OMBUDSPERSON
BRITISH COLUMBIA

ANNUAL REPORT 2020•2021

ABOUT OUR OFFICE

As an independent officer of the Legislature, the Ombudsperson investigates complaints of unfair or unreasonable treatment by provincial and local public authorities and provides general oversight of the administrative fairness of government processes under the *Ombudsperson Act*. The Ombudsperson conducts three types of investigations: investigations into individual complaints; investigations that are commenced on the Ombudsperson's own initiative; and investigations referred to the Ombudsperson by the Legislative Assembly or one of its Committees.

The Ombudsperson has a broad mandate to investigate complaints involving provincial ministries; provincial boards and commissions; Crown corporations; local governments; health authorities; colleges and universities; schools and school boards; and self-regulating professions and occupations. A full list of authorities can be found in the *Ombudsperson Act*. The Office of the Ombudsperson responds to approximately 8,000 enquiries and complaints annually.

Under the *Public Interest Disclosure Act* the Ombudsperson investigates allegations of wrongdoing from public employees in or relating to a public body covered by the Act as well as allegations of reprisal.

Our Consultation and Training Team offers educational webinars, workshops and individual consultation with public organizations to support fairness and continuous improvement across the public sector.

For more information about the BC Office of the Ombudsperson and for copies of published reports, visit bcombudsperson.ca.

OMBUDSPERSON
BRITISH COLUMBIA

June 2021

The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Parliament Buildings
Victoria BC V8V 1X4

Dear Mr. Speaker,

It is my pleasure to present the Ombudsperson's 2020/2021 Annual Report to the Legislative Assembly.

The report covers the period April 1, 2020 to March 31, 2021 and has been prepared in accordance with section 31(1) of the *Ombudsperson Act* and section 40(1) of the *Public Interest Disclosure Act*.

Yours sincerely,

Jay Chalke
Ombudsperson
Province of British Columbia

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MESSAGE FROM THE OMBUDSPERSON

For all of us, this past year will be one that challenged us, and tested us like none other. Like organizations around the world, the world we work in changed radically almost overnight. In late March 2020, as the fiscal year covered by this report was just about to begin, the COVID-19 pandemic arrived in British Columbia and our corner of the globe became a dramatically different place.

The pandemic meant that as an oversight office, our work took on an even greater urgency as new emergency powers gave government sweeping powers to do more with the stroke of a cabinet minister's pen, while at the same time public services contracted as some services were reduced or eliminated. Government programs that we oversee changed rapidly and in order to give accurate information to the public and have up to date information to conduct our investigations, we quickly adopted multiple approaches to gather and track changes to public services. This allowed us to identify pandemic-related issues to which our office could proactively, as well as reactively, respond. With over 1,000 public sector entities under our jurisdiction, this was, and continues to be, a challenging but vital task as services continue to shift while the pandemic continues.

At the same time, our normal work of receiving and investigating complaints of public sector unfairness from the public and disclosures of workplace wrongdoing from public service employees continued. Our complaint volumes while dipping slightly at the beginning of the year with the onset of the pandemic, quickly rebounded to normal levels. Our investigative work in relation to both our fairness and public interest disclosure mandates continued to have tangible positive impacts on the lives of individual people, and made public administration better as well. Two systemic reports released in the year highlighted important fairness issues and our monitoring work ensured that governments that accept our recommendations are held to those implementation commitments.

It was a busy year for our Public Interest Disclosure Team as this was the first full year that we carried out our new investigative role under the *Public Interest Disclosure Act*. We were encouraged that current and former BC public service employees who are currently covered by the legislation had the confidence to contact our office to seek advice or to make disclosures. Our Public Authority Consultation and Training Team was also busier than ever delivering workshops and webinars on a range of fairness education topics, producing publications and sharing consultation services in relation to a number of programs, including several high-profile COVID-related issues.

The issues that people brought to us were, as always, diverse, but this past year there were new problems, new questions and often a new complexity in the complaints we received. But with these challenges came satisfaction that in many instances we were able to resolve issues and suggest improvements to public bodies to make service delivery better for many.

“The pandemic meant that as an oversight office, our work took on an even greater urgency as new emergency powers gave government sweeping powers to do more with the stroke of a cabinet minister’s pen...”

– JAY CHALKE, OMBUDSPERSON

An important focus of our work this year both externally and internally was on strengthening diversity, inclusion and Reconciliation. Our work to develop an Indigenous Communities Services Plan involved engagement with a diverse range of Indigenous service providers this past year. We listened to experiences and frustrations faced by Indigenous people of navigating public sector organizations. We also heeded their teachings and knowledge, deepening our understanding of where and how we need to change our service to ensure Indigenous people are being treated fairly by the public bodies we oversee. I look forward to sharing our plan publicly this fall.

Finally, for a number of years I have been calling for a structural way for legislators to consider the reports we deliver to them. I look forward to the Legislature fulfilling my request to mandate a legislative committee to consider our reports. This has proved to be a practical and cost-effective method of ensuring the reports of other independent officers are given focused attention by legislators and our reports ought also to be so considered.

As set out in this report, it has been a full year and a fairer one thanks to the people who came to our office with the courage to speak up. My gratitude to all of them.

Sincerely,

Jay Chalke
Ombudsperson
Province of British Columbia

YEAR AT A GLANCE

7,714 Complaints and enquiries under the *Ombudsperson Act*

118 Enquiries, disclosures and reprisal reports received under the *Public Interest Disclosure Act*

Most common complaint issues

2,018 Disagreement with decision or outcome

1,453 Process or procedure

931 Communication

Top 3 authorities by complaint volume

491 ICBC

481 Ministry of Children and Family Development

419 Ministry of Public Safety and Solicitor General

46 Tailored training and fairness consultations

1,181 Number of Complaints Assigned to Investigation

68 Communities reached through virtual public webinars

16% of all jurisdictional complaints received were about public services impacted by COVID-19

ROLE OF OUR OFFICE

The Office of the Ombudsperson is an independent office of the Legislature with oversight jurisdiction over more than 1,000 provincial and local public bodies in British Columbia. The office has existed since 1979 and now serves British Columbians under two provincial statutes.

Under the *Ombudsperson Act*, the office receives and investigates complaints from members of the public who believe they have been treated unfairly by public sector bodies and have not been able to resolve their concerns through internal complaint, review or appeal processes. Issues we can investigate under the *Ombudsperson Act* include situations where laws or policies are not being properly followed, decisions are not being made equitably, administrative errors are made, or practices or procedures are unfair. Less complex issues such as delay, adequacy of information, or challenges with accessing complaint systems can also be addressed through our early resolution process. The office not only responds to individual complaints, but also conducts systemic investigations and issues public reports and recommendations.

In 2019, the Ombudsperson received a second statutory mandate to investigate allegations of wrongdoing under BC's new whistleblower protection law, the *Public Interest Disclosure Act*. Under this law, current and former BC public servants are able to seek advice and make disclosures of public sector wrongdoing to the Ombudsperson and are protected from reprisal for doing so.

Since 2017, the Ombudsperson has also offered training and consultation services to public sector organizations strengthening fairness in service delivery, complaint handling and program design.

Our work improves public services for all British Columbians. We:

Listen to and investigate complaints

Receive and investigate allegations about wrongdoing and reprisal

Educate and provide consultation services

THE ROLE OF OUR OFFICE

Our Vision

British Columbia's Independent Voice for Fairness

We help public sector organizations be more fair and accountable by:

- Listening, assessing and responding to enquiries and complaints from the public
- Educating citizens and public organizations about how to be fair in the delivery of services
- Conducting thorough, impartial and independent investigations
- Resolving complaints and recommending improvements to policies, procedures and practices
- Reporting publicly to bring attention to issues that impact the public

Our Goals

- People who need us are aware of our services and can access them
- Complaints are addressed efficiently
- Thorough and impartial investigations promote fair public administration
- Public authorities are supported in improving administration
- Staff are recognized for their expertise

Our Guiding Principles

- We are fair and impartial
- We are professional and thorough
- We listen with respect
- We seek resolutions that are principled and practical

OUR WORK UNDER THE OMBUDSPERSON ACT

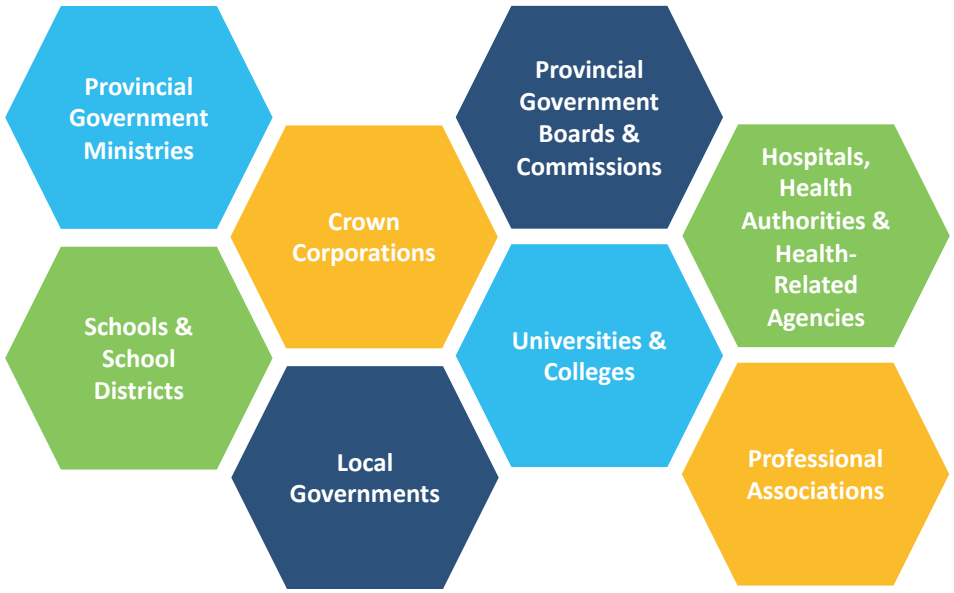
OUR APPROACH

We have been serving the public for over 40 years under the *Ombudsperson Act* which came into force in 1979. This law gives us the legal authority to receive and investigate complaints when members of the public feel they have been treated unfairly by more than 1,000 public sector bodies. When people contact our office, it is our goal to ensure they are able to resolve the myriad issues they share with us in the most efficient and effective way possible. Sometimes this means we refer them to an internal complaint-handling mechanism that exists within the public body they're complaining about, other times we are able to resolve their complaint quickly through our early resolution process, and finally sometimes more complex issues are assigned to one of our specialized investigative teams for closer investigation. Individual complaints can shine a light on issues that may impact many and become part of a broader systemic investigation. While most of the work we do is reactive, we also take a proactive approach to strengthening fairness through the training and voluntary consultation work of our Public Authority Consultation and Training Team that works with organizations to try to help prevent unfairness from happening in the first place.

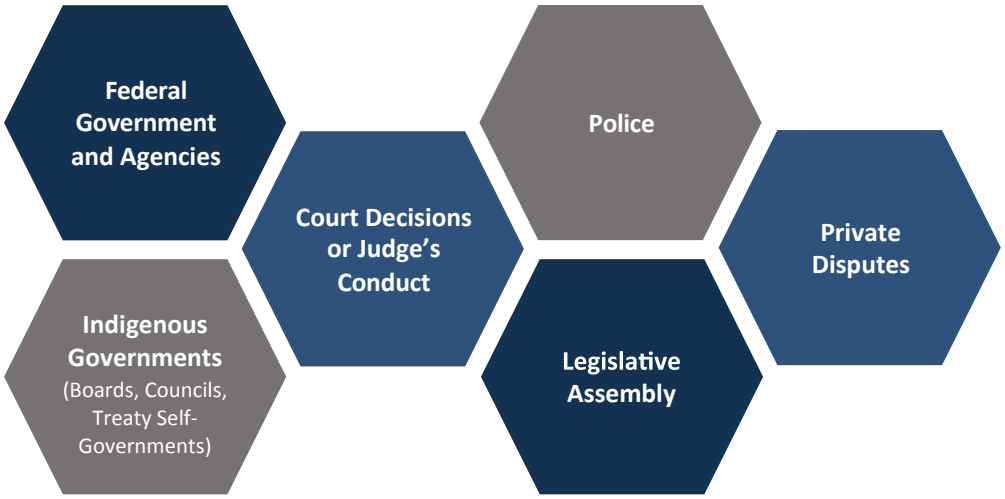
In all of our work under the *Ombudsperson Act* our ultimate goal is to make public administration fairer for all.

