Manitoba Ombudsman

2008

Annual Report

Manitoba Ombudsman

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March 31, 2009

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, 2008 to December 31, 2008.

Yours truly,

Original signed by

Irene A. Hamilton
Manitoba Ombudsman

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A Message From the Ombudsman

In 2008, my office continued to engage in outreach and education activities designed to meet Manitobans in their home communities, to promote fairness in administrative decision making, and to increase awareness of access and privacy issues.

Many of the cases I report on arising under *The Ombudsman Act* relate to complaints alleging that government's actions and decisions were unfair. They are a collection of cases that, taken together, demonstrate both the requirements of fairness in administrative decision making and some of the ways in which administrative decisions or actions can fall short of meeting those requirements.

Provincial and municipal government bodies are interested in achieving fairness in administrative decision making, and we are working with both to improve the understanding of fairness. Our investigations of complaints from a nurse, a farm couple, an injured worker and an environmentalist all resulted in enhancements to the fairness of specific decision-making processes.

On a broader scale, we undertook an extensive education program to enhance fairness in municipal decision making. In cooperation with Manitoba Intergovernmental Affairs, the Association of Manitoba Municipalities, and the Manitoba Municipal Administrators' Association, we produced *Understanding Fairness*, a practical guide to fairness for municipal decision makers.

In 2008, we concluded our first investigation into an allegation of wrongdoing under *The Public Interest Disclosure (Whistleblower Protection) Act*. Although our investigation concluded that there was no wrongdoing as defined under the Act, we made recommendations for administrative improvements that were accepted by the entity about which the disclosure had been made.

Under *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA), I report on a number of proactive reviews of government initiatives with significant privacy implications. My role under these statutes is that of information and privacy commissioner. It is a dual role; educator and consultant on the one hand, and watchdog on the other. Performing that role requires that I work cooperatively with public bodies to enhance their understanding of the legislation and enhance privacy protections as new programs are designed, while maintaining public confidence in the neutrality of my office.

I am pleased to report that in 2008, my office was able to successfully fulfill that role by working with the Winnipeg Police Service on a pilot project involving the use of Closed Circuit Television Cameras in public places, and with the provincial government and Manitoba Public Insurance on their Enhanced Identity Card/Enhanced Driver's Licence (EIC/ EDL) program. I believe that in both cases, our involvement resulted in greater awareness of privacy issues and improved privacy protection for the public.

With respect to access to information, I have noted a particular concern about the continuing inability of public bodies to provide meaningful reasons for their decisions when denying requests for information. Fairness and transparency require that decision makers explain the reasons for their decisions to the people affected. FIPPA and PHIA require that applicants be given the reasons for the refusal and the specific provision of the Act on which the refusal is based.

Complaints about refusal of access form the bulk of our investigation caseload under FIPPA. In many of our investigations, the public body involved has been unable to provide adequate explanations for its decisions. This raises a question about the soundness of the decisions, as well as a concern about the public body's ability to respond adequately to the public and to my office.

I have reported as well on an ongoing concern about the inability of Manitoba Conservation to comply with the requirements of FIPPA. Its inability to meet statutory time limits or to comply with my recommendations, even after it accepted those recommendations, is unacceptable.

On a positive note, on October 9, 2008, amendments to FIPPA and PHIA were passed. In the amendments, an Information and Privacy Adjudicator is created who will be an independent officer of the Legislative Assembly. The role of the Adjudicator will be to review, at my request, any access or privacy matter related to the recommendations I have made in a report about an investigation of a complaint under Part 5 of FIPPA or PHIA. The Adjudicator will have the power to order compliance with the legislation. At the time of writing this report, these amendments have not been proclaimed in force.

Last year, I reported on a number of long-standing concerns, including the practice of holding intoxicated youth in a correctional facility (the Manitoba Youth Centre) under *The Intoxicated Persons Detention Act*. I suggested that the ministers responsible impose a deadline to end this inappropriate practice.

While the problem has not yet been resolved, I am pleased to report that government has advised that it is in discussions with a private community agency regarding the feasibility of using their premises as a site for detaining intoxicated youth. We have been advised that the department is confident that a resolution will be forthcoming.

I also reported last year on my concern for people living with mental illnesses or mental disabilities who are detained in provincial correctional centres, and suggested that responsibility for addressing the needs of these high risk/high needs inmates goes beyond Manitoba Justice alone.

In 2008, we participated in various meetings with Corrections, Family Services and Housing,

and Community Mental Health for the purpose of bringing together the departments to enhance and improve the continuity of care in the areas of release planning and reintegration in the community.

I have also raised concerns around limitations of the current Cross Departmental Protocols for High Risk/High Needs adults that exist between Manitoba Health and Healthy Living, Manitoba Family Services and Housing, and Manitoba Justice. The three departments have agreed to revisit the current protocols in light of our concerns.

Although some progress has been made, my 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 need to rely upon cannot find suitable community placements. We will continue to pursue this matter in 2009.

I would like to thank my colleagues in the Office of the Ombudsman for their hard work and dedicated service to the public. The mandate and responsibilities of the office have expanded considerably in the four years that I have been in this position, with the addition of responsibilities for reviews of recommendations made in relation to the deaths of children in care, and investigations into allegations of wrongdoing made by whistleblowers. Although the staffing in the office has not increased as the mandate has expanded, we continue to provide service to the public on matters of importance to Manitobans, and achieve improvements in administration through our work.

OUTREACH AND EDUCATION ACTIVITIES

COMMUNITY OUTREACH

One of our goals is to meet with Manitobans in their own communities. These meetings are designed to enhance awareness of the mandate of the office, provide general information and respond to specific local concerns.

This year, community outreach activities again took us to Thompson and The Pas. Over a two day period presentations were made to employees of the City of Thompson, Burntwood Regional Health Authority, Thompson Immigrant Women's Association and students and teachers at R.D. Parker Collegiate in Thompson. We also presented at the University College of the North (The Pas campus).

For most of a week in October, an office team visited Winkler, Altona, Steinbach and Portage la Prairie. We met with municipal officials from all of these communities, and health professionals and administrators from Eden Mental Health Centre, Boundary Trails Health Centre and the Central Manitoba Regional Health Authority. In Winkler, I was especially pleased to speak with new Canadians at South Central Settlement and Employment Services and students and teachers at Winkler Elementary School.

As well, we made *Joining the Herd* presentations to 14 schools around Manitoba, including eight in Winnipeg.

Staff from my office participated in the 2008 Law Day Open House at the Winnipeg Law Courts. My office has been participating in this annual public event for almost 20 years and again had an exhibitor table where we distributed information and informally discussed our role and function with the public.

MUNICIPAL OUTREACH

2008 was a year of significant relationship building between my office and Manitoba municipalities. In June, managers from my office attended the seven district meetings of the Association of Manitoba Municipalities. This provided an opportunity for us to talk to over 600 municipal leaders from 173 municipalities about the role and function of our office. In September 2008, we attended seven district meetings of the Manitoba Municipal Administrators' Association, speaking to chief administrative officers, assistant chief administrative officers and other municipal staff.

We worked with the Municipal Services Branch of Manitoba Intergovernmental Affairs, the Association of Manitoba Municipalities and the Manitoba Municipal Administrators' Association to develop an educational project aimed at elected municipal officials and administrators. In November, we attended the annual convention of the Association of Manitoba Municipalities in Winnipeg. During two separate breakout sessions, we discussed fairness requirements in municipal decision making. As well, we distributed over 200 *Understanding Fairness* folders, containing information about the Ombudsman and also Fairness Checklists created specifically for municipal decision makers.

CORRECTIONS OUTREACH

We continue our outreach activities in youth correctional centres and the women's correctional centre in Portage la Prairie. These activities include quarterly talks at the women's facility and semi-annual presentations for youth regarding the services my office provides. This affords both staff and residents an opportunity to identify issues. We were also privileged to attend the Pow Wow at Agassiz Youth Centre.

RIGHT TO KNOW

For the third consecutive year, a manager in my office chaired the Manitoba Right to Know Committee, leading Manitobans' participation in activities marking international Right to Know Day (September 28) and Right to Know Week (celebrated September 29 – October 3, 2008).

The international Right to Know movement promotes the individual's right of access to information held by government and public institutions.

As part of the Right to Know Week celebrations, we invited Alasdair Roberts, Professor of Law and Public Policy at Suffolk University in Boston, to Winnipeg. Dr. Roberts gave a fascinating presentation titled, "Blacked Out: Government Secrecy in the Information Age" at the University of Winnipeg to members of the public. Assistant Information Commissioner of Canada, Suzanne Legault also visited Manitoba for Right to Know Week. Madame Legault presented "Moderniser l'accès a l'information au Canada: de crieur public au village mondial..." (Modernizing Access to Information in Canada: From Town Crier to Global Village) at College universitaire de Saint-Boniface, the first local public event on Right to Know in French.

EDUCATIONAL SERVICES

Informing Public Servants

Over the past four years, my office has committed to providing information to public servants about our role, function and perspective on the oversight work that we do under *The Ombudsman Act, The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

Our educational sessions on administrative fairness and compliance with access and privacy legislation have now been introduced in the City of Winnipeg Corporate Education Calendar.

We continued our monthly series of Brown Bag Talks at our Winnipeg office where, with Access and Privacy Coordinators, we discuss thorny issues and our interpretation of FIPPA and PHIA. We also presented Brown Bag Talks to health administrators and other professionals at the Brandon, Burntwood, and Central Manitoba Regional Health Authorities.

Informing Private Sector Health Professionals

Private sector health professionals are defined as "trustees" under *The Personal Health Information Act* and have statutory obligations to protect patients' personal health information.

There are thousands of registered or licensed health professionals working in the province to whom PHIA applies. To assist in providing information about the Act to all health professionals, we again teamed up with colleagues from Manitoba Health and met with the regulatory bodies that govern these professions. We were invited to provide day-long workshops to members of two of these professions – the College of Registered Psychiatric Nurses (on how our two Divisions can help them help their patients) and the College of Podiatrists of Manitoba (on PHIA issues). These workshops allowed us to tailor our presentations specifically to the services provided by these particular professionals.

Informing Municipal Leadership

Following up on our municipal outreach in 2008, we undertook a substantial education project aimed specifically at municipal leadership. After discussions with the Manitoba Intergovernmental Affairs and the Association of Manitoba Municipalities, we began production of a document titled *Understanding Fairness*, a comprehensive guide to fairness designed specifically for municipal decision makers. *Understanding Fairness* was completed in 2008 and distributed in early 2009.

Understanding Fairness is intended to assist municipal councillors and administrators to achieve fairness in the important and challenging work that they do, and to provide municipal leaders with the tools to help promote fairness and make it the standard of practice.

A copy of *Understanding Fairness* is included on the CD format of this Annual Report in *Other Publications* and is also available on our website at www.ombudsman.mb.ca.

Informing Correctional Officers

In our last annual report, I commented on the volume of complaints we receive from inmates in provincial correctional centres. Our ability to address these complaints quickly and thoroughly is enhanced by an excellent working relationship between my office and Manitoba Corrections.

Both my office and Manitoba Corrections believe that it is important for all correctional staff to understand the role and function of the Manitoba Ombudsman in relation to correctional complaints. For the past several years, my office has been providing training sessions to all correctional officer recruit classes. In 2008, my staff presented to nine correctional officer recruit classes.

There are hundreds of men and women employed by Manitoba Corrections and it is not possible for our office to provide onsite presentations to all staff. In 2008, our office developed a training tool that would be accessible to all correctional staff in the field. We created an electronic Correctional Officers Presentation that Manitoba Corrections can utilize at any time. We believe that this information is an excellent resource for correctional staff who have daily interaction with individuals incarcerated in provincial correctional centres.

ORGANIZATIONAL DEVELOPMENT

In the work that we do, we find it particularly valuable to share insights and discuss issues with colleagues from other oversight offices across the country.

In February, investigators from our Access and Privacy Division participated in a National Privacy Investigators meeting in Ottawa, organized by the federal Privacy Commissioner's Office. Two colleagues from my office presented at this conference, speaking on "Investigations of Verbal Disclosures of Recorded Information" and "Approaches to Intake and Early Resolution."

In May, several people from my office attended the 2008 Manitoba Access and Privacy Conference in Winnipeg. Three of my colleagues presented "Avoiding Access Pitfalls: Advice from the Ombudsman" and "Collection: Where Privacy Begins." I was pleased to share my views in a presentation, "Challenges and Opportunities for Access and Privacy: The Ombudsman's View".

In September, my office and the Forum of Canadian Ombudsman co-hosted the conference, "The Specialist Ombudsman: Working Behind Prison Walls". This conference was attended by over thirty ombudsman staff and senior ministry officials from across Canada. The conference offered a number of interactive sessions, which included discussion of issues affecting the marginalized of our society, the delivery of mental health services in correctional facilities and the use of tasers. The keynote speaker, the Honourable Serge LeClerc (MLA, Province of Saskatchewan), shared his life story of abuse, drug addiction and violence that led to 21 years in some of Canada's toughest prisons.

In October, we also hosted the Prairie Health Information Privacy Day conference, which was organized and sponsored jointly with the Information and Privacy Commissioners of Saskatchewan and Alberta. The conference, which was preceded by a day of workshops, drew over 100 health professionals, administrators and access and privacy oversight officers to Winnipeg from across western Canada, and also from as far away as Singapore.

Our office presented on the plenary panel, "Stories from the Trenches." I had the pleasure of providing the opening address and chairing the final plenary panel, "Weighing Social Responsibility v. An Individual's Right to Privacy," which featured thought-provoking comments from Micheal Vonn, Policy Director of the B.C. Civil Liberties Association and Paul Thomas, Duff Roblin Professor of Government, University of Manitoba Department of Political Studies.

CULTURAL COMPETENCY

Our office remains committed to reaching and providing service to Aboriginal people in Manitoba. Our immediate goals are to provide more culturally competent service by recruiting Aboriginal staff, and to develop relationships in First Nations communities.

In keeping with our goal to recruit Aboriginal staff, we welcomed an intern from the Aboriginal Public Administration Program (APAP) co-sponsored by the Civil Service Commission and Manitoba Aboriginal and Northern Affairs. The Program offers its interns training and development opportunities so that they may successfully compete for professional and managerial positions within the civil service.

The APAP intern joined our office in June 2007 to assist with outreach activities in the Aboriginal community, the *Joining the Herd* schools project, the Child Welfare Review, our work with the Corrections system, as well as numerous other responsibilities within the office. The intern remained with us until March 2008, and provided insight about networking with the Aboriginal community.

Our commitment to cultural competency and our effort to better serve residents of northern Manitoba will continue to be a priority in the coming year.

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 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 investigations 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, 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 universities, 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. To achieve this, a manager has been assigned to oversee all investigations under the Act.

Educating the civil service about the requirements of this new legislation was necessary and important. Manitobans have been well served by the Civil Service Commission and Treasury Board Secretariat through their leadership in educating executive management of departments and the public service on its requirements before the legislation was proclaimed. Ongoing information sessions are available to managers and supervisors through the Organization and Staff Development Agency.

