Manitoba Ombudsman

2018 Annual Report

The view from our office at
500 Portage Avenue in Winnipeg

Manitoba Ombudsman

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May 21, 2019

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, 2018, to December 31, 2018.

Yours truly,

Marc Cormier
Acting Manitoba Ombudsman

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Available in alternate formats upon request

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Ombudsman's Message


Marc Cormier

I am honoured to present Manitoba Ombudsman's 2018 annual report that describes the office's accomplishments and endeavours over the year.

2018 was marked with a transition of leadership midway through the year. Charlene Paquin took on the important role as the Civil Service Commissioner at the end of July 2018. I volunteered to act in her capacity in the interim until the selection of an ombudsman. Throughout the last half of the year, my office colleagues as well as the staff and leadership within the legislative assembly have been instrumental in assisting me to ensure the effective continuance of office operations.

In 2018, we built upon the successes of restructuring the office into two distinct operational divisions (Ombudsman Division and Access and Privacy Division) and perfected our associated business processes. Additionally, the new Corporate Services team began taking on new office-wide tasks and projects with the aim to relieve the two divisions of non-operational requirements, allowing the divisions to focus on dealing more efficiently with complaints and investigations.

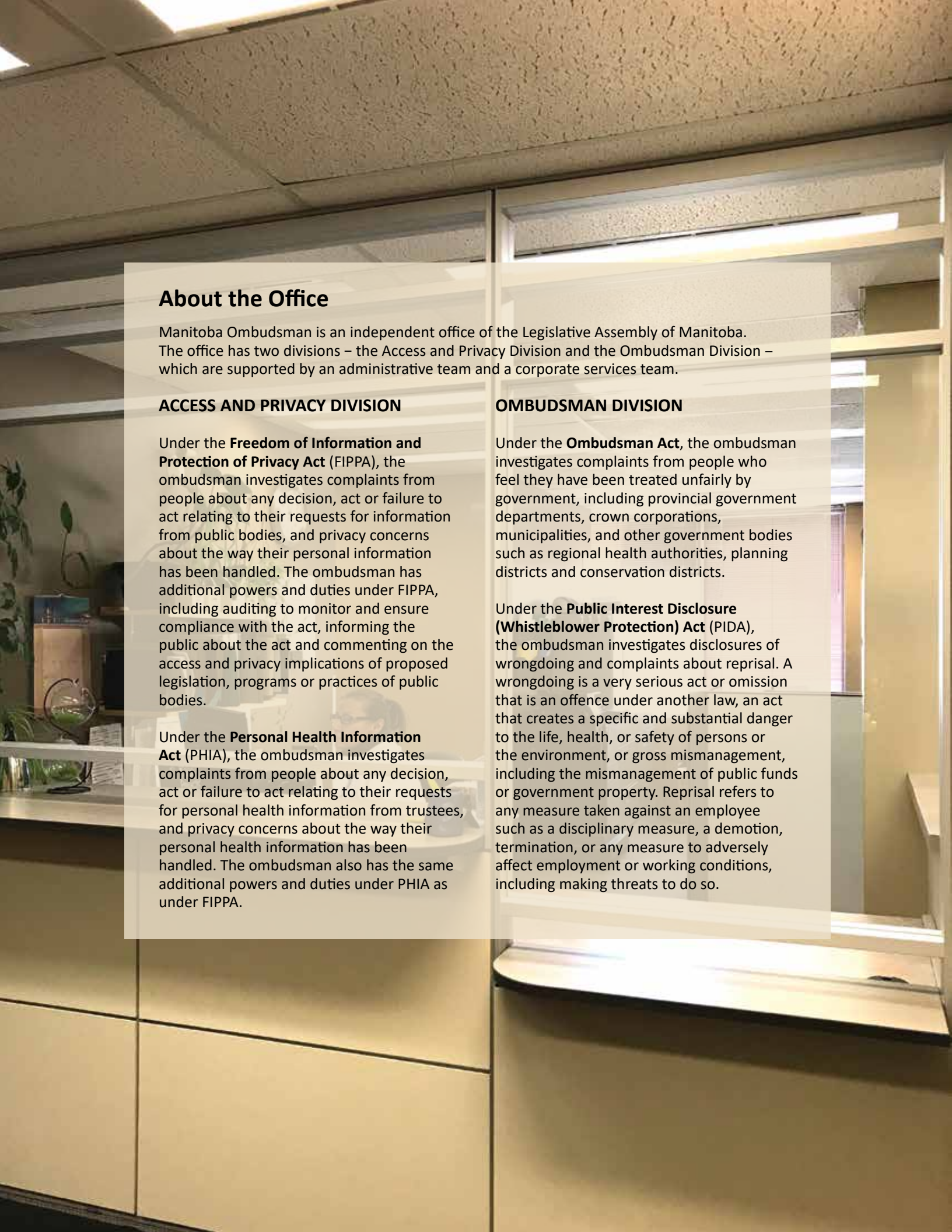
We investigated important complaints under the Ombudsman Act, the Public Interest Disclosure (Whistleblower Protection) Act (PIDA), the Freedom of Information and Protection of Privacy Act (FIPPA) and the Personal Health Information Act (PHIA). Some of the investigations completed in 2018 are highlighted throughout this report. I am proud that many of our investigations have had noticeably positive outcomes in ensuring that citizens are treated fairly in their interactions with government. I also commend Manitoba's public bodies and trustees that have enhanced administrative fairness and the protection of privacy for those they serve.

In early December 2018, amendments to PIDA were enacted augmenting the protections for whistleblowers in the province and granting additional powers to government bodies to effectively deal with disclosures of wrongdoing internally. I believe these amendments will serve to enhance and promote ethical culture within the public service. The amendments also granted our office additional mandates and powers to investigate allegations of reprisal under PIDA and to compel public bodies to produce their whistleblower procedures for our review and recommendation.

This year we began enhancing the measurement of our performance through the conduct of an operational planning process for the 2019 year. The planning process commenced in the fall of 2018 with the aim to set realistic and measurable objectives for our teams, based on our core legislated mandates. The process identified key activities and tasks that need to be performed to accomplish our objectives and set the parameters on how success is to be measured in 2019. The intent is to increase our own accountability over our performance and to identify effective solutions to enhance it.

In 2018, we also collaborated closely with the Manitoba Advocate for Children and Youth in two distinct endeavours: a joint investigation into the use of pepper spray and segregation in youth corrections facilities and the implementation of a pilot project to open a joint office in Thompson, Manitoba. Both projects were actually achieved in 2019, but the majority of the collaborative work resulting in positive outcomes occurred in the 2018 calendar year.

I am proud to lead the dedicated and professional staff of this office in accomplishing our mission: to foster enhancements and improvements to openness, transparency, fairness, accountability, and respect for privacy in the design and delivery of public service. Manitobans should know that we take pride in what we do, as is reflected in this annual report.



About the Office

Manitoba Ombudsman is an independent office of the Legislative Assembly of Manitoba. The office has two divisions – the Access and Privacy Division and the Ombudsman Division – which are supported by an administrative team and a corporate services team.

ACCESS AND PRIVACY DIVISION

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.

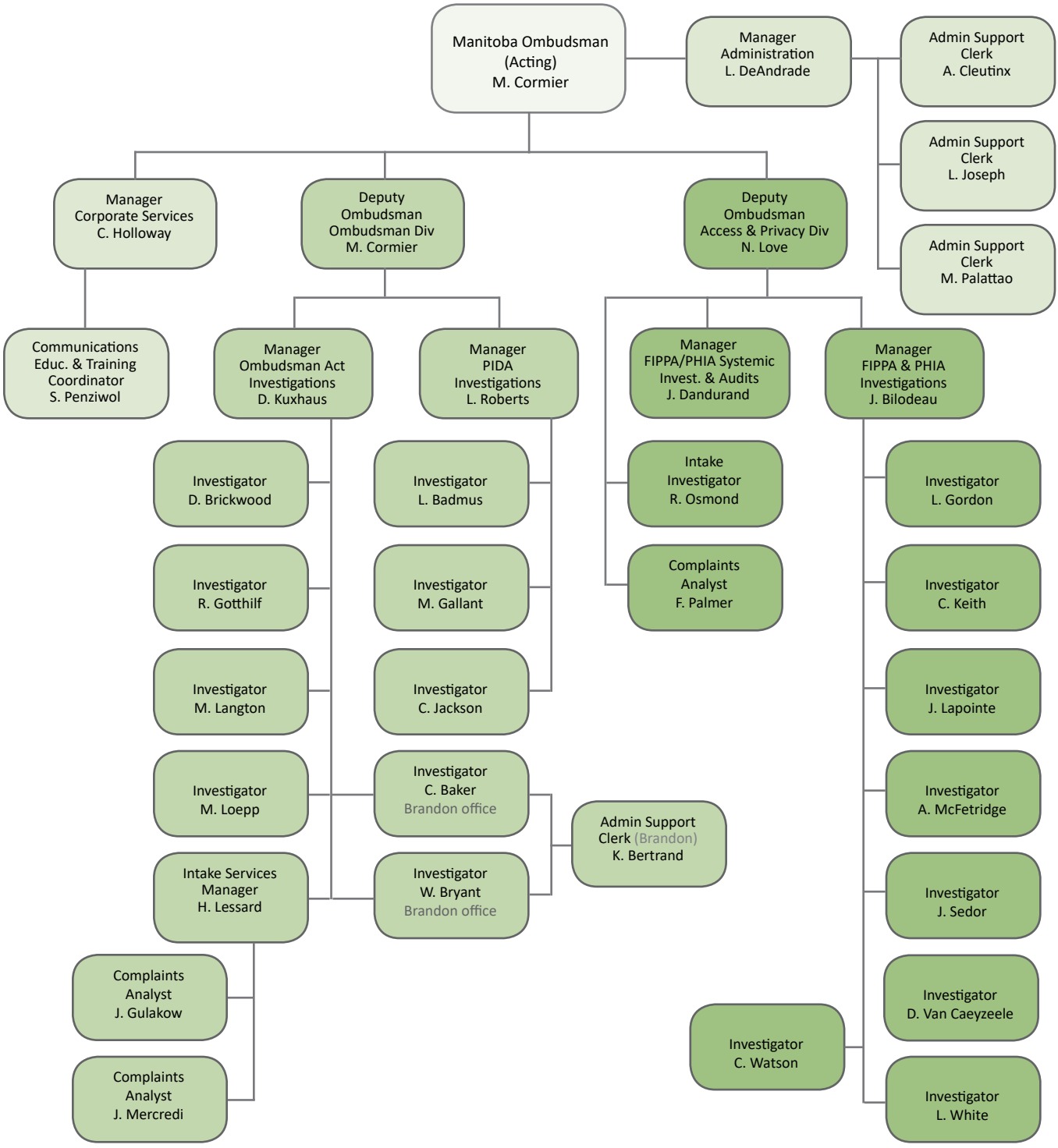
Under the **Personal Health Information Act** (PHIA), the ombudsman investigates complaints from people about any decision, act or failure to act relating to their requests for personal health information from trustees, and privacy concerns about the way their personal health information has been handled. The ombudsman also has the same additional powers and duties under PHIA as under FIPPA.