THE PUBLIC BODIES WE CAN INVESTIGATE

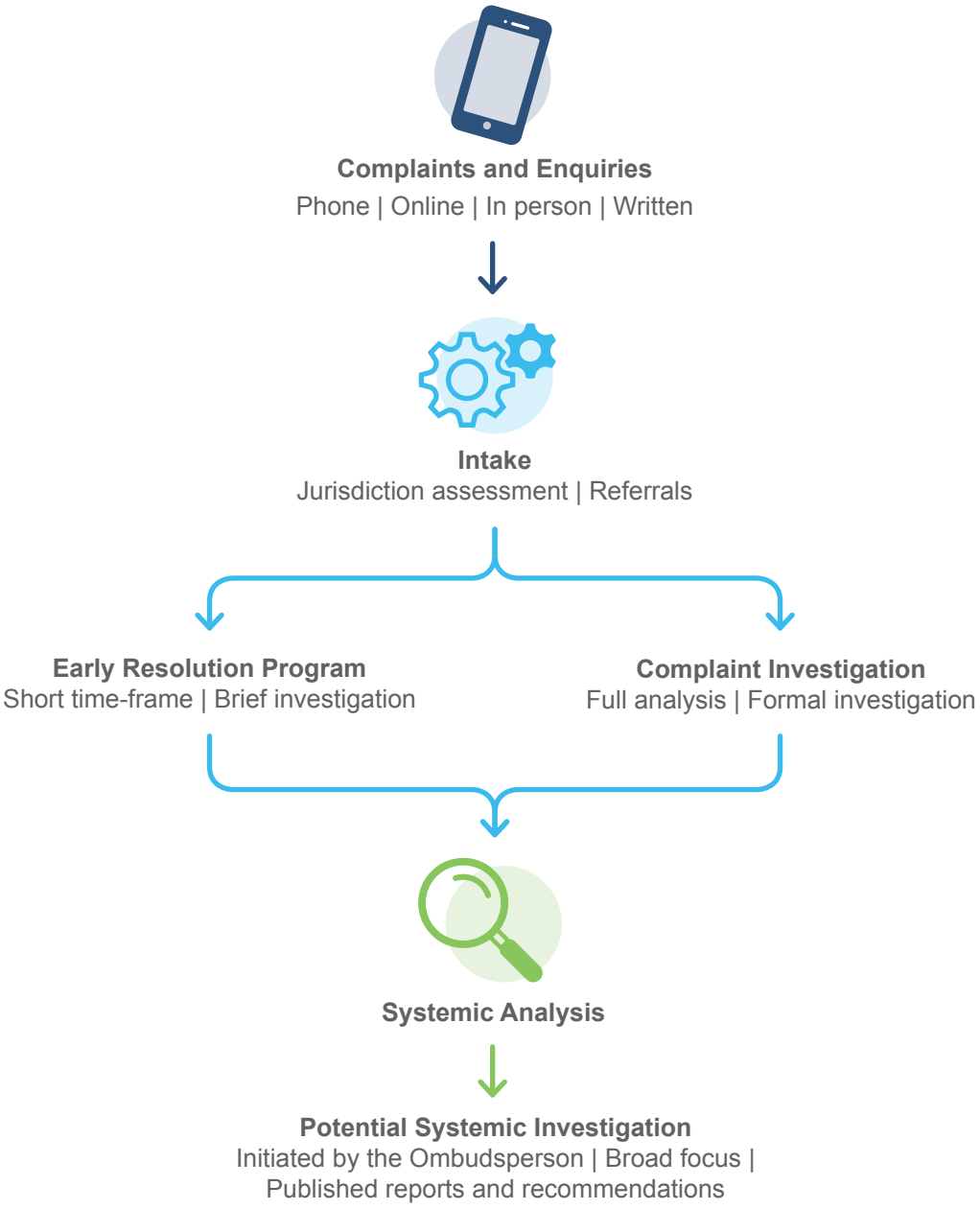
The public bodies we can investigate are set out in the *Ombudsperson Act*. The Ombudsperson **can** investigate a wide range of provincial and local organizations including:



There are some organizations that we **cannot** investigate because they are not under our jurisdiction. For these complaints, we help by connecting people with the most applicable complaint avenue.

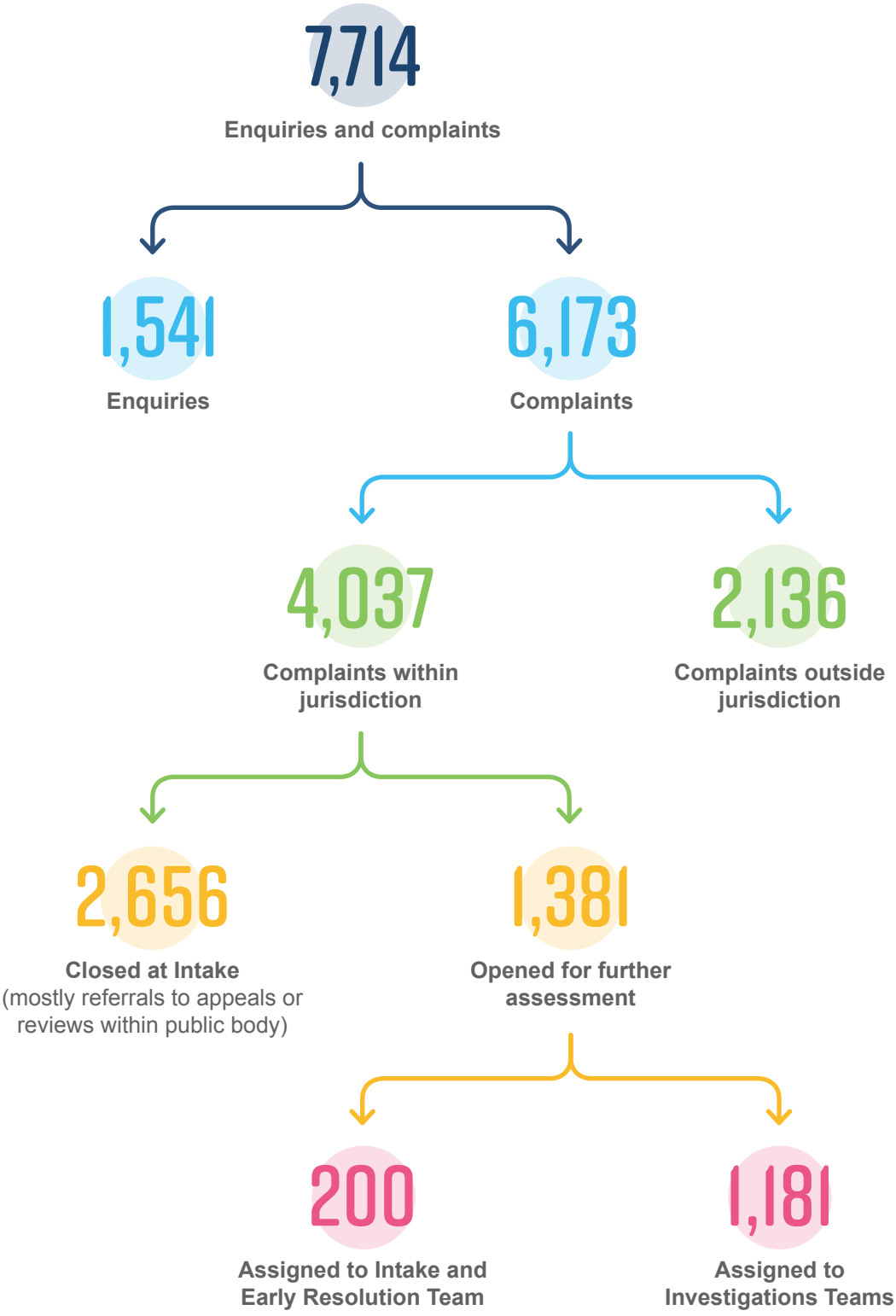


OUR INVESTIGATIVE PROCESS



NUMBERS AT A GLANCE

Complaints and Enquiries Received in 2020/21



INTAKE AND EARLY RESOLUTION

INTAKE AND EARLY RESOLUTION

As the Intake and Early Resolution Team prepared to begin 2020/21, the onset of the pandemic meant that our services shifted significantly. Our in-person service was temporarily suspended and Intake staff joined the rest of our office in quickly shifting to a telework model. While the volume of complaints and enquiries from the public declined temporarily during the first weeks of the pandemic, volumes quickly returned to normal and stayed steady over the year.

Depending on the nature of a complaint, there are many avenues an individual can take before they reach out to our office. We recommend contacting an organization's internal complaint process first and if an individual remains unsatisfied, we invite them to contact us.

While many of the questions and complaints that came to us were similar to past years, some were new. With public services rapidly changing due to the pandemic, and in some cases contracting, we received many complaints.

"I would like to thank you for helping me out. You guys did in two weeks what I couldn't do in months."
- Complainant

Furthermore, the closure of public libraries and reduced access to free computers in the province, meant we received many questions about navigating the system, as well as more questions relating to non-jurisdictional issues – from federal tax questions to policing-related matters. The questions relating to the public bodies we can investigate covered a diverse range of areas as can be seen below.

COVID-19 Complaints at a Glance

INVESTIGATIONS

OUR INVESTIGATIONS

Our investigations are at the centre of our work under the *Ombudsperson Act*. This past year, nearly 1,200 cases were assigned to one of our three investigative teams. The law that governs this work gives us broad authority to collect information and evidence that the public may not have access to. Our rigorous and impartial approach allows us to hear both sides of each issue that comes to us. Sometimes through the course of our investigative work, we find unfairness has occurred and other times we find public sector bodies treated people fairly and reasonably.

In the early months of the pandemic, our investigative approach shifted and we increased our focus on the early resolution of complaints, recognizing the unprecedented strain people were under. While many of our COVID-related complaints were resolved through early resolution, some required longer, more robust investigations. When conducting investigations during the pandemic we were cognizant of the need to balance the requirement for information from public bodies, with a recognition that timelines might be longer given the additional workload challenges these public authorities were facing arising from the pandemic.

If we determine unfairness may have occurred resolutions include:

A better explanation or clearer reasons for a decision

A new hearing or reconsideration of a decision

An apology

Employee training

Access to a benefit previously denied

A commitment to follow policy in the future

A refund or reimbursement of expenses

Changes to policy, procedures and sometimes to legislation

Highlighted Cases

The next few pages highlight a few cases from our Intake and Early Resolution and Investigation Teams. To read more case summaries, see the full case summary section beginning on page 45.

Cases were assigned to investigations

Highlights of our investigations:

- A seriously injured worker had slipped through the cracks at WCB and was awarded $52,000 in retroactive payments for benefits he was unaware he qualified for.
- A violence alert placed arbitrarily on a patient's medical record was removed and a letter of apology was sent to a patient who felt discriminated against by hospital staff.
- Following a complaint from a concerned parent, guidance documents were developed by a school district to inform school staff of the requirements before medically excluding or suspending a student.
- A new procedure was implemented to ensure that prescribed medical equipment accompanies inmates when transferred between custody facilities.

The purple dot

Island Health

Adequate notice of when decisions are made and explanations of why they were made are cornerstones of fairness.

In 2019, Tammy went to the hospital's emergency department seeking medical treatment. She told us she waited for a long time to be seen and was called names by hospital staff. When Tammy contacted our office, among other concerns, she told us a violence alert was on her medical record by way of a purple dot affixed to her file and she didn't understand why.

We looked into the violence alert placed on Tammy's medical record. Despite having a suite of policies and procedures in place to ensure that Island Health provides a safe and respectful environment for all of its staff and patients, Island Health was unable to provide any documentation to support why the violence alert was placed on Tammy's file in the first place. Further, Island Health confirmed that there was no record that Tammy had ever been notified of the alert, that she had been advised of reasons why it was placed on her file, or that the alert was reassessed at established intervals, as required, by the applicable violence assessment procedure.