THE ACCESS AND PRIVACY DIVISION

The Freedom of Information and Protection of Privacy Act

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 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, Tourism and Sport provides information on FIPPA, including instructions on how to apply for access to information, how to request a correction to personal information, 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 2008/09

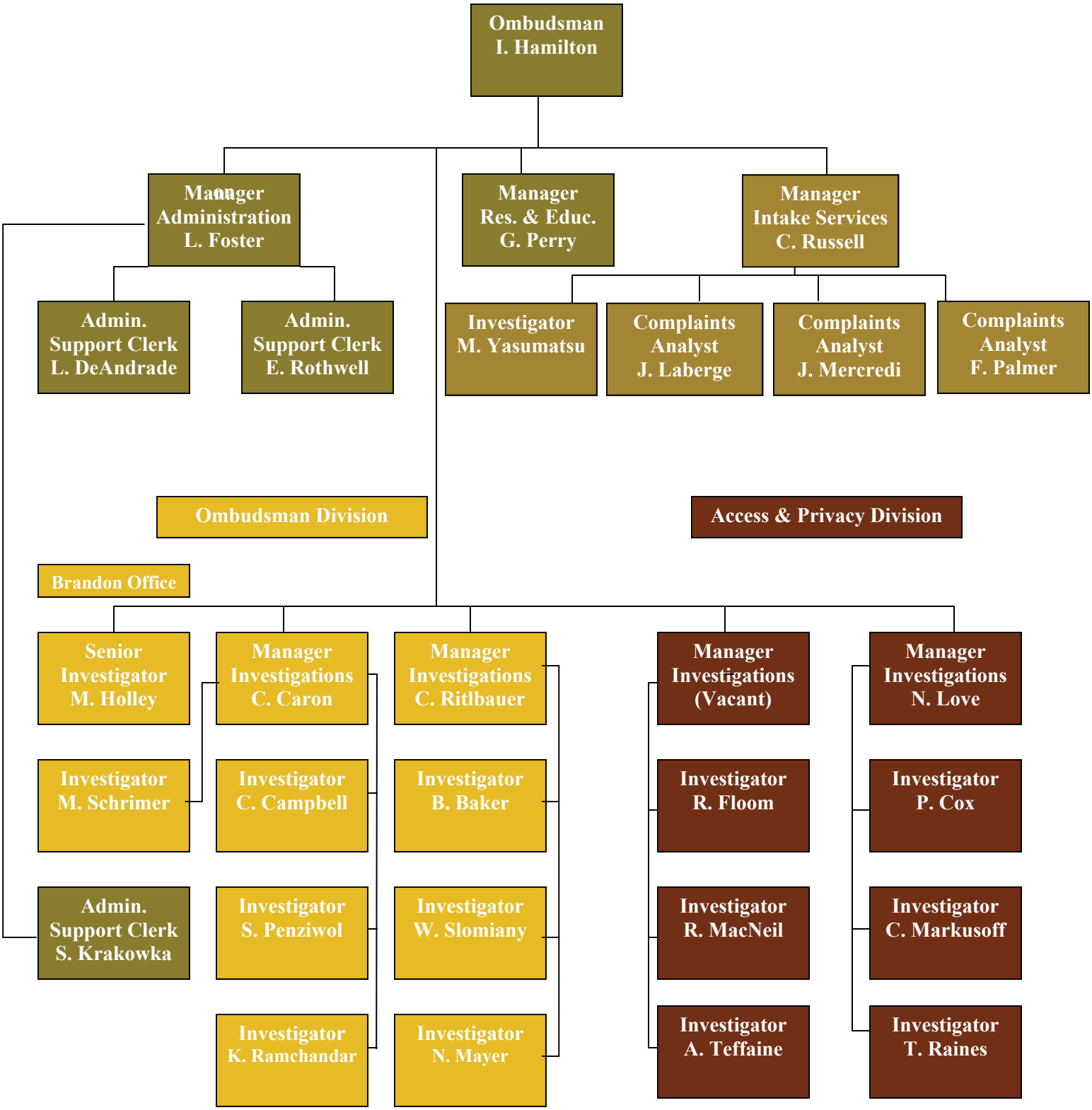
Our budget of $2,720,000 for salaries and other expenditures is broken down as follows:

Total salaries and employee benefits for 30 positions		$2,256,000
Positions allocated by division are:		
Ombudsman Division	11	
Access and Privacy Division	8	
General	11	
Other expenditures		$464,000

Staffing

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

ORGANIZATIONAL CHART



Report on the Activities of the Ombudsman Division

ACTIVITES OF THE OMBUDSMAN DIVISION

In previous annual reports, we have commented on issues that require ongoing attention, often because their resolution will be long-term and involve a coordinated effort among government departments or crown agencies. We continue to raise these issues to ensure they remain a priority for government and to encourage the interdepartmental cooperation that is required to address them.

Investigating complaints of a systemic nature allows us to respond to situations where there may be a gap between the policy goal set by government, and the results actually achieved for the public in the implementation of programs.

While we must address these larger issues, it is important that we continue to be able to respond to individual complaints alleging maladministration or unfairness.

The investigations included in this report include examples of our work in each of the areas described above.

FOLLOW-UP ON 2007 CONCERNS

HIGH RISK/HIGH NEEDS INMATES

In 2007, we reported on our concern for people living with mental illnesses or mental disabilities who are detained in provincial correctional centres. We noted that it was unreasonable and unrealistic to expect that Manitoba Justice bear sole responsibility for dealing with the problems high risk/high needs inmates face, and that solutions must be achieved through a planning and implementation process that includes Manitoba Justice, Manitoba Health and Healthy Living, and Manitoba Family Services and Housing. We are pleased to report that in 2008 some progress was made.

Manitoba Corrections has formed a Mental Health Leadership Committee that is designed to provide leadership and strategic direction in the development of policy, standards and/or protocols that are well researched and sensitive to the complex issues surrounding the mental health and needs of their clients.

This leadership committee will provide recommendations to senior management in Corrections, including superintendents and area directors, on trends and best practices as they relate to mental health services in a facility or community correctional environment.

On another positive note, our office was advised by the Deputy Minister of Health and Healthy Living that a cross departmental coordination initiative, a housing and support plan for Manitobans with mental health and homelessness issues is being planned:

> *This is a joint initiative between the Department of Family Services and Housing and Manitoba Health and Healthy Living. This new initiative is a nine point plan aimed at developing a range of housing options and support services for individuals with mental health issues, who are homeless or at risk of homelessness.*

Projects currently proposed will include the development of transitional, supported and supportive housing options that provide affordable housing with support services. The 9 projects within the plan will add 70-80 new housing units, redevelop 200 existing units and will provide over 3000 individuals with better mental health and housing supports to assist them in maintaining a stable tenancy and support their mental health recovery. The projects will include the engagement of Regional Health Authorities, community service agencies and housing providers within urban, rural and northern communities. Planning on the proposed projects is in the preliminary stages. Although these projects provide additional capacities around mental health housing and support services, it should be noted that these projects are not targeted for individuals with dual diagnosis.

In 2008, we made inquiries with the Deputy Minister of Family Services and Housing who advised that the Supported Living Program does not track how many of their clients are incarcerated in provincial correctional centres, the length of their incarceration, or the charges for which their clients were remanded in custody. We believe this statistical information would be helpful to Family Services and Housing in identifying any progress that is being made to reduce the periods of incarceration for vulnerable persons living with a disability. Our office will continue to discuss this matter with Family Services and Housing in 2009.

In 2008, we participated in various meetings with Corrections, Family Services and Housing, and Community Mental Health for the purpose of bringing together the departments to enhance and improve the continuity of care in the areas of release planning for inmates and their reintegration in the community. It is our hope that in 2009, meaningful protocols can be developed and implemented among the departments that jointly serve this clientele, in an effort to break down silos and enhance service delivery to this vulnerable population.

Our office has raised concerns around limitations of the current Cross Departmental Protocols for High Risk/High Needs adults that exist amongst Manitoba Health and Healthy Living,

Manitoba Family Services and Housing, and Manitoba Justice. The three departments have agreed to revisit the current protocols in light of our concerns.

Although some progress has been made, 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 need to rely upon cannot find suitable community placements. As a result of this situation, we have asked Manitoba Corrections to identify those cases where high risk/high needs individuals are remanded in custody for prolonged periods as result of these circumstances.

In a case reported on under *Cases of Interest*, a complaint from the mother of a high needs inmate resulted in our being able to identify and suggest improvements with respect to release planning.

THOMPSON HOLDING CELLS

In our 2007 report, we identified long-standing concerns about the conditions of confinement for provincial prisoners held at the Thompson Holding Cells (THC). We were particularly concerned about the inability to separate adults prisoners from youth, and male and female prisoners. We noted that while Manitoba Justice had made commendable efforts to reduce the negative impacts of the conditions at the Thompson Holding Cells, they are not a substitute for the long term solutions that are needed.

As a short term solution, the department is examining the possibility of staffing the THC with Manitoba Sheriff's Officers, supplementing the combination of RCMP and civilian staff currently in place.

We are unaware of any progress that has been made toward a long term solution to address the concern for the conditions under which prisoners continue to be held at the Thompson Holding Cells.

MANITOBA PUBLIC INSURANCE PREMIUM REFUNDS

Last year, we reported that the Ombudsman had made a recommendation that the Manitoba Public Insurance Corporation provide refunds to vehicle owners who had overpaid premiums, and that recommendation was not accepted.

The role of the Ombudsman within the structure of democratic government is to investigate complaints and report findings and recommendations. The Ombudsman can recommend, but cannot order. In cases where Ombudsman recommendations are not accepted, her power lies in the ability to publish her findings and recommendations so as to facilitate further discussion on an issue between decision makers and their constituents.

The public report of the Ombudsman's recommendation appears to have prompted such discussions. We are pleased to report that shortly after the publication of our 2007 Annual Report, Manitoba Public Insurance reversed its position and issued the appropriate refunds.

INAPPROPRIATE DETENTION OF YOUTH

For over a decade, our office has reported on the issue of intoxicated youth being detained in a correctional facility (the Manitoba Youth Centre) under *The Intoxicated Persons Detention Act*. Government has been discussing the issue for even longer. It is an issue on which there is consensus: intoxicated youth should not be detained in jails.

This long-standing issue requires a resolution which will involve several departments. Last year, we reported that the matter was with the Healthy Child Manitoba Deputy Ministers' Committee. We were told that there would be continued study and analysis. We suggested that the ministers responsible impose a deadline to end this inappropriate practice.

We are pleased to report that government is now discussing with a private agency, the feasibility of their property being a site for the youth *Intoxicated Persons Detention Act* facility. We have been advised that the department is confident that a resolution will be forthcoming.

INQUEST REPORTING

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

After an inquest report is received, the Ombudsman contacts 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 web site. To date, follow-up reports by the Ombudsman to the Chief Judge have not been published and the public has not been informed of the provincial and municipal governments' responses to the recommendations.

In 2008, we adopted a new process for reporting on the implementation of recommendations made by provincial judges following inquests under *The Fatality Inquiries Act.*

In order to provide greater transparency to this process, the Chief Judge has agreed that the Ombudsman may publish the letters that are written to him, advising of the responses to the inquest report recommendations within the jurisdiction of the Ombudsman.

In order to provide context for the public, an Inquest Reporting Table has been posted on our website to provide information about the deceased (name, date, place and cause of death), date of the inquest report, whether the deceased was an adult or a child, a list of the inquest

recommendations, the provincial or municipal department or agency to which they are 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 of the recommendations.

This system of reporting commenced as of January 2008, and the website includes all inquests where the response from the Ombudsman to the Chief Judge was pending at that time. As new inquest reports and closing reports become available, they will be added to the website.

UPDATE ON CHILD WELFARE REVIEW

This is the second year that we monitored the implementation of the recommendations from our 2006 report, *Strengthen the Commitment*. The report contained over 100 recommendations designed to improve the administration of the child welfare system in Manitoba. All the recommendations were accepted. A copy of the report can be found on our website at www.ombudsman.mb.ca.

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*.

Our 2007/08 Progress Report can be found on our website at www.ombudsman.mb.ca. Our 2008/09 Progress Report will be submitted separately from this annual report, and will comment on a number of critical issues including:

- 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).

CHILD DEATH REVIEWS

Our 2006 review of the child welfare system in Manitoba, *Strengthen the Commitment,* identified a significant flaw in the process used under *The Fatality Inquiries Act* to review the deaths of children.

The reviews conducted by staff at the Office of the Chief Medical Examiner (OCME) were thorough and impartial, independent of the child welfare system. However, the findings and recommendations of the OCME were provided only to the department responsible for overseeing the child welfare system. There was no external review of the recommendations to determine whether or not they had been accepted and implemented in a way that might prevent further deaths. The process lacked transparency and public accountability.

The recommendations made in *Strengthen the Commitment* included transferring responsibility for the reviews from the OCME to the Office of the Children's Advocate (OCA), expanding the scope of the reviews, and assigning responsibility for monitoring the implementation of the recommendations made, to our office.

These recommendations were accepted by government and implemented in 2008 through amendments to *The Child and Family Services Act*. Pursuant to those amendments, responsibility for the reviews has been transferred to the OCA. The scope of the reviews has been expanded to allow the OCA to examine the standards and quality of any publicly funded social services, mental health or addiction treatment services that were provided to the child, or

in the opinion of the Children's Advocate should have been provided, and make any recommendations she finds necessary.

Expanding the scope of the reviews to include collateral agencies will permit 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 agency or authority.

Recommendations from the OCA will continue to be forwarded to the child welfare system, but will now be forwarded to our office as well, to monitor implementation. By assigning that responsibility to our office, the new structure assures the parties involved in child welfare and the public that the monitoring of the implementation of recommendations, with the goal of preventing future deaths, is truly independent, impartial and external to the child welfare system.

Because we are required to report our findings publicly, the outcomes of the review process will be transparent and public accountability will be strengthened.

SYSTEMIC INVESTIGATIONS

EMPLOYMENT AND INCOME ASSISTANCE

Late in 2008, we began the investigation of a complaint from a number of community groups about the fairness and effectiveness of the Employment and Income Assistance Program. We asked Manitoba Family Services and Housing to participate in the investigation from the outset to ensure it is a collaborative effort. We were pleased that the department agreed with that approach, which should result in a more efficient investigation process and in recommendations based on a comprehensive analysis of the issues raised in the complaint.

WATER STEWARDSHIP

In April 2008, our office released its *Report on the Licensing and Enforcement Practices of Manitoba Water Stewardship.* This report was particularly relevant to rural residents but also touched on an issue important to all Manitobans, the environmental impact of agricultural drainage.

Although the investigation behind this report was completed in 2007, we did not release the report publicly until the department had an opportunity to review the report and respond to its contents. From December 2007 to April 2008, we discussed our findings with the department.

The department's response identified improvements it had already undertaken and provided details of its ongoing efforts to address both the specific administrative issues we had identified and the requirements of evolving provincial water policies. In addition to this, the department provided us with a document setting out the principles and processes guiding its work plan and objectives that can be used to measure success.

