Manitoba Ombudsman

2009 Annual Report

Manitoba Ombudsman

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March 31, 2010

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, 2009 to December 31, 2009.

Yours truly,

Original signed by

Irene A. Hamilton
Manitoba Ombudsman

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MESSAGE FROM THE OMBUDSMAN

In 2009, ombudsman offices around the world celebrated the 200th anniversary of the first independent public sector ombudsman. As Manitoba's Ombudsman, I am pleased to be part of an institution that began two hundred years ago in Sweden. The word "ombudsman" is Swedish, and is often translated as "citizen's representative" or "representative of the people".

The concept of a public sector ombudsman emerged in Canada in the 1960s. Alberta established an ombudsman in January 1967, followed by New Brunswick a few months later, and Quebec in 1969. Manitoba was the fourth province to establish an ombudsman. Our office opened in 1970, and we will be celebrating our 40th anniversary in April 2010.

Over the last 40 years, the mandate of the office has grown from investigating complaints under *The Ombudsman Act*, to investigating matters under *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA), to more recently reviewing matters under *The Public Interest Disclosure (Whistleblower Protection) Act* (PIDA). In addition, my office monitors the implementation of recommendations in inquest reports made under *The Fatality Inquiries Act*, and in child death review reports made under *The Child and Family Services Act*.

One of our most significant undertakings in 2009 was our systemic investigation into the Employment and Income Assistance Program, discussed later in this report. This investigation, conducted with the cooperation of the department of Family Services, was the focus of a team of investigators for several months. Large, systemic reviews can have far-reaching results, and I hope that future changes in the EIA program resulting from our review will positively affect many Manitobans.

Many of the issues we raise are addressed as departments and agencies work toward administrative improvement. However, some seem to take an inordinate amount of time to resolve. One issue that has been unresolved for more than a decade is the detention of intoxicated young people in a correctional facility (the Manitoba Youth Centre) under *The Intoxicated Persons Detention Act* (IPDA*).* Last year we were advised that government was discussing with a private agency the feasibility of using their site for a youth *Intoxicated Persons Detention Act* facility. Government was confident that a resolution would be forthcoming. Now, a year later, we have been advised that a site and service provider for a new IPDA youth community-based facility have been identified. While this is progress from last year, I am unable to report that the issue has been resolved. The facility still requires formal approval from Boards of the organizations involved, financial arrangements need to be finalized, and the facility must be built.

As in previous annual reports, we once again highlight several long-standing concerns related to high risk/high needs inmates in provincial correctional facilities. We continue to bring these concerns to light, not because of lack of progress by government in addressing our concerns, but because the pace of administrative improvement can sometimes be slow and we want to acknowledge both successes and areas where progress has slowed. We also highlight our concern with the composition of inmate discipline boards in this report. As discipline boards can significantly affect inmates and their conditions of confinement, the boards must operate in an administratively fair manner. We believe improvements can be made in this regard.

This is the second full year of experience with *The Public Interest Disclosure (Whistleblower Protection) Act* for my office, government and the public. Although there have been few investigations, numerous inquiries from the public have served to highlight issues and questions arising from this new legislation. These questions often lead us to explain the process that we follow after a disclosure is received, and we provide more information on our process in this report.

My role under FIPPA and PHIA is that of information and privacy commissioner. It is a dual role, involving both education and consultation on one hand to enhance public bodies' understanding of the legislation, and 'watchdog' on the other hand to review compliance with the legislation.

In 2009, we engaged in a number of proactive reviews of initiatives with significant privacy implications. With the cooperation of the Flin Flon School Division, we reviewed its proposed drug and alcohol testing policy that would apply to approximately 1300 students. We also continued working with Manitoba Public Insurance on its Enhanced Driver's Licence and Enhanced Identification Card Program. In all cases, it is our intent to increase awareness of privacy issues and provide improved privacy protection for the public.

In 2008, we reported that we undertook an extensive education program to enhance fairness in municipal decision making. In early 2009, we published *Understanding Fairness*, a guide for municipal decision makers. We believe it is important for all government employees and the public to understand the principles of fair decision making, and we plan to develop additional fairness materials and presentations in 2010.

In the work we do, it is important to maintain positive relationships with both the public and government. Although FIPPA, PHIA, PIDA and *The Ombudsman Act* enable my investigators to conduct thorough investigations with access to people, information, and offices as required, we prefer to operate in a more informal way. I would like to thank staff of both municipal and provincial governments, and other public sector bodies and trustees, for their continued

cooperation when I or my staff contact them for information related to an investigation or review we are conducting.

Lastly, I must thank my colleagues in the Office of the Ombudsman for their dedication to the important work we do, for their commitment to making a difference, and for their willingness to take on whatever issue comes through the door. Collectively, office staff responded to 4076 complaints and inquiries in 2009. Manitoba's population is diverse and government is complex, and the variety of issues handled by staff in my office is reflective of this environment.

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 has continued to increase. 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 policy and preparing background reports on the history of a complaint or issue.

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 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, people can be assured that her investigations will be neutral. Broad and substantial powers of investigation ensure that her investigations will be 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.

The Act 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.

The Act 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 the Act.

The Act 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, referring matters to the Auditor General where appropriate, 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 require 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 the Act. Given the serious nature of an allegation of wrongdoing, and because personal and professional reputations could be at stake, it is of utmost important that our office handle these investigations sensitively, thoroughly and as quickly as possible.

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.

When the Ombudsman has not supported a refusal of access complaint, or when she has supported a complaint but the public body or trustee has failed to act on the Ombudsman's recommendation, an access applicant may appeal to the Manitoba Court of Queen's Bench. The Ombudsman can also appeal a refusal of access to the court in place of the applicant and with the applicant's consent. However, when appealing under FIPPA, the Ombudsman must be of the opinion that the decision raises a significant issue of statutory interpretation or that the appeal is otherwise clearly in the public interest.

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 are 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 the Act at www.gov.mb.ca/health/phia.

More information about the Ombudsman's office 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/.

Budget and Staffing for 2009/10

Budget

Total salaries and employee benefits for 30 positions		$2,439,300
Positions allocated by division are:		
Ombudsman Division	11	
Access and Privacy Division	8	
General	11	
Other expenditures		$ 461,900
Total Budget		**$2,901,200**

Staffing

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

Organizational Chart

2009 Statistical Overview

In 2009, 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)	1430
Inquiries responded to by Intake Services (information supplied or assistance provided)	1861
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*	164
Cases opened for investigation under *The Ombudsman Act*	210
Cases opened for investigation under *The Public Interest Disclosure (Whistleblower Protection) Act*	0
Cases opened in response to recommendations made under *The Fatality Inquiries Act* and *The Child and Family Services Act*	61
Cases opened for investigation under Part 5 of *The Freedom of Information and Protection of Privacy Act* (FIPPA)	309
Cases opened for investigation under Part 5 of *The Personal Health Information Act* (PHIA)	21
Cases opened under Part 4 of FIPPA and PHIA	20
Total Contacts	**4076**

EDUCATION AND OUTREACH

Public awareness of the Ombudsman's Office and its role and responsibilities, and a clear understanding throughout provincial and municipal governments, and other agencies, boards and commissions, of the jurisdiction and mandate of the office is essential. In 2009, a position within the office was assigned to coordinate all communications and education activities, and to create a training program for office staff to support highly skilled and knowledgeable investigative teams.

Presentations

Published in 2007, *Joining the Herd: A Handbook on Participating in Manitoba's Government,* is our educational guide for grades 6, 9 and 11. In 2009, we gave "Joining the Herd" presentations in seven schools, including schools in Brandon, Carman, Gimli, and Winnipeg. We also presented to students at adult education centres in Brandon, Swan River, and Winnipeg, and to students at the University of Winnipeg , University of Manitoba, and University College of the North.

General presentations on the Ombudsman's role and function were provided to several organizations, including Welcome Place, the Manitoba Interfaith Immigration Council, the Rotary Club, and to Partners for Careers. As part of our efforts to reach and provide service to Aboriginal people in Manitoba, we met with a number of organizations including Lord Selkirk Park Aboriginal Women's Group, the Manitoba Association of Friendship Centres, Ka Ni Kanichihk, Blue Sky Youth Alliance, and the Native Addiction Council of Manitoba.

As we have noted in previous annual reports, our office has been providing training sessions to all correctional officer classes to ensure officers understand the role and function of the Manitoba Ombudsman when complaints about the correctional system are received. In 2009, we presented eleven correctional officer training sessions.

Increasing awareness of the kind of work that we do helps to foster better working relationships when we do contact a government department or agency after we have received a complaint. In 2009, we were invited to make presentations to staff at the Manitoba Developmental Centre in Portage la Prairie, and the Manitoba Civil Service Commission. We also presented two half-day sessions to City of Winnipeg employees – one about the Ombudsman's role under FIPPA and PHIA, and the other about working with the Ombudsman under *The Ombudsman Act*.

For a third year, our office collaborated with colleagues from Manitoba Health on a session about current practice issues and PHIA for regulatory bodies that govern health professionals

(there are 22 such organizations in Manitoba, including the College of Physicians and Surgeons, Pharmaceutical Association and Association of Optometrists). Although these organizations are not subject to PHIA, their members are. The health regulatory bodies serve an important role keeping health professionals informed on PHIA issues and resources. Staff also presented to members of the College of Occupational Therapists on the role and mandate of the Ombudsman under PHIA.

In 2009, we hosted ten "Brown Bag Talks" in our Winnipeg Office for access and privacy coordinators and officers. Discussion at these lunch-time talks focused on issues of interest under FIPPA and PHIA. We also provided a customized lunch-time presentation for journalists at the Winnipeg Free Press concerning available resources that assist in making access to information requests.

The Ombudsman is frequently invited to speak at conferences and other events. Ombudsman Irene Hamilton participated on a panel with other Information and Privacy Commissioners at a national conference in Ottawa held for access and privacy investigators. As part of the British Columbia Ombudsman's 30th anniversary celebration, she was invited to represent the provincial ombudsman model on a panel that examined different kinds of "ombudsmanship". She also presented on "Working with the Ombudsman" at a FIPPA workshop hosted by the Manitoba Municipal Administrators' Association, on the appreciative inquiry process at the Annual General Meeting of the General Child and Family Services Authority, on the role of the Ombudsman to Legislative Interns, and on her experience as a leader to participants in the Civil Service Commission's Women's Leadership Program.

Ombudsman staff are also invited to speak at conferences. At the Ottawa conference noted above, staff presented information on the duty to assist an applicant seeking access to information. Staff also presented a session on fair decision making at the Northern Association of Community Councils Conference in Winnipeg.

In addition to the presentations noted above, we staffed exhibitor tables at the 2009 Law Day open house at the Winnipeg Law Courts, at the Manitoba Centre for Health Policy's 16th Annual Rural and Northern Healthcare Day, at a career and resource fair at Children of the Earth School, and at the Manitoba Social Studies Teachers' Special Area Groups Conference at Kildonan East School in Winnipeg.

Events

The fourth Right to Know Week was celebrated in Canada from September 29 to October 2, 2009, coinciding with international Right to Know Day on September 28. Right to Know celebrations promote an individual's right of access to information held by government and

other public institutions, and provide valuable opportunities to appreciate and critically assess this right.

Leading Manitoba's Right to Know celebrations was keynote speaker Janet Keeping, President of the Calgary-based Sheldon Chumir Foundation for Ethics in Leadership. Ms Keeping presented on "The Struggle against Corruption: The Rule of Law and 'Right to Know' -- an international perspective." Among other activities, Ombudsman Irene Hamilton also presented on "Your Right to Know and the Manitoba Ombudsman" following the annual general meeting of the Consumers' Association of Canada (Manitoba).

November 20, 2009 marked the 20th anniversary of the United Nations' Convention on the Rights of the Child (CRC). In collaboration with the Manitoba Human Rights Commission, the Office of the Children's Advocate, UNICEF, and Voices: Youth in Care, we produced a collection of materials on compact disc to celebrate the CRC.

Publications

Four new Access and Privacy "Practice Notes" were produced to assist persons using the legislation, including *The Exercise of Discretion When Applying Discretionary Exceptions to Refuse Access under FIPPA*, *The Duty to Assist under FIPPA and PHIA*, *Making Effective Written Representations in Responding to Complaints about Refused Access under FIPPA*, and *Considerations for Applying Exceptions when Refusing Access under The Freedom of Information and Protection of Privacy Act (FIPPA).*

Understanding Fairness: A Handbook on Fairness for Manitoba Municipal Leaders was published in March 2009 to assist municipal leaders and administrative staff in achieving and promoting fairness.