We were concerned that Tammy's repeated requests for information about why the violence alert was on her record, who put it there and whether it could be removed, were not responded to adequately or appropriately. Rather than assisting Tammy to access the information she was entitled to about her own medical record, Island Health raised several barriers that made it difficult for her to find the answers she was looking for. The violence alert on her medical record created a stigma which made it more likely to lead to discriminatory treatment by staff.

It appeared that the placement of the violence alert on her medical records was arbitrary and contrary to principles of administrative fairness. Based on our review of Tammy's complaint, we asked Island Health to remove the violence alert from Tammy's medical record in its entirety and to write her a letter confirming that it had been removed as well as explaining the reasons why.

Island Health agreed to our recommendations and took the steps necessary to resolve the fairness concerns identified. Island Health wrote Tammy a detailed letter of apology, and committed to removing the violence alert from her medical records.

Unfortunately, a few weeks later when Tammy attended the emergency department to seek treatment, she saw her medical record and noticed that the violence alert still appeared to be on her file. We followed up with Island Health to find out why it had not been removed. Island Health looked into the matter and discovered that there had been a mistake made in removing the violence alert from all parts of Tammy's medical record. Island Health wrote to Tammy again to explain the mistake and to confirm, with written evidence, that the alert had now been completely removed from her records.

I'd like a second opinion please

Vancouver Coastal Health

Delivering a sincere apology is one of the most important steps a public body can take to restore trust and resolve conflict when a mistake or error has occurred.

Harry, who was involuntarily detained under the *Mental Health Act*, reached out to our office after his request to have his family doctor provide a second opinion was denied.

In the course of our investigation, VCH informed us that Harry was assessed by two different physicians at the time of his admission to the hospital. We also learned that Harry's request to have his family doctor provide a second opinion was considered but deemed to not be possible because his doctor did not have hospital privileges. Acquiring hospital privileges is a lengthy process that can take several months and thus was deemed to be impractical in Harry's case.

Based on our review of several regulations and the *Mental Health Act*, we determined that a family physician, including those who do not have admitting privileges or a hospital permit to practice, has the right to provide a second opinion for patients who are involuntarily detained.

As a result, we asked VCH to ensure staff are aware of the provisions of the *Mental Health Act* regarding requests for second opinions. We also asked VCH to write a letter of apology to Harry acknowledging his request should have been accommodated. VCH agreed to our recommendations.

Not making the grade

School District 35 (Langley)

When a decision is made, it is important to provide adequate notice and information about the right to appeal.

When Noreen's daughter Johnna was suspended, the school did not provide information about the suspension or the return-to-school plan until she spoke to the principal in person several days later. Noreen was also concerned because the school did not provide schoolwork for Johnna to complete during the suspension and she wasn't provided with information about the School District's (the District) appeal process.

Frustrated, Noreen brought her complaint to us.

Our investigation focused on whether the District followed a reasonable process in communicating with Noreen about Johnna's suspension.

In speaking with the District, we learned that staff had not intended to formally suspend Johnna. The District said the school staff required Johnna to be absent to allow them to assemble a complex care team in order to develop a safety plan and a return-to-school schedule, a process that took more time than anticipated. The District also explained that staff had unsuccessfully attempted to reach Noreen on the day of the incident and while schoolwork was not initially provided, it was provided eventually.

We considered the District's process in light of the requirements in the *School Act* and identified three concerns:

1. The Act provides legal authority to suspend or medically exclude a student, but not to informally remove them as the District had in this case.
2. The Act requires that an educational program be provided to any student who is suspended or medically excluded, but it was not clear District staff were aware of this requirement.
3. The Act grants parents the right to appeal significant decisions of District staff to the Board of Education.

As a result of our investigation the District began to work on improving its guidance for staff for supporting students who have been suspended as well as developing guidelines for medical exclusions. The District confirmed its guidance documents would include information about the requirement to provide an educational program to students who are suspended or medically excluded and would instruct staff to provide proactive information about the right to appeal such decisions. The District explained that the guidance documents would be finalized and then presented to the Board of Education for consideration. The District also agreed to speak to the staff involved in this case to discuss the fairness concerns identified.

Short notice

Ministry of Children and Family Development

Providing adequate notice of service changes is imperative to make sure potentially serious consequences do not occur.

Paige was on a Youth Agreement (YAG) with the Ministry of Children and Family Development that was about to expire. Paige understood from their social worker that they would continue on a YAG and the social worker would help with an application for an Agreement with Young Adults (AYA) so they could transition to that program when they turned 19. However, a week later, just three days before the YAG expired, the social worker told Paige that their YAG would not be extended and she would not be proceeding with their AYA application. In addition, the social worker also told them that their allowance cheque might be delayed.

Paige was really distressed. They had three days to find a job, figure out their tenancy with their landlord, and figure out how they were going to live, a lot for an 18-year-old to handle in a very short period of time.

Our office investigated whether the ministry followed a reasonable process dealing with the renewal of Paige's YAG, the decision not to proceed with an AYA application and the potential delays with their allowance cheque.

The ministry told us that Paige had not completed an independence planner, which was a document needed to proceed with their YAG extension. It appears that because it was not received, a decision was made to discontinue the YAG and not proceed with the AYA. We discussed the importance of providing adequate notice of a decision, particularly one that significantly impacts a person. The ministry acknowledged that the notice provided to Paige was not sufficient and also clarified that it had intended to provide some additional support after the YAG ended. We discussed that it was not apparent this had been adequately communicated to Paige.

To remedy the fairness concerns, staff met to discuss what happened in Paige's case and to review their file. Staff also took steps to ensure that Paige received their allowance cheque on time. After the review, the ministry decided to renew the YAG and met with Paige to help them complete the required paperwork. The social worker also agreed to revise their system of bringing files forward to ensure more notice in situations where an agreement was coming to an end.

Eviction avoided

Ministry of Social Development and Poverty Reduction

Leaving out pertinent details on a client's file nearly cost this family a roof over their heads.

Jessie was concerned with the process followed by the Ministry of Social Development and Poverty Reduction (MSDPR) in responding to her request to add her children as dependents. By adding the children, Jessie would receive additional funds from the ministry to assist her in supporting her family. Jessie informed us that her children were recently returned to her care by the Ministry of Children and Family Development (MCFD). When she asked the ministry to add her children as dependents, Jessie provided a letter from MCFD confirming her children had been returned to her care. While she was waiting for MSDPR's approval for her children to be added as dependents, Jessie had to direct a portion of her shelter funds to support the children. This resulted in her not being able to pay her entire rent.

When Jessie contacted the ministry and told staff about the financial hardship she was experiencing due to the delays, she was told that her request would be assessed on an urgent basis and to check back the following day. She called back the next day and was told that her request had been re-categorized as non-urgent and that it would not be reviewed until the following week. That same day Jessie received notification from her landlord that she had three business days to pay her rental arrears or be evicted. Jessie called the ministry again and asked to speak with a supervisor but didn't receive a response.

We quickly investigated whether MSDPR followed a reasonable process responding to Jessie's urgent request.

We discussed Jessie's complaint and requested information about how the ministry had assessed her request. The ministry noted that when Jessie initially contacted them, two service requests were created, both identified as being "urgent". However, another staff member reviewed the service requests and assigned a standard date for adding Jessie's children as dependents because no details were included in the request explaining the urgency of her requests. The records indicated that when Jessie told ministry staff that the delay would cause financial hardship, the staff member failed to return the service request to its urgent status.

The ministry acknowledged that this did not reflect expectations for how the information provided by Jessie should have been recorded by staff and that steps would be taken to address the issue. The ministry also confirmed that Jessie's request would be expedited and we were notified that she was issued a cheque later that same day.

Jessie's contact with us resulted in the ministry addressing her urgent need expeditiously and avoiding eviction from her home.

COVID-19

Launch interrupted

Ministry of Forests, Lands, Natural Resource Operations and Rural Development

The impact of emergency restrictions led to long delays and less than fair treatment for this tour guide.

EARLY RESOLUTION

Jack purchased a Freshwater Guiding Licence in hopes of starting a new boat tour business. However, due to COVID-19 restrictions, boat launches and provincial parks were closed and social gatherings were prohibited. These restrictions meant Jack was unable to launch his business as planned. He contacted the Ministry of Forests, Lands, Natural Resource Operations and Rural Development (FLNRORD) to have his licence refunded but never received a response. Frustrated by the delays and lack of response, Jack reached out to us for assistance.

We contacted FLNRORD about Jack's situation and staff apologized for the delay and informed Jack that his refund would be processed.

Twice the victim

Public Safety and Solicitor General

Not following policies correctly is a common administrative error that can result in significant harm to individuals.

Emily was the victim of a crime and the accused was her sister, Beth. Beth pleaded guilty to a lesser charge and a pre-sentence report was prepared by a probation officer. The probation officer called Emily to provide input into the report but she didn't feel that her feedback was given the attention it deserved. Emily told us the officer did not contact other families and had not verified the accuracy of their report. When Emily attended the sentencing hearing with her family she heard many serious inaccuracies about her and her family and was quite upset. The report was read out loud by the judge and was potentially relied upon by the judge to determine Beth's sentence.

Emily sent a letter outlining her concerns to the Regional Probation Office and requested an investigation into the report. The Regional Probation Office launched an investigation but ultimately determined that the report was prepared appropriately and that the judge had enough information to inform sentencing.

Frustrated that her voice wasn't being heard, Emily called our office.

Through our investigation, we found that the probation officer failed to review Emily's victim impact statement prior to interviewing her as required by the Community Corrections Policy. The officer also failed to inform Emily that she was entitled to have a victim services worker or advocate attend the report preparation meeting. Although the internal investigation identified some deficiencies with the officer's report, the Regional Probation Office did not provide that information to Emily.

We proposed and BC Corrections agreed to send Emily a letter outlining the steps that the officer should have followed, apologize for not following policy and provide training for managers and probation officers across the province on how to apply the Community Corrections Policy.

Falling through the cracks

WorkSafeBC

A complaint about unfair treatment that led to a significant reimbursement and helped many others.

Tristan was injured at work and suffered a severe stroke which left him with significant cognitive and communicative impairments. As a result of this injury, he was granted a 100% permanent functional impairment award from the WorkSafeBC. Tristan's wife managed the ongoing aspects of his claim but when she died, contact with WorkSafeBC ceased for over five years. During this time, WorkSafeBC's efforts to reach out to Tristan consisted of two unanswered phone calls. Several years later, WorkSafeBC successfully re-established contact with Tristan and scheduled a home visit. It was during this home visit that WorkSafeBC learned of his wife's death.

We investigated a number of issues that arose between Tristan and WorkSafeBC and determined that WorkSafeBC had acted reasonably. However, we became concerned about WorkSafeBC's lack of outreach to Tristan, especially given the nature of injury, and his potential eligibility for benefits that he might not have been aware of.

In regard to the lack of outreach, we determined that WorkSafeBC has a Special Care Services department which manages claims involving severely injured workers who require additional supports. However, older claims, such as Tristan's, were not automatically referred to this department. Instead, individual case managers were given the discretion to refer those claims or to retain them. In Tristan's case, his file had been retained by his local WorkSafeBC office until 2019 before it was transferred to Special Care Services.WorkSafeBC could not explain to us why Tristan's file was not transferred earlier.

Concerned that there might be other workers whose files had yet to be transferred, we asked WorkSafeBC to conduct a review to identify other workers in similar situations. WorkSafeBC agreed to the review and identified twelve additional severely injured workers whose files had yet to be transferred.