The department accepted all 15 recommendations made in the report. Many of those recommendations will require planning and action by the department in the long-term and we

are committed to monitoring the department's progress toward the administrative improvements identified in the report and recommendations.

For many years, Manitoba Water Stewardship lacked the resources needed to meet the statutory obligations imposed upon it by *The Water Rights Act* (1987) with respect to drainage licensing and enforcement.

In addition to a long standing shortage of resources, the investigation disclosed that:

- an awkward licence application process had contributed to both a backlog and to a practice of constructing drainage works without a licence;
- historically, enforcement powers had been weak and penalties had been too low to act as a deterrent to those who would break the law;
- the department has had difficulty in both licensing and enforcement because of a lack of technical capacity;
- the licence application assessment and approval process can be improved through the involvement of conservation districts (where they are willing to participate), which provides access to local knowledge;
- users of the drainage licensing system should be informed about the need to consider the environmental impact of drainage and how to reduce that impact;
- long standing problems in the department's record keeping and file management systems made it difficult for departmental management to track and quantify their workload province-wide, and for applicants and complainants to communicate with the department on files;
- the requirements and provisions of the Act and Regulation relating to both licensing and enforcement, needed to be clearly communicated to the public, as did the role of departmental staff and others involved in licensing decisions; and
- the department needed to inform stakeholders of its plan to address the current licensing and enforcement backlog, and its long term plan for processing licence applications and responding to complaints.

At the time the report was issued to the public in April 2008, we were satisfied that the department had initiated action intended to address all issues identified.

Throughout the investigation, we received the full cooperation of Manitoba Water Stewardship. We also received cooperation and significant assistance from Conservation Districts. Valuable background information on this complex issue was also obtained from the Association of Manitoba Municipalities.

To ensure that the department's actions and its implementation of the recommendations made in the report result in the resolution of the problems identified, we have asked the department to provide us with annual updates on its progress.

The full report is available on our website at www.ombudsman.mb.ca.

MUNICIPAL FAIRNESS PROJECT

Municipalities today are operating in an era of accountability. Governing is becoming increasingly complex, and government is subject to ever increasing scrutiny. Citizens have the right to expect that their governments – federal, provincial and municipal – will act in a fair, open and transparent manner.

Municipal councillors act primarily in a law-making or policy-making capacity. However, because they wear many different hats when performing the duties that fall within Council's jurisdiction, some of the actions they take and decisions they make are subject to the requirements of administrative fairness. It is important for municipal councillors to understand which of their actions and decisions have fairness requirements attached, what those requirements are, and how they can best meet them while ensuring that municipal business proceeds in the normal course. Municipal councillors are also responsible for ensuring that all municipal policies and procedures are fair and fairly applied by staff. Fairness starts at the top.

Every time a municipal council makes a decision, some person or group of people is affected by that decision. Someone may disagree with the decision, and complain about it. There is a range of options available to citizens unhappy with the actions and decisions of their municipal government including internal complaint mechanisms, statutory appeal or review processes, legal challenges, and external review mechanisms such as the Office of the Auditor General in respect of certain financial matters, and the Ombudsman in respect of matters of administration.

The Office of the Ombudsman investigates complaints from members of the public who believe they have not been treated fairly by government, including municipal government. When we investigate complaints, it is our job to assess the fairness of government's actions and decisions. We feel it is important therefore to explain our understanding of fairness, and our investigative process, so that everyone will be operating from a common understanding when complaints are made.

After consultation with Manitoba Intergovernmental Affairs and the Association of Manitoba Municipalities, we undertook to produce a fairness guide titled *Understanding Fairness,* a comprehensive guide to fairness designed specifically for municipal decision makers.

Understanding Fairness is intended to assist municipal councillors and administrators to achieve fairness in the important and challenging work that they do, and to provide municipal leaders with the tools to help promote fairness and make it the standard of practice.

The tools in *Understanding Fairness* include:

- a fairness framework that recognizes three aspects of fairness: procedural, substantive, and relational;
- standard definitions of some commonly used fairness terms;
- a guide to meeting the requirements of fairness in municipal decision making;
- helpful hints for conducting public hearings and meetings;
- tips for analyzing decision-making processes;
- fairness "checklists" for councillors and municipalities;
- case examples of actions and decisions that are considered unfair;
- a decision-making checklist; and
- information on how we investigate and analyze complaints about municipalities from members of the public.

Understanding Fairness has been produced with the support and cooperation of Manitoba Intergovernmental Affairs, the Association of Manitoba Municipalities, and the Manitoba Municipal Administrators' Association.

At the end of 2008, *Understanding Fairness* had been completed and was distributed in early 2009. *Understanding Fairness* may be viewed on our website at www.ombudsman.mb.ca, and also on the websites of Manitoba Intergovernmental Affairs, www.gov.mb.ca/ia/, the Association of Manitoba Municipalities, www.amm.mb.ca, and the Manitoba Municipal Administrators' Association, www.mmaa.mb.ca.

CASES OF INTEREST - PROVINCIAL GOVERNMENT

The Ombudsman Act

PROTECTION FOR PERSONS IN CARE OFFICE

The mandate of the Protection for Persons in Care Office (PPCO) - to protect persons living in care facilities from mistreatment - is crucial. At the same time as PPCO provides protection, it must also act fairly. The PPCO's investigative processes need to be thorough, impartial and transparent. All parties involved (alleged victim, family, staff, administration and alleged abusers) need to have confidence in the system and the fairness of its outcomes.

An investigation concluded in 2008 by our office found that an individual investigated by the PPCO had not been treated fairly, and that further safeguards were needed to ensure its investigation processes are fair.

A Licensed Practical Nurse advised our office that as a result of a PPCO investigation, she was dismissed from her nursing position. The nurse advised us that she was not informed that she was the subject of an investigation until it had been completed and that she was not given the opportunity by the PPCO to respond to or refute the allegations against her.

The PPCO had determined that the allegations of abuse against our complainant were founded and advised the Regional Health Authority (the nurse's employer) of its findings. Shortly after, the nurse was terminated from her employment.

In response to the nurse's complaint, the PPCO took the position that it was not responsible for her termination, as that was a decision made by her employer. However, the practical implication is that facilities, whose employees are subject to investigation, will likely accept the PPCO's findings at face value and take action. The potential impact on a facility if it did not

accept the findings, such as damage to reputation and the potential liability for failing to take action, are serious considerations for the health authority involved.

During our investigation, we examined *The Protection for Persons in Care Act*, PPCO policies, processes and practices and the file documentation relating to the investigation that gave rise to the complaint. We met with PPCO representatives on several occasions and provided the organization with an opportunity to respond to all of the issues raised. On the basis of our review, we found that the PPCO investigation was seriously flawed. We found that:

- there was no documentation to indicate that the allegations of abuse had been confirmed by the alleged victim, nor was the alleged victim interviewed during the investigation. There was no determination of any impact, potential or real, on the alleged victim;
- the only basis for concluding that there had been abuse were untested witness statements alleging abuse;
- the alleged abuser was neither interviewed nor given an opportunity to respond to or refute the allegations against her;
- there was no documented analysis or explanation for the basis on which it was concluded that there had been "serious harm" in this case; and
- the PPCO investigator failed to provide reasons for her conclusions, as required by *The Protection for Persons in Care Act.*

On the basis of these findings we concluded that the nurse had not been treated fairly, and that the determination by the PPCO that she was a "founded abuser" was unreasonable as it was not supported by the facts of the case. We made the following recommendations:

- that the PPCO policies and procedures be revised so it will be mandatory for the PPCO to notify alleged abusers that they are the subject of an investigation, and that they are advised of and are given the opportunity to address the allegations against them;

- that all statements taken by PPCO investigators be tape recorded and transcribed to confirm the nature of the questions asked by the investigator and to ensure the context of statements, reducing the possibility of bias; and
- that a letter of apology be sent to the nurse which also includes an explanation that, based on a review, the PPCO investigator's conclusions cannot be relied on because there is a lack of corroborating evidence and documentation and the nurse was not given the opportunity to address the allegations.

In response, the PPCO advised that several improvements have already been implemented and that it continues to review its policies and procedures. It indicated that it would consider our recommendation to tape investigator's interviews as part of its review. The PPCO also accepted our observations regarding procedural fairness and intends to promote this concept and has agreed to send the nurse a letter of apology.

Our office rarely becomes involved in labour relations matters, particularly where a complainant has access to union representation and an existing grievance process. In this case, the nurse did have access to such a process so our involvement was restricted to addressing the concerns about the PPCO process that preceded and led to the termination.

We will continue to monitor changes to the PPCO policies and procedures to ensure that our recommendations are implemented.

PUBLIC UTILITIES BOARD

Sometimes achieving fairness requires taking the necessary steps to ensure that all aspects of the decision-making process are effectively communicated to affected parties, including any review or appeal rights.

An individual complained to our office about certain aspects of the Public Utilities Board (the

Board) rates approval process. Because the Board is a quasi-judicial tribunal, the Ombudsman does not have the authority to substitute her opinion for that of the Board. In order to make a recommendation in respect of the complaint she would have to be satisfied that the Board rates approval process was clearly wrong or unreasonable.

In this case, our investigation concluded that the process was not clearly wrong or unreasonable, as the Board had acted within its statutory authority and that the rules of procedure had facilitated a fair hearing of the issues at hand. However, part of the individual's concern was apparent uncertainty about his capacity as an interested party to request that the Board reconsider its Order.

The Board's *Rules of Practice and Procedure* outlines a process and time frames for review by the Board of its orders and decisions. We advised the complainant of this and indicated that the *Rules of Practice and Procedure* were available on the Board's website. At the same time, we suggested to the Board that while its rules were available on its website, advising affected parties of the process for requesting a review of a Board decision would best demonstrate the Board's commitment to open and transparent administration.

In response, the Board made specific changes to address our comments. The Board advised that in future all public notices will make reference to Board proceedings being conducted in accordance with its *Rules of Practice and Procedure*, which clearly set out the process for requesting a reconsideration by the Board. As well, Board Orders will contain a standard clause at the end of the "Board findings" section indicating that Board decisions may be appealed in accordance with the provisions with section 58 of *The Public Utilities Board Act* or reviewed in accordance with section 36 of the Board's *Rules of Practice and Procedures*.

We believe that these changes will assist the public in understanding the Board's process and serve to enhance the public's perception of fairness in that process. The Board's prompt

attention to this matter and the action taken demonstrates an exemplary commitment to fairness.

WORKERS COMPENSATION BOARD

Fairness requires that when the government plans to make a decision affecting a person's rights or benefits, the person should be made aware of the circumstances, and given an opportunity to respond prior to the decision being taken.

A man who had been receiving Workers Compensation Board (WCB) benefits complained that his benefits were discontinued after the Board considered video surveillance evidence presented to the Board by his employer. He stated that he had not been given any opportunity to respond to the surveillance evidence prior to his benefits being discontinued. He questioned why there had not been any process whereby this new evidence could be presented at a hearing where he would have an opportunity to respond.

The WCB advised us that the actions taken were pursuant to a policy, which indicated that advance notice would not be provided when the decision to terminate benefits was based on the fact that important information had been misrepresented by the worker.

We wrote to the WCB, indicating that while we understood the decision had been made pursuant to existing policy, it seemed that the WCB should allow the worker the opportunity to review and rebut the information provided prior to its discontinuing his benefits.

In response, the WCB advised us that the issue raised by the complaint had been considered by the Board of Directors and that the policy would be changed. In future, when the WCB obtains evidence suggesting that a worker had misrepresented his or her medical condition and/or level of disability, the Board will immediately notify the worker of the existence of such evidence and provide that worker with up to five business days from the day of notification to respond to it.

The amended policy guideline is consistent with the requirements of fairness and the Workers Compensation Board is to be commended for its actions in response to this complaint.

EMPLOYMENT AND INCOME ASSISTANCE

Assignment of Canada Pension Plan Disability Benefits

In 2008, we concluded two lengthy investigations involving people who were enrolled as participants in the provincial Employment and Income Assistance Program (EIA) but who were also eligible for Canada Pension Plan Disability **(**CPPD**)** benefits.

EIA is a program of last resort and participants are required by law to seek any alternative sources of income that might be available to them. Since 2002, EIA has had a program to assist participants to apply for any CPPD benefits for which they might be eligible. Any benefits received from the CPPD program would reduce the benefits payable by the EIA program.

Concerns were raised about the process by which EIA participants were required to apply for CPPD benefits; and about the fairness of the method used to calculate the assignment of benefits retroactive to the date of the CPPD application, a period during which they continued to receive EIA benefits.

Canada Pension Plan Disability Application Process

Complainants alleged that insufficient information was shared with EIA recipients during the application process, that the assignment of benefits and application form were not made clear, and that recipients felt they were forced to sign forms that they did not understand.

Based on these concerns, our office reviewed the application process for all recipients and noted some areas of the process that we felt could be improved. The EIA Program reviewed our comments and revised the *Canada Pension Plan Disability Project Administrative Manual* to ensure that staff conduct the application process in a sensitive manner and share all information

with participants concerning the application form and reasons for completion. The revised manual included a directive to advise participants of their right to have a friend or advocate assist them and attend meetings with the EIA worker throughout this process.

In addition, EIA revised a fact sheet titled, *Employment Income-Applying for Canada Pension Plan Disability Benefits*. The fact sheet includes clarification on how a participant would have to give money back to EIA under the assignment of benefits process. EIA confirmed that the fact sheet would now be provided to participants before an interview is scheduled rather than during the interview.

These administrative revisions to the CPPD application process have clearly resulted in an improvement to the application process, which should better serve EIA participants who may be eligible to apply for CPPD benefits.

Assignment of retroactive disability benefit payments

When EIA program participants qualify for CPPD benefits, there may be some retroactive benefits paid that overlap with the benefits they received from EIA. To make sure they do not receive benefits from both programs for the same period, recipients are required to sign a consent form authorizing EIA to recover benefits it had paid to recipients, from recipients' CPPD retroactive payments. In calculating the amount recoverable, EIA included all payments it had made to, or for, a program participant, including the cost of medications.

Recipients of CPPD benefits pay for their own medications, but are eligible for Pharmacare benefits. Entitlement to Pharmacare benefits is based on income. When people reach their "deductible" amount, they no longer have to pay for medications. EIA participants do not pay for medications directly and therefore are not eligible for Pharmacare benefits.

However, when the EIA participants received their retroactive payments of CPP disability

benefits, they were not able to retain any amounts paid for medications in excess of the Pharmacare deductible. Instead, all of those funds were paid to EIA, because EIA had in fact paid the medication costs. While this is not unreasonable, it meant that the participants' disability benefits were reduced below what they should have been.

We believed that an equitable resolution would result in EIA retaining the recovered amounts for the medications for which it had paid; and the newly enrolled CPP disability recipients receiving a refund from Pharmacare for amounts in excess of their deductible.

Our office made inquiries with Pharmacare and were informed that a person cannot claim a refund from the Pharmacare program retroactively. As a result, EIA participants were required to repay their EIA benefits from retroactive CPPD benefits, but they were not entitled to receive retroactive Pharmacare refunds.

