

# Manitoba Ombudsman

## 2013 Annual Report under The Ombudsman Act and The Public Interest Disclosure (Whistleblower Protection) Act

Independent, Impartial, Fair

### Message from the Ombudsman



Last year I reported on a number of initiatives undertaken to enhance our investigative procedures and improve our public communication. I am pleased to report that two of our communications initiatives,

our new website and our Facebook page, were launched in March of 2013. We have also created a YouTube channel, allowing us to provide more information about Manitoba Ombudsman and also about specific events and topics of interest.

Our new website is easier to navigate and provides more information about our core function -- investigating and reporting on administrative complaints from the public. It also includes online complaint and disclosure forms. In 2013 we began posting selected investigation reports on our website, with the goal of building a body of knowledge about best practices intended to help municipal and provincial governments improve administration. Posting investigative reports also enhances our own transparency, helping to explain our investigative process and the basis on which we make findings and issue recommendations.

A revised edition of *Understanding Fairness*, our guide for municipal decision makers, was published in 2013. This guide continues to be in demand by municipalities and the public, and provides a framework for fair decision making and practical tips for municipal leaders. The impetus for a revision and fourth printing of *Understanding Fairness* was the ongoing high volume of requests we receive for this publication. Complaints about municipalities continue to be a significant part of our operations. Many of these complaints go beyond matters of individual dispute, and raise concerns about the fairness and transparency of municipal procedures. An analysis of the types of complaints we receive suggests a greater interest in accountability at the local government level.

Following up on a 2012 review of our intake process, we designed and developed a new customized intake computer program. As the access point for service relating to every

aspect of our statutory mandate, intake is a critical function. Implementing the new program will be the most significant overhaul of our intake process in our 40-year history. The new program serves a dual purpose, facilitating easier access to information for improved response to the public as well as data tracking for management purposes such as quality control and trends analysis. Training and testing will occur in early 2014, followed by full implementation by mid-year.

Last year I reported on the development of office standards to assess the overall performance and accountability of our office. In 2013, after a full year of experience, I asked both divisions, Ombudsman and Access and Privacy, to review their divisional standards and recommend any necessary changes. I am pleased to report that this was a successful collaborative process between management and investigators, indicative of an office-wide commitment to continuous evaluation and improvement.

The entire office also participated in the development of Manitoba Ombudsman's mission, vision and values statements, which were added to our website in December 2013, and proudly presented in this report.

A significant part of this annual report deals with our activities under *The Public Interest Disclosure (Whistleblower Protection) Act*. We saw a tremendous increase in disclosures of alleged wrongdoing in 2013, and an increase in files opened for investigation. Although such dramatic increases tax our investigative resources, we view the increase as a positive sign that the legislation is working as it was intended to facilitate disclosures. While we do not publish whistleblower investigation reports, we have for the first time included in this annual report a general description of the disclosures received in the last year, as well as information about our disclosure assessment and investigative processes.

This is the second year in which we include a report under section 16.1 of *The Ombudsman Act* on the implementation of recommendations made by the children's advocate in reports of the deaths of children involved with the child welfare

system. This report is largely statistical, but provides an indication of how the system is responding to recommendations designed to prevent the deaths of children in the future. We are pleased to report that in 2013 there was a system-wide improvement in the implementation of these important recommendations.

Monitoring the implementation of these recommendations can also serve to measure the ability of the child welfare system, and our ability as a society, to address the larger underlying issues, such as poverty and geographical disparity, that bring families into contact with the child welfare system.

Manitoba Ombudsman has the broadest jurisdiction of any ombudsman office in Canada. The responsibilities and authority of the ombudsman are set out in *The Ombudsman Act*, *The Freedom of Information and Protection of Privacy Act*, *The Personal Health Information Act*, and *The Public Interest Disclosure (Whistleblower Protection) Act*. There are benefits to bringing the ombudsman model to the oversight role we play in access and privacy and whistleblower legislation, primarily the collaborative approach wherever possible and our focus on administrative improvement rather than on finding fault. There are challenges as well, primarily relating to resources and the changing demands and expectations on the office.

Manitoba Ombudsman continues to refine work processes to provide quality service in the face of increasing expectations in a time of general fiscal restraint. While complaint numbers are relatively consistent, complainant expectations have increased along with the complexity of issues raised by complaints. Our revised intake system is an example of an initiative that allows us to devote more time to investigations without reducing the quality of service to those whose concerns can be addressed by providing information or making an appropriate referral.

Another example is the work we have done to reduce the number of routine complaints from provincial inmates. Inmate complaints

The Honourable Daryl Reid  
Speaker of the Legislative Assembly  
Province of Manitoba  
Room 244 Legislative Building  
Winnipeg, MB R3C 0V8

Dear Mr. Speaker:

In accordance with section 42 of *The Ombudsman Act* and subsection 26(1) of *The Public Interest Disclosure (Whistleblower Protection) Act*, I am pleased to submit the annual report of the ombudsman for the calendar year January 1, 2013 to December 31, 2013.

Yours truly,

Mel Holley  
Acting Manitoba Ombudsman

are important because administrative decisions affecting the conditions of confinement can have a significant impact on an inmate's daily life, and their options for redress are limited by their incarceration. Over the past few years we have worked diligently to provide fairness training for new correctional officers and to provide inmates with assessment and self-help tools to facilitate complaints resolution within facilities. All of our initiatives have been undertaken with the full support of Manitoba Corrections. While we still receive complaints from inmates, and each is addressed on its individual merit, we are confident that our efforts in prevention and self help have succeeded, to the benefit of both inmates and the correctional system.

We continue to be open to initiatives that will enhance our work and help us meet the obligations of our broad statutory mandate. Management and staff work collectively on such initiatives, increasing the likelihood of success and positioning our office to accept inevitable changes and meet new challenges as they arise.



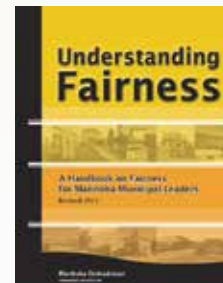
In March 2013 we launched a new website with online complaint forms. Between March and the end of the year, the site had almost **20,000** visitors. In that same period, **74** complaints under *The Ombudsman Act* and **11** disclosures under *The Public Interest Disclosure (Whistleblower Protection) Act* were submitted online.



Also in March 2013 we ventured into the world of social media with the launch of our Facebook page, followed by the launch of our YouTube channel. Manitoba Ombudsman's social media policy is available on our website.



Acting Ombudsman Mel Holley and ombudsman staff gave over 20 presentations to a variety of audiences, including a session on whistleblower legislation at the Manitoba labour conference (top left - Mel with co-presenter Susan Dawes), a whistleblower session in Regina (top right - Mel with former Saskatchewan Ombudsman and Public Interest Disclosure Commissioner Kevin Fenwick), and 10 sessions as part of Manitoba Justice's correctional officer training program. Staff also attended various events to distribute information, including Law Day in Winnipeg and Brandon (bottom left and centre) and the Manitoba Social Sciences Teachers Association Conference (bottom right).



In November 2013 we released an updated version of our indispensable guide *Understanding Fairness: A Handbook on Fairness for Manitoba Municipal Leaders*.



In December 2013 we began posting selected investigation reports under *The Ombudsman Act* in the Ombudsman Division part of our website. By posting these Ombudsman Act web reports we will start to build a body of knowledge about best practices in government administration.