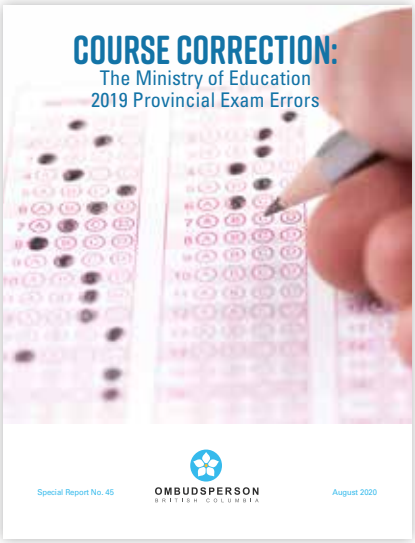
We also investigated whether Tristan was eligible for other benefits and found that he was eligible for an Independence and Home Maintenance Allowance benefit. Tristan should have been receiving this benefit when he was found to be permanently injured several years earlier. As a result, Tristan received $52,000 in retroactive benefits from WorkSafeBC.

SYSTEMIC INVESTIGATIONS AND MONITORING

SYSTEMIC INVESTIGATIONS AND MONITORING

Systemic Investigations

In addition to investigating complaints from individuals, the Ombudsperson has the authority to initiate investigations. These "own motion" investigations are often about issues that have the potential to impact a large number of people or where there is an increase in, or large number of complaints or conversely where there are barriers to individuals making complaints. These systemic investigations result in public reports that contain formal findings and recommendations and often lead to significant system-wide improvements. Our office completed two such reports this past year. We also continued to monitor the progress by public authorities on their implementation of our recommendations from previous systemic investigations.



Our Reports

Course Correction: The Ministry of Education 2019 Provincial Exam Errors

This report followed our investigation into errors made by the Ministry of Education involving the posting of more than 18,000 incorrect grade 12 exam marks in 2019. The investigation examined both how the errors were made and how the ministry responded to them. The report highlights that tabulation processes were rushed and that both internal and external concerns highlighting discrepancies were not immediately addressed. Gaps in the ministry's quality assurance process meant incorrect results were released even after ministry staff, students and secondary institutions were aware of problems and some of the communication with students and families was either inaccurate or misleading. The report made six recommendations, including enhancing quality assurance processes and establishing strengthened communications protocols. The report also recommended that the ministry apologize to students impacted by the error and compensate any student who was financially harmed. The ministry accepted all of the recommendations.

WHAT WE EXAMINED

How incorrect marks were released and the ministry's response

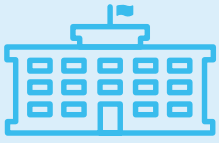
32,000
Grade 12 exams written June 2019

18,741
incorrect exam marks posted beginning July 26, 2019

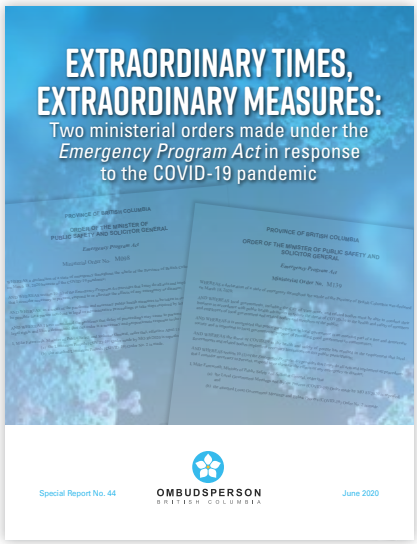
9,946
marks were lower than they should have been,

8,795
were higher

112,187
transcripts received by post-secondary institutions and others with potentially incorrect marks



COVID-19



Extraordinary Times, Extraordinary Measures: Two ministerial orders made under the Emergency Program Act *in response to the COVID-19 pandemic*

This report was the result of an investigation into two ministerial orders made during the COVID-19 pandemic by BC's Minister of Public Safety and Solicitor General under the *Emergency Program Act* that we determined were made contrary to law. One order suspended limitation periods and allowed statutory decision-makers to waive, suspend or extend a mandatory time-frame relating to decision-making powers. The second order we investigated exempted local governments from statutory requirements related to the conduct of meetings and public hearings and the passage of bylaws. The Ombudsperson concluded that in purporting to amend or suspend British Columbia statutes the orders exceeded the authority given to the Minister by the *Emergency Program Act*.

The Ombudsperson made five recommendations to government in the report including the introduction of legislation to validate the orders and to not make any further orders amending statutes unless the Legislature passed legislation authorizing such orders. The remaining three recommendations focused on applying safeguards that would ensure orders were not too broad, would not go further than their objectives and would be debated in the Legislature.

The day our report was tabled in the Legislature, the government introduced Bill 19, *The COVID-19 Related Measures Act* which addressed most of the recommendations in the report. A further recommendation was addressed when Bill 19 was amended during the legislative process.

> ***"I recognize speed was important in responding to the pandemic. However, while the intent and even the content of these orders may be worthy, that is not enough. Every exercise of public authority in a democratic system must find its source in law."***
>
> **– JAY CHALKE**

Monitoring

One of the key ways our work can effect change in the administration of government programs is by making recommendations that result from investigative findings of unfairness. Our recommendations may involve individual remedies or systemic change, and often contain timelines that we expect a public body to adhere to. To ensure accepted recommendations are implemented, we liaise with public bodies and ask for regular, specific and verifiable information on the progress being made. We regularly issue monitoring reports on our assessment of public bodies' implementation of our recommendations.

In 2020/21, we continued to monitor the implementation of recommendations in several reports, including:

- *Striking a Balance: The Challenges of Using a Professional Reliance Model in Environmental Protection - British Columbia's Riparian Areas Regulation*
- *In the Public Interest: Protecting Students through Effective Oversight of Private Career Training Institutions*
- *Under Inspection: The Hiatus in BC Correctional Centre Inspections*
- *Misfire: The 2012 Ministry of Health Employment Terminations and Related Matters*
- *Stem to Stern: Crown Land Allocation and the Victoria International Marina*
- *Holding Pattern: Call Wait Times for Income and Disability Assistance*
- *Working within the Rules: Supporting Employment for Income Assistance Recipients*
- *Committed to Change: Protecting the Rights of Involuntary Patients under the* Mental Health Act
- *Extraordinary Times, Extraordinary Measures: Two ministerial orders made under the* Emergency Program Act *in response to the COVID-19 pandemic*
- *Course Correction: The Ministry of Education 2019 Provincial Exam Errors*

We anticipate releasing updates on the implementation of recommendations from many of these reports in 2021/22.

OUTREACH AND COMMUNITY ENGAGEMENT

OUTREACH AND COMMUNITY ENGAGEMENT

Numbers at a Glance

9

Virtual Tours of Adult & Youth Correctional Centres

436

Letters to stakeholders outlining our services during the pandemic

68

Communities reached through virtual public webinars

9

Indigenous engagement dialogues with 380 participants

87

Information packages sent to MLAs in the 42nd Parliament

Community Engagement

As the pandemic continued, our community engagement approach changed substantially. While normally we visit communities across the province meeting with complainants face-to-face and raising awareness about our services with community organizations and the public, this year our engagement was done virtually. While every year we strive to make sure that all British Columbians know who we are and what we do, this past year, we developed a specific COVID-19 outreach strategy that focused on key sectors of the public impacted by the pandemic. Our targeted outreach focused on those who are detained, newcomers to BC, people who are homeless and those who are experiencing poverty, seniors and their families, women fleeing domestic abuse and Indigenous communities. Our outreach included a range of activities, from social media and transit ads to targeted mail-outs to community organizations, advocates and others explaining our role and services.

Complaining 101: Public Webinar Series

This past year, we piloted a new approach to educating the public. Complaining 101, an interactive webinar, was a new way for us to engage with the public and share our suggestions on how individuals can bring complaints forward to public organizations. With 40-plus years of complaint handling expertise we shared our tips on how to complain to ensure issues are resolved and people's voices are heard. These webinars were extremely well attended with participation from across the province.

Round Table Dialogues with Indigenous Service Providers

This past year we held nine engagement dialogues with Indigenous service providers that served multiple purposes: increasing awareness of our role and services, strengthening relationships, providing networking opportunities for participants, and receiving input on what our Indigenous services should look like. Between January and March 2021, we met with over 300 different Indigenous service providers through a series of virtual round table discussions followed by a series of virtual focus groups to dive deeper into key themes that arose during the round tables. In addition to building reciprocal working relationships, these engagement dialogues have been indispensable to our learning and will be invaluable as we develop our plan to improve services to Indigenous people. We plan to meet with Indigenous communities across the province in the coming months to further this work.

Correctional Centre Virtual Tours

Every year staff from our office visit adult and youth correctional facilities. The purpose of these visits is for our investigators to meet with staff and inmates to learn of emerging issues of concern and to ensure information about how to complain to our office is available to those who are detained. With the onset of the pandemic, we made the difficult decision to suspend all of our planned in-person visits to correctional centres and moved to virtual visits instead.

BC Corrections reported to us it had taken steps to respond to the threat of COVID-19 including screening staff upon arrival to facilities, limiting inmate transfers, screening and isolating new admissions, increasing facility cleaning and disinfecting, and using PPE for staff. Visits with inmates were suspended and were replaced with free phone calls. Some programs were suspended in an attempt to ensure the health and safety of inmates and staff.

In response to these changes, our office implemented virtual visits to correctional centres focusing on the impact of the measures that had been adopted by BC on inmates. These guidelines considered access to programs and other services, access to outdoor exercise and conditions for inmates in COVID isolation. Starting in October 2020 we virtually visited nine correctional centres. We also held regular meetings with senior staff at BC Corrections. When the pandemic-related restrictions end we will resume in-person visits.

PUBLIC AUTHORITY CONSULTATION AND TRAINING

PUBLIC AUTHORITY CONSULTATION AND TRAINING

Year in Numbers

19

Tailored virtual trainings delivered to public sector organizations

5

Publications: 1 Best Practice Guide & 4 Quick Tips

Top 3 public organizations with most staff registering for Fairness 101:

66

Ministry of Children and Family Development

23

Civil Resolution Tribunal

20

Ministry of Public Safety and Solicitor General

374

Registrations for Fairness 101 online course

27

Requests from public organizations seeking fairness consultations

860

Training and webinar participants over the year

Public Authority Consultation and Training Team

The Public Authority Consultation and Training (PACT) team, initially a pilot project, was made an ongoing program of the office in 2020 following an extensive independent evaluation of the program. PACT works proactively with BC public organizations, offering education, voluntary consultation and sharing of complaint data to enhance fairness and continuous improvement across the public sector.

Education and Training

PACT has been delivering in-person administrative fairness workshops since April 2018, and has trained over 3,000 public sector employees around the province to date. These workshops cover topics such as:

- what administrative fairness means in public service delivery;
- how to make and communicate decisions fairly;
- implicit bias;
- exercising discretion fairly;
- essential skills in effective complaint handling.

At the onset of the pandemic, PACT transitioned its training sessions to online delivery. During the year PACT delivered 19 tailored virtual training sessions to 442 public sector employees from various public organizations, including health authorities, provincial government ministries, schools and universities, local governments and Crown corporations such as Community Living BC.

95%
of attendees rated the workshops as excellent or good

95%
agreed the workshops are relevant to their role

Our Fairness 101 course, a free, introductory online course on administrative fairness, attracted 374 registrants from various BC public organizations with the highest number of registrations coming from the Ministry of Children and Family Development, the Civil Resolution Tribunal and Ministry of Public Safety and Solicitor General. Several BC organizations are using Fairness 101 as onboarding for new staff, as it provides an excellent overview of administrative fairness in a variety of different public service contexts.

Fairness 101 has been recognized outside of BC as well. The Government of Northwest Territories has added Fairness 101 to their Learning and Development System as a course recommended for new employees, with nearly 150 NWT staff completing the training.

Publications and Resources

In December 2020, the Ombudsperson released a *Complaint Handling Guide* to help public organizations handle complaints fairly, efficiently and effectively. In our work, we find that members of the public often contact us directly when the organization they are complaining about does not have an accessible complaint or appeal process. This guide calls on public sector organizations to have clear information listed on their website about how to raise a complaint, and to have an adequate system in place to receive, investigate and track complaints to ensure continuous improvement. It also includes a model complaint policy and self-assessment checklist for organizations wishing to enhance their capacity to resolve complaints from their service users, ideally right at the point they are received.

Following the release of our Complaint Handling Guide, PACT delivered a webinar called The Essentials of Fair Complaint Handling that was attended by over 400 public sector employees.

