Manitoba Ombudsman

2012 Annual Report under The Ombudsman Act and The Public Interest Disclosure (Whistleblower Protection) Act

Independent, Impartial, Fair

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

Dear Mr. Speaker:

In accordance with section 42 of *The Ombudsman Act* and subsection 26(1) of *The Public Interest Disclosure (Whistleblower Protection) Act,* I am pleased to submit the Annual Report of the Ombudsman for the calendar year January 1, 2012 to December 31, 2012.

Yours truly,

Mel Holley

Mel Holley
Acting Manitoba Ombudsman

About the office

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

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

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

Message from the Ombudsman

As Acting Ombudsman in 2012, I had the pleasure of facilitating a number of improvements to our core operations, including some significant changes to how we communicate with the public. Although Manitoba Ombudsman as an office has existed for over forty years, we remain committed to exploring ways of improving our efficiency, our transparency and our accountability. I believe we must move forward to keep up with advancing technology, and to respond to changing expectations.

In the past year we finalized and implemented an investigation planning process for our Ombudsman Division. This initiative was part of a larger process of developing and implementing standards intended to improve overall performance and accountability. This process begins with improved issue identification, allowing us to more clearly and concisely inform departments and agencies of the allegations against them and the information we need to investigate those allegations. It also sets timelines for investigations, allowing us to more closely monitor file progress and conclude files in a timely fashion.

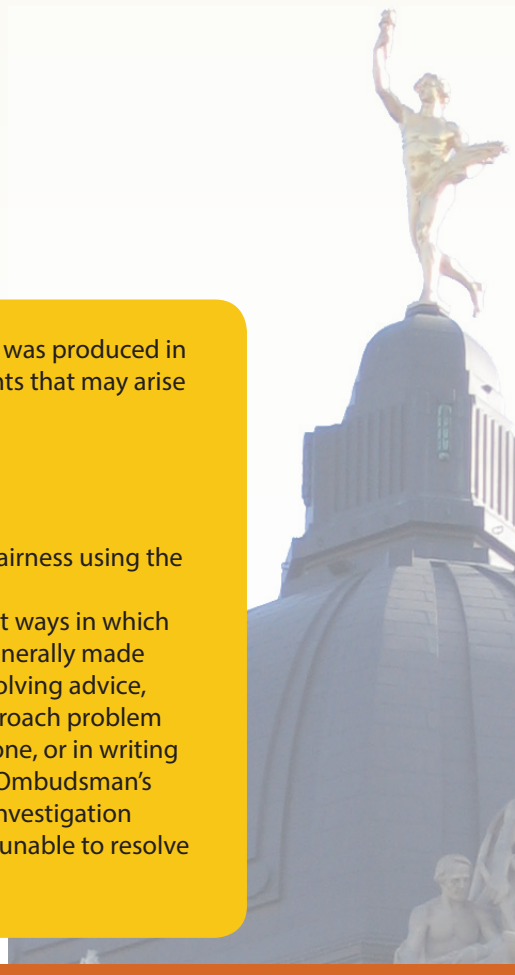
We also undertook a comprehensive review of our intake procedures in 2012. Following up on an intake protocol we adopted in 2011, a management committee reviewed all intakes to ensure that we were properly identifying administrative issues for investigation, providing callers with the most helpful and useful information, and making the most appropriate referrals. This review led to a decision to broaden our intake training and to make a significant investment in technology to allow our intake staff to more quickly retrieve and convey information to the public.

The public face of the office has become our website. We spent much of 2012 working on a makeover, resulting in the launch of the new website in early 2013, followed by our first foray into using social media. We are hoping to use Facebook to talk about the work we do, to stimulate discussion about important issues and to receive feedback from the public on the work that we produce. All of this is in aid of trying to practice what we preach – that it is important not only to be accountable but also to demonstrate accountability by being transparent and responsive.

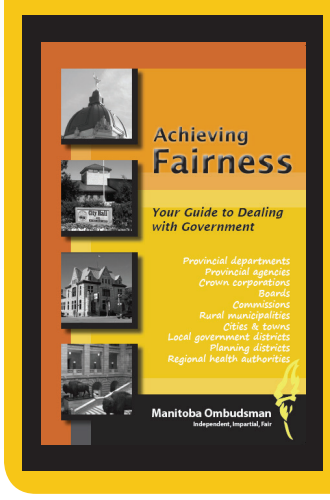
In the summer of 2012 we published a fairness guide for the public titled *Achieving Fairness: Your Guide to Dealing with Government*. This guide was intended as a companion piece to our earlier publication *Understanding Fairness: A Handbook on Fairness for Manitoba Municipal Leaders*.

This past year the nature of our workload changed in a couple of significant ways. While we continue to work at resolving cases earlier through our intake process to reduce the number of formal investigations we undertake, we saw an increase in the number of inquiries and disclosures under *The Public Interest Disclosure (Whistleblower Protection) Act.* As well, our work in following up on recommendations made by the Office of the Children's Advocate to child welfare and other government entities increased dramatically, placing pressure on our investigative resources. I am pleased that included in this annual report, for the first time, is our supplementary report on the implementation of the recommendations made by the Children's Advocate.