This practice resulted in differential treatment of people with disabilities, given that it applied only to those who qualified for disability benefits. We suggested to both Manitoba Family Services and Housing, and Manitoba Health and Healthy Living that the practice resulted in unfair and differential treatment, and arose because of their inconsistent approach to retroactive benefits.

The departments reviewed our concerns and determined that sixty-five EIA/CPPD applicants should receive refunds. These refunds represented the difference between the prescription drug costs EIA had recovered and the amount that participants would have paid until they were eligible for Pharmacare benefits.

EIA also changed its policy on recoveries, to only claim the amount of drug costs up to the amount of the Pharmacare deductible from retroactive payments from the CPPD program.

MANITOBA AGRICULTURE SERVICES CORPORATION

When taking action that is going to directly affect a person's livelihood, government must act fairly and on a sound legal and factual basis. A 2008 complaint about the Manitoba Agriculture Services Corporation (MASC) demonstrated the pitfalls of acting without that sound basis.

The mission of MASC is to provide financial products and services that help manage agricultural risk and assist in the sustainable development of rural Manitoba. It offers insurance and specialized lending products to Manitoba's agricultural and rural business sectors.

A farmer complained to our office that MASC had seized the auction proceeds from the sale of cattle owned by her and her husband, without the authority to do so. Based on our investigation of the complaint, we concluded that MASC's decision to seize proceeds from the sale of the complainants' cattle was unfair and wrong.

In January 2008, the complainant had cattle delivered to auction and consigned them for sale in her name. She called the auction mart a few days after the sale to inquire when she could expect payment and was advised by auction mart personnel that MASC had seized the proceeds.

In response to our inquiries, MASC advised that it held a judgment against the complainant's parents-in-law and that it had a security interest in their personal property pursuant to *The Personal Property Security Act*. MASC asserted the cattle belonged to the parents-in-law, based on information that the cattle had been loaded from their property.

The complainant contacted MASC and explained that as their property is adjacent to her parents-in-law, they had moved their cattle across a field to the in-laws property to use their loading chutes. She also advised MASC that the Canadian Cattle Identification Agency ear tags on the cattle sold were registered to her and her husband and faxed MASC copies of receipts

for cattle they had purchased. MASC refused to return the funds to the complainants.

MASC reached a settlement agreement with the complainant's parents-in-law, and two weeks later, forwarded a cheque to the complainant together with the original sale statement from the auction mart.

After considering all the information provided by MASC and the couple, we advised MASC that in our opinion it failed to:

- establish ownership of the cattle before seizing the funds;
- establish its authority to seize the proceeds;
- notify the couple of its intent to claim the proceeds of the cattle sold; and
- provide the couple with an opportunity to respond or refute its claim to the proceeds from the sale of cattle delivered for sale in the complainant's name.

We also advised MASC that we were not disputing any right of action MASC had with respect to the parents-in-law, however, it was our opinion that MASC had not established that its right of action extended to the complainants.

MASC's position was that the cattle at auction were the property of the parents-in-law, but could not offer any proof to us to support that assertion.

As MASC had not shown our office any documentation that demonstrated it had the authority to seize the couple's funds, the Ombudsman made the following recommendations:

- That MASC send a letter of apology to the complainant for seizing the proceeds from the sale of cattle sold, as it did not have the authority to do so; and
- That MASC amend its practices and establish a policy that will require that before any seizure action is taken by it, it must clearly establish that the funds or collateral seized are in fact owned by its debtor.

MASC accepted the Ombudsman's recommendations and advised that it is amending its practices and collections and recovery policy respecting the seizure of payment or collateral, and sending the complainants a letter of apology.

MANITOBA CORRECTIONS

Release Planning

In our 2007 Annual Report, we identified an ongoing concern for the welfare of inmates who are living with mental illnesses or mental disabilities. In addition to the challenges faced by correctional centres in providing care and obtaining treatment for such inmates, planning for their successful release back into the community can also be difficult.

In 2008, we received a complaint from the mother of an inmate living with a mental illness. The inmate was admitted to the Winnipeg Remand Centre in October 2007 and identified by Corrections as "mentally disordered." Corrections confirmed that he was a client of the Public Trustee. Eight days later, the man was transferred to the Headingley Correctional Centre (HCC), where he remained until his release in February 2008.

A court ordered assessment in January 2008 states, in part:

> *... Mr. [inmate] would also benefit from increased community supports and monitoring. Towards this end, I would suggest that for any noncustodial sentence Mr. [inmate] might receive that he be referred to [specified referral] so that appropriate plans for support and monitoring can be arranged.*

There is no evidence to confirm that appropriate plans for support and monitoring were arranged and the man's release plan indicates that he would reside at the Main Street Project following his release. No reference is made to any discussions involving the Public Trustee, Community Mental Health or the man's family when decisions were made with respect to his reintegration into the community.

In February 2008, HCC contacted the inmate's mother. She said she was told that her son would be released to either her residence or the Main Street Project. She chose to provide him with shelter, recognizing that her son was living with a mental illness and required assistance managing his personal affairs.

For the next two months he was transient, staying with his mother or other family members who were concerned about his well being. In April 2008, he was entered into an Individualized Supported Independent Living Program which provided up to 12 hours of daily support. This type of program is reflective of the kind of supports that were required and should have been in place at the time of his release.

As a part of our review, we had discussions with staff from the Office of the Public Trustee, Community Mental Health and HCC and considered all the documentary evidence provided. We offered the following observations based on our review of the release planning process:

- Communication between the Headingley Correctional Centre and stakeholders in the community such as Community Mental Health, the Office of the Public Trustee, Employment and Income Assistance and family could be improved;
- Release planning should begin in a timely manner for the purpose of identifying, documenting and addressing any special needs the inmate may have prior to his release date; and
- There would appear to be a benefit in having purposeful standards or guidelines to assist caseworkers when preparing comprehensive release plans for inmates living with mental illnesses and/or mental disabilities.

We are pleased to report that as a result of our review of this case, there has been some improvement in the release planning process. HCC conducted an internal audit of its release planning practices and committed to the following improvements:

- The development of policy or standards concerning the preparation of release plans for inmates living with major mental illnesses and/or mental disabilities;
- The enhancement of external communication with stakeholders such as Community Mental Health, the Office of the Public Trustee, Employment and Income Assistance and family during the release planning process; and
- The consideration of a process whereby inmates, who are clients of the Public Trustee or Community Mental Health, can be readily identified to their respective caseworkers while adhering to existing privacy legislation.

HCC is to be commended for its efforts. Our office will continue to monitor this issue as part of our ongoing investigation related to high risk/high needs people in custody.

Sentence Calculation

As in most jurisdictions, inmates in Manitoba correctional facilities are entitled by law to earn "remission," a means by which their custodial sentences are reduced. Earned remission requires appropriate behaviour and inmates may lose remission for breaching institutional rules. Accordingly, an inmate's release date can change, and determining the correct date requires a precise calculation.

Ensuring that an inmate is detained no longer than legally permitted is crucial for both the inmate and the correctional centre charged with the inmate's care and custody.

Our office received a letter from an inmate who believed that a correctional centre had not accurately calculated the remission that he had earned during his custodial sentence. He indicated that he would be serving more time in custody as a result of this administrative error and was unable to resolve his concern by dealing directly with the Centre.

The Centre advised our office that the inmate's sentence calculation was recalculated using both an automated and manual process. It was confident that the sentence had been calculated appropriately based on the information available.

With the full cooperation of the Centre, our office reviewed the administrative process and the records that were considered by the Centre when calculating the inmate's sentence. Two issues were identified, including an apparent misapplication of a section of *The Correctional Services Act*.

As a result of our review, the Centre recalculated the inmate's sentence, and it resulted in an earlier release date for the inmate.

This was an administrative error and we noted that the centre had taken appropriate action to achieve a satisfactory resolution. An investigator from our office met with the inmate and correctional staff together to discuss this complicated process and explain the error that had occurred during the calculation stage.

Living Conditions

Each year, staff members from our office visit numerous provincial health and corrections facilities to examine the living conditions of people who may be confined to those facilities.

In December 2008, an investigator found that the living conditions in an adult correctional centre had fallen below an acceptable standard. We advised the centre that:

> *It would appear that a number of units are in need of extensive repair. The condition of some bathroom facilities included: inoperative showers; lighting not working in some of the communal showers; extensive water damage to walls; and what appears to be a general state of overall poor condition and uncleanliness.*

One of the communal showers… had inoperative lighting and wall damage that was repaired using a vinyl patch and exposed duct tape. Additionally, the aging materials in many of the showers had stains from years of use which appeared unclean.

We asked the Centre to provide us with copies of all outstanding work orders and clarification of how work orders are prioritized to address potential safety risks. Staff of the Centre were fully cooperative with our office, providing us with an explanation of the unique and challenging circumstances that gave rise to the conditions we observed and the ongoing efforts to improve those conditions.

At the end of 2008, we were provided with information confirming that work on all but three work orders had been completed. As well, we received an explanation for the delay in completing the three outstanding orders and a description of the procedures adopted to ensure that work orders would be completed in a more timely fashion.

We were satisfied that the correctional centre had responded promptly and confirmed that the necessary action to restore living conditions to an acceptable standard would be taken.

We will continue visiting facilities to ensure that those confined there have reasonable living conditions.

CASES OF INTEREST - MUNICIPAL GOVERNMENT

RURAL MUNICIPALITY OF LAC DU BONNET

Fairness requires that anyone who will be affected by a decision be notified that the decision is going to be made, and given an opportunity to have his or her position on the matter considered before the decision affecting him is made. A case involving a municipality demonstrates the importance of clear and timely notice.

Under *The Municipal Act,* elected municipal officials who miss three consecutive meetings become ineligible to continue as a member of council unless the council approves the extended absences, by resolution, thus allowing the absent elected official to avoid the statutory disqualification. This provision appears to eliminate the need for notice to a councillor who has abandoned his or her responsibilities. In this case however, council was aware of the reasons for the complainant's absence from council.

In 2008, a former reeve complained to our office after he had been disqualified for missing three meetings. He was absent from the meetings for health reasons. He indicated that he had not been informed in advance that council would be voting on a resolution to grant his continued absence and was not aware that if the resolution were defeated he would lose his seat on council.

Our investigation included discussions with the Chief Administrative Officer and members of the council, as well as discussions with the complainant and with Manitoba Intergovernmental Affairs.

Evidence from the investigation suggested that council was aware that the reeve was absent for health reasons. Prior to the meeting in question, in June 2008, he had sent an email indicating that he would not likely be returning to council until July. The meeting at which he was

disqualified contained the following agenda item:

[Reeve] - Resolution to be absent for more than three meetings.

Our review indicated that while the proper procedure for including the item on the agenda was followed, and there was no breach of any procedure required by *The Municipal Act,* the former reeve had not been treated fairly.

At the end of the investigation, we advised council of our conclusion that council …*failed to take reasonable steps to notify [the reeve] of its intention to vote on the resolution that, if defeated, had the potential to disqualify him from office. In fact, that is exactly what transpired.*

It is important that the public have confidence that public institutions make fair decisions and demonstrate openness and transparency in matters of government administration. In this case, the former reeve had not been treated fairly. We advised council that:

> *Based on our review of the information presented to our office, we are of the view that council's decision to vote on a resolution to extend [the reeve's] leave without notifying him in advance of the vote was unreasonable. Council was aware that [the reeve's] illness was the reason for his absence and was also aware that he did not anticipate returning until sometime in July 2008. Council's actions adversely impacted [the reeve] in a significant way in that he was disqualified from his elected position as Reeve and from running for office during the recent by-election.*

The Ombudsman recommended that the Municipality:

> *… implement a policy to guide future actions in similar situations that clearly distinguishes between a situation in which a council member has been absent with the knowledge of council; versus being absent without notice to council. In cases where*

council has knowledge of the reason for a member's absence from council meetings, such as a medical condition, council should take steps to provide adequate notice to the absent member that continued absence will be an agenda item at a future council meeting and will be subject to a vote. That notice should clearly indicate that if the vote is defeated, the member may be disqualified from council.

The Ombudsman also recommended that the Municipality apologize to the former reeve for the manner in which this situation had been handled.

The Municipality accepted the Ombudsman's recommendation to strengthen its policy on notice in situations like this, but declined the recommendation to issue an apology to the former reeve.

RURAL MUNICIPALITY OF PARK

In another complaint alleging unfair process, a complainant asserted that a municipal by-law was *…structured to effectively prevent public participation by way of delegation at council meetings because of notice requirements*.

The by-law at issue was a municipal procedures by-law that required all individuals wishing to attend a council meeting as a delegation to register as a presenter with the Municipality at least 168 hours (7 days) before the council meeting and advise the Municipality of the topic of the presentation.

At the same time, the procedures by-law required that a draft agenda be made available to the public at least 96 hours (4 days) before the council meeting and that all items to be placed on the agenda be provided to the Municipality at least 120 hours (5 days) before the council meeting.

The Municipal Act requires municipal councils to establish procedural by-laws creating rules of procedure, and to review such by-laws at least once during their term of office. The complainant in this case indicated the concern had been raised with the Municipality in writing before contacting our office, but it had not been addressed.

Although municipalities are required to review their procedures by-law once during their term, there did not appear to be anything prohibiting the Municipality from reviewing and addressing this obvious concern sooner. We contacted the Municipality and were told that the by-law at issue would be reviewed at its upcoming meeting.

Shortly thereafter, we were advised that the Municipality had amended its procedures by-law, and that the amended by-law required only that:

> *... persons wishing to appear as a delegation in regards to an item placed on the agenda provided to the public 4 days prior to the scheduled meeting, shall register with the CAO a minimum of two (2) hours before the council meeting and advise the CAO of the topic of the presentation. In any case, registration of a delegation must occur prior to the commencement of a council meeting.*

The amendment that the Municipality made to its procedures by-law addressed the concern raised and we advised the complainant that based on our review of the matter, we felt the action taken by the Municipality was fair and reasonable.

RURAL MUNICIPALITY OF DALY

Clean Environment Commission

A third municipal case in 2008 dealt with a complaint about an issue on which a recommendation had already been made by the Clean Environment Commission (CEC).

The R.M. of Daly contacted us after the Court of Queen's Bench quashed a municipal decision under *The Planning Act* to approve an intensive livestock operation as a conditional use under its zoning provisions. The basis on which the municipal decision was quashed was that the Municipality had failed to consider statutory criteria set out in *The Planning Act*.

The difficulty from the Municipality's perspective was that the statutory criteria that they had failed to consider related to information they were supposed to have received from a provincial Technical Review Committee (TRC). Because the report of the TRC did not address the issues specifically identified in the statutory criteria to be considered by the Municipality, the Municipality did not consider them at its hearing and consequently its decision was quashed.

After the Municipality contacted us, we noted that the role and function of provincial Technical Review Committees, and the means by which they provide information to municipalities to assist in making decisions under *The Planning Act,* was a matter that had already been dealt with in a report issued by the CEC in December 2007.