PACT also produced a number of Quick Tips on topics such as how to exercise discretion fairly and how to respond to complaints effectively when faced with more challenging conduct. These publications, along with our webinars and additional educational materials, are all available on our website.

COVID-19

PACT Voluntary Consultations

PACT also offers voluntary fairness consultations to public bodies on issues not currently being addressed through our office's primary investigative mandate. During a voluntary consultation, PACT works collaboratively with the public organization, provides practical advice and suggestions to support fairness in service delivery, and proactively identifies and addresses potential fairness issues outside of the context of an investigation of a complaint.

At the onset of the pandemic, PACT reached out proactively to a number of government organizations to offer support and advice as those public bodies were making rapid changes to their service delivery models and assuming new responsibilities in relation to various COVID-19 public health orders. The benefits of this proactive approach were quickly realized, as many organizations wanted to engage with us to ensure they were conducting their operations and delivering their services fairly throughout the pandemic. Some examples of these voluntary consultations include:

- PACT engaged regularly with the **Ministry of Public Safety and Solicitor General** who provide province-wide leadership relating to enforcement of the Public Health Officer's orders. We reviewed draft training materials that were created for compliance and enforcement officers, provided feedback on procedures relating to border control measures, and engaged regularly with ministry staff on the design of enforcement activities under the PHO's orders relating to face coverings and gatherings and events. The ministry was willing to engage with PACT throughout the year to help promote fair, proportionate, and reasonable enforcement of these various orders.

- The **Island Health Patient Care Quality Office** (PCQO) requested our feedback on draft policy they had created to resume in-person PCQO resolution meetings during COVID-19. In the initial stages of the pandemic, Island Health's PCQO had ceased all in-person resolution meetings. In July 2020, they wished to update their policy to allow for some in-person service in specific situations where warranted, while ensuring the focus remained on prioritizing the health and safety of the staff, patients and families engaged in the review process. We made suggestions on how their policy could be enhanced by clarifying the criteria for in-person meetings, ensuring a clear decision maker is identified for these decisions, and establishing an appeal process for those who are not provided an in-person resolution meeting.

PACT was also approached by several public organizations this year with requests for assistance on issues that were not related to COVID-19, including:

- **Community Living BC** (CLBC) reached out to PACT for advice on how to enhance the timeliness and effectiveness of their complaint process. PACT met with CLBC's Quality Assurance staff and provided advice on the levels of review in CLBC's complaint process. We also discussed best practices in complaint handling, including trying to resolve complaints at the earliest point possible, making sure people have a chance to be heard in the complaint process, and ensuring the person receives an understandable response following review of their complaint.
- **The Vehicle Sales Authority** (VSA) contacted PACT to request assistance and feedback on the procedural fairness of their investigative and compliance processes. The VSA is responsible for regulating the motor dealer industry in BC. As part of this voluntary consultation, PACT reviewed the VSA's enabling legislation and relevant policies, and interviewed a number of VSA board members, management, staff and external stakeholders. During this process, PACT noted that VSA staff and management were knowledgeable about procedural fairness and were committed to taking a proactive approach to continuing to improve the procedural fairness of their decision-making processes. Based on the information gathered, PACT provided the VSA with a detailed report that contained 40 suggestions on how they could enhance the procedural fairness of their processes. These suggestions, if implemented by the VSA, will help to ensure procedural fairness in the VSA's decision-making processes and will enhance public confidence in the VSA's ability to carry out its regulatory role in the public interest. We made suggestions on how the VSA could increase transparency in their processes, operationalize their regulatory approach, and support staff and management by establishing clear roles and providing more comprehensive training. We also made suggestions with respect to the roles and responsibilities of the VSA's board of directors, executive and Registrar in order to enhance fairness, impartiality and transparency in the VSA regulatory process.

PUBLIC INTEREST DISCLOSURE ACT

OUR APPROACH

On December 1, 2019 the Ombudsperson's mandate materially changed with the coming into force of BC's new whistleblower protection law, the *Public Interest Disclosure Act* (the 'Act' or 'PIDA'). The Act provides current and former provincial government employees with a legal framework to bring forward concerns about wrongdoing in their workplace and protects them from reprisal for doing so. The Ombudsperson has the statutory mandate to both provide advice and conduct whistleblowing investigations if employees do not wish to report these concerns internally to their employer. In addition the Ombudsperson has the sole mandate to investigate allegations of reprisal under the Act.

The Ombudsperson's Role Under PIDA

Enquiries and Requests for Advice

This past year, employees came to us with a range of enquiries and requests for advice. We were able to confidentially provide information about what wrongdoing and reprisal are, what the process for reporting wrongdoing or reprisal is, and to outline our procedures for reviewing and investigating disclosures. Some of the questions we heard include:

Assessing Disclosures

Every report of wrongdoing made to our office is assessed on its merits to determine if an investigation is warranted. When we receive a disclosure, we conduct a two-stage assessment to determine whether the allegation is within our jurisdiction and whether there is any bar to us investigating or other valid reason not to investigate. Reports of wrongdoing must meet specific criteria to be eligible for investigation under the Act.

An Investigator will contact the person who made the report to ensure we have enough information to determine whether:

- ☑ **they are a current or former employee of a ministry or independent office**
- ☑ **the alleged wrongdoing relates to a ministry or office of the Legislature**
- ☑ **the allegations meet the threshold of wrongdoing as defined in the Act**
- ☑ **our investigation of the allegations is not barred by any provision in the Act**

PUBLIC INTEREST DISCLOSURE INVESTIGATIONS

How Our Investigative Process Works

One of the key enquiries we hear from employees is what to expect in the various phases of our process. This chart outlines our process.

Advice

1. Employees may seek advice from us before making a disclosure or reprisal complaint. Advice may include information about whether the person is eligible to make a disclosure, their options for disclosing wrongdoing, details about our process, how to manage any reprisal risk and confidentiality and reprisal protections under the Act.

Disclosure

2. An employee covered by the Act reports something they believe to be wrongdoing.

Assessment

3. We contact the discloser to confirm that they are covered by PIDA.

4. We gather additional information from the discloser to assess:
   a. whether the allegations, if proven, would rise to the threshold of wrongdoing as defined by PIDA
   b. whether we have sufficient information to initiate an investigation
   c. whether a bar to investigation applies

Investigation

5. The discloser is informed about whether or not their disclosure will be investigated. The public body in question is notified if we initiate a PIDA investigation.

6. We evaluate the urgency of investigation files and the potential risk of reprisal to the discloser. We develop our investigation plan accordingly.

7. The investigation is undertaken including interviews with the discloser and relevant witnesses, gathering evidence, and engaging subject-matter experts where necessary. Witnesses are protected from reprisal for participating in an investigation.

Reporting and Recommendations

8. We issue summary reports to the discloser and anyone alleged to be responsible for wrongdoing. A full report is provided to the Chief Executive of the public body subject to the investigation. If it is in the public interest, a public report may be issued.

9. Our report includes findings and recommendations, where appropriate, and can make recommendations regardless of whether wrongdoing was found.

10. We monitor the responses to, and implementation of, any recommendations.

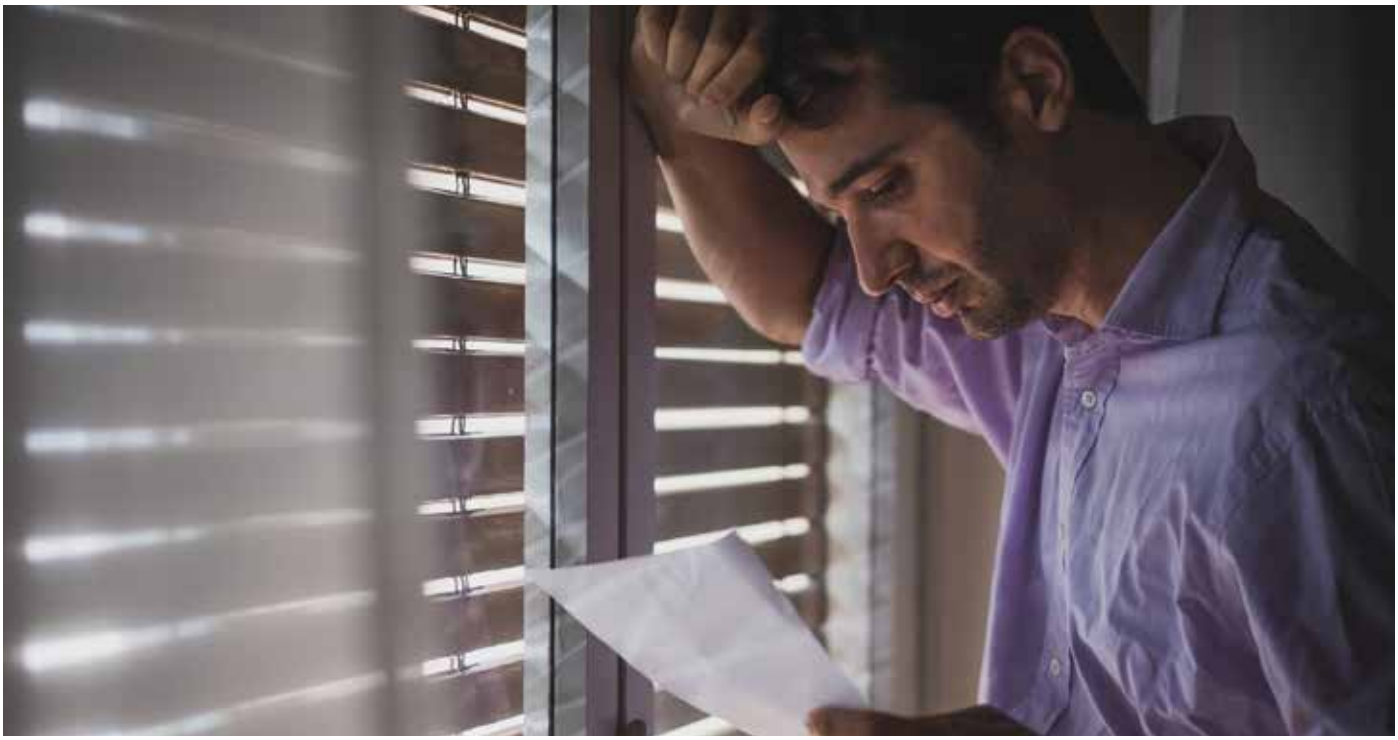
Investigative Work This Past Year

2020/2021 was the first full fiscal year that PIDA was in force. For the numbers of cases we dealt with under PIDA see page 93.

One investigation was completed in the year. The investigation did not result in a finding of wrongdoing but one recommendation was made to the public authority. Implementation of the recommendation is ongoing and is not yet complete.

PIDA requires that we report whether the Ombudsperson is of the opinion that there are systemic problems that give rise to wrongdoing. The Ombudsperson is of the opinion that given the recent coming into force of PIDA it is premature to identify any systemic problems giving rise to wrondoings.

> ***"Working as a PID investigator is a unique opportunity to assist public servants that bring forward serious cases. These employees are best positioned within the organization to know if someone has done something wrong, systems aren't working as they should, or a public body is wasting funds. PID provides an avenue and protection for whistleblowers to bring these types of cases forward and the tools necessary to conduct thorough investigations that get to the bottom of things. Through these investigations, we can determine whether government mismanagement and corruption has occurred."***
>
> **– PIDA INVESTIGATOR**



OUTREACH, TRAINING AND EDUCATION

BC's whistleblower protection law is still relatively new. Therefore, raising awareness and supporting implementation of PIDA by public bodies currently covered by the Act, and those that will be in the coming years, is a priority for our office.

The Ombudsperson Marks PIDA Day

For the second year, our office hosted a provincial conference (virtually) to raise awareness of emerging issues in relation to PIDA. This year our focus was on encouraging a Speak Up culture. Nearly 100 public service leaders, academics, whistleblower advocates and other key stakeholders attended from across BC and Canada, along with several international attendees. Ombudsperson Jay Chalke shared key lessons learned from our office this past year, senior staff of the Public Service Agency shared their perspectives on how PIDA fits into a broader ethical framework, and author and workplace culture expert Craig Dowden provided practical tips and tools about how to encourage employees to speak up.