Finally, I am pleased to report that my year of serving as Acting Ombudsman has been a smooth one, due in large part to the tremendous work and support of the entire Manitoba Ombudsman team and the support of the provincial and municipal entities we work with on a daily basis.



Achieving Fairness: Your Guide to Dealing with Government was produced in 2012 to assist Manitobans in resolving problems or disagreements that may arise when accessing provincial or municipal programs and services.



Divided into four parts, the guide:

- introduces the principles of fairness using the "fairness triangle" model
- explains some of the different ways in which government decisions are generally made
- provides practical problem solving advice, including tips on how to approach problem solving in person, via telephone, or in writing
- provides an overview of the Ombudsman's jurisdiction and complaints investigation process for when people are unable to resolve problems on their own.

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Fax: 204-942-7803

In Brandon:
202 - 1011 Rosser Avenue
Brandon, MB R7A 0L5
204-571-5151
1-888-543-8230 (toll free in Manitoba)
Fax: 204-571-5157

On the web:
www.ombudsman.mb.ca
www.facebook.com/manitobaombudsman

The Ombudsman Act

Public participation in municipal borrowing

A complainant from the R.M. of Portage la Prairie contacted us about what he described as a "loophole" in provincial law dictating the ways in which municipalities raise money for special projects.

This file came after a 2008 Court of Queen's Bench decision quashing a "local improvement plan" by-law due to a procedural defect. The local improvement plan by-law had been passed by the municipality for the purposes of funding a multi-use recreation complex. Rather than correct the defect and try again to pass the local improvement plan by-law, the R.M. chose to proceed by way of a general borrowing by-law. Our complainant believed that funding the recreation complex in this manner did not provide the same opportunity for him or other citizens to fully scrutinize such large public expenditures, and he was concerned about the effect of the R.M.'s borrowing on municipal taxpayers.

The Municipal Act had different notice requirements for proposed local improvement and general borrowing by-laws given the different impact to taxpayers. Public notice and hearing requirements for capital projects funded as a local improvement reflect that local improvements are considered additional services, paid for by only benefiting property owners, including exempt property. Capital projects funded by general borrowing are funded by the annual budget (financial plan) and are part of municipal services paid for by all properties, excluding exempt properties. Approval of the financial plan, including proposed capital projects, is required.

We talk to a lot of municipalities and understand the financial pressures they face and the constant demand to modernize municipal facilities and infrastructure. We have dealt with complaints about local improvement plans and special levies in the past. Decisions about what to spend money on are best left to elected officials, but we do investigate to ensure that proper procedures have been followed and that ratepayers are afforded the transparency and input required by law.

In this case we understood the complainant's point but there was little for us to investigate. After a brief inquiry to confirm that the R.M. had followed the required procedures for the general borrowing by-law, we raised this issue with Manitoba Local Government. We asked them to consider changes to increase the amount of information provided to the public about proposed general borrowing by-laws.

We are pleased to report that Manitoba Local Government gave serious consideration to this issue and that, in 2012, section 174 of *The Municipal Act* was amended to include public notice requirements for general borrowing by-laws, making notice requirements for borrowing by-laws the same as notice requirements for local improvement plan by-laws. The *Municipal Act Procedures Manual*, a kind of "how to" guide for municipalities, was also updated to include a new section on "Public Notice of Proposed Borrowing for Capital Projects." In our view these changes addressed the concerns raised by our complainant.

You're not on our list

A case that might be described as a classic example of a failure to communicate began with a complaint from a person who operated a private school, known as a private vocational institution (PVI), offering health care aide training.

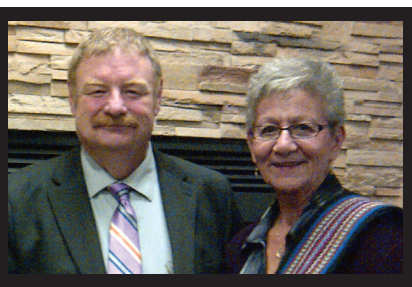
Although the school was registered as a PVI under *The Private Vocational Institutions Act*, and registered, monitored, and regulated by the PVI Office of Manitoba Advanced Education and Literacy, graduates of the school were not being recognized as trained health care aides by Manitoba Health or the Winnipeg Regional Health Authority (WRHA).

The WRHA, which hires health care aides, was using an "approved list" to identify which schools produced certified health care aide graduates. Graduates from schools on the approved list could be hired as trained health care aides at a higher rate of pay than untrained aides. The school belonging to our complainant was not on this list. It was however on a list of registered schools maintained by the PVI Office on its website.

In this case, there was a communication gap between Manitoba Health, Manitoba Advanced Education and Literacy and the WRHA. In the course of our investigation, it became apparent that the approved list used by Manitoba Health and the WRHA had been created several years ago and was not updated to include PVIs that were registered at a later date. The complainant's school had been registered after the approved list used by the WRHA was created.