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Winnipeg, MB R3C 3X1  
204-982-9130  
1-800-665-0531 (toll free in Manitoba)  
Fax: 204-942-7803

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202 - 1011 Rosser Avenue  
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On the web:  
[www.ombudsman.mb.ca](http://www.ombudsman.mb.ca)  
[www.facebook.com/manitobaombudsman](http://www.facebook.com/manitobaombudsman)



# The Ombudsman Act

## Complaints about municipalities

In 2013, Manitobans raised a number of concerns about municipal government with our office, sometimes about decisions affecting an individual, and in other cases about procedural concerns that could have broader impact. The complaints below reflect the variety of issues raised with the ombudsman about municipal administration.

### By-law enforcement failure

A resident of the RM of Alexander complained after he was required by the RM to obtain a survey certificate at his own expense to prove that his neighbour’s portable car tent and trellis/fence structures were not in compliance with the RM’s zoning by-law. A by-law enforcement officer had inspected the neighbour’s property but was unable to determine if the structures met the required setback distances. In the RM’s view, the structures “appeared to conform.” During this process the RM learned that the neighbour did not have a permit for the portable car tent structure, and asked that he apply for one. The RM, however, did not ask the neighbour to prove he was in compliance with local by-laws as part of the permitting process. Instead, the RM asked our complainant to bear the cost of obtaining a survey. The survey obtained by our complainant indicated that his neighbour’s structures were closer to the shared property line than allowed under the by-law.

The ombudsman found that the complainant in this case had been treated unreasonably by the RM. After an unsuccessful attempt to resolve this matter informally, the ombudsman made three recommendations to the municipality, including a recommendation that the RM reimburse our complainant for the expense of the survey certificate. The RM did not accept this recommendation.

Residents have a legitimate expectation that municipal government will enforce its own by-laws. They should not be required to incur additional costs to have government do its job. The failure to determine whether there was compliance, or the failure to require the owner of the structures to demonstrate compliance as part of a required permit process, was an abdication of responsibility by this municipal government.

### Building permits issued in error - a costly mistake

Property owners in the RM of St. Clements complained to Manitoba Ombudsman that the Selkirk and District Planning Area Board had unfairly revoked the building permits that allowed them to build a single family home on their property.

After construction began, and more than a year after the permits were issued, the owners were instructed by the board to remove the building foundation and return the property to its pre-construction state. The owners, who were obviously upset, were unable to receive a timely and straightforward answer from the board to clarify why the permits had been revoked and construction halted.

In this case the building permits were issued in error in 2011. Under a 2002 zoning by-law, a single family dwelling was listed as a permitted use within a general industrial designation. An amendment to the by-law, passed in 2006, resulted in changes whereby a single family dwelling was only permitted as an accessory to the primary use of the land (an industrial purpose). Pursuant to the provisions of the amended by-law, the owners’ application to construct their retirement home on the property should not have been approved because it was not related to an industrial purpose.

The board became aware of the error when the owners requested a one-year extension of the building permits during the summer of 2012, but did not disclose this error to the owners, opting rather to inform them that an extension would not be granted.

Unaware that the permits were issued in error, and unable to obtain an extension, the owners began construction of the building foundation before the end of August 2012 when the permits would expire. It was not until early 2013, approximately six months after the board discovered their error, that they informed the property owners about the mistake and ordered them to halt construction and remove the building foundation.

The board suggested to us that the owners should have known that a single family dwelling was not a permitted use on their property which is zoned “general industrial”. Our investigation disclosed no basis of support for this position. It is the role of the planning board to ensure planning by-laws are applied correctly and that any permits and other approvals are in compliance with existing laws. Citizens have a legitimate expectation that municipal officials and representatives will be knowledgeable about the by-laws, rules, regulations and policies they are responsible for implementing and enforcing.

The appropriate course of action for the board would have been to immediately notify the property owners that the permits were issued in error and to revoke them. Unfortunately, due to the board’s failure to alert the property owners about the error in a timely manner, the owners incurred construction costs for a home that cannot be completed. While the owners have been reimbursed for the permit fees, the issue of further compensation remains outstanding.

The planning board acknowledged that a regrettable error occurred and has taken administrative steps to ensure this type of mistake does not recur in the future.

Accountability and transparency are the hallmarks of good government. In this instance the planning board failed to meet those principles by choosing not to immediately disclose its error to the complainants.

### Building permit placed on hold – finding a solution

An individual purchased property in a cottage development from the RM of Grahamdale. The property owner approached the RM for assistance in locating survey stakes that marked the lot’s boundaries. In response, the RM provided a map and the property owner located two stakes that appeared to correspond with the map provided. Although the owner could have obtained a survey certificate, she did not, relying instead on the map provided by the RM.

In early 2012, the property owner proceeded through the permit application process, received approval, and began construction of a cottage.

In July 2012, the owner was notified by the RM that her building permit had been placed on hold. A surveyor’s report showed that the cottage encroached on adjacent land owned by the RM.

The RM asked the property owner for proposals to resolve the encroachment issue. The owner suggested options, none of which were initially accepted by the RM. Moreover, the RM took the position that the owner’s decision to build on vacant land without the benefit of a surveyor’s certificate was at her own risk. The RM requested the owner to move the cottage within the lot’s boundaries by the end of August 2013, and later extended that deadline to the end of October. Feeling that she had been treated unfairly, the property owner complained to the ombudsman.

During the course of our investigation, the RM accepted the property owner’s offer to purchase the adjacent lot, allowing the existing cottage to remain in place. In return, the property owner agreed to construct an additional building on the adjacent lot within three years.

We were pleased that a resolution satisfactory to both parties was achieved. This case highlights the benefits of seeking a reasonable solution as an alternative to a protracted conflict.

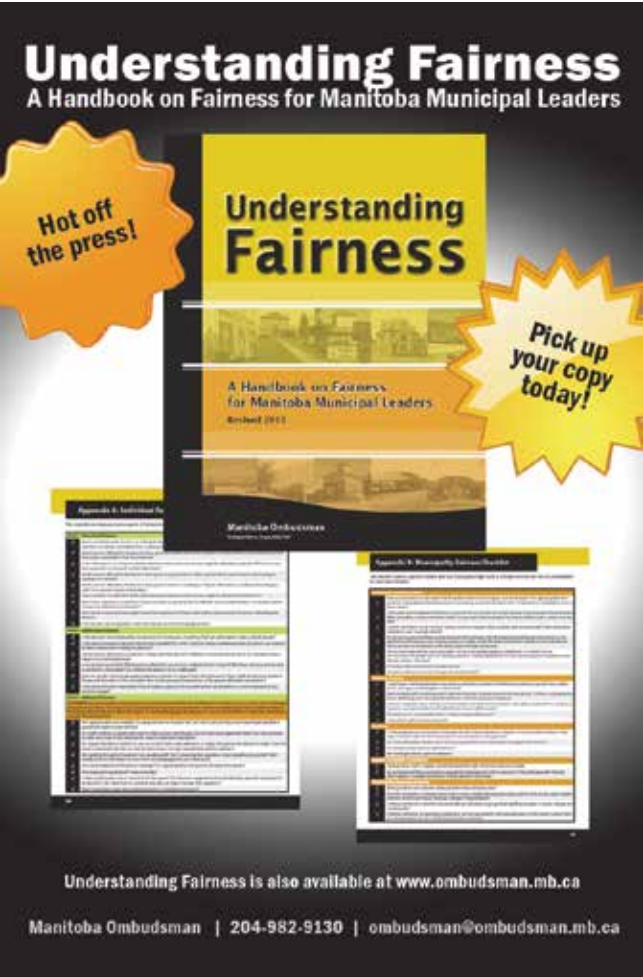
### Reasons for decisions

Two cases in 2013 reinforced the need for decision makers to communicate reasons for their decisions. In the first case, a landowner complained about the RM of Saskatchewan’s decision to deny a conditional use request for the construction of a residence on agricultural land in the municipality. Although the ombudsman did not find that the conditional use was denied unfairly, it became apparent in the course of the investigation that the landowner felt he was treated unfairly by the RM because no reasons were provided when denying the request. In the absence of reasons, people are free to speculate, and often assume the worst. This kind of situation is frequently at the heart of complaints to the ombudsman. While no recommendations were made in this case, the ombudsman suggested that the municipality (and all municipalities) issue reasons for their decisions.