The Rights of Youth pamphlet series published jointly by our office, the Office of the Children's Advocate and the Manitoba Human Rights Commission, remains one of our most popular information series. In 2009, six pamphlets in the series were updated, including *Human Rights*, *On the Job*, *Adoption*, *Family Matters*, *Neglect & Abuse*, and *Youth in Care*. The remaining two – *Criminal Justice*, and *You and School* – are currently under revision.

Working with our office, a Faculty of Social Work graduate student completed an appreciative inquiry into the child welfare system. The final report of this project, *In Their Own Words: An Appreciative Inquiry into the Experiences of Youth in Foster Care*, was published.

In conjunction with the launch by Manitoba Public Insurance of the Enhanced Identification Card (EIC) Program in February 2009, we released *Manitoba EIC: 10 Points for Privacy*

Awareness, a fact sheet for people considering application for the voluntary card. The fact sheet has since been expanded to include the new voluntary Enhanced Driver's Licence (EDL).

Our newsletter, *Manitoba OmbudsNews*, was published quarterly to highlight office events and initiatives.

REPORT ON ACTIVITIES OF THE OMBUDSMAN DIVISION

Overview of 2009

Investigators in the Ombudsman Division investigate complaints under *The Ombudsman Act* relating to "matters of administration", a phrase that refers to everything done by government authorities in the implementation of government policy, including issues related to fairness. As we reported in our 2008 Annual Report, we developed a fairness guide to assist government staff in understanding and applying the concepts of administrative fairness. *Understanding Fairness: A Handbook on Fairness for Manitoba Municipal Leaders* was released in 2009. While the guide is directed at municipalities, the fairness principles apply broadly.

It is through individual complaints about government actions or decisions that we obtain a snapshot of how a government department or agency works. Resolving an individual complaint can make a difference to one person, and if the government department or agency is proactive, it can result in administrative improvement that can affect many. It is by investigating these individual complaints that areas requiring administrative improvement are identified. These issues may be followed up through our "Ombudsman's Own Initiative" investigations.

As we reported in our 2008 Annual Report, we have also made a conscious effort through our investigation process to identify and investigate broad systemic complaints as well as individual issues. As a result, we continue to address situations where there appears to be gaps between the intention of legislation and subsequent policy set by government, and the actual results that occur when policies and programs are implemented. These kinds of gaps often affect large numbers of people. Administrative improvements in these kinds of situations can have far-reaching results.

In 2009, two large systemic reviews occurred through a team investigation model. We completed our second follow-up review of the implementation of the recommendations from our 2006 report *Strengthen the Commitment* and also initiated and completed a review of the Employment and Income Assistance Program.

The investigative work we do, problems we identify, and improvements we suggest are only of benefit if government is responsive to our findings and suggestions. Administrative improvement is an ongoing process and only through the sincere effort and commitment of government employees and administrators can real, positive change occur. When there is a willingness and desire for improvement, changes do occur, despite the sometimes slow pace of change.

Included in this report are examples of various types of investigations and reviews conducted by Ombudsman Division staff.

Cases of Interest

Individual Complaint Investigations

Responding to complaints from individuals is one of the key functions of the Ombudsman Division. Once we receive a complaint, we work with the individual making the complaint and with government to gain a thorough understanding of the situation. Whatever the complaint, we investigate independently and impartially without advocating for either the individual or government.

The nature of the complaints we receive varies widely. They can be about any provincial government department, board, commission, agency, Crown corporation, or municipal government. Most complaints, however, do have one feature in common. They are usually about an action or decision of government that a person believes was unfair.

In this report, we highlight complaints about medical care at the Headingly Correctional Centre and the Grace Hospital, the unauthorized removal of furniture by the Manitoba Housing Authority, the refusal of Manitoba Infrastructure and Transportation to compensate a landowner for its removal of trees on his property, and about Manitoba Public Insurance's assessment of liability for a participant in its High School Driver Education Program.

Emergency medical care

An individual raised concerns with our office regarding the process involved in obtaining medical treatment, first at Headingley Correctional Centre (HCC) and then at the Grace Hospital. The individual experienced stomach pain, dizziness and nauseau, and his condition rapidly deteriorated due to a severe infection that affected his pancreas and kidneys. He advised us that the HCC did not promptly provide him with an escort to the hospital and as a result he suffered long-term medical complications. The individual also expressed concern regarding the triage process after his arrival at the Grace Hospital. While our office was without grounds to make a formal recommendation on his behalf to HCC and the Grace Hospital, during the course of our investigation into his complaint we identified specific areas requiring administrative improvement.

HCC has approximately 700 inmates in its care at any given time and inmates are typically permitted out of their cells between the hours of 7:00 a.m. to 11:00 p.m. daily. When the individual’s medical condition began to deteriorate, there were no nurses on duty at HCC to

conduct an assessment to determine the type of intervention necessary, as nurses are on duty at the HCC from 8:00 a.m. to 8:00 p.m. daily. We were advised that it is the intent of the HCC to extend the hours that nurses are available at the centre to 11:00 p.m. daily once the Medical Unit is fully staffed.

HCC also transported the individual to the Grace Hospital in a van. We suggested that it may have been preferable had the HCC utilized ambulance service when it was evident the individual required hospitalization and his condition had worsened to the extent that he was no longer ambulatory.

This particular case also highlights the importance for correctional staff to complete accurate and detailed incident reports. The reports that we examined during the course of our review appeared to lack the detail necessary to sufficiently clarify the chain of events that occurred. Further, important details that were shared with our office during staff interviews were not included in the reports on the HCC's information database. Incidents of this nature should be appropriately documented.

As a result of this complaint, the Grace Hospital conducted an internal review of the incident pertaining to the care that the individual received. We were advised that the Medical Manager of the Emergency Department concluded that although the individual was triaged as Level 4 (Less Urgent), it would have been more appropriate had he been triaged as a Level 3 (Urgent). It is our understanding that the Grace Hospital has interviewed the involved personnel and continues to make strides to improve its communication with patients, families and other stakeholders.

Missing chair

An individual living in a Manitoba Housing Authority (MHA) suite received a gift of a new leather chair purchased by his daughter. He authorized MHA staff to enter his suite and remove the old chair in order to make room for the new one. The old chair was removed, and the new one was in place. A short time later, however, the individual returned home to find his new chair missing. He contacted the MHA property manager who informed him that the chair was removed as authorized. The individual explained that two chairs had been removed – the old one as arranged, and the new one while he was not at home. The property manager would not accept fault for the removal of his new chair. The individual contacted our office for assistance.

We contacted MHA for more information. MHA determined that the authorization to remove the chair was inadvertently provided to two staff persons, both of whom removed a chair. MHA agreed to meet with the individual, and asked that the individual provide a receipt for the chair.

His daughter was able to provide a receipt. The individual was reimbursed the purchase price of the new chair.

Removal of trees

An individual owned 20 acres of land with 300 feet of frontage along a Provincial Road. Six years ago, the individual planted 50 golden willow trees as a shelter belt, 12 feet within his property line. The individual returned from vacation to discover that all 50 trees had been cut down by a contractor employed by Manitoba Infrastructure and Transportation. The department had not provided written notice or reasons for the removal of the trees.

The individual sought compensation from the department, but the department refused on the basis that the individual did not have a permit for the trees as required by subsection 14(3) of *The Highways and Transportation Act*, at the time of the loss. Subsection 14(3) states, "*except as may be authorized by a permit issued by the minister, no person shall plant or place, or cause to be planted or placed, any tree, shrub or hedge upon or within 50 feet of a departmental road outside a city, town, village or unincorporated village district*." After the trees had been removed , but prior to the denial of his claim for compensation, the individual applied for a permit to plant trees in the same location as the trees that had been cut. A permit was granted.

The individual complained to our office. At the time he initially planted the trees, he explained that he was not aware that a permit was required. He expressed the opinion that his trees did not in any way create a hazard to traffic or obstruct the view of the roadway. The fact that the department issued a permit to plant new trees in the same location appeared to indicate that the department also had no concerns with the placement of the trees.

After we contacted the department, the department reviewed the situation and concluded that it had not followed its usual administrative processes for removing unauthorized structures, including trees, along departmental roads. The department made the decision to compensate the individual for the removal of the trees.

Manitoba Public Insurance's High School Driver Education Program

A father complained about Manitoba Public Insurance (MPI) and its assessment of liability is his daughter's motor vehicle accident; an accident that occurred in less-than-ideal winter driving conditions while she was participating in MPI's High School Driver Education Program. The father explained that he had reservations about his daughter participating in the driving lesson due to the weather conditions, but the lesson proceeded as scheduled. He felt that his daughter should not be 100% liable for the accident that resulted.

While we did not make any recommendations to MPI on the complainant's behalf, we made further inquiries with MPI regarding its in-car lesson cancellation policy as it relates to safety/unsafe road and weather conditions. MPI's cancellation policy indicates that 24-hour notice to instructors is required to cancel an in-car lesson, but in extenuating circumstances, for example, illness or safety concerns, the requirement for 24-hour notice could be waived. If a parent was concerned about their child's safety due to poor weather conditions, an in-car driving lesson could be cancelled with less than 24-hour notice.

During the investigation of the individual complaint, MPI explained that its cancellation policy is verbally explained to parents at the Driver Education Program's parent meetings. Our office suggested that written information about the policy could benefit program participants. In response to our suggestion, MPI readily agreed to include information about its in-car cancellation policy as it relates to safety/unsafe road conditions in the information package it provides to program participants and their parents or guardians.

"Ombudsman's Own Initiative" Investigations

In some cases, in the course of investigating an individual complaint, we may identify areas of concern that could benefit from further review. These situations often result in an investigation by the "Ombudsman's Own Initiative" (OOI). As a result of OOI investigations, sometimes recommendations are made that result in changes to policies or programs that will benefit all individuals who participate or are affected by the policies and programs.

In this report, we highlight two OOI cases, including investigations into the discharge process in Burntwood Regional Health Authority and limitations on recreation at Winnipeg Remand Centre.

Discharge Process in Burntwood Regional Health Authority

After investigating an individual complaint about patients who were discharged from the Thompson General Hospital to the Acquired Brain Injury Program (ABIP) residence in response to concerns about the patients' ability to manage on their own without appropriate supports, our office began an OOI investigation to review the discharge process in the Burntwood Regional Health Authority (BRHA). As a result of our investigation, the BRHA committed to:

- Consult with the Office of the Vulnerable Persons' Commissioner to develop an informational session on the subject of vulnerable persons' living with a mental disability to offer to ABIP staff.
- Develop a policy to ensure vulnerable and high needs clients are connected with the appropriate community supports prior to discharge.

- Develop policy and procedure whereby ABIP will notify senior management of those cases where individuals are denied access to the five bed ABI residence.
- Develop a review process for those situations where clients of the ABIP are criminally charged by their healthcare providers.
- Ensure that summaries are completed for all future case conferences and retained on the patient file for future reference. This will augment the care plans that are currently prepared for patients of the BRHA.
- Conduct an internal review of the ABIP admission criteria to ensure the five bed unit is being utilized to its fullest potential.

Limited recreation and fresh air for segregated inmate population

The Winnipeg Remand Centre (WRC) could not provide adequate levels of recreation and fresh air to segregated inmates in custody due to physical plant limitations. The WRC has one central open area and gym to meet the needs of approximately 400 inmates, a number that exceeds the rated bed capacity of the facility. Our office raised concern with Adult Corrections regarding its inability to provide the basic care necessary for inmates in segregation.

The WRC acknowledged this concern and wrote in part: "*From a human rights perspective, we are currently unable to meet basic requirements of fresh air and exercise for our segregated inmate population. The Division Segregation order defines basic rights as including 'food, hygiene, exercise, medical and spiritual care' at best given an equitable recreation rotation, inmates in segregation are receiving recreation once every second week.*"

Adult Corrections further reviewed this situation and the WRC submitted capital project proposals to remedy the situation. On September 1, 2009, we were notified that renovations to the open area and gym would begin in the fall. Renovations are now underway, and should be completed in 2010.

Systemic Investigations

Systemic investigations are comprehensive reviews of government programs and services. Often such complaints arise because there appears to be a gap between administrative policies and procedures put in place by governments to achieve certain goals, and the actual outcomes that occur. The purpose of systemic investigations is to achieve administrative improvement that results in better government programs and services for all citizens.

Systemic investigations may arise through multiple individual complaints that are received about the same issue, or arise through an OOI investigation. In the case highlighted in this report, a group of non-governmental organizations whose clients include large numbers of

Employment and Income Assistance recipients expressed numerous concerns about the province's EIA Program. We also provide an update on our Child Welfare Review.