The school operated by the complainant was added to the approved list, ensuring that graduates of his school were eligible for hiring of health care aides within the Winnipeg Health Region.

To ensure that this situation does not happen in the future, the PVI office decided they would send an interdepartmental notice of any newly registered PVIs offering Health Care Aide training to Manitoba Health, helping to ensure that information regarding registered health care aide training programs remains current.



Acting Ombudsman Mel Holley with Rita Cullen, Chair of the Board of Directors of the Métis Child and Family Services Authority, at the Authority's annual general meeting.

Manitoba Ombudsman staff at the Manitoba Social Sciences Teachers' Association Conference.

Troubled waters

When we have significant natural disasters such as floods, the impacts are felt for years. Homes and lives are disrupted, government resources are stretched, aid and compensation programs are created and administered and there are invariably complaints of undue delay and other maladministration. Frustrations can run high when people already under stress feel they are not being treated fairly. We do not usually get a flood of complaints, but rather a steady trickle that can continue for years as people work their way through compensation processes and appeal mechanisms.

A couple of cases from 2012 highlight the need for transparency, open communication, and reasonableness as we work through times of crisis.

Not quite ready yet…

We all know how frustrating it can be when we find out that something we have been looking for doesn't exist. That's how a complainant felt when he was told to appeal to an appeal body that hadn't yet been created.

In November 2010 the Manitoba Individual Flood Proofing Initiative (IFPI) was launched to provide financial assistance for home, business, and farm owners to flood proof their buildings and structures. The deadline for applying for funding was December 31, 2010.

In April 2012, we received a complaint from an individual who had applied for assistance in December 2010 and was told a year later that his application had been denied. The letter notifying him that his application had been denied, as well as published program guidelines, stated he could appeal in writing. In mid-December 2011, he submitted a letter of appeal. In March 2012, he contacted the IFPI program to find out when his appeal would be heard as he had not received any information from the department. He was advised to "wait" without any explanation for the delay. Frustrated by the vague response he had received, the individual complained to our office.

When we contacted Manitoba Infrastructure and Transportation we learned that an appeal committee had not yet been struck. We learned that, in fact, establishing the appeal process was still a "work in progress."

We expressed our concern about this to the department. We didn't want to be too critical of the department in this instance because they made a good case for much of the delay – they were busy dealing with the flood of 2011. We understand that the 2011 flood contributed to delays in many programs as staff resources were required to deal with the extraordinary circumstances of widespread and significant flooding.

While delay can be understandable when it is due to legitimate reasons, those reasons cannot be understood unless they are communicated. We frequently remind government bodies that a lack of communication between the person making a decision and the person affected by a decision is often at the centre of complaints to our office.

In this case, a program was announced setting out an appeal process that did not appear to have been fully formulated and further delays were experienced due to the unforeseen circumstances of the 2011 flood. This situation highlighted the need for government transparency and open communication with stakeholders, even in times of crisis. It would have been preferable to have simply advised the complainant that his appeal would be delayed pending the creation of the appeal panel. He probably would have understood. We did.

A difference of opinion

In the second case, a frustrated resident complained that a municipality was refusing to compensate him for damage caused to his property after the municipality carried out flood protection work to prevent overland flooding.

In spring 2011, the municipality issued an Emergency Protection Order in accordance with *The Emergency Measures Act* for the purposes of carrying out flood protection work. While undertaking work to construct earth dikes, damage occurred to the complainant's residential property. Both sides agreed that the property required restoration, but could not agree on how this restoration would be done.

The municipality was ready to repair the damage and restore the property to its original state. The resident, however, wanted to restore the property himself, and he wanted the municipality to compensate him for any work undertaken. Because of this difference in proposed approach, discussions about restoration work had stalled. The resident complained to our office.

Flooding can have a significant impact on municipal budgets and municipalities have both the authority and the responsibility to determine how to spend finite resources. Their decisions have to be in accordance with their lawful authority, and they have to be fair. When we examine the fairness of municipal decisions we have to consider as well the reasonableness of the position taken by both parties to a dispute.

We concluded that the municipality had acted within its lawful mandate in carrying out its flood protection work. We learned as well that as part of the subsequent restoration process, the municipality invited the resident to participate in discussions between the municipality and the provincial government regarding detailed design work needed to restore the area, including the complainant's property.

After reviewing all the facts of this case, we concluded that the municipality was not refusing to restore the property as alleged, and that the position taken by the municipality was reasonable. During the course of our investigation the complainant had expressed some reluctance to provide access to his property. In all of the circumstances, that did not seem reasonable.

We concluded the investigation by encouraging the complainant to continue dialogue and negotiations to bring the matter to a satisfactory conclusion.