The CEC Report, *Environmental Sustainability and Hog Production in Manitoba,* contains a detailed and thorough analysis of the issues associated with the use of TRC reports considered by municipal decision makers under *The Planning Act*. If implemented, the CEC's recommendations would address the concerns raised by the Municipality whose decision had been quashed. Those recommendations had been accepted, in principle, by Manitoba Conservation at the time we received the complaint from the R.M. of Daly.

After consultation with the Chair of the CEC, we decided that it would be a duplication of effort for our office to undertake an investigation into the Technical Review Committee process. The CEC had conducted exhaustive public hearings, provided a detailed analysis and historical review of the process, and crafted recommendations to address the identified concerns.

We advised both the Municipality and Manitoba Conservation that our office would actively monitor the implementation of the CEC recommendations by the department, which is not a function of CEC in its capacity as an administrative tribunal. This will also allow us to respond to the municipality's complaint and will be an efficient use of our resources.

THE PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT

In 2008, we completed an investigation of a disclosure of wrongdoing received in 2007. The disclosure related to a post secondary educational institution.

Our investigation of the disclosure did not find that there had been *gross mismanagement* as alleged; however, we did conclude that the institution had made decisions that amounted to mismanagement. The Ombudsman made recommendations for corrective measures, which the post secondary educational institution accepted and fully implemented**.**

In this case, we decided that it was necessary to consult with financial accounting experts. We were fortunate to work with the experienced and capable staff of the Auditor General of Manitoba, whose expertise ensured that the review of financial transactions was credible and thorough. We anticipate that involving various specialists in investigations under this Act will be a common occurrence.

In 2008, our office opened three files in response to disclosures of wrongdoing; two involving healthcare facilities and one involving a crown corporation. These investigations are ongoing.

Report on the Activities of the Access and Privacy Division

OVERVIEW OF 2008

In 2008, our office opened 239 new cases under *The Freedom of Information and Protection of Privacy Amendment Act* and *The Personal Health Amendment Act* (FIPPA and PHIA). Of these, 198 were access and privacy complaints from the public, and 23 were cases initiated by our office to review, monitor or comment on compliance with the Acts. The bulk of our work continues to be about decisions, acts or failures to act that relate to access applications made under FIPPA, mainly about refusals of access. Information about our case-related work under the Acts is contained in the *Cases of Interest* and the *Statistical Review of 2008* sections.

This past year, our office reviewed the format of our investigation reports under FIPPA and PHIA to improve the way in which we communicate the results of our investigations to complainants, public bodies and trustees. We introduced some changes to clearly set out the complainant's issues, the position of the public body or trustee about the complaint, our analysis, findings, and any recommendations made about the complaint.

These changes to the format of our reports will assist in highlighting the key issues and our findings about them. Where recommendations are contained in a report, the new format will ensure that the basis for our recommendations and the recommended actions are clearly outlined to assist public bodies and trustees in responding to the Ombudsman.

The Ombudsman is required to report on any formal recommendations made, and in 2008 there were recommendations made in four cases. These cases relate to access complaints about the public bodies' failures to respond within the required time limit under FIPPA. Summaries of these cases are included under the *Cases of Interest* section. There were no recommendations under PHIA in 2008.

FIPPA and PHIA provide a right of appeal to the Manitoba Court of Queen's Bench for individuals who have been refused access to information 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 a public body or trustee has not acted on the Ombudsman's recommendation to release records.

In 2008, two individuals filed FIPPA appeals to the Court of Queen's Bench because they had been refused access and the Ombudsman did not support their complaints. One appeal (Court File CI08-01-58184) is against the City of Winnipeg and the other appeal is against Manitoba Labour and Immigration (Court File CI08-01-59380). Both of these appeals are pending.

FIPPA AND PHIA AMENDMENTS

During 2008, amendments to FIPPA and PHIA were introduced. *The Freedom of Information and Protection of Privacy Amendment Act* and *The Personal Health Amendment Act* were given royal assent on October 9, 2008. At the time of writing this Annual Report, these amendments have not been proclaimed in force.

One significant change introduced in the amending Acts is the creation of an Information and Privacy Adjudicator. The Adjudicator will be an independent officer of the legislature. The role of the Adjudicator will be to review, at the request of the Ombudsman, any access or privacy matter related to the Ombudsman's recommendations made in a report about an investigation of a complaint under Part 5 of FIPPA or PHIA. The Adjudicator will have the power to order compliance with the legislation.

The amendments provide that in circumstances where the Ombudsman has made recommendations in a report, she may request a review by the adjudicator if the public body or trustee:

- fails to respond to the Ombudsman within the required time limit after receiving the report;
- refuses to take action to implement the recommendations; or

- accepts the recommendations but fails to comply with the recommendations within the specified time period or within an additional period the Ombudsman considers reasonable.

The time limit within which the Ombudsman may request a review is 15 days after receiving the response, in the circumstances where the public body or trustee refuses to take action to implement the recommendations, or accepts the recommendations but fails to comply with them within the specified time period. If the public body or trustee does not respond to the Ombudsman's report, the Ombudsman may also ask for a review within 15 days after the deadline for a response has expired.

It will be critical for public bodies and trustees to provide timely responses to the Ombudsman's recommendations and, if the recommendations are accepted, to take action to implement them within the specified time period and provide evidence to demonstrate compliance with the recommendations.

The consequence of the amendments is that the failure to comply with the time limits set by law could result in the Ombudsman requesting a review of the matter by the Adjudicator.

SAFEGUARDING PERSONAL AND PERSONAL HEALTH INFORMATION

The Freedom of Information and Protection of Privacy Act (FIPPA) and *The Personal Health Information Act* (PHIA) require public bodies and trustees to implement reasonable security safeguards to ensure confidentiality and protect personal and personal health information. Developing policies that set out procedures for ensuring the security of the information is a requirement under PHIA and a best practice under FIPPA.

Several privacy breaches reported to our office have resulted from situations in which employees had taken personal information and personal health information outside of their

workplaces. In some cases, records which were being transported from one location to another contained personal and personal health information and were accidently lost or stolen from an employee's vehicle. In other cases, faxes containing personal and personal health information were inadvertently sent by employees of public bodies and trustees to unintended recipients.

Public bodies and trustees should provide employees with ongoing training about their responsibilities under FIPPA and PHIA and should make them aware of workplace policies that have been implemented to avoid privacy breaches.

Our Practice Notes, *Protecting Personal and Personal Health Information When Working Outside the Office, Privacy Considerations for Faxing Personal and Personal Health Information* and *Privacy Considerations for Emailing Personal and Personal Health Information* can assist public bodies and trustees in developing policies for their employees and mitigating privacy risks. They also provide useful tips to consider when faxing, emailing and taking personal and personal health information outside of the office.

DEALING WITH A PRIVACY BREACH

Under FIPPA and PHIA our office may conduct investigations and make recommendations to monitor and ensure compliance with the legislation. In 2008, the number of privacy breaches being reported to our office by public bodies and trustees increased. As well, we became aware of some privacy breaches through media reports.

These privacy breaches resulted from inadequate measures to protect personal information and personal health information in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA). Privacy breaches happen when, for example, personal information of clients, patients or employees is stolen, lost or mistakenly disclosed. This might occur when a computer containing personal or personal health information is stolen or information is inadvertently faxed or emailed to an unintended recipient.

Although reporting a privacy breach to our office is not mandatory under FIPPA and PHIA, making our office aware of a breach can assist us in responding to any privacy complaints we may receive from affected individuals. Additionally, when a privacy breach is reported to us we can assist public bodies and trustees in developing a plan for responding to the breach. We can offer suggestions and help ensure that appropriate steps are being taken to mitigate the breach and prevent similar breaches from occurring in the future.

Responding immediately to a privacy breach is crucial. Key steps in responding include: containing the breach by stopping the unauthorized practice and, where possible, recovering the records; evaluating the risks associated with the breach considering the sensitivity of the information involved, the cause and extent of the breach, the individuals affected and the foreseeable harm that could result from the breach; and notification in appropriate circumstances. Once these steps to mitigate risk are taken and an investigation of the cause of the breach is completed, changes to security safeguards should be made to prevent further breaches.

Our Practice Note *Key Steps in Responding to Privacy Breaches under The Freedom of Information and Protection of Privacy Act (FIPPA) and The Personal Health Information Act (PHIA)* provides guidance to public bodies and trustees when a privacy breach occurs.

We have created a Privacy Breach Reporting Form for use by public bodies and trustees which can assist them in completing an analysis of the breach. This form is also contained in our Practice Note *Reporting a Privacy Breach to Manitoba Ombudsman*.

All of our Practice Notes are included on the CD format of this Annual Report in *Other Publications* and are also available on our website at www.ombudsman.mb.ca.

EXPLAINING DECISIONS TO REFUSE ACCESS TO INFORMATION

When public bodies and trustees make decisions to refuse access to requested records, they should be able to explain the basis for those decisions. FIPPA and PHIA require that applicants be given the reasons for the refusal and the specific provision of the Act on which the refusal is based.

Complaints about refusal of access form the bulk of our investigation caseload under FIPPA. To investigate these complaints, we ask for all the records to which access has been refused, and written representations to explain the decision to not release the records.

In many of our investigations, we have observed that some public bodies have been unable to provide adequate explanations for their decisions. This raises a question about the soundness of the decisions, as well as a concern about the public body's ability to respond adequately to the public and to our office.

Most exceptions under FIPPA are discretionary. Exercise of discretion requires that the public body consider whether it will grant access in these circumstances; and if it decides not to, to state the reasons for its decision. Therefore, its representations should include the factors that were considered when exercising that discretion.

Often, responses to our office are too general and do not make the necessary connections between the exception and the information withheld, or do not address issues we have raised for consideration. This results in unwarranted delay while we seek additional clarification. As well, we sometimes receive conflicting information from the public body, further complicating and protracting our investigation process.

Accurate and thorough responses to our office are essential from a public body when stating its case for relying on the exceptions that have been cited to withhold information.

Representations should demonstrate how all of the required elements of each claimed exception apply to the withheld information. Simply reiterating or rephrasing the language of the exception, without explaining the connection between the wording of the exception and the withheld information, is not adequate.

Receiving effective representations enables us to move forward with the investigation to analyze the position of the public body and determine whether the decision to refuse access was in compliance with FIPPA or whether an applicant is entitled to access under the Act.

The foundation of good explanations to the public, and representations to our office, is laid long before a complaint is made. It begins with thorough documentation during the FIPPA decision-making process. Well-documented decisions enable public bodies to provide comprehensive responses during a complaint investigation, which takes place well after decisions on the initial application for access have been discussed and made.

Thorough documentation includes recorded details in the applicant's access file about:

- how, why and by whom specific decisions were made;
- specific steps taken to locate responsive records;
- how fees were calculated;
- how the elements of an exception apply to the withheld information;
- the circumstances that were considered for exercising discretion to withhold rather than release when citing a discretionary exception;
- advice given from program areas or consultations with other parties; and
- reasons under FIPPA as to why a specific provision applies when an extension is taken.

In an effort to address this ongoing concern, our office has issued *Practice Notes* providing guidance for public bodies and trustees in explaining access decisions.

In our Practice Note, *Documenting Access Decisions under FIPPA and PHIA*, we set out best practices for public bodies and trustees to follow. This Practice Note provides a context for the importance and the benefits of thorough documentation.

In our Practice Note, *Responding to a Complaint about a Refusal of Access under The Freedom of Information and Protection of Privacy Act,* we provide guidance and tips for public bodies when providing written representations (as well as a records package) to the Ombudsman.

All of our Practice Notes are included on the CD format of this Annual Report in *Other Publications* and are also available on our website at www.ombudsman.mb.ca.

CASES OF INTEREST

Under FIPPA and PHIA, the Ombudsman has both proactive review powers and responsive duties relating to the investigation of complaints received from the public or initiated by my office. For 2008, we are reporting on three proactive reviews and four complaints investigations.

Three proactive reviews were conducted under the provisions of FIPPA or PHIA that allow us 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.

The four complaints investigations that we highlight all concern access to information and resulted in recommendations. Both FIPPA and PHIA require that the Ombudsman report annually on recommendations made under these Acts.

PROACTIVE REVIEWS

Privacy concerns can arise in projects initiated by governments to meet international commitments, to seek improved efficiency through the use of technology, and to respond to public concerns, both real and perceived.

Challenges for decision makers include the fact that privacy concerns are not always identified at the planning stage of a project, that addressing privacy concerns may be seen as adding cost to a project or resulting in project delay, and the fact that privacy issues can be complex. The proactive identification and consideration of privacy issues has not yet become a standard component of the decision making process. Based on our experience in 2008 however, we are pleased to report that this may be changing.

The challenges for our office include explaining and maintaining our independence while performing the dual role of privacy educator on the one hand, and privacy watchdog on the other. In performing our education role, our participation should not be viewed as support for or approval of a particular initiative. Our office must remain neutral and be seen to remain neutral, in order to maintain the confidence of the public. Our experience in 2008 has been positive in that we have been able to work collaboratively with different levels of government to consider privacy concerns, and have them addressed by government, without compromising our independence or neutrality.

We are pleased to note that we were invited by the entities involved, early in the development of their projects, to comment on the privacy issues their projects raised.

When we participate in reviews like these, the role of our office is advisory and cannot interfere with or fetter the Ombudsman's powers and duties relating to any future comments or investigations on these same projects or issues. All three reviews are ongoing, with the intention that our office will continue to provide comments.

ENHANCED IDENTITY CARDS/ENHANCED DRIVERS LICENCES

On February 2, 2009, Manitoba became one of the first jurisdictions in Canada to offer citizens the opportunity to apply for an "enhanced identity card" (EIC). A Manitoba "enhanced driver's licence" (EDL) will be offered later in 2009.

The purpose of the Manitoba EIC/EDL program, introduced by Manitoba Public Insurance (MPI) and the government, is to provide a voluntary form of identification for eligible Manitobans that will meet the requirements of the United States Western Hemisphere Travel Initiative and serve as an alternative to the Canadian passport when entering the U.S. by land or water from June 1, 2009.

Throughout 2008, there was considerable consultation between my office and officials from MPI and government about the privacy issues the EIC/EDL program raises. Our review to date on the privacy implications of the program has resulted in less personal information being collected and promotional communications being expanded and clarified to assist the public's understanding of this complex program.

Privacy Concerns Raised by our Review

Whether there is need for EIC/EDL

The collection, use, disclosure and retention of personal information in the Enhanced Identity Card/Enhanced Driver's Licence Program is authorized by *The Drivers and Vehicles Act* and various multi-jurisdictional agreements. It remains important however, from a privacy point of view, to consider whether the collection and resulting handling of personal information is necessary, effective and proportional to the privacy risks.

The EIC/EDL program requires the collection of personal information not previously collected by MPI and other entities. Because every collection of personal information has inherent privacy risks, the collection of personal information must be properly administered. Canadians already have a well-established, secure travel identification document in the form of a passport. The Canadian passport enables travel to other countries in addition to the U.S. and entry to the U.S. by air in addition to entry by land and water. The government has said that Manitobans may want an alternative to the Canadian passport and has promoted the EIC as being more economical, more convenient (wallet sized) and secure.