Employment and Income Assistance Program

In August 2008, twelve non-governmental organizations wrote to the Manitoba Ombudsman to request a review of Manitoba's Employment and Income Assistance (EIA) program - a program that provides income assistance to Manitobans in need, and helps Manitobans regain their financial independence by assisting them to make the transition from income assistance to work. Their letter of complaint stated, in part:

On behalf of the social service agencies listed below, we would like to file a systemic complaint regarding the way in which the mandate, administrative policies and regulations and procedures are implemented by the staff of the Manitoba Employment and Income Assistance Program (EIA). As a group we feel it was important to register our concerns and seek your intervention, as we have discovered that many of us have experienced the same difficulties. The result of this common experience is that many EIA recipients we assist have been negatively impacted and we feel a review of how this program functions is necessary.

The complaint specifically identified concerns with how the program communicates with applicants and participants, the right to apply for assistance, the definitions of "disability" and "basic needs", the disability assessment process, the program's policies and practices on common-law relationships, the use of discretion in decision making, and many other aspects of the program.

Over the course of approximately thirteen months, a team of six Manitoba Ombudsman staff conducted an investigation into the EIA complaint. The investigation included a review of relevant legislation and regulations, annual reports, publications prepared for program participants, departmental policies available to the public, and operational directives provided to program staff. In addition to reviewing program documentation, interviews were conducted with representatives of the complainant organizations and staff of both governmental and non-governmental collateral organizations to obtain their views on the administration of the EIA program. Interviews were also conducted with over 125 representative program staff at all levels in every EIA office in Manitoba.

Investigation of the EIA complaint concluded in 2009 and found many areas where administrative improvements could be made. A report outlining our investigative findings and recommendations will be published in 2010.

Child Welfare Review Update

In our second report submitted to those responsible for the governance of the child welfare system, we commented on the progress to March 31, 2009 towards the implementation of the over 100 recommendations in *Strengthen the Commitment* designed to improve the administration of the child welfare system in Manitoba.

All the recommendations were accepted by the Province. Upon accepting the report, the Minister of Family Services and Housing announced that … *public accountability for the action on the recommendations will be enhanced with report cards on action taken to be released by…the ombudsman on the review of the child welfare system for the fiscal years 2007/08 and 2008/09*.

A copy of the *Strengthen the Commitment* report and the 2007/08 and 2008/09 Progress Reports can be found on our website at www.ombudsman.mb.ca.

We limited the focus of our 2008/09 progress report to the following ten areas:

- The Child Welfare Secretariat (now the Standing Committee Office);
- Child Death Reviews;
- Transfer of Responsibility for Protection Hearings;
- Use of Voluntary Placement Agreements;
- Foundational Standards/Protocols/Directives;
- Standardized Risk Assessment;
- Child and Family Services Information System (CFSIS);
- Authority Determination Protocol (ADP);
- Designated Intake Agencies (DIAs); and
- All Nations Coordinated Response Network (ANCR).

Some foundational issues identified in our 2006 report have not yet been completely resolved and implemented throughout the system for a variety of reasons. There are also some areas that appear to be moving more slowly than we had anticipated.

We reiterate that it is essential that staffing in the child welfare system be stabilized. Vacant positions throughout the system need to be filled as soon as possible with permanent staff rather than with staff who are in temporary or term positions, secondments or in acting status appointments. This stability is required to ensure that there is consistency and continuity in front line service delivery as well as in foundational policy work, both of which are critical to the child welfare system. Only with a full staff complement and a strong foundation will improvements and

enhancements to child welfare service delivery be achieved in a way that is responsive to the needs of the system.

We will continue to review the child welfare system in conjunction with our monitoring of the implementation of recommendations made by the Children's Advocate in child death review special investigation reports. Our annual report will contain a section on this responsibility each year.

Public Interest Disclosure Act Investigations

This is the second full year of experience with *The Public Interest Disclosure (Whistleblower Protection) Act* for our office, government and the public. Although there have been few investigations to date, numerous inquiries from the public have served to highlight issues and questions arising from this new legislation. These questions often lead us to explain the process that we follow after a disclosure is received.

After we receive a disclosure, we must first determine if the Act gives us jurisdiction over the alleged wrongdoer. The entities to which PIDA applies are:

- all provincial government departments and all agencies set out in *The Financial Administration Act*;
- all universities and colleges;
- all personal care homes; and
- all organizations providing residential and vocational services to person with mental disabilities where the organization receives 50% or more of its operation funding from the provincial government.

Secondly, we must determine if the disclosure received discloses a “wrongdoing” as defined under the Act. Generally a wrongdoing is something that would:

- be an offence under a provincial or federal statute;
- be gross mismanagement; or
- create danger to the safety or health of the public.

Thirdly, we must determine if an investigation is required. Subsection 21 of the Act sets out a number of circumstances where the Ombudsman is not required to investigate, including circumstances where:

- the disclosure could be more appropriately dealt with under another act;
- the disclosure is frivolous, vexatious, is not made in good faith, or does not deal with sufficiently serious subject matter;
- so much time has elapsed that investigating would not serve a useful purpose;

- the disclosure is about a matter that results from a balanced and informed decision-making process; or
- the disclosure could more appropriately be dealt with under a collective agreement or employment agreement.

This last point is consistent with our practice to not investigate labour relations matters. Deciding whether a matter is a labour relations issue is not complex, and can often be done at the intake stage.

Other circumstances where investigation is not required are more complicated, such as a determination about whether the matter disclosed results from a balanced and informed decision-making process regarding a public policy or operational issue. In our view, this creates a high threshold test, reflective of the Legislature's intent as set out in the purpose of the Act, namely to facilitate the disclosure and investigation of significant and serious matters. This provision clearly precludes an investigation about a decision where there is dispute between the decision-making entity and an employee about the decision.

To determine if the subject matter of the disclosure could more appropriately be dealt with, initially or completely, according to a procedure provided for under another Act, we must consider the expertise and experience of other bodies that have jurisdiction to determine the issue.

All of these issues have arisen as a result of complaints to our office in 2009. Our intake services team received 12 inquiries about the Act in 2009. In all of these cases, information was provided, and no further investigation was necessary. One investigation related to a disclosure about a government agency received in 2008 remains pending.

In 2009, we completed investigations into two disclosures of wrongdoing received in 2008 relating to the same healthcare facility. While both disclosures pertained to the same division of the facility, they were from two different individuals with slightly different perspectives on the situation based on their work responsibilities within that sector.

Our investigation of the disclosures did not find that there had been *gross mismanagement* as alleged. Concerns expressed indicated a lack of effective controls over certain practices in one particular operational sector of the facility, as well as concerns with the management of that area. After reviewing the disclosures, our office requested information from the facility and had discussions with representatives of the facility. Once the concerns had been brought to the attention of the chief operating officer, it was not necessary for the Ombudsman to make recommendations for corrective measures; the facility itself had assessed the situation and implemented new policies to prevent the occurrences which had given rise to the disclosures.

The Ombudsman was satisfied that the facility had considered the disclosures and acted appropriately to institute measures to resolve the concerns that had been raised with our office.

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 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 2009, five inquest reports with recommendations were received by our office for follow-up, and one of those cases was completed. Four additional cases that had been received in previous years were also completed.

Child Death Reviews

On September 15, 2008, Bill 11, *The Children's Advocate's Enhanced Mandate Act*, was proclaimed. This legislation transferred the responsibilities for conducting Section 10 reviews from the Chief Medical Examiner to the Children's Advocate. The Section 10 reviews are now referred to as Child Death Review Special Investigations.

The Office of the Children's Advocate has responsibility for conducting comprehensive reviews of the deaths of children and makes recommendations she finds necessary to the child welfare

system and publicly funded social services, mental health, or addictions treatment services that were provided to the child, or in the opinion of the Children's Advocate should have been provided. Expanding the scope of the reviews to include collateral agencies permits recommendations to be made to all systems that have, or should have, provided services to the child, rather than being solely focused on the child welfare system.

With the change to the legislation, the Children's Advocate now also forwards her recommendations to the Ombudsman. As with inquest reporting, we monitor the implementation of those recommendations. The new structure assures the public that monitoring of the implementation of recommendations is truly independent, impartial and external to the child welfare system and to government.

The Child Protection Branch has committed to provide our office, on a semi-annual basis, system-wide reports on government's progress in implementing all recommendations arising from Child Death Review Special Investigations. In this way, the outcomes of the review process will be transparent and public accountability will be strengthened.

As of December 31, 2009, we received 21 Child Death Review Special Investigations reports from the Children's Advocate.

The Office of the Children's Advocate received notification of 182 child deaths in 2009, and determined that 68 special investigation reports require completion. Together with 14 cases where the death of the child occurred after September 15, 2008 (the date the new legislation came into effect) there are 82 child death reviews in total that require completion. The office also needs to complete 88 child death reviews in cases where the death of the child occurred prior to September 15, 2008.

Appreciative Inquiry

In our ongoing review of the Child Welfare System we were interested in hearing from young people who are affected by it. A question that is not often asked of them is what is working well for them in the system. We undertook a study to find this out by interviewing young people between the ages of 14 and 21 who were in foster care, or had recently been in foster care. The study was conducted as part of our follow-up to the *Strengthen the Commitment* review of the child welfare system and was conducted using "appreciative inquiry".

A graduate student from the University of Manitoba Social Work program researched the appreciative inquiry model, designed and conducted the interviews, and wrote the report. The report provides information about the interviews and makes recommendations about what works well that can be replicated for the benefit of youth in care. It is our understanding that

most of the young people found this experience quite interesting and enjoyed the chance to tell their stories to an interested listener.

We believe that the positive information contained in the report will provide useful information to service providers in the system, and foster parents in particular, about what young people believe some of the best practices might be for welcoming them into foster homes in a way that assures that they will feel wanted and valued.

A copy of the report produced from this study, *In Their Own Words: An Appreciative Inquiry into the Experiences of Youth in Foster Care,* is included on the CD version of this annual report and also is available on our website at www.ombudsman.mb.ca.

Update on Licensing and Enforcement Practices of Water Stewardship

In 2008 our office released its *Report on the Licensing and Enforcement Practices of Manitoba Water Stewardship,* containing fifteen recommendations intended to address long standing concerns identified by individuals, municipalities and conservation districts. Manitoba Water Stewardship accepted all of the recommendations. With the understanding that implementing our recommendations would require planning and action in the long-term, we undertook to follow-up with the department to ensure the appropriate action was being taken. In 2009 we asked the department for a status report on the activities they had undertaken to give effect to our recommendations.

Our initial investigation had disclosed that unlicensed drainage was often undertaken under the guise of "maintenance" of existing drains. Although *The Water Rights Act* (the Act) did not distinguish new works from maintenance, the department had adopted a practice of exempting drain maintenance. This practice had become a source of confusion and contention between landowners and made it difficult to enforce the provisions of the Act when disputes arose. We recommended that the department consider an amendment to *The Water Rights Act* to create a distinction between the creation of new water control works, and maintenance or minor works; and include a clear definition of ”maintenance”. We also recommended that the department consider an amendment to *The Water Rights Regulation* to create an expedited application process when appropriate for licensing maintenance and minor works.

The department advised us that drain maintenance is no longer exempt from licensing requirements under the Act, and that they have adopted a policy and procedure for expedited authorization of minor water control works. Officers may grant authorization if works are minor, according to a definition established in policy, and unlikely to cause impacts. The definition of minor water control works is included in the policy document, application form and licence form. A legislative amendment was not required as new application and licence

forms and policy for expedited authorization of minor water control works were approved by the minister. We believe that the department has taken the action necessary to give effect to these recommendations.

Because of concerns about inconsistent or inadequate enforcement in response to complaints about illegal drainage we recommended that the department develop a policy to be consistently applied to take enforcement action when illegal drainage is occurring. The department confirmed that such a policy was finalized and approved in 2009 following extensive consultation with stakeholders, including representatives from conservation districts, municipalities, agricultural producers and environmental agencies. The intention of the policy is to provide a consistent approach to enforcement province-wide. The policy has been reviewed with all Water Resource Officers and is being considered for addition to the Manitoba Water Stewardship website.

Adding this policy to the department's website would be consistent with another of our recommendations, that the department develop a clear public policy on enforcement and communicate it to municipalities, conservation districts and the general public. In response to that recommendation, the department advised that its efforts are ongoing and include presentations to municipalities, conservation districts, producer groups and staff from other departments. As well, the department has had display/information booths at events such as Ag Days, and at some meetings of both the Manitoba Conservation Districts Association and the Association of Manitoba Municipalities. Advertisements, letters, presentations, news releases, and the department's website have all been utilized to inform the public of program changes.