In another case, a landowner in the RM of Macdonald believed that the RM unfairly denied two variance applications for subdivision of his land, and that the public hearing held to consider the applications was procedurally unfair. Similar to the RM of Saskatchewan case, the ombudsman did not make recommendations, but identified that the absence of reasons for the RM’s decisions contributed significantly to the complainant’s perception that he was treated unfairly.

### Conflict of interest

Conflict of interest occurs when someone’s personal interest conflicts with the public interest, or with his or her duty as a public official. Allegations of conflict of interest are sometimes made to the ombudsman. In one such case, a complainant alleged that a Neepawa councillor placed himself in a conflict of interest position by being present at two meetings of council that included discussions of an item in which the councillor had a personal interest. In this case, the councillor was interested in subdividing his own property. After a review of the facts, the ombudsman concluded that there was no evidence to support a conflict of interest, but that there was clearly the perception of a conflict of interest. Often the perception of a conflict of interest can be as damaging as the real thing. The ombudsman suggested procedural administrative improvements to help avoid these situations and to ensure that appropriate procedures for declaring a conflict of interest are followed. Council agreed to implement the suggested improvements.





Out of (purple) gas

Tax-exempt marked fuel, commonly called “purple gas,” is available in Manitoba under *The Fuel Tax Act* for the operation of agricultural machinery and registered farm trucks. Because this marked fuel is available from only a limited number of suppliers, the act provides for a tax refund to purchasers if they buy unmarked fuel because marked fuel was unavailable. To receive a tax refund, the purchaser must submit an application within two years of the purchase and must include a copy of the fuel purchase invoice and evidence demonstrating the purchaser’s entitlement to the refund.

A farmer submitted an application for a tax refund on his unmarked fuel purchase to Manitoba Finance and was denied the refund. His application was submitted within the required two year period,

the fuel was used for legitimate farming purposes, and the purchaser provided the department with an affidavit from his fuel supplier indicating that when the unmarked fuel was delivered, the supplier did not have any marked fuel available. The farmer submitted his application twice for reconsideration but the department remained firm in their denial. The farmer complained to the ombudsman on the basis that his application was unfairly denied.

In the course of our investigation, the department explained that, in their view, marked fuel was not “unavailable” to the purchaser since it was available at another supplier in the community; a supplier with whom the purchaser did not have a business relationship.

This matter had become a protracted dispute and there was some merit to the position of both the complainant and the department. The ombudsman questioned whether the department’s position was consistent with the primary purpose of *The Fuel Tax Act*, namely, to exempt farmers from paying taxes on fuel used in operating agricultural machinery while carrying out agricultural work. The ombudsman also noted that “unavailable” is not defined in the act.

At our suggestion, the department reassessed the circumstances and chose to issue the purchaser a tax refund.

Damage claims

During the execution of a search warrant, Winnipeg Police Service (WPS) officers forced their way through the front door of a house, damaging the door during entry. The homeowner submitted a property damage claim, which was denied by the City of Winnipeg. There was no mechanism to appeal the decision and so the homeowner complained to the ombudsman about the claim denial and also about the lack of an appeal mechanism.

During our review, the city explained that generally compensation for property damage from the execution of a search warrant is not provided. Similarly, compensation is not available when property damage occurs during emergency service calls such as those when there is a medical emergency or suspected death, or when fire fighters break down doors in response to alarms.

Every complaint is assessed on its own merit. There was no evidence on which to conclude that the decision to deny the damage claim in this individual case was unreasonable. However, our review did disclose an absence of written policies or procedures for handling claims, and criteria on which such claims decisions would be based.

We followed up with the city regarding the absence of written policies or procedures, and the city was open to considering changes. As a result, a “claims handling protocol” was developed for the WPS and Winnipeg Fire and Paramedic Service. The protocol sets out property damage claims handling procedures as well as a two-level appeal process.

Changes to the role of pharmacy technicians

Sometimes Manitoba Ombudsman can assist people by explaining or clarifying issues of concern, without investigating allegations of maladministration. We often do this through our intake unit, explaining the law or policy authorizing a particular action or decision affecting a person. Sometimes we encounter an issue affecting a large number of people.

In 2013 we received over two dozen complaints about changes to the role of pharmacy technicians, set out in regulation under *The Pharmaceutical Act*. With the regulatory changes, the complainants’ occupational titles had been changed from “pharmacy technician” to “pharmacy assistant.” This was a legislative decision, rather than an administrative matter over which we have jurisdiction. However, we researched the matter in order to fully respond to the complainants.

The new legislation effectively creates a regulated profession called “pharmacy technician” and does so by imposing standards of practice, requirements for qualifications and ongoing assessment of practice, and registration. Legislated regulatory authority will be provided by the College of Pharmacists of Manitoba.

Previously, pharmacy technicians did not have set and specific standards and practices as aligned and implemented by both the federal and provincial pharmacy regulatory bodies. Also, the education and experience required to become a pharmacy technician was not clear, specific, or regulated. Individuals practicing the occupation of pharmacy technician had varying educational backgrounds and experience. In Manitoba, and many other provinces as well, the title of pharmacy technician is being legislated to become a restricted title, whereby a strict set of criteria and education is required to legally use the title. As the practice of pharmacy continues to evolve, so too does the role of pharmacy technicians.

With the cooperation of Manitoba Health, we were able to provide some information about the basis for the changes facing pharmacy technicians and also some further avenues for the complainants to explore with respect to educational requirements of the profession.

This is an important change for pharmacy workers, and also one of interest to the public.



Manitoba Ombudsman was established as an independent office of the Legislative Assembly of Manitoba 44 years ago. Although we know what we do and why we do it, we felt it was important to revisit what we stand for and believe in as an organization, and to articulate those beliefs and share them with others. In 2013, we took the opportunity to do just that.

We began by stating our mission and goals, and followed up by talking about our values as employees and as an organization. Everyone at Manitoba Ombudsman had input into the development of our mission, goals and values.

This work will serve as the basis for continued improvement and refinement of our service standards and investigative processes. In a sense, our mission will be our compass, helping us to navigate in the right direction and stay on course.



Your 2013 Manitoba Ombudsman team

Mission

To promote and foster openness, transparency, fairness, accountability, and respect for privacy in the design and delivery of public services.

Goals

- to provide effective, competent and efficient service
- to foster working relationships based on trust, respect and confidentiality
- to lead by example and demonstrate fairness in all that we do
- to facilitate fair treatment in public service delivery and in the development and implementation of public policy

Values

**Integrity:** Demonstrating the highest standards of professional and personal conduct and taking responsibility for our actions.