While the EIC/EDL is a less expensive alternative to the passport for the individual who purchases one, there is a cost to the Manitoba public for the establishment and maintenance of the EIC/EDL program. The Manitoba program duplicates services already provided by the Canadian passport process.

The Radio Frequency Identification Technology Being Used in the Manitoba Program

In order to speed crossing at the U.S. border, the U.S. Government is requiring that Enhanced Identity Cards or Enhanced Driver's Licences have Radio Frequency Identification (RFID) chips embedded in them.

This technology uses radio waves for the purpose of automatic identification by transmitting information contained on a microchip in the card when the card is exposed to a card reader. The information on the chip will be limited to an identification number (a form of personal information) unique to the cardholder. The RFID, used together with border crossing secure software, will read the number on the chip and enable U.S. border authorities to request and receive from Canadian border authorities additional personal information about the cardholder. That information will be used by U.S. border authorities to determine the cardholder's eligibility to enter the U.S.

The Manitoba EIC/EDL program intends to use "passive" RFID. This means that the transmission setting of the chip embedded in the card will always be "on". An unauthorized card reader or network of card readers could potentially read the chip. Because the unique identifying number on the chip is exclusive to one person and potentially accessible to an unauthorized card reader, the individual's identification could be ascertained and their location could be tracked.

This risk to personal privacy has been recognized by the Manitoba EIC/EDL program. To prevent surreptitious location tracking, EIC/EDL holders will be provided with a protective sleeve for the card which blocks the ability of any RFID reader to scan the chip in an Enhanced Identity Card or Enhanced Driver's Licence without the holder's knowledge.

However, the sleeve will only serve as privacy protection if it is used properly by the EIC/EDL holder. It is possible that the individual will not appreciate the purpose or importance of the

sleeve or will forget to use it. Even when the sleeve is used properly, the individual's personal privacy will be at risk when the card is removed from the sleeve for use.

Also, the sleeve is only effective as privacy protection if it is physically intact. We have been advised by MPI that if the sleeve is torn or damaged, the RFID chip could be read by an unintended reader. We have also been assured by MPI that if an EIC or EDL holder wants a replacement sleeve, new sleeves are available, free of charge, at any broker office or MPI service location.

We are concerned that because of the passive RFID technology used in Manitoba's EIC/EDL program, cards are always "on", resulting in a default position that is privacy intrusive. The sleeve solution places a constant burden of privacy protection on the individual. There is alternative RFID technology emerging that could enable the cardholder to turn the card's transmission setting "on" and "off" as needed. This alternative technology is not being considered for the EIC/EDL program at this time. We have asked that MPI make further enquiries and report to my office about the feasibility of using other RFID technology.

Informing Manitobans about Privacy Concerns in the EIC/EDL Process

The collection, use and disclosure of personal information necessary to obtain an EIC or EDL is complicated. Regardless, the process must be made clearly known to the public in order to ensure that the risks to privacy are understood. That way, if a person decides to participate in the program, he or she can provide consent on an informed basis to the sharing of his or her personal information. During the application process, the individual should know that he or she can raise any questions or concerns about the program with MPI or the Autopac broker and receive answers before continuing and deciding to sign any documents.

There are over 300 independent Autopac outlets across Manitoba and over 100 MPI interviewers. Manitobans are entitled to a consistent, high standard of service regardless of with whom they do business. Our office is working with MPI and the Manitoba Government to

ensure that Manitobans are informed of pertinent information clearly and consistently, early and throughout the application process.

MPI has prepared brochures on the EIC program and Facial Recognition technology (another new technology being used in the program) and will be preparing a brochure on RFIDs. As well, existing brochures concerning MPI's protection of personal privacy and establishing identity have been revised.

Most importantly, a comprehensive EIC *Applicant's Guide* has been prepared and is available at www.mpi.mb.ca. The *Applicant's Guide* thoroughly explains the program. It is important that individuals considering participation in the EIC program first read the *Guide* to determine if they are comfortable with the application process, the questions they will be asked and how their personal information will be used and shared with Canadian and U.S. authorities.

If a person proceeds with an application, documents containing detailed personal information must be provided by the applicant and scanned copies will be retained by MPI. As well, various forms will be signed, including consents allowing some of the individual's personal information to be shared between Manitoba entities, Manitoba and Canada and also Canada and the U.S.

Once the information has been shared with U.S. authorities, there is the potential for it to be used by them for purposes other than border crossing. The retention period for the information in the U.S. is 75 years. Manitoba and Canadian laws protecting information privacy do not extend to that information once it is in U.S. data banks.

The EIC/EDL Should Remain Voluntary

Currently, the EIC/EDL program is voluntary and for the purpose only of U.S. border crossing by land or by water (the EDL will be dual purpose, also serving as a driver's

licence). The Ombudsman has urged that the EIC/EDL Program remain solely for the purpose of secure border crossing. In view of the personal privacy implications of the Manitoba EIC/EDL program, the Ombudsman has also urged that the program remains voluntary.

Ombudsman Comments on EIC/EDL

With the February 2009 launch of the EIC/EDL program, the Ombudsman issued a news release and fact sheet to highlight privacy concerns and to supplement information about privacy for the public. The news release and fact sheet, *The Manitoba Enhanced Identification Card (EIC): 10 Points for Privacy Awareness,* is included on the CD format of this Annual Report in *Other Publications* and also available on our web site at www.ombudsman.mb.ca.

In addition to our collaborative efforts to work with the government and MPI to enhance privacy protection in the development of this initiative, we will continue to perform the monitoring and investigative functions prescribed by legislation.

VIDEO SURVEILLANCE IN DOWNTOWN STREETS BY WINNIPEG POLICE SERVICE

In January 2008, Winnipeg's City Council directed the Winnipeg Police Service (WPS) …*to investigate the feasibility of developing a pilot project utilizing monitored cameras in high crime areas of the City.* In April 2008, based on a report by the Chief of Police, City Council directed the WPS to proceed with the implementation of Phase 1 of the pilot project, which included such tasks as determining the rationale and objectives for the closed circuit television (CCTV) pilot, identifying the scope of the pilot and exploring privacy rights of individuals. It was at this point that our office was invited by the City of Winnipeg to sit on a WPS working group for the pilot, specifically to provide information and advice about privacy. FIPPA must be considered in a project such as this because CCTV technology creates a record of captured images of identifiable individuals.

This was an excellent opportunity for our office to increase privacy awareness and help influence decision making with respect to privacy. We note that early on in the project the WPS had undertaken detailed privacy research and, throughout, were committed to being FIPPA compliant. We are of the opinion that by the conclusion of Phase 1 of the pilot, in October 2008, privacy had been addressed to a higher degree than initially contemplated.

One of the grounds in FIPPA for collecting personal information is "for law enforcement purposes or crime prevention." One of the rationales for the City of Winnipeg choosing to collect personal information in this way was that CCTV is an additional tool to assist police after an incident has taken place. However, CCTV indiscriminately captures and retains personal information, whether or not passersby whose images are captured have done anything to arouse suspicion.

Where CCTV is used in the streets, the individual does not have a reasonable choice to avoid the collection of their personal information. The impact on personal privacy by CCTV is especially intrusive when the cameras are located on downtown streets frequented by large numbers of people going about their daily business.

Privacy has been recognized as a fundamental human right by the Supreme Court of Canada. Individuals have the right to be safe in their day-to-day activities, but also have the right to be free of unwarranted intrusion into their lives. In that CCTV narrows this fundamental human right of Canadians, it should only be utilized if the collection is demonstrably justifiable.

In determining when and how it might be appropriate to narrow a privacy right, our office has recognized that the problem to be addressed should be real, pressing and substantial and that the privacy-invasive collection should only be considered as an exceptional step to be taken in the absence of a less privacy-invasive alternative.

We were pleased with the openness of the WPS to discuss issues with us and their responsiveness to our questions and suggestions relating to the project. Areas of the project that were discussed in Phase 1 and, in our opinion, enhanced were:

- the need to be transparent with the public about the collection of their personal information and how individuals' personal information will be handled by the City of Winnipeg;
- the requirement to provide specific particulars as notification of the collection of one's personal information (in this situation, in and/or around the locations where CCTV will be utilized);
- the need for broad public consultation with Winnipeggers; and
- preparing clear policies and procedures concerning the project.

Other refinements were the decisions by the WPS not to live-monitor the images during the camera deployment phase of the pilot project, to reduce the retention period for the images (except as may be required for police investigation, court purposes and access to information requests) and to acquire software to enable the severing of images of other people when those images are not required.

The camera deployment phase of the pilot project is set to end in January 2010. At that point, an independent evaluation of the outcomes and effectiveness will be undertaken to determine whether the objectives of the system have been achieved. Such an evaluation is an important step. It should take into account the views of the different groups in the community affected by CCTV and the results of the evaluation should be made publicly available. It is important that this evaluation include an assessment of the effectiveness of the CCTV in relation to its impact on personal privacy.

THE ELECTRONIC HEALTH RECORD

Canada is moving toward an "electronic health record" system. Although the electronic health record system has largely been designed, many privacy issues have not been resolved. The role of accelerating the use of electronic health records in Canada has been assigned to Canada Health Infoway, an organization whose board is composed of Canada's 14 Deputy Ministers of Health. Infoway provides much of the funding and has designed the information systems framework for projects that form the building blocks of the EHR within a province or territory.

The document, *A 'Conceptual' Privacy Impact Assessment (PIA) on Canada's Electronic Health Record Solution (EHRS) Blueprint Version 2* contains an explanation of the electronic health record being developed across Canada. The document can be found on the Canada Health Infoway website www.infoway-inforoute.ca. A description of the electronic health record is found on page 15:

> *An **electronic health record (EHR)** is a compilation, in digital format, of personal health information about a single patient. It provides secure, real-time, patient-centric information to aid clinical decision-making by allowing authorized health providers access to a patient's health information when needed at the point of care. An EHR is typically accessed from a computer connected by a network to one or more remote servers where the data is stored.*
>
> *Depending on the implementation, an EHR may also contain non-clinical demographic and administrative information, as well as data about any of the following: medical referrals, current and past treatments, diagnostic test results, diagnostic images such as X-rays, current prescriptions and medical histories and immunizations.*
>
> *An EHR is not necessarily a single, concise record for each patient. Rather, it is more likely to be a collection of records for each patient that can be organized and stored in one or more separate repositories….*

In the traditional "document based" health care system, the patient's personal health information is collected and used by a health care provider and may be disclosed by that health care provider to someone else. In the electronic health record environment, health care providers will be able to draw from the various repositories holding, for example, collections of records concerning prescriptions, lab test results and immunization records. Ideally, only authorized health care providers who need to know specific information about a specific patient at a specific time will be able to gain access to that information.

The rules set out in information privacy legislation, including Manitoba's *Personal Health Information Act* (PHIA), may be able to address the flow of information in the new networked electronic environment. However, the flow of information becomes more complex and raises unprecedented privacy issues when multiple health care providers can withdraw information from multiple repositories across regions and across provincial/territorial borders. Different privacy laws will potentially apply if the information flows across jurisdictional boundaries.

It is important for the public to clearly understand the privacy implications of such networked systems. For example, individuals must know how information in the EHR system can be used and by whom; what control they will have over what personal health information is included in their health record; who will have access to their personal health information; with whom that information may be shared; how to prevent unwanted sharing; and to whom to complain if they have concerns.

Manitoba eHealth

In Manitoba, Manitoba eHealth is responsible for planning, designing and developing the provincial electronic health record system within Infoway's information systems framework. The goal is to have, for each individual within Manitoba's health care system, a secure and private electronic record of the key health history and care of that individual. Manitoba eHealth is a program formed and funded by Manitoba Health and administered by, and housed in, the Winnipeg Regional Health Authority (WRHA). It is accountable to the

Manitoba eHealth Board, composed of the Deputy Minister of Health, Deputy Minister of Energy, Science and Technology, the Chief Executive Officers of the WRHA and the Interlake RHA and the Chief Financial Officer of Manitoba Health.

To date, Manitoba-approved projects funded by Infoway include the client registry, telehealth and diagnostic imaging. Information on Manitoba eHealth, including projects that will form part of the Manitoba EHR record that are in progress or have been completed, is available on its web site, www.manitoba-ehealth.ca.

Reviewing the Development of the Electronic Health Record

Our office continues to participate in two groups related to the development of electronic health records.

Pan-Canadian Privacy Forum on EHR Information Governance

Our office participates in the Pan-Canadian Privacy Forum on EHR Information Governance. The Forum was created by Infoway to help share information and explore governance or policy issues. The group is composed of a representative from the oversight office and the health ministry for each province and territory. It is intended to allow sharing of knowledge and perspectives on policy issues related to EHR development. As a first step, forum members have identified and been focusing on the priority issues of accountability, consent, secondary uses and disclosures, and inter-jurisdictional dataflow of personal information in the EHR environment.

Provincial Privacy and Security Council

Our office also participates in the Privacy and Security Council, facilitated by the WRHA and Manitoba eHealth. This body, with representation from various Manitoba health organizations and disciplines, is responsible for identifying the privacy and security requirements that an EHR must meet to protect an individual's privacy. To maintain the independence of our office, the Ombudsman is a non-voting member of this group.

Many discussions of the Council over the year have focused on security, which is an element of privacy. Privacy, more broadly, concerns the kind of control that an individual may assert over his or her own personal health information. It is important that privacy be addressed before the system's design decisions have been determined.

We have expressed the view that the EHR system should define the role of any person in the health care system able to gain access to a patient's EHR, in the narrowest of terms. The system also requires robust and active audit features that will notify the system administrators if an unauthorized person has attempted to or has gained access to information without authorization. The province should also explore technologies that allow an individual the ability to gain access directly to his or her own health records and see who has gained access to their information.

Public Information About Electronic Health Records

There needs to be a comprehensive public education process conducted to ensure that the public understands the privacy implications of the EHR. With policy decisions still to be made, the public should be fully engaged in the process leading up to those decisions. These policy decisions rest with the governments that initiate EHR projects and who are accountable to the people in their jurisdictions.

Questions posed in Infoway's conceptual Privacy Impact Assessment, found on Infoway's website at www.infoway-inforoute.ca., need to be answered. Some of those questions are:

- Does the EHR system provide mechanisms to delineate accountability for personal health information as it is transmitted…between regional EHR systems within a jurisdiction; between jurisdictions; and between EHR systems and third-party service providers?
- Will individuals be notified of the purposes for which their information will be transmitted to the EHR system?

- Can patients refuse to have their personal health information added to an EHR system?
- Can authorized users of the EHR system override patients' consent directives?
- Does the EHR system allow for alerts to health care providers notifying them of corrections or challenges to data accuracy?
- Do mechanisms exist to manage multi-institutional/jurisdictional privacy or security complaints and/or breach investigations?

The answers to these questions will promote public understanding of the EHR system.