"I really enjoyed the keynote speaker Craig Dowden. He shared some incredibly valuable insights about leadership and culture that I think many across government could benefit from (not just those involved in PIDA). Same with the Ombudsperson's insights - broad application across all ministries!"

- Attendee

"I thought it [the conference] was great. I liked the ability to give anonymous comments in the chat and I think it was well planned out."

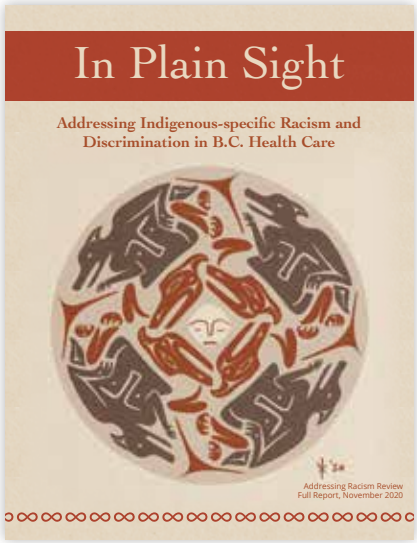
- Attendee

Next Phases of PIDA in BC

Currently PIDA applies to more than 35,000 public service employees, as well as former employees, however the intent of the Act is to eventually apply to the broader public sector.

It is government's decision, through Cabinet, to decide which organizations or sectors PIDA will apply to and the timing of the roll-out. The phased expansion schedule is to be determined by Cabinet. We expect government to announce the next phases later this year.

In Plain Sight



Last year, a high-profile report was released: *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*. The review and report commisioned by the Ministry of Health and conducted by Mary Ellen Turpel-Lafond, provided data and related stories from Indigenous people and health care providers and found widespread Indigenous-specific stereotyping, racism and discrimination in BC's health care system.

The report offered 24 recommendations to eliminate Indigenous-specific racism and make health care safer and more effective in BC. One of those recommendations was to apply PIDA to employees of the health authorities without further delay to assist in strengthening a Speak Up culture in that sector.

CASE SUMMARIES

CASE SUMMARIES

Case summaries help tell the stories of our investigations. They provide a lens into understanding the kinds of individual complaints that come to us and highlight outcomes when we find that either a public body acted unfairly or rules were followed as they were intended.

These case summaries reflect the types of matters we deal with on a daily basis, but they are only a small fraction of the work we do. It is important to note that names have been changed to protect the privacy of complainants. Photos are for illustrative purposes only.

COVID-19

FEATURE: COVID-19 AND VISITATION CHALLENGES IN LONG-TERM CARE

Over this past year, the tragedies and challenges experienced by people working in long-term care, living in long-term care and visiting and caring for loved ones in long-term care were acute not only in BC, but across the country. Our office received numerous complaints related to this area, particularly around visitor restrictions put into place as a result of the pandemic.

In February 2021 the Ombudsperson released a public statement calling on government to amend its pandemic long-term care visits policy to address a range of fairness concerns including:

- ***a lack of consistent and easy to access public information about the visits policy and process***
- ***inconsistencies in how the province's visiting policy was being applied in facilities***
- ***a lack of timeliness relating to the appeals process***
- ***a lack of the provision of adequate written reasons why a person's appeal was being denied***

Government made a number of changes following the Ombudsperson's statement. The call to government came following a number of investigations related to visitation issues. Some of those cases are highlighted below.

It's essential I visit my mom

Fraser Health

Applying policies evenly can ensure all are treated fairly.

Jo contacted our office after she was denied essential visitor status at her mother, Jenny's, long-term care home. She was told by the facility that they were not allowing essential visitors and when she complained to the Patient Care Quality Office she was told she didn't qualify. Confused and feeling like she was being treated unfairly, Jo asked us to investigate.

We reviewed the Ministry of Health's Essential Visits Policy as well as the facility's approach to visitors. We learned that while social visits and end of life visits were allowed, essential visits were not. To better understand the application of the policy at the facility, we met with Fraser Health representatives and learned that the facility had focused on social and virtual visits for the 100 residents who lived there, but essential visits had not been occurring.

In reviewing the Essential Visits Policy, we noted that residents could be assisted with a range of care needs including feeding, mobility and communications assistance and we asked the facility to review which residents might need this type of assistance. Through the course of the facility's review, 25 residents who would benefit from essential visits were identified, including Jo's mom, and these visits were introduced.

A socially distanced wave

COVID-19

Fraser Health

A blanket approach does not always account for individual needs and can result in unfair decision-making.

Pavan's mother, Aarti's birthday was approaching and she wanted to be able to visit with her to celebrate at the long-term care home she was living in. While the home had initially approved the social visit, days before it was supposed to take place, the facility contacted Pavan and told her another family member, Jessie, who was the regularly approved visitor, was the only person who would be able to visit. Desperate to see her mom, Pavan travelled to the facility and stood behind a chain link fence approximately 35 feet from where Aarti and Jessie were sitting outside and waved to her. Pavan's frustration mounted when a week later, Jessie received a request from the facility asking him to sign a contract that stated he would not bring a second visitor within the visual sightline of Aarti and if he did, his visits would be cancelled and replaced with virtual ones only.

Frustrated, Pavan asked for our help.

In reviewing Pavan's complaint, the terms of the contract regarding visual sightlines raised fairness concerns. We appreciated a gathering on the other side of the fence could be disruptive and challenging for residents, and depending on the size, may be in contravention of a public health order; however, we concluded that situations like Pavan's could be dealt with on a case by case basis. In looking more closely at the visitor contract, we also noted it included a provision that stated: *"I understand that my loved one may become upset by the possibility of seeing me and not being able to touch or hug me. If I see they are becoming upset, I will say goodbye and end the visit"*.

Given the profile and complexity of heath, mental health and cognitive decline for long-term care residents which might have been negatively impacted by the pandemic-related visiting restrictions, it seemed that a resident may become upset during a visit for several reasons. The blanket response outlined in the visiting contract did not consider the reasons why the resident may be upset, nor did it consider involving the visitor to assist in calming the situation. Depending on the circumstances, a variety of factors could be considered to determine how best to respond to a resident becoming upset during a visit.

In order to settle the matter of unfairness, we asked Fraser Health to remove the provision dealing with visual sightlines and to reconsider the condition that deals with how a loved one responds when a resident becomes upset during a social visit. In response, Fraser Health replaced the visitor contract with visitor guidelines that addressed the concerns we raised.

Eating is essential

COVID-19

Interior Health

Ensuring a timely response can have significant impacts.

Anne contacted our office and told us she had been restricted from visiting her husband, Karl, who lived in a long-term care facility due to COVID-19 restrictions. Ten years ago, Karl suffered brain damage from an accident and as a result, he was easily confused and distracted, and it could take him a long time to eat. Anne would visit Karl every day and assist with his care, including bringing extra food and taking extra time to feed him to ensure that he ate one complete meal per day. Since visits had been restricted, Karl had lost about 30 pounds. Anne's doctor had sent a letter of support so she could be declared an essential visitor, but Interior Health had not responded to the request.

As we investigated, a COVID-19 outbreak in Karl's facility was declared over and our questions helped expedite Anne's essential visitor exemption request to the Medical Health Officer. We were advised shortly thereafter that the Medical Health Officer approved Anne as a visitor, with conditions.

Father's Day Revisited

COVID-19

Interior Health

One complaint can benefit many.

Lydia contacted our office with a complaint about a virtual Father's Day visit. Her husband, Derek, was living in long-term care and due to COVID-19, in person visits were not allowed. Lydia requested a virtual family visit for Father's Day but her request was denied because the facility didn't have enough staff to accommodate the visit. Lydia then requested to have the virtual Father's Day visit the following day, but she did not receive a response.

We investigated whether Interior Health provided a reasonable response to Lydia's request. In response to our questions, Interior Health advised us that they would facilitate a three-way virtual visit with Lydia, Derek and her son, who lived in a different town.

Due to the declining health of residents in long-term care and the ongoing stress associated with in-person visit restrictions as a direct result of the pandemic, we asked Interior Health to accommodate virtual visit requests for all families of residents living in the facility. Interior Health confirmed it would do so whenever possible.

Getting a pass

COVID-19

Vancouver Coastal Health

Adapting to a new normal during the public health emergency is okay, as long as it's done fairly and reasonably.

Kris was involuntarily detained at Lions Gate Hospital and complained to us because he was not allowed to have a community pass to go outside due to COVID-19 restrictions. Kris also informed us that when the COVID restrictions that limited visitors to the hospital were initially imposed, patients had easy access to iPads for FaceTime visits with loved ones. However, he said staff had recently taken away the iPads and terminated patients' internet access.

We investigated whether Vancouver Coastal Health (VCH) acted fairly in providing care to patients detained under the *Mental Health Act*.

We spoke to VCH about patient access to the outdoors, access to technology for visits and access to lawyers/legal advocates. In response, VCH advised that due to COVID-19 and the highly vulnerable population in the hospital, the decision was made to suspend community passes in order to prevent the transmission of the virus from the community into the hospital. Instead, patients were provided access to the outdoors via a patio that is part of the hospital. In these circumstances, this seemed reasonable.

VCH also informed us that when the COVID-related hospital visitation restrictions were implemented, involuntarily detained patients did have relatively unrestricted access to iPads. However, access to the iPads was eventually restricted for security reasons. Patients were now required to book an appointment with staff to use the device so staff could ensure the iPad was being used for the intended purpose.

We also investigated patients' ability to meet with their lawyer or legal advocate in person and were initially told that their access was by telephone; that in-person meetings were prohibited. This raised questions because these patients were being detained against their will. After further consultation with VCH, they agreed that in person visits with lawyers and/or legal advocates would fall within the exception category. It was noted that no in-person visits of this nature had been requested. We also confirmed that patients did have access to a private space to have telephone calls with counsel.

We were satisfied that under the circumstances limiting community access was reasonable in order to prevent transmission of the virus and given the security concerns with iPad use, it seemed appropriate to limit access to "by appointment only" and for staff to confirm it was being used for its intended purpose. With respect to access to counsel, we were satisfied that with the changes made by VCH to broaden access to lawyers and legal advocates this concern was resolved.

Getting the story straight

COVID-19

Ministry of Social Development and Poverty Reduction

To be fair, information provided to the public should be consistent and accurate, especially during a public health emergency.

Terry complained about the Ministry of Social Development and Poverty Reduction's process for submitting their monthly income assistance report forms. Terry explained that he was unable to submit his forms via My Self Serve and submitted them by fax instead. However, shortly afterwards he received a letter indicating that the ministry does not accept monthly report forms by fax and that the reports should be submitted as soon as possible. Terry explained to us that he was concerned that his monthly income assistance cheque might be delayed so he attended the local office to deliver his forms. Terry said this was stressful because his doctor had advised him to remain in isolation due to medical vulnerabilities at the time. Terry complained about his experience to ministry staff, but was not satisfied with the response he received.

Our investigation focused on whether the ministry followed a reasonable process in communicating with Terry about how to submit his monthly report forms.

We spoke to a Community Relations and Service Quality Manager who confirmed that the ministry does accept monthly report forms via fax and that the usual requirement for them to be submitted by a certain deadline to remain eligible for assistance had been waived in response to the COVID-19 pandemic. We reviewed case notes related to Terry's situation and concluded that ministry staff advised Terry that the forms had been entered into the system. Ministry staff explained to us that the images were blurry, but that Terry could submit clearer copies at a later time when it was safe to leave his home. A different staff told Terry that it was okay for him to submit the documents sometime in the following months and that his assistance cheque would be released.

In the circumstances, it appeared that the ministry had provided correct information to Terry over the telephone, but conflicting information by way of letter. The conflicting information was that faxed forms were not acceptable and should be submitted as soon as possible. Given the conflicting information, we understood Terry's confusion about which advice to follow.

We raised this concern with the Manager, who agreed to write a note to Terry on the ministry's behalf extending an apology for the difficulties he experienced.

HEALTH

Reading between the lines

Ministry of Health - Health Insurance BC - MSP

Providing clear and publicly accessible information about policies is an important aspect of fairness.