Rough road ahead

The state of aging municipal roads is an issue of frequent discussion and concern to residents and local governments alike. In one rural municipality, a group of residents complained to the Ombudsman about the R.M.'s decision to repair certain roads but not others. The residents believed that the R.M. had not prioritized their road maintenance budget appropriately.

As set out in *The Municipal Act,* municipal councils must adopt an annual financial plan that includes operating and capital budgets. Public notice of the plan must be given, and a public hearing must be held. An R.M.'s financial plan has implications for road maintenance and repair.

In this case, the R.M. fulfilled its responsibilities with respect to its financial plan. When developing policies and plans for the municipality, councils must balance priorities and budgets, and in doing so, cannot accommodate all requests by residents in the time frame that some residents desire. Also in this case, members of council and the municipality's Chief Administrative Officer communicated regularly with the concerned residents about their road issues and the CAO offered to meet with the residents prior to the 2013 financial plan public hearing to discuss their concerns further.

After reviewing this matter, we felt that although the residents were not happy with the road maintenance and repair choices made by council, there was no evidence to suggest that the decisions made by council were unfair or that the residents were treated unfairly.

What do I do if I disagree with a decision?

A client of Manitoba Housing applied for a transfer and was denied. While the decision letter provided reasons for the denial, no information was provided to the client about what to do if she disagreed with the decision.

For most decisions of Manitoba Housing, tenants and landlords have a statutory right of appeal under *The Residential Tenancies Act* to the Residential Tenancies Branch. For other decisions that fall outside the scope of the formal appeal process, such as rent calculations, cancelled applications, or denial of transfer requests, clients have the option of pursuing an internal review process. But when the person who was denied a transfer brought her complaint to our office, it became apparent that tenants were not being told about this internal review process.

After discussions with Manitoba Housing regarding the benefits of letting clients know about how to address their complaints or appeals, Manitoba Housing agreed to make some changes to its processes. For those matters that fall outside of the scope of the Residential Tenancies Branch, Manitoba Housing will include a message in decision letters to advise clients about how to raise concerns through a local and regional review process. If the matter cannot be resolved at the regional level, correspondence will advise the client of their right to appeal to the Manitoba Housing Board of Directors. Additionally, the *Tenant Handbook* will be amended to include this information.

Being clear about statutory appeal rights, internal review options, or any other complaint mechanisms benefits all parties and makes the entire process more transparent and administratively fair. In this case, Manitoba Housing is making administrative changes that will positively improve service delivery.

Cottaging rules

We received a complaint from a frustrated cottager who was unable to obtain clarification from the department about requirements for dock construction for backtier cottages. Policies governing cottage development in Manitoba's provincial parks are available in a document known as *The Cottager's Handbook for Manitoba Provincial Parks*. Written and maintained by Manitoba Conservation and Water Stewardship, the Handbook, last updated in 2000, is available in print and on the department's website. A note on the document's cover indicates that the Handbook is currently under revision.

The Handbook functions in a similar manner to a municipal zoning by-law. Both documents articulate and specify property development requirements. Municipal zoning by-laws establish the rules for development, approved uses of land, general building size and location requirements, and all other pertinent matters related to property development. They are also used for by-law enforcement. *The Cottager's Handbook* performs a very similar function, albeit for development and enforcement in Manitoba's provincial parks.

Although most policies, procedures and specifications noted in the Handbook are current, some are no longer applicable, have been revised or new policies have been adopted. This has caused confusion for cottagers as it is not clear which policies and specifications are current, which are revised or if new policies or specifications are missing.

This is not the first complaint we have received where the currency of *The Cottager's Handbook* has been called into question. In the course of obtaining information about the rules for dock construction, the department advised us that it anticipates a revised *Cottager's Handbook* will be released in spring 2013.

Information about cottage development in provincial parks that is current and accurate assists both cottagers and department staff as properties are developed and rules are enforced. Making current and accurate information available, and regularly updating it as changes in policy occur, will improve services to cottagers and make the entire decision making process related to cottage development more transparent and fair.

The Public Interest Disclosure (Whistleblower Protection) Act

Exceptions under PIDA

Organizations covered by PIDA are required to appoint a designated officer to receive complaints and to set up procedures for receiving and handling disclosures of wrongdoing. After consultation with the Ombudsman, organizations can be exempted from these requirements if they are not practical, for example, because of the small size of the organization .

In late 2012 we received a number of inquiries about granting exceptions, for the most part, from small organizations that had not previously been aware that they fell under the jurisdiction of PIDA.

To ensure that we employ a consistent approach when responding to these consultations, we developed guidelines that are publicly available on our website. A questionnaire is also available in order to assist chief executives in the consultative process with our office.

The Ombudsman agreed that an exception to the procedures required in PIDA was reasonable in only a small percentage of the consultations we received.

In cases where the Ombudsman agreed to the appropriateness of the exception, we clearly advised the chief executive that, as required by PIDA, they would serve as the designated officer and remain responsible for ensuring that information about PIDA and procedures regarding disclosures are widely communicated to the employees and ensuring that a report is prepared each year regarding any disclosures of wrongdoing that have been made within that organization.