OMBUDSMAN DIVISION

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 and complaints about reprisal. 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. Reprisal refers to any measure taken against an employee such as a disciplinary measure, a demotion, termination, or any measure to adversely affect employment or working conditions, including making threats to do so.

Organizational Chart



2018 OVERVIEW	
3,673	**INQUIRIES AND COMPLAINTS**
2,965	Intake staff in both divisions handled 2965 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
49	The PIDA investigation team handled 17 inquiries and 32 disclosures related to the Public Interest Disclosure (Whistleblower Protection) Act (PIDA)
659	The administration team also handled 659 general inquiries
401	**INVESTIGATIONS OPENED**
250	FIPPA (parts 4 and 5)
46	PHIA (parts 4 and 5)
103	Ombudsman Act
2	PIDA
9	**RECOMMENDATIONS MONITORED**
9	7 inquest reports with 9 recommendations were received from the Provincial Court of Manitoba
19	**INVESTIGATION REPORTS POSTED ON WEBSITE**
13	FIPPA
2	PHIA
4	Ombudsman Act

Corporate Services and Support

In 2018, our office established a Corporate Services and Support team. This team is responsible for overseeing the office's internal corporate services and office-wide initiatives, including work related to strategic and business planning, the development of internal policies, procedures and tools for staff, and all communications, education and training initiatives.

An accomplishment for the Corporate Services and Support team has been the coordination of the opening and operations of the joint Thompson office between Manitoba Ombudsman and the office of the Manitoba Advocate for Children and Youth (MACY). This shared office, located in City Centre Mall, is part of a two-year pilot project. We look forward to being a part of the Thompson community and connecting with people throughout the north.

In 2018, two workshops were arranged for ombudsman staff. We held Organization and Staff Development's "Indigenous Peoples: Building Stronger Relationships" workshop to increase awareness about the history, values and practices of Indigenous peoples and to deepen understanding about the direct and intergenerational effects of colonization and the legacy of residential schools. We also coordinated with MACY to host "Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs," a workshop developed and delivered by Ombudsman Ontario.

2018/19 Office Budget	
Total salaries and employee benefits	$3,233,000
Other expenditures	$665,000
Total budget	**$3,898,000**

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

Two Brown Bag Talks for access and privacy coordinators and officers:

- Requesting a Longer Extension Under FIPPA
- Finding Solutions - Responding to FIPPA Requests and Complaints

Six access and privacy presentations:

- 2018 National Privacy and Data Governance Congress
- Southern Health-Santé Sud annual PHIA Day
- Manitoba Council of Administrative Tribunals conference
- Civil Service Commission staff
- Manitoba Connections: Access, Privacy, Security and Information Management Conference (two sessions)

Five PIDA-related presentations to public servants under the act

Nine general ombudsman presentations to:

- community groups in Brandon and Winnipeg (three)
- students at the University of Manitoba
- correctional officer recruits as part of their regular training program through Manitoba Justice (four)
- municipalities

Events

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

- Law Day 2019 and the Law Courts Open House, Winnipeg
- Comic Con C4, Winnipeg, in collaboration with the Office of the Privacy Commissioner of Canada
- Manitoba Social Science Teachers Association PD day conference, Winnipeg
- Brandon Teachers' Association LIFT conference, Brandon
- Association of Manitoba Municipalities Annual Convention, Winnipeg

Canadian Council of Parliamentary Ombudsman Meeting

It was our pleasure to host the annual Canadian Council of Parliamentary Ombudsman meeting in Winnipeg, June 11-13, 2018. CCPO meetings give provincial and territorial ombudspersons the chance to share accomplishments and discuss areas of common interest.

L-R: Diane McLeod-McKay (Yukon), Jay Chalke (British Columbia), Marianne Ryan (Alberta), Mary McFadyen (Saskatchewan), Charlene Paquin (Manitoba), Paul Dubé (Ontario), Marie Rinfret (Quebec), Charles Murray (New Brunswick), William A. Smith (Nova Scotia), Barry Fleming (Newfoundland and Labrador)

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 or personal health 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 FIPPA or PHIA

The ombudsman has additional duties and powers under FIPPA and PHIA, and these include:

- conducting audits to monitor and ensure compliance with FIPPA and PHIA
- commenting on the implications of proposed legislation or programs affecting access and privacy rights
- commenting on the implications of the use of information technology in the collection, storage, use or transfer of personal and personal health information
- informing the public about FIPPA and PHIA and receiving comments from the public

2018 Access and Privacy Division Overview

The Access and Privacy Division's broad responsibilities under FIPPA and PHIA include both reactive duties, such as the investigation of access to information and privacy complaints from citizens, as well as proactive duties, such as promoting public bodies and trustees' compliance with obligations under the acts and promoting citizens' awareness of their rights under the acts. In 2018, our office restructured its intake services and a complaints analyst and an investigator were allocated to the division to handle all access and privacy-related intake matters. This has enhanced our intake services to the public, public bodies and trustees and it has also supported our investigation work under FIPPA and PHIA.

Divisional intake staff deal with all access and privacy inquiries from the public by telephone, email, mail or in person. They provide information about FIPPA and PHIA and assist citizens to exercise their rights under the acts. All formal complaints received by our office under FIPPA and PHIA first undergo a preliminary review by intake staff, who follow up with complainants to obtain clarifying information about the complaints. When cases are being opened for investigation, intake staff obtain necessary information from public bodies and trustees in order to prepare cases for investigation. The volume of complaints investigated under FIPPA and PHIA is significant, and the preliminary work by intake staff facilitates the division's ability to commence investigations as quickly as possible after receipt of complaints. This is invaluable, given that FIPPA and PHIA set out time limits for our investigations. Some cases are assigned to intake staff, particularly when options for an early resolution are identified during the preliminary review of complaints at the intake stage.

144 cases carried into 2018

296 new cases in 2018

440 total cases in 2018

317 cases closed during 2018

123 cases carried into 2019

The investigation of complaints from citizens remained the primary focus of our work during 2018. We commenced investigations in response to 245 new access and privacy complaints we received under FIPPA and PHIA. We also opened 51 other cases, which included reviewing public bodies and trustees' handling of privacy breaches they reported to our office, conducting audits of access to information practices of public bodies, reviewing requests from public bodies for our approval of longer extensions under FIPPA, and providing comments to public bodies and trustees on the access and privacy implications of new programs or initiatives or proposed legislation.

In addition to our case-related work, we updated some of our access and privacy online resources for public bodies and trustees and created some new ones, providing guidance on responding to privacy breaches and requesting our approval of longer extensions of the time limit to respond to access requests under FIPPA. Divisional staff gave two brown bag talks held at our office for access and privacy personnel of public bodies and trustees. The topics discussed were our process and considerations about requests seeking our approval of longer extensions under FIPPA and our advice in responding effectively to access requests and complaints.

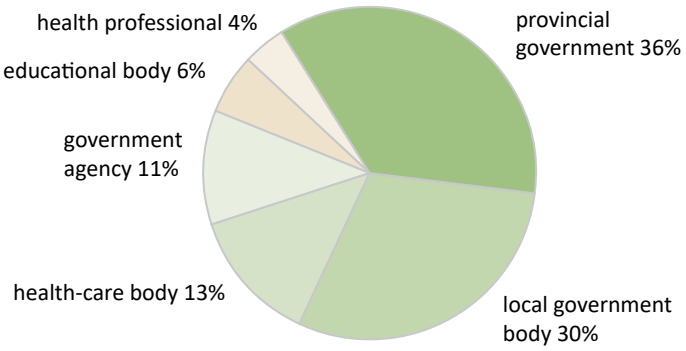
All divisional staff also provide access and privacy guidance during informal consults from employees of public bodies and trustees. During 2018, staff completed 64 informal consults from public bodies and trustees. We provide general advice on interpreting and applying provisions of FIPPA and PHIA, suggest best practices to follow, and refer them to specific investigations reports, practice notes and other resources on our website that may assist them in dealing with challenging issues.

We created a new fact sheet to inform Manitobans of their access and privacy rights under PHIA and we updated our FIPPA guide for the public. Additionally, divisional staff participated in the planning of the Manitoba Connections: Access, Privacy, Security and Information Management conference, held in Winnipeg in 2018. We delivered two presentations to employees of public bodies and trustees attending the conference.