Evan's common-law wife, Jackie, applied for permanent residency in 2017 after Evan's family sponsored her. All the required fees to process her application had been paid. Evan was concerned that Jackie's Medical Service Plan (MSP) coverage should have begun shortly thereafter, but her coverage wasn't approved for seven months. Jackie was pregnant at the time of the application and they had to pay nearly $3,500 for prenatal care.

Evan raised his concerns with the Ministry of Health and was told they would not backdate Jackie's MSP coverage. Evan explained that at the time of the application, the ministry's publicly available information did not specify that they were required to pay the Right of Permanent Residence Fee (RPRF) in order to be deemed a resident in BC. As such, Evan and Jackie delayed paying the RPRF. As a result, the ministry began calculating the wait period from the time that the RPRF was paid, which delayed Jackie's MSP coverage date.

Evan appealed the decision twice, and was denied. Feeling the ministry's decision was unfair, Evan approached our office.

We reviewed the ministry's publicly available information about the payment of fees for permanent resident applicants. We noted that the ministry had changed its messaging about the fees payable in order for a permanent resident applicant to be deemed a resident after Evan's complaint was opened. When Evan made his complaint, the ministry's website did not include any reference to the RPRF needing to be paid.

Upon our review, we felt it was unfair of the ministry to calculate Jackie's MSP coverage from the time that the RPRF was paid because information about the RPRF payment was not publicly available at that time. The ministry recognized the need for clarity in this area and had modified its website to include specific reference to the RPRF payment requirement.

We asked the ministry to backdate Jackie's MSP coverage and the ministry agreed. It also provided Evan with information about how to claim reimbursement for any insured medical and hospital expenses incurred. Satisfied that the ministry took the steps necessary to resolve the fairness concern identified, we ended our investigation.

A breach of rights

Interior Health

Providing clear reasons for how a decision is made is a key element of fair service.

Christie was detained involuntarily under the *Mental Health Act* and contacted us because she felt her rights were being breached. She explained that her telephone access had been restricted and she disagreed with her treatment plan.

In our investigation, we noted that as part of Christie's care plan, she was allowed four, 15-minute supervised calls per day. She had also agreed that staff could be in the room to support her during the calls. However, when we reviewed her calls, we learned that staff had listened to phone calls to our office as well as to the Mental Health Review Board (the Board), and had written detailed notes in her patient chart about her conversations. While there may be clinical and/or security-related reasons to listen to a patient's telephone calls, there are privacy protections that must also be observed.

The *Ombudsperson Act* allows for confidential written communication between our office and complainants confined to a hospital or facility operated by or under the direction of a health authority. In discussions with the Chair of the Board, we also learned that involuntarily detained patients are entitled to a reasonable expectation of privacy when speaking to a staff member of the Board.

The other concern raised by Christie's experience was related to the telephone calls being recorded in the patient's chart. Not only was there no way of knowing if what was recorded was accurate, but it remains in the record for an unknown number of individuals to access.

While Christie's chart indicated she had agreed to staff being in the room during her calls, there was no record that her right to privacy had been explained to her. For this reason, it was our view that the consent referred to in the record was not informed consent. In our recent report, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act,* we discussed the vulnerability of patients detained under the *Mental Health Act* and the need for strict adherence to the safeguards and other requirements established for their protection.

In response to this investigation, Interior Health agreed to undertake a number of changes including removing the notes of Christie's calls to our office and to the Board from her patient chart, providing a written apology and developing a revised policy and procedure relating to patient phone calls, including prohibitions on monitoring privileged communications.

Too many mistakes

Ministry of Health, Health Insurance BC

Making sure all the i's are dotted and t's are crossed can prevent unfairness from occurring.

Lise's Medical Services Plan (MSP) coverage was suspended due to a delay in obtaining her Quebec birth certificate. She had significant medical problems and had not been covered for two months. When her coverage was finally reinstated, her maiden name was used instead of her married name. Although she had been separated from her husband, there was no divorce decree or separation agreement and Lise had continued to use her married name for many years.

Feeling she was being treated unfairly, she contacted our office for help.

We contacted MSP and learned that Lise's marriage certificate had not been entered on her file and thus her maiden name had been used. MSP agreed to correct it to her married name. MSP had also backdated her coverage because she had provided valid identification and ordered a copy of her Health Services card to be issued.

We followed up with Lise to inform her that we had spoken with MSP and that her Health Services Card would be issued in her married name.

Admitting the need for a fresh start

Mental Health Review Board

To make fair decisions evidence should be considered and used according to governing legislation.

Saul complained to our office about a hearing with the Mental Health Review Board (the Board). He explained that during his hearing the panel did not provide an adequate opportunity for him to be heard nor did the panel provide him with adequate reasons for the decision for why his involuntary detention should continue.

The focus of our investigation was whether the panel followed a fair process in conducting the hearing.

With respect to Saul's complaint that he was not provided an opportunity to be heard, we noted he was represented by counsel at the hearing. It was difficult to assess if Saul was provided with an opportunity to be heard because the hearing was not taped as per usual panel procedures, which the Mental Health Review Board acknowledged was an oversight. However, the written decision reflected information provided by his lawyer in support of his position that his involuntary detention should cease to continue.

With respect to the reasons provided, the written decision appeared to adequately explain why the panel concluded that Saul met the criteria under the *Mental Health Act* for continued detention. We noted that the psychiatric case note provided to the panel by the health authority included information that would have identified Saul as having been dealt with under the *Young Offenders Act*. Although the record did not list specific offences, it did identify several periods of time spent in a youth custody centre. Saul's history in the youth justice system was referenced by the panel in their decision.

Both the *Young Offenders Act* and the *Youth Criminal Justice Act* provide protections regarding disclosure of youth records. Based on the information available, we were concerned that the Mental Health Review Board might not have adequately considered whether this information should have been allowed as evidence at Saul's hearing. We considered that the panel's use of this information could be highly prejudicial and could bias Saul's ability to have the "fresh start" intended by the young offender legislation.

As a result, we asked the Mental Health Review Board to settle the administrative fairness concerns identified by including information about evidence admissibility in their Review Panel procedures. Specifically, in accordance with the provisions of sections 110-128 of the *Youth Criminal Justice Act*, information that would identify a person as having been dealt with under the *Youth Criminal Justice Act* (which replaced the *Young Offenders Act*) may not be disclosable to the review board panel. In cases where such information is presented to the panel, the panel chair must determine whether or not the information is disclosable under the federal legislation. In order to make this determination, the panel chair should seek submissions regarding the admissibility of this evidence. If the panel chair determines the evidence is admissible, the panel chair should include a summary of the reasons for their decision to allow the evidence in the review panel's decision. The Board agreed and we closed our file.

Policy follows law, not the other way around

Ministry of Health

Sometimes unfairness occurs when the scope of a policy exceeds what is set out by law.

Several families complained to our office about residential care fees charged to their elderly loved ones. The health authorities were charging the maximum fees possible after the elderly residents became medically incapacitated and were unable to complete income tax returns. When families completed the needed income tax returns, the health authorities refused to adjust care fees.

Our investigation noted that the Continuing Care Fees Regulation authorizes residential care to charge a maximum of 80% of after-tax income. These complainants paid well in excess of that amount. As a result of our investigation, the health authorities fully reimbursed the residents the excessive fees paid for care.

We continued to investigate the Ministry of Health because their Home and Community Care Policy directed health authorities to refuse to adjust fees retroactively for the calendar year. Instead, health authorities were directed to adjust fees beginning in the month they received the Notice of Assessment, and not for the full calendar year. Noting the ministry's policy exceeded the limit of 80% of after-tax income set out in the Continuing Care Fees Regulation, we asked it to amend its policy to align with the Regulation. The ministry agreed and issued a new policy to ensure health authorities do not charge residents more than what is permitted under the law.

Sirens for change

Ministry of Finance

Providing a timely response to complaints is critical to avoid unnecessary escalation.

EARLY RESOLUTION

Mark was concerned about Revenue Services of BC's ambulance billing charges for his wife Kathleen. They received a bill for 28 ambulance rides, several of which Mark disputed, as well as a dishonoured payment fee. Mark tried raising his concerns with Revenue Services of BC and was informed they would investigate the issue, however he never heard back. Frustrated, Mark reached out to us for help.

We contacted the Ministry of Finance and asked if it could review Kathleen's ambulance billing charges.

We also asked staff to contact Mark and respond to his questions and concerns. In response, Mark received a call from Revenue Services of BC informing him that arrangements had been made to have BC Emergency Health Services complete a review of the ambulance charges. Following the review, Mark was provided with a detailed spreadsheet of all the ambulance charges and noted ten duplicate charges had been removed. Mark paid the remaining ambulance fees in full and confirmed that his complaint had been resolved.

LOCAL GOVERNMENT

What a nuisance!

City of Terrace

Procedures should be reviewed regularly to make sure they comply with regulations.

Richard complained to our office after he received a fine for $100 under the City of Terrace's (the City) nuisance bylaw about a pile of dirt in his driveway. Richard sent a dispute notice to the City but was concerned that the City had not forwarded the notice to the Court because the notice was handwritten and not signed by Richard. We confirmed that Richard was correct, the city had not forwarded the dispute notice.

Through the course of our investigation we determined that the *Community Charter* stipulated that handwritten notices were acceptable and that the City should have forwarded the matter to the Court for a hearing.

In response to our investigation, Richard was reimbursed $100 and the City agreed to review its procedures regarding ticket disputes to ensure they comply with stated regulations.

The steps to fairness

Township of Esquimalt

Fair decisions are ones made in accordance with applicable rules, laws and policies

Sam contacted our office with a complaint involving his local municipality. He felt that the Township of Esquimalt (the Township) had acted unfairly by removing a set of stairs located on a Township-owned boulevard fronting his property. Due to the difference in elevation between his property and the street, the stairs through the boulevard were the only way to safely access his house. When Sam complained to the Township, he was informed that he would have to replace the stairs at his own cost and build them in a different location.

Through the course of our investigation, we noted that Sam had expressed his concerns to the Township about the removal of the stairs both before and after they were removed. We also learned that the Township had acknowledged not only that a set of stairs within the boulevard was necessary but that there was a bylaw in place to allow for the stairs. There also had been no complaints about the stairs.

Considering there was no fair rationale provided to Sam, we asked the Township to consider re-installing the stairs in the boulevard at or close to their original location at the Township's expense. Mayor and Council agreed to fund the cost of a new stairway.

Flooded with high water bills

Mill Bay Waterworks District

Bylaws must take individual circumstances into account and be applied appropriately.

Claudette lived in a strata building and she and her neighbors had concerns about their high water bills. Claudette shared her water bills with us and explained that even though the strata consumed approximately the same volume of water per unit as a single-family dwelling, they were being charged a disproportionately higher cost per cubic foot of water in comparison with single-family dwellings.

We investigated the fairness of Mill Bay Waterworks District's water toll bylaw. We learned that indeed, those living in multi-family dwellings were being charged for most of their water at a higher rate without justification, which in our view was not equitable or fair.

We asked the District to amend the bylaw so that multi-family dwellings like Claudette's would be charged for their water consumption in the same way as single-family dwellings in the District. After receiving confirmation from the District that this amendment was made, we closed our file.

EDUCATION

Reopening a tuition refund claim

Ministry of Advanced Education, Skills and Training, Private Training Institutions Branch

It's important to let people present their side of the story before making decisions as often the customer is indeed, correct.

Peggy contacted our office to complain about the Private Training Institutions Branch (PTIB) because the PTIB refused to process her claim for a tuition refund. She was told that the program she was enrolled in was not an approved program under PTIB's governing legislation. However, Peggy was never informed by the training institution that she was enrolled in an unapproved program.

Upon investigating the file, it appeared that Peggy was correct and that some or all of the tuition amount she had paid to the training institution was for an approved program. As a result of our findings, the PTIB agreed to re-open the matter and reached out to Peggy for further details. With Peggy and the PTIB in contact and working towards a resolution, we ended our investigation and closed our file.

Transparency helps

School District 61 (Greater Victoria)

Providing clear reasons as well as detailed information about the process and the right to appeal is key.