Considering gross mismanagement under PIDA: a case study

In 2012, under PIDA, we investigated and made recommendations related to disclosures of wrongdoing at a personal care home.

The disclosures made to our office contained allegations of conflict of interest, as well as numerous allegations of questionable expenditure management. An initial review by the Winnipeg Regional Health Authority also identified possible wrongdoing related to board governance.

At the end of our investigation we determined that wrongdoing had occurred and we made recommendations for corrective actions, not only to the home but also to the Winnipeg Regional Health Authority and to Manitoba Health. Subsequent to our report, Manitoba Health placed the home under a third party administrator.

Much of the "wrongdoing" alleged and confirmed by our investigation fell into the category of "gross mismanagement." So what is that?

Our framework for assessing gross mismanagement

Gross mismanagement must be mismanagement that is both significant and serious. It occurs when a decision, act, or omission results (or could result) in a serious and significant breach of public interest, or risk to public safety. Gross mismanagement can also involve, but is not limited to, the misuse of public funds or public assets.

We view gross mismanagement as being more than an ordinary breach of a duty or policy. For mismanagement to be considered "gross", the management act, decision, or omission must be a very marked departure from established standards.

Some of the factors that we consider when assessing whether alleged acts, decisions, or omissions constitute gross mismanagement are as follows:

- the seriousness and significance of the deviation from standards, policies or practices;
- the functions and responsibilities of the public servant alleged to be responsible for the gross mismanagement;
- the seriousness and willfulness of the acts, decisions or omissions in question;
- the repetitive or systemic nature of the acts, decision or omissions;
- the impact or potential impact of the mismanagement on the organization's ability to carry out its mandate;
- the impact or potential impact on the organization's employees, clients and the public trust.

In order to determine if an alleged act, decision, or omission may constitute gross mismanagement, we assess where it falls in the spectrum of each of these factors. This is not a checklist (nor an exact science), but rather a manner in which to consider multiple facets and circumstances of the alleged act, decision, or omission in order to assess its level of significance and seriousness. Not all factors are relevant to every case and, of course, each case is considered within its own particular context.

Our framework for assessing gross mismanagement allows us to carry out thorough and structured analyses of disclosures and assists us in making reasonable determinations as to how best to handle these types of disclosures under PIDA. This framework is also used in the analysis of the evidence in ongoing PIDA investigations, allowing us to draw conclusions as to whether particular acts, decisions, or omissions actually constitute "gross mismanagement".

2012 in numbers

2012 Statistical Overview of the Office	
General Inquiries responded to by administration staff (caller was assisted, without need for referral to Intake Services)	2706
Inquiries and concerns handled by Intake Services	1790
Cases opened for investigation under *The Ombudsman Act*	88
Cases opened for investigation under *The Public Interest Disclosure (Whistleblower Protection) Act*	5
Cases resulting from inquest report recommendations under *The Fatality Inquiries Act*	3
Cases opened for investigation under Part 5 of *The Freedom of Information and Protection of Privacy Act*	205
Cases opened for investigation under Part 5 of *The Personal Health Information Act (PHIA)*	19
Cases opened under Part 4 of FIPPA and PHIA	19
Total Contacts	**4835**

Administration
assists callers by providing information about the office and the complaints process

Intake Services
responds to inquiries, provides information about making complaints, assesses jurisdiction, provides information about review and appeal options, undertakes early resolution of concerns if possible, and prepares files for investigation

Ombudsman Division
promotes fairness and administrative accountability through investigation of complaints about matters of administration under *The Ombudsman Act* and disclosures of wrongdoing under *The Public Interest Disclosure (Whistleblower Protection) Act*

Access and Privacy Division
upholds access to information and privacy rights by investigating complaints and reviewing compliance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act*

2012/13 Office Budget	
Total salaries and employee benefits for 31 positions	$2,569,000
Positions allocated by division are:	
Ombudsman Division 12	
Access and Privacy Division 8	
General 11	
Other expenditures	$506,000
Total Budget	$3,075,000

More Information

Manitoba Ombudsman has issued a supplementary 2012 report under *The Ombudsman Act*, section 16.1. As part of our mandate, Manitoba Ombudsman has responsibility for monitoring and reporting annually on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA).