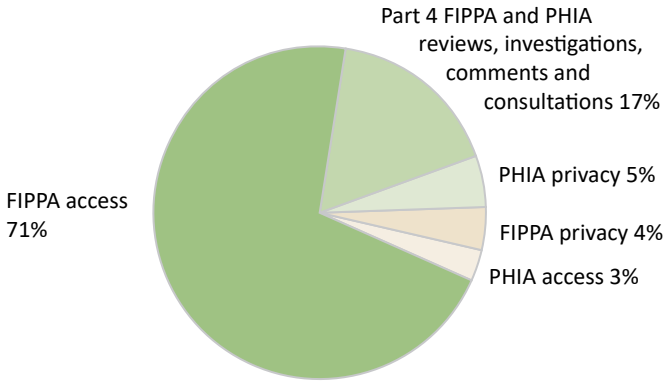
Our outreach activities and resources support the work of access and privacy staff in public bodies and trustees and promote compliance with FIPPA and PHIA. This work by the division is also instrumental in fostering common understandings in interpreting and applying provisions of FIPPA and PHIA and following best practices. In view of our significant workload during 2018, we postponed conducting a survey of public bodies and trustees with respect to obtaining their input about our outreach activities.

2018 Access and Privacy Division Overview, continued

Distribution of complaints opened under part 5 of FIPPA and PHIA in 2018



Types of cases opened under parts 4 and 5 of FIPPA and PHIA in 2018



Investigations

Recommendation Made

Under FIPPA and PHIA, the ombudsman may make any recommendations considered appropriate about an access to information or privacy complaint. In most cases, it is not necessary to make recommendations. In cases where our investigation findings support the complaint in whole or in part, we discuss with the public body or trustee the actions we believe should be taken to address the specific complaint issue (for example, to release information to the applicant, respond to an access request or modify a fee estimate). In 2018, we supported complaints in whole or in part in 82 cases, and in all but one of these cases, we were able to informally effect the outcome to address the complaint, without needing to make a recommendation.

If a report contains a recommendation, the acts set out a specific process and time frame for a public body or trustee to respond to the recommendation and to comply with a recommendation that it has accepted. FIPPA and PHIA were amended in 2011 to provide the ombudsman with an additional avenue of review in circumstances where a public body or trustee does not respond to the ombudsman's recommendation, does not accept the recommendation or accepts it but does not comply with it. In such circumstances, the ombudsman may request a review by the information and privacy adjudicator. On completing a review, the adjudicator issues an order. Since 2011, recommendations have been made in 13 cases under FIPPA and PHIA, and of these, one case has been referred for review to the information and privacy adjudicator.

During 2018, the ombudsman made a recommendation in one case, which concerned an access complaint under FIPPA. The complainant had made an access request to the City of Winnipeg - Winnipeg Police Service (the WPS) for copies of police records regarding charges made against the complainant that were stayed by the Manitoba Prosecution Service. The WPS determined that the records were related to an ongoing prosecution and were not subject to FIPPA. A complaint was made to our office about this access decision.

The ombudsman found that, with the exception of one record, the responsive records did not relate to an ongoing prosecution. Therefore, these records were subject to FIPPA and the WPS was required to make a decision about whether to give access to these records. The ombudsman recommended that the WPS issue an access decision to the complainant on this basis. The WPS responded to our report in accordance with the requirements of FIPPA. The WPS accepted the recommendation and complied with it by issuing an access decision to the complainant. In that decision, access was granted in part to the requested records.

This report is available on our website at www.ombudsman.mb.ca/uploads/document/files/case-2017-0458-en.pdf

Investigation Reports Posted in 2018

In addition to publishing our investigation reports that contain recommendations made under FIPPA and PHIA, we publish selected investigation reports in cases where recommendations were not made. Very few investigations result in the need to make recommendations to ensure compliance with FIPPA and PHIA. In many cases we have investigated we find that public bodies and trustees have met their obligations under the acts and the complaints are not supported. There are many lessons that can be drawn from cases where we have supported, partly supported, or not supported complaints, as well as when complaints have been resolved without making findings.

We publish these additional reports to enhance the transparency of our access and privacy investigations by describing the issues we considered in a case and explaining our interpretation of provisions of FIPPA and PHIA and our findings about the complaint. These reports can have educative value for public bodies and trustees who may consider our analysis and findings from previous cases to assist in making future decisions, which may improve compliance. We may also refer to published reports during investigations to indicate our opinions on the requirements that must be met to rely on various provisions, which may help to facilitate resolution of a complaint.

In some cases, a complaint from an individual can bring about positive changes implemented by public bodies and trustees, from which other citizens may benefit. Also, other public bodies and trustees may benefit from learning how others have addressed issues more systemically. For example, in our case 2017-0479, an individual brought forward privacy concerns about having to verbally provide personal health information, including medical history, during an intake procedure at a hospital, with other people in very close proximity able to hear what was being discussed. The hospital made changes to the layout of the unit to improve the privacy of the personal health information being discussed with and shared by patients during an intake procedure. In our case 2018-0077, an individual had concerns about the continued disclosure of personal information posted in online decisions by an investigative body, which raised questions about whether such disclosure was serving the original purpose for which the disclosure was made. The investigative body decided to make changes to its policies and procedures relating to the internet posting of its disciplinary decisions that would meet the requirements of FIPPA and fulfill its mandate.

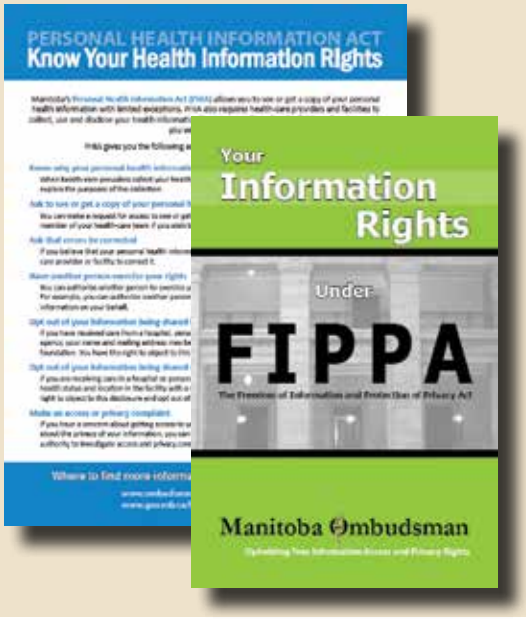
In 2018, we published 15 other investigation reports: 13 related to FIPPA access and privacy complaints and two related to PHIA privacy complaints.
FIPPA investigation reports can be found on our website at www.ombudsman.mb.ca/documents_and_files/investigation-reports.html
PHIA investigation reports can be found at www.ombudsman.mb.ca/documents_and_files/investigation-reports-1.html

New Publications

In addition to investigating complaints, Manitoba Ombudsman plays an important educational role by informing the public about access and privacy laws.

In 2018 we released *Your Information Rights Under FIPPA*, which is an updated version of our *User's Guide to FIPPA*, initially published in 2012. The guide is available at www.ombudsman.mb.ca/uploads/document/files/fippa-guide-2018-web-en.pdf

We also released *Know Your Health Information Rights*, an information sheet that sets out access to information and protection of privacy rights under PHIA. The information sheet is available at www.ombudsman.mb.ca/uploads/document/files/health-info-rights-access-privacy-en.pdf



Corroborating Audits of Employees' Use of Personal Health Information

In 2018, we investigated a complaint that an individual's personal health information had been inappropriately accessed by an employee of a trustee. Our investigation identified some key considerations concerning audits of employees' access to electronic records that could be instructive to all trustees.

Prior to making a complaint to our office, the individual had initially approached the trustee's privacy officer with concerns that an employee of the trustee had snooped in the individual's electronic medical record (EMR) maintained by the trustee. The privacy officer obtained a record of user activity (RoUA) regarding the individual's EMR that showed which employees of the trustee accessed what information and when this took place. The RoUA demonstrated that, two years prior, the employee had in fact accessed the individual's EMR on four occasions over the span of almost six months.

During our investigation of the individual's privacy complaint, the privacy officer explained to our office that the fourth instance of the employee's access had actually been detected during the month it took place, by an audit of "same name" user access. This type of access is a common red flag for potential unauthorized use (snooping) in electronic health-care records. According to the trustee's records of its internal investigation, the employee asserted that the affected individual, a relative, had asked the employee to look at specific lab results for the individual. Because the employee was not providing health care for the individual, the trustee determined that this access to the EMR of the affected individual was not authorized, regardless of the purpose.

The trustee did not notice, at the time of its initial internal investigation, that the employee looked at chart items, medical summaries and letters, but did not actually look at the individual's lab results, which was the employee's explanation for accessing the EMR. Furthermore, because the trustee did not conduct a detailed examination of the nature of the employee's access to the individual's EMR, the trustee did not identify that there had been three earlier instances of access by the employee to the individual's EMR, which would have also required further internal investigation. Additionally, the trustee did not notify the individual of the unauthorized access when it was detected by the audit, because the trustee did not believe that there was a risk of harm to the individual. Because contact was not made with the individual, this meant that the trustee was not able to verify the employee's account of the reason for accessing the EMR.

This complaint investigation highlighted the following considerations about audits of employees' access to electronic health-care records:

- When an audit identifies one instance of possibly unauthorized access to a patient's record by an employee, a trustee should conduct a more targeted audit to determine whether the employee accessed the patient's record on any other occasions. This is particularly important if the first audit covered only a small period of time. The trustee should also consider checking if the employee's pattern of potentially inappropriate access extends to other individuals as well. Taking these steps ensures that the trustee has a more accurate and complete picture of the extent of the employee's access.
- When an employee offers an explanation for unauthorized access, the trustee should verify that it is consistent with the circumstances of the access. Depending on the circumstances, this could involve verifying what information the employee accessed and for how long. If the employee asserts that an affected individual requested the access, the affected individual should be contacted to obtain their version of events.