**Respect:** Treating all people with respect, dignity and courtesy, valuing diversity, fostering positive relationships, and being fair and consistent in our treatment of others.

**Independence:** Acting in the public interest in accordance with our statutory mandate and demonstrating neutrality and impartiality by ensuring that our actions are influenced by neither fear nor favour.

**Excellence:** Achieving the highest standards in the work that we do and adding value to the democratic process by facilitating interaction between the public and those who serve them.



Manitoba Ombudsman received an All Charities Campaign award for 100% staff participation in the 2013 campaign.

# The Public Interest Disclosure (Whistleblower Protection) Act

## The Year of the Whistleblower

Manitoba Ombudsman has had responsibility for receiving and investigating whistleblower disclosures since *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA) came into effect in April 2007.

In 2013, our office experienced a significant increase in the number of disclosures received and investigations undertaken. We feel that this is a positive indicator as it may demonstrate increased confidence and willingness of individuals to come forward with allegations of what they perceive as wrongdoing in the public service.

Whistleblower legislation was put in place to facilitate the disclosure of “serious and significant” matters in or relating to the public service; matters that are potentially unlawful, dangerous to the public or injurious to the public interest. It is also there to protect persons (whistleblowers) who make those disclosures.

Experience here and elsewhere tells us that disclosures of alleged wrongdoing, made in good faith, can be

difficult for loyal employees. Making a disclosure can be an act of courage and integrity, motivated by a desire to do the right thing. A finding that there has been a wrongdoing can have significant consequences for both individuals and organizations. Manitoba Ombudsman has established procedures to ensure that the confidentiality of all disclosers is protected and that everyone involved in a whistleblower investigation is treated fairly.

Manitoba Ombudsman does not publish investigation reports under PIDA or post case summaries on our website as we do with many investigations under *The Ombudsman Act*, *The Freedom of Information and Protection of Privacy Act*, or *The Personal Health Information Act*. This longstanding practice is based on concern for the confidentiality and protection of disclosers. There is also a risk that reporting allegations of wrongdoing, before those allegations have been investigated, may unfairly tarnish the reputations of individuals or organizations. These are legitimate concerns.

It has been suggested over the last couple of years that it would be in the public interest for us to provide more information about whistleblower complaints and that the public has a right to know. As well, it has been suggested that providing more information could demonstrate that the whistleblower law is effective in meeting the goal of facilitating the disclosure and investigation of significant and serious matters.

In an effort to be as transparent as possible without compromising anyone’s right to fairness or confidentiality, we have determined that it would be appropriate and in the public interest to report generally upon the types of matters disclosed to our office on an annual basis. Accordingly, we have included in this report the number of disclosures received in 2013 under each category of wrongdoing set out in the statute, and the status of the disclosure at the end of the year. We have also included information on our processes for dealing with disclosures, as well as suggestions we have made to government for improving PIDA.

### Our PIDA process

#### Preliminary analysis of disclosures

PIDA disclosures require extensive analysis to determine whether allegations meet the threshold of “wrongdoing” that would warrant investigation, or whether there should be a preliminary or final referral to another body, or an attempt at informal resolution. Accordingly, once it is determined by our intake unit that the disclosure relates to a matter that may be considered wrongdoing under PIDA, the matter is referred immediately to our Manager of Systemic and Public Interest Investigations, who deals with the individual whistleblowers (disclosers) personally. This personal interaction is key in establishing a trusting relationship between our office and disclosers.

The analysis of a disclosure can and usually does involve a review of documentary evidence provided by disclosers, and often extensive interviews with disclosers and witnesses. In many cases there are multiple disclosers wishing to make a disclosure in respect of the same alleged wrongdoing. For example, one active investigation involves the analysis of disclosures from 21 different disclosers. In this case, the volume of documentary evidence fills numerous boxes and audio testimonial evidence of the disclosers alone exceeds 20 hours of initial interviewing time.

#### Investigative options/referrals

Not all disclosures result in PIDA investigations by our office. There are other options available to us to ensure that all serious concerns can be addressed in the appropriate manner. If a disclosure does not warrant a whistleblower investigation but presents as a complaint of maladministration, we can deal with that matter under *The Ombudsman Act*. PIDA legislation gives us the authority to take any steps we consider appropriate to help resolve the matter within the department, government body or office. This allows us to identify matters that should be investigated or addressed internally under existing departmental or organizational policies, rather than as an investigation of wrongdoing.

We sometimes receive disclosures involving serious allegations of abuse, neglect or risk to safety that require immediate attention. We have, with the cooperation of government bodies, requested and received access to specialized staff to assist us with

investigations or to respond to concerns that must be addressed immediately.

The legislation also authorizes the ombudsman to refer a matter to another body for investigation if we believe that the subject matter of the disclosure could more appropriately be dealt with, initially or completely, according to a procedure provided for under another act. This section has been used to ensure that investigations are conducted by bodies with the necessary specialized expertise. While this has been helpful, only the ombudsman is authorized to make a determination that there has been a wrongdoing and to issue recommendations under PIDA. For that reason, investigations being conducted by other bodies must be monitored and/or reviewed. In some cases after an initial review, an ombudsman investigation is still required.

In any investigation that results in PIDA recommendations, we are then responsible for monitoring the implementation of those recommendations.

#### Investigations

The purpose of an investigation into a disclosure of wrongdoing is to bring the wrongdoing to the attention of the appropriate department, government body or office, and to recommend corrective measures that should be taken.

Whistleblower investigations can be complex and time consuming, often because of a larger body of evidence. There are additional requirements related to the sensitivity of the evidence, maintaining the confidentiality of disclosers and witnesses, and ensuring procedural fairness to all parties.

Investigative procedures can be more formal than with investigations under *The Ombudsman Act*, with most interviews recorded. At least two investigators are assigned to each file.

As with all ombudsman investigations, respondent entities are apprised of our investigative findings and conclusions and invited to provide a response prior to the preparation of a final report.

Reports on ombudsman PIDA investigations are provided to both the whistleblower(s) and the respondent government body or organization.

#### Assessing threshold of allegations of wrongdoing

When we receive a disclosure under PIDA, we must first determine if the allegations made relate to “significant and serious matters,” that fall within the definition of wrongdoing under the legislation. We have termed this assessment process a “threshold assessment.” This assessment is a means by which the ombudsman can make a decision as to whether an investigation is required, either under PIDA or another act as appropriate, or whether some other disposition is appropriate.

Sometimes written disclosures lack sufficient detail or clarity to make such an assessment after simply reviewing the allegations. Therefore, we routinely interview all whistleblowers after a disclosure is made, in order to determine whether the allegations they have brought forward are clearly allegations of wrongdoing, as defined by PIDA.

Some of the questions that we contemplate in this process are as follows (note that this is not a comprehensive list):

- Is there an indication of the willfulness or purposefulness of the alleged acts, decisions, omissions?
- Is there an indication that the acts, decisions or omissions are repetitive or subversive in nature?
- Are the allegations so egregious that an investigation is clearly necessary?
- Could the issues being alleged risk jeopardizing public confidence in the government or constitute a risk to the safety of persons?
- Do the alleged acts, decisions or omissions potentially impact or directly affect many people?

It must be noted that a threshold assessment is not an assessment as to the validity, accuracy, or truth of the allegations of wrongdoing. Upon reviewing a disclosure and speaking with the whistleblower, it would be impossible (and unfair) to determine at that point whether the allegations brought forward are founded. We do not make any assessment as to the whether there is merit or truth to the allegations, but rather a determination that the allegations relate to serious and significant matters and, if proven, would demonstrate “wrongdoing” as defined in the legislation. Certainly, a determination as to whether allegations are founded must only be made after an investigation into the matter is complete.

There are situations where we find that allegations of wrongdoing do not pass the threshold assessment for investigation under PIDA, but are nonetheless important and need to be looked at as matters of administration. In a number of instances this year we have forwarded allegations to the particular organizations or departments from which the allegations arose and suggested that they be investigated internally. In cases such as these, the whistleblower’s identity remains protected by our office. Allegations can be investigated in light of organizational policies and approved procedures and, if necessary, appropriate corrective measures can be taken.



Disclosures in 2013

Set out below are the number of disclosures received in 2013 under each category of wrongdoing identified in section 3 of PIDA, and the status of the disclosure at the end of the year.

PIDA subsection	Disclosure	Status
(3) (a) an act or omission constituting an offence under an Act of the Legislature or the Parliament of Canada, or a regulation made under an Act;	No such disclosures were received in 2013	N/A
(3)(b) an act or omission that creates a substantial and specific danger to the life, health or safety of persons, or to the environment, other than a danger that is inherent in the performance of the duties or functions of an employee;	Abuse and risks to health and safety	Investigation ongoing
	Abuse and safety concerns	Investigation ongoing
	Neglect, as well as risks to health and safety	Investigation ongoing
	Risk to public health	Investigation ongoing
	Abuse and inappropriate conduct	Investigation ongoing
	Unsafe and improperly developed program	Awaiting additional evidence in order to determine whether the allegations would meet the threshold of wrongdoing under the PIDA
(3)(c) gross mismanagement, including of public funds or a public asset;	Favoritism in hiring and promotion practices, as well as an improper tendering practice	Referred to the Office of the Auditor General
	Fraudulent billing practice	Resolved
	Improper Respectful Workplace investigation procedures and retaliatory termination of employment	This matter was pending on December 31, 2013 (At the time of reporting, the matter was declined under section 21(1)(f) of PIDA due to the matter being the subject of an ongoing arbitration process)
	Fraudulent income received	Investigation ongoing
	Improper conduct, improper hiring practices, financial mismanagement, and conflict of interest	Ongoing. The matter is currently being reviewing internally by the public service.
	Inappropriate audits and breach of a service purchase agreement	Investigation ongoing
	Intentional misapplication of employment regulations, improper hiring practices, and misuse of public funds benefitting personal acquaintances	This matter was pending on December 13, 2013 (At the time of reporting, the matter was declined after determining that the allegations did not amount to a “significant and serious matter in or relating to the public service” under PIDA. The matter will be investigated internally by the public service.)
	Intentionally misrepresenting a large over-expenditure of funds	Investigation ongoing
	Improper behavior, conflict of interest, and breach of fiduciary duties	Declined (After assessment, it was determined that the allegations did not amount to a “significant and serious matter in or relating to the public service” under PIDA.)
	Misuse of public funds, improper conduct, and conflict of interest	Declined (After assessment, it was determined that the allegations did not amount to a “significant and serious matter in or relating to the public service” under PIDA. The matter will be investigated internally by the public service.)
(3)(d) knowingly directing or counselling a person to commit a wrongdoing described in clauses (a) to (c).	No such disclosures were received in 2013	N/A

In some cases, a disclosure was made by more than one person. The disclosures above were made by 47 people. In addition, we received the following verbal allegations that did not result in formal disclosures, regarding:

- misuse of funds by executives of a corporation (not within our jurisdiction)
- misappropriation of funds
- improper case management in a facility, and
- discrimination in an employment decision.



Acting Ombudsman Mel Holley spoke about Manitoba’s whistleblower legislation at an access and privacy conference in Edmonton in June 2013

Recommended improvements to The Public Interest Disclosure (Whistleblower Protection) Act

In 2013 we had occasion to look back at our experience and contemplate the “lessons learned” in dealing with our whistleblower legislation.

Manitoba has had a mechanism for receiving disclosures of alleged wrongdoing and protecting whistleblowers since PIDA came into effect in April 2007. Disclosures may be made internally to a supervisor or designated officer, or to Manitoba Ombudsman.

During the past six years our work with the legislation has given us an opportunity to identify areas where this legislation might be improved. In addition to our six years of experience with PIDA, we also have the benefit of comparing our legislation with more recent whistleblower legislation in other provinces. Since 2007, both Saskatchewan and Alberta have adopted whistleblower legislation. In both provinces the provincial ombudsman has been designated the PIDA commissioner.

At the end of 2012 we brought certain issues to the attention of the Manitoba Civil Service Commission, the provincial body which administers the legislation, and we were advised in 2013 that the legislation was being reviewed. In aid of this review we identified a number of issues we felt warranted further consideration.

In Manitoba, a discloser seeking reprisal protection must file a complaint with the Manitoba Labour Board. Complaints alleging reprisal are dealt with in accordance with the procedures for dealing with an unfair labour practice. Disclosers have described this practice as cumbersome and intimidating, noting that as this process identifies them as the complainant, it effectively identifies them as a whistleblower, thus defeating the confidentiality protections of the legislation. Both Saskatchewan and Alberta legislation deals with allegations of reprisal differently, articulating a role for the commissioner. We have suggested that the government consider a procedure in which the ombudsman has authority to promptly investigate and report on allegations of reprisal, which can then be acted upon promptly by a decision making body (such as the Manitoba Labour Board) or a government department in order to halt or rapidly rectify reprisals against whistleblowers.

Organizational procedures for investigating whistleblower disclosures must contain provisions for protecting the confidentiality of information. Investigations by the ombudsman are confidential because of the incorporation of privacy provisions from *The Ombudsman Act*. Under section 21(1)(a) of PIDA Manitoba Ombudsman may refer a disclosure to another entity when we conclude that the subject matter of the disclosure could more appropriately

be dealt with, initially or completely, according to a procedure provided for under another act. However, when we refer disclosures to another body for investigation under the provisions of another statute there is no explicit confidentiality protection. This means that other entities conducting PIDA investigations may be subject to *The Freedom of Information and Protection of Privacy Act* (FIPPA). We have recommended that if this was not the government’s intent, other entities conducting PIDA investigations should be afforded the same confidentiality protections as this office when conducting PIDA investigations.

Finally, we have suggested that the explicit right to procedural fairness and natural justice required in internal organizational and external ombudsman investigations be extended to include investigations conducted by other entities to whom we refer disclosures for investigation under section 21(1)(a) as described above.

These are a few of the issues we have raised with government in aid of their review of this valuable and important piece of legislation. Periodic review of legislation, particularly new legislation, can ensure that we benefit from the lessons learned through experience.