Our 2008 report made a number of recommendations designed to enhance the department's enforcement powers to address the concern that penalties for breaching the Act were insufficient to act as a deterrent to draining water without a licence. The department advised that it has implemented set fines under *The Summary Convictions Act,* ranging up to $2500 per offense using a Common Offence Notice. Each day an offence continues is a new offence under the Act, so that total fine levels can be a substantial deterrent. The department will continue to monitor the effectiveness of existing fine levels.

One of the most significant issues facing the department as it moved forward was an existing backlog in licensing and enforcement. We recommended that the department develop a concrete and detailed work plan outlining how new resources will be allocated to deal with the existing backlog, while also addressing new applications and enforcement concerns.

In their status report the department advised that a reduction of the licensing backlog is the highest priority for the immediate future and some progress has been made in this respect. A plan for addressing the backlog is in place and progress is being monitored against that plan.

In reviewing the department's status report we noted that their ability to reduce the backlog has been affected by a number of factors beyond their control. We were advised that in the last fiscal year, the licence application rate increased to almost equal the number of licences produced. Licensing and enforcement are in a period of change that involves a learning curve for both departmental staff and the public, particularly around changes such as the new provisions for approving maintenance and minor works and in light of increased enforcement activities generally.

Despite the additional work necessitated by the significant changes occurring, progress has been made in addressing the backlog. Water Resource Officers have set targets for licence, complaint and compliance check files to complete. In the fiscal year 2008/09 there was a net reduction in the licence application backlog from 2289 to 1762, representing a reduction of 23%. We will continue to ask for status reports on the department's efforts to further reduce and ultimately eliminate the backlog.

There are two further areas we will continue to monitor in the upcoming year - the department's ongoing efforts to work more closely with conservation districts and the development of a proposed "environmentally friendly" drainage manual.

The department reported some progress in its efforts to work more closely with conservation districts, pending the development of approved watershed management plans that could serve as the basis for entering into formal licensing partnerships. In the upcoming year we will canvass conservation districts to ascertain their views on the extent to which the evolving relationship with the department is working to enhance local input into licensing decisions.

Finally, to address a broader environmental issue we recommended that the department complete and publish its proposed “environmentally friendly” drainage manual as a priority. Despite the fact that funding for the manual had been approved in 2007, and we were told it would be completed in 2008, it has not been completed. We are now advised that it is expected to be finalized in 2010. We will follow-up with the department in 2010 to determine the status of this manual.

High Risk/High Needs Inmates

Our office continues to have significant concern regarding the incarceration of high risk/high needs individuals who are unable to meet the conditions of bail because the systems they rely upon cannot find suitable community placements. Many people living with a mental illness or mental disability who have been charged with an offence are experiencing lengthy periods of incarceration. Based on our continued interactions with the criminal justice system, we

acknowledge there continues to be challenges in the development of placements so these individuals can obtain bail and be released from custody within more reasonable time frames.

In its 2008/09 annual report, the Office of the Correctional Investigator (for inmates in federal facilities) reported that "*at admission, 11% of federal offenders have a significant mental health diagnosis and over 20% are taking a prescribed medication for a psychiatric condition*". The report also noted that "*female offenders are twice as likely as male offenders to have a mental health diagnosis at admission —over 30% of female offenders had previously been hospitalized for psychiatric reasons*." While similar statistics are not available for provincial correctional centres, the Corrections Division of Manitoba Justice reported to us that it is undertaking a "mental health screening tool" pilot project. In 2009, use of the screening tool began at the Manitoba Youth Centre, and in 2010, it will be used at the Winnipeg Remand Centre. The tool is designed to identify people who have disorders that warrant immediate attention, intervention, or more comprehensive assessment.

There is not yet a mechanism in place such as a specialized court as found in other jurisdictions that could divert mentally ill or mentally disabled individuals out of the criminal justice system – an overcrowded system with limited resources and treatment options – into the community with the necessary supports to treat their illness or disability. In June 2009 the province's Disabilities Issues Office released its report "*Opening Doors: Manitoba's Commitment to Persons with Disabilities*". A key accomplishment noted in the report was the announcement by Manitoba Justice to create "*a new court system dedicated to offenders who have mental health issues*." In 2009, the Provincial Court also reiterated its position to the Ministers of Justice, Health, and Healthy Living that a mental health court for those with a serious mental illness who come into conflict with the criminal justice system should be established. While the committee established to move the concept forward has been working toward this goal, and the concept is obviously supported by government, funding has not been realized and the province has no timeline for the establishment of such a court. This continues to be an outstanding concern for our office.

In our 2007 Annual Report, we reported on our concern regarding incarcerating people living with mental illness and the deterioration of their mental health while in custody. These inmates required hospitalization in a psychiatric facility but they remained in correctional facilities on a waiting list for admission. As these individuals are in custody, the only suitable hospital setting is the secure 14-bed, short-term Forensic Services Unit at the Health Sciences Centre's PsycHealth Centre in Winnipeg. The Selkirk Mental Health Centre maintains 18 longer-term forensic rehabilitation beds.

"*A Statistical Survey of Canadian Forensic Mental Health Inpatient Programs*," published in *Healthcare Quarterly* in 2006, indicated that Manitoba ranked lowest compared to other

Canadian jurisdictions in terms of forensic beds per unit of population. Statistics regarding waiting times for forensic services in Manitoba are concerning. In 2008, the average waiting time for admission to the Forensic Services Unit was 15.8 days, and individuals in 17 cases waited 25 days or longer for forensic services while incarcerated in provincial jails. In one case, it appeared that an individual remained incarcerated for 69 days before being admitted to the Forensic Services Unit, and was later found to be not criminally responsible. In 2009, the average waiting time increased to 24.2 days, and in one case, an individual waited 82 days.

In 2009, our office requested clarification from PsycHealth's Forensic Services Unit to determine if the 14-bed unit was adequate to address the needs of the provincial inmate population in Manitoba. We were advised by the unit's director:

In my opinion, the number of beds available for this purpose is inadequate…While more beds, both acute short-term and long-term, would definitely be beneficial in terms of serving this population, I wish to indicate that the problem is not related to bed space alone. The establishment of a Mental Health Court system with adequate resources and an increase in the availability of supervised community housing would also go a long way towards meeting the needs of this population.

Manitoba Health advised our office that the WRHA is projecting a significant increase in funding of specialized contracts to assist forensic clients from both the Selkirk Mental Health Centre's and PsycHealth's forensic units in transitioning to the community. It remains unknown what impact this might have on those in custody who wait for bed space to become available.

In 2007, we were advised that for an individual with an acute mental illness, waiting for treatment can lead to further impairment, delayed recovery and increased residual symptoms. This may also increase the risk of self-harm and self-neglecting behaviour. In addition to the significant consequences for the individual whose mental illness remains untreated while in custody awaiting admission to a hospital, there are also safety concerns for them, for other inmates, and for correctional staff. It remains clear that it is inappropriate for individuals with deteriorating mental health to remain incarcerated in provincial jails, unable to access the treatment they require in an appropriate time frame.

In 2008, we reported that Family Services' Supported Living Program did not track how many of their clients were incarcerated in provincial correctional centres, the length of their incarceration, or the charges for which their clients were remanded in custody. We believed that this information would be helpful to the department in identifying any progress that is being made to reduce the periods of incarceration for vulnerable persons living with a mental disability. In 2009, the department began tracking this kind of information.

In 2007, we reported that Family Services and the Winnipeg Remand Centre developed a protocol that allows correctional staff to determine if an individual is a client of the Supported Living Program. If a client is identified as a Supported Living client, department staff can provide information to assist correctional staff in addressing challenging behaviours. The protocol states that if the individual is to be in custody for an extended period, the assigned community services worker should arrange to visit the vulnerable person on a regular basis to ensure their well-being and to support correctional staff in dealing with the individual appropriately. In 2009, this protocol was expanded for use in all adult provincial correctional centres.

In 2008, we reported that we raised concerns with the limitations of the current "Cross-Department Protocols for High Risk High Needs Adults" that exist between Manitoba Health, Manitoba Family Services, and Manitoba Justice. Judge Gregoire, in the Peter Stevenson Inquest Report, recommended the establishment of a protocol to ensure that information that is known by one government agency providing care is shared with other departments or agencies where it is reasonable to believe that the sharing of the information would be in the best interests of the client or patient. This appeared to be a recommendation for a provincial protocol for a cross-departmental approach to service coordination for all clients and patients.

In response, the departments formed a working group to review the protocols. The working group considered whether the protocols (that provide for service coordination to those high risk/high needs adults who have a history of violent behaviour and who are assessed as posing a risk of serious danger to the public) could be expanded to include high risk/high needs adults who are vulnerable and are involved with the justice system but are neither violent nor pose a risk of serious danger to the public. The working group acknowledged the importance of providing services to this group, but indicated that the difficulty with this approach is that there are cases where individuals do not meet eligibility for existing programs.

While the cross-department protocols remain unchanged, the province has been or is in the process of developing services for complex multi-needs vulnerable individuals, including:

- Spectrum Connections FASD Services;
- Homeless Strategy with an emphasis on mental health housing:
    - Housing with Services
    - Portable Housing Benefit
    - Community Wellness Initiative (Winnipeg Regional health Authority and Tenant Services and Asset Management in specific Manitoba Housing sites)
    - An increase in emergency shelter beds
    - Permanently house long-term shelter users with supports, and
    - Funding of seven outreach mentors to work with vulnerable people living in the community. The outreach mentors will work out of the main Street Project,

Salvation Army, RaY, Spence Neighbourhood Association, CMHA Westman, CMHA Thompson and The Pas Friendship Centre; and

- Winnipeg Co-occurring Disorders Initiative (support to Justice by the WRHA and the Addictions Foundation of Manitoba).

Inmate Discipline Boards

Inmate Discipline Boards are established by subsection 25(1) of *The Correctional Services Act* and Part 3 of the *Correctional Services Regulation*. The superintendent of each adult correctional centre appoints a correctional officer who does not supervise inmates to chair the discipline board. The chair arranges for at least two additional correctional officers to sit on the discipline board. If an inmate is charged with a disciplinary offence, they can elect to plead not guilty and appear before the discipline board.

Discipline boards can significantly affect inmates and their conditions of confinement. Subsection 13(1) of the Regulation establishes penalties that the discipline board can impose, including a reprimand or a warning, a fine not exceeding $200, payment of restitution in respect of any property that was lost or damaged as a result of the offence, not more than 40 hours of extra duties in the facility, loss of privileges for not more than 30 days, not more than 15 days of segregation, or the forfeiture of not more than 30 days of remission.

During the investigation of two individual complaints we became concerned about the discipline board process, including a concern about documentation to record what evidence was considered in the decision making process. At that time, Adult Corrections was developing policy regarding discipline boards that we believed would address the shortcomings identified in our review.

In 2006, we were provided with an initial draft of the training package developed for all correctional staff who would regularly be assigned discipline board duties. Corrections also developed a disciplinary hearing information handout for inmates that would allow inmates to better prepare for hearings, and to better understand the hearing process.

At the same time, the Honourable Justice R.P. Marceau of the Alberta Court of Queen's Bench in the case of Currie v. Alberta (Edmonton Remand Centre) [2006 ABQB 858] noted, "*there is such a clear conflict between the duties of staff members of a d-board in Alberta's correctional centres to maintain discipline and staff morale and the right of the prisoner to have his charge's dealt with before a tribunal with sufficient degree of independence and impartiality, that both the perception of lack of independence and bias and the fact that in a substantial number of cases there is a reasonable apprehension of bias.*" Justice Marceau went on to say, "*while training the board members in administrative law will assist in achieving procedural fairness, it*

cannot remove the inevitable bias in favour of the evidence of correctional officers. Giving prisoners the right to counsel and the presence of counsel at the hearings will help to achieve procedural fairness, but it will not overcome the reasonable apprehension of bias."

In 2007, our office made inquiries with Corrections regarding their policy development, in light of the court decision in Alberta. In 2008, Corrections committed to do the following:

- Determine the composition and size of discipline boards and clarify the manner in which membership is selected,
- Develop formalized training for discipline board members in the areas of administrative law and the Correctional Services Act and Regulation,
- Establish exclusion criteria for the board members to enhance the neutrality of the board,
- Develop audio recording capabilities of all discipline board hearings and establish an archival process for those recordings,
- Develop a database to systematically record sanctions imposed by discipline boards according to disciplinary offences, and
- Develop a quality control process by which internal audits of the discipline board process can occur to ensure policy and statute compliance.

In January 2009, Corrections provided our office with a finalized copy of its divisional policy regarding inmate discipline. Our office, once again, raised concern regarding the composition of inmate discipline boards, which had not changed. We advised the department that when inmates observe correctional officers investigating disciplinary offences, laying disciplinary charges, and then presenting evidence to a disciplinary board comprised of other correctional officers, it may cause the individual to believe that decision makers will be biased. Our office believes there are viable alternatives that will enhance the discipline board process and promote the principles of administrative fairness.