This chart shows the disposition of 175 Ombudsman Division case files in 2012 under *The Ombudsman Act, The Public Interest Disclosure (Whistleblower Protection) Act,* and *The Fatality Inquiries Act.*

	Case Numbers			Case Dispositions								
	Carried over into 2012	New Cases in 2012	Total cases in 2012	Pending at 12/31/2012	Information Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
The Ombudsman Act												
Advanced Education & Literacy		1	1							1		
Conservation & Water Stewardship												
General	3	2	5	3			1	1				
Ombudsman's Own Initiative - OOI	1		1	1								
Entrepreneurship, Training & Trade												
General		1	1	1								
Employment & Income Assistance		2	2	1	1							
Family Services & Labour												
Child & Family Services	2	2	4	1	2			1				
Ombudsman's Own Initiative - OOI	3	1	4	1						1		2
Finance												
General		1	1	1								
Securities Commission	1	1	2	1								1
Health												
Regional Health Authority	1		1							1		
Ombudsman's Own Initiative - OOI	2	1	3	2								1
Healthy Living, Seniors & Consumer Affairs												
General		1	1	1								
Residential Tenancies Branch	1	2	3				2	1				
Housing & Community Development												
Ombudsman's Own Initiative - OOI	1	1	2	1						1		
Immigration & Multiculturalism		1	1	1								
Infrastructure & Transportation	3	5	8	5	1			1		1		
Justice												
General	1		1	1								
Courts		2	2	2								
Brandon Correctional Centre		1	1	1								
Headingley Correctional Centre		2	2	1								1
The Pas Correctional Centre	1	1	2	1	1							
Winnipeg Remand Centre	1	3	4	1	1			1				1
Women's Correctional Centre		2	2	1				1				
Manitoba Youth Centre		1	1					1				
Maintenance Enforcement	2		2					1			1	
Human Rights Commission	3	2	5	1	1			3				
Legal Aid		1	1					1				
Public Trustee	2	3	5	1	1	1		2				
Ombudsman's Own Initiative OOI	8	5	13	7						1	1	4
Corporate & Extra Departmental												
Manitoba Agricultural Services Corporation		2	2	1	1							
Manitoba Housing & Renewal Corporation	1		1					1				
Manitoba Hydro		1	1						1			
Manitoba Public Insurance	3	5	8	2				3	1	2		
Manitoba Review Board	1		1									1
Workers Compensation Board	1	1	2	1				1				
WCB Appeal Commission		3	3				1	1				1
Municipalities												
City of Winnipeg	7	5	12	6	2			1		2		1
Other RMs, Cities, Towns & Villages	13	24	37	17	7		3	6		4		
Local Planning Districts	1		1							1		
Ombudsman's Own Initiative - OOI		2	2	2								
Subtotal	**63**	**88**	**151**	**66**	**18**	**1**	**7**	**27**	**2**	**15**	**2**	**13**
The Public Interest Disclosure (Whistleblower Protection) Act												
Crown Corporation & Government Agency	1		1				1					
Government Department	1	4	5	3	1	1						
Health Care Facility	1	1	2								2	
Subtotal	**3**	**5**	**8**	**3**	**1**	**1**	**1**				**2**	
Cases Resulting from Inquest Report Recommendations under The Fatality Inquiries Act												
Family Services	2		2	1						1		
Health	4		4	3								1
Justice	1	3	4	3								1
Labour & Immigration*	3		3							2		1
City of Winnipeg	3		3	2								1
Subtotal	**13**	**3**	**16**	**9**						**3**		**4**
TOTAL	**79**	**96**	**175**	**78**	**19**	**2**	**8**	**27**	**2**	**18**	**4**	**17**

* old department name

Pending: Complaint still under investigation as of January 1, 2013.

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.

Manitoba Ombudsman

2012 Report under Section 16.1 of *The Ombudsman Act*

The Ombudsman Act

Monitoring children's advocate's recommendations

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

Report to assembly

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

Aggregate Investigations

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

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

As part of our mandate, Manitoba Ombudsman has responsibility for monitoring and reporting annually on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA).

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

The OCA investigates child deaths that meet the criteria and may make recommendations in their Special Investigation Reports (SIRs) to improve services and enhance the safety and well-being of children and prevent deaths in similar circumstances in the future.

After a reasonable period of time, our office follows up with the entity or entities to which the recommendations have been made to determine what action has been taken in response to the recommendations, and to report publicly on those actions to ensure accountability.

Since the OCA received its mandate to perform Special Investigation Reviews on September 15, 2008, to the end of our reporting period December 31, 2012, the office has reviewed 271 child deaths, produced 250 Special Investigation Reports, and made recommendations in 75 of those reports, for a total of 347 recommendations. In total, thirty percent of the child death reports by the OCA resulted in recommendations.

Through our mandate to track and monitor the implementation of the OCA's recommendations, we have noted that while all the recommendations within the SIRs are intended to improve services and enhance the safety and well-being of children and prevent future similar deaths, the recommendations range from specific, single-agency improvements to complex, multi-organizational system changes, even legislative changes. It is clear that some recommendations lend themselves to immediate implementation; others may require intensive consultation, coordination and collaboration. Still others may pose significant challenges and the entity to which the recommendation was made may develop an alternate solution which addresses the concern.

We have also noted that most child deaths in the province of Manitoba occur naturally – whether a child has received services from a child welfare agency or not.