## 2013 in numbers

2013 Statistical Overview of the Office	
<b>Intake and Administration</b>	
Information or referrals provided by administration staff in response to inquiries	322
Inquiries and concerns handled by Intake Services	2104
<b>Ombudsman Division</b>	
Complaints opened for investigation under <i>The Ombudsman Act</i>	66
Ombudsman-initiated investigations under <i>The Ombudsman Act</i>	9
Disclosures received under <i>The Public Interest Disclosure (Whistleblower Protection) Act</i> (PIDA)	47
Disclosures opened for investigation under PIDA	16
Child death review reports received under <i>The Child and Family Services Act</i>	68
Recommendations requiring follow-up	43
Inquest reports received under <i>The Fatality Inquiries Act</i>	2
Recommendations requiring follow-up	2
<b>Access and Privacy Division</b>	
Complaints opened for investigation under <i>The Freedom of Information and Protection of Privacy Act</i> (FIPPA) (part 5)	210
Ombudsman-initiated reviews and investigations under <i>The Freedom of Information and Protection of Privacy Act</i> (part 4)	20
Complaints opened for investigation under <i>The Personal Health Information Act</i> (PHIA) (part 5)	25
Ombudsman-initiated reviews and investigations under <i>The Personal Health Information Act</i> (part 4)	5
Comments, consultations and collaborative initiatives under FIPPA and/or PHIA (part 4)	18

2013/14 Office Budget	
Total salaries and employee benefits for 32 positions	\$2,737,000
Positions allocated by division are:	
Ombudsman Division 13	
Access and Privacy Division 8	
General 11	
Other expenditures	\$519,000
Total Budget	\$3,256,000

## About the office

Manitoba Ombudsman is an independent office of the Legislative Assembly of Manitoba and is not part of any government department, board or agency. The office has a combined intake services team and two operational divisions - the Ombudsman Division and the Access and Privacy Division.

Under *The Ombudsman Act*, the Ombudsman Division investigates complaints from people who feel they have been treated unfairly by government, including provincial government departments, Crown corporations, municipalities, and other government bodies such as regional health authorities, planning districts and conservation districts. The Ombudsman Division also investigates disclosures of wrongdoing under *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA). Under PIDA, a wrongdoing is a very serious act or omission that is an offence under another law, an act that creates a specific and substantial danger to the life, health, or safety of persons or the environment, or gross mismanagement, including the mismanagement of public funds or government property.

Under *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA), the Access and Privacy Division investigates complaints from people about any decision, act or failure to act relating to their requests for information from public bodies or trustees, and privacy concerns about the way their personal information or personal health information has been handled. “Public bodies” include provincial government departments and agencies, municipalities, regional health authorities, school divisions, universities and colleges. “Trustees” include public bodies and additional entities such as health professionals, medical clinics, laboratories and CancerCare Manitoba. Our office has additional powers and duties under FIPPA and PHIA, including auditing to monitor and ensure compliance with these Acts, informing the public about the Acts and commenting on the implication of proposed legislation, programs or practices of public bodies and trustees on access to information and privacy.

**More Information**

Manitoba Ombudsman has issued a supplementary 2013 report under *The Ombudsman Act*, section 16.1. As part of our mandate, Manitoba Ombudsman has responsibility for monitoring and reporting annually on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA).

	Case Numbers			Case Dispositions								
	Carried over into 2013	New Cases in 2013	Total Cases in 2013	Pending at 12/31/2013	Information Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
This chart shows the disposition of 171 Ombudsman Division case files in 2013 under <i>The Ombudsman Act</i> , <i>The Public Interest Disclosure (Whistleblower Protection) Act</i> , and <i>The Fatality Inquiries Act</i> .												
The Ombudsman Act												
Agriculture, Food & Rural Development	1	1	1									
Conservation & Water Stewardship												
General	3	1	4	3				1				
Ombudsman's Own Initiative - OOI	1		1	1								
Entrepreneurship, Training & Trade (now Jobs & the Economy)												
General	1		1		1							
Employment & Income Assistance	1		1			1						
Ombudsman's Own Initiative - OOI		1	1	1								
Family Services												
Child & Family Services	1	1	2	1		1						
Ombudsman's Own Initiative - OOI	1		1	1								
Finance												
General	1		1						1			
Securities Commission	1		1	1								
Health												
General		1	1		1							
Regional Health Authority		1	1	1								
Ombudsman's Own Initiative - OOI	2	1	3	2	1							
Healthy Living & Seniors	1		1						1			
Housing & Community Development												
General		1	1		1							
Ombudsman's Own Initiative - OOI	1		1	1								
Immigration & Multiculturalism	1		1	1								
Infrastructure & Transportation	5	2	7	4			3					
Innovation, Energy & Mines (now Mineral Resources)		1	1	1								
Justice												
General	1		1			1						
Courts	2		2	1					1			
Brandon Correctional Centre	1	2	3	1			1		1			
Headingley Correctional Centre	1		1			1						
The Pas Correctional Centre	1	1	2	1				1				
Thompson Holding Cells		1	1	1								
Winnipeg Remand Centre	1	1	2		1			1				
Women's Correctional Centre	1	2	3		2		1					
Manitoba Youth Centre		1	1						1			
Maintenance Enforcement		1	1						1			
Human Rights Commission	1		1				1					
Legal Aid		2	2	2								
Public Trustee	1	2	3		2		1					
Ombudsman's Own Initiative OOI	7	3	10	7		1		1	1			
Labour & Immigration												
Labour Board		1	1		1							
Pension Commission		1	1		1							
Tourism, Culture, Heritage, Sport & Consumer Protection												
Residential Tenancies Branch		1	1		1							
Corporate & Extra Departmental												
Manitoba Agricultural Services Corporation	1	2	3	2	1							
Manitoba Hydro		1	1		1							
Manitoba Public Insurance	2	5	7	3	3	1						
Workers Compensation Board	1	2	3	2								
WCB Appeal Commission		2	2	2								
Ombudsman's Own Initiative - OOI		2	2	2								
Municipalities												
City of Winnipeg	6	4	10	8	1		1					
Other RMs, Cities, Towns & Villages	17	24	41	29	2		1	5	3		1	
Local Planning Districts		1	1	1								
Ombudsman's Own Initiative - OOI	2	2	4	3					1			
Subtotal	66	75	141	84	20	1	6	14	7	8	1	0
The Public Interest Disclosure (Whistleblower Protection) Act												
Government department	3	6	9	7		2						
Health care facility		3	3	2					1			
Personal care home		1	1	1								
Publicly-funded organization		3	3	3								
Regional health authority		2	2	2								
University		1	1	1								
Subtotal	3	16	19	16		2				1		
Cases Resulting from Inquest Report Recommendations under The Fatality Inquiries Act												
Family Services	1		1	1								
Health	3	1	4	4								
Justice	3	1	4	4								
City of Winnipeg	2		2	2								
Subtotal	9	2	11	11								
TOTAL	78	93	171	111	20	3	6	14	7	9	1	0
Pending: Complaint still under investigation as of January 1, 2014.			Partly Resolved: Complaint is partly resolved informally.									
Information supplied: Assistance or information provided.			Resolved: Complaint is resolved informally.									
Declined: Complaint not accepted for investigation by Ombudsman, usually for reason of non-jurisdiction or premature complaint.			Recommendation Made: All or part of complaint supported and recommendation made after informal procedures prove unsuccessful.									
Discontinued: Investigation of complaint stopped by Ombudsman or client.			Completed: Case where the task of monitoring, informing or commenting has been concluded.									
Not Supported: Complaint not supported at all.												





# Manitoba Ombudsman

## 2013 Report under Section 16.1 of *The Ombudsman Act*

### The Ombudsman Act

Monitoring children's advocate's recommendations

16.1(1) The Ombudsman must monitor the implementation of recommendations contained in the reports provided to the Ombudsman by the children's advocate under section 8.2.3 of *The Child and Family Services Act*.

