the Ombudsman from the OCA by Calendar Year – September 15, 2008 to December 31, 2017

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
2017	40	40	9	22
Total	**551***	**515***	**143**	**546**

* 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 on the following page encompasses the recommendations within 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.

Table 3: September 15, 2008 to December 31, 2017								
	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 (CPB)	63	57	3	-	3	-	-	
CFS Standing Committee	1	1	-	-	-	-	-	
CPB & CFS Standing Committee	4	4	-	-	-	-	-	
Department of Families* (FS)	26	25	1	-	-	-	-	
Southern Authority (SA)	173	152	16	-	2	3	-	
Northern Authority (NA)	166	142	21	-	-	-	3	
General Authority (GA)	36	35	-	-	-	1	-	
Metis Authority (MA)	21	20	1	-	-	-	-	
Multiples – FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	20	14	4	-	2	-	-	
External organizations (other departments, private service providers)	36	31	4	-	-	-	1	
TOTAL NUMBER	**546**	**481**	**50**	**-**	**7**	**4**	**4**	
TOTAL PERCENTAGE		**88%**	**9%**	**-**	**1%**	**1%**	**1%**	



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

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.