RECOMMENDATION CASES

Most access and privacy complaints are resolved informally. When an informal resolution cannot be reached, formal recommendations may be made in a report by the Ombudsman to the public body or trustee. *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* set out requirements for public bodies and trustees to respond to Ombudsman recommendations.

Under FIPPA, the head of the public body must, within 15 days (14 days for PHIA) after receiving the report, send 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.

All of our Practice Notes are included on the CD format of this Annual Report in *Other Publications* and are also available on our website at www.ombudsman.mb.ca.

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 limits under FIPPA

require the head to comply with the recommendations within 15 days of acceptance, if the complaint is about access and within 45 days in any other case, or within such additional period as the Ombudsman considers reasonable. The time limit for complying with recommendations made under PHIA is also 15 days within acceptance of the recommendation or within such additional period as the Ombudsman considers reasonable.

In 2008, there were four cases where recommendations were made. These cases all involved complaints that the public body had failed to respond to the applicants within the 30-day time limit required under FIPPA.

Two cases involving Manitoba Conservation resulted in recommendations because the applicants had been advised by the department that information they requested would be posted on a website it was developing. The department had advised our office that the website would be up and running by November 30, 2007. When this deadline was not met, we advised the department to provide paper records to affected applicants by January 31, 2008. Two applicants did not receive a response by January 31, 2008 and complained to us on February 20, 2008 about the department's failures to respond. As a result, on February 26, 2008 we made recommendations for the department to respond to the applicants by March 17, 2008. In both cases, the department accepted our recommendations.

In two additional cases, an applicant made one access application to Conservation and one to Water Stewardship, both on September 25, 2007. On November 21, 2007 we received complaints about the failure of both departments to respond to the applications. On March 18, 2008 we made recommendations to both departments to respond to the applicant by April 3, 2008. Conservation advised the Ombudsman that it accepted the recommendation and responded to the applicant on April 1, 2008. Water Stewardship advised the Ombudsman that it accepted the recommendation. However, it failed to comply with the recommendation and did not respond to the applicant until April 30, 2008.

FOLLOW-UP ON COMPLIANCE WITH RECOMMENDATIONS MADE IN 2007

FIPPA requires that when a head of a public body accepts a recommendation about an access matter, it must be complied with or implemented within 15 days of acceptance. In 2008, we followed up on ten cases where recommendations were made in 2007 but were not complied with by the end of that year. All of these cases involved Conservation and in each case the recommendations were accepted but were not complied with by the date specified in the recommendation.

The Act provides discretion for the Ombudsman to allow a longer period of time to comply with my recommendations where the circumstances warrant this. In these cases, the department did not ask us to consider a longer period.

Eight of the ten cases involved complaints from an applicant who had submitted access applications to the department in 2003. The Ombudsman made recommendations to Conservation to respond to the applicant within a specified time frame. Although the department accepted these recommendations, it failed to respond to the applicant within the time frame it had accepted.

In two other Conservation cases that concerned complaints about refused access, our recommendations were also accepted and were to have been implemented in January 2008, but this did not happen.

During 2008, we continued to follow up with Conservation on its progress in implementing our recommendations. By the end of 2008, nine of these ten cases were closed. One case, where recommendations were made for the department to conduct further searches for records, remains open, pending the completion of our investigation about refused access.

It is of concern to our office that despite the mandatory time limits set out in FIPPA for compliance with recommendations, which the department had accepted, it did not take action to implement these recommendations in a timely manner. Failure to comply with a recommendation that has been accepted is an affront to the rights of an applicant established by law.

STATISTICAL

OVERVIEW

In 2008, 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)	1264
Inquiries responded to by Intake Services (information supplied or assistance provided)	1805
Cases 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*	215
Cases opened for investigation under *The Ombudsman Act*	164
Cases opened for investigation under *The Public Interest Disclosure (Whistleblower Protection) Act*	3
Cases opened for investigation under Part 5 of *The Freedom of Information and Protection of Privacy Act* (FIPPA)	208
Cases opened for investigation under Part 5 of *The Personal Health Information Act* (PHIA)	8
Cases opened under Part 4 of FIPPA and PHIA	23
Total Contacts	**3690**

Statistical Review of 2008 for the Ombudsman Division

CASES IN 2008 BY ACT, DEPARTMENT AND DISPOSITION

This chart shows the disposition of 284 cases investigated by the Ombudsman Division in 2008 under *The Ombudsman Act* and *The Public Interest Disclosure (Whistleblower Protection) Act*.

Department or Category	Carried over into 2008	New cases in 2008	Total cases in 2008	Pending at Dec. 31, 2008	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
THE OMBUDSMAN ACT													
PROVINCIAL GOVERNMENT DEPARTMENTS													
Aboriginal & Northern Affairs													
General	1	-	1	-	-	-	-	-	1	-	-	-	-
Advanced Education & Literacy				-									
General	-	1	1	-	-	-	-	-	1	-	-	-	-
Agriculture, Food & Rural Initiatives													
General	-	2	2	2	-	-	-	-	-	-	-	-	-
Manitoba Crop Insurance Corporation	1	-	1	-	-	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative-OOI	-	1	1	-	-	-	-	-	-	-	1	-	-
Conservation													
General	2	3	5	2	-	1	-	-	-	1	-	-	1
Ombudsman's Own Initiative-OOI	-	1	1	1	-	-	-	-	-	-	-	-	-
Water Stewardship	1	2	3	-	-	-	1	-	2	-	-	-	-
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	1	-
Family Services & Housing													
General	2	2	4	3	-	-	-	-	-	1	-	-	-
Child & Family Services	1	7	8	1	-	1	-	-	3	1	2	-	-
Employment & Income Assistance	3	2	5	2	-	-	1	-	1	1	-	-	-
Employment, Income & Housing	2	-	2	-	-	-	1	-	-	1	-	-	-
Housing Renewal Corporation	-	1	1	1	-	-	-	-	-	-	-	-	-
Manitoba Housing Authority	-	1	1	-	-	-	-	1	-	-	-	-	-
Social Services Advisory Board	1	1	2	1	-	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative-OOI	8	2	10	8	-	-	-	-	-	-	1	-	1
Finance													
General	-	3	3	1	-	-	-	1	1	-	-	-	-
Automobile Injury Compensation Appeal Commission	1	2	3	1	-	-	-	-	2	-	-	-	-
Securities Commission	1	-	1	-	-	-	-	1	-	-	-	-	-

CASES IN 2008 BY ACT, DEPARTMENT AND DISPOSITION

Department or Category	Carried over into 2008	New cases in 2008	Total cases in 2008	Pending at Dec. 31, 2008	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
Residential Tenancies Branch	1	-	1	-	-	-	-	-	-	-	1	-	-
Ombudsman's Own Initiative-OOI	-	1	1	-	-	-	-	-	-	-	-	1	-
Health													
General	4	1	5	1	-	-	-	-	1	1	1	-	1
Mental Health	-	7	7	1	-	-	-	1	4	-	1	-	-
Regional Health Authority	2	3	5	1	-	-	1	1	-	1	-	-	1
Ombudsman's Own Initiative-OOI	10	6	16	12	-	-	1	-	-	-	2	-	1
Infrastructure & Transportation													
General	2	7	9	3	-	-	-	3	1	-	1	1	-
Intergovernmental Affairs & Trade													
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	-	1
Justice													
General	3	1	4	2	-	-	1	-	1	-	-	-	-
Brandon Correctional Centre	4	2	6	-	-	-	1	-	-	2	3	-	-
Headingley Correctional Centre	-	8	8	-	-	-	-	-	4	-	4	-	-
The Pas Correctional Centre	1	1	2	-	-	-	-	-	1	-	1	-	-
Portage Correctional Centre	1	1	2	-	-	-	-	-	1	1	-	-	-
Thompson Holding Cells	1	-	1	-	-	-	-	1	-	-	-	-	-
Winnipeg Remand Centre	2	4	6	1	-	-	-	-	3	1	1	-	-
Manitoba Youth Centre	-	4	4	-	-	-	-	-	-	1	3	-	-
Maintenance Enforcement	1	1	2	-	-	-	-	1	1	-	-	-	-
Human Rights Commission	3	5	8	1	-	-	-	-	6	1	-	-	-
Law Enforcement Review Agency	-	1	1	-	-	-	-	1	-	-	-	-	-
Public Trustee	-	1	1	-	-	-	-	1	-	-	-	-	-
Ombudsman's Own Initiative-OOI	19	7	26	18	-	-	-	-	-	1	2	-	5
Labour & Immigration													
General	1	-	1	-	-	-	-	-	1	-	-	-	-
Employment Standards	-	1	1	1	-	-	-	-	-	-	-	-	-
Manitoba Labour Board	1	-	1	-	-	-	-	-	1	-	-	-	-

CASES IN 2008 BY ACT, DEPARTMENT AND DISPOSITION

Department or Category	Carried over into 2008	New cases in 2008	Total cases in 2008	Pending at Dec. 31, 2008	Assist. Rendered	Declined	Discontinued	Inform. Supplied	Not Supported	Partly Resolved	Resolved	Recommendation	Completed
Pension Commission	1	-	1	-	-	-	-	-	1	-	-	-	-
Worker Advisor	-	1	1	-	-	-	-	-	1	-	-	-	-
Ombudsman's Own Initiative-OOI	-	1	1	1	-	-	-	-	-	-	-	-	-
Transportation & Government Services													
Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	-	1
Corp. & Extra Departmental													
Liquor Control Commission Ombudsman's Own Initiative-OOI	1	-	1	-	-	-	-	-	-	-	-	-	1
Lotteries Corporation	1	-	1	-	-	-	-	1	-	-	-	-	-
Manitoba Agriculture Services Corp.	-	1	1	-	-	-	1	-	-	-	-	-	-
Manitoba Hydro	2	1	3	1	-	-	-	-	2	-	-	-	-
Workers Compensation Board	3	3	6	1	-	-	2	1	1	1	-	-	-
WCB Appeal Commission	1	3	4	2	-	-	-	1	1	-	-	-	-
Manitoba Public Insurance													
General	10	25	35	11	-	3	1	1	14	-	3	1	1
Ombudsman's Own Initiative-OOI	-	1	1	-	-	-	-	-	-	-	-	-	1
MUNICIPALITIES													
General	4	11	15	7	-	-	1	-	4	-	2	1	-
City of Brandon	2	-	2	1	-	-	-	-	1	-	-	-	-
City of Dauphin	1	-	1	-	-	-	-	-	1	-	-	-	-
City of Winnipeg	3	4	7	3	-	-	1	-	2	-	-	-	1
Conservation District	1	1	2	-	-	-	-	-	2	-	-	-	-
Local Planning District	3	3	6	-	-	-	-	1	2	1	2	-	-
Ombudsman's Own Initiative-OOI	-	16	16	13	-	-	-	-	-	-	-	-	3
THE PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT													
Educational Body	1	-	1	-	-	-	-	-	-	-	-	1	-
Government Agency	-	1	1	1	-	-	-	-	-	-	-	-	-
Regional Health Authority	-	2	2	2	-	-	-	-	-	-	-	-	-
TOTAL CASES	**117**	**167**	**284**	**107**	-	5	13	17	70	16	31	6	19

CASES IN 2008 BY ACT, DEPARTMENT AND DISPOSITION

Of the 177 cases closed in 2008:

30% were resolved in whole or in part (the Ombudsman made recommendations in 3% of these cases);

40% were not supported;

10.5% were completed under *The Ombudsman Act*;

9.5% were concluded after information was provided;

10% were discontinued either by the Ombudsman or the complainant or declined.

In addition to the 284 cases investigated by the Ombudsman Division in 2008, Intake Services informally resolved 176 cases under *The Ombudsman Act* and 3 cases under *The Public Interest (Whistleblower Protection) Disclosure Act*.

The following table provides a summary of activities for 2008 under *The Public Interest Disclosure (Whistleblower Protection) Act*.

Inquiries Received	12
Disclosures received and not investigated	4
Disclosure received and opened for investigation	3
Exemption Requests approved	8
Exemption Requests denied	2

The office received 12 inquiries about the Act that resulted in formation being provided. Seven disclosures of wrongdoing were received, three of which were opened for investigation under *The Public Interest Disclosure (Whistleblower Protection) Act*. Two others were investigated under *The Ombudsman Act* and two were referred to the Manitoba Civil Service Commission.

DEFINITION OF DISPOSITIONS

Not Supported
Complaint not supported at all.

Supported
Complaint fully supported because the decision was not compliant with the legislation.

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

Resolved
Complaint is resolved informally.

Partly Resolved
Complaint is partly resolved informally.

Discontinued
Investigation of complaint stopped by Ombudsman or Client.

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

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

Pending
Complaint still under investigation as of January 1, 2009.

Statistical Review of 2008 for the Access and Privacy Division

OVERVIEW OF ACCESS COMPLAINTS OPENED IN 2008

In 2008, 198 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	50	50	-
Extension	1	1	NA*
Fees	10	10	-
Correction	1	-	1
Refused Access	134	133	1
Other	2	2	-
Total	**198**	**196**	**2**

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

OVERVIEW OF ACCESS COMPLAINTS CLOSED IN 2008

During 2008, 162 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	89	3	92	3	38	46	5
No Response	58	1	59	12	37	5	5
Fees	3	-	3	1	-	2	-
Correction	1	-	1	-	-	1	-
Extension	2	-	2	-	-	2	-
Other	5	-	5	-	-	5	-
Total	**158**	**4**	**162**	**16**	**75**	**61**	**10**

OVERVIEW OF PRIVACY COMPLAINTS OPENED IN 2008

In 2008, 18 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.