As a result of our review of this matter, Adult Corrections committed to re-examining this matter and expect to achieve a resolution in 2010.

Statistical Review of the Ombudsman Division

Cases in 2009 by Act, Department and Disposition

This chart shows the disposition of 378 Ombudsman Division case files in 2009 under *The Ombudsman Act*, *The Public Interest Disclosure (Whistleblower Protection) Act, The Fatality Inquiries Act, and The Child and Family Services Act*.

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2009	New cases in 2009	Total cases in 2009	Pending at 12/31/2009	Info. Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
THE OMBUDSMAN ACT												
PROVINCIAL GOVERNMENT												
Agriculture, Food & Rural Initiatives												
General	2	1	3	1	-	-	-	1	-	-	1	-
Civil Service Commission												
General	-	1	1	1	-	-	-	-	-	-	-	-
Competitiveness, Training & Trade												
Ombudsman's Own Initiative - OOI	-	1	1	1	-	-	-	-	-	-	-	-
Conservation												
General	1	8	9	6	-	-	-	2	1	-	-	-
Ombudsman's Own Initiative - OOI	2	-	2	2	-	-	-	-	-	-	-	-
Culture, Heritage & Tourism												
General	-	1	1	-	-	-	-	1	-	-	-	-
Executive Council												
General	-	1	1	1	-	-	-	-	-	-	-	-
Family Services & Housing												
General	2	1	3	1	-	-	-	2	-	-	-	-
Child & Family Services	1	12	13	9	-	2	-	1	-	2	-	-
Employment & Income Assistance	2	2	4	1	-	-	-	-	-	3	-	-
Housing Renewal Corporation	1	-	1	-	-	-	-	1	-	-	-	-
Manitoba Housing Authority	-	5	5	4	-	-	-	-	-	1	-	-
Social Services Advisory Board	1	-	1	-	-	-	-	1	-	-	-	-
Vocational Rehabilitation	-	1	1	-	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative - OOI	4	4	8	8	-	-	-	-	-	-	-	-
Finance												
General	1	1	2	1	1	-	-	-	-	-	-	-
Automobile Injury Compensation Appeal Commission	1	-	1	-	-	-	-	1	-	-	-	-
Securities Commission	-	1	1	1	-	-	-	-	-	-	-	-
Residential Tenancies Branch	-	1	1	-	-	1	-	-	-	-	-	-
Residential Tenancies Commission	-	2	2	1	-	-	-	1	-	-	-	-
Vital Statistics	-	2	2	-	1	-	-	-	-	-	-	-
Health												
General	-	6	6	2	1	-	-	-	-	2	-	1

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2009	New cases in 2009	Total cases in 2009	Pending at 12/31/2009	Info. Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
Health Appeal Board	-	3	3	3	-	-	-	-	-	-	-	-
Mental Health	2	-	2	-	-	-	-	-	1	1	-	-
Regional Health Authority	1	1	2	1	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative - OOI	6	1	7	4	-	-	-	-	-	1	-	2
Infrastructure & Transportation												
General	1	3	4	3	1	-	-	-	-	-	-	-
Licence Suspension Appeal Board	-	2	2	-	-	-	-	1	-	1	-	-
Intergovernmental Affairs												
General	-	3	3	3	-	-	-	-	-	-	-	-
Justice												
General	2	4	6	2	1	-	1	1	-	1	-	-
Agassiz Youth Centre	-	1	1	-	-	-	1	-	-	-	-	-
Brandon Correctional Centre	-	7	7	1	-	-	1	2	-	3	-	-
Chief Medical Examiner	-	2	2	-	1	-	-	-	-	1	-	-
Headingly Correctional Centre	-	6	6	1	2	-	2	-	-	1	-	-
The Pas Correctional Centre	-	2	2	-	-	-	-	-	2	-	-	-
Portage Correctional Centre	-	1	1	1	-	-	-	-	-	-	-	-
Milner Ridge Correctional Centre	-	4	4	-	-	-	-	-	1	3	-	-
Winnipeg Remand Centre	1	2	3	-	1	-	-	1	-	1	-	-
Manitoba Youth Centre	-	1	1	-	-	-	1	-	-	-	-	-
Maintenance Enforcement	-	4	4	2	1	-	-	1	-	-	-	-
Human Rights Commission	1	6	7	4	-	-	-	2	-	1	-	-
Public Trustee	-	3	3	3	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative - OOI	13	4	17	11	-	-	-	-	1	4	-	1
Labour & Immigration												
Employment Standards	1	3	4	1	1	-	-	1	-	1	-	-
Ombudsman's Own Initiative	1	-	1	-	-	-	-	1	-	-	-	-
Water Stewardship												
General	1	7	8	5	1	-	-	1	-	1	-	-
Corporate & Extra Departmental												
Legal Aid	-	3	3	1	-	-	1	1	-	-	-	-
Manitoba Agricultural Services Corp. Ombudsman's Own Initiative – OOI	-	1	1	-	1	-	-	-	-	-	-	-
Manitoba Crown Lands Appeal Board	-	1	1	-	-	-	-	1	-	-	-	-
Manitoba Hydro	1	6	7	2	1	-	-	3	-	1	-	-
Workers Compensation Board	1	4	5	3	1	-	-	-	-	1	-	-
WCB Appeal Commission	2	1	3	1	-	-	-	1	-	1	-	-
Manitoba Public Insurance												
General	10	34	44	12	4	5	6	15	-	2	-	-
Ombudsman's Own Initiative - OOI	-	1	1	1	-	-	-	-	-	-	-	-
MUNICIPALITIES												
City of Portage la Prairie	-	2	2	2	-	-	-	-	-	-	-	-

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2009	New cases in 2009	Total cases in 2009	Pending at 12/31/2009	Info. Supplied	Declined	Discontinued	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
City of Winnipeg	2	11	13	5	3	-	1	1	1	2	-	-
Other RMs, Towns, Villages	7	23	30	13	3	-	3	7	3	1	-	-
Local Planning Districts	2	2	4	4	-	-	-	-	-	-	-	-
Ombudsman's Own Initiative - OOI	1	-	1	1	-	-	-	-	-	-	-	-
Sub-total	**74**	**210**	**284**	**130**	**25**	**8**	**17**	**53**	**10**	**36**	**1**	**4**
THE PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT												
Government Agency	1	-	1	1	-	-	-	-	-	-	-	-
Regional Health Authority	2	-	2	-	-	-	-	2	-	-	-	-
Sub-total	**3**	**-**	**3**	**1**	**-**	**-**	**-**	**2**	**-**	**-**	**-**	**-**
CASES RESULTING FROM INQUEST REPORT RECOMMENDATIONS[1] UNDER *THE FATALITY INQUIRIES ACT*												
Family Services	4	-	4	3	-	-	-	-	-	-	-	1
Health	6	2	8	6	-	-	-	-	-	-	-	2
Infrastructure and Transportation	1	-	1	-	-	-	-	-	-	-	-	1
Justice	5	3	8	6	-	-	-	-	-	-	-	2
Labour and Immigration	1	-	1	1	-	-	-	-	-	-	-	-
Liquor Control Commission	-	1	1	1	-	-	-	-	-	-	-	-
City of Winnipeg	3	2	5	1	-	-	-	-	-	-	-	4
Other municipalities	10	-	10	-	-	-	-	-	-	-	-	10
Sub-total	**30**	**8**	**38**	**18**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**20**
CASES RESULTING FROM CHILD DEATH REVIEW REPORT RECOMMENDATIONS[2] UNDER *THE CHILD AND FAMILY SERVICES ACT*												
Education	-	1	1	1	-	-	-	-	-	-	-	-
Family Services	-	50	50	50	-	-	-	-	-	-	-	-
Healthy Living	-	1	1	1	-	-	-	-	-	-	-	-
Justice	-	1	1	1	-	-	-	-	-	-	-	-
Sub-total	**-**	**53**	**53**	**53**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL	**107**	**271**	**378**	**202**	**25**	**8**	**17**	**55**	**10**	**36**	**1**	**24**

[1] In 2009, 5 new inquest reports were received, resulting in 8 new case files. Please see page 30 for more information on inquest reporting.

[2] In 2009, 21 child death review reports were received, resulting in 53 case files. Please see page 30 for more information on child death reviews.

Summary

Of the 176 cases closed in 2009:

27% were resolved in whole or in part (the Ombudsman made recommendations in 0.05% of these cases);
14% were completed;
31% were not supported;
14% were concluded after information was provided;
14% were discontinued either by the Ombudsman or the complainant, or declined.

Definitions

Pending: Complaint still under investigation as of January 1, 2010.

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 or inquiry where the task of auditing, monitoring, informing, or commenting has been concluded.

REPORT ON ACTIVITIES OF THE ACCESS AND PRIVACY DIVISION

Overview of 2009

In 2009, our office opened 350 new cases under *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA). Of these, 330 were access and privacy complaints from the public under Part 5 of the Acts and 20 were cases initiated by our office under Part 4, to review, 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 2009* sections. Examples of cases where we provided comments to public bodies and trustees in 2009 are included in the *Proactive Reviews* section.

In 2009, an existing position within the Access and Privacy Division was converted to a new position, Manager of Systemic Investigations and Audits. This position is dedicated to broad-based reviews to ensure and monitor compliance pursuant to clause 49(a) of FIPPA and clause 28(a) of PHIA. Although we have conducted broad-based reviews over the years, we have not had dedicated resources to carry out this part of our mandate, until this position was established.

With the expanded capacity that the position brings to the Division, we hope to have a wider impact on matters that contribute to the overall state of compliance with both FIPPA and PHIA. We expect that better compliance in the areas that we will be assessing will positively affect the rights of individuals under both Acts and contribute constructively to the operations of public bodies and trustees.

Our plan for the next few years will be to do three initiatives each year. In 2010 we will be conducting a PHIA Compliance Assessment which will involve medical clinic trustees and will primarily assess compliance with requirements relating to policies and procedures; an Access Practices Assessment that is focused on the processing of FIPPA requests and will involve public bodies, including local public bodies; and, a Timeliness Audit that will assess compliance with sections 11 and 15 of FIPPA which will also involve public and local public bodies. The PHIA Compliance Assessment and the Access Practices Assessment are core initiatives that will be conducted annually for the next few years.

Each year different entities will be selected for review for one of the initiatives although there could be situations where the same entity is selected successively due to non-compliance issues. While compliance is the focus of these initiatives, it is also our intention to identify processes or approaches that are successful and can be shared and adopted by other public bodies or trustees.

The results of these initiatives will form part of our annual report each year. We may also publish special reports where appropriate.

Under FIPPA and PHIA, the Ombudsman may initiate investigations and reviews of privacy breaches concerning personal and personal health information. In our last annual report, we provided information about dealing with privacy breaches and preventing breaches by implementing reasonable safeguards to protect personal and personal health information.

It is concerning that individuals' personal information entrusted to the care of public bodies and trustees is put at risk by leaving it unattended in vehicles. There have been instances of thefts of unattended personal and personal health information from vehicles parked on a private driveway, at a grocery store, at a restaurant and at a shopping mall. The risk of break-ins or thefts concerning vehicles, particularly in Winnipeg, is well-known.

Locking the information in the trunk of a vehicle offers no increase in protection if the vehicle is stolen. Leaving personal and personal health information unattended in any part of a vehicle exposes the information to foreseeable risks such as disclosure of the information, loss, theft and destruction. These risks are not only foreseeable, they are also preventable.

Both FIPPA and PHIA require public bodies and trustees to implement “reasonable” safeguards for personal and personal health information. Public bodies and trustees should have written policies that outline the manner in which the information will be kept secure when it is necessary for employees to transport personal and personal health information in vehicles.

In our view, personal and personal health information (whether contained in paper records, on a lap top, or on a mobile storage device) should not be left unattended in a vehicle unless there is no option for an employee to take the information with them when exiting the vehicle. It is difficult to imagine a scenario where it would be impossible for employees to carry the information with them. While it may be inconvenient to take the information with them, the only way for employees to adequately protect it is to do so, even when leaving the vehicle for a few minutes.

During 2009, we completed eight cases where the Ombudsman made recommendations under FIPPA. There were no recommendations made under PHIA in 2009. Additionally, we followed up on a previous case where recommendations had been made but not implemented in 2008. Summaries of these cases are included under the *Cases of Interest* section.

FIPPA and PHIA provide an appeal to the Manitoba Court of Queen’s Bench for individuals who have been refused access to a record or part of a record requested under either Act. Appeals may be made if the Ombudsman has not supported the complaint and therefore the records are not released, or if the Ombudsman has supported the complaint but the public body or trustee has not released the records.