Marisol contacted us with concerns about the process School District 61 followed in medically excluding her child, Jordan. Marisol disagreed with the decision but was unaware she could appeal the decision and said the District did not explain this to her. Marisol also said that the District undertook a Violence Threat Risk Assessment (VTRA) process about Jordan but the District did not provide her with any information about what the VTRA process was beyond letting her know that it would occur.

We investigated whether the District followed a reasonable process in excluding Jordan from school, including whether the District reasonably communicated with Marisol about the exclusion.

In speaking with the District, we noted that the District's letter to Marisol advised of the decision to exclude Jordan but it did not include information about her right to appeal the decision to the Board of Education. When we inquired about this gap, the district indicated its complaints policy and appeal process bylaw was available online and noted that it clearly outlined the steps required to appeal a decision. We explained the importance of providing information about a person's appeal or review rights with a decision.

To address this fairness concern, we asked the District to ensure that staff inform parents and guardians about the right to appeal a decision to medically exclude a child. The District accepted our recommendation to review and revise its written communications about and policy documents for medical exclusions.

We also spoke to the District about Marisol's concern that it did not provide adequate information about the VTRA process. The District explained that VTRAs are intended to assess risk to the school and that the school had a safety plan document that outlined the procedures to be followed in emergencies, including VTRAs as well as the requirement to provide fair notice to parents. We reviewed the safety plan document and noted that it explained when a VTRA may be necessary, but provided few details about what the VTRA process involved. Based on our review, it did not appear that there was District-wide, public-facing information about the VTRA process. In Marisol's case, although the District advised her that the VTRA would be conducted, we were concerned that it did not provide adequate information about the process. We were also not satisfied that the safety plan would have furthered her understanding of the situation had she known to review it.

We asked the District to resolve this concern by developing a District-wide, public-facing document about the VTRA process and to proactively provide it to parents/guardians when the process is undertaken with respect to their child.

The District agreed to our suggested resolution.

INCOME & BENEFITS

Auction avoided

Ministry of Social Development and Poverty Reduction

To make a well-informed decision all evidence and information must be gathered and reviewed.

Fanny contacted our office with a complaint that the Ministry of Social Development and Poverty Reduction (MSDPR) had denied their request for a moving supplement to cover the cost of storing their belongings. Fanny told us it was unfair because the ministry had previously indicated that it would pay for the storage of their belongings while they were hospitalized. Fanny explained that when they were released from the hospital, they found out the storage had not been paid for and without approximately $1,900 to pay the bill for storage, their belongings would be auctioned off within days.

The focus of our investigation was whether the ministry acted fairly when it considered Fanny's request for a moving supplement. We spoke with a manager about Fanny's situation who agreed to review Fanny's file. Upon review, the manager assessed Fanny as being eligible for storage costs as they were related to a move they had made earlier in the year. As a result, ministry paid the outstanding $1,900 bill to the storage provider and Fanny's belongings were returned.

With the fairness issue resolved, we ceased our investigation.

A misunderstood debt

Ministry of Social Development and Poverty Reduction

Fixing administrative errors can require multiple steps, including acknowledging a person's concerns.

Brian contacted us after learning the Ministry of Social Development and Poverty Reduction (MSDPR) had assessed that he owed a significant debt due to alleged overpayments made several years prior. Brian explained he had been receiving Persons with Disabilities (PWD) assistance from the ministry for several years before leaving Canada in 2018. When he returned the following year, the ministry reinstated his assistance, but a few months later Brian noticed a $20 deduction from his monthly assistance amount.

When Brian contacted the ministry enquiring about the deduction he was told it was a repayment for assistance overpayments made to him in 2016 and 2017. He later received a letter from the ministry notifying him about the overpayment and advising a debt of nearly $9,000 had been added to his file. The letter explained the ministry determined Brian had received payments he was not entitled because of income reporting errors.

Brian felt the ministry had not provided enough notice of the alleged overpayments or a reasonable explanation for how they had accrued. His attempts to address these issues through numerous contacts with the ministry were unsuccessful.

We investigated whether the ministry followed a reasonable procedure in responding to Brian's concerns.

After obtaining ministry records and speaking with several staff members, the ministry appeared unable to offer an adequate explanation for how it had determined Brian owed $9,000. We also questioned whether the ministry's communications with Brian about both the overpayment and in response to the issues he had identified were adequate in the circumstances.

The ministry subsequently agreed to conduct a review of Brian's assistance history. The review, which was expanded to include all of the years in which Brian had been a recipient, found numerous instances where the ministry had issued the incorrect amount of monthly assistance. The review concluded that while Brian had been overpaid nearly $6,000, he had also been underpaid approximately $3,000 by the ministry.

Some of the errors appeared related to Brian's reporting to the ministry. However, the ministry also acknowledged mistakes were made in how they had assessed his assistance entitlement. In such situations, the ministry may agree to waive debts a person accrues through no fault of their own. In Brian's case, the ministry concluded it would be appropriate to remove over $2,000 from the total overpayment amount, leaving him with a debt of only $900.

To resolve the complaint, we asked the ministry do a number of things, including:

- write a letter of apology to Brian and explain the payment issued identified in the review, including records the ministry relied upon in reaching its conclusions;
- invite Brian to meet to discuss the review; and,
- follow-up with individual ministry staff, and their supervisors, who contributed to the errors to provide them with relevant training to ensure similar issues do not occur in the future.

The ministry agreed, and we considered the fairness issues in Brian's complaint resolved.

Multiple barriers to fairness

Ministry of Social Development and Poverty Reduction

Sometimes processes are fair in one way, but unfair in another.

Jamie applied to the Ministry of Social Development and Poverty Reduction for a Persons with Disabilities (PWD) designation. He contacted our office because he was concerned there was a delay in the adjudication process.

The focus of our investigation was whether the ministry followed a reasonable process in adjudicating Jamie's PWD application. We contacted the ministry and obtained the records associated with Jamie's application as well as details about how the ministry responded to his attempts to raise his concerns.

Based on our review, it appeared that the ministry's process was fair. The records confirmed that after Jamie's application was received he had been informed about the ministry's service delivery timelines for PWD designation determination. In addition, the ministry forwarded Jamie's request to expedite the adjudication to a Supervisor.

However, through our investigation we discovered that in the same month that Jamie was approved for PWD, the ministry had determined he no longer qualified for a Person with Persistent Multiple Barriers (PPMB) designation and was issued a lower rate of assistance as an "employable" client instead. We pointed to the information the ministry had on its file, including reports provided by Jamie about his limitations on his ability to work due to health problems, his understanding that he would continue to receive assistance under the PPMB rate pending the outcome of his PWD application, and the ministry's stated policy purpose of the PPMB designation, which is to support clients transitioning to PWD. We questioned whether the ministry had adequately considered the information available to it.

The ministry agreed to review Jamie's file and determined he was eligible for the PPMB rate. An administrative underpayment equalling the difference between the "employable" rate and the PPMB rate for the month in question was then issued to Jamie. We considered this action taken by the ministry addressed the fairness issue identified through our investigation of Jamie's complaint.

A respite from unfairness

Ministry of Children and Family Development

A fair process demands that recognition of the unique needs of individuals be carefully considered.

Alice, a foster parent, had recently cancelled her foster home contract with the Ministry of Children and Family Development. She had been fostering a high needs youth until the end of her contract. However, Alice did not receive her final payment as expected after the contract ended. Alice called the ministry and was informed that payment could not be issued because there was a discrepancy between the amount of respite funding she requested and what was approved by the ministry. Unable to resolve the issue with the ministry and concerned about upcoming bill payments, Alice reached out to our office.

We investigated whether the ministry followed a fair and reasonable process for issuing Alice's final foster parent payment.

We spoke with ministry staff and obtained the ministry's records related to Alice's foster contract. The ministry explained that nearly $3,000 for fixed costs was still owed to Alice under the contract and this amount was not in dispute. However, there was a disagreement about the amount of respite funds owed because the amount Alice had claimed was more than what the ministry had pre-approved. This discrepancy seemed to be the reason why Alice's final payment was being held up.

Under the contract, Alice was provided $3,000 per month in respite funding and could request extra as needed. She had requested, and the ministry had approved, an additional $600 in respite funding for a total of $3,600. The ministry told us that Alice had claimed $4,600, $1000 over the amount that was pre-approved before the contract ended.

Based on our review, it was not clear why the ministry had not issued payment for the fixed costs. This amount was not in dispute and was not related to the respite payment issue. It was also unclear whether there was a process available to allow Alice to request approval for the additional $1,000 in respite funds retroactively as it looked like the service was completed while the contract was valid.

We discussed these questions with the ministry and were told that a process was not in place to consider retroactive requests of respite payments. However, in recognition of the high needs of the youth Alice fostered, the ministry agreed to review whether a one-time retroactive approval could be made in Alice's case. The ministry also agreed to issue Alice a cheque for the fixed costs on an expedited basis, acknowledging that the fixed costs should not have been withheld.

Subsequently, the ministry confirmed that they had considered and approved Alice's request for additional respite funding and that the payment was also processed on an expedited basis. We considered the actions of the ministry to settle the fairness concerns raised by Alice's complaint.

Delays that bite

COVID-19

Ministry of Social Development and Poverty Reduction

Miscommunication can lead to delays in getting fair service.

EARLY RESOLUTION

Gary, who uses a wheelchair, submitted a request to the Ministry of Social Development and Poverty Reduction (MSDPR) for a new bed because his was infested with bed bugs. He was sleeping on the couch and this was causing him a lot of discomfort. At the time, the residents of Gary's building were under a COVID-19 quarantine and MSDPR asked him to get in touch through his Third-Party Administrator once the quarantine was over. Following the quarantine, Gary contacted MSDPR and provided confirmation of the fumigation as requested. He then waited over two weeks before getting a response from MSDPR through his Third-Party Administrator that a second fumigation was required.

Unclear why a second fumigation was required and concerned about further delays, Gary contacted our office.

We contacted MSDPR to enquire about the status of Gary's request for a new bed as well as to ask what appeal or complaint processes were available to address his concerns about the delay and requirement for a second fumigation. After reviewing Gary's file, MSDPR advised us that there had been a miscommunication. The ministry did not intend for Gary to fumigate a second time, but rather had requested that he re-submit the original fumigation report because it was not attached to the file.

With the fumigation confirmed by the building's landlord, Gary's request for a new bed was approved and delivery was arranged by the ministry's supplier.

A failure to communicate

Public Guardian and Trustee

Offering clear and meaningful criteria regarding why decisions are made is something all public bodies should do.

Due to the volume of previous communications, Luke's communication with the Public Guardian and Trustee (PGT) was restricted to one phone call per week. The restriction impacted his ability to bring outstanding bill payments to the attention of his case worker and this was negatively impacting his credit.

Feeling like he was being treated unfairly, Luke called our office.

We investigated whether the PGT followed a reasonable process in implementing the restriction, including how it communicated the restriction to Luke.

The PGT's policy outlines procedures for implementing communication restriction plans. In the letter the PGT provided to Luke about the communication restriction, we noted it did not include any information about a timeline for review or how Luke could appeal the decision to impose the restriction. We also noted that fairness and transparency would be improved by including more information explaining the reasons why the restrictions were implemented. We recommended providing Luke with a brief but factual description of the behaviour that resulted in the restrictions.

The PGT acknowledged that the letter to Luke did not include the information specified in the policy and agreed to review the policy as well as our suggestions to include reasons for how and why the decision was made with staff. In Luke's case, after reviewing their file, the PGT decided to lift Luke's restrictions. The PGT also confirmed that Luke's outstanding bills had been paid and arranged for timely payment of bills going forward.

CHILDREN & YOUTH

Putting a relationship back on track

Ministry of Children and Family Development

Providing people with an opportunity to be heard and thoroughly understanding their complaints can prevent serious misunderstandings.

Denny, a youth in continuing care, was concerned about the conduct of his social worker and the amount of financial and other supports he was receiving from the Ministry of Children and Family Development. Denny had disclosed to his social worker that he was experiencing suicidal thoughts during a recent meeting and his social worker said it was "too much" and stood up to leave. Understandably, Denny was shaