Manitoba Ombudsman

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March 31, 2011

The Honourable George Hickes
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,* 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 Act*, I am pleased to submit the Annual Report of the Ombudsman for the calendar year January 1, 2010 to December 31, 2010.

Yours truly,

Original signed by

Irene A. Hamilton
Manitoba Ombudsman

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MESSAGE FROM THE OMBUDSMAN

In April 2010, the Manitoba Ombudsman's office celebrated its 40th anniversary, an anniversary that followed the celebration in 2009 of the 200th anniversary of the parliamentary Ombudsman role. Anniversaries prompt us to celebrate and reflect on our roots and accomplishments, and our 40th anniversary was no exception. Our celebrations included an open house, a reception, a public presentation at the Winnipeg Public Library, and a retrospective look at our first 40 years in the 2010-1 issue of *OmbudsNews*, our quarterly newsletter. In the Ombudsman Division section of this annual report, we also share some tips and best practices for fair decision making gleaned from 40 years of investigating fairness issues.

For many years, the Ombudsman Division in my office has been conducting investigations into system-wide issues. In 2009 we reported that we concluded our investigation into the Employment and Income Assistance Program, and in 2010 we issued two reports on that investigation - one with our findings and recommendations, and another with the department's responses to the 68 recommendations that we made. I am pleased that the department agreed to implement the majority of my recommendations as I believe the changes will improve both fairness and administrative efficiency of the program, and assist in aligning the program with the province's overall goal of poverty reduction.

In 2010, we also conducted a systemic investigation into the Protection for Persons in Care Office of Manitoba Health that resulted in five recommendations. Manitoba Health accepted all recommendations.

I am pleased to report that in 2010, our Access and Privacy Division also began conducting systemic investigations and audits with the launch of our FIPPA (*The Freedom of Information and Protection of Privacy Act*) Access Practices Assessment project. The project involves an audit of a public body's FIPPA files where access has been denied, partly granted, or where the response has been that records do not exist. Audits will be carried out at different public bodies annually for the next several years. This year, five public bodies were audited: Manitoba Hydro; Manitoba Innovation, Energy and Mines; Manitoba Justice; the Workers Compensation Board (WCB) of Manitoba; and the University of Manitoba. The WCB merits special acknowledgement for its exemplary performance - it achieved 100% in each category that was assessed. For the other public bodies, the 2010 audit identified modest changes that could be made to strengthen the access practices process in the organizations audited, and also within other organizations interested in improving their FIPPA processes.

In 2010, the Access and Privacy Division also audited the performance of Manitoba Public Insurance (MPI) in meeting the time requirements to respond to applications for access under FIPPA. Two recommendations were made to MPI, and both were accepted. We will continue conducting timeliness audits on an occasional basis and release the results publicly.

In addition to the systemic investigation work conducted in both divisions of my office, the majority of our time and effort continues to be focused on individual complaint investigations. Collectively, office staff responded to 4127 inquiries and complaints in 2010. In this report we highlight a cross section of some of the interesting investigations in both divisions.

Manitoba's access and privacy landscape changed significantly in 2010 and these changes continued into 2011. Amendments to PHIA and FIPPA passed on October 9, 2008, were proclaimed on May 1, 2010 and January 1, 2011. As well, in late 2010, eChart Manitoba was launched as a major component of Manitoba's electronic health record system, enabling authorized health care providers to view select personal health information of Manitobans. New sites, health care providers and personal health information will continue to be added to eChart Manitoba. My office issued news releases and fact sheets to inform Manitobans of the rights available to them as part of these developments.

In 2010, we had an intern from the Civil Service Commission's Aboriginal Public Administration Program join our office. Our intern, a former teacher, was instrumental in revising and updating our curriculum guide for grades 6, 9 and 12. The guide introduces students to the Ombudsman's work in the context of active citizenship. *Joining the Herd II: A Collection of Learning Activities Designed to Support the Manitoba Social Studies Curriculum for Grades 6, 9 and 12* was published in early 2011. A French version, *À vos marques, prêts... participez!* was also published.

Achieving either compliance with access and privacy legislation or administrative improvement requires that a public body demonstrate cooperation and a willingness to address concerns. Maintaining positive working relationships also helps us to conduct our investigations, audits and reviews as thoroughly and expeditiously as possible. I would like to thank staff of municipal and provincial governments, along with staff of other public sector bodies and trustees, for their continued assistance and cooperation.

I would like to extend my thanks to the Legislative Assembly's human resources, finance, and information technology staff who provide my office ongoing support. Throughout 2010, Ombudsman staff in our Winnipeg and Brandon offices again demonstrated commitment to the work that we do, and I thank them for that.

ABOUT THE OFFICE OF THE OMBUDSMAN

The Ombudsman is an independent officer of the Legislative Assembly and is not part of any government department, board or agency. The Ombudsman has the power to conduct investigations 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*.

The office has a combined intake services team and two operational divisions – the Ombudsman Division and the Access and Privacy Division.

The Intake Services Team

Intake Services responds to inquiries from the public and provides information about making 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*. Intake Services analyzes each complaint to determine jurisdiction and provides information about referral and appeal options. Information is provided about how to address concerns informally and how to submit a complaint to the Ombudsman. Individuals may contact Intake Services for additional assistance if matters cannot be resolved or if additional information is needed.

The number of issues resolved at the intake stage continued to increase in 2010. Intake staff are often able to contact a department or agency to clarify or expand upon the reasons for its action or decision, and then convey that information to a complainant. Intake staff can clarify the authority for an action or decision, based upon their experience and knowledge of statutes, regulations and government policies. In other instances, intake staff can review information a complainant has already received to ensure that he or she understands it. Information provided by Intake Services about problem solving can be a valuable tool to assist individuals in resolving issues on their own. The ability to resolve concerns informally and quickly reduces the need for formal investigation.

When a complaint cannot be resolved, Intake Services is responsible for gathering and analyzing information in preparation for the complaint investigation process. This can involve gathering documents, researching applicable policies and preparing background reports on the history of a complaint or issue.

The Access and Privacy Division

The Freedom of Information and Protection of Privacy Act and *The Personal Health Information Act*

Under the provisions of *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (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 sector bodies or trustees, or a privacy concern about the way their personal information has been handled. Access and privacy legislation also gives the Ombudsman the power to initiate her own investigation where there are reasonable grounds to do so.

The Ombudsman has additional duties and powers with respect to access and privacy legislation 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 legislative schemes or programs affecting access and privacy rights; and
- commenting on the implications of record linkage or the use of information technology in the collection, storage, use or transfer of personal and personal health information.

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 Ombudsman has jurisdiction over public bodies, which include:

- provincial government departments, offices of the ministers of government, the Executive Council Office, 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; and,
- health care bodies such as hospitals and regional health authorities.

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. The Ombudsman has jurisdiction over trustees, which include:

- public bodies (as set out above);
- 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; and
- health services agencies that provide health care under an agreement with a trustee.

Under FIPPA or PHIA, a person can complain to the Ombudsman about various matters, including 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.

After completing an investigation, if the Ombudsman finds that the action or decision complained about is contrary to FIPPA or PHIA, she can make recommendations to the public body or trustee to address the complaint-related issues. For complaints received by the Ombudsman as of January 1, 2011 if, after completing a FIPPA or PHIA complaint investigation the Ombudsman makes a recommendation and the public body or trustee does not act on it, the Ombudsman may refer the matter to the Information and Privacy Adjudicator for review. The Adjudicator has the power to make various orders. An order made by the Adjudicator can be reviewed by the Court of Queen's Bench.

An individual can still appeal a public body's decision concerning a refusal of access to Court, but only if the person has made a complaint to the Ombudsman, the Ombudsman has provided a report about the complaint, and the Ombudsman has not asked the Adjudicator to review the complaint. The Adjudicator process does not apply to FIPPA or PHIA complaints under investigation by the Ombudsman at the time these changes came into effect (since before January 1, 2011).

If the Ombudsman believes an offence has been committed under the acts, she may disclose information to the Minister of Justice, who is responsible for determining if any charges will be pursued through prosecution in court.

Access and privacy matters can be complicated. Manitoba Culture, Heritage and Tourism provides information on FIPPA, including instructions on how to apply for access to information, how to request a correction to personal information, and how to complain to our office and appeal to court at www.gov.mb.ca/chc/fippa/index.html.

Manitoba Health provides information on PHIA, including an informative Question and Answer section that addresses most of the issues a person might raise when first inquiring about their rights under PHIA at www.gov.mb.ca/health/phia.

Information about the Ombudsman's office and various resources can be found on our website at www.ombudsman.mb.ca. A copy of the acts mentioned above can be found on the statutory publications website at www.gov.mb.ca/chc/statpub/.

The Ombudsman Division

The Ombudsman Act

Under the provisions of *The Ombudsman Act,* the Ombudsman investigates complaints from people who feel that they have been treated unfairly by government. "Government" includes provincial government departments, crown corporations, and other government entities such as regional health authorities, planning districts and conservation districts. It also includes all municipalities. The Ombudsman cannot investigate decisions made by the Legislative Assembly, Executive Council (Cabinet), the Courts or decisions reflected in municipal policy by-laws.

The Ombudsman may investigate any matter of administration. While *The Ombudsman Act* does not say what a matter of administration means, the Supreme Court of Canada has defined it as *...everything done by governmental authorities in the implementation of government policy.*

Most of the public's everyday interactions with government will be with its administrative departments and agencies, rather than with the legislative or judicial branches. Experience tells us that it is in the administration of government programs and benefits, through the application of laws, policies, and rules, where the public encounters most problems or faces decisions they feel are unfair or unreasonable. These are the "matters of administration" about which a person who feels aggrieved can complain to the Ombudsman.

In addition to investigating complaints from the public, the Ombudsman can initiate her own investigations. She can investigate system-wide issues to identify underlying problems that need to be corrected by government, with the hope of eliminating or reducing any gap between government policy and the administrative actions and decisions intended to implement those policies.

The Ombudsman Act imposes restrictions on accepting complaints when there is an existing right of review or appeal, unless the Ombudsman concludes that it would be unreasonable to expect the complainant to pursue such an appeal. This can occur in situations when the appeal is not available in an appropriate time frame or when the cost of an appeal would outweigh any possible benefit.

The Ombudsman may decline to investigate complaints that the complainant has known about

for more than one year, complaints that are frivolous or vexatious or not made in good faith, and complaints that are not in the public interest or do not require investigation.

The Ombudsman's investigative powers include the authority to require people to provide information or documents upon request, to require people to give evidence under oath and to enter into any premises, with notice, for the purpose of conducting an investigation. Provincial laws governing privacy and the release of information do not apply to Ombudsman investigations. It is against the law to interfere with an Ombudsman investigation.

The Ombudsman has a wide range of options available in making recommendations that the government may use to correct a problem. After completing an investigation, the Ombudsman can find that the action or decision complained about is contrary to law, unreasonable, unjust, oppressive, discriminatory or wrong. She can find that something has been done for an improper reason or is based on irrelevant considerations. If she makes such a finding, she can recommend that a decision be reconsidered, cancelled or varied, that a practice be changed or reviewed, that reasons for a decision be given or that an error or omission be corrected.

Because the Ombudsman is an independent officer of the Legislative Assembly and accountable to the Assembly, her investigations are neutral. Broad and substantial powers of investigation ensure that her investigations are thorough.

After conducting a thorough and impartial investigation, the Ombudsman is responsible for reporting her findings to both the government and the complainant. Elected officials are responsible for accepting or rejecting those findings and are accountable to the public.

The Public Interest Disclosure (Whistleblower Protection) Act

The Public Interest Disclosure (Whistleblower Protection) Act (PIDA) was proclaimed as law in Manitoba on April 2, 2007. The purpose of PIDA is to give government employees and others a clear process for disclosing significant and serious wrongdoing in the Manitoba public service and to provide protection from reprisal.

PIDA applies to provincial government departments, Crown corporations, regional health authorities, child and family services agencies and authorities, universities, personal care homes, and the independent offices of the Legislative Assembly. It also applies to designated bodies, where at least 50% of the funding of the organization is provided by the government. This includes child-care centres, agencies that provide support services to adults and children, social housing services, family violence crisis shelters and licensed or approved residential-care facilities.

PIDA identifies the Ombudsman as one of the parties to whom a disclosure may be made, and sets out other specific duties in responding to disclosures, investigating allegations of wrongdoing, and reporting on activities arising from PIDA.

PIDA defines wrongdoing as:

- an act or omission that is an offence under an Act or regulation (breaking the law);
- an act or omission that creates a substantial and specific danger to the life, health or safety of persons or the environment (not including dangers that are normally part of an employee's job);
- gross mismanagement, including mismanaging public funds or a public asset (government property); and
- knowingly directing or advising someone to commit any wrongdoing described above.

The Ombudsman is responsible for responding to requests for advice, responding to and investigating disclosures of wrongdoing, and reporting annually to the Legislative Assembly.

Disclosures of alleged wrongdoing are made to our office in confidence. This means that we will, to the extent possible, protect the identity of an individual who in good faith makes a disclosure of wrongdoing. A person who makes a disclosure is acting in good faith if the person honestly believes that the allegation made constitutes wrongdoing and if a reasonable person placed in the same circumstances would have arrived at the same belief based on the facts reported.

Responding to disclosures requires staff to conduct several interviews with the whistleblower and thoroughly review the allegations in relation to the definition of "wrongdoing." This must be done before the Ombudsman can decide that, on the face of it, the disclosure meets the test for investigation under PIDA. Given the serious nature of an allegation of wrongdoing, and because personal and professional reputations could be at stake, it is of utmost importance that our office handle these investigations sensitively, thoroughly, and as quickly as possible.

Budget and Staffing for 2010/11

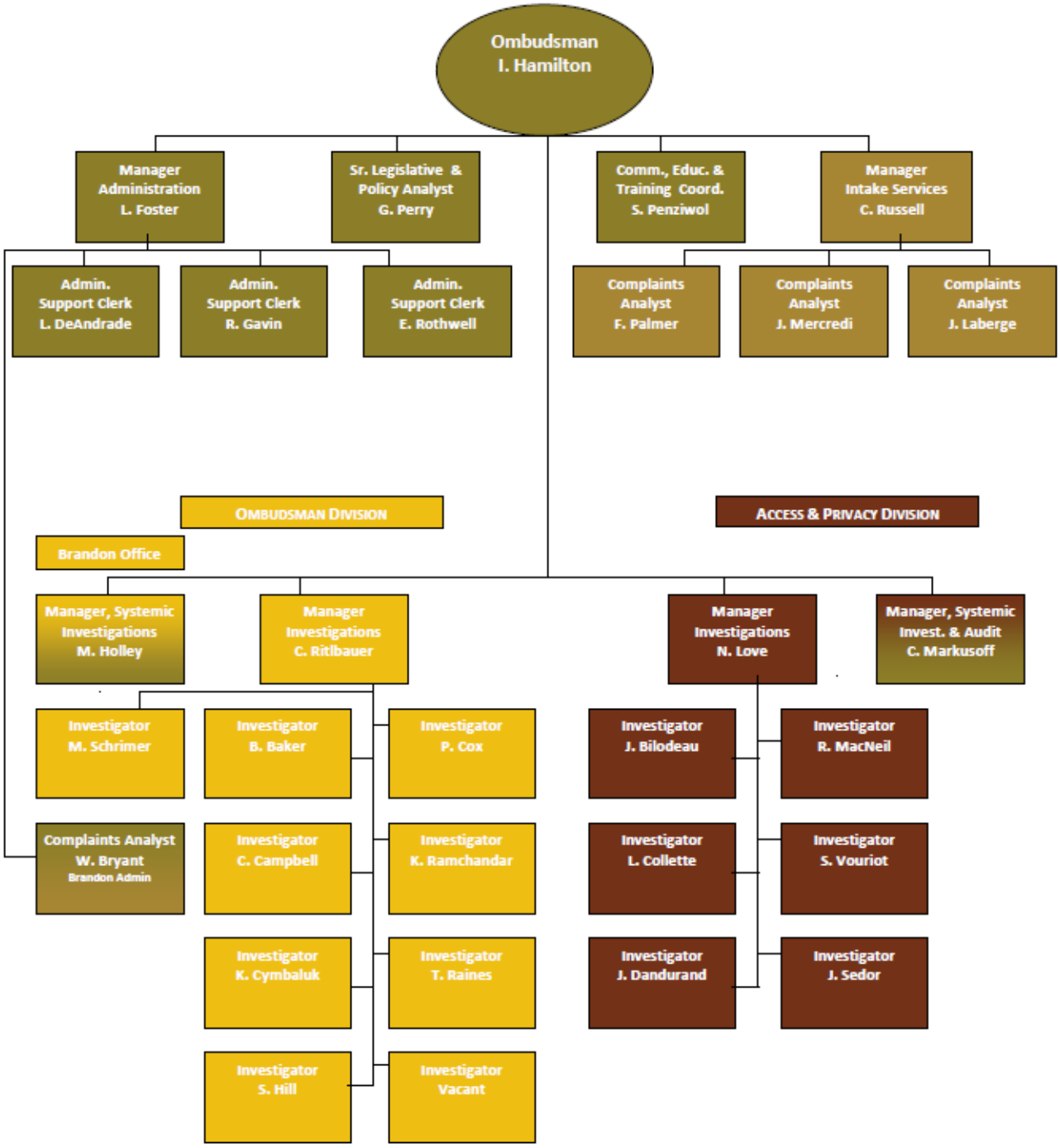
Budget

Total salaries and employee benefits for 31 positions		$2,523,000
Positions allocated by division are:		
Ombudsman Division	12	
Access and Privacy Division	8	
General	11	
Other expenditure		$ 498,000
Total Budget		**$3,021,000**

Staffing

The following chart details the organization of positions and staff in the office.

Organizational Chart



2010 Statistical Overview

In 2010, our office responded to inquiries and opened cases for investigation as follows:

General inquires responded to by administration staff (caller was assisted, without need for referral to Intake Services)	1517
Inquiries responded to by Intake Services (information supplied or assistance provided)	1602
Concerns resolved by Intake Services under *The Freedom of Information and Protection of Privacy Act*, *The Ombudsman Act*, *The Personal Health Information Act*, and *The Public Interest Disclosure (Whistleblower Protection) Act*	485
Cases opened for investigation under *The Ombudsman Act*	136
Cases opened for investigation under *The Public Interest Disclosure (Whistleblower Protection) Act*	8
Cases received in response to recommendations made by the Children's Advocate under *The Child and Family Services Act*	23
Cases opened for investigation under Part 5 of *The Freedom of Information and Protection of Privacy Act* (FIPPA)	306
Cases opened for investigation under Part 5 of *The Personal Health Information Act* (PHIA)	20
Cases opened under Part 4 of FIPPA and PHIA	30
Total Contacts	**4127**

EDUCATION AND OUTREACH

Government and public awareness of the Ombudsman's Office and its role and responsibilities is essential and achieved through presentations, attendance at events, the publication of reports and other resources, and the office's website.

Presentations and Events

In 2010, 62 presentations were delivered by the Ombudsman and office staff to various audiences including:

Provincial Government:
Civil Legal Services
Protection for Persons in Care Office
Manitoba Justice, Correctional Officers (12 training sessions)
Brown Bag Talks to Access and Privacy Coordinators and Officers (9 sessions)

Legislative Assembly:
Office of the Auditor General
Teachers Institute on Parliamentary Democracy

Local Public Bodies:
Annual Regional Conference for ANA Mayors and Councils
Manitoba Municipal Administrators' Association
Introduction to FIPPA for Local Public Bodies (3 sessions delivered in partnership with the Information and Privacy Policy Secretariat)

Youth and Educators:
University of Winnipeg, Masters of Public Administration Public Sector Ethics class
University of Winnipeg, Poverty and the Law class
University of Manitoba, Public Sector Management class
Agassiz Youth Centre (8 presentations)
Manitoba Youth Centre (10 presentations)
Carman Elementary School (2 presentations)

General Public:
Fairness, Government and You (Winnipeg Public Library)
Right to Know national online chat

Organizations, Committees, and Conferences:
Community Legal Education Association
Elizabeth Fry Society

Manitoba Council on Poverty Reduction
Manitoba Parole Citizens Advisory Committee, Correctional Service of Canada
Canadian Mental Health Association Stakeholders Consultation
Saskatchewan Access, Privacy, Security & Records Management Conference panel

Trustees under PHIA:
College of Physiotherapists of Manitoba

The office participated in various events including Law Day, Right to Know Week, the Manitoba Social Sciences Teachers' Association Conference, and the Association of Manitoba Municipalities' Annual Convention. The office also hosted a 40th anniversary reception at the Manitoba Council of Administrative Tribunals Conference, and a 40th anniversary open house in our office at 750-500 Portage Avenue, Winnipeg.

Office staff also attended various community events and organizations, including the Manitoba Youth Centre Pow Wow, the Brandon Friendship Centre, the Sisters in Spirit Walk in Brandon, and various open houses, including those at the First Nations of Southern Manitoba Child and Family Services Authority, Assembly of Manitoba Chiefs, Metis Child and Family Services Authority, First Nations of Northern Manitoba Child and Family Services Authority, and Onashowewin. Office staff also attended the Manitoba Aboriginal Youth Achievement Awards.

Publications

General:

- OmbudsNews (quarterly newsletter)
- "Ombudsman Oversight: Promoting Accountability, Best Practices, and Statutory Compliance", in *Municipal Leader*, Summer 2010, p. 25
- Joining the Herd II: A Collection of Learning Activities Designed to Support the Manitoba Social Studies Curriculum for Grades 6, 9 and 12

Access & Privacy Division:

- 2010 Timeliness Audit of Manitoba Public Insurance
- 2010 Access Practices Assessment of The Workers Compensation Board; Manitoba Justice; The University of Manitoba; Manitoba Hydro; and Manitoba Innovation, Energy and Mines
- 10 Changes to FIPPA (fact sheet)
- 10 Points to Know about eChart Manitoba, Part of Manitoba's Electronic Health Record (EHR) System (fact sheet)
- 10 Points about Controlling and Seeing your Personal Health Information (fact sheet)
- The Manitoba Enhanced Driver's Licence (EDL) and Enhanced Identification Card (EIC): 10 Points for Privacy Awareness (revised fact sheet)

- Practice Notes:

  New
  - Overview of FIPPA Amendments
  - Disclosure Under FIPPA
  - Disclosure Under PHIA
  - Overview of PHIA amendments (new; subsequently revised)
  - The Interaction between FIPPA and other Acts (new; subsequently revised)

  Revised
  - Use Under FIPPA
  - Use Under PHIA
  - Collection and Providing Notice of Collection of Personal Health Information Under PHIA
  - Documenting Access Decisions Under FIPPA and PHIA
  - The Duty to Assist Under FIPPA and PHIA
  - Distinguishing between Personal Information and Business Information under FIPPA
  - Providing Notice to a Third Party under Section 33 of FIPPA
  - Dealing with Access Requests Involving Employee Information
  - Considerations for Applying Exceptions when Refusing Access under FIPPA
  - The Exercise of Discretion when Applying Discretionary Exceptions to Refuse Access under FIPPA
  - Severing Information in Records under FIPPA and PHIA
  - Collection and Providing Notice of Collection of Personal Information under FIPPA
  - Responding to Recommendations Made by the Ombudsman under FIPPA
  - Considerations for Applying Exceptions when Refusing Access under PHIA
  - Responding to Recommendations Made by the Ombudsman under PHIA

Ombudsman Division:

- Report on the Protection for Persons in Care Office
- Report on Manitoba's Employment and Income Assistance Program: Updated with Departmental Responses to Recommendations
- Report on Manitoba's Employment and Income Assistance Program
- Report Regarding the Progress on the Implementation of the Recommendations "Strengthen the Commitment", April 1, 2008 - March 31, 2009

Additionally, materials were produced in conjunction with other offices. A brochure titled *Health Information Access and Privacy: A Guide to The Personal Health Information Act* was published jointly with Manitoba Health. Two pamphlets in the Rights of Youth series were updated, *Criminal Justice* and *You and the School*, and a new pamphlet in the series, *Disability*, was developed. The Rights of Youth series is published jointly by our office, the Office of the Children's Advocate, and the Manitoba Human Rights Commission.

REPORT ON ACTIVITIES OF THE ACCESS AND PRIVACY DIVISION

OVERVIEW OF 2010

In 2010, our office opened 356 new cases under *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA). Combined with the existing 109 cases carried forward from 2009, the total workload of cases was 465, which was about the same volume as our total workload in 2009.

Of the cases opened in 2010, 326 were access and privacy complaints from the public under Part 5 of the Acts and 30 were cases initiated by our office under Part 4, to investigate, audit, monitor or comment on compliance with the Acts. Information about our case-related work under the Acts is contained in the *Cases of Interest* and the *Statistical Review of 2010* sections.

Of the 326 new complaints, the majority were about access matters under FIPPA (272) and most of these concerned refusals of access (119). A significant number of complaints were also made about failures to respond within the time limits under the Act (109). FIPPA and PHIA require public bodies and trustees to respond to a request for access within 30 days of receiving it. However, FIPPA permits a public body to extend the 30-day time limit for up to an additional 30 days in one of the four circumstances authorized under the Act, and it may extend for a longer period if the Ombudsman agrees. Extensions are not permitted under PHIA. Of the 109 new complaints alleging failures to respond, 73 complaints were supported because of non-compliance with the time limit. In many of these cases, efforts had not been made by the public body to communicate the delay to the applicants. In our view, the failure to communicate with applicants about delays in responding is contrary to the duty to assist an applicant under the Act.

We received 5 requests under FIPPA, from public bodies seeking an extension longer than 30 days for responding to access applications. Requests for longer extensions are dealt with under Part 4 of FIPPA. Our office has an established process to investigate whether an extension is permitted under FIPPA and whether in the circumstances, a longer extension is justified. Our Practice Note, *Making a Submission to the Ombudsman for an Extension Longer than 30 Days*, sets out the information that we require when a request is made.

Of the 5 requests made to our office in 2010, 3 were withdrawn by the public bodies and 2 cases were investigated and we agreed to the longer extension. Both cases involved situations where a 30-day extension had been taken on the basis that time was needed to consult with a third party or another public body before deciding whether or not to grant access to the requested records.

In one case the public body was consulting with a federal government department because it had been the source of the requested records. The consultations initiated by the public body

were not completed within the 30-day extended time period. Similarly, the other case involved records relating to three levels of government, including the public body which received the access request. Consultations involving the Government of Manitoba were completed within the 30 day extended time period, however additional time was required for consultations with the Government of Canada.

In both cases, the public bodies had taken 30-day extensions, after being unable to respond within 30 days of receiving the access applications, but were unable to complete the consultations within the total of 60 days. We considered that the access applicants had already waited 60 days for a response and the public bodies were seeking a longer extension of another 30 days, bringing the total waiting period to 90 days from making the applications. We also considered the efforts undertaken by the public bodies to complete the consultations in a timely manner and the potential outcome for the applicant if the access decisions were made without the completion of the consultations. FIPPA requires access to be refused if the records reveal information provided in confidence by another government, unless consent is provided. Based on our consideration of these factors, we agreed to the longer extensions.

During 2010, we received 56 complaints from individuals about breaches of their privacy. This is the highest number received per year to date. Most of these complaints related to disclosures of personal or personal health information.

Of the 30 cases opened in 2010 under Part 4 of FIPPA and PHIA, 12 concerned privacy breaches that were self-reported to our office by the public bodies and trustees. Of the 12 privacy breach incidents reported to our office, 4 incidents resulted from personal information left unattended in vehicles, from which the information was stolen. In 3 of those 4 incidents, the personal information had been stored on laptops, 2 of which were not encrypted, and in 1 incident, paper records in a briefcase were left in a vehicle.

In our 2009 Annual Report, we commented that personal and personal health information should not be left unattended in vehicles unless there is no other option. Both FIPPA and PHIA require that public bodies and trustees implement “reasonable” safeguards to protect personal and personal health information against risks such as theft, loss, and improper disclosure and destruction. In our view, exposing personal and personal health information to foreseeable risks by leaving it unattended in a vehicle is not compliant with the requirement to protect information through reasonable safeguards. Additionally, personal and personal health information stored on a laptop or any mobile storage device should be encrypted.

We have published Practice Notes on our website to assist public bodies and trustees to respond effectively to privacy breaches: *Key Steps in Responding to a Privacy Breach under The Freedom of Information and Protection of Privacy Act and The Personal Health Information Act* and *Reporting a Privacy Breach to Manitoba Ombudsman*. The latter contains a form that is used when public bodies and trustees self-report a breach to our office.

Although the Acts do not require privacy breaches to be reported to our office, we encourage public bodies and trustees to do so. In most instances, we are able to provide assistance in addressing the privacy issues arising from the breach. Whether a privacy breach is self-reported or is made public in the media, we may initiate an investigation under Part 4 of FIPPA or PHIA. Further to our review of steps taken to contain the breach and evaluate the risk and harm, steps to prevent a future breach are considered. This can involve ensuring that public bodies/trustees take steps to: make all employees aware of and follow existing policies intended to prevent a breach, or develop new policies and procedures, or provide staff training on privacy issues.

Our office made recommendations concerning 3 cases in 2010. Two cases related to privacy matters under FIPPA and one related to an access matter under FIPPA. We have included summaries about these cases in the *Cases of Interest* section.

In cases where a complaint about a refusal of access under FIPPA or PHIA has not resulted in all withheld information released, the complainant has a right of appeal to the Court of Queen's Bench. In 2010, 3 appeals were initiated and all were under FIPPA: Court File CI10-01-67093 concerning the Winnipeg Regional Health Authority; Court File CI10-01-64614 (involving multiple access requests) concerning the City of Winnipeg (Winnipeg Police Service); and Court File CI10-01-69768 concerning Manitoba Family Services and Consumer Affairs (Residential Tenancies).

An appeal that was initiated in 2009 under FIPPA concerning a refusal of access by the City of Winnipeg (Court File CI09-01-63160) was still pending at the end of 2010. Two other appeals that were initiated in 2008 concerning the City of Winnipeg (Court File CI08-01-58184) and one concerning Manitoba Labour and Immigration (Court File CI08-01-59380) were also still pending at the end of 2010.

In the spring of 2010, as part of the Division's systemic investigations and audits function, we launched our FIPPA Access Practices Assessment audit initiative. Later in the year, we launched our Timeliness Audit initiative. The audits were conducted pursuant to section 49 of FIPPA, which gives the Ombudsman the authority to monitor and ensure compliance with the Act and the regulations.

These types of audits are undertaken to assess the access practices of public bodies and where non-compliance or weaknesses are identified, recommendations are made. The audits are based on our view that good access practices are:

- efficient to satisfy the time requirements of FIPPA;
- thorough so that all provisions of FIPPA are fully considered in the course of the access decision deliberations; and,
- well-documented to account for decisions that are made under FIPPA.

The year 2010 ushered significant changes to Manitoba's access and privacy landscape and these changes continued into 2011. Amendments to PHIA and FIPPA passed on October 9, 2008, were proclaimed on May 1, 2010 and January 1, 2011. eChart Manitoba was launched on December 6, 2010, as a major component of Manitoba's electronic health record (EHR) system, enabling authorized health care providers to view select personal health information of Manitobans. New sites, health care providers and personal health information will continue to be added to eChart Manitoba.

FIPPA AND PHIA AMENDMENTS

Recent amendments to FIPPA and PHIA include permitted disclosures by public bodies and trustees without consent to particular interest groups in specific contexts. Our office featured these situations in news releases and fact sheets because this sharing might not be anticipated by the public and because of the "opt outs" available to individuals. Manitobans should be aware of their rights in these situations:

- *An educational institution that is a public body may share personal information from alumni records as is reasonably necessary for fundraising to a person or persons with whom it has entered a fundraising agreement as set out in FIPPA.*
  Individuals are to be informed by the fundraiser that they can request that their personal information no longer be disclosed, have access to the personal information that has been disclosed in the fundraising and request that the person to whom the information was disclosed no longer use it (FIPPA).

- *A hospital and personal care home where an individual is an in-patient or resident may share the individual's name, location in the facility and general health care status to a representative of a religious organization.*
  Individuals are to be notified by the trustee that this information may be shared and they must be given the opportunity to object (PHIA).

- *A hospital and personal care home where an individual is or was an in-patient or resident may share the individual's name and mailing address with a charitable fundraising foundation affiliated with the trustee.*
  Individuals are to be notified by the trustee that this information may be shared and they must be given the opportunity to object (PHIA).

FIPPA amendments effective January 1, 2011 also created an Information and Privacy Adjudicator, an additional level of review and complaint resolution available to the Ombudsman in access and privacy matters. The Ombudsman may refer a matter to the Adjudicator for review if a public body or trustee does not act on a recommendation made by the Ombudsman. The Adjudicator has the power to make orders. PHIA was also amended effective January 1, 2011 to include the Adjudicator.

Our fact sheets, *10 Points about Controlling and Seeing Your Personal Health Information* and *10 Changes to FIPPA*, are available on our website at www.ombudsman.mb.ca.

Information about the PHIA amendments is also available on the Manitoba Health website at www.gov.mb.ca/health/phia/index.html.

Information about the FIPPA amendments is also available on the Manitoba Culture Heritage and Tourism website at www.gov.mb.ca/chc/fippa/amend.html.

CASES OF INTEREST

Included in this section are summaries of 3 cases where recommendations were made under FIPPA. Two cases were complaints made under Part 5 of the Act and one case was an investigation initiated by our office under Part 4 of FIPPA.

In circumstances where access and privacy complaints under Part 5 are not resolved informally at the conclusion of an investigation under FIPPA or PHIA, the Ombudsman may make any recommendations to the public body or trustee considered appropriate respecting the complaint. These recommendations are contained in a written report provided to the complainant and the public body or trustee concerned.

If a report concerning a complaint contains recommendations, FIPPA and PHIA set out certain requirements for the public body's or trustee's response to the Ombudsman. Under FIPPA, these requirements are that the head of the public body must, within 15 days (14 days for PHIA) after receiving the report, provide the Ombudsman a written response indicating that the head accepts the recommendations and provide a description of any action the head has taken or proposes to take to implement them; or the reasons why the head refuses to take action to implement the recommendations. Our office has prepared Practice Notes to assist public bodies and trustees in responding to recommendations.

FIPPA and PHIA have specific time frames for complying with the Ombudsman's recommendations when the head of the public body or trustee accepts the recommendations. The time limits under FIPPA require the head to comply with recommendations within 15 days of acceptance, if the complaint is about access, and within 45 days in any other circumstance, or within such additional time period as the Ombudsman considers reasonable. The time limit for complying with recommendations made under PHIA is within 15 days of acceptance of the recommendations or within such additional period as the Ombudsman considers reasonable.

The third case relates to an investigation initiated by the Ombudsman under Part 4 of FIPPA. Under both FIPPA and PHIA, the Ombudsman may initiate an investigation and make recommendations to ensure compliance with the Acts.

Manitoba Labour and Immigration (Manitoba Labour Board) – Disclosure via the Internet

Our office received a complaint concerning the Manitoba Labour Board's (the Board) publication of two Orders containing the complainant's personal information, including her name and other personal information, on the Board's website. The complainant expressed concern that a search of her name on the internet could result in her personal information being revealed to anyone in "the whole world" and could negatively affect her future job prospects. The complainant requested that the Board remove the Orders containing her personal information from its website but the Board refused.

The Board took the position that its disclosure of the complainant's personal information was authorized under clause 44(1)(a) of FIPPA as it was for the purpose for which the information was collected or compiled under section 45. The Board also took the position that disclosure was limited to the minimum amount of information necessary to accomplish the purpose for which it was disclosed in accordance with subsection 42(2) of FIPPA. The Board advised that it adheres to an "open court principle" in performing its quasi-judicial function and that parties bringing matters before it are, or should be, aware of the fact that they are embarking on a process that presumes a public airing of what may be a private dispute. The Board also advised that its practice of naming the parties appearing before it and publishing names online is consistent with that of other labour boards across the country.

We advised the Board that while it may be desirable to open its decision-making processes up to further public scrutiny, we are not able to conclude that the *open court principle*, in and of itself, requires the internet publication of the Board's decisions *in identifiable form* by naming individuals. In any event the open court principle should result in the Board being subjected to additional public scrutiny, not the individuals who come before it.

Based on our review of this matter, we could not conclude that the disclosure of the complainant's personal information on the Board's website was *consistent with the purpose for which it was collected* pursuant to clauses 45(a) and (b) of FIPPA. We were unable to find a reasonable and direct connection between publication of the Orders containing the complainant's personal information *in identifiable form* on the Board's website and the original purpose of collection. We were also unable to determine that publication of the Orders containing the complainant's personal information *in identifiable form* on the Board's website was necessary for the Board to carry out its duties or operate its program.

Based on our investigation and after considering the representations made by the Board, the Ombudsman found that the Board's disclosure of the complainant's personal information contained in Orders which the Board published on its website was not authorized under clauses 44(1)(a) and 45(a) and (b) of FIPPA.

The Ombudsman provided the Board and the complainant with a report of her investigation findings and made recommendations that the Board:

1. Remove the Orders that form the basis of this complaint from the Labour Board website on a priority basis until such time as the identity of the applicant and other individuals referenced in the Orders can be masked or obscured through the use of randomly assigned initials or some other means and re-posted in compliance with FIPPA.

2. Restrict the ability of global search engines to index or search past Labour Board decisions by name through the implementation and use of an appropriate web-robot-exclusion-protocol OR remove all past Labour Board decisions on the Labour Board website until such time as the identity of the individuals appearing before the Board (ex. applicants, respondents and/or witnesses) can be masked or obscured through the use of randomly assigned initials or some other means and re-posted in compliance with FIPPA.

3. Review its practice of disclosing in paper records the identity of individuals appearing before it and consider whether routinely masking or obscuring the identity of said individuals can be accommodated on a routine basis for paper as well as electronic records.

4. Develop comprehensive written policies and procedures with respect to the protection of privacy and the collection, correction, retention, use and disclosure of personal information by the Labour Board and make said policies available on the Labour Board website.

5. Ensure that all individuals appearing before the Labour Board are provided with clear and understandable notice about the manner in which their personal information and personal health information will be retained, used and disclosed by the Labour Board.

6. Provide ongoing FIPPA/PHIA awareness and education sessions for Labour Board members and staff to help ensure that they are fully aware of their responsibilities under FIPPA/PHIA.

7. Send the complainant a letter of apology concerning the unauthorized disclosure of her personal information in the Orders of the Labour Board.

The Board responded to the recommendations within 15 days after receiving them, however, the Ombudsman determined that further clarification was required with respect to several of the recommendations and a request for further clarification was made to the Board. The Board clarified its response in a timely manner.

The Board initially advised that it was prepared to accept recommendations 1, 2, 4, 5 and 6 but that it did not accept recommendations 3 and 7. The Board further advised that it required additional time to fully implement recommendations 1, 2, 4 and 5.

The Board did not accept recommendation 7 as the Board is of the view that its disclosure of the complainant's personal information was for a legitimate purpose in the context of reasonably fulfilling its legislative mandate and it is not prepared to apologize. The Board advised that once its new Policy on Privacy and notice are finalized, it is prepared to deliver copies to the complainant along with a letter acknowledging her efforts in bringing the issues to the Board's attention.

The Board did not accept recommendation 3 as the Board did not accept the Ombudsman's finding that its disclosure of the complainant's personal information was not authorized under FIPPA. The Board advised that it adheres to an "open court principle" and that it was not prepared to routinely mask or obscure the identity of individuals appearing before it when drafting its orders and/or decisions.

The Board subsequently advised that it had established new Privacy Guidelines with respect to the publication of Board Orders and Reasons for Decision. In this regard, the Board indicated that, effective March 31, 2011 on a go-forward basis, it would ensure that the identity of any applicant or other individuals referenced in its Orders or Reasons for Decision was masked or obscured prior to the Board publishing or otherwise distributing same.

The Board has also advised that this new practice would apply retroactively to all of the Board's decisions currently available on the Board's website. In this regard, the Board indicated that it could take a significant amount of time to revise all of the Orders and Reasons for Decision currently posted on its website. In the meantime, the Board advised that it has ceased to publish decisions to its website that include personal information and that it has undertaken to restrict decisions through the implementation of appropriate technology.

Finally, the Board advised that its written policy reflecting the above referenced changes will be posted on its website.

The Ombudsman will continue to monitor the implementation of the recommendations and the changes the Board has indicated it will make.

Pikwitonei Community Council – Failure to Respond

An applicant made an access application to Manitoba Aboriginal and Northern Affairs (ANA) in November 2009, seeking financial records involving the Pikwitonei Community Council (the Council). The ANA sent a notice to the applicant advising that it did not have the requested information and that the application was transferred to another public body, the Council, in December 2009. When an access application is transferred to another public body, the receiving public body has 30 days to respond to the application after receiving it.

We received a complaint about the Council's failure to respond to the application on May 31, 2010. When we notified the Council of this complaint, our office was verbally advised that it intended to respond. We requested that the Council provide our office with a copy of its response. When no response was forthcoming, our office followed up with the Council to ensure it was aware of the requirements for responding. We also ensured that the Council was aware of resources available to assist in responding, including our *Practice Notes* available on our website.

We determined that the Council had not demonstrated that it made reasonable efforts to respond or to explain the delay to the applicant. The Ombudsman found that the Council failed to fulfill its duty to assist the applicant under section 9 of FIPPA and did not comply with the time limit for responding to an applicant under section 11.

Efforts to resolve the complaint informally were not successful and the Ombudsman issued her report with recommendations to the Council on August 10, 2010. The Ombudsman recommended that the Council provide the applicant with a written response informing him of its access decision and provide a copy of this response to our office. The Ombudsman further recommended that if access was granted, that it provide copies of the records to the applicant with the response letter. However, if access was refused, the Ombudsman recommended that the Council provide a copy of the withheld records to our office clearly indicating the information being withheld and the specific provision(s) of FIPPA under which the information is being refused.

The report set out in detail the requirements under FIPPA for responding to the Ombudsman's recommendations. However, the Council did not respond in writing to the Ombudsman within the time limit under FIPPA nor did it comply with the recommendation to respond to the applicant.

Our office undertook further steps in an effort to ensure that the applicant received a response to his access application. The Council provided some information to the applicant on August 28, 2010, and further responded to the applicant on October 13, 2010.

Rural Municipality of La Broquerie – Surveillance Cameras

In the spring of 2010 news articles began to appear in the media, purporting that the Rural Municipality of La Broquerie (the RM) had installed covert surveillance cameras in its municipal office. In response to this, our office initiated an investigation under Part 4 of FIPPA about the use of surveillance cameras by the RM and any associated issues relating to collection, use, disclosure and protection of personal information.

Our investigation found that personal information was being collected by surveillance cameras which had been installed in 2008 and 2009. The RM cited clause 36(1)(c) of the Act as its

authority to collect personal information for the purposes of law enforcement or crime prevention.

In circumstances where it can be demonstrated that personal information was collected for law enforcement or crime prevention purposes, authority for the collection would exist under clause 36(1)(c) of FIPPA. To the extent that authority exists for the collection of personal information for law enforcement or crime prevention, authority for use/disclosure would be found, respectively, under clauses 43(a)(c) and 44(1)(a)(r) of the Act, as the purpose for use/disclosure would be consistent with the purpose of collection.

Although the RM provided information to our office about its considerations for installing surveillance cameras (there were concerns about unauthorized access to computer systems and to the municipal building, suspected thefts, altered work stations, and safety concerns at the front counter), it was our view that the need for surveillance was based on what appeared to be unsubstantiated concerns by the former CAO, some of which were not related to law enforcement or crime prevention.

Concerning the limit on the amount of personal information collected, we noted to the RM that subsection 36(2) of the Act states that a public body shall collect only as much personal information about an individual as is reasonably necessary to accomplish the purpose for which it is collected. Our view was that if collection was strictly for the purposes of law enforcement and crime prevention, then collection of personal information would only need to occur at those times when unlawful access to the building or thefts were expected to occur, and not whenever motion was detected by the surveillance system sensors, as was the case in this situation.

The RM advised that it relied on clause 37(1)(g) as its authority to indirectly collect the personal information via surveillance because the collection was for law enforcement purposes or crime prevention. We indicated to the RM that personal information collected for those purposes could be collected through surveillance in areas deemed reasonably and legitimately susceptible to crime and/or break-ins.

With respect to the protection of personal information, the Act places a duty on public bodies to protect personal information against such risks as unauthorized access, use and disclosure (section 41 of the Act). This means that public bodies need to employ physical, administrative and technical safeguards in order to meet their obligation to secure personal information at all times.

In lieu of broad surveillance, we suggested that the RM focus on alternative measures that are less privacy-intrusive yet still beneficial to enforcing law, preventing crime, and providing a safe and secure environment for employees. As a result of our investigation, the Ombudsman provided the RM with a list of suggested safeguards, as follows:

- Ensure that the security system is activated to alarm in the event of unauthorized access to the building.
- In the event that a security system to detect unauthorized access to the building is not sufficient, provide overt surveillance as required for legitimate law enforcement and crime prevention purposes. Ensure that only those views that require surveillance are captured. If possible, activate the surveillance system to record only at those times when there is likelihood of unauthorized access to the building (i.e., outside of normal business hours).
- Ensure that the reception area is staffed, whenever there is public access to the building.
- Lock filing cabinets or desk drawers containing personal information and establish a clean desk policy.
- Lock doors, vault area, vault, windows as appropriate.
- Ensure that only those that need access to the vault and office have access, i.e., only provide those individuals requiring access with the appropriate key(s)/codes and ensure that keys are locked up and codes are protected/secure.
- Use locking cables or devices to secure any laptops to workspaces.
- Ensure that there are appropriate firewalls/anti-virus programs on computers.
- Ensure that staff create passwords that are hard to guess; have staff change passwords frequently.
- Ensure that employees log off or lock their computers when they leave their workstations.
- Do not leave personal information on desks or otherwise unprotected when workstations are unattended.
- Locate computers, printers and fax machines in areas away from the general public.
- Create privacy and security policies to ensure adherence with the Act and ensure employees are familiar with these policies.
- Create a "safe" reception area, e.g., install a panic button, install a physical barrier, if needed.

The Ombudsman provided the RM with eight recommendations to ensure compliance with the Act. The recommendations included that the RM review the need for surveillance for purposes of law enforcement and crime prevention in terms of what is reasonable and legitimate and that the RM consider other less privacy-intrusive methods for ensuring the safety and protection of staff, personal information and other assets. The Ombudsman made further recommendations in the event that overt surveillance was reasonable and legitimate for law enforcement/crime prevention purposes within certain areas of the public body's office and that no other functional, alternative security measure that is less privacy-intrusive, could be implemented. These recommendations included collecting/using/disclosing only the personal information necessary for these purposes; providing notification of collection to ensure that the requirements under subsection 37(2) of the Act are met; and limiting retention of the records for a limited time period, for which they may be required as part of a criminal, safety, or security investigation or for evidentiary purposes.

In response to the recommendations, the RM advised the Ombudsman that it would cease its surveillance activities and would notify the Ombudsman if the surveillance camera system was reactivated.

SYSTEMIC INVESTIGATIONS AND AUDITS

The FIPPA Access Practices Assessment initiative consists of conducting audits of a public body's completed FIPPA files to examine key components in the processing of a FIPPA Application for Access. Each year, for the next several years, 5 different public bodies will be audited and if recommendations are made, the public body will be subject to a follow-up audit in the next year. In 2010 we audited the access practices of Workers Compensation Board, Manitoba Justice, the University of Manitoba, Manitoba Hydro, and Manitoba Innovation, Energy and Mines.

The timeliness audit assesses a public body's performance in meeting the mandatory time requirements under FIPPA to respond to applications for access. Under this initiative in 2010 we audited Manitoba Public Insurance.

FIPPA Access Practices Assessment

The purpose of the FIPPA Access Practices Assessment audits is to assess key components of the processing of an access application to ensure compliance and best practices starting from the point of receiving the application to the issuance of the response letter.

The key components examined in the audits are: (1) compliance with time requirements of the Act; (2) compliance with the requirements of a response to an applicant under section 12 of the Act; (3) adequacy of the contents of the FIPPA file; and, (4) adequacy of records preparation. These components are examined and assessed because they are pivotal to an efficient, thorough and accountable access decision.

In undertaking each audit, we examine the public body's due diligence in processing access applications through a review of the contents of the completed FIPPA files (files that are set up to process applications for access) from the previous year where decisions have been made to refuse access to records in full or in part, or where records do not exist or cannot be located.

Where weaknesses are found during the course of the audit, recommendations are made to improve the particular weakness that was identified. Section 12 compliance and compliance with time requirements are mandatory provisions under the Act, therefore recommendations are made if compliance is not 100%. Recommendations for the adequacy of records preparation and file documentation may be made if compliance is less than 90%.

Audits were conducted in June and July 2010. Individual audit reports were provided to each of the 5 public bodies. Recommendations were made to all of the public bodies except WCB, where no recommendations were needed. In January 2011 we released a public report on the findings of the 5 audits that were conducted in 2010. The full audit report is available at:

www.ombudsman.mb.ca/pdf/2011_01_FAPA_Public_Audit_Report.pdf

WCB merits special recognition for its exemplary performance of 100% in each component category that was assessed.

OVERALL PERFORMANCE AVERAGES OF EACH PUBLIC BODY

- Workers Compensation Board - 100%
- Justice - 72%
- University of Manitoba - 59%
- Hydro - 41%
- Innovation, Energy and Mines - 36 %

Average 62%

COMPONENT CATEGORY AVERAGES

- Compliance with section 12 - an average of 77% of all the files reviewed were compliant
- Compliance with time requirements - an average of 65% of all the files reviewed were compliant
- Adequacy of records preparation - an average of 62 % of all the files reviewed were adequate
- Adequacy of the contents of the FIPPA file - an average of 43% of all the files reviewed were adequate

Average 62%

RECOMMENDATIONS

All recommendations made to the public bodies were accepted.

To Manitoba Justice, it was recommended that:

- Justice keep a copy of the severed and unsevered records in the central FIPPA file;
- Justice comply with the required contents of a response letter under section 12 of FIPPA for each request;
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that Justice adopt the guideline, "The Standard Contents of a FIPPA File" as its standard for FIPPA file documentation; and

- Justice ensure that staff who are involved in the processing of a FIPPA request include the Coordinator in the email distribution so that all emails and attachments are printed and placed in the central FIPPA file.

To the University of Manitoba (U of M), it was recommended that:

- U of M ensure that all responses are compliant with section 12;
- U of M comply with the time requirements of the Act;
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that U of M adopt "The Guideline on Time Frames for Processing a FIPPA Request" to facilitate compliance with time requirements of the Act;
- U of M conduct a line-by-line review for each record that is reviewed in response to an Application of Access;
- when information is withheld, that the applicable exceptions are noted on the FIPPA file copy of the record beside the information that is being withheld; and
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that U of M adopt the guideline, "The Standard Contents of a FIPPA File" as its standard for FIPPA file documentation.

To Manitoba Hydro, it was recommended that:

- Hydro ensure that non-voluminous severed and unsevered records are kept in the FIPPA file;
- for each request, Hydro comply with the required contents of a response letter under section 12 of FIPPA;
- Hydro include in all of its response letters, the Hydro FIPPA file number and the wording of the applicant's request;
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that Hydro adopt the guideline, "The Standard Contents of a FIPPA File" as its standard for FIPPA file documentation;
- Hydro comply with the time requirements of the Act;
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that Hydro adopt "The Guideline on Time Frames for Processing a FIPPA Request" to facilitate compliance with time requirements of the Act; and
- Hydro advise the Ombudsman of actions that will be taken to ensure compliance with the time frames required by the Act.

To Manitoba Innovation, Energy and Mines (IEM), it was recommended that:

- IEM ensure that all responses are compliant with section 12;
- IEM comply with the time requirements of the Act;
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that IEM adopt "The Guideline on Time Frames for Processing a FIPPA Request" to facilitate compliance with time requirements of the Act;
- IEM advise the Ombudsman of actions that will be taken to ensure compliance with the time frames required by the Act;

- IEM conduct a line-by-line review of each record responsive to an Application for Access;
- IEM ensure that when a portion of information is withheld from a record, that the applicable exceptions are fully cited on the FIPPA file copy of the record beside the information that is being withheld; and
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that IEM adopt the guideline, "The Standard Contents of a FIPPA File" as its standard for FIPPA file documentation.

Timeliness Audit

In this audit we assessed the timeliness of MPI's responses to applicants in relation to the mandatory requirements of the Act through a review of the 65 FIPPA files that MPI completed in 2009. The audit report, *2010 Timeliness Audit of Manitoba Public Insurance: Audit Report under Section 49 of The Freedom of Information and Protection of Privacy Act*, was publicly released in March 2011 and is available on our website at:

www.ombudsman.mb.ca/pdf/MPI_Timeliness_Audit_2010.pdf.

Performance was assessed from different perspectives: the overall percentage of responses that were "on time"; timeliness of responses by type of applicant and by type of record requested; and, by the year in which the file was opened. We also compared our audit findings with the MPI statistics published in Table 6 - in the three "Response Time" columns, in Manitoba Culture, Heritage and Tourism's (CHT) *Freedom of Information and Protection of Privacy Act Annual Report 2009.* (CHT's annual report on FIPPA provides statistics and analysis on the FIPPA experience of public bodies that have reported statistical information to it. The statistics are submitted by the public body to CHT, usually quarterly, on a specific form.)

We found that MPI faced significant challenges surrounding 15 applications for access received in 2008 and this resulted in very late responses to the majority of these applications in 2009. Eleven of the responses to these applications were hundreds of days late. However, we also observed positive aspects with respect to MPI's processing of requests such as: acknowledgement letters are promptly sent out and there appears to constructive contact with applicants. There also seems to be a positive organization-wide commitment to fostering a culture of access and there is good cooperation across MPI departments in making FIPPA a priority.

Highlights of the audit findings included:

- 68% (44 responses) of responses were in compliance with time requirements;
- of the 32% (21 responses) of responses that were late, the average number of days late was 150;
- the average number of days late for the responses in files opened in 2008 and completed in 2009, was 237;

- the average number of days late for the responses in files opened and completed in 2009, was 9;
- late responses were somewhat concentrated in 13 files carried over from 2008 but there were 8 files that were opened in 2009 which were also late;
- 18% (12 responses) of responses took "more than 60 days" and the time taken was without the agreement of the Ombudsman;
- of the 10 time extensions taken, 1 was determined to be invalid because it was taken after the first 30 days from the day the application was received;
- of the 9 valid time extensions taken, 2 or 22% of the responses met the extended due date/were on time;
- although only 2 or 22% of the time extensions taken were met, the reasons for taking the extensions for all of the time extensions taken appeared to be allowed under subsection 15(1) of FIPPA and the content of the extension letters was in compliance with subsection 15(2).
- it could not be concluded that there were any serious patterns of delay in relation to type of applicant.

RECOMMENDATIONS

Both recommendations made to MPI were accepted. It was recommended that:

- MPI comply with the time requirements of the Act; and
- effective upon notifying the Ombudsman of the acceptance of this recommendation, that MPI adopt the "Guideline on Time Frames for Processing a FIPPA Request" to facilitate compliance with time requirements of the Act.

COMMENTS

The Ombudsman has powers and duties under FIPPA and PHIA additional to investigating complaints and auditing. They include:

- commenting on the implications for access to information or for the protection of privacy of proposed legislative schemes or programs or practices of public bodies and trustees
- commenting on the implications for the protection of privacy of using or disclosing personal or personal health information for record linkage or using information technology in the collection, storage, use or transfer of that information
- informing the public about FIPPA and PHIA

Again this year, upon the request of public bodies and trustees, our office provided Ombudsman comments containing analysis, advice and suggestions to help influence FIPPA and PHIA considerations and assist in mitigating complaints.

eChart Manitoba Touches All Manitobans

Manitoba eHealth, a program of the Winnipeg Regional Health Authority, has been developing Manitoba's electronic health record (EHR) system on behalf of the Manitoba Government since 2007. This includes development of a system capable of drawing together select elements of an individual's personal health information from various electronic sources to provide an authorized health care provider (user) with an up-to-date record of the individual's key health history.

The project came to be known as "eChart Manitoba" in the fall of 2010. The first phase of eChart was launched in the week of December 6, 2010 at three Manitoba facilities. Despite the limited number of sites involved, eChart immediately became relevant to all Manitobans because elements of everyone's personal health information were now available to the system.

Manitobans should know that:

- The following personal health information about all Manitobans is on eChart:

    1) demographic information - name; date of birth; gender; age; home address; home and work telephone number; Personal Health Identification Number (PHIN); family registration number; and medical record numbers
    2) all prescriptions dispensed through retail pharmacies in Manitoba, including historical data since April 2010
    3) all immunization information, including historical data on child immunization since 1980 and on adult immunization since 2000
    4) laboratory test information from one laboratory as of the week of December 6, 2010

- The system does not have the technical ability to limit an authorized eChart user to viewing only his or her patient's/client's personal health information. Technical controls provide some limits to the extent of information available to different job roles (for example, physicians can see all information on the system, while registration clerks can see all demographic information on the system). Legislative, contractual and policy requirements set out what an authorized user should view.

Manitobans should know they have some control over their personal health information on eChart Manitoba and can self-audit activities relating to their information:

- Although an individual cannot opt out of having personal health information on eChart, an individual may have his or her personal health information on eChart masked, with the exception of demographic information. An individual can file a "disclosure directive"

which will hide their personal health information from the view of all eChart users. In special circumstance, a health care provider can "override" the disclosure directive and see the information for a limited time to provide specific care (for example, with the individual's consent or if the individual is unable to communicate in an emergency).

- Because every use of eChart Manitoba is being recorded, a record of user activity can be produced on request. An individual can file a form requesting a record of user activity to see who has viewed his or her information on eChart and when.

- An individual can file a form requesting access to his or her own personal health information on eChart.

These measures are available to all individuals, even if they are not a patient at one of the locations currently using eChart Manitoba.

Manitoba eHealth has posted information about eChart, including the forms for individuals to request a disclosure directive, record of user activity and access to their own information on eChart. These are available by phoning 1-855-203-4528 or at www.connectedcare.ca/echartmanitoba/index.html.

A fact sheet, *10 Points to Know about eChart Manitoba,* is available on our website at www.ombudsman.mb.ca.

STATISTICAL REVIEW OF THE ACCESS AND PRIVACY DIVISION

Overview of Access Complaints Opened in 2010

In 2010, 270 new complaints about access matters were opened under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. The following chart provides a breakdown of the access complaints.

Type of Access Complaint	Total	FIPPA	PHIA
No Response	109	104	5
Extension	2	2	NA*
Fees	32	31	1
Refused Access	119	116	3
Other	8	8	-
Total	**270**	**261**	**9**

*NA: Not Applicable as extensions cannot be taken under PHIA

Overview of Access Complaints Closed in 2010

During 2010, 250 complaints under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* about access matters were closed. The following chart provides a breakdown of the dispositions of these access complaints.

Type of Access Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or whole	Not Supported	Resolved
Refused Access	88	2	90	13	16	53	8
No Response	105	1	106	18	76	11	1
Fees	34	1	35	1	-	30	4
Extension	2	NA*	2	2	-	-	-
Other	17	-	17	3	1	11	2
Total	**246**	**4**	**250**	**37**	**93**	**105**	**15**

*NA: Not applicable as extensions cannot be taken under PHIA

Overview of Privacy Complaints Opened in 2010

In 2010, 56 new complaints about privacy matters were opened under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*. The following chart provides a breakdown of the privacy complaints.

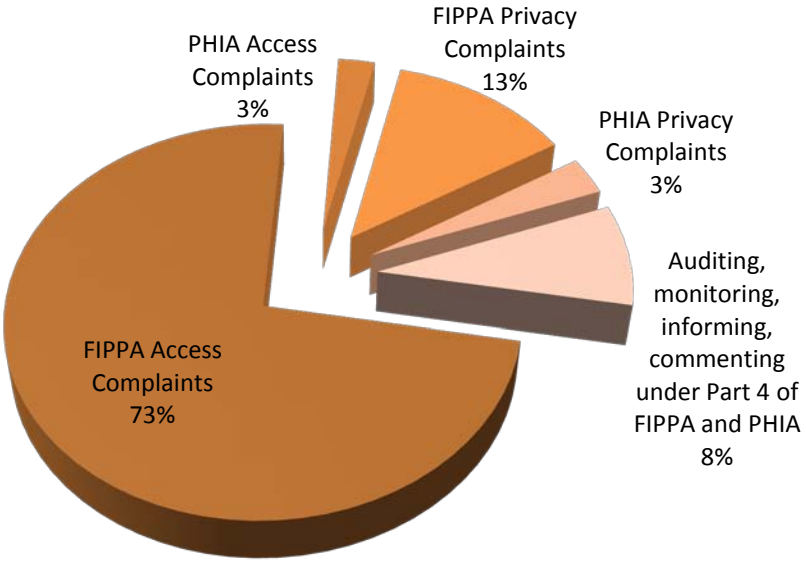
Type of Privacy Complaint	Total	FIPPA	PHIA
Collection	12	8	4
Use	16	13	3
Disclosure	26	24	2
Security	1	-	1
Other	1	-	1
Total	**56**	**45**	**11**

Overview of Privacy Complaints Closed in 2010

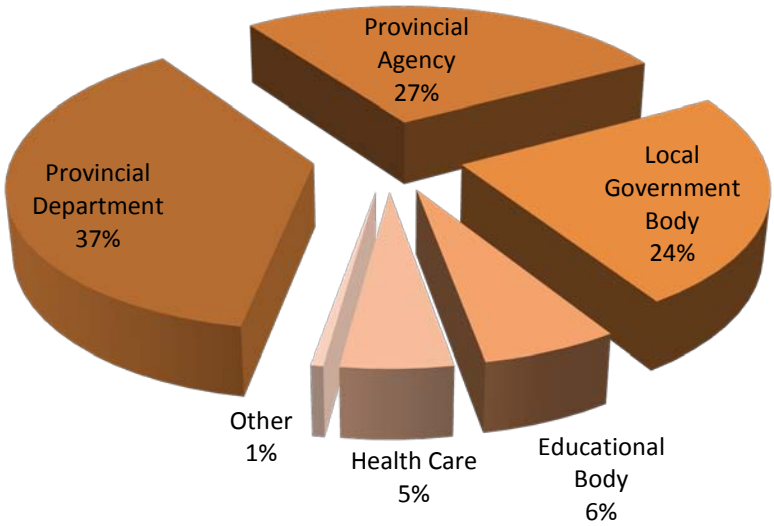
During 2010, 52 privacy complaints under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* were closed. The following chart provides a breakdown of the dispositions of these privacy complaints.

Type of Privacy Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or whole	Not Supported
Collection	8	3	11	2	4	5
Use	9	1	10	-	5	5
Disclosure	24	7	31	-	15	16
Total	**41**	**11**	**52**	**2**	**24**	**26**

Types of Cases Opened in 2010



Distribution of Cases Opened in 2010



Cases in 2010 by Act, Public Body/Trustee and Disposition

This chart shows the disposition of the 465 Access and Privacy cases investigated in 2010 under Part 4 and 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act.*

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2010	New cases in 2010	Total cases in 2010	Pending at 12/31/2010	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
PART 5 OF *THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT* (FIPPA)												
PUBLIC BODY												
Provincial Department												
Aboriginal & Northern Affairs	-	2	2	-	-	2	-	-	-	-	-	-
Advanced Education & Literacy	-	2	2	-	-	-	-	-	-	2	-	-
Agriculture, Food & Rural Initiatives	1	4	5	-	-	-	1	3	-	1	-	-
Civil Service Commission	-	3	3	1	-	1	1	-	-	-	-	-
*Competitiveness, Training & Trade	6	-	6	3	-	-	3	-	-	-	-	-
Conservation	4	26	30	-	-	1	28	-	-	1	-	-
Culture, Heritage & Tourism	1	-	1	-	-	-	1	-	-	-	-	-
Executive Council	2	1	3	-	-	2	1	-	-	-	-	-
Entrepreneurship, Training &Trade	-	3	3	2	-	-	1	-	-	-	-	-
**Family Services & Consumer Affairs	6	27	33	6	-	4	4	-	18	1	-	-
Finance	2	16	18	10	-	4	2	1	-	1	-	-
*Health & Healthy Living	3	-	3	2	-	-	1	-	-	-	-	-
Healthy Living, Youth and Seniors	-	1	1	-	-	1	-	-	-	-	-	-
**Housing & Community Development	-	10	10	-	-	-	-	1	9	-	-	-
Infrastructure & Transportation	1	2	3	1	-	-	2	-	-	-	-	-
*Intergovernmental Affairs & Trade	1	-	1	-	-	-	1	-	-	-	-	-
Justice	4	17	21	14	-	1	2	1	2	1	-	-
Labour & Immigration	4	3	7	2	-	-	4	-	-	-	1	-
*Science, Technology, Energy & Mines	2	-	2	-	-	-	1	1	-	-	-	-
Water Stewardship	7	-	7	-	-	-	2	5	-	-	-	-
Minister responsible for Hydro	-	1	1	-	-	-	-	-	1	-	-	-
Crown Corporation and Government Agency												
Manitoba Lotteries Corporation	-	4	4	1	-	-	2	-	1	-	-	-
Manitoba Housing Authority	-	5	5	-	-	-	3	-	1	1	-	-
Manitoba Human Rights Commission	-	7	7	2	-	1	4	-	-	-	-	-
Manitoba Hydro	12	52	64	11	3	1	10	-	39	-	-	-
Manitoba Public Insurance	1	9	10	3	3	-	2	1	1	-	-	-
Winnipeg Child & Family Services	-	4	4	-	-	-	4	-	-	-	-	-
Workers Compensation Board	1	3	4	1	1	-	1	-	-	1	-	-

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2010	New cases in 2010	Total cases in 2010	Pending at 12/31/2010	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
LOCAL PUBLIC BODY												
Local Government Body												
Pikwitonei Community Council	-	1	1	-	-	-	-	-	-	-	1	-
City of Winnipeg	10	45	55	24	-	3	22	3	2	1	-	-
Town of Churchill	-	1	1	-	-	-	-	-	1	-	-	-
Town of Powerview/Pine Falls	1	-	1	-	-	-	-	-	-	1	-	-
Town of Leaf Rapids	-	2	2	2	-	-	-	-	-	-	-	-
Town of Ste. Anne	-	16	16	4	2	3	4	-	3	-	-	-
R.M. of Armstrong	-	1	1	-	-	-	1	-	-	-	-	-
R.M. of Brokenhead	3	1	4	-	-	-	4	-	-	-	-	-
R.M. of Gimli	-	1	1	-	-	-	-	-	-	1	-	-
R.M. of Grahamdale	-	2	2	-	-	-	2	-	-	-	-	-
R.M. of Lac du Bonnet	1	2	3	-	-	1	1	1	-	-	-	-
R.M. of La Broquerie	-	2	2	2	-	-	-	-	-	-	-	-
R.M. of Piney	-	1	1	1	-	-	-	-	-	-	-	-
R.M. of Rockwood	-	1	1	-	-	-	1	-	-	-	-	-
R.M. of Whitemouth	-	2	2	-	-	-	-	-	-	2	-	-
Educational Body												
Division scolaire franco-manitoban	-	1	1	1	-	-	-	-	-	-	-	-
Flin Flon School Division	1	-	1	-	-	1	-	-	-	-	-	-
Lakeshore School Division	-	2	2	2	-	-	-	-	-	-	-	-
Prairie Spirit School Division	-	5	5	-	-	-	-	-	5	-	-	-
River East Transcona School Division	-	1	1	-	-	1	-	-	-	-	-	-
St. James-Assiniboia School Division	2	2	4	-	-	-	2	2	-	-	-	-
Winnipeg School Division	-	1	1	-	-	-	-	-	1	-	-	-
University of Manitoba	6	7	13	9	-	-	2	2	-	-	-	-
University of Winnipeg	3	1	4	1	-	-	-	2	1	-	-	-
Health Care Body												
Burntwood Regional Health Authority	1	2	3	-	3	-	-	-	-	-	-	-
Winnipeg Regional Health Authority	1	4	5	1	-	-	3	1	-	-	-	-
Sub-total	**87**	**306**	**393**	**106**	**12**	**27**	**123**	**24**	**85**	**14**	**2**	**-**
Part 5 of *The Personal Health Information Act* (PHIA)												
Provincial Department												
*Family Services & Housing	1	-	1	1	-	-	-	-	-	-	-	-
Conservation	-	1	1	1	-	-	-	-	-	-	-	-
Health	-	3	3	3	-	-	-	-	-	-	-	-
LOCAL PUBLIC BODY												
Local Government Body												
City of Winnipeg	-	1	1	1	-	-	-	-	-	-	-	-
Educational Body												
University of Manitoba	-	1	1	-	-	-	-	-	1	-	-	-

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2010	New cases in 2010	Total cases in 2010	Pending at 12/31/2010	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
Health Care Body												
CancerCare Manitoba	2	1	3	1	-	-	2	-	-	-	-	-
Medical Clinic	-	3	3	-	-	1	1	-	-	1	-	-
Laboratory	-	3	3	3	-	-	-	-	-	-	-	-
St. Boniface Hospital	1	-	1	-	-	-	-	-	1	-	-	-
North Eastman Health Association Inc.	-	1	1	-	-	-	-	-	1	-	-	-
Parkland Regional Health Authority	-	1	1	-	-	-	1	-	-	-	-	-
Crown Corporation and Government Agency												
Manitoba Human Rights Commission	-	1	1	-	-	-	1	-	-	-	-	-
Manitoba Hydro	-	1	1	-	1	-	-	-	-	-	-	-
Manitoba Public Insurance	-	1	1	1	-	-	-	-	-	-	-	-
Winnipeg Child & Family Services	-	1	1	-	-	-	1	-	-	-	-	-
Workers Compensation Board	-	1	1	-	-	-	1	-	-	-	-	-
Health Professional												
Physician	2	-	2	-	-	-	-	-	2	-	-	-
Sub-total	**6**	**20**	**26**	**11**	**1**	**1**	**7**	**-**	**5**	**1**	**-**	**-**
Part 4 under FIPPA and PHIA												
PUBLIC BODY												
Provincial Department												
Advanced Education & Literacy	-	1	1	-	-	-	-	-	-	-	-	1
Conservation	-	1	1	-	-	1	-	-	-	-	-	-
*Family Services & Consumer Affairs	-	5	5	1	-	-	-	-	-	-	-	4
Health	1	-	1	-	-	-	-	-	-	-	-	1
Justice	-	3	3	3	-	-	-	-	-	-	-	-
Labour	1	1	2	-	-	-	-	-	-	-	-	2
Crown Corporation and Government Agency												
Manitoba Hydro	1	2	3	-	-	2	-	-	-	-	-	1
Manitoba Public Insurance	4	5	9	5	-	-	-	-	-	-	-	4
LOCAL PUBLIC BODY												
Local Government Body												
City of Winnipeg	3	5	8	2	-	-	-	-	-	-	-	6
R.M. of La Broquerie	-	1	1	-	-	-	-	-	-	-	1	-
Educational Body												
Flin Flon School Division	1	-	1	-	-	-	-	-	-	-	-	1
University of Manitoba	-	1	1	1	-	-	-	-	-	-	-	-
Health Care Body												
Regional Health Authority Interlake	-	1	1	1	-	-	-	-	-	-	-	-

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2010	New cases in 2010	Total cases in 2010	Pending at 12/31/2010	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
South Eastman Regional Health Authority	1	-	1	-	-	-	-	-	-	-	-	1
Winnipeg Regional Health Authority	1	1	2	-	-	-	-	-	-	-	-	2
Health Professional												
Physiotherapist	-	1	1	-	-	-	-	-	-	-	-	1
Physician	1	-	1	1	-	-	-	-	-	-	-	-
Other												
Other	2	2	4	2	-	-	-	-	-	-	-	2
Sub-total	**16**	**30**	**46**	**16**	**-**	**3**	**-**	**-**	**-**	**-**	**1**	**26**
Total	**109**	**356**	**465**	133	13	31	130	24	90	15	3	26

* Names of departments have changed.
**New department names

Summary

Of the 332 cases closed in 2010:

34% were supported in whole or part (the Ombudsman made recommendations in 1% of these cases);
39% were not supported;
5% were resolved before a finding was reached;
8% were completed under Part 4 of FIPPA or PHIA;
13% were discontinued either by the Ombudsman or the complainant, or declined.

Definitions

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: Upon making enquiries, complaint not accepted for investigation by Ombudsman, usually for reason of non-jurisdiction or premature complaint.

Completed: Cases conducted under Part 4 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* where the task of auditing, monitoring, informing, or commenting has been concluded.

Pending: Complaint still under investigation as of January 1, 2011.

REPORT ON ACTIVITIES OF THE OMBUDSMAN DIVISION

OVERVIEW OF 2010

The Ombudsman strives to ensure that the public receives fair and equitable treatment from provincial and municipal governments and, when appropriate, facilitates administrative improvement.

Forty years of working for administrative fairness under *The Ombudsman Act* has given the office considerable insight into best practices when it comes to fair decision making. Anniversaries provide an opportune time to celebrate accomplishments and to reflect on learning. So what have we learned in 40 years?

Being an independent, impartial, non-partisan body that often gets involved in an issue when it is brought to our office allows us to ask questions that can bring clarity to all the parties directly involved (complainant and department or agency of government). We have found that a common sense approach to dealing with people and issues goes a long way in making a decision fair. Yet on occasion, we have observed that decisions and actions are not fair, despite everyone's good intentions.

Fairness can mean different things to different people. To assist in achieving a common understanding of what fairness means in a provincial and municipal government context, we use a tool called the "fairness triangle". From the Ombudsman's perspective, there are three separate but inter-related sides to fairness - relational, procedural and substantive. We outline how to achieve these three aspects of fairness below:

Relational Fairness (how people are treated and how they feel about the process and outcome)

- ✓ Service is important. Treat everyone with respect. Relational fairness will sometimes forgive other aspects of decisions that are unfavourable.
- ✓ An apology can be powerful.
- ✓ Listen to what people are saying and try to understand their issue. Do not make judgments strictly based on behaviour.
- ✓ If it appears something is unfair, speak up. There is a good chance others have had the same experience. If the matter is not raised, there is a good chance that nothing will change.
- ✓ Explain to people what can and cannot be done, and do not promise something that cannot be delivered.
- ✓ Be truthful.

Procedural Fairness (the process by which a decision is made)

- ✓ Everyone has the right to be heard and present their case.
- ✓ Make sure people understand the process and what should happen.
- ✓ If a mistake is brought to your attention, correct it. We are all human and we all make mistakes.
- ✓ Follow the lines of authority and avenues of appeal. There are people everywhere that understand the system and want to see improvements to it.
- ✓ Follow the rules (law, policy, etc.). If it is wrong or outdated, change it.
- ✓ Be sure everyone understands the reasons for the decision that was made.
- ✓ Good administrators are open to and strive for administrative improvement.

Substantive Fairness (the decision must be fair and be seen to be fair)

- ✓ Be reasonable.
- ✓ Only make decisions you have the authority to make.
- ✓ Come to conclusions based on fact.
- ✓ Do not make a judgment until all the facts are available.
- ✓ Always keep an open mind and be open to new information.
- ✓ Do not discriminate against people.
- ✓ Sometimes when people fully understand a situation, it makes it easier to accept an answer they do not like, and this allows them to move on.

In 2010, we investigated several cases under *The Ombudsman Act* where we were able to facilitate administrative improvements that promoted fairness in government decision making, including the following:

- the agreement of an administrative board to re-hear a matter because, admittedly, the initial hearing process was procedurally flawed.
- amendments to information provided to clients to clarify processes and fees.
- amendments to municipal by-laws to better align enforcement responsibilities with *The Municipal Act*.
- amendments to policies to provide better guidance to staff and improve fairness to clients.
- the agreement to provide notice when decisions or actions affect individuals, for example, when fees are increased and when outstanding accounts are added to property tax rolls.

In addition to investigations under *The Ombudsman Act*, the Ombudsman Division conducts investigations into disclosures made under *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA). In our 2009 Annual Report, we highlighted our growing experience with investigations under PIDA, which came into force in 2007. We discussed the process our office follows after a disclosure has been received. In 2010, continued review of the factors to make a determination of whether a matter constitutes wrongdoing as defined in PIDA occurred.

CASES OF INTEREST

Individual Complaints

Responding to complaints from individuals aggrieved by a government action or decision is a key function of the Ombudsman Division. Often complaints are about an action or decision that an individual believes was unfair. Investigations into these complaints are carried out impartially without advocating for either the individual or government. Once a complaint is received, Ombudsman investigators work with both complainants and government to gain a thorough understanding of the issue before reaching any conclusions. In this report, we highlight 7 individual complaint investigations that occurred or concluded in 2010.

Anishinaabe Child and Family Services and First Nations of Southern Manitoba Child and Family Services Authority

The Child and Family Services Act (CFSA) provides foster parents with a process by which they can appeal decisions of agencies to remove children in their care. Subsections 51(3), (4) and (5) of the Act and *The Foster Parent Appeals Regulation* set out the appeal process.

In 2009, we received a complaint from foster parents who had followed the legislated appeal process. At the conclusion of the appeal process, an independent adjudicator determined that children who had been removed from the foster parents' home should be returned to the home. Anishinaabe Child and Family Services (ACFS) and the First Nations of Southern Manitoba Child and Family Services Authority (the Southern Authority) refused to comply with the adjudicator's decision.

There is no provision in the Act or regulation that would permit a party to the appeal process to overturn an independent adjudicator's decision on the basis of disagreement. Neither the Act nor the regulation provides for an appeal of the adjudicator's order. We raised concerns about this significant gap in the legislation that does not provide a remedy in those situations where there is disagreement with an adjudicator's order.

The Ombudsman recommended that the Minister of Family Services and Consumer Affairs order a review of the decision of ACFS and the Southern Authority in light of the adjudicator's report, to ensure Child and Family Services has carried out its responsibilities in accordance with the Act. Upon the completion of this review, the Ombudsman further recommended that the Minister make a determination of what would be in the best interests of the children in relation to their foster parent placement and take whatever action is deemed appropriate to address the situation.

In this case, the foster parents incurred the costs of pursuing the appeal process which appear to have been spent in futility as a result of ACFS failing to comply with the adjudicator's

decision. The Ombudsman recommended that financial compensation be provided for the legal costs incurred. At this time the matter remains unresolved.

From a broader perspective, the Ombudsman recommended that after an internal review of the adjudicative process and the implementation of any changes, the Minister of Family Services and Consumer Affairs issue a directive respecting the manner in which adjudicator decisions should be processed, and that the Minister's directive be disseminated to all agencies, authorities and the branch to ensure compliance.

Child Protection Branch, Family Services and Consumer Affairs

We investigated 2 complaints this year with respect to the Provincial Child Abuse Investigation Unit (PCAI) of the Child Protection Branch under Family Services and Consumer Affairs. The PCAI Unit is responsible for conducting investigations, as set out in section 18.6 of *The Child and Family Services Act,* where an agency receives information that a child was or might have been abused by a person who provides work or services to an agency or to a child care facility or other place where a child has been placed by an agency.

In the course of our investigations, we noted differing views of the criteria for referral to the PCAI Unit, and the range of the types of cases being investigated at the Branch level. We suggested that these components of the program be reviewed by the Child Protection Branch, in consultation with the four child welfare authorities and their agencies. We noted the need for and importance of a consistent understanding throughout the system of the types of cases referred to and investigated by the PCAI Unit, in accordance with the requirements of section 18.6 of *The Child and Family Services Act* and the child and family service standards regarding provincial child abuse investigations.

Legal Aid

An individual sought Legal Aid representation. As her income was above the income eligible for free legal services, an expanded eligibility contract was developed in which the individual agreed to pay for legal services provided at a reduced cost. During the period when representation was provided, the individual requested information regarding the balance she owed, but Legal Aid did not respond to the request. Furthermore, toward the end of the representation, a discretionary increase was applied to the case as the matter was deemed to be complex. The individual was unaware of the fee increase that applied to her case. Her final legal bill was significantly higher than expected.

During our investigation of the matter, Legal Aid advised our office that a new in-house tracking system will assist in providing more up-to-date billing information to clients; a system that was not yet in place when the individual was a client. Legal Aid made changes to the information sheet provided to expanded eligibility clients and advised staff lawyers to provide clients with current hours billed to the file upon the client's request. Legal Aid also agreed to

waive the discretionary increase in fees that had been applied to the individual's account without notice.

Manitoba Disaster Assistance Appeal Board

An individual raised a concern with a hearing conducted by the Manitoba Disaster Assistance Appeal Board. The individual was not provided with sufficient information about the hearing process or the Board's rules of procedure prior to the hearing. The Board confirmed that the individual did not receive all of the information due to an oversight. Failure to provide proper notice is a breach of procedural fairness, and as a result, the individual did not have a fair opportunity to prepare for the hearing. At the conclusion of our investigation, the Board agreed to grant a new hearing to the individual.

Manitoba Public Insurance

We received a complaint regarding Manitoba Public Insurance's (MPI) handling of a particular Permanent Impairment award as a result of an automobile accident. Among other things, the complaint related to a delay in the administration of the case and MPI's process for reconsideration of a decision.

The Manitoba Public Insurance Act provides that MPI may reconsider a decision if new information arises or if it realizes it has made an error. It must do so before application for review is filed. In the case of our complainant, MPI initiated two reconsiderations on its own accord while the complainant wanted MPI to proceed to its internal review process. In both instances, the reconsiderations delayed the internal review process. MPI amended its reconsideration policy to require customer agreement in order to proceed with reconsideration, and if the customer does not agree to the reconsideration, the internal review process will proceed without delay.

MPI acknowledged that the individual experienced delays in the administration of the claim, and issued a letter of apology to the claimant.

Rural Municipality of La Broquerie

A number of administrative complaints related to property development in the Rural Municipality of La Broquerie were raised with our office.

A municipal zoning by-law will identify, within a specific zoning category, whether the use of land or a building is permitted or conditional. A conditional use is one that is generally consistent with other uses in the zone and which may be allowed under certain circumstances at a municipality's discretion. In one instance, a conditional use permit was granted whereby development of a certain property was allowed to proceed on the condition that an existing building be removed. Development, however, proceeded without building removal and the

conditions of the permit were not enforced. As a result of our investigation, the RM ensured compliance and the building was removed.

In another case, a property was developed in a way that was inconsistent with the RM's zoning by-law, yet a permit had been issued by the RM allowing the development to occur. The RM indicated that its new Development Plan was awaiting approval by the Minister, and if approved, the property in question would be appropriately zoned to allow the development that had already proceeded. If the Development Plan was not approved, the property owner would make an application to have the property rezoned.

On another property, a stop work order was issued by a by-law officer. The stop work order was removed by a municipal councillor. While Council may confirm, vary, substitute or cancel an order, in this case, an individual councillor acted independently, without authority. To clarify roles and responsibilities with respect to by-law enforcement, the RM repealed one of its by-laws, replacing it with a new policy on by-law enforcement that reflects the by-law enforcement requirements of *The Municipal Act*.

Rural Municipality of Strathcona

An individual raised concern with charges levied by the Rural Municipality of Strathcona for the cost of snow removal and the application of outstanding charges to his property tax bill. The individual received an invoice from the RM for custom ploughing that noted the total fee, but did not provide an adequate breakdown of the fee. The individual disputed the total fee, and could not determine how it was calculated. He made a partial payment in anticipation of receiving a breakdown of the charges. The RM did not provide clarification and added the outstanding balance to his property tax bill without notice to the individual.

Our investigation revealed that the total charges for ploughing included travel time charges. The RM's *Snow Removal Policy* did not reference travel time costs. As a result of our investigation, the RM amended its policy to include travel time costs when special requests are made for snow clearing. The RM also advised that any customer making a request for snow removal will be advised, in advance, of the hourly rate and any other charges that apply. The RM further advised that customers with accounts in default will receive a notice with the final bill indicating that the outstanding amount will be added to the tax roll of the property. Lastly, the RM waived 1.5 hours of travel time for the individual, and agreed to remove arrears relating to those charges on his property tax roll.

Ombudsman's Own Initiative Investigations

In some cases, in the course of conducting investigations into individual complaints, areas of concern that may benefit from further review are identified. The Ombudsman can initiate her own investigation into such matters. In this report, we highlight one "OOI" investigation that concluded in 2010.

Office of the Chief Medical Examiner

In 2008, a complaint was received from a mother about the length of time it took for her to receive an autopsy report after her son's death. Under *The Fatality Inquiries Act*, the pathologist is required to submit an autopsy report to the chief medical examiner within 60 days of commencing the autopsy. The chief medical examiner may extend the period within which an autopsy report must be submitted by a further 30 days. In the case of our complainant, an autopsy report was received approximately 5 months after the autopsy. As the individual matter was resolved, our case was closed.

We did, however, open an "Ombudsman's Own Initiative" investigation into the length of time it was taking to complete autopsy reports. We made inquiries with the Office of the Chief Medical Examiner (OCME) of Manitoba Justice and learned that it contracted with Diagnostic Services of Manitoba (DSM) to conduct autopsies. Due to staffing issues, increasing numbers of autopsies, and increasing complexity of some autopsies, there were delays in completing reports within legislated timeframes.

DSM, Manitoba Justice, and Manitoba Health were working to find solutions to the problem, but despite continued efforts, legislated time frames were not being met. As we felt that it was important to meet legislated requirements, we wrote to the departments of Justice and Health and requested that we be informed of steps taken to remedy the situation. In late 2010, we were advised that funding for a new Deputy Chief Medical Officer in the OCME was confirmed, and DSM had hired a new forensic pathologist. As reasonable action was taken to address this matter, our file was closed.

Systemic Investigations

Investigations into system-wide issues are comprehensive reviews of government programs and services. Often these investigations arise because there appears to be a gap between administrative policies and procedures put in place by government to achieve certain goals, and the actual outcomes that occur. Systemic investigations can achieve administrative improvement that results in better government programs and services for all citizens. In this report, we highlight 2 systemic investigations that occurred or concluded in 2010.

Employment and Income Assistance Program

In 2009 we reported that our investigation into the Employment and Income Assistance Program of Family Services and Consumer Affairs had concluded. The investigation was undertaken in response to a complaint from 12 community organizations, many of whom have clients who are participants in the EIA program.

In May 2010, the Ombudsman issued a report with 68 recommendations for administrative improvement. The recommendations were made to improve the fairness and administrative efficiency of the program, and to assist in aligning the program with the province's overall goal of poverty reduction. The department was asked to formally respond to the report as required under subsection 37(1) of *The Ombudsman Act*.

The department accepted the majority of the recommendations. It disagreed with, and continues to consider, some of the recommendations. In December 2010, a full report that includes the department's responses to the recommendations was published. The EIA report is available on our website at:

www.ombudsman.mb.ca/pdf/EIA_report_with_departmental_responses_Dec2010.pdf

Protection for Persons in Care Office

In June 2010, the Ombudsman received a number of disclosures under *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA), alleging wrongdoing at the Protection for Persons in Care Office (PPCO) of Manitoba Health. While it was determined that the issues disclosed would not amount to wrongdoings as defined by PIDA, a decision was made to proceed with an investigation under *The Ombudsman Act* since the issues identified related to matters of administration.

The PPCO receives and investigates abuse allegations in care facilities throughout the province. In recent years, it engaged in an organizational change exercise that included a re-interpretation of the statutory definition of abuse. The complaint to our office alleged that the re-interpretation could result in the premature closure of cases for not meeting the now higher threshold, or result in investigative findings that abuse did not occur, when in fact it may have. Additional concerns focused on the lack of clarity surrounding the PPCO's referral policies to professional bodies such as the College of Physicians and Surgeons when abuse allegations were made against physicians, and to law enforcement agencies when abuse allegations appeared to be criminal in nature.

As a result of the investigation, the Ombudsman made 5 recommendations to Manitoba Health. The Ombudsman recommended that:

- the PPCO's working definition of abuse be revised to include both the acts of abuse and the outcomes of those acts, that the threshold for serious harm be defined in accordance with case law, and that the PPCO's working definition of 'reasonably likely' to cause serious harm be revised,
- PPCO policy on referrals to professional bodies such as the College of Physicians and Surgeons be revised to clarify when there are reasonable grounds to make such referrals,

- PPCO policy on referrals to law enforcement agencies be revised to clarify when there are reasonable grounds to make such referrals,
- the PPCO revise its inquiry phase in which it is required to determine if a matter should be more thoroughly investigated. The inquiry phase should focus on whether or not there are reasonable grounds to believe that a patient has been or is likely to be abused, and on obtaining the necessary information to make that determination, and
- the PPCO issue necessary directions to facilities to ensure patient safety even if there has been no finding of abuse, if the directions would assist facilities in further preventing mistreatment and in ensuring patient safety.

The department accepted all 5 recommendations. The Ombudsman published a report on the PPCO investigation in March 2011. The PPCO report is available on our website at:

www.ombudsman.mb.ca/pdf/2011-03-11_PPCO_Report.pdf

Public Interest Disclosure Act Investigations

This is the third full year of experience with *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA), and every year the office's body of knowledge about PIDA continues to expand. In 2010, the opportunity to again consider the meaning of 'wrongdoing' arose on several occasions.

In one case, as noted in the systemic investigations section, the office received disclosures of wrongdoing in relation to the Protection of Persons in Care Office. After considerable analysis, it was determined that the issues and concerns disclosed did not amount to wrongdoing as defined in section 3 of PIDA. There were, however, several administrative matters that could be investigated under *The Ombudsman Act*. Since the disclosures arose under PIDA, the reprisal protection outlined in section 27 of PIDA applies, even though the investigation occurred under *The Ombudsman Act*.

As outlined in the statistical review section of this report, 8 new cases under PIDA were opened in 2010 and one was carried over from the previous year. Of the 9 cases in total, 7 were pending at the end of 2010, and 2 were declined.

OTHER ACTIVITIES AND ISSUES

Inquest Reporting

Under *The Fatality Inquiries Act*, the Chief Medical Examiner may direct that an inquest, presided over by a provincial judge, be held into the death of a person. 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.

After an inquest report is received, Ombudsman staff contact each department or agency of government or a municipality to which a recommendation is directed to determine what action it is taking. After a satisfactory response to all recommendations has been received, a letter is sent to the Chief Judge of the Provincial Court advising of those responses.

Inquest reports are published on the Manitoba Courts website. An Inquest Reporting Table on the Manitoba Ombudsman website provides information about the deceased (name, date, place and cause of death, and whether the deceased was adult or child); date of the inquest report; a list of recommendations; the provincial department or agency, or municipality, to which the recommendations were directed; and the status of the response to the recommendations. The table has links to the full-text of the Inquest Report and the Ombudsman's closing letter to the Chief Judge, detailing the response to each recommendation.

In 2010, no new inquest reports were received by our office for follow-up. Nineteen files related to previous inquests were worked on, and 8 of those files were closed. Overall, this resulted in our completing follow-up on 5 inquests. The 5 closing letters to the Chief Judge are posted on our website.

Child Death Reviews

In 2006, our review of the child welfare system in Manitoba recommended changes to the process for investigating and reporting on the deaths of children who were in the care of the system, had recently been in care, or whose families had received services from the system.

Our recommendations were accepted by government and given effect through statutory amendments that transferred responsibility for child death investigations from the Office of the Chief Medical Examiner (OCME) to the Office of the Children's Advocate (OCA). This transfer occurred on September 15, 2008.

At the same time, responsibility for monitoring and reporting on the implementation of recommendations made by the OCA was assigned to the Ombudsman in order to have an independent body determine what action has been taken in response to those

recommendations, and to report publicly on those actions. Reporting publicly can serve to alert the legislature and the public if progress appears to be inadequate.

The OCA refers to their investigations of the deaths of children in care as Special Investigation Reviews (SIRs). The purpose of SIRs is to identify ways in which the programs and services under review may be improved to enhance the safety and well-being of children, and prevent deaths in similar circumstances. SIRs may contain findings and recommendations with respect to one or more child welfare agencies, one or more of the four child welfare Authorities, the Child Protection Branch, Manitoba Family Services and Consumer Affairs, any other government department, or any mental health or addictions treatment services or publicly funded social services, identified in the course of the special investigation by the OCA.

Completed SIRs are forwarded to the Ombudsman, the Chief Medical Examiner and the Minister of Family Services and Consumer Affairs. The Minister forwards reports to the Executive Director of the Child Protection Branch, and the Branch notifies the responsible Authority or Authorities of the report and provides them with a copy or, where more than one Authority is identified, with the relevant sections and recommendations applicable to each.

At the Branch, SIRs are assigned to an Authority Relations specialist, each of whom has responsibility for working with one of the four child welfare Authorities. The role of the Authority Relations specialists is to review responses to the recommendations received from the Authority and confirm that recommendations have been implemented. We were advised that this process involves not only a review of the information provided but also of the evidence that a recommendation has been implemented.

To inform the Ombudsman of the status of SIR recommendations, Family Services and Consumer Affairs proposed to prepare a report, twice annually, containing summaries of the responses from Authorities and categorizing recommendations to identify systemic issues arising from recommendations. We have not received these reports semi-annually as proposed. The first report was provided to our office in June 2009 and a second report was received in June 2010.

When responsibility for completing SIRs was transferred to the OCA on September 15, 2008 there were 106 cases that had not been reviewed. By December 31, 2010 the number of cases requiring review was 182.

As of December 31, 2010 the OCA had completed 44 reports and forwarded them to the Minister, the OCME and the Ombudsman. Those reports contained 234 recommendations, including 19 recommendations to other government departments and external organizations including social service, mental health and addictions treatment services. We have been advised that special investigation reports and recommendations cannot be released directly to external organizations without breaching section 76(3) of *The Child and Family Services Act,* requiring that any records created under the Act be kept confidential. We have also been

advised that only one of the 44 cases has been closed by the Branch following its review of the implementation of recommendations.

In order for our office to complete our review of the implementation we need to know when the system views the recommendation as having been implemented or otherwise responded to. Delays in completion of semi-annual reports from Family Services and Consumer Affairs on the progress of implementation of special investigation recommendations and delays in completion of status reports from the Child Protection Branch have raised questions about the number of cases that have been fully completed.

We anticipated receiving more than 44 reports and having more reports signed off by the Branch in the period from September 2008 to December 2010. The limited results reflect expected transitional challenges but raise some concerns about the extent to which adequate administrative processes have been developed and implemented to give effect to the statutory amendments arising from our 2006 report.

In 2010 we will be producing a special report addressing issues of concern and identifying possible solutions based upon our own analysis of the issues and the positions of the parties involved in the SIR process.

High Risk/High Needs Inmates

For many years our office has raised concerns about mentally ill or mentally disabled individuals who come into conflict with the criminal justice system. We have advocated for the establishment of a specialized court such as a mental health court to divert those individuals from an overcrowded criminal justice system into the community with the necessary supports to treat their illness or disability. In 2010, the province announced in its throne speech that it would proceed with the development of a mental health court. We have been informed that planning for the initiative is underway.

We also continue to raise concerns about incarcerated individuals with mental health issues and the deterioration of their mental health while in custody. When hospitalization is required for those inmates in custody, the only suitable hospital setting is the secure 14-bed, short-term Forensic Services Unit at the Health Sciences Centre's PyscHealth Centre in Winnipeg. Eighteen longer term beds are available at the Selkirk Mental Health Centre.

In 2008, the average waiting period for the Forensic Services Unit was 15.8 days, and the average rose to 24.2 days in 2009. We were informed that in 2010 the average waiting period further increased to 26.8 days. In 9 instances, individuals waited over 20 days to be admitted. Of these individuals, three waited 69, 70, and 103 days for admittance and were subsequently determined to be not criminally responsible. We continue to request information from Manitoba Health regarding the steps that it will be taking to address the growing backlog of cases and increased wait times for admission to Forensic Services.

In 2008 and 2009 we discussed our concerns with the current "Cross-Department Protocols for High Risk High Needs Adults" that exist between Manitoba Health, Manitoba Family Services, and Manitoba Justice to facilitate service coordination. In 2010, the Deputy Minister of Health reported that "*while the relevant stakeholders recognize the continuing importance of ensuring cross-jurisdictional service coordination as a standard element of effective clinical care and one that is currently utilized, they also indicated several difficulties with the current version of the Protocols due to their length and complexity to the point that these conditions undermine the Protocols' utility."* The department also reported that it was updating the Protocols to reflect a plain-language service coordination process that meets the service, risk mitigation and accountability requirements, and that the updated Protocols would be tested in 2011, and finalized.

STATISTICAL REVIEW OF THE OMBUDSMAN DIVISION

Cases in 2010 by Act, Department and Disposition

This chart shows the disposition of 292 Ombudsman Division case files in 2010 under *The Ombudsman Act, The Public Interest Disclosure (Whistleblower Protection) Act, and The Fatality Inquiries Act.*

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2010	New cases in 2010	Total cases in 2010	Pending at 12/31/2010	Information Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
THE OMBUDSMAN ACT												
PROVINCIAL GOVERNMENT												
Aboriginal & Northern Affairs												
General	-	1	1	1	-	-	-	-	-	-	-	-
Agriculture, Food & Rural Initiatives												
General	1	1	2	1	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative – OOI	-	1	1	-	-	-	-	-	-	-	-	1
Civil Service Commission												
General	1	-	1	-	-	-	-	1	-	-	-	-
***Competitiveness, Training & Trade**												
Ombudsman's Own Initiative – OOI	1	-	1	-	-	-	-	1	-	-	-	-
Conservation												
General	6	5	11	3	1	-	1	5	1	-	-	-
Ombudsman's Own Initiative - OOI	2	-	2	-	-	-	2	-	-	-	-	-
Executive Council												
Ombudsman's Own Initiative – OOI	1	-	1	-	-	-	-	-	-	-	-	1
****Family Services & Consumer Affairs**												
General	1	2	3	1	-	-	-	-	-	-	1	1
Automobile Injury Compensation Appeal Commission	-	2	2	1	1	-	-	-	-	-	-	-
Child & Family Services	9	11	20	5	-	1	-	9	2	3	-	-
Employment & Income Assistance	-	3	3	1	-	-	-	-	1	-	-	1
Residential Tenancies Branch	-	1	1	1	-	-	-	-	-	-	-	-
Residential Tenancies Commission	1	2	3	3	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative – OOI	4	1	5	2	-	-	1	-	-	-	1	1
Finance												
General	1	-	1	-	-	-	-	-	1	-	-	-
Securities Commission	1	1	2	2	-	-	-	-	-	-	-	-
Health												
General	2	1	3	3	-	-	-	-	-	-	-	-
Health Appeal Board	3	1	4	2	-	-	-	2	-	-	-	-
Protection for Persons in Care Office	-	1	1	1	-	-	-	-	-	-	-	-
Mental Health	-	3	3	1	-	-	-	1	-	1	-	-

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2010	New cases in 2010	Total cases in 2010	Pending at 12/31/2010	Information Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
Regional Health Authority	1	2	3	-	2	-	-	1	-	-	-	-
Ombudsman's Own Initiative – OOI	4	2	6	4	-	-	-	-	-	1	-	1
****Housing & Community Development**												
Manitoba Housing Authority	4	4	8	4	-	-	1	-	-	-	1	2
Ombudsman's Own Initiative - OOI	4	1	5	3	-	-	1	-	-	-	1	-
Infrastructure & Transportation												
General	3	1	4	1	-	-	-	1	-	1	-	1
Licence Suspension Appeal Board	-	2	2	-	-	-	2	-	-	-	-	-
***Intergovernmental Affairs**												
General	3	-	3	-	-	-	-	3	-	-	-	-
Justice												
General	2	2	4	4	-	-	-	-	-	-	-	-
Brandon Correctional Centre	1	2	3	1	1	-	-	1	-	-	-	-
Headingley Correctional Centre	1	1	2	1	-	-	-	-	-	-	-	1
The Pas Correctional Centre	-	1	1	-	-	-	-	1	-	-	-	-
Portage Correctional Centre	1	-	1	-	1	-	-	-	-	-	-	-
Winnipeg Remand Centre	-	3	3	1	-	-	-	-	-	1	-	1
Manitoba Youth Centre	-	2	2	-	1	-	-	1	-	-	-	-
Courts	-	1	1	-	-	-	-	1	-	-	-	-
Maintenance Enforcement	2	4	6	2	-	-	-	2	-	2	-	-
Human Rights Commission	4	8	12	8	-	-	-	3	-	1	-	-
Law Enforcement Review Agency	-	2	2	-	1	-	-	1	-	-	-	-
Legal Aid	2	2	4	2	-	-	-	1	-	1	-	-
Public Trustee	3	4	7	1	1	-	-	5	-	-	-	-
Ombudsman's Own Initiative – OOI	10	3	13	9	-	-	-	-	-	1	-	3
Labour & Immigration												
Employment Standards	1	-	1	-	-	-	1	-	-	-	-	-
****Local Government**												
General	-	1	1	1	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative – OOI	-	1	1	-	-	-	1	-	-	-	-	-
Water Stewardship												
General	5	1	6	3	-	-	-	2	-	1	-	-
Corporate & Extra Departmental												
Manitoba Hydro	2	4	6	3	-	-	-	2	-	1	-	-
Workers Compensation Board	2	1	3	1	-	-	-	2	-	-	-	-
WCB Appeal Commission	1	-	1	1	-	-	-	-	-	-	-	-
Manitoba Public Insurance												
General	11	21	32	6	1	3	1	16	1	4	-	-
Ombudsman's Own Initiative - OOI	2	-	2	-	-	-	-	-	-	2	-	-
MUNICIPALITIES												
City of Winnipeg	5	10	15	6	1	-	1	4	-	3	-	-

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2010	New cases in 2010	Total cases in 2010	Pending at 12/31/2010	Information Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
Other Cities, RMs, Towns, Villages	16	11	27	15	2	-	1	3	-	5	1	-
Local Planning Districts	3	1	4	3	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative - OOI	1	1	2	-	-	-	1	-	-	-	-	1
Sub-total	**128**	**136**	**264**	**108**	**13**	**4**	**14**	**71**	**6**	**28**	**5**	**15**
THE PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT												
Crown Corporation and Government Agency	1	3	4	2	-	2	-	-	-	-	-	-
Educational Body	-	4	4	4	-	-	-	-	-	-	-	-
Regional Health Authority	-	1	1	1	-	-	-	-	-	-	-	-
Sub-total	**1**	**8**	**9**	**7**	**-**	**2**	**-**	**-**	**-**	**-**	**-**	**-**
CASES RESULTING FROM INQUEST REPORT RECOMMENDATIONS UNDER *THE FATALITY INQUIRIES ACT*												
Family Services	4	-	4	2	-	-	-	-	-	-	-	2
Health	6	-	6	4	-	-	-	-	-	-	-	2
Justice	6	-	6	3	-	-	-	-	-	-	-	3
Labour and Immigration	1	-	1	1	-	-	-	-	-	-	-	-
Liquor Control Commission	1	-	1	1	-	-	-	-	-	-	-	-
City of Winnipeg	1	-	1	1	-	-	-	-	-	-	-	-
Sub-total	**19**	**-**	**19**	**12**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**7**
TOTAL	**148**	**144**	**292**	**127**	**13**	**6**	**14**	**71**	**6**	**28**	**5**	**22**

* Names of departments have changed.
**New department names

Summary

Of the 165 cases closed in 2010:

21% were resolved in whole or in part (the Ombudsman made recommendations in 0.3% of these cases);
13% were completed;
43% were not supported;
8% were concluded after information was provided;
12% were discontinued either by the Ombudsman or the complainant, or declined.

Definitions

Pending: Complaint still under investigation as of January 1, 2011.

Information Supplied: Assistance or information provided.

Declined: Complaint not accepted for investigation by Ombudsman, usually for reason of non-jurisdiction or premature complaint.

Discontinued : Investigation of complaint stopped by Ombudsman or client.

Not Supported: Complaint not supported at all.

Partly Resolved: Complaint is partly resolved informally.

Resolved: Complaint is resolved informally.

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

Completed: Case where the task of monitoring, informing, or commenting has been concluded.