Manitoba Ombudsman
2015 ANNUAL REPORT

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June 15, 2016

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

Dear Madam Speaker:

In accordance with section 42 of *The Ombudsman Act*, subsections 58(1) and 37(1) of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* respectively, and subsection 26(1) of *The Public Interest Disclosure (Whistleblower Protection) Act*, I am pleased to submit the annual report of Manitoba Ombudsman for the calendar year January 1, 2015 to December 31, 2015.

Yours truly,

Charlene Paquin
Manitoba Ombudsman

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OMBUDSMAN'S MESSAGE

I am pleased to present the 2015 Annual Report in a new format with some new features and additional information about the operations of the office. The intent of this format is to provide practical and useful information about the office, while also highlighting our work and accomplishments in the past year.

I was appointed as the new Manitoba Ombudsman on May 4, 2015, marking a year of change for the office. In the summer and fall, I spent time meeting with a variety of municipalities and provincial government departments to introduce myself and talk about the work of the office, including the principles of fairness, good governance, access to information and privacy.

Outreach with the public, community organizations and governments is an important part of our work and ensures that our stakeholders understand what we do and why it is important. In 2015, our outreach included speaking with public bodies about the importance of making information available to the public and how proactively disclosing information can promote transparency as well as potentially reduce formal information requests and access complaints. We saw several municipalities and provincial departments make additional efforts to proactively disclose information on their websites in response to topics of interest as well as common requests for information.

I also participated in discussions and collaborated with my ombudsman, information and privacy commissioner and public interest commissioner counterparts across the country on areas of common interest. Some examples can be found later in the report.

In 2015, the office continued to investigate complaints under *The Ombudsman Act*, *The Freedom of Information and Protection of Privacy Act*, *The Personal Health Information Act* and *The Public Interest Disclosure (Whistleblower Protection) Act*. In total, the office opened 308 investigations and posted 41 reports on our website. These reports illustrate the range of issues investigated, as well articulate the important role that the office plays facilitating communication and resolving issues, both during the investigative process or as a result of recommendations to public bodies.

Under *The Ombudsman Act*, we investigated several complex and high profile matters in 2015. In these cases, recommendations were made for administrative improvements. We continued to see a significant number of complaints and investigations about municipal governments. Themes seen in this year's report relate to conflict of interest, tendering and procurement, recordkeeping and reasons for decisions.

In the area of *The Public Interest Disclosure (Whistleblower Protection) Act*, we hired new investigators in 2015, allowing for the completion of more reports. Although no wrongdoing was found in any of the investigations concluded this past year, we did make several recommendations for administrative improvements as a result. The PIDA team continues to assess allegations of wrongdoing that are courageously brought forward to our office.

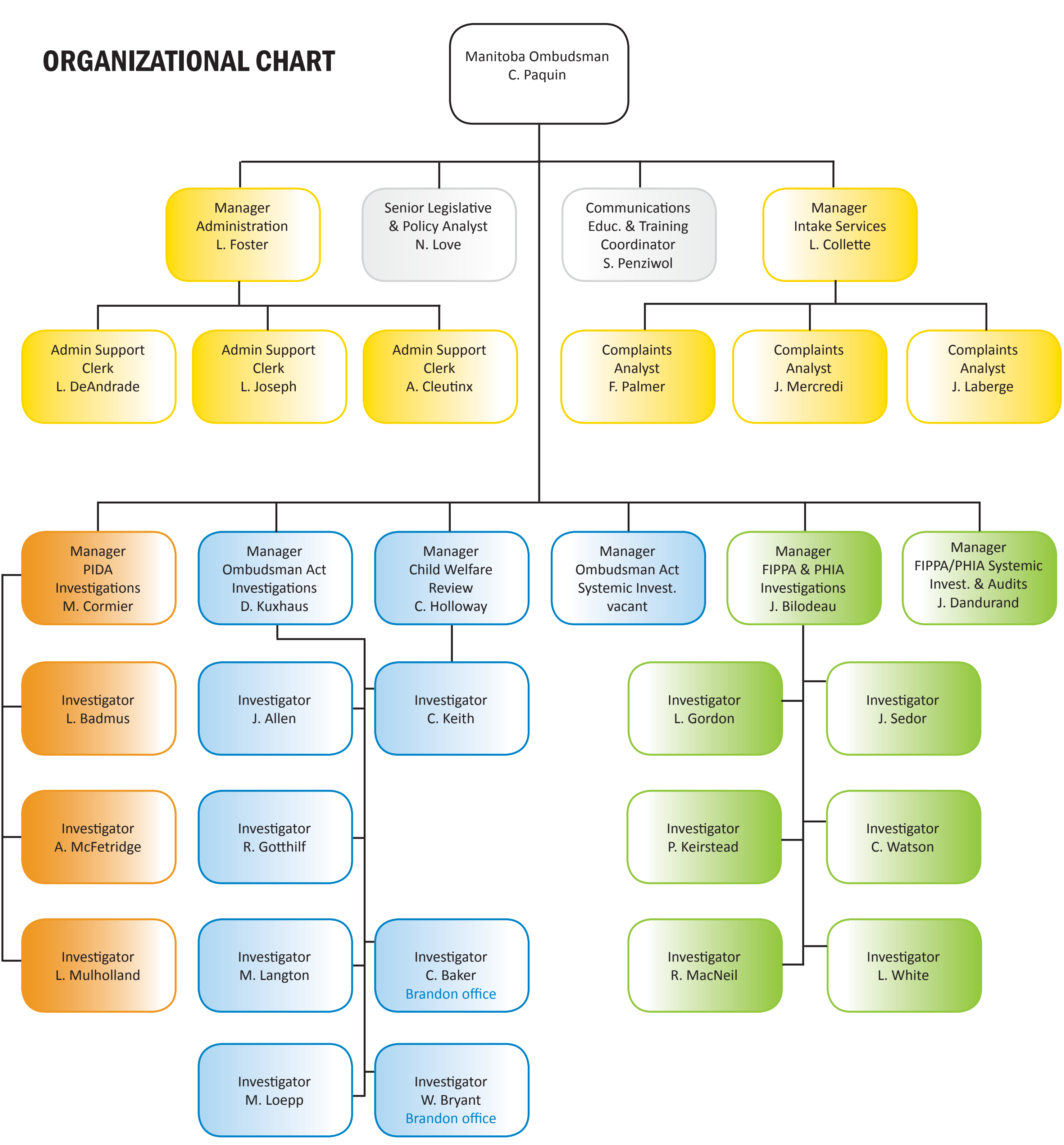
In addition to investigating many access and privacy complaints, the office also published three new documents this past year, which provide guidance and advice to the public sector on what to consider and how to best protect individual privacy. These include our *Video Surveillance Guidelines*, *Privacy Guidelines for Administrative Tribunals on the Online Publication of Decisions* and a new *Privacy Impact Assessment Tool*.

Finally, I would like to thank the staff of the Manitoba Ombudsman's office for their support and guidance during my first months in the role of ombudsman. They are committed to the work of the office and their professionalism and expertise has been invaluable in assisting me.

BUDGET AND STAFF

2015/16 Office Budget	
Total salaries and employee benefits	$2,882,000
Other expenditures	$551,000
Total Budget	$3,433,000

ORGANIZATIONAL CHART



About the Office

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

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

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

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

2015 OVERVIEW

3531 INQUIRIES AND COMPLAINTS

2984 The Intake Services team handled 2984 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*

40 The PIDA investigation team handled 22 inquiries and 18 disclosures related to *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA)

507 The administration team also handled 507 general inquiries

308 INVESTIGATIONS OPENED

205 FIPPA (parts 4 and 5)

55 PHIA (parts 4 and 5)

45 *The Ombudsman Act*

3 PIDA

53 RECOMMENDATIONS MONITORED

10 7 inquest reports with 10 recommendations were received from the Provincial Court of Manitoba

43 51 special investigation reports with 43 recommendations were received from the Office of the Children's Advocate

41 INVESTIGATION REPORTS POSTED ON WEBSITE

26 FIPPA

5 PHIA

10 Ombudsman Act

Some information in the 2015 Annual Report is presented differently than in previous reports. Please contact our office if you have questions – other information may be available on request.

OUTREACH AND OTHER ACTIVITIES

Ombudsman Activities

Charlene Paquin was officially sworn in as ombudsman, with the Honourable Daryl Reid, former speaker of the Legislative Assembly of Manitoba, on May 4, 2015.

Manitoba's ombudsman met with a number of individuals and groups to introduce herself as ombudsman and talk about the work of the office, including:

- attending three district meetings of the Manitoba Municipal Administrators Association
- meeting with the executive of the Association of Manitoba Municipalities (AMM)
- meeting with numerous Manitoba government deputy ministers, executive management committees and employee groups
- meeting with staff and touring five correctional facilities
- attending three national meetings, including meetings of ombudsmen, information and privacy commissioners, and public interest disclosure commissioners
- presenting a session, "Ombudsman oversight: a practical perspective," at the AMM annual convention

Employee Presentations

In addition, ombudsman employees delivered presentations to the following groups:

- Correctional officer recruits – nine sessions as part of their regular training program
- Correctional food service managers
- Newly elected municipal officials training – two sessions at workshops developed by Manitoba Municipal Government and the AMM
- Eastern region municipal CAOs, at their quarterly meeting
- AMM annual convention – participation on a panel about decision making
- Manitoba Bar Association mid-winter conference – participation on a panel presentation on the Current State of Privacy Law in Manitoba
- Manitoba chapter of ASIS International – presentation on our video surveillance guidelines
- Community Legal Intermediary Training Course, Manitoba's Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Act (PHIA) – presentation on Privacy and Access to Information Laws
- Southern Health/Santé Sud – PHIA Day session on Practicing Good Privacy and Security Hygiene
- Access and privacy coordinators and officers, at our Brown Bag Talk series, including sessions on:
    - Manitoba Ombudsman's new Privacy Impact Assessment Tool
    - Severing and Redactions Under FIPPA
    - Providing Representations to the Ombudsman in Complaints of Refused Access
    - Reasonable Security Safeguards Under FIPPA and PHIA

Fundraising

Ombudsman employees accepted an award on behalf of the office for achieving 100% participation in the All Charities Campaign for the second year in a row.

Events

Ombudsman employees staffed display tables at the following events:

- Law Day (Winnipeg and Brandon)
- Manitoba Youth Centre and Agassiz Youth Centre youth resource fairs
- Brandon Correctional Centre resource fair
- Manitoba Centre for Health Policy's annual RHA workshop
- Manitoba Social Science Teachers Association SAGE conference (Winnipeg)
- Social Sciences Teachers Conference LIFT (Brandon)

NEW PUBLICATIONS

VIDEO SURVEILLANCE GUIDELINES

Introduction

Purpose and scope

Manitoba Ombudsman

PRIVACY GUIDELINES FOR ADMINISTRATIVE TRIBUNALS on the Online Publication of Decisions

Introduction

Manitoba Ombudsman

PRIVACY IMPACT ASSESSMENT TOOL

Introduction

Acknowledgments

Manitoba Ombudsman

Surveillance methods that capture us walking down the street, travelling on a bus or entering a public building generate electronic records of personal and/or personal health information, which results in responsibilities and obligations set out in FIPPA and PHIA for organizations using surveillance. Implementing a surveillance system requires consideration and planning to minimize the impact on the privacy rights of individuals. Our *Video Surveillance Guidelines* can assist organizations in deciding whether a proposed or existing surveillance system is operating in a privacy protective manner.

Manitobans come into contact with many specialized boards and commissions, also known as administrative tribunals, when dealing with the Manitoba government. When these organizations make their decisions available online, it helps the public understand the work of the tribunal and how it deals with the cases before it. To help administrative tribunals comply with Manitoba's privacy laws when they post decisions online, we developed *Privacy Guidelines for Administrative Tribunals on the Online Publication of Decisions*.

A user friendly *Privacy Impact Assessment Tool* was developed that encourages organizations to think about privacy when evaluating an existing or proposed program, service or activity. This PIA tool replaces our 2003 *Compliance Review Tool for Manitoba's Information Privacy Laws*. The tool supports organizations in assessing privacy risks when planning or evaluating any initiative that involves personal or personal health information. If potential privacy risks are identified, reasonable steps can be taken to safeguard information and minimize risk.

INTAKE SERVICES

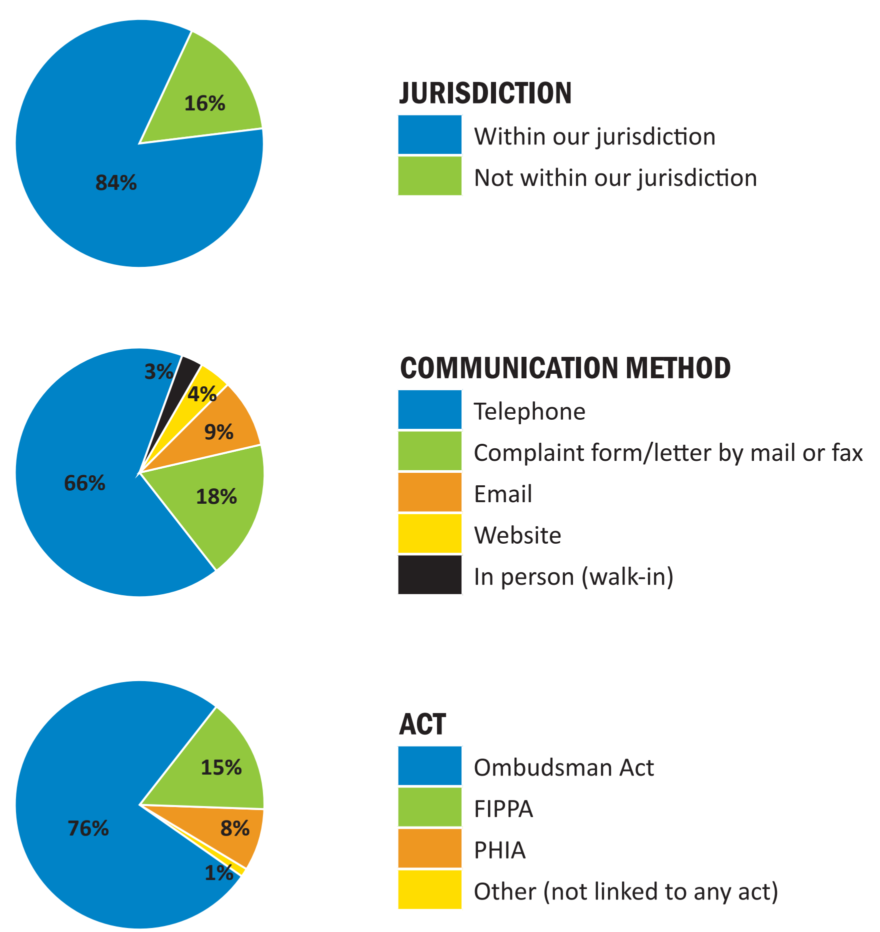
All inquiries and complaints received under *The Freedom of Information and Protection of Privacy Act* (FIPPA), *The Personal Health Information Act* (PHIA) and *The Ombudsman Act* are initially reviewed by the Intake Services team. Inquiries and disclosures related to *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA) are handled by the PIDA investigation team (see pages 22-23).

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

Thank you for taking the time to look into this matter on my behalf. I received a call from a supervisor...and the matter has been resolved.

(email from a complainant after Intake Services made some initial inquiries with the organization)

In 2015, Intake Services handled **2984** inquiries and complaints:



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

Early Resolution Case Studies: Facilitating Communication

Intake Services staff communicate with complainants on a daily basis. In the majority of instances, intake staff assist complainants by explaining referral and appeal options that might be helpful as a first step in solving their issues and concerns. In some situations, intake staff will attempt to informally resolve an issue, often by facilitating communication between the complainant and the organization being complained about.

For example, Manitoba Public Insurance determined that an individual was 100 per cent responsible for an accident that occurred while the individual was driving a vehicle. MPI had witness testimony that the individual hit a parked car while driving. The individual believed that he was not responsible at all for the accident. Unhappy with the decision of MPI, the individual submitted a written complaint to our office.

When MPI issues an initial decision, they explain in their letter that the individual may file an appeal with an independent adjudicator. When our intake staff reviewed the complaint, it appeared that the individual had not formally appealed the decision of the MPI adjustor. We generally require that a complainant under *The Ombudsman Act* pursue existing avenues of appeal before submitting a complaint to us – the ombudsman process does not replace those avenues of appeal that already exist. We suggested that the complainant file an appeal with MPI.

The complainant did appeal to MPI and the adjudicator upheld the initial decision.

Unhappy with that decision, the individual returned to us and since all appeal options had been exhausted, intake staff attempted to informally resolve this issue by contacting MPI and asking them to determine whether all relevant and available evidence, including video footage, was considered before they made a final decision.

After looking into the matter, MPI agreed to contact the individual to further discuss the circumstances surrounding the case. In the end, after obtaining a copy of video evidence from the complainant's employer, MPI determined that the individual was not responsible for the accident.

In another case, an individual was "showered" with salt pellets by a City of Winnipeg salting/sanding truck. Concerned with the way streets were being maintained and the possibility of injury to citizens, the individual contacted the city's 311 service. The individual was told that the status of his 311 service request could be tracked online if so desired – an option the individual pursued. When he checked the status, however, he saw that his complaint had been closed and it appeared to him that no action had been taken. A service representative at 311 was able to confirm that the Public Works department was unable to take further action.

The individual contacted our office, expressing his frustration at the way his concern was handled by the city. Intake staff contacted the city's 311 service and asked them if they would be willing to conduct a further assessment of the individual's concerns. After looking into the matter, 311 staff were able to confirm with us that a representative from Public Works would contact the individual. A short time later, the individual contacted us again explaining that someone from Public Works had called him, and he was satisfied with the outcome.

In both of these cases, Intake Services staff were able to connect complainants and organizations after initial communication efforts had stalled. Once communication was re-established, a satisfactory outcome was achieved and the complaints did not require a formal investigation.

The Intake Services team was able to informally resolve **96** cases in 2015.

ACCESS AND PRIVACY

The Freedom of Information and Protection of Privacy Act (FIPPA) governs access to general information and personal information held by public bodies and sets out requirements that they must follow to protect the privacy of personal information contained in the records they maintain. *The Personal Health Information Act* (PHIA) provides people with a right of access to their personal health information held by trustees and requires trustees to protect the privacy of personal health information contained in their records.

FIPPA applies to:

- provincial government departments, offices of the ministers of government, the office of the executive council, and agencies including certain boards, commissions or other bodies
- local government bodies such as the City of Winnipeg, municipalities, local government districts, planning districts and conservation districts
- educational bodies such as school divisions, universities and colleges
- health-care bodies such as hospitals and regional health authorities

PHIA applies to:

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

The Ombudsman's Role Under FIPPA and PHIA

Under FIPPA and PHIA, the ombudsman investigates complaints from people who have concerns about any decision, act or failure to act that relates to their requests for information from public bodies or trustees, or a privacy concern about the way their personal information has been handled. For example, a person can make a complaint if he or she believes a public body or trustee has:

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

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

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

Complaint Investigations

Recommendations Made Under FIPPA

In 2015, the ombudsman made recommendations in two cases under FIPPA.

In one case, an applicant requested information from the City of Winnipeg about renovations to the Public Safety Building and Canada Post building. The city responded to the access application by refusing access in full on the basis of clause 23(1)(a) of FIPPA. The ombudsman found that the city had issued a decision regarding access without conducting a search for records or reviewing records identified as responsive and that the city failed in its duty to assist. During the course of our investigation, responsive records were located and provided for our review. The ombudsman found that the information was subject to the exception applied by the city, however, the city did not exercise its discretion in a reasonable fashion.

Based on our findings, the ombudsman recommended that the city revisit its exercise of discretion in deciding to withhold rather than to give access and re-issue its decision concerning access to information. The city accepted the ombudsman's recommendation, requesting additional time to comply with the recommendation. The city granted access in part to the information requested.

In another case, applications were made to Manitoba Infrastructure and Transportation (MIT) for records about 46 different contracts awarded under the Winter Roads Program. MIT estimated that it would take two hours to process each request. After two free hours of search and preparation time, an Estimate of Costs totaling $2700 for the remaining 90 hours was issued. The ombudsman found that each application was for different records pertaining to different contracts and projects and that each request was a separate request entitled to two free hours of search and preparation time.

Based on our findings, the ombudsman recommended that MIT withdraw its Estimate of Costs. MIT accepted the recommendation, however, it later notified the complainant that it was disregarding the 46 access requests in accordance with subsection 13(1) of FIPPA. We did not investigate the decision to disregard the requests as a complaint was not made about that decision.

First Information and Privacy Adjudicator Decision

In early 2015, we referred a matter under PHIA to Manitoba's information and privacy adjudicator for additional review after a trustee did not comply with the ombudsman's recommendations. In this case, we received a complaint that a registered psychologist and health information trustee had refused access in response to a request from an individual to view and receive copies of the individual's own personal health information as allowed under PHIA. The ombudsman recommended release of the records to the complainant, but the trustee refused so the ombudsman referred the matter to the information and privacy adjudicator.

The adjudicator concluded that the trustee must provide the records, subject to certain conditions, to the complainant and issued an order to the trustee.

The adjudicator role was created in legislation in 2011.

Ombudsman-Initiated Activities Under FIPPA and PHIA

In addition to the investigation of access and privacy complaints, FIPPA and PHIA allow the ombudsman to undertake other activities including consultation and providing advice.

In 2015, we initiated **42** reviews and investigations – 25 under part 4 of FIPPA and 17 under part 4 of PHIA. Including the 14 cases carried over from 2014, we worked on a total of 56 cases and concluded 35 of them. These included consideration of longer extension requests under FIPPA and reviews of privacy breaches voluntarily reported to our office under both FIPPA and PHIA.

Consultation and Comments

New initiatives, proposed legislation, programs or practices of public bodies and trustees often have privacy or access to information implications. The ombudsman's role under FIPPA and PHIA enables the ombudsman to reach out or respond to requests for consultation about access or privacy implications and provide comments about these matters.

Our office generally does not report publicly about these matters, unless there is a public interest in doing so, due to their confidential nature.

During 2015, we were consulted and provided comments in **12** matters, all of which related to potential privacy implications. The Personal Identification Card initiative (see right) is one such example.

The Personal Identification Card Initiative

The Manitoba government announced that it approved an all-in-one Personal Identification Card (PIC). The PIC is intended to integrate the Personal Health Identification Number (PHIN) that Manitoba Health, Healthy Living and Seniors maintains, with a driver's license or identification card that Manitoba Public Insurance (MPI) issues to Manitobans.

Both MPI and Manitoba Health, Healthy Living and Seniors are subject to PHIA and FIPPA. MPI has been consulting with our office concerning the privacy impact of introducing the PIC to ensure that any privacy risks are carefully assessed and ensure that privacy laws are being followed. This will be an ongoing consultation process as MPI and Manitoba Health, Healthy Living and Seniors move forward with the development and implementation of the PIC.

Privacy Breach Reports

In addition to the investigation of privacy complaints we receive from individuals, our office also initiates investigations of privacy breaches that come to our attention in other ways. We may hear about breaches through the media or through a member of the public contacting our office; however, the majority of our investigations arise from reports of breaches made to our office by public bodies and trustees. Privacy breach reports are not mandatory in Manitoba.

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

In 2015, our office initiated **21** privacy breach investigations, the majority of which related to breaches voluntarily reported to our office by public bodies and trustees. We completed 15 of these investigations.

Interjurisdictional Collaboration

Manitoba Ombudsman is part of a federal, provincial and territorial community of access and privacy oversight offices across Canada. As an oversight community, we often work together on issues of mutual interest and concern. In 2015, our office participated in a variety of joint initiatives:

Body-worn cameras: The Office of the Privacy Commissioner of Canada, in consultation with the oversight offices, developed *Guidance for the Use of Body-worn Cameras by Law Enforcement Authorities*. The document identifies some of the privacy considerations that should be taken into account when deciding whether to outfit law enforcement officers with body-worn cameras. It also provides a privacy framework that should be a part of a body-worn camera program, including the development of policies and procedures governing the use of these cameras.

Joint resolution on information sharing: A joint resolution was developed on protecting and promoting Canadians' privacy and access rights in information sharing initiatives that involve the sharing of personal information to better serve citizens in the delivery of social programs, community safety, research, health and education. The resolution outlines actions to take to protect and promote privacy and access to information rights when embarking on information sharing initiatives.

Joint statement on duty to document: In a joint statement, oversight offices outlined the importance of creating a legislated duty to document to ensure that a public body's key decisions and actions are recorded to create full and accurate records of their business activities. By creating records that explain the 'what' and 'why' of public body decision making, a duty to document promotes accountability, transparency, good governance and public trust. It also enables the ability to make evidence-based decisions, fulfill legal obligations, and preserve the historical record.

Proactive Disclosure

Access to information legislation, such as Manitoba's FIPPA, promotes accountability and transparency on the part of public bodies by providing members of the public the right of access to records held by public bodies. In practice, accountability and transparency may often be best served by making records about matters of public interest widely available to the public at large by making a proactive disclosure of the information, rather than waiting for an application for access under FIPPA. Subsection 76(1) of FIPPA explicitly permits public bodies to identify records that it will make available to the public outside of the FIPPA application process.

In 2015, the movement toward proactive disclosure gained momentum. Many municipalities have made progress in sharing information such as policies, administrative procedures, bid opportunity documents and financial reports with their ratepayers and the general public.

The latter half of 2015 also saw some specific and significant advancements in proactive disclosure at the City of Winnipeg, Manitoba Finance, Manitoba Health, Healthy Living and Seniors and Manitoba Infrastructure and Transportation.

Many of these initiatives have arisen in response to interest in certain topics by the general public and/or as a result of a pattern of FIPPA access requests for certain types of data/information.

SUMMARY OF ACCESS AND PRIVACY COMPLAINTS OPENED AND CLOSED

Overview of Access Complaints Opened in 2015: 176 new complaints about access matters were opened under Part 5 of FIPPA and PHIA

Type of Access Complaint	FIPPA	PHIA	Total
Refused access	106	3	109
No response	31	1	32
Request was disregarded	1	NA*	1
Extension	11	NA**	11
Fees	5	2	7
Fee waiver	1	-	1
Correction	-	1	1
Other	13	1	14
Total	**168**	**8**	**176**

NA* Not applicable as requests cannot be disregarded under PHIA
NA** Not applicable as extensions cannot be taken under PHIA

Overview of Privacy Complaints Opened in 2015: 42 new complaints about privacy matters were opened under Part 5 of FIPPA and PHIA

Type of Privacy Complaint	FIPPA	PHIA	Total
Collection	3	4	7
Use	4	15	19
Disclosure	5	10	15
Security	-	1	1
Total	**12**	**30**	**42**

Overview of Access Complaints Closed in 2015: 159 complaints about access matters were closed under part 5 of FIPPA and PHIA

Type of Access Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or in whole	Not Supported	Resolved	Recommendation Made
Refused Access	79	4	83	8	6	47	21	1
No Response	40	1	41	1	35	-	5	-
Request was Disregarded	3	NA*	3	1	1	1	-	-
Fees	10	2	12	-	2	7	2	1
Fee Waiver	-	-	-	-	-	-	-	-
Correction	-	1	1	-	-	1	-	-
Extension	7	NA**	7	-	4	3	-	-
Other	11	1	12	1	5	5	1	-
Total	**150**	**9**	**159**	**11**	**53**	**64**	**29**	**2**

NA* Not applicable as requests cannot be disregarded under PHIA
NA** Not applicable as extensions cannot be taken under PHIA

Overview of Privacy Complaints Closed in 2015: 37 privacy complaints were closed under part 5 of FIPPA and PHIA

Type of Privacy Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or in whole	Not Supported	Resolved	Recommendation Made
Collection	2	1	3	-	-	3	-	-
Use	4	6	10	1	5	3	1	-
Disclosure	13	11	24	1	4	18	1	-
Security	-	-	-	-	-	-	-	-
Total	**19**	**18**	**37**	**2**	**9**	**24**	**2**	**-**

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

	Case Numbers				Case Dispositions						
	Carried over into 2015	New cases in 2015	Total cases in 2015	Pending at 12/31/2015	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Provincial Departments											
Agriculture, Food & Rural Development	2		2	1				1			
Civil Service Commission	1		1		1						
Conservation & Water Stewardship	8	20	28	11			2	1	14		
Education & Advanced Learning	7	1	8				1		1	6	
Executive Council		9	9	9							
Family Services	18	15	33	16			9	1	6	1	
Finance	5	5	10	5		1	3		1		
Health, Healthy Living & Seniors	1	3	4				3	1			
Housing & Community Development	1	3	4				2		1	1	
Infrastructure & Transportation	3	19	22	7		2	6	1		5	1
Jobs & the Economy	3	5	8	2		1	1	3	1		
Justice	5	17	22	9			10		2	1	
Labour & Immigration	1	5	6	3		1	2				
Municipal Government		1	1			1					
Crown Corporation and Government Agency											
Manitoba Cattle Enhancement Council	1		1				1				
Manitoba Floodway Authority		3	3	2				1			
Manitoba Gaming Control Commission		1	1	1							
Manitoba Hydro	4	2	6	5		1					
Manitoba Lotteries Corporation	1		1				1				
Manitoba Public Insurance	1	5	6	1			5				
The Funeral Board of Manitoba	1		1				1				
Workers Compensation Board		2	2	2							
Local Government Body											
City of Winnipeg	36	32	68	44		2	14	2	1	4	1
Town of Beausejour		2	2	2							
Town of Churchill	1		1			1					
Town of Neepawa	1		1						1		
Town of Niverville		3	3						3		
Town of Stonewall		1	1				1				
RM of De Salaberry		5	5	2			1		2		
RM of Gimli		3	3	2						1	

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

	Case Numbers				Case Dispositions						
	Carried over into 2015	New cases in 2015	Total cases in 2015	Pending at 12/31/2015	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendations
Local Government Body, continued											
RM of MacDonald	12		12				5		7		
RM of Rosedale		1	1	1							
RM of St. Clements		2	2	2							
RM of Siglunes	3		3	3							
RM of Swan Valley West		3	3							3	
Eastern Interlake Planning District	1		1	1							
Red River Planning District		2	2					1		1	
Educational Body											
Mystery Lake School Division	1		1	1							
Pembina Trails School Division	1		1				1				
Red River College	1		1				1				
Winnipeg School Division		1	1					1			
Universite de Saint-Boniface	1		1	1							
University of Manitoba	4	3	7			1	4	1		1	
University College of the North		1	1	1							
University of Winnipeg		1	1	1							
Health -Care Body											
Misericordia General Hospital		1	1	1							
Prairie Mountain Health Authority	1	1	2	2							
Northern Regional Health Authority	2		2							2	
Winnipeg Regional Health Authority		2	2	1			1				
TOTAL											
	128	**180**	**308**	**139**	**1**	**11**	**75**	**14**	**40**	**26**	**2**

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, 2015.

PHIA INVESTIGATIONS OF INDIVIDUAL COMPLAINTS (UNDER PART 5 OF PHIA)

	Case Numbers				Case Dispositions						
	Carried over into 2015	New cases in 2015	Total cases in 2015	Pending at 12/31/2015	Declined	Discontinued	Not supported	Partly supported	Supported	Resolved	Recommendation
Provincial Department											
Education & Advanced Learning	1		1				1				
Family Services	1		1	1							
Health, Healthy Living & Seniors	3	6	9	9							
Jobs & the Economy		2	2	2							
Justice		1	1							1	
Health-Care Body											
Diagnostic Services of Manitoba		4	4						4		
CancerCare Manitoba	2		2	1			1				
Medical Clinic		5	5			1	2			2	
Designated Health-Care Facility		4	4	4							
Grace Hospital		1	1	1							
Health Sciences Centre	3		3				3				
Prairie Mountain Regional Health	1	2	3	2						1	
Northern Regional Health Authority	1		1	1							
Winnipeg Regional Health Authority		5	5	4						1	
Local Government Body											
City of Winnipeg	1		1				1				
Educational Body											
Brandon School Division	1		1				1				
Pembina Trails School Division	1		1				1				
Winnipeg School Division	1		1	1							
Universite de Saint-Boniface	1		1	1							
Crown Corporation and Government Agency											
CFS Agency		1	1	1							
Manitoba Public Insurance	1	1	2	1				1			
WCB Appeal Commission		1	1	1							
Workers Compensation Board		2	2						2		
Health-Care Practitioner											
Physician		3	3				2	1			
Physiotherapist	1		1				1				
TOTAL											
	19	**38**	**57**	**30**		**1**	**13**	**2**	**6**	**5**	

PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER)

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

PIDA Investigation Team

In 2015, we were able to more effectively address outstanding and new PIDA cases due to the expansion of the PIDA investigation team, now comprised of a team manager and three investigators.

2015 Investigations and Reports

In 2015, three PIDA investigations were initiated into allegations of wrongdoing. Additionally, three PIDA reports were completed and several others were in the process of being finalized by the end of the year. Of the three reports completed, one related to alleged gross mismanagement of public funds in a provincial government department, one related to alleged gross mismanagement of public funds in a university program, and the last related to alleged serious dangers to health and life at a personal care home. None of the investigations resulted in findings of wrongdoing.

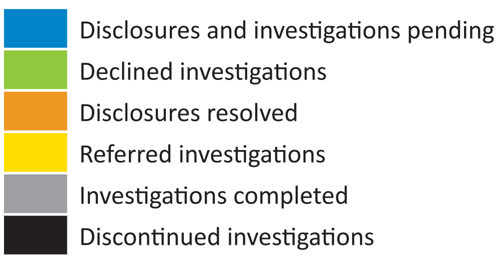
These reports are each examples that the threshold to arrive at a wrongdoing is fairly high. For a wrongdoing to be found, we must have determined that the act, decision or omission at hand was both a serious and significant matter.

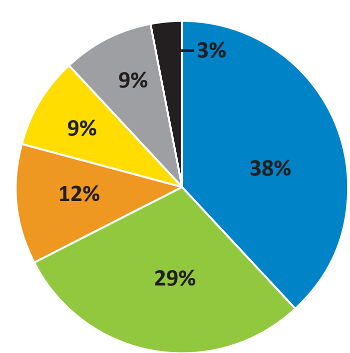
In one report related to a personal care home, we did make some recommendations for administrative improvement and improved care. Subsection 24(1) of PIDA allows the ombudsman to make recommendations related to the disclosure. This allows the ombudsman to make recommendations that are not specifically related to correcting wrongdoings, but that will create other improvements within public bodies, supported by our findings.

PIDA Amendments

Our experience with investigations under PIDA since 2007 led us to identify areas in the legislation that we believed could be improved. We discussed many of our proposed improvements in our 2013 and 2014 annual reports. In 2015, amendments to PIDA were introduced. If passed, the amendments, particularly with respect to enhanced powers for designated officers and our ability to investigate reprisal complaints, will strengthen PIDA and increase the confidence of whistleblowers in the complaint process.

CASE STATUS AT END OF 2015





PIDA INQUIRIES AND INVESTIGATIONS

	Case Numbers			Case Status							Recommendations	
	Assistance provided	Cases carried over into 2015	New disclosures received in 2015	Total disclosures and investigations pending at 12/31/2015	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		4	2	1	3			1		1		
Health-care facility		2	-	2								
Personal care home		2	2	2	1					1	1	
Regional health authority		1	1	1				1				
Child and Family Services agency/authority		3	2	2	2		1					
Corrections facility			2	1	1							
University/college		2	2	-		1		2		1		
Crown corporation			4	2	2							
Other government body or publicly-funded organization		2	2	2			2					
Non-jurisdictional public body			1	-	1							
TOTAL	22	**16**	**18**	**13**	10	1	3	4	0	3	1	0

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.

Cases carried over into 2015: Disclosures that were pending resolution at the beginning of 2015.

New disclosures received in 2015: Written disclosures received this year.

Total disclosures and investigations pending at 12/31/2015: Assessment of disclosures and investigations still in progress as of December 31, 2015.

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

Discontinued investigation: Investigation of disclosure ceased by the ombudsman.

Referred investigation: Disclosures referred to another public body to be reviewed 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.

OMBUDSMAN

In 2015, Manitoba Ombudsman completed a number of investigations under *The Ombudsman Act*, several of which involved municipal governments. Administrative matters were also reviewed with respect to provincial government departments, planning districts and commissions. The office continued its work in monitoring and reporting on the status of inquest recommendations made by provincial court judges under *The Fatality Inquiries Act*. The office also tracked the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate.

Manitoba Ombudsman Investigation into Flood-Fighting Equipment for the Interlake Emergency Operations Centre

In the summer of 2015, the ombudsman initiated a review of a proposed provincial government purchase of flood-fighting equipment for First Nation communities in the Interlake.

The ombudsman found that Manitoba Infrastructure and Transportation (MIT) did not conduct sufficient research and analysis to support the type of flood-fighting equipment to be purchased. The ombudsman also determined that MIT lacked sufficient justification in its initial attempt for an untendered purchase of the equipment.

Eventually MIT went to tender for the contract and issued a request for proposals. Overall the investigation found that legislation and policy related to tendering were followed.

The ombudsman made seven recommendations to the province for administrative improvements related to following existing procurement policy, reinforcing the expectation to consult the Procurement Services Branch when tendering, and better communication with provincial staff regarding key principles of financial accountability. The province agreed with all seven recommendations.

The ombudsman's report on this matter was released in early 2016.

Municipal Investigations

In some instances our investigations resulted in administrative suggestions and/or recommendations designed to improve accountability and transparency, particularly regarding municipal governments. The challenges faced by municipal government are diverse. Local governments are responsible for providing a range of services such as waste management, maintenance of roads, economic development and recreation. Nevertheless, it is important that council conducts its business in a fair manner and adheres to applicable legislation, policy and procedures.

Through the course of our investigative work in 2015, we documented a number of reoccurring themes.

Conflict of Interest

It is important that council business is conducted in an open and transparent manner and that council members act in the best interests of the citizens they represent. When that is not the case, or if there is a perception of bias, the credibility of council as a whole is diminished.

In one instance, a councillor was involved in making decisions on the construction of a new fire hall, even though he was employed by a company involved in doing some of the work.

Sometimes a conflict of interest may not be so readily apparent. For example, our office investigated a conflict of interest allegation where a councillor supported a petition for a low pressure sewage system that was brought forward by his brother, a local contractor. Although the councillor would not financially benefit from the project, there was the possibility that his brother might if it went ahead. Such circumstances could create a perception that the councillor's support of the project was due to his brother's involvement and not based on the merits of the project.

In both instances, we noted that councillors should have recused themselves from all discussions and votes related to the projects.

Value for Money

Procedural fairness is an important part of an open, fair and competitive bidding process. A consistent and fair tendering process encourages the broadest possible pool of qualified bidders and helps to ensure the best value for tax dollars. As such, each bid should be evaluated on pre-set known criteria that are part of the tender documents.

In one of our investigations, we discovered that suppliers who bid on a multi-million dollar capital project did not follow the format set out in the tendering package.

In another matter, an RM tender for engineering services did not meet the minimum number of four invitations for the tender opportunity as required by the RM's policy.

In both instances we recommended further training for RM council members and administrative staff with respect to procurement and tendering.

Process

Manitoba Ombudsman supports good governance and proper public administration. The understanding and application of procedure allows for the orderly conduct of public business. It also ensures that the principles of accountability and transparency are present in the carrying out of council business.

In one of our investigations, there was confusion among councillors as to the outcome of a council vote concerning the approval of a borrowing by-law for a local improvement costing $1.14 million. A written motion would have eliminated the confusion but one was never put forward.

Proper recording of minutes is also important in so much as it provides the public with a written record of what transpired at council/committee meetings. Reviewing the minutes can give the public a sense of the nature of the debate and how council members voted on issues. Taking it a step further, our office routinely suggests that adopting the practice of audio and/or video recording council meetings would provide a comprehensive record to support the factors and information council considers in reaching its decisions.

Reasons for Decisions

Reasons for decisions can demonstrate that decision makers considered and understood the information presented to them, and that they considered relevant criteria.

In one of our investigations, a landowner believed a decision to reject his variance application appeared to be based on personal assumptions and information that was inaccurate. Upon investigating, we determined that the decision by the RM was in fact reasonable and just. In our view, the best way to demonstrate that a council has made a fair decision that is consistent with applicable criteria and statutory requirements is for the council to issue clear written reasons for its decision, which did not occur in this case.

OMBUDSMAN ACT INVESTIGATIONS

	Case Numbers			Case Dispositions							
	Carried over into 2015	New cases in 2015	Total cases in 2015	Pending at 12/31/2015	Case resolved early	Declined or discontinued	Not supported	Partly resolved	Resolved	Recommendation(s) made	Other
Departments											
Agriculture, Food & Rural Development	2		2	2							
Conservation & Water Stewardship	4	1	5	4	1						
Family Services	1		1							1	
Finance	6	1	7	5	1					1	
Health, Healthy Living & Seniors	4		4	2					1	1	
Housing & Community Development	1	1	2	2							
Infrastructure & Transportation	4	1	5	5							
Jobs & the Economy	1	1	2								2
Justice	12	5	17	8	4	1			4		
Municipal Government	13		13	13							
Tourism, Culture, Sport & Consumer Protection		2	2		1				1		
Corporate & Extra Departmental											
Manitoba Hydro	1		1	1							
Manitoba Public Insurance	3	3	6	2	1	1	1		1		
WCB Appeal Commission	2	2	4	1	2		1				
Municipalities											
City of Winnipeg	7	7	14	8	2	1	1	1	1		
Other cities, RMs, towns, villages	36	19	55	24	10	1	3	4	2	11	
Local planning districts	4	2	6	5			1				
TOTAL											
	101	**45**	**146**	**82**	**22**	**4**	**7**	**5**	**10**	**14**	**2**

Pending: Complaint still under investigation as of December 31, 2015.

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

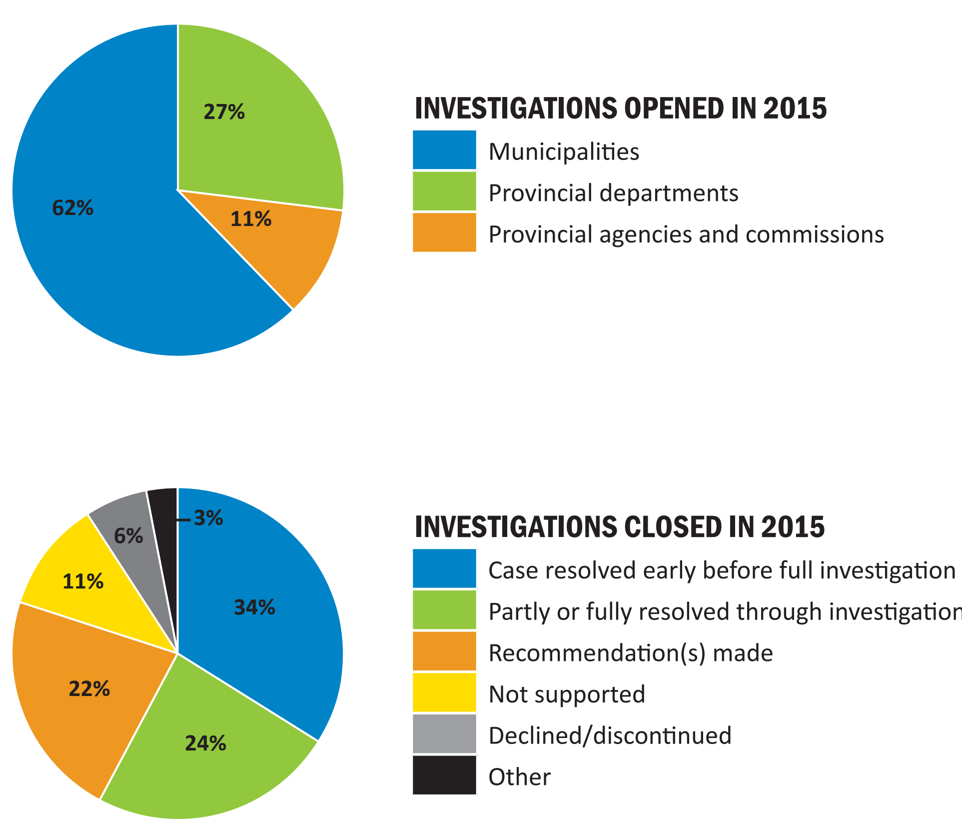
Declined or discontinued: Investigation ceased as complaint was withdrawn or complaint does not meet the requirements of *The Ombudsman Act*.

Not Supported: Complaint not supported at all.

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

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

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



Inquest Reporting

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

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

In 2015, 10 files were opened relating to seven inquests (one file may be related to multiple departments). Since 2008, we have publicly reported on 43 inquests.

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

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

The OCA is responsible for conducting a Special Investigation Review (SIR) of services that were delivered in the life of a child or youth if that young person or the family received child welfare services in the year before the death of the child.

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

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

Since the OCA received its mandate to perform special investigation reviews on September 15, 2008, to the end of our reporting period December 31, 2015, the OCA has made 496 recommendations. To date 387 recommendations have been implemented (78 per cent). We have observed that many of the recommendations which remain to be implemented relate to challenges that are long standing and systemic in nature or that require collaboration between departments involved in working with youth and their families.

Through our mandate to monitor and report annually on the implementation of the OCA'S recommendations, our office initially completes a thorough look at the SIR, the circumstances reported surrounding the child death, and the community context in which the child and family resided throughout the child's life. We then review documentation provided by an authority, CFS agency or provincial department and complete an evidence-based analysis regarding the implementation of the recommendation. We may request additional information to determine if a recommendation has been fully implemented. Ongoing consultation with the CFS authorities, various departments and publicly funded social services is required to support this process and to engage in further implementation planning.

Our office may also consult with the OCA concerning the implementation process or completeness of responses to recommendations. There is value to the system and to the children and youth in the province of Manitoba to share our communications with the child welfare system and external departments with the OCA on the actions being taken to implement recommendations. Over the last year we have observed a recurring theme emerging specifically in relation to the ongoing challenge of accessibility of mental health and counselling services for youth. The OCA has made a number of recommendations for improvement in these areas that involve various departments.

Our office will continue to monitor the implementation of these recommendations that are important for Manitoba's children and youth.

The following Table 1 illustrates the number of special investigation reports received by the office from the OCA by fiscal year from September 15, 2008 to December 31, 2015. 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 29 of this report.

Aggregate Investigations

In 2011 – 2012, the OCA began grouping some special investigation reviews together thematically into one special investigation report (SIR). Called an aggregate report, this type of SIR groups together a number of child death investigations according to service delivery from particular agencies, or examinations of certain issues linking multiple agencies. Some of the systemic themes explored involve staff training, 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.

Table 1: Special Investigation Reports Received by the Ombudsman from the OCA by Fiscal Year – September 15, 2008 to December 31, 2015				
Fiscal Year	Child Deaths Investigated	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008 - 2009	7	7	7	40
2009 - 2010	21	21	19	141
2010 - 2011	27	26	16	63
2011 - 2012	154*	147	15	44
2012 - 2013	89	76	22	72
2013 - 2014	82	69	24	60
2014 - 2015	55	53	12	49
2015 - Dec 31, 2015	29	29	9	27
Total	**464***	**428***	**124**	**496**

Table 2: Special Investigation Reports Received by the Ombudsman from the OCA by Calendar Year – September 15, 2008 to December 31, 2015				
Calendar Year	Child Deaths Investigated	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008	3	3	3	17
2009	19	19	17	83
2010	23	22	18	135
2011	148*	141	17	43
2012	78	65	20	69
2013	68	68	15	43
2014	72	59	21	63
2015	53	51	13	43
Total	**464****	**428****	**124**	**496****

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

** Note: The OCA may complete a report at the request of Manitoba Family Services regarding a young person receiving child welfare support beyond the age of 18 at the time of death. Although recommendations may be made, cases involving youth over the age of 18 remain outside of the ombudsman's child death review mandate and therefore are not tracked by our office.

Status Definitions

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

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

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

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

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

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

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

Table 3: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity

Glossary of Acronyms

CFS – Child and Family Services

CFS Act – *Child and Family Services Act*

CPB – Child Protection Branch/ Division

FS – Department of Family Services

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

January 1, 2009 to December 31, 2009

	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NOT ACCEPTED	REJECTED	NO STATUS REPORTED TO THE OMBUDSMAN
Child Protection Branch	14	13	1	0	0	0	0
CFS Standing Committee	0	0	0	0	0	0	0
CPB & CFS Standing Committee	1	1	0	0	0	0	0
Family Services*	1	1	0	0	0	0	0
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	3	3	0	0	0	0	0
Southern Authority	39	34	5	0	0	0	0
Northern Authority	19	18	1	0	0	0	0
General Authority	6	6	0	0	0	0	0
Metis Authority	0	0	0	0	0	0	0
External organizations (other departments, private service providers)	0	0	0	0	0	0	0
TOTAL NUMBER	**83**	**76**	**7**	**0**	**0**	**0**	**0**
TOTAL PERCENTAGE		**92%**	**8%**	**0%**	**0%**	**0%**	**0%**

STATUS OF RECOMMENDATIONS

In progress or pending 8%

Complete 92%

January 1, 2010 to December 31, 2010

	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NOT ACCEPTED	REJECTED	NO STATUS REPORTED TO THE OMBUDSMAN
Child Protection Branch	14	11	0	0	3	0	0
CFS Standing Committee	0	0	0	0	0	0	0
CPB & CFS Standing Committee	0	0	0	0	0	0	0
Family Services*	11	11	0	0	0	0	0
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency)	5	4	0	0	1	0	0
Southern Authority	36	33	3	0	0	0	0
Northern Authority	41	36	5	0	0	0	0
General Authority	9	9	0	0	0	0	0
Metis Authority	0	0	0	0	0	0	0
External organizations (other departments, private service providers)	19	18	1	0	0	0	0
TOTAL NUMBER	**135**	**122**	**9**	**0**	**4**	**0**	**0**
TOTAL PERCENTAGE		**90%**	**7%**	**0%**	**3%**	**0%**	**0%**

In progress or pending 7%

Not accepted 3%

Complete 90%

January 1, 2011 to December 31, 2011

	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NOT ACCEPTED	REJECTED	NO STATUS REPORTED TO THE OMBUDSMAN
Child Protection Branch	11	11	0	0	0	0	0
CFS Standing Committee	0	0	0	0	0	0	0
CPB & CFS Standing Committee	0	0	0	0	0	0	0
Family Services*	4	4	0	0	0	0	0
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency)	2	2	0	0	0	0	0
Southern Authority	8	7	1	0	0	0	0
Northern Authority	14	12	2	0	0	0	0
General Authority	2	2	0	0	0	0	0
Metis Authority	1	1	0	0	0	0	0
External organizations (other departments, private service providers)	1	0	1	0	0	0	0
TOTAL NUMBER	**43**	**39**	**4**	**0**	**0**	**0**	**0**
TOTAL PERCENTAGE		**91%**	**9%**	**0%**	**0%**	**0%**	**0%**

In progress or pending 9%

Complete 91%

Table 3, continued

January 1, 2012 to December 31, 2012	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NOT ACCEPTED	REJECTED	NO STATUS REPORTED TO THE OMBUDSMAN
Child Protection Branch	4	3	1	0	0	0	0
CFS Standing Committee	0	0	0	0	0	0	0
CPB & CFS Standing Committee	0	0	0	0	0	0	0
Family Services*	2**	2	0	0	0	0	0
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	3**	2	1	0	0	0	0
Southern Authority	30**	24	6	0	0	0	0
Northern Authority	22	19	3	0	0	0	0
General Authority	4	4	0	0	0	0	0
Metis Authority	3	3	0	0	0	0	0
External organizations (other departments, private service providers)	1	1	0	0	0	0	0
TOTAL NUMBER	**69**	**58**	**11**	**0**	**0**	**0**	**0**
TOTAL PERCENTAGE		**84%**	**16%**	**0%**	**0%**	**0%**	**0%**

STATUS OF RECOMMENDATIONS

January 1, 2013 to December 31, 2013	NUMBER OF RECOMMENDATIONS	COMPLETE	IN PROGRESS	RESPONSE UNDER REVIEW	NOT ACCEPTED	REJECTED	NO STATUS
Child Protection Branch	3	3	0	0	0	0	0
CFS Standing Committee	0	0	0	0	0	0	0
CPB & CFS Standing Committee	0	0	0	0	0	0	0
Family Services*	1	1	0	0	0	0	0
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency)	4	2	2	0	0	0	0
Southern Authority	13	10	3	0	0	0	0
Northern Authority	14	9	5	0	0	0	0
General Authority	0	0	0	0	0	0	0
Metis Authority	4	3	1	0	0	0	0
External organizations (other departments, private service providers)	4	3	1	0	0	0	0
TOTAL NUMBER	**43**	**31**	**12**	**0**	**0**	**0**	**0**
TOTAL PERCENTAGE		**72%**	**28%**	**0%**	**0%**	**0%**	**0%**

January 1, 2014 to December 31, 2014	NUMBER OF RECOMMENDATIONS	COMPLETE	IN PROGRESS	RESPONSE UNDER REVIEW	NOT ACCEPTED	REJECTED	NO STATUS
Child Protection Branch	3	2	1	0	0	0	0
CFS Standing Committee	0	0	0	0	0	0	0
CPB & CFS Standing Committee	0	0	0	0	0	0	0
Family Services*	3	3	0	0	0	0	0
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency)	1	1	0	0	0	0	0
Southern Authority	15	3	6	0	0	0	6
Northern Authority	31	13	18	0	0	0	0
General Authority	2	2	0	0	0	0	0
Metis Authority	7	2	5	0	0	0	0
External organizations (other departments, private service providers)	1	1	0	0	0	0	0
TOTAL NUMBER	**63**	**27**	**30**	**0**	**0**	**0**	**6**
TOTAL PERCENTAGE		**43%**	**48%**	**0%**	**0%**	**0%**	**9%**

Table 3 on pages 30 to 32 encompasses the recommendations within the special investigation reports received by Manitoba Ombudsman from the Office of the Children's Advocate 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 the CFS Standing Committee (see Status Definitions for further information).

There were also 17 recommendations made in 2008, which have all been implemented.

Table Notes

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

**The 2012 annual report incorrectly attributed six 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.

Table 3, continued

January 1, 2015 to December 31, 2015								
	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NOT ACCEPTED	REJECTED	NO STATUS REPORTED TO THE OMBUDSMAN	STATUS OF RECOMMENDATIONS
Child Protection Branch	7	4	3	0	0	0	0	
CFS Standing Committee	0	0	0	0	0	0	0	
CPB & CFS Standing Committee	0	0	0	0	0	0	0	
Family Services*	3	1	2	0	0	0	0	
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	1	0	1	0	0	0	0	
Southern Authority	5	0	1	0	0	0	4	
Northern Authority	14	3	1	0	0	0	10	
General Authority	5	5	0	0	0	0	0	
Metis Authority	1	0	1	0	0	0	0	
External organizations (other departments, private service providers)	7	4	2	0	0	0	1	
TOTAL NUMBER	**43**	**17**	**11**	**0**	**0**	**0**	**15**	
TOTAL PERCENTAGE		**40%**	**25%**	**0%**	**0%**	**0%**	**35%**	

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

Table 4: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity September 15, 2008 to December 31, 2015

September 15, 2008 to December 31, 2015								
	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NOT ACCEPTED	REJECTED	NO STATUS REPORTED TO THE OMBUDSMAN	STATUS OF RECOMMENDATIONS
Child Protection Branch	57	48	6	0	3	0	0	
CFS Standing Committee	1	1	0	0	0	0	0	
CPB & CFS Standing Committee	4	4	0	0	0	0	0	
Family Services*	25	23	2	0	0	0	0	
Multiples -- FS, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	19	14	4	0	1	0	0	
Southern Authority	152	117	25	0	0	0	10	
Northern Authority	156	111	35	0	0	0	10	
General Authority	28	28	0	0	0	0	0	
Metis Authority	21	14	7	0	0	0	0	
External organizations (other departments, private service providers)	33	27	5	0	0	0	1	
TOTAL NUMBER	**496**	**387**	**84**	**0**	**4**	**0**	**21**	
TOTAL PERCENTAGE		**78%**	**17%**	**0%**	**1%**	**0%**	**4%**	

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