In 2009, one appeal was initiated by an applicant under FIPPA concerning a refusal of access by the City of Winnipeg (Court File CI09-01-63160). This matter was still pending at the end of 2009. One appeal that had been initiated in 2007 concerning Manitoba Family Services and Housing (Court File CI07-01-50441) was dismissed in 2009. Two other appeals that were

initiated in 2008 concerning the City of Winnipeg (Court File CI08-01-58184) and Manitoba Labour and Immigration (Court File CI08-01-59380) were still pending at the end of 2009.

Cases of Interest

Under FIPPA and PHIA, the Ombudsman has both proactive powers to undertake access and privacy reviews under Part 4 of the Acts and responsive duties relating to the investigation of complaints received or initiated by the Ombudsman under Part 5 of the Acts.

Both Acts authorize the Ombudsman to comment on:

- the implications of proposed legislative schemes or programs affecting access and privacy rights; and
- the use of information technology in the collection, storage, use or transfer of personal or personal health information.

For 2009, we are reporting on two proactive reviews, each based on one of these grounds for issuing comments. We have summarized our comment on the Flin Flon School Division's proposed voluntary drug testing policy and are also reporting on our ongoing review of the Manitoba Enhanced Driver's Licence and Enhanced Identification Card Program, about which we have urged cardholders to be vigilant about the card's Radio Frequency Identification (RFID) technology and MPI's process for avoiding the scanning of third party information.

Both FIPPA and PHIA require that the Ombudsman report annually on recommendations made under these Acts. We are reporting on eight complaint investigations that were completed in 2009 where recommendations were made, and one case where we followed up to ensure compliance with previous recommendations.

Recommendation Cases

In circumstances where access and privacy complaints 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 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 Acts require the Ombudsman to report annually on recommendations made and whether public bodies or trustees have complied with the recommendations. In 2009, eight cases were closed where recommendations were made to public bodies under FIPPA. All concerned access complaints.

University of Manitoba – Two Refusals of Access

The Ombudsman received two complaints from two applicants who had been refused access to the same record by the University of Manitoba. The complainants had made applications for access under FIPPA to a particular agreement between the University of Manitoba and a third party.

The University withheld the entire agreement based on its decision that disclosure of the information would harm the business interests of the third party (under clauses 18(1)(b) and 18(1)(c)(ii)) and harm the economic and other interests of the University (under clauses 28(1)(b) and 28(1)(c)(iii)).

The University provided representations to our office concerning specific parts of the agreement, namely three clauses within the agreement and one of the schedules of the agreement. The University advised that these parts of the record would reveal commercial, financial and labour relations information of the third party. The University stated that this information was explicitly provided in confidence and that the third party has kept it confidential. The University also advised that the release of these key parts of the agreement would potentially expose details of the agreement to competitors of the third party and to other educational institutions with whom the third party may negotiate agreements, thereby interfering with negotiations of the third party.

The University advised that these key parts of the agreement were also subject to the exceptions cited under section 28 of FIPPA. The University stated that these parts of the agreement contain information that is proprietary and that the University has a right of use because it entered into a contract with the third party. The University also advised that release of the information could harm the University's commercial relationship with the third party and interfere with the university's future negotiations.

Based on our review of the information in the record and the representations, the Ombudsman found that these specific parts of the agreement were subject to the exceptions cited under sections 18 and 28 of FIPPA.

We reviewed the remaining withheld information in the agreement and sought representations from the University about its decision to refuse access to this information. It appeared to us that the University and the third party had previously agreed that some of this information could be summarized and made available to the public. The University did not provide specific evidence to support its decision to apply the exceptions to the remaining withheld information. The Ombudsman found that the University did not establish that the cited provisions applied to other information within the agreement.

The Ombudsman provided the University and the complainants with reports of the investigation findings and made recommendations that the University release to both complainants all information contained in the agreement with the exception of the three clauses and a schedule of the agreement.

The University responded to the Ombudsman's reports within 15 days after receiving them. The University indicated that it accepted the Ombudsman's recommendation and that a copy of the severed version of the agreement would be mailed to the complainants. The University complied with the recommendations within the required time limit of 15 days of acceptance.

Manitoba Conservation – Refusal of Access

The complainant made a request under FIPPA to Manitoba Conservation for access to all records regarding his grant application to a program administered by the department. The department refused access to some of the information based on its decision that disclosure of the information would be an unreasonable invasion of privacy of third parties (under subsection 17(1) and clause 17(3)(i)) and that it would reveal advice to a public body (under clauses 23(1)(a) and (b)).

Our review of information in the records suggested to us that other records could be responsive to the access request. Further to our discussions with the department, it located additional responsive records, most of which were released in full to the complainant. These additional responsive records were located in the file from which the initial records were found. A public body must conduct reasonable searches for records in order to respond accurately and completely. The Ombudsman found that the department had not met its duty to assist the applicant under section 9 of FIPPA.

The department withheld the names, job titles, and telephone and fax numbers of public body employees who were involved in assessing the complainant's grant application. The records did not reveal any other personal information about the employees. Our investigation determined that disclosure of names and work contact information of employees of a public body in the context of work they were performing would not be an unreasonable invasion of their personal

privacy. The Ombudsman found that the section 17 exceptions did not apply to the withheld information and the department agreed to release the information.

Manitoba Conservation withheld some parts of the records on the basis that the information would reveal advice of the public body and consultations involving employees of the public body. When discretionary exceptions apply to information, a public body may refuse access or it may choose to release the information. Exercising discretion requires looking at the specific factors or relevant circumstances of the situation (including those that may weigh in favour of releasing the information) and considering whether or not the information can be disclosed despite the fact that it qualifies for exception.

During our investigation, the department released some of the information previously withheld under section 23. We asked the department to explain the factors it considered in deciding to refuse access to the remaining withheld information. The Ombudsman found that the department was unable to demonstrate that it reasonably exercised discretion in making its decision.

The Ombudsman recommended to the department that it release the remaining information that was withheld under clauses 23(1)(a) and (b). The department responded to the Ombudsman within 15 days and accepted the Ombudsman's recommendation. The department released the remaining information to the complainant within the time frame required under FIPPA.

Manitoba Lotteries Corporation – Refusal of Access

The complainant requested access to information in reports that detailed the amount of money that people gambled in casinos over periods of time. The complainant was not seeking the names of people involved.

Manitoba Lotteries Corporation refused access to all of the information in the reports. The Corporation's refusal was on the basis that the disclosure would be an unreasonable invasion of privacy of third parties because disclosure would be inconsistent with the purpose for which the personal information was obtained (under subsection 17(1) and clause 17(3)(i)).

Manitoba Lotteries Corporation advised that reports are made available to club card members upon request so they can track their play and behaviour. The Corporation was of the view that releasing information from these reports would deter the client group that would access this responsible gaming initiative. The Corporation advised that providing the information in the reports, with the personal information of the casino patrons severed, would undermine the players' confidence in the confidentiality of the program.

Our review of the records determined that they contained personal information of third parties, including their names, contact information and account numbers. We considered whether other information contained in the records could be linked to individuals. We were of

the view that specific jackpot amounts, particularly ones of a significant amount, could identify individuals. We also noted that actual dates contained in the records may identify individuals and the complainant requested only the period of time over which the money was gambled.

As the exceptions in section 17 protect personal information of *identifiable* third parties, we considered whether the personal information could be severed. The complainant requested only the "amount of money gambled over what period of time". We determined that the personal information that was subject to the cited exceptions, which the complainant was not specifically seeking, could be severed from the records and the remaining information could be released. In our opinion, the remaining information would not be linkable to identifiable individuals and if disclosed, would fulfill the complainant's access request.

Based on this finding, the Ombudsman recommended that Manitoba Lotteries Corporation release the reports to the complainant with the account numbers, names, contact information of the individuals, jackpot amounts and specific dates removed.

The Corporation responded to the Ombudsman's report within 15 days advising that the recommendation was accepted. The Corporation complied with the recommendation within the required time limit.

Rural Municipality of Springfield – Three Failures to Respond

In 2008, our office received three complaints concerning the Rural Municipality of Springfield's failing to respond to three applications submitted to it by the complainant under FIPPA. The Act requires that a public body respond to an applicant within 30 days after having received an access request. A public body may, in certain circumstances as specified in FIPPA, extend the initial time limit for responding to a request for an additional 30 days, or for a longer period with the agreement of the Ombudsman.

The RM wrote to the complainant and advised that it would endeavour to respond within the stipulated 30 day time period and that should there be a delay then an explanation would be provided.

Following our receipt of the complaints, the RM was advised of its obligation under the Act to provide a response to the complainant. In addition, the RM was asked to provide its response within a specified number of days. The solicitor for the RM informed our office that in order for the RM to respond to these applications an additional 60 days would be necessary. By this time, the applications were now three months old.

Efforts by our office to resolve these complaints informally were unsuccessful. Consequently, the Ombudsman issued a report containing recommendations to the RM to provide responses to the complainant's three access applications. Although the RM did not, as required under FIPPA, direct a written response to the Ombudsman indicating either that it accepted the

recommendations or that it refused to implement the recommendations, it nevertheless verbally suggested that it would continue to process the complainant's FIPPA applications.

Subsequent investigation by our office determined that the RM had not communicated further with the complainant. The Ombudsman then initiated a meeting with the RM's Chief Financial Officer and solicitor, who again undertook to resume the processing of the access applications.

In due course, the RM wrote to the complainant advising that search and preparation fees permitted under FIPPA would be applicable to the processing of her applications. Once a fee estimate is issued the Act stipulates that the time limit for responding is suspended until the applicant notifies the public body that upon payment of the fee estimate he or she wishes to proceed with the application.

Our office concluded that no further action on our part was required at this time.

Manitoba Conservation – Failure to Respond

The complainant submitted an access application to Manitoba Conservation requesting records relating to a hydro proposal in a provincial park. Within 30 days of receiving the application, the department notified the complainant that it was extending the time limit for responding to the application for an additional 30 days. The department also notified the complainant of the date by which it would respond to the request.

The complainant had contested the need for this extension and filed a complaint with our office about the decision to extend. The Ombudsman found that the extension of the time limit for responding was not authorized under section 15 of FIPPA. The department should have responded to the applicant by the 30th day, rather than extending the time limit for an additional 30 days.

The complainant waited for the department to respond and when no response was received, he made a subsequent complaint about the failure to respond. Our office contacted the department after receiving the complaint and we were advised that the response letter and requested records had been prepared and were being reviewed. A response still had not been made when we followed up with the department two weeks later.

Based on the finding that Manitoba Conservation was not in compliance with the time limit for responding, the Ombudsman recommended that the department respond to the complainant with an access decision forthwith, provide the complainant with reasons for the delay in responding, and provide an apology for the delay.

Manitoba Conservation responded to the Ombudsman within 15 days after receiving the report and advised that it accepted the recommendations. Manitoba Conservation complied with the recommendations within the required time limit.

Follow-up on Compliance with Previous Recommendations

FIPPA and PHIA have specific time frames for complying with recommendations when the head of a public body or a trustee accepts the recommendations. The time limit set out in subsection 66(6) of FIPPA requires the head to comply with the recommendations within 15 days of acceptance if the complaint is about access or within 45 days in any other case, or within such additional period as the Ombudsman considers reasonable. The time limit under subsection 48(6) of PHIA for complying with recommendations is also 15 days within acceptance or within such additional period as the Ombudsman considers reasonable.

During 2009, we followed up on one case where recommendations were made to Manitoba Conservation in 2007 but had not been complied with by the end of 2008. This case was carried into 2009 and we monitored the progress of the department in implementing the recommendations.

The department had responded to the access request in 2007. A complaint was made to the Ombudsman because the complainant believed that records should exist. He provided a list of some of these records as part of his complaint to our office. The department advised our office that it may have records in locations not covered by the initial search, and that an additional search would be conducted. In December 2007 we recommended that the department conduct a search for responsive records, make a decision with respect to access if records are located, and provide our office with its position if it decides to refuse access to any information it locates.

We monitored the implementation of the recommendations during 2008. Further searches were undertaken by the department, which yielded over 750 documents. Manitoba Conservation considered release of these records. Access was granted in part and information was withheld under four exceptions. We proceeded to review the withheld information and determined that the cited exceptions applied. This case was closed in 2009.

Proactive Reviews

Privacy considerations should be addressed when a new initiative - legislation, a system, project, policy or procedure - is being developed so that FIPPA and/or PHIA and privacy best practices are integrated and not grafted to the initiative. In the lifetime of an initiative, the impacts on privacy should regularly be evaluated and, from time to time, audited. When an initiative is revised, the privacy implications should again be considered.