Report to assembly

16.1(2) In the annual report to the assembly under section 42, the Ombudsman must report on the implementation of the children's advocate's recommendations.

### Aggregate Investigations

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

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

Manitoba Ombudsman is an independent office of the Legislative Assembly of Manitoba which investigates administrative acts, decisions or omissions by departments and agencies of the provincial and municipal governments in Manitoba. Our role is to promote fairness and administrative improvement. As part of our mandate, Manitoba Ombudsman has responsibility for monitoring and reporting annually on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA).

When a child dies in Manitoba, the Office of the Chief Medical Examiner (OCME) determines the manner of death according to an established protocol. Child deaths that meet the criteria for special investigation reviews by the OCA include those cases where the child, or the child's family, had an open file with a child welfare agency or a file was closed within one year preceding the child's death.

In their special investigation reviews (SIRs), the OCA may make recommendations to improve services, enhance the safety and well-being of children, and prevent deaths in similar circumstances in the future. After a reasonable period of time, our office follows up with the entity or entities to which the recommendations have been made to determine what action has been taken in response to the recommendations, and to report publicly on those actions to ensure accountability.

The OCA has made 390 recommendations since they received their mandate to perform special investigation reviews on September 15, 2008, to the end of our reporting period December 31, 2013. Our office continues to track and monitor the recommendations made by the OCA, and the tables that follow in this report provide the status of the implementation of the recommendations made up to December 31, 2013.

Through our mandate to track and monitor the implementation of the OCA's recommendations, we have noted that while all the recommendations within the SIRs are intended to improve services and enhance the safety and well-being of children and prevent future similar deaths, the complexity of the recommendations and the challenges facing entities to implement the recommendations range greatly.

The child welfare system in Manitoba is a large and complex network of entities that has evolved over time. Recommendations made by the OCA resulting from special investigations of child deaths often reflect this complexity, providing an avenue to examine the larger issues that underpin and impact the child welfare system, and make administrative improvements to help the complex system work together to implement larger systemic, planned changes. The identification, monitoring and tracking of larger and systemic issues in the delivery of child welfare services is paramount for the continued development of improved services for children, youth and their families in the province of Manitoba.

Our office has noted that a great deal of work is being done by the child welfare entities to whom recommendations have been directed; over 67 per cent of the recommendations made within the OCA's special investigation reviews from September 15, 2008 to December 31, 2013, are now considered complete or implemented. We have noted that all four authorities have regularly provided our office with updates on the action they have taken in response to the recommendations, and are working towards the improvements

recommended in the OCA special investigation reviews. The General Authority, for example, has implemented all 21 recommendations made to December 31, 2013. The Metis Authority has implemented all but three of their 10 recommendations, the three outstanding having only recently been issued. The Southern Authority has worked steadily on the implementation of their 131 recommendations, successfully implementing 64 of them. And the Northern Authority has been providing regular updates to our office in a timely manner regarding the implementation of the 110 recommendations made to their authority and agencies since 2008, with 68 implemented.

However, it is important to note that many of the 390 special investigation report recommendations made by the OCA since it received its mandate relate to challenges that are significant, long-standing and systemic in nature. In 2006, the ombudsman and the OCA published a joint report titled *Strengthen the Commitment: An External Review of the Child Welfare System*. A significant challenge identified in the report was the computer-based information management system that Manitoba child welfare agencies are required to use and how it related to case management at that time. The system is comprised of two distinct applications: the Intake Module (IM) and the Child and Family Services Information System (CFSIS). Throughout the ongoing process of monitoring the implementation of recommendations made by the OCA, it has become apparent that the use of CFSIS continues to remain a systemic issue that affects the delivery of child welfare in the province of Manitoba, particularly in rural, remote and on-reserve communities.

A concerning result of the lack of CFSIS use is that detailed child welfare information is not readily available to workers across the province, affecting basic case management such as risk assessment, case planning and service delivery. Historical and current information about children and families involved with Child and Family Services is of great importance to a case manager in order to guide the assessment and case planning process. Evidence provided to our office indicates that CFSIS has been an ongoing area of contention for northern First Nations agencies, and political commitment to the implementation of CFSIS on northern reserves appears to remain lacking at present.

Our office has raised our present concerns surrounding the use of CFSIS with the minister of Manitoba Family Services. The minister has advised that this matter is a priority, and has issued a letter of direction to the Child and Family Service authorities advising that the authorities have a statutory duty and obligation to ensure agencies under their purview comply with Manitoba's case management standards -- particularly those standards that require the use of CFSIS applications. Our office has also been informed that the use of CFSIS for on-reserve cases has been elevated to the leadership council, and the minister has committed to bring these concerns to the forefront of the agenda of the leadership council to bring them to a conclusion in the near future. We are hopeful that the implementation of recommendations pertaining to CFSIS use in our province will remain a priority in order to bring forth a resolution to this long standing systemic issue, and to effect positive outcomes in the quality of services received by Manitoba children and their families.

The following Table 1 illustrates the number of special investigation reports received by our office from the OCA by fiscal year from September 15, 2008 to December 31, 2013. Table 2 illustrates the status of special investigation report recommendations by calendar year and by the entity to which the recommendation was directed. For status definitions, please see page 2 of this report.

Table 1: Special Investigation Reports received by the Ombudsman from the OCA by fiscal year - September 15, 2008 to December 31, 2013				
Fiscal Year	Child Deaths Investigated	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008 - 2009	7	7	7	40
2009 - 2010	21	21	19	141
2010 - 2011	27	26	16	63
2011 - 2012	154*	147	15	44
2012 - 2013	89	76	22	72
2013- Dec 31, 2013	41	41	11	30
Total	339*	318*	90	390

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

Table 2: Special Investigation Reports received by the Ombudsman from the OCA by calendar year - September 15, 2008 to December 31, 2013				
Calendar Year	Child Deaths Investigated	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008	3	3	3	17
2009	19	19	17	83
2010	23	22	18	135
2011	148*	141	17	43
2012	78	65	20	69
2013	68	68	15	43
Total	339*	318*	90	390

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

Glossary of Acronyms

AJI-CWI – The Aboriginal Justice Inquiry – Child Welfare Initiative

CEO – Chief Executive Officer of one of the four Child and Family Service authorities

CFS – Child and Family Services

CFSIS – Child and Family Services Information System

CFSSC – Child and Family Services Standing Committee

CFS Act – *Child and Family Services Act*

CPB – Child Protection Branch

FS – Department of Family Services

FSCA – Family Services and Consumer Affairs, former name of the department of Family Services

FSL – Family Services and Labour, former name of the department of Family Sevices

GA – General Child and Family Services Authority

MA – Metis Child and Family Services Authority

NA – First Nations of Northern Manitoba Child and Family Services Authority

OCA – Office of the Children’s Advocate

OCME – Office of the Chief Medical Examiner

SA – Southern First Nations Network of Care Child and Family Services Authority

SIR – Special Investigation Report

Status Definitions

In 2012, CFS Standing Committee, the advisory body comprised of the CEOs from the four authorities and the director of CFS, agreed upon common status definitions with regard to recommendations made in Special Investigation Reports. Each respective recommendation referenced in this report is delineated as one of the following:

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

**Complete: Alternate Solution** – The organization to which the recommendation is directed disagrees with the recommendation but accepts the general concern raised in the report and has developed an alternate solution which addresses the concern. The organization has formulated an implementation plan to fully respond to the issue underlying the recommendation. The organization has demonstrated that it has taken all necessary steps to respond to the recommendation.