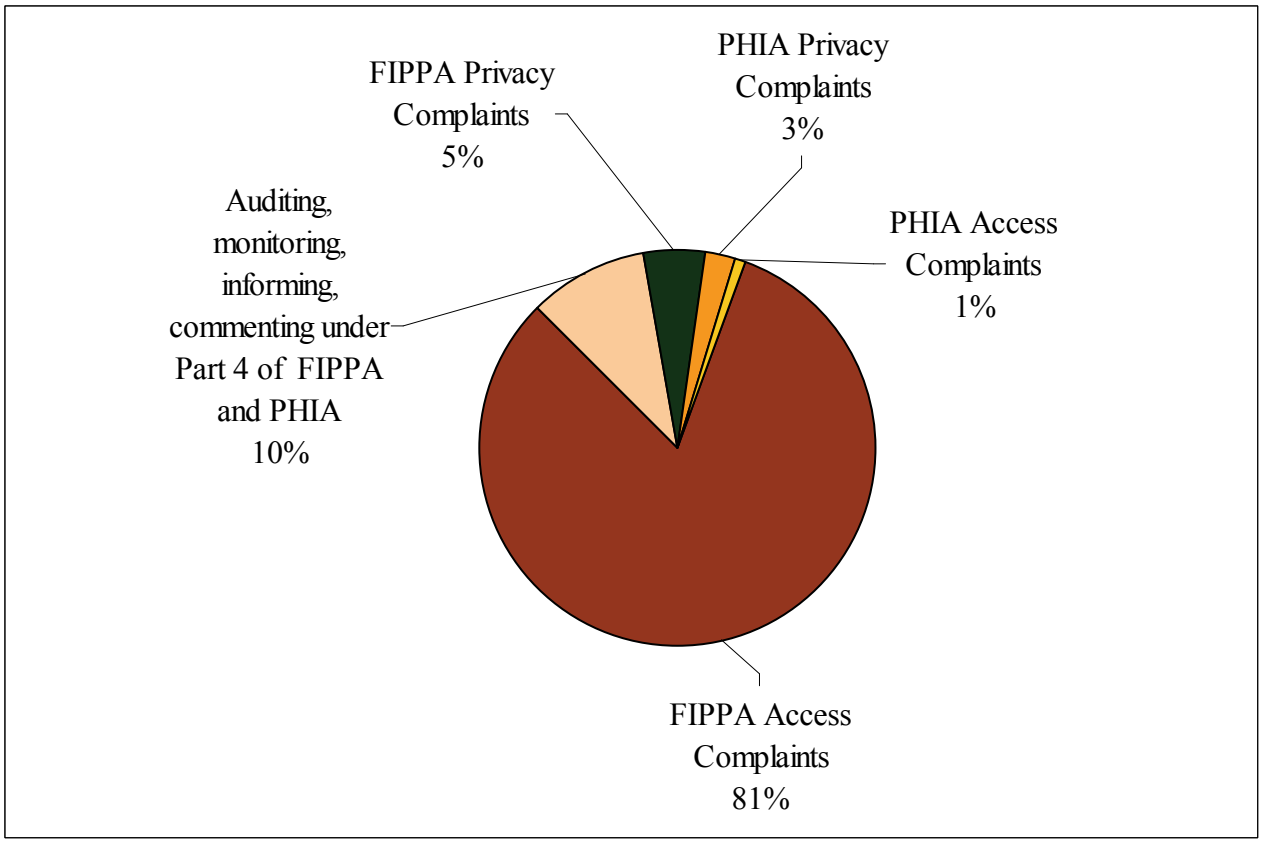
Type of Privacy Complaint	Total	FIPPA	PHIA
Collection	4	3	1
Use	5	3	2
Disclosure	9	6	3
Total	**18**	**12**	**6**

OVERVIEW OF PRIVACY COMPLAINTS CLOSED IN 2008

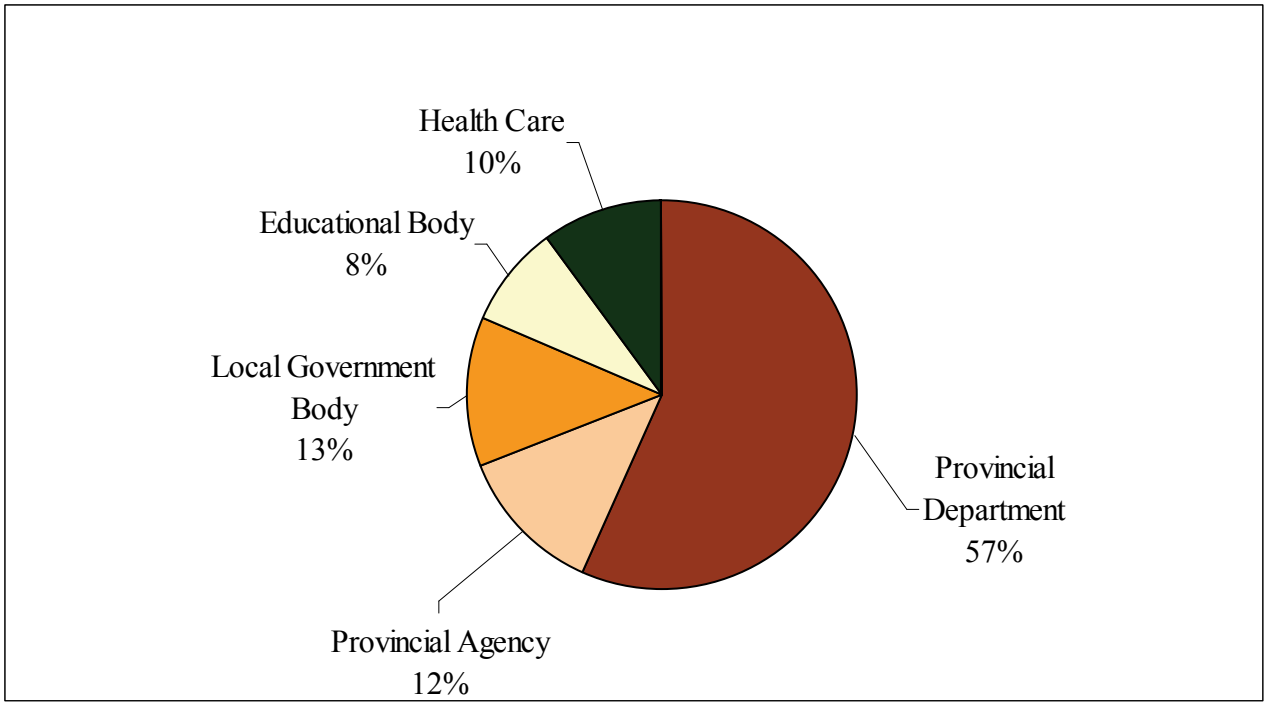
During 2008, 10 privacy complaints under Part 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* were closed. The following chart provides a breakdown of the dispositions of these privacy complaints.

Type of Privacy Complaint	FIPPA	PHIA	Total	Declined or Discontinued	Supported in part or whole	Not Supported	Resolved
Collection	3	-	3	-	1	2	-
Use	1	3	4	2	-	2	-
Disclosure	7	3	10	1	3	6	-
Security	-	1	1	-	-	1	-
Total	**11**	**7**	**18**	**3**	**4**	**11**	**-**

TYPES OF CASES OPENED IN 2008



DISTRIBUTION OF CASES OPENED IN 2008



CASES IN 2008 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

This chart shows the disposition of the 351 access and privacy cases investigated in 2008 under Part 4 and 5 of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*.

Act/Department or Category	Carried over into 2008	New cases in 2008	Total cases in 2008	Pending at Dec. 31, 2008	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
***Part 5 of The Freedom of Information and Protection of Privacy Act* (FIPPA)**												
PUBLIC BODY												
Provincial Department												
Aboriginal & Northern Affairs	2	1	**3**	1	-	-	-	-	2	-	-	-
Agriculture, Food & Rural Initiatives	1	-	**1**	-	-	-	1	-	-	-	-	-
Competitiveness, Training & Trade	1	-	**1**	-	-	-	1	-	-	-	-	-
Conservation	29	39	**68**	13	-	7	16	12	7	1	12	-
Education, Citizenship & Youth	-	3	**3**	2	-	-	1	-	-	-	-	-
Executive Council	-	2	**2**	-	-	-	-	2	-	-	-	-
Family Services & Housing	-	12	**12**	3	-	1	1	-	7	-	-	-
Finance	-	1	**1**	1	-	-	-	-	-	-	-	-
Health	1	9	**10**	5	-	-	3	-	2	-	-	-
Infrastructure & Transportation	2	7	**9**	1	-	2	6	-	-	-	-	-
Intergovernmental Affairs & Trade	-	2	**2**	2	-	-	-	-	-	-	-	-
Justice	3	4	**7**	3	1	-	2	1	-	-	-	-
Labour & Immigration	-	3	**3**	1	-	-	2	-	-	-	-	-
Science, Technology, Energy & Mines	1	-	**1**	1	-	-	-	-	-	-	-	-
Water Stewardship	17	43	**60**	45	-	1	5	-	6	2	1	-
Crown Corporation and Government Agency												
Credit Union Deposit Guarantee Corp.	-	2	**2**	-	-	-	2	-	-	-	-	-
Diagnostic Services of Manitoba Inc.	-	2	**2**	2	-	-	-	-	-	-	-	-
Manitoba Housing Authority	1	-	**1**	-	-	-	-	-	1	-	-	-
Human Rights Commission	-	2	**2**	1	-	-	-	-	1	-	-	-
Hydro	2	6	**8**	5	-	-	2	-	1	-	-	-
Manitoba Public Insurance	-	11	**11**	4	-	1	4	2	-	-	-	-
Workers Compensation Board	-	3	**3**	1	-	-	2	-	-	-	-	-
Winnipeg Child & Family Services	1	-	**1**	-	-	-	1	-	-	-	-	-

CASES IN 2008 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2008	New cases in 2008	Total cases in 2008	Pending at Dec. 31, 2008	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
West Region Child & Family Services	1	-	**1**	-	-	-	1	-	-	-	-	-
LOCAL PUBLIC BODY												
Local Government Body												
City of Winnipeg	8	9	**17**	3	2	1	6	4	1	-	-	-
R.M. of Daly	-	4	**4**	-	-	-	-	-	4	-	-	-
R.M. of De Salaberry	-	2	**2**	-	-	-	1	-	-	1	-	-
R.M. of East St. Paul	1	-	**1**	-	-	-	1	-	-	-	-	-
R.M. of Kelsey	1	-	**1**	-	-	-	-	-	1	-	-	-
R.M. of Lac du Bonnet	3	-	**3**	-	-	-	-	3	-	-	-	-
R.M. of Rockwood	-	1	**1**	-	-	-	-	-	-	1	-	-
R.M. of Springfield	-	5	**5**	5	-	-	-	-	-	-	-	-
R.M. of Victoria Beach	-	1	**1**	-	-	-	1	-	-	-	-	-
R.M. of Wallace	-	4	**4**	4	-	-	-	-	-	-	-	-
R.M. of West St. Paul	-	1	**1**	-	-	-	-	1	-	-	-	-
Educational Body												
Hanover School Division	-	3	**3**	-	-	-	-	-	-	3	-	-
Interlake School Division	1	-	**1**	-	-	-	-	-	-	1	-	-
Louis Riel School Division	1	-	**1**	-	-	-	1	-	-	-	-	-
Southwest Horizon School Division	-	1	**1**	-	-	-	-	-	1	-	-	-
University of Manitoba	5	6	**11**	10	-	-	-	1	-	-	-	-
University of Winnipeg	1	2	**3**	3	-	-	-	-	-	-	-	-
Health Care Body												
Burntwood Regional Health Authority	1	14	**15**	7	-	-	5	-	3	-	-	-
Norman Regional Health Authority	-	1	**1**	-	-	-	-	-	1	-	-	-
South Eastman Health/Sante Sud-Est Inc.	-	1	**1**	-	-	-	-	-	-	1	-	-
Winnipeg Regional Health Authority	1	1	**2**	1	-	1	-	-	-	-	-	-
***Part 5 of The Personal Health Information Act* (PHIA)**												
PUBLIC BODY												
Government Department												
Justice	1	-	**1**	-	-	-	1	-	-	-	-	-

CASES IN 2008 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2008	New cases in 2008	Total cases in 2008	Pending at Dec. 31, 2008	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
Crown Corporation and Government Agency												
Hydro	1	1	**2**	-	-	-	1	-	1	-	-	-
Manitoba Public Insurance	1	1	**2**	1	-	-	1	-	-	-	-	-
Workers Compensation Board	-	3	**3**	3	-	-	-	-	-	-	-	-
Health Care Body												
Winnipeg Regional Health Authority	-	1	**1**	1	-	-	-	-	-	-	-	-
Health Professional												
Physician	-	2	**2**	2	-	-	-	-	-	-	-	-
LOCAL PUBLIC BODY												
Educational Body												
University of Manitoba	2	-	**2**	-	-	2	-	-	-	-	-	-
Health Care Body												
Brandon Regional Health Authority	2	-	**2**	-	-	-	2	-	-	-	-	-
North Eastman Health Association	1	-	**1**	-	-	-	-	-	1	-	-	-
Winnipeg Regional Health Authority	1	-	**1**	-	-	-	1	-	-	-	-	-
Personal Care Home												
Middlechurch Personal Care Home	1	-	**1**	-	-	-	1	-	-	-	-	-
Part 4 under FIPPA and PHIA												
PUBLIC BODY												
Provincial Department												
Advanced Education & Training	1	-	**1**	-	-	-	-	-	-	-	-	1
Competitiveness, Training & Trade	1	-	**1**	-	-	1	-	-	-	-	-	-
Family Services & Housing	-	7	**7**	2	-	-	-	-	-	-	-	5
Conservation	2	1	**3**	-	-	-	-	-	-	-	-	3
Health	1	-	**1**	-	-	-	-	-	-	-	-	1
Justice	1	-	**1**	1	-	-	-	-	-	-	-	-
Crown Corporation and Government Agency												
Manitoba Housing	1	-	**1**	-	-	-	-	-	-	-	-	1
Manitoba Public Insurance	2	-	**2**	1	-	1	-	-	-	-	-	-

CASES IN 2008 BY ACT, PUBLIC BODY/TRUSTEE AND DISPOSITION

Act/Department or Category	Carried over into 2008	New cases in 2008	Total cases in 2008	Pending at Dec. 31, 2008	Declined	Discontinued	Not Supported	Partly Supported	Supported	Resolved	Recommendation	Completed
LOCAL PUBLIC BODY												
Local Government Body												
City of Brandon	1	-	**1**	-	-	-	-	-	-	-	-	1
City of Winnipeg	2	3	**5**	4	-	-	-	-	-	-	-	1
Educational Body												
Prairie Spirit School Division	-	1	**1**	1	-	-	-	-	-	-	-	-
University of Manitoba	1	-	**1**	1	-	-	-	-	-	-	-	-
University of Winnipeg	-	7	**7**	-	-	-	-	-	-	-	-	7
Medical Clinic												
Wong Medical Clinic	1	-	**1**	-	-	-	-	-	-	-	-	1
Health Care Body												
St. Boniface General Hospital	-	1	**1**	1	-	-	-	-	-	-	-	-
Laboratory	-	1	**1**	-	-	-	-	-	-	-	-	1
Health Professional												
Chiropractor	-	1	**1**	-	-	-	-	-	-	-	-	1
Orthodontist	1	-	**1**	1	-	-	-	-	-	-	-	-
Pharmacist	2	-	**2**	-	-	-	-	-	-	-	-	2
Other												
Other	-	1	**1**	1	-	-	-	-	-	-	-	-
Total	**112**	**239**	**351**	**144**	**3**	**18**	**72**	**26**	**40**	**10**	**13***	**25**

* This includes 9 cases where recommendations were made in 2007 and the cases were closed in 2008.

Of the 207 cases closed in 2008:

38 % were supported in whole or part (the Ombudsman made recommendations in 6% of these cases);
35% were not supported;
5% were resolved before a finding was reached;
12% were completed under Part 4 of FIPPA or PHIA;
10% were discontinued either by the Ombudsman or the complainant or declined.

In addition to the 351 cases investigated by the Access and Privacy Division in 2008, Intake Services informally resolved 22 cases under *The Freedom of Information and Protection of Privacy Act* and 14 cases under *The Personal Health Information Act*.

DEFINITION OF DISPOSITIONS

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 since 2002, 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, 2009.