Our office provides analysis, advice and recommendations to public bodies and trustees on their privacy impact assessments, information sharing agreements, draft public communications and policies and procedures. In this way, we can review what is being planned, take privacy positions on behalf of the public where specifically needed, help influence the process and assist in reducing privacy complaints.

In 2009, we continued our involvement in the proactive projects highlighted in last year's annual report - Enhanced Identification Cards and Enhanced Drivers' Licences, video surveillance by the Winnipeg Police Service in downtown streets and the development of the Manitoba Electronic Health Record. In these and other long term projects, we were invited to provide our comments. The challenge remains for our office to maintain and be seen as maintaining our independence when serving as both an educator and privacy watchdog.

Also in 2009, new initiatives came to our attention where we offered to provide our comments. In these situations, the public bodies we reviewed assisted our involvement and were responsive to our advice.

Our work on two proactive reviews is discussed in this report. We have summarized our comment on the Flin Flon School Division's proposed voluntary drug testing policy because of the interest the proposal generated and because we think our position will be of interest to other Manitoba school divisions. We are also reporting on our ongoing review the Manitoba Enhanced Identification Card and Enhanced Driver's Licence Program to heighten the privacy awareness of those who are considering participating in the program.

Flin Flon School Division's Proposed Voluntary Drug Testing Policy

On April 9, 2009, it came to our attention from media reports that the Flin Flon School Division was considering a division-wide "Drug and Alcohol Use" policy that would apply to the approximately 1300 students of the division. With the full cooperation of the School Division, our office undertook a review and commented on the privacy implications of using the proposed substance detectors.

When the Flin Flon School Division drafted its proposed "Drug and Alcohol Use" policy, there were existing provisions for addressing alcohol and other drug use. Consistent with *The Safe School Charter* of Manitoba, Flin Flon School Division adopted as a Code of Conduct that students are expected to refrain from using, possessing or being under the influence of alcohol or illicit drugs at school. This is reiterated in various school policies within the School Division.

Manitoba's *Education Administration Miscellaneous Provisions Regulation* states that a teacher may suspend a student from the classroom for conduct the teacher considers detrimental to the classroom learning environment or contravenes the school's code of ethics. Also, the principal may suspend from school a student who engages in conduct that the principal considers injurious to the school's welfare or educational purposes. The principal has disciplinary authority over students' conduct at school and on the way to and from school in terms of their conduct towards one another.

When a teacher in the Flin Flon School Division suspects that a student is under the influence of alcohol or an illegal drug, he or she may refer the student to the principal who uses his or her best judgment to determine whether the student is under the influence. We understand that there are no formally established criteria in the School Division for supporting the

determination but indicators would include the odor of alcohol or marijuana on the student, other physical manifestations or behaviour suggestive of substance use and/or the student's admission to being under the influence.

Under the proposed policy that we reviewed, if the student claimed he or she was not under the influence and wanted to provide proof in support of that claim, the student could volunteer to undergo testing with a detection device in the principal's office. We were advised that the use of detectors would not be imposed on a student but rather would be the student's choice.

The School Division advised that under these procedures, the principal would have the use of science to help make the determination that a student was not under the influence, based on objective method rather than opinion. Where the testing device showed a substance to be present, the School Division would interpret that as meaning the student was "under the influence" and would rely and act on that finding.

We were informed that no record of the test would be kept if the test were passed. If the test were not passed, it would be recorded in the student's file that the student was in fact under the influence of alcohol or other drugs. We were advised by the School Division that the student would be suspended as a result. This would be no different from the existing situation where a student was deemed to be under the influence of drugs or alcohol while at school.

For suspected alcohol use, the proposed testing device was one designed to measure a person's blood alcohol concentration at the time the test was taken. The device included a mouthpiece into which the student would blow a moderate, continuous breath sample for six seconds. If alcohol were detected, the device would display the measurement of the student's blood alcohol concentration within eight seconds. This would be shown by the "illumination" of an LED (light emitting diode) meter ranging from a .01% to 0.1% blood alcohol concentration, displayed in .01% increments.

For substances other than alcohol, the proposed testing device was designed to detect identified drugs of abuse in human saliva, specifically cocaine, methamphetamines (including Ecstasy), THC (marijuana), amphetamines, opiates, phencyclidine (PCP or "angel dust") and benzodiazepines. The device consisted of a "collection pad" for obtaining a saliva sample and a display of six test windows that, during a single testing, would provide presumptive results for six drugs. The collection pad would be rubbed inside the mouth in 15-20 circular motions at four separate places -- inside each cheek, on top of the tongue and beneath the tongue. After five minutes, any presence of a coloured band at a particular test window would indicate a negative result for that specific drug. The absence of colour at a window would indicate a presumptive positive result for the drug being tested at that particular window. In either case, a colour band at a "control region" would need to appear to indicate that the test was performed properly. If the control band does not appear, the presumptive test results would be invalid and the test would need to be repeated with a new device. We were advised by the School Division that the device could detect the presence of marijuana from an outer limit of 6-18 hours and for all of the other drugs tested, an outer limit of 2-3 days.

Under PHIA, "personal health information" means recorded information about an identifiable individual that, among other things, relates to the individual's health. Under PHIA, this information must be collected or maintained by a person or entity defined as a "trustee" under the Act. A School Division is a trustee under PHIA. The first consideration under PHIA was whether, pursuant to the proposed policy, the School Division was collecting personal health information.

The School Division advised that if the blood alcohol testing device showed any blood alcohol concentration reading whatsoever, a written notice would be produced stating that the student was under the influence of alcohol. In our opinion, this would be personal health information under PHIA, being recorded health information about an identifiable individual, in this case the determination of the student having measurable alcohol in his or her blood. In our view, the illumination of the meter on the blood alcohol testing device would not in itself constitute "personal health information" because it would not be a *record* of information.

The School Division advised that if the saliva testing device showed a presumptive positive reading for any of the drugs tested, a written notice would be produced stating that the student was under the influence of a drug or drugs. This recorded information would be personal health information. In our opinion, the result apparent on the device would also be personal health information.

The School Division indicated that substance testing would occur only when a student suspected of being under the influence of a substance chose to submit to testing. There is, however, no provision in PHIA for a person to consent to a trustee's collection of his or her personal health information. Under PHIA, a trustee can collect personal health information only if it is authorized to do so under the Act. If an individual collected the information himself or herself and then gave it to a trustee, that, too, would be a collection by the trustee which could only lawfully be made if the trustee were authorized to make the collection. Section 13 of PHIA sets out when a trustee is authorized to collect personal health information:

> ***Restrictions on collection***
> ***13(1)*** *A trustee shall not collect personal health information about an individual unless*
> *(a) the information is collected for a lawful purpose connected with a function or activity of the trustee; and*
> *(b) the collection of the information is necessary for that purpose.*

For our consideration of the proposed policy in relation to clause 13(1)(a) of PHIA, the School Division provided our office with information about its legal obligations for maintaining order and discipline in schools and at school activities. The School Division also advised our office that the basis for the proposed policy was that someone under the influence of alcohol, or other drugs, places their education and that of others at risk. More specifically, we were advised that

in shop, physical education and science classes, there is added physical risk to the person and others, similar to when a person drives under the influence.

We recognize that principals and teachers are charged with the responsibility for maintaining order and discipline in school and at school activities. We observed that if a student's behaviour is apparently placing the student and others at risk or disrupting the classroom environment, the teacher and the principal already have the authority to send the student home.

We also noted that under the proposed policy, any presence of alcohol confirmed by the blood alcohol testing device would be "written up" as the student being "under the influence."

In order to meet the necessity requirement of clause 13(1)(b) of PHIA, the trustee must show that the personal health information to be collected is necessary to properly administer the lawfully authorized activity. Where the personal health information would merely be helpful to the activity, it would not be "necessary" within the meaning of the Act. Where the purpose could be accomplished another way, the collection could not be said to be necessary. To be necessary, the collection would also, in our view, have to be effective.

If the testing was voluntary, it could not be said to be necessary. It also could not be said to be effective where to say that the student in fact has alcohol in their system or has a presumptive positive reading for another drug would not provide any more evidence than is now necessary to exercise discipline. Also, as the policy was proposed, if there were a negative result, the school official would not take disciplinary action, even though the test result contradicted the "just cause" that was the basis for the test.

Based on the information reviewed, we were of the opinion that the draft policy would not be compliant with PHIA. Further to our review and December 7, 2009 report, the School Division advised us on January 20, 2010 that it decided not to pursue the policy further and will not authorize the use of detectors. We understand that in formulating the proposed policy, the School Division acted in the best interests of students' safety and wellbeing. In the final result, the School Division also demonstrated its commitment to personal privacy.

Our office appreciated the comprehensive information and timely responses of the Flin Flon School Division in the course of this important review.

Enhanced Drivers' Licences and Enhanced Identification Cards

In our 2008 Annual Report, we discussed our privacy review of the Enhanced Identification Card (EIC) and Enhanced Driver's Licence (EDL) being introduced by Manitoba Public Insurance (MPI) and government. In 2009, MPI began accepting and administering EIC applications, issuing EICs, and completed work on making EDLs available to interested Manitobans. The EIC was launched on February 2, 2009 and the EDL on January 10, 2010.

As of June 1, 2009, American authorities require Canadian citizens 16 and over to have a passport or approved alternative to enter the U.S. by land or water. EDLs and EICs are two voluntary options for identification of eligible Manitobans. Like the Canadian passport, either card meets the requirements of the United States Western Hemisphere Travel Initiative.

Our office continued reviewing the EDL and EIC Program in 2009, including providing comments on the draft EDL application form, consents, a new combined *EDL and EIC Applicant's Guide* and new and revised brochures. MPI has provided more clarity to these documents which will enhance public understanding.

We continue to caution those holding or applying for an EDL or EIC to be aware that the Radio Frequency Identification (RFID) technology used in the cards presents the risk of location tracking. The RFID technology uses a chip whose unique identification number is intended to be read by a scanning device for the purpose of automatic identification at the U.S. border.

Because a card's transmission setting is always "on," it is important that a person holding an EDL or EIC keep the card in its protective sleeve at all times, except when in use at the U.S. border. Without protection of the sleeve (or if the sleeve is torn or damaged), the chip contained in the card could be read by an unintended RFID card reader, allowing the movements of the cardholder to be tracked. A replacement sleeve can be obtained free of charge from any MPI service location or Autopac broker office.

EDL or EIC applicants should also be sure that, during the application process, the MPI employee or Autopac broker does not scan information from their documents (required for proving identity or residency) that is about any other person. This could be, for example, information about a spouse contained on a marriage certificate or a parent's information on a birth certificate or utility bill.

In late 2009, as a result of a privacy complaint that we found to be substantiated, it became apparent that MPI's procedures for not scanning third party information in the application process may not be properly followed. During our review of the EIC and EDL Program in 2008, we had requested that these procedures for third party privacy be developed and we were aware that they were the subject of staff and broker information and training with the introduction of the EIC in 2009.

We are satisfied that MPI is taking reasonable measures to ensure that the third party privacy procedures are followed in the EDL and EIC application process and we are reviewing MPI's monitoring of its employees' and Autopac brokers' performance in this step of the process.

At the same time, we are advising EDL and EIC applicants to ensure that the privacy of the people close to them is protected. A person presenting documents containing third party information should be sure that the MPI employee or Autopac broker copies the documents and "blacks out" the third party information on the copy before it is scanned. The applicant should be asked to review the "blacked out" copy and to initial it before it is scanned.

In conjunction with the February 2, 2009 launch of the EIC, our office released a privacy fact sheet for those considering applying for the card, *EIC: 10 Points for Privacy Awareness*. On January 10, 2010, once the EDL was introduced, we issued a revised version of the fact sheet which benefitted from the EIC experience and addressed privacy issues relating to both EICs and EDLs. The fact sheet included the following points for consideration:

1. The EDL or EIC is voluntary and not necessary if you already have a passport.
2. A person interested in an EDL or EIC should first read the *Manitoba EDL and EIC Applicant's Guide*.
3. A person should understand the consents and declarations that must be signed to qualify for an EDL or EIC before beginning the application process.
4. Up to five provincial, national and international authorities will handle the personal information of an EDL or EIC applicant and cardholder.
5. Third party information should not be collected or used in the Manitoba EDL and EIC Program.
6. The Radio Frequency Identification (RFID) technology used in the EDL and EIC presents a risk of location tracking of the cardholder.
7. The protective sleeve issued with each Manitoba EDL and EIC prevents this risk, but the cardholder must always be vigilant.
8. A damaged sleeve must be replaced immediately to maintain privacy which can be done, free of charge, at any of MPI service location or Autopac dealer office.
9. Once a traveller's personal information is shared with U.S. authorities (from EDLs, EICs or passports), the Manitoba government and MPI have no control over how it may be stored, used and further shared; it is retained in the U.S. Border Crossing Information System for 75 years.
10. To find out more about privacy in the EDL and EIC Program or to raise concerns, contact the MPI Access and Privacy Coordinator at (204) 985-7525; if your concerns cannot be resolved by MPI, contact Manitoba Ombudsman at (204) 982-9130 or 1-800-665-0531.