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

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

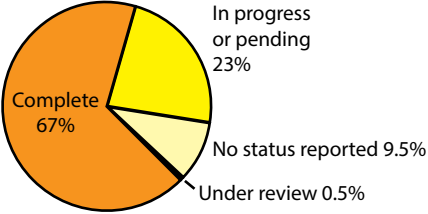
**Not Accepted (unachievable)** – The organization to which the recommendation is directed agrees with the recommendation but cannot implement the recommendation based on existing resources, legislation, or governance structure.

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

The ombudsman’s office has created two additional Status Definitions for the purposes of our report:

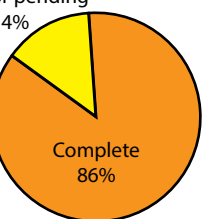
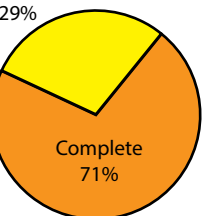
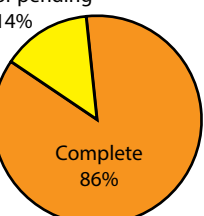
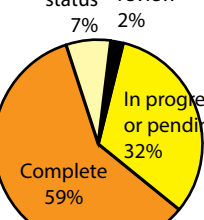
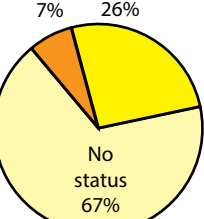
**Recommendations “Response Under Review”** – The Manitoba Ombudsman has received information from the entity to which the recommendation is directed and is currently reviewing the information.

**No Status Reported** – The organization to which the recommendation is directed has not yet reported to the Manitoba Ombudsman. Note that because our reporting period includes recommendations made within SIRs released up to December 31, 2013, it is expected that entities would not yet have any information to report on recently released recommendations.

Table 4: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity September 15, 2008 - December 31, 2013						
Authority/Agency/ Entity to which the recommendation was directed	RECOMMENDATIONS	RECOMMENDATIONS “COMPLETE” OR “COMPLETE-ALTERNATE SOLUTION”	RECOMMENDATIONS “IN PROGRESS” OR “PENDING”	RECOMMENDATIONS “RESPONSE UNDER REVIEW”	NO STATUS REPORTED TO THE OMBUDSMAN	
Child Protection Branch	47	35	12	0	0	
CFS Standing Committee	1	0	1	0	0	
CPB & CFS Standing Committee	4	3	1	0	0	
Family Services*	19	13	6	0	0	
Multiples - FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	17	8	9	0	0	
Southern Authority	132	87	29	0	16	
Northern Authority	111	70	26	1	14	
General Authority	21	21	0	0	0	
Metis Authority	13	8	2	0	3	
External Organizations (other departments, private service providers)	25	18	4	0	3	
TOTAL NUMBER	390	263	90	1	36	
TOTAL PERCENTAGE		67%	23%	0.5%	9.5%	
						

\* Note: Family Services includes former department names Family Services & Labour and Family Services & Consumer Affairs.

Table 3 below encompasses the recommendations within the special investigation reports received by the ombudsman from the Office of the Children’s Advocate in special investigation reports by calendar year since January 1, 2009. The table illustrates the status of the recommendations as reported to the ombudsman’s office by the entities to which the recommendations were made using the status definitions as per Standing Committee (see Status Definitions for further information). There were also 17 recommendations made in 2008; 14 have been implemented while 3 remain “in progress” or “pending” (one made to the Child Protection Branch; one made jointly to the Child Protection Branch and CFS Standing Committee; and one to the CFS Standing Committee).

Table 3: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity January 1, 2009 - December 31, 2013						
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2009 to December 31, 2009 by Entity						
Authority/Agency/Entity to which the recommendation was directed	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NO STATUS REPORTED TO THE OMBUDSMAN	Status of Recommendations
Child Protection Branch	14	12	2	0	0	
CFS Standing Committee	0	0	0	0	0	
CPB & CFS Standing Committee	1	1	0	0	0	
Family Services*	1	1	0	0	0	
Multiples - FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	3	3	0	0	0	
Southern Authority	39	34	5	0	0	
Northern Authority	19	14	5	0	0	
General Authority	6	6	0	0	0	
Metis Authority	0	0	0	0	0	
External Organizations (other departments, private service providers)	0	0	0	0	0	
TOTAL NUMBER	83	71	12	0	0	
TOTAL PERCENTAGE		86%	14%	0%	0%	
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2010 to December 31, 2010 by Entity						
Child Protection Branch	14	10	4	0	0	
CFS Standing Committee	0	0	0	0	0	
CPB & CFS Standing Committee	0	0	0	0	0	
Family Services*	11	8	3	0	0	
Multiples - FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	5	3	2	0	0	
Southern Authority	36	22	14	0	0	
Northern Authority	41	27	14	0	0	
General Authority	9	9	0	0	0	
Metis Authority	0	0	0	0	0	
External Organizations (other departments, private service providers)	19	17	2	0	0	
TOTAL NUMBER	135	96	39	0	0	
TOTAL PERCENTAGE		71%	29%	0%	0%	
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2011 to December 31, 2011 by Entity						
Child Protection Branch	11	10	1	0	0	
CFS Standing Committee	0	0	0	0	0	
CPB & CFS Standing Committee	0	0	0	0	0	
Family Services*	4	4	0	0	0	
Multiples - FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	2	2	0	0	0	
Southern Authority	8	7	1	0	0	
Northern Authority	14	11	3	0	0	
General Authority	2	2	0	0	0	
Metis Authority	1	1	0	0	0	
External Organizations (other departments, private service providers)	1	0	1	0	0	
TOTAL NUMBER	43	37	6	0	0	
TOTAL PERCENTAGE		86%	14%	0%	0%	
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2012 to December 31, 2012 by Entity						
Child Protection Branch	4	2	2	0	0	
CFS Standing Committee	0	0	0	0	0	
CPB & CFS Standing Committee	0	0	0	0	0	
Family Services*	2**	0	2	0	0	
Multiples - FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	3**	0	3	0	0	
Southern Authority	30**	17	9	0	4	
Northern Authority	22	16	4	1	1	
General Authority	4	4	0	0	0	
Metis Authority	3	1	2	0	0	
External Organizations (other departments, private service providers)	1	1	0	0	0	
TOTAL NUMBER	69	41	22	1	5	
TOTAL PERCENTAGE		59%	32%	2%	7%	
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2013 to December 31, 2013 by Entity						
Child Protection Branch	3	1	2	0	0	
CFS Standing Committee	0	0	0	0	0	
CPB & CFS Standing Committee	0	0	0	0	0	
Family Services*	1	0	1	0	0	
Multiples - FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	4	0	4	0	0	
Southern Authority	13	1	0	0	12	
Northern Authority	14	0	1	0	13	
General Authority	0	0	0	0	0	
Metis Authority	4	0	1	0	3	
External Organizations (other departments, private service providers)	4	1	2	0	1	
TOTAL NUMBER	43	3	11	0	29	
TOTAL PERCENTAGE		7%	26%	0%	67%	

\* Note: Family Services includes former department names Family Services & Labour and Family Services & Consumer Affairs.  
\*\*Note: The 2012 Annual Report incorrectly attributed six total recommendations to Multiples instead of three. The three Multiples recommendations that were incorrect should have been attributed as follows: two to Family Services and one to the Southern Authority.