Determining Whether a Public Body has Custody or Control of a Record

FIPPA applies to all records that are "in the custody or under the control" of the public body. But how does a public body determine whether it has custody or control of a record for the purpose of FIPPA? This seemingly straightforward question has become more challenging to answer with the proliferation of records such as email, instant messaging and texting, which are created with digital communication technologies. If a record is maintained on a public body's network server or a work-issued smartphone, does this mean that the record is in the custody or control of the public body for the purposes of FIPPA? The short answer is it depends. Other factors, as explained below, must also be considered in reaching a determination about custody or control of a record for the purposes of FIPPA.

A record is generally considered to be in the custody of a public body if the public body has physical possession of the record. However, the mere possession of a record does not necessarily mean that the record falls under FIPPA. For example, if an employee happens to maintain a personal letter or greeting card in their desk at work, the record is physically located in the public body's offices, but the public body does not have custody of the record for the purpose of FIPPA. A record is under the control of a public body when the public body has the authority to manage the record, including restricting, regulating, and administering its use, disclosure or disposition. Using the same example of an employee's personal letter or greeting card stored in their desk, the public body would not have authority to manage the record, and therefore would not have control of the record. We seem to understand these things intuitively when dealing with paper records, yet, if the same questions were asked about an employee's personal emails located on the public body's server or personal texts on a business cellphone, many people would come to a different conclusion.

In determining whether a public body has custody or control of a record, it is necessary to consider all aspects of the creation, maintenance and use of the record. This can be determined by asking questions such as:

- how was the record created and by whom?
- how closely is the record integrated with other records held by the public body?
- does the public body have the authority to regulate the record's use or to dispose of the record?

The overarching consideration is the purpose for which the record was created and a key question is whether the content of the record relates to the public body's function and mandate.

In the past year, our office investigated cases involving access requests for records that were maintained on public body email servers and business devices, but seemed to be personal employee communications. Although we noted that the records were in the physical possession of the public body in each case, we determined that the records were not subject to the application of FIPPA. In making this determination, we observed that:

- the records were outside the context of the business of the public body
- the records were unrelated to the public body's mandate and function
- the employee had the authority over disposal of the information unlike official public body records which must not be destroyed unless authorized by the public body's record retention schedule, and
- the records were not integrated with other business information of the public body other than existing on a business device

With respect to determining whether a public body has control of records that are not in its possession, our office previously considered a case (2017-0081) where records of a business nature were located on a personal device. The key factor in determining that the records were in the control of the public body was that they were about public body business.

On the flip side, a public body may have possession of records that are not considered to be in the custody of the public body for the purposes of FIPPA. We previously considered this issue in the context of a privacy complaint (2013-0309) that related to emails sent by an employee from their work email account. As the emails were purely personal in nature, we determined that the records were not in the custody or control of the public body.

We discussed the issue of custody or control of records in relation to public-private partnerships and subsidiary corporations in our 2014 annual report.

Decisions Not to Investigate Complaints

Both FIPPA and PHIA permit the ombudsman to decide *not* to investigate a complaint in certain circumstances, which are described in subsections 41(1) of PHIA and 63(1) of FIPPA. The ombudsman may decline to investigate a complaint if the ombudsman is of the opinion that:

1. a significant amount of time has passed since the date of the subject matter of the complaint arose, making an investigation no longer practicable or desirable (this applies to all types of complaints, except access complaints under FIPPA, which have defined time limits to make a complaint); or
2. the subject matter of the complaint is trivial or the complaint is not made in good faith, or is frivolous, vexatious, or an abuse of process; or
3. the circumstances of the complaint do not require investigation.

Because the circumstances of each complaint received by our office is different, a decision to decline to investigate is made on a case-by-case basis, and is generally rare. Each decision reflects a careful balancing of the complainant's right of complaint with the responsible exercise of that right, in a manner that is consistent with achieving the purposes of the acts. If a decision is made not to conduct an investigation, the ombudsman must provide reasons for this decision in writing to both the complainant and the public body or trustee the complaint is about.

Of the 386 complaints our office dealt with under both FIPPA and PHIA in 2018, the ombudsman declined to investigate 13 complaints. Nine of these complaints were directly related to each other and involved similar circumstances, which contributed to them being declined.

Examples of complaints that our office has declined to investigate include:

- complaints about privacy made years after the subject of the complaint arose, when the public body or trustee's privacy practices have changed, and/or where relevant information or witnesses are no longer available
- complaints about access requests that were made for a purpose other than gaining access to records
- complaints about matters that our office has previously reviewed in order to attempt to obtain a different outcome
- an access applicant submitting an unreasonably high number of requests to a public body and then making complaints about the public body not meeting the time limits for responding under FIPPA
- circumstances where a person enlists a number of other individuals to submit identical or systematic access requests to the same public body, and then enlists them to make subsequent complaints to our office

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 2018, we initiated 51 reviews and investigations – 29 under part 4 of FIPPA and 22 under part 4 of PHIA. Including the three cases carried over from 2017, we worked on a total of 54 cases and concluded 38 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 2018, we were formally consulted on four 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. During 2018, we were informally consulted on 64 matters.

Longer Extensions of the Time Limit for Responding to FIPPA Requests

FIPPA permits a public body to extend the 30-day time limit for responding to an access request in certain circumstances described in section 15 of the act. This includes when a large number of records is requested or must be searched, and responding within 30 days would interfere unreasonably with the operations of the public body, or when time is needed to consult with a third party or another public body before deciding whether to give access to a record. In such circumstances, a public body can take an extension for up to an additional 30 days, or for a longer period if the ombudsman agrees. If the public body has determined that responding to the request will require more than a total of 60 days, the public body may request approval from the ombudsman for a longer extension.

In 2018, our office received 12 requests from public bodies for approval of longer extensions. Of these, eight were approved, two were declined on the basis that the public body's time limit for responding had expired prior to requesting approval, and two were declined on the basis that none of the circumstances that permit an extension under section 15 of FIPPA were applicable.

Seeking approval from our office for a longer extension is time sensitive due to the time limits within which an extension must be taken by a public body under FIPPA. To expedite the process for seeking approval, we have developed new online resources. These include a Longer Extension Request Form, which can be submitted online through our website, or filled out electronically and submitted by email or fax. We have also updated our practice note *Making a Submission to the Ombudsman for an Extension Longer than 30 Days under the Freedom of Information and Protection of Privacy Act* to provide public bodies with more detailed information about the process. This practice note will also assist public bodies with completing the form.

These resources can be found on our new "Longer Extensions under FIPPA" web page for public bodies at www.ombudsman.mb.ca/info/longer-extensions-under-fippa.html

Privacy Breach Reports

Our office encourages public bodies and trustees to report privacy breaches of personal information or personal health information to our office where there may be a risk of significant harm to citizens affected by the breach. Reporting these breaches to our office enables an independent review of the actions taken to address the breach and prevent future breaches from occurring. Although reporting these breaches to our office is not mandatory under Manitoba's FIPPA and PHIA, we believe there are significant benefits to reporting:

- **For public bodies and trustees:** they can receive guidance from our office about their response to the breach and steps that can be taken to prevent future breaches; and reporting a breach demonstrates accountability for the management of personal and personal health information entrusted to its care by citizens.
- **For citizens:** it provides assurance that serious breaches by public bodies and trustees will be independently reviewed, including a review of their decisions on whether to notify affected individuals so they can take steps to reduce the impact of the breach; and our review also considers steps that can be taken to better protect citizens' information and prevent breaches from occurring.
- **For our office:** receiving reports about breaches enables us to respond more proactively, by reviewing the public body or trustee's response to the breach and providing guidance on steps that can be taken to mitigate the harm to individuals and prevent future breaches; and it also enables us to prepare to respond to potential complaints that may be made from affected individuals, particularly when numerous individuals are affected. It also enables our office to identify systemic issues or trends and publish guidance to assist all public bodies and trustees with prevention.

Although public bodies and trustees may strive to handle personal and personal health information in accordance with FIPPA and PHIA, privacy breaches can still occur due to human error, use of technology or malicious actions. The types of privacy breaches reported to our office vary in circumstances, such as a misdirected fax or an intentional snooping of personal health information. The harm to an individual resulting from a privacy breach may also vary from minimal impact to having significant consequences. For example, personal health information sent by mail or fax to the wrong person can have various risks to the individual the information is about. The risks may vary based on the level of sensitivity of the information and who the received the information.

In 2018, 30 privacy breaches were reported to our office. Of these 30 reports, 20 involved personal health information (PHIA) and 10 involved personal information (FIPPA). Of the 30 privacy breach reports, 15 were accidental, 8 were intentional, 6 were a result of theft, and one was received from an organization not subject to FIPPA or PHIA.

Since there are a variety of circumstances that surround a privacy breach, there are different ways in which our office responds to a breach. In determining our response to a breach reported to our office, we would conduct a review of how the public body or trustee responded to the breach in the context of the four key steps as outlined in our practice note *Key Steps in Responding to Privacy Breaches*. Specifically, we would review whether all reasonable steps have been taken by the public body or trustee to contain the breach, whether the risks associated with the breach have been thoroughly considered, whether affected individuals have been notified, and whether all appropriate measures are being implemented to prevent future occurrences. In some cases, we may decide to conduct our own investigation of a breach.

In 2018, we created additional resources to further assist public bodies and trustees in managing privacy breaches. We updated our practice note, *Key Steps in Responding to Privacy Breaches under FIPPA and PHIA*, developed a new practice note that includes a checklist of the information to provide to affected individuals being notified of a breach, and we updated our Privacy Breach Reporting Form. These resources are available on our privacy breach resources web page at
www.ombudsman.mb.ca/info/privacy-breaches.html

We also directly informed public bodies and trustees of these resources, including provincial government departments, municipalities, universities, school divisions, regional health authorities and health professional regulatory bodies.

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 2018, Canada's information and privacy commissioners, including our office, issued a joint resolution that called on governments to pass legislation requiring political parties to comply with globally recognized privacy principles, to provide Canadians with access to the personal information they hold about them, and to provide for independent oversight to verify and enforce privacy compliance.

As part of Infrastructure Canada's Smart Cities Challenge, communities across Canada were invited to develop innovative solutions to their data and technology challenges. Information and privacy commissioners collectively wrote a letter to the infrastructure and communities minister to recommend that privacy protections be considered in the selection, design, and implementation of winning proposals.

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

Our office also participated in a cross-jurisdictional working group that developed three new privacy lessons for students in grades 6-12. Our collection of learning activities, including the privacy lessons, is available at
www.ombudsman.mb.ca/info/teachers-and-students.html

Conference Sessions

Our office participated in the Manitoba Connections: Access, Privacy, Security and Information Management conference held in Winnipeg. We participated on the advisory committee along with representatives of public bodies and trustees to help Verney Conference Management plan the conference agenda. Ombudsman staff delivered two presentations:

- Finding Solutions – Responding to FIPPA requests (and complaints): This session provided tips and tools to help address even the most challenging FIPPA situations. Topics covered included approaches for identifying what an applicant truly wants, focusing on issues rather than positions, problem-solving tips and strategies for finding win-win outcomes.
- Claiming Your (solicitor-client) Privilege and Proving it, too (co-presented with an access and privacy officer): The law relating to solicitor-client privilege and the right of access to information has evolved and so have the practices around demonstrating the privilege exists. This session delivered what participants needed to know on the topic of dealing with FIPPA requests for information subject to solicitor-client privilege and responding to complaints arising from a refusal to give access to this information. It also addressed the substantive and practical issues in applying the FIPPA exception for solicitor-client privilege and proving the privilege exists in responding to a complaint investigation by the ombudsman.

Summary of 2018 FIPPA and PHIA Complaints Opened and Closed

FIPPA

FIPPA Complaints Opened	
Type of Access Complaint	
Refused access	120
No response	33
Request was disregarded	20
Extension	2
Fees	9
Fee waiver	5
Correction	-
Other access matters	20
Sub-total	**209**
Type of Privacy Complaint	
Collection	3
Use	2
Disclosure	7
Sub-total	**12**
Other	
Third party contests access	-
Complaint by relative of deceased	-
Sub-total	**-**
Total FIPPA complaints opened	**221**

FIPPA Complaints Closed	Total	Declined or discontinued	Supported in part or in whole	Not supported	Resolved	Recommendation made
Type of Access Complaint						
Refused access	137	11	33	70	23	-
No response	36	5	27	-	4	-
Request was disregarded	13	8	-	2	3	-
Extension	2	1	-	1	-	-
Fees	12	2	2	1	7	-
Fee waiver	7	2	-	4	1	-
Correction	-	-	-	-	-	-
Other access matters	30	2	7	12	8	1
Sub-total	**237**	**31**	**69**	**90**	**46**	**1**
Type of Privacy Complaint						
Collection	2	-	-	2	-	-
Use	1	-	-	1	-	-
Disclosure	10	-	3	6	1	-
Sub-total	**13**	**-**	**3**	**9**	**1**	**-**
Other						
Third party contests access	-	-	-	-	-	-
Complaint by relative of deceased	-	-	-	-	-	-
Sub-total	**-**	**-**	-	**-**	-	-
Total FIPPA complaints closed	**250**	**31**	**72**	**99**	**47**	**1**

PHIA

PHIA Complaints Opened	
Type of Access Complaint	
Refused access	4
No response	3
Fees	-
Fee waiver	-
Correction	1
Other access matters	-
Sub-total	**8**
Type of Privacy Complaint	
Collection	5
Use	4
Disclosure	7
Failure to protect	-
Sub-total	**16**
Total PHIA complaints opened	**24**

PHIA Complaints Closed	Total	Declined or discontinued	Supported in part or in whole	Not supported	Resolved	Recommendation made
Type of Access Complaint						
Refused access	5	-	-	3	2	-
No response	2	-	2	-	-	-
Fees	-	-	-	-	-	-
Fee waiver	-	-	-	-	-	-
Correction	1	-	-	1	-	-
Other access matters	2	-	1	-	1	-
Sub-total	**10**	**-**	**3**	**4**	**3**	**-**
Type of Privacy Complaint						
Collection	4	1	1	2	-	-
Use	8	-	4	4	-	-
Disclosure	6	-	1	5	-	-
Failure to protect	1	-	1	-	-	-
Sub-total	**19**	**1**	**7**	**11**	**-**	**-**
Total PHIA complaints closed	**29**	**1**	**10**	**15**	**3**	**-**

PHIA Investigations of Individual Complaints (Under Part 5)

	Case Numbers			Case Dispositions							
	Carried over into 2018	New cases in 2018	Total cases in 2018	Pending at 12/31/2018	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Provincial government											
Infrastructure	1	-	1	-	-	-	-	1	-	-	-
Government agency											
Manitoba Housing & Renewal Corporation	1	-	1	-	-	-	-	-	1	-	-
Manitoba Hydro	-	1	1	1	-	-	-	-	-	-	-
Manitoba Public Insurance	-	2	2	-	-	-	2	-	-	-	-
Workers Compensation Board	-	1	1	-	-	-	1	-	-	-	-
Educational body											
University of Manitoba	4	-	4	-	-	-	2	2	-	-	-
Health-care body											
Deer Lodge Centre	1	-	1	-	-	-	1	-	-	-	-
Designated health-care facility	-	1	1	-	-	-	1	-	-	-	-
Interlake-Eastern Regional Health Authority	-	2	2	2	-	-	-	-	-	-	-
Laboratory	-	1	1	1	-	-	-	-	-	-	-
Northern Regional Health Authority	1	2	3	1	-	-	1	-	1	-	-
Prairie Mountain Health	-	1	1	-	-	-	-	-	1	-	-
Shared Health Inc.	1	1	2	-	-	-	1	-	1	-	-
Southern Health-Santé Sud	-	1	1	-	-	-	1	-	-	-	-
Winnipeg Regional Health Authority	4	2	6	2	-	-	3	-	1	-	-
Health professional											
Physician	1	7	8	3	-	1	2	-	1	1	-
Physiotherapist	1	-	1	-	-	-	-	1	-	-	-
Psychologist	-	2	2	-	-	-	-	-	-	2	-
TOTAL											
	15	**24**	**39**	**10**	**-**	**1**	**15**	**4**	**6**	**3**	**-**

Complaint dispositions used in the tables on pages 22-25:

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, 2018.

FIPPA Investigations of Individual Complaints (Under Part 5)

	Case Numbers			Case Dispositions							
	Carried over into 2018	New cases in 2018	Total cases in 2018	Pending at 12/31/2018	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Provincial government											
Agriculture	-	1	1	-	-	-	1	-	-	-	-
Civil Service Commission	4	-	4	-	-	-	2	1	-	1	-
Crown Services	-	1	1	1	-	-	-	-	-	-	-
Education & Training	4	2	6	2	-	-	2	-	-	2	-
Executive Council	2	4	6	-	-	-	-	-	3	3	-
Families	2	8	10	3	-	-	4	1	-	2	-
Finance	2	14	16	8	-	1	1	-	3	3	-
Growth, Enterprise & Trade	5	4	9	1	-	-	6	-	-	2	-
Health, Seniors & Active Living	4	3	7	2	-	-	-	2	-	3	-
Indigenous & Northern Relations	-	1	1	-	-	-	-	-	1	-	-
Infrastructure	4	7	11	2	2	-	7	-	-	-	-
Intergovernmental Affairs & International Relations	-	4	4	4	-	-	-	-	-	-	-
Justice & Attorney General	9	9	18	4	-	-	9	4	1	-	-
Municipal Relations	-	3	3	-	-	-	-	-	2	1	-
Sport, Culture and Heritage	-	2	2	-	-	-	-	-	1	1	-
Sustainable Development	22	24	46	11	9	4	5	3	13	1	-
Government agency											
CFS Agency/Authority	2	3	5	3	-	-	-	1	1	-	-
Manitoba Agricultural Services Corporation	-	1	1	1	-	-	-	-	-	-	-
Manitoba Housing & Renewal Corporation	1	1	2	1	-	-	1	-	-	-	-
Manitoba Hydro	5	7	12	3	-	3	3	1	1	1	-
Manitoba Institute of Trades & Technology	-	3	3	2	-	-	-	-	-	1	-
Manitoba Liquor & Lotteries	2	2	4	-	-	1	2	-	-	1	-
Manitoba Public Insurance	-	4	4	-	-	-	3	-	-	1	-
Workers Compensation Board	12	3	15	-	-	-	7	7	-	1	-
Local government body											
City of Brandon	-	4	4	-	-	-	2	1	1	-	-
City of Dauphin	-	1	1	-	-	-	-	-	-	1	-
City of Thompson	1	1	2	-	-	-	1	-	-	1	-
City of Winnipeg	16	35	51	10	1	4	18	3	5	9	1
Dallas/Red Rose Community Council	1	-	1	1	-	-	-	-	-	-	-
Municipality of Boissevain-Morton	-	2	2	-	-	-	1	1	-	-	-
Municipality of Norfolk-Treherne	1	-	1	-	-	1	-	-	-	-	-
Red River Planning District	-	2	2	1	-	-	1	-	-	-	-

FIPPA Investigations of Individual Complaints (Under Part 5)

	Case Numbers			Case Dispositions							
	Carried over into 2018	New cases in 2018	Total cases in 2018	Pending at 12/31/2018	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Local government body, continued											
RM of Alexander	-	1	1	-	-	1	-	-	-	-	-
RM of Grey	-	2	2	2	-	-	-	-	-	-	-
RM of La Broquerie	-	2	2	-	-	-	-	2	-	-	-
RM of Lac du Bonnet	-	6	6	6	-	-	-	-	-	-	-
RM of St. Andrews	1	1	2	-	-	-	1	-	-	1	-
RM of Tache	2	-	2	-	-	-	1	1	-	-	-
RM of West St. Paul	-	13	13	12	-	-	-	-	-	1	-
RM of Whitehead	2	-	2	-	-	-	-	-	2	-	-
South Interlake Planning District	1	-	1	-	-	-	1	-	-	-	-
Town of Churchill	-	1	1	1	-	-	-	-	-	-	-
Town of Lac du Bonnet	-	2	2	1	-	-	-	-	1	-	-
Town of Niverville	-	1	1	-	-	-	-	-	-	1	-
Educational body											
Brandon School Division	-	3	3	2	-	1	-	-	-	-	-
Hanover School Division	1	1	2	1	-	-	1	-	-	-	-
Lakeshore School Division	-	1	1	1	-	-	-	-	-	-	-
Prairie Spirit School Division	1	-	1	-	-	-	-	-	1	-	-
Red River College	-	2	2	1	-	-	-	-	-	1	-
River East Transcona School Division	2	-	2	-	-	-	-	2	-	-	-
Seven Oaks School Division	-	3	3	-	-	-	3	-	-	-	-
Southwest Horizon School Division	-	1	1	-	-	-	-	1	-	-	-
University of Manitoba	2	2	4	1	-	1	1	1	-	-	-
University of Winnipeg	-	3	3	3	-	-	-	-	-	-	-
Health-care body											
CancerCare Manitoba	-	3	3	-	-	-	3	-	-	-	-
Interlake-Eastern Regional Health Authority	1	-	1	-	-	-	1	-	-	-	-
Misericordia Health Care Centre	-	2	2	-	-	-	1	1	-	-	-
Northern Health Authority	-	1	1	1	-	-	-	-	-	-	-
Prairie Mountain Health	1	1	2	-	-	-	1	-	-	1	-
St. Boniface Hospital	1	-	1	-	-	-	-	-	-	1	-
Shared Health Inc.	-	1	1	-	-	-	-	-	-	1	-
Winnipeg Regional Health Authority	12	12	24	5	1	1	9	2	1	5	-
TOTAL											
	126	**221**	**347**	**97**	**13**	**18**	**99**	**35**	**37**	**47**	**1**

Ombudsman Division

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

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

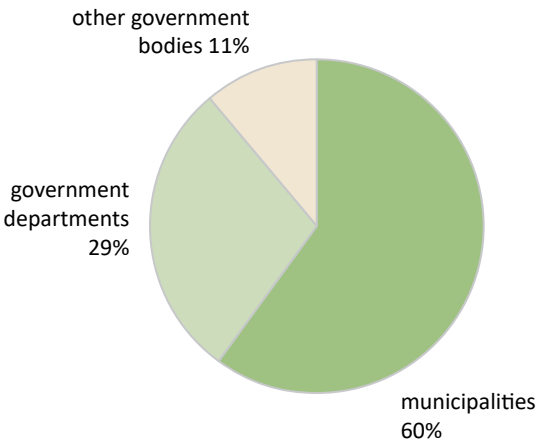
Our office also monitors and reports on the status of inquest recommendations made by provincial court judges under the Fatality Inquiries Act.

2018 Ombudsman Division Overview

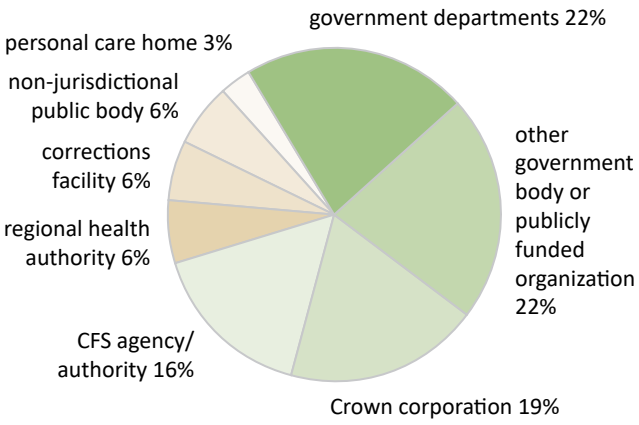
In 2018, the Ombudsman Act investigative team, PIDA investigative team and the divisional intake services team collaborated closely on common tasks. Additionally, an investigator position was re-classified to an intake manager position in order to provide effective operational control over the intake services team.

The priority of the Ombudsman Division was investigating and reporting on complaints received under both the Ombudsman Act and PIDA, as well as early resolution of complaints and inquiries at the intake level. A number of resource-intensive systemic investigations were also conducted throughout the year.

Distribution of Cases Opened Under the Ombudsman Act in 2018



Distribution of Cases Opened Under PIDA in 2018



Public Interest Disclosure (Whistleblower Protection) Act

In 2018 we received 32 new disclosures of wrongdoing. All disclosures go through an assessment to determine if the allegations meet the threshold of significance and seriousness to warrant opening an investigation. Often, the allegations that do not meet the threshold to be a PIDA matter will be redirected for a solution through another act, process or procedure or brought to the attention of the public body as a possible concern to be addressed.

Of the 32 new disclosures received in 2018, we initiated two PIDA investigations. In addition, two PIDA investigations were finalized and our findings were reported back to the respective public bodies.

One of our concluded investigations in 2018 resulted in findings of wrongdoing and we made three recommendations in the case. All three recommendations were accepted by the public body.

In the other investigation, we did not find wrongdoing nor reason to provide recommendations for administrative improvement.

Case Summary

We investigated a disclosure of alleged wrongdoing within a designated "government body" under PIDA. It was alleged that an executive within the government body shared a draft Request for Proposals (RFP) relating to a proposed capital project with a private company in order to give the private company an advantage in a tendering process.

Our office found that the allegation that an executive had shared the draft RFP to a private company was substantiated. The evidence did not conclusively demonstrate that the executive shared the RFP with the intention of giving the private company an advantage in the tendering process. We found, however, that the executive's actions, omissions and decisions in doing so were serious and substantial deviations from the applicable policies, procedures and agreements. We also found that the executive acted in a manner which gave rise to a reasonable apprehension of an intention to deceive the government body and its stakeholders.

As a result, we found that wrongdoing had occurred under section 3(c) of PIDA. We made the following recommendations for corrective action:

- That the government body's management provide all staff involved in the development of a capital project with mandatory education sessions on all policies and procedures applicable to the project (including policies on industry relationships and conflict of interest).
- That any individual or company providing advice or guidance to the government body on a capital project be identified as a potential consultant and retained pursuant to the applicable consultant selection and industry relationships policies.
- That confidentiality agreements be reviewed and signed by all individuals involved in the development of future capital projects, with relevant consequences for breaches clearly articulated in the agreement.

It was also alleged that a supervising executive was aware that the RFP had been shared by the other executive and did nothing to address the matter. Our office did not find that the evidence supported this allegation. As a result, no wrongdoing was found and no areas for recommendation were identified.

Legislative Amendments

After many years, a number of recommendations intended to strengthen PIDA were implemented and the changes took effect on December 1, 2018.

Reprisal investigations

One of the most notable amendments is our enhanced power to receive and investigate employee or former employee complaints of reprisal. Reprisal means any measure taken against an employee such as a disciplinary measure, a demotion, termination, or any measure to adversely affect employment or working conditions, including making such threats to do so. Under PIDA, employees are protected from reprisal for seeking advice, making a disclosure or cooperating in an investigation into alleged wrongdoing(s).

Until December 1, 2018, complaints of reprisal were filed with the Manitoba Labour Board. After this date, complaints of reprisal will be managed and investigated by our office using the same procedures established for disclosures of wrongdoing. In cases where we determine to investigate a reprisal complaint, a report containing the findings and any recommendations will be prepared upon completion of the investigation. The new process allows for greater protection of the whistleblower's identity, as well as a less adversarial and more investigative approach. If the complainant is not satisfied with the outcome of our process, a new complaint may then be filed with the labour board.

Other key changes

- Municipalities may now request to be designated as public bodies by regulation under the act. Both the City of Winnipeg and the City of Brandon submitted their requests for inclusion and the Public Interest Disclosure (Whistleblower Protection) Regulation was amended to include both municipalities. This voluntary opting-in shows the desire to increase transparency and accountability within their organizations and to support a culture where management and employees are encouraged to identify and remedy wrongdoing to protect the public interest as well as afford protections to those who make disclosures. The opportunity remains for other municipalities to request inclusion.
- School divisions and school districts are now included in the definition of "government body." Disclosures of wrongdoing occurring within school divisions and districts can now be reported and employees are afforded protection from reprisal for seeking advice, making a disclosure or participating in a PIDA investigation.
- The roles of Manitoba Ombudsman and the designated officer of a public body have been clarified and includes strengthening investigatory powers of designated officers. This enhances the ability for public bodies to receive complaints and conduct investigations internally in order to identify and address potential occurrence of wrongdoing within their organization.
- Our office has the added authority to request a copy of PIDA procedures (whistleblower policies) from public bodies and provide recommendations to improve procedures so that they comply with PIDA. Established procedures must facilitate awareness of roles and responsibilities regarding receiving and investigating disclosures within the organization. With clear and appropriate procedures in place, disclosures received by Manitoba Ombudsman may now be referred to the designated officer for investigation in appropriate circumstances.
- The chief executive of each public body must now communicate information about PIDA and the procedures annually to their employees. Awareness and understanding of PIDA will facilitate disclosures, investigations and corrective action of significant and serious matters that could be dangerous to the public interest. Routine and consistent conversations about the act and about internal PIDA procedures will foster healthy communication within public bodies.
- The protection of a whistleblower's identity is strengthened by prohibiting the disclosure of information in a civil court proceeding or a proceeding of an administrative tribunal that could reveal the person's identity (aside from further reprisal complaints adjudicated by the Manitoba Labour Board).
- The act is required to be reviewed every five years. Regular review provides the opportunity to monitor the amendments and ensure the act remains aligned with its founding principles of facilitating and promoting good faith disclosures of wrongdoing in the public service, and protecting whistleblowers who make those disclosures.