Our news release and fact sheet, *The Manitoba Enhanced Driver's Licence (EDL) and Enhanced Identification Card (EIC): 10 Points of Privacy Awareness*, is included on the CD version of this annual report and also available on our website at www.ombudsman.mb.ca.

Statistical Review of the Access and Privacy Division

Overview of Access Complaints Opened in 2009

In 2009, 299 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	117	112	5
Extension	6	6	NA*
Fees	22	20	2
Collection	1	1	-
Correction	1	-	1
Refused Access	139	138	1
Other	13	13	-
Total	**299**	**290**	**9**

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

Overview of Access Complaints Closed in 2009

During 2009, 233 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	98	1	99	23	10	58	8
No Response	95	5	100	10	81	8	1
Fees	13	2	15	2	1	8	4
Correction	-	1	1	-	1	-	-
Extension	6	NA*	6	1	3	2	-
Other	12	-	12	12	-	-	-
Total	**224**	**9**	**233**	**48**	**96**	**76**	**13**

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

Overview of Privacy Complaints Opened in 2009

In 2009, 31 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.

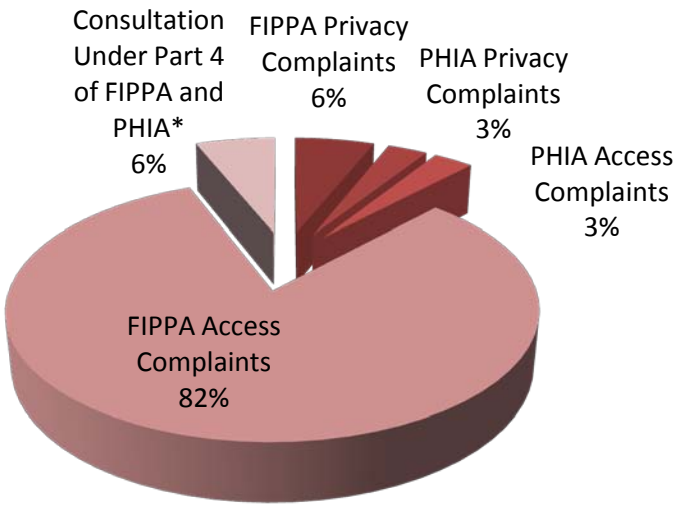
Type of Privacy Complaint	Total	FIPPA	PHIA
Collection	6	4	2
Use	4	2	2
Disclosure	21	13	8
Other	-	-	-
Total	**31**	**19**	**12**

Overview of Privacy Complaints Closed in 2009

During 2009, 21 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.

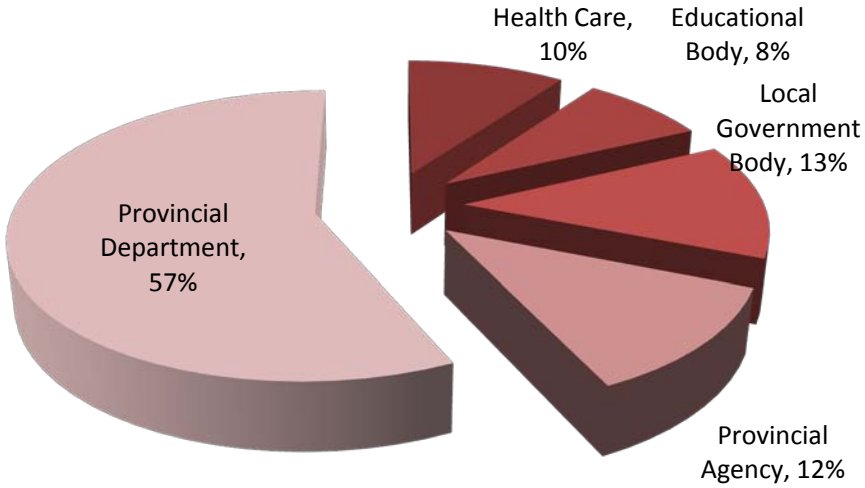
Type of Privacy Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or whole	Not Supported	Resolved
Collection	2	2	4	2	-	2	-
Use	2	2	4	-	4	-	-
Disclosure	10	2	12	2	2	8	-
Other	1	-	1	1	-	-	-
Total	**15**	**6**	**21**	**5**	**6**	**10**	**-**

Types of Cases Opened in 2009



*Consultation Under Part 4 of FIPPA and PHIA includes auditing, monitoring, informing, and commenting

Distribution of Cases Opened in 2009



Cases in 2009 by Act, Public Body/Trustee and Disposition

This chart shows the disposition of the 494 Access and Privacy cases investigated in 2009 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 2009	New cases in 2009	Total cases in 2009	Pending at 12/31/2009	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	1	1	2	-	-	-	2	-	-	-	-	-
Advanced Education & Literacy	-	1	1	-	-	-	1	-	-	-	-	-
Agriculture, Food & Rural Initiatives	-	3	3	1	-	1	1	-	-	-	-	-
Competitiveness, Training & Trade	-	7	7	6	-	-	1	-	-	-	-	-
Conservation	13	12	25	4	-	1	8	6	4	-	2	-
Culture, Heritage & Tourism	-	1	1	1	-	-	-	-	-	-	-	-
Education, Citizenship & Youth	2	-	2	-	-	-	2	-	-	-	-	-
Executive Council	-	2	2	2	-	-	-	-	-	-	-	-
Family Services & Housing	3	41	44	7	-	3	10	3	21	-	-	-
Finance	1	4	5	2	-	-	2	1	-	-	-	-
Health	5	7	12	3	-	-	6	1	2	-	-	-
Infrastructure & Transportation	1	2	3	1	-	1	1	-	-	-	-	-
Intergovernmental Affairs & Trade	2	2	4	1	-	-	2	1	-	-	-	-
Justice	3	7	10	4	-	1	2	1	1	1	-	-
Labour & Immigration	1	9	10	4	-	1	2	2	-	1	-	-
Science, Technology, Energy & Mines	1	2	3	2	-	-	-	1	-	-	-	-
Water Stewardship	45	3	48	7	37	-	-	2	2	-	-	-
Crown Corporation and Government Agency												
Manitoba Floodway Authority	-	2	2	-	-	-	2	-	-	-	-	-
Manitoba Legal Aid	-	1	1	-	1	-	-	-	-	-	-	-
Manitoba Lotteries Corporation	-	2	2	-	-	-	-	-	1	-	1	-
Manitoba Human Rights Commission	1	3	4	-	1	-	2	1	-	-	-	-
Manitoba Hydro	5	27	32	12	-	3	5	-	12	-	-	-
Manitoba Public Insurance	4	13	17	1	4	4	8	-	-	-	-	-
Winnipeg Child & Family Services	-	1	1	-	-	-	-	-	1	-	-	-
Workers Compensation Board	1	2	3	1	-	1	1	-	-	-	-	-
LOCAL PUBLIC BODY												
Local Government Body												
City of Brandon	-	1	1	-	-	-	1	-	-	-	-	-

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2009	New cases in 2009	Total cases in 2009	Pending at 12/31/2009	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
City of Winnipeg	3	37	40	10	1	2	19	3	3	2	-	-
Town of Powerview Pine Falls	-	1	1	1	-	-	-	-	-	-	-	-
Village of Dunnottar	-	2	2	-	-	-	2	-	-	-	-	-
R.M. of Alexander	-	2	2	-	-	-	-	-	2	-	-	-
R.M. of Brokenhead	-	3	3	3	-	-	-	-	-	-	-	-
R.M. of Lac du Bonnet	-	1	1	1	-	-	-	-	-	-	-	-
R.M. of Rockwood	-	2	2	-	-	-	1	-	-	1	-	-
R.M. of Ste. Anne	-	26	26	-	7	7	9	1	1	1	-	-
R.M. of Springfield	5	1	6	-	-	-	1	-	2	-	3	-
R.M. of Wallace	4	3	7	-	-	-	-	-	4	3	-	-
Educational Body												
St. James School Division	-	8	8	2	-	-	1	3	-	2	-	-
Flin Flon School Division	-	1	1	1	-	-	-	-	-	-	-	-
Whiteshell School Division	-	1	1	-	-	-	1	-	-	-	-	-
University of Manitoba	10	5	15	6	-	3	2	1	1	-	2	-
University of Winnipeg	3	-	3	3	-	-	-	-	-	-	-	-
Health Care Body												
CancerCare Manitoba	-	2	2	2	-	-	-	-	-	-	-	-
Diagnostic Services Manitoba Inc.	2	-	2	-	-	-	1	-	1	-	-	-
Medical Clinic	-	6	6	-	-	-	2	-	2	2	-	-
St. Boniface Hospital	-	1	1	1	-	-	-	-	-	-	-	-
Victoria General Hospital	-	1	1	-	-	-	-	-	1	-	-	-
Burntwood Regional Health Authority	7	56	63	1	15	-	6	30	10	1	-	-
Central Manitoba Regional Health Authority	-	1	1	-	-	-	1	-	-	-	-	-
Winnipeg Regional Health Authority	1	11	12	1	-	-	8	1	2	-	-	-
Sub-total	**124**	**327**	**451**	**91**	**66**	**28**	**113**	**58**	**73**	**14**	**8**	**-**
Part 5 of *The Personal Health Information Act* (PHIA)												
Crown Corporation and Government Agency												
Manitoba Public Insurance	1	-	1	-	-	-	-	1	-	-	-	-
Workers Compensation Board	3	-	3	-	-	-	2	1	-	-	-	-
Health Care Body												
Winnipeg Regional Health Authority	1	-	1	-	-	-	-	-	1	-	-	-
Health Professional												
Physician	2	3	5	2	-	1	1	-	1	-	-	-
Sub-total	**7**	**3**	**10**	**2**	**-**	**1**	**3**	**2**	**2**	**-**	**-**	**-**
Part 4 under FIPPA and PHIA												
PUBLIC BODY												
Provincial Department												
Culture, Heritage & Tourism	-	1	1	-	-	-	-	-	-	-	-	1
Family Services & Housing	2	1	3	-	-	-	-	-	-	-	-	3

Department or Category	Case Numbers			Case Dispositions								
	Carried over into 2009	New cases in 2009	Total cases in 2009	Pending at 12/31/2009	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
Health	-	3	3	1	-	-	-	-	-	-	-	2
Justice	1	1	2	-	-	-	-	-	-	-	-	2
Labour	-	1	1	1	-	-	-	-	-	-	-	-
Crown Corporation and Government Agency												
Manitoba Hydro	-	1	1	1	-	-	-	-	-	-	-	-
Manitoba Public Insurance	1	3	4	4	-	-	-	-	-	-	-	-
LOCAL PUBLIC BODY												
Local Government Body												
City of Winnipeg	4	1	5	3	-	2	-	-	-	-	-	-
Village of Glenboro	-	1	1	-	-	-	-	-	-	-	-	1
Educational Body												
Flin Flon School Division	1	1	2	1	-	-	-	-	-	-	-	1
University of Manitoba	1	-	1	-	-	1	-	-	-	-	-	-
Health Care Body												
St. Boniface General Hospital	1	-	1	-	-	-	-	-	-	-	-	1
South Eastman Regional Health Authority	-	1	1	1	-	-	-	-	-	-	-	-
Winnipeg Regional Health Authority	-	2	2	1	-	-	-	-	-	-	-	1
Health Professional												
Pharmacist	-	1	1	-	-	-	-	-	-	-	-	1
Physician	-	1	1	1	-	-	-	-	-	-	-	-
Orthodontist	1	-	1	-	-	1	-	-	-	-	-	-
Other												
Other	1	1	2	2	-	-	-	-	-	-	-	-
Sub-total	**13**	**20**	**33**	**16**	**-**	**4**	**-**	**-**	**-**	**-**	**-**	**13**
Total	**144**	**350**	**494**	109	66	33	116	60	75	14	8	13

Summary

Of the 385 cases closed in 2009:

37% were supported in whole or part (the Ombudsman made recommendations in 2% of these cases);
30% were not supported;
4% were resolved before a finding was reached;
4% were completed under Part 4 of FIPPA or PHIA;
25% 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, 2010.