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

Many of the 347 Special Investigation Report recommendations made by the OCA since it received its mandate September 15, 2008, relate to challenges that are significant, long-standing and systemic in nature. Our office has identified that a recurring area of concern in recommendations made by the OCA is case management as it pertains to risk assessment, case planning and service delivery. According to the Manitoba Child and Family Services Standards, assessment begins at the first contact with a case and is ongoing. It includes information on the strengths, needs and resources of a person or family and could include family and community resources. Assessment becomes the basis for case management and effective service delivery. Part of the case management is planning, which ensures that risk factors identified in the assessment are addressed to keep children safe and strengthen family functioning.

A great deal of work has been done, however, to implement the many recommendations to improve these concerns. Many of the recommendations that have been implemented by each authority relate directly to staff training, and we are hopeful that both mandatory and authority-specific training that has occurred in the Province of Manitoba will positively impact the skill level of caseworkers in the area of case management.

The following Table 1 illustrates the number of Special Investigation Reports received by our office from the OCA by fiscal year from September 15, 2008 to December 31, 2012. Table 2 illustrates the number of Special Investigation Reports received by our office from the OCA by calendar year from September 15, 2008 to December 31, 2012. For Status Definitions, please see page 2 of this report.

Tables 1 and 2 encompass the Special Investigation Reports received by the Ombudsman from the Office of the Children's Advocate from September 15, 2008 to December 31, 2012. Table 1 is by fiscal year and Table 2 is by calendar year.

Table 1: Special Investigation Reports received by the Ombudsman from the OCA by fiscal year - September 15, 2008 to December 31, 2012

Fiscal Year	Child Death Investigations	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008 - 2009	7	7	7	40
2009 - 2010	21	21	19	141
2010 - 2011	27	26	16	63
2011 - 2012	154*	147	15	44
2012 - Dec 31, 2012	62	49	18	59
Total	**271***	**250***	**75**	**347**

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

Table 2: Special Investigation Reports received by the Ombudsman from the OCA by calendar year - September 15, 2008 to December 31, 2012

Calendar Year	Child Death Investigations	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008	3	3	3	17
2009	19	19	17	83
2010	23	22	18	135
2011	148*	141	17	43
2012	78	65	20	69
Total	271*	250*	75	347

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

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204-571-5151
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www.ombudsman.mb.ca
www.facebook.com/manitobaombudsman

Glossary of Acronyms

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

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

CFS – Child and Family Services

CFSIS – Child and Family Services Information System

CFSSC – Child and Family Services Standing Committee

CFS Act – *Child and Family Services Act*

CPB – Child Protection Branch

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

FSL – Family Services and Labour

GA – General Child and Family Services Authority

MA – Metis Child and Family Services Authority

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

OCA – Office of the Children's Advocate

OCME – Office of the Chief Medical Examiner

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

SIR – Special Investigation Report

Status Definitions

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

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

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

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

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

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

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

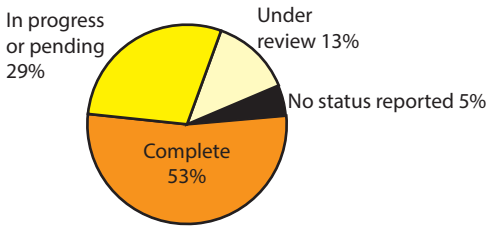
The Ombudsman's office has created two additional Status Definitions for the purposes of our report:

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

No Status Reported – The organization to which the recommendation is directed has not yet reported to the Manitoba Ombudsman. Note that because our reporting period includes recommendations made within SIRs released up to December 31, 2012, it is expected that entities would not yet have any information to report on recently released recommendations.

Table 4: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity September 15, 2008 - December 31, 2012

Authority/Agency/ Entity to which the recommendation was directed	RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NO STATUS REPORTED TO THE OMBUDSMAN
Child Protection Branch	**44**	24	20	0	0
CFS Standing Committee	**1**	0	1	0	0
CBP & CFS Standing Committee	**4**	3	1	0	0
Family Services & Labour*	**16**	11	5	0	0
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	**16**	7	4	1	4
Southern Authority	**118**	47	43	19	9
Northern Authority	**97**	48	22	26	1
General Authority	**21**	21	0	0	0
Metis Authority	**9**	6	0	0	3
External Organizations (other departments, private service providers)	**21**	17	4	0	0
TOTAL NUMBER	**347**	**184**	**100**	**46**	**17**
TOTAL PERCENTAGE		**53%**	**29%**	**13%**	**5%**



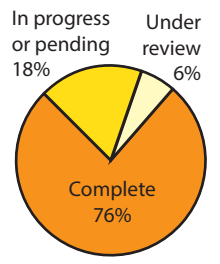
* Note: Family Services & Labour includes former department name Family Services & Consumer Affairs.

Table 3 below encompasses the recommendations within the Special Investigation Reports received by the Ombudsman from the Office of the Children's Advocate in Special Investigation Reports by calendar year since the enactment of the *Children's Advocate's Enhanced Mandate Act* on September 15, 2008. The table illustrates the status of the recommendations as reported to the Ombudsman's office by the entities to which the recommendations were made using the Status Definitions as per Standing Committee (see Status Definitions for further information).