PIDA Inquiries and Investigations

	Case Numbers			Case Status							Recommendations	
	Assistance provided	PIDA case files carried over into 2018	New PIDA case files opened in 2018	Total PIDA case files pending at 12/31/2018	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	7	1	5	1	-	-	-	1	-	1
Health-care facility		1	-	-	-	-	-	-	1	-	3	3
Personal care home		-	1	-	1	-	-	-	-	-	-	-
Regional health authority		-	2	1	1	-	-	-	-	-	-	-
Child and Family Services agency/authority		3	5	-	7	-	-	1	-	-	-	-
Corrections facility		1	2	-	1	-	-	2	-	-	-	-
University/college		2	-	-	2	-	-	-	-	-	-	-
Crown corporation		-	6	2	4	-	-	-	-	-	-	-
Other government body or publicly funded organization		2	7	2	7	-	-	-	-	-	-	-
Non-jurisdictional public body		-	2	-	2	-	-	-	-	-	-	-
TOTAL	**17**	**10**	**32***	**6***	**30**	**1**	**-**	**3**	**1**	**1**	**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 2018: Case files that were pending resolution at the beginning of 2018. Case files can contain more than one disclosure.

New PIDA case files opened in 2018: 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, 2018: PIDA case files pending resolution as of January 1, 2019. 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 under PIDA. The matter may be investigated by Manitoba Ombudsman under another act .

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.

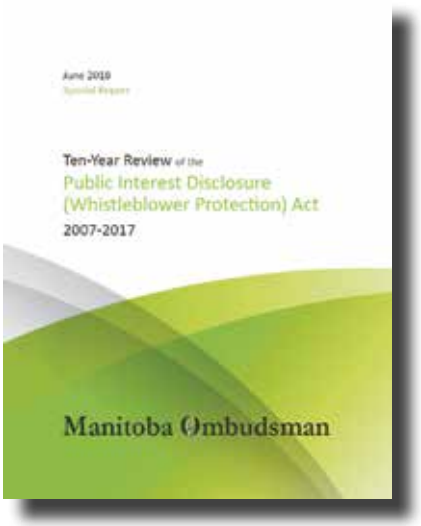
Recommendations made: As a result of an investigation, recommendations were made to one or more public bodies, whether wrongdoing was found or not.

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.

* Includes one new complaint of reprisal since December 1, 2018, when ombudsman powers were enhanced to receive and investigate such complaints.

Ten-Year Review of PIDA

Our office released a 10-year review of PIDA that highlights themes and trends that we observed between 2007 and 2017. The report provides information about PIDA, the ombudsman's responsibilities under the act and statistics from the 10-year period, including the number of disclosures made to the ombudsman, the number of recommendations made to public bodies after the ombudsman's investigations and the general nature of those recommendations. Recent amendments to the act are also highlighted. The report is available at: www.ombudsman.mb.ca/uploads/document/files/pida-ten-year-review-en.pdf



Inquest Reporting

Under the Fatality Inquiries Act, the chief medical examiner (CME) 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.

In 2018, we changed our approach to reporting in order to decrease the time to report to the chief judge on the outcome of recommendations. Our reports are sent to the chief judge and copied to the CME and any public bodies that provided a final response to a recommendation in the course of our review. The office of the chief judge makes the reports available to the provincial court so that judges who may preside over future inquests similar in nature are aware of the responses.

Some inquests do not result in recommendations being made, while in others, recommendations may pertain to organizations outside of provincial jurisdiction such as the Royal Canadian Mounted Police or federal institutions. In such cases, there is no follow up required by our office and we do not issue a final report to the chief judge.

In 2018, we closed 13 files relating to 11 inquests and we opened eight files relating to seven inquests. Since 2008, we have publicly reported on the status of recommendations made in 57 inquests.

The status of the reviews and responses to the recommendations by the public bodies are available on our website at www.ombudsman.mb.ca/documents_and_files/inquest-reports.html

Ombudsman Act

Intake Services

All inquiries and complaints received under the Ombudsman Act are initially reviewed by Intake Services in the Ombudsman Division.

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.

The following cases reflect the diversity of issues handled by Intake Services:

Case 1: A hotel staff member contacted our office wanting clarification about what act/guidelines a hotel should follow when evicting someone. We contacted the Residential Tenancies Board (RTB) and discovered that a number of factors need to be considered, for example, the length of stay at the hotel and the services provided by the hotel. Depending on the circumstances, the Hotel Keepers Act, Residential Tenancies Act, Public Health Act and other acts and by-laws might apply. When there is a dispute about whether someone is a tenant or a temporary occupant, the RTB will schedule a determination hearing at no cost to the parties to determine whether a residential tenancy agreement exists under the Residential Tenancies Act. When a residential tenancy agreement exists, the rights and obligations of the landlord and tenant are set out in the act.

Case 2: A resident called with a complaint about receiving a large water bill based on an estimate. Our office contacted the City of Winnipeg Water and Waste Department. Their office booked an appointment to read the water meter, which confirmed that the estimate was higher than the usage. As a result, the Water and Waste department reduced the bill to reflect the actual usage.

Case 3: An inmate submitted a complaint stating that his cell phone, wallet and other personal belongings went missing when he transferred between correctional facilities. The inmate notified his case worker, who notified the sheriff's office and the correctional centre, but there was no resolution. We contacted the RCMP and sheriff's office to determine who would be the ones to deliver his belongings. The sheriff's office was in charge of the items; however, could not determine the whereabouts. Ultimately, the sheriff's office issued a payment to the inmate to cover the value of lost items.

Case 4: An individual called about issues with Manitoba Public Insurance, stating that they did not respond in a timely manner and he did not agree with their decision. According to the individual, MPI unfairly decided that he was 100 per cent at fault in an accident, wrote off his vehicle and provided him with a low appraisal value. He was displeased that the only options at that point were to appeal the decision, which included a $50 application fee, or take the issue to court. We explained that as an office of last resort, we could not overturn the actual decision made by MPI but could review any administrative concerns he had. Our office referred him to the MPI Fair Practices Office to weigh his options and request a review of his concerns.

Case 5: An individual called to ask whether our office could assist with removing his mother from being under the care of the Public Guardian and Trustee of Manitoba (PGT). We advised him that our office does not have jurisdiction to contest an Order of Committeeship and if he wanted to pursue the matter, his mother would need to be re-assessed by a psychiatrist. Under the Mental Health Act, the PGT can be appointed as Committee for a person who has been found incapable of managing his or her property and personal care. As this order was in line with their policy, we referred the complainant to speak with the PGT or pursue re-assessment.

Investigations

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.

During 2018 we investigated provincial and municipal public bodies involving a wide range of issues, such as youth corrections, by-law enforcement, and procurement and tendering practices. Below and on the following pages are highlights of some of the investigations we completed in 2018.

A Clean Resolution

We received a complaint from a female resident at the Manitoba Youth Centre (MYC) who raised health and hygiene concerns due to a change in policy restricting residents from having or wearing their own underwear.

Under this policy, MYC residents were issued institutional underwear, which was randomly distributed to them after laundering. Residents also expressed concern about the lack of notice of the policy change and no opportunity for consultation and consideration of resident concerns.

In response to the concerns and our inquiries, MYC changed this policy and now provides female residents with three pairs of institutional underwear, which are labelled for female residents' exclusive use during their stay at MYC, and which are returned to the resident after laundering.

We made two additional suggestions:

- That MYC reconsider using mesh laundry bags in the facility so that all residents' personal clothing could be kept together and separate from others.
- That MYC consider establishing procedures in its standing orders to assist with information sharing, and to encourage a consultative approach whenever appropriate on process and policy changes (such as clothing restrictions directly affecting residents) with input from residents and their guardians.

MYC agreed to adopt our suggestions.

Explain Yourself

An individual complained about the independence of an investigation and decision of the Fair Practices Advocate (FPA) at the Workers Compensation Board (WCB). The FPA acts as an ombudsman for injured workers, their dependents and employers, to resolve issues they may have with the WCB, while also helping the WCB improve its quality of service.

The FPA advised our office that while it does not have a formal policy about conducting investigations, there are general practices it follows when complaints are received, whereby it can review a file and speak to involved parties, such as WCB claims staff.

We concluded that the FPA did take reasonable steps to review the issues raised. However, these actions were not communicated in the letter the complainant was sent by the FPA upon completion of its review. The FPA did not, in our view, provide sufficient reasons or fully explain how it arrived at its findings. Providing details about the basis for a decision is important, as the absence of clear and meaningful reasons for decisions can result in individuals forming the belief that the decision maker was biased and/or the decision itself was unfair.

It is our position that the best way for decision makers to demonstrate that they have considered the evidence and arrived at a decision based on relevant considerations is to issue clear reasons for decisions. As such, we suggested the FPA provide detailed reasons explaining the reasons for its decisions and how those decisions were arrived at. The FPA agreed to consider ways to enhance its communication practices in these types of situations.

Clean Relations

A tenant complained to our office that the Residential Tenancies Branch (RTB) failed to take action when he complained about laundry rates in his building. The RTB indicated it did not have jurisdiction because the washing and drying machines were owned by a third party, which operated at arm's length from the landlord (the building owner).

The tenant maintained the landlord was involved in setting laundry rates and determining the refund policy for payments on faulty machines. The tenant believed that the third party was also sharing laundry revenue with the landlord. Given all this, the tenant believed the two were operating as partners.

The RTB advised our office that it uses the same definition of arm's length relationship that is used in the Income Tax Act. Section 251 of the Income Tax Act sets out how arm's length relationships are determined under the act; that if the two parties are related, they are deemed not to deal with each other at arm's length.

The RTB further explained that revenue sharing and refund policies are aspects of the business relationship agreed upon by the two companies, but they are not in themselves conclusive evidence that the companies are not acting in their own self interest. The RTB stated that as a for-profit private enterprise, the external laundry service provider would not be expected to stay in business with the landlord if the elements of the business arrangement were not in the independent self-interest of the provider.

It is up to the RTB to set policy and determine how to categorize or define arms' length relationships. However, we did note that the process for doing so is not entirely clear. The RTB has committed to clarifying the definition of "arm's length" in its policy guidebook and more clearly explain the factors and evidence that the RTB may require in order to make a determination on the issue.

Incorrect Assumptions

A complainant alleged the Municipality of Swan Valley West did not provide any notification that she would not be reappointed to the municipality's library board prior to the decision being made. She also believed the decision was unfair, given that she was interested in continuing to serve on the board.

Municipal staff made the assumption that due to certain circumstances, the complainant would not be interested in continuing to serve on the board.

Our office found that the municipality had no policy or established process with regard to the recruitment and appointment of citizens to serve on various boards and committees. Instead the municipality uses an informal process, where interested persons express their wish to the administration or council members to serve on a board or committee. A list is assembled and presented to council for ratification. There are no term limits for appointments and typically the practice is to let individuals serve for as long as they are interested.

While there is no legal requirement for the municipality to provide notice to board members that their term of service is coming to an end and to inquire about whether they are interested in continuing in the position; it is good administrative practice to do so. By giving notification, the municipality would also have an opportunity to identify those positions where people want to continue to serve and those positions that would become vacant.

Without an established process to solicit interest in the available positions, the selection of citizen members for these volunteer positions can appear arbitrary. We recommended that municipality develop and implement a policy for the recruitment and appointment of citizens to boards and committees. In addition to setting out the process of solicitation and reappointments to these positions, a notification process should be included as part of the overall policy. The municipality accepted our recommendation.

A Road More Travelled

A resident complained about a spring road restriction (SRR) exemption in the Rural Municipality of West St. Paul. Road restrictions help protect surfaced pavement roads from damage by reducing allowable axle weights during the spring thaw season.

The resident was concerned about the RM's decision-making process for such exemptions, whether council authorized the exemption process, what criteria are considered when such exemptions are granted, and how details of these decisions are communicated to the public. In addition, he was of the view that individuals and companies granted exemptions were not being held financially liable for damages to roads.

The RM stated the chief administrative officer allowed the exemption to the developer based on a recommendation from public works staff. Staff felt it was reasonable to allow the exemption because the province also allowed for an exemption on a nearby road.

The RM also had a written agreement with the developer that any damage in relation to the use of the road during the SRR period would be the responsibility of the developer. The developer provided liability insurance and a line of credit as a guarantee. The RM advised that it took photos of the road before and after the developer used it during the SRR period and found that no damage had occurred.

This is a case in which the decision by the RM to allow the exemption was reasonable as well as the steps taken to ensure the developer would be responsible for any potential damage. However, we did note that the RM did not have a policy that sets out the SRR exemption decision-making process and the relevant criteria for allowing exemptions. A policy that explains the relevant considerations for allowing exemptions would help ensure a consistent and transparent decision-making process. Potential applicants for exemptions and the general public would both benefit from such information.

As a result, we recommended that the RM formalize its SRR exemption decision-making process by putting it in writing. The following information should be included:

- who is the decision maker on SRR exemptions
- what are the criteria for allowing exemptions
- how the RM communicates exemptions to the public
- the criteria for requiring exemption applicants to cover the cost of any damage caused to the municipal road affected by the exemption, what documentation is required for this arrangement, and when and how damage is assessed

Our recommendation was accepted by the RM.

Pay Up

A property owner in the Rural Municipality of Alexander filed a complaint with our office after he was told his carport was unsafe and unsightly. The complainant believed the RM's issuance of a municipal order regarding his carport did not meet applicable legislative and procedural requirements. The property owner further disputed being charged for the RM's legal costs related to this matter. These legal fees exceeded $9,400, of which approximately $8,650 were added to the complainant's property tax bill.

Based on our investigation, the RM met the legislative and by-law requirements to issue a municipal order but did not provide the complainant with written reasons that clearly explained why the by-law was being enforced. The RM also failed to notify the complainant of the appeal date as required in the RM's by-law.

We agreed that the RM has some discretion with respect to the costs it may charge an individual, which in some instances may include legal fees. However, when taking into account the principles of fairness in this case, we were of the view that legal counsel consultation costs should not be included. We recommended the RM reverse the charges for legal fees. In this case, the RM chose not to accept our recommendation. It maintained that it had the authority to charge legal fees and that is was appropriate and fair to do so given the circumstances of this case.

Our office will be consulting with Manitoba Municipal Relations with regard to the scope of bylaw enforcement costs that may be passed on to individuals by municipal governments.

Pilfered Plates

A Winnipeg citizen whose licence plates were stolen complained to our office after receiving a parking ticket issued to another vehicle bearing the stolen plates. The citizen tried to appeal the ticket but missed the deadline for doing so even though she followed instructions provided to her by the City of Winnipeg's 311 service. She was subsequently advised by the Winnipeg Parking Authority (WPA) that it could not reconsider the parking violation and that the $100 fine must be paid.

Our office found that the WPA followed the relevant legislation with respect to issuing the parking ticket and the associated time limitations for appeal. However, we were of the opinion that because the 311 service did not provide complete information on how to address the parking violation, there was an issue of administrative fairness to be considered. As a result, our office made the following recommendations:

- That the WPA take steps to clearly communicate the requirement to request a review within the 30 day time limit, especially when there are unusual circumstances, as in the case of a reported theft of licence plates or a vehicle.
- That if the WPA continue to use the City of Winnipeg's 311 service to provide information about its review process, it takes steps to ensure operators provide the complete information to citizens.
- That, in order to protect the privacy of citizens, the WPA and the Winnipeg Police Service formalize an agreement to exchange information related to police reports when citizens are contesting a parking ticket as a result of stolen license plates or a stolen vehicle.
- That collection action taken against the complainant be withdrawn and the payment of the ticket not be pursued.

The WPA advised our office that it accepted the recommendations, including not enforcing the $100 fine.

A Fair Ride

Our office completed a sweeping review of the City of Winnipeg's Handi-Transit Service, issuing a 152-page report that included 19 recommendations. The investigation was in response to a complaint from the Independent Living Resource Centre (ILRC), an organization that supports people with disabilities, many of whom use the city's Handi-Transit service (now called Transit Plus).

Handi-Transit provides transportation for approximately 7,500 clients who are unable to use the fixed-route transit system because they are legally blind or have a physical disability that significantly impairs their mobility.

Our investigation looked at three main areas of operations:

- Eligibility and appeals
- Customer service and quality assurance
- Transparency and communication

Overall, our office determined that in many instances, Handi-Transit provided a reasonably equivalent service to fixed-route transit, but in certain areas fell short. We believed that many of the shortcomings could be addressed through consideration of the recommendations and suggestions we made as a result of our investigation.

Some of our recommendations included that the city:

- broaden its Handi-Transit eligibility criteria
- change the membership of the appeal hearing body (the panel that hears appeals from applicants determined to be ineligible for Handi-Transit service)
- better communicate about its complaint process and about the outcome of complaint investigations
- revisit its approach to "no show" charges (penalties applied in order to discourage registrants from booking trips but not taking them)
- produce a comprehensive user guide

The city accepted all 19 recommendations, and has taken steps to implement some of them, while other recommendations will be further studied and would ultimately require funding and council approval.

Ombudsman Act Investigations

	Case Numbers			Case Dispositions									
	Carried over into 2018	New cases in 2018	Total cases in 2018	Pending at 12/31/2018	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	-	1	1	1	-	-	-	-	-	-	-	-	-
Crown Services	1	-	1	1	-	-	-	-	-	-	-	-	-
Families	2	1	3	1	1	-	-	-	1	-	-	1	-
Growth, Enterprise & Trade	-	1	1	-	-	1	-	-	-	-	-	-	-
Health, Seniors & Active Living	1	2	3	1	-	1	-	-	1	-	-	1	-
Infrastructure	1	3	4	1	1	1	1	-	-	-	-	-	-
Justice & Attorney General	5	14	19	12	-	1	-	3	3	-	1	-	-
Municipal Relations	1	1	2	-	-	1	-	-	1	-	-	-	-
Sustainable Development	1	7	8	7	-	1	-	-	-	-	-	-	-
Other Manitoba government bodies													
Addictions Foundation of MB	-	1	1	-	-	1	-	-	-	-	-	-	-
Assiniboine Community College	1	-	1	-	-	-	-	-	1	-	-	-	-
CFS Agency/Authority	-	2	2	-	2	-	-	-	-	-	-	-	-
Interlake-Eastern Regional Health Authority	-	1	1	-	-	-	-	-	1	-	1	-	-
Liquor, Gaming & Cannabis Authority of Manitoba	-	1	1	1	-	-	-	-	-	-	-	-	-
Manitoba Hydro	1	-	1	1	-	-	-	-	-	-	-	-	-
Manitoba Public Insurance	2	3	5	3	-	1	-	1	-	-	-	-	-
Workers Compensation Board	1	3	4	1	-	2	-	-	1	-	-	-	-
Municipalities													
City of Winnipeg	6	7	13	10	-	1	-	1	1	-	-	1	-
Other cities, RMs, towns, villages	12	54	66	46	1	4	4	3	8	-	1	3	1
Planning districts	2	1	3	2	-	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative (OOI) -- municipal (general)	1	-	1	1	-	-	-	-	-	-	-	-	-
TOTAL													
	38	**103**	**141**	**89**	**5**	**15**	**5**	**8**	**19**	**-**	**3**	**6**	**1**

Pending: Complaint still under investigation as of December 31, 2018.

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.