Table 3: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity September 15, 2008 - December 31, 2012

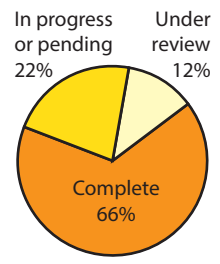
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA September 15, 2008 to December 31, 2008 by Entity

Authority/Agency/Entity to which the recommendation was directed	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NO STATUS REPORTED TO THE OMBUDSMAN	Status of Recommendations
Child Protection Branch	**1**	0	1	0	0	
CFS Standing Committee	**1**	0	1	0	0	
CBP & CFS Standing Committee	**3**	2	1	0	0	
Family Services & Labour*	**0**	0	0	0	0	
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	**0**	0	0	0	0	
Southern Authority	**6**	5	0	1	0	
Northern Authority	**1**	1	0	0	0	
General Authority	**0**	0	0	0	0	
Metis Authority	**5**	5	0	0	0	
External Organizations (other departments, private service providers)	**0**	0	0	0	0	
TOTAL NUMBER	**17**	**13**	**3**	**1**	**0**	
TOTAL PERCENTAGE		**76%**	**18%**	**6%**	**0%**	



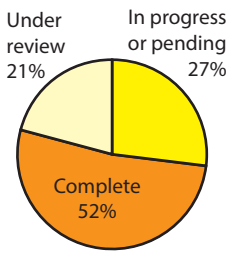
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2009 to December 31, 2009 by Entity

Child Protection Branch	**14**	7	7	0	0	
CFS Standing Committee	**0**	0	0	0	0	
CBP & CFS Standing Committee	**1**	1	0	0	0	
Family Services & Labour*	**1**	1	0	0	0	
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	**3**	2	1	0	0	
Southern Authority	**39**	26	7	6	0	
Northern Authority	**19**	12	3	4	0	
General Authority	**6**	6	0	0	0	
Metis Authority	**0**	0	0	0	0	
External Organizations (other departments, private service providers)	**0**	0	0	0	0	
TOTAL NUMBER	**83**	**55**	**18**	**10**	**0**	
TOTAL PERCENTAGE		**66%**	**22%**	**12%**	**0%**	



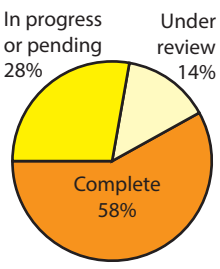
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2010 to December 31, 2010 by Entity

Child Protection Branch	**14**	8	6	0	0	
CFS Standing Committee	**0**	0	0	0	0	
CBP & CFS Standing Committee	**0**	0	0	0	0	
Family Services & Labour*	**11**	7	4	0	0	
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	**5**	2	2	1	0	
Southern Authority	**36**	12	14	10	0	
Northern Authority	**41**	16	8	17	0	
General Authority	**9**	9	0	0	0	
Metis Authority	**0**	0	0	0	0	
External Organizations (other departments, private service providers)	**19**	17	2	0	0	
TOTAL NUMBER	**135**	**71**	**36**	**28**	**0**	
TOTAL PERCENTAGE		**52%**	**27%**	**21%**	**0%**	



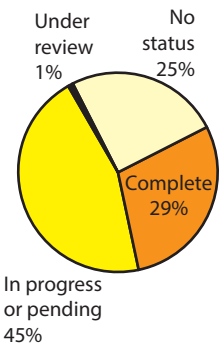
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2011 to December 31, 2011 by Entity

Child Protection Branch	**11**	9	2	0	0	
CFS Standing Committee	**0**	0	0	0	0	
CBP & CFS Standing Committee	**0**	0	0	0	0	
Family Services & Labour*	**4**	3	1	0	0	
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	**2**	2	0	0	0	
Southern Authority	**8**	2	5	1	0	
Northern Authority	**14**	6	3	5	0	
General Authority	**2**	2	0	0	0	
Metis Authority	**1**	1	0	0	0	
External Organizations (other departments, private service providers)	**1**	0	1	0	0	
TOTAL NUMBER	**43**	**25**	**12**	**6**	**0**	
TOTAL PERCENTAGE		**58%**	**28%**	**14%**	**0%**	



Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2012 to December 31, 2012 by Entity

Child Protection Branch	**4**	0	4	0	0	
CFS Standing Committee	**0**	0	0	0	0	
CBP & CFS Standing Committee	**0**	0	0	0	0	
Family Services & Labour*	**0**	0	0	0	0	
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	**6**	1	1	0	4	
Southern Authority	**29**	2	17	1	9	
Northern Authority	**22**	13	8	0	1	
General Authority	**4**	4	0	0	0	
Metis Authority	**3**	0	0	0	3	
External Organizations (other departments, private service providers)	**1**	0	1	0	0	
TOTAL NUMBER	**69**	**20**	**31**	**1**	**17**	
TOTAL PERCENTAGE		**29%**	**45%**	**1%**	**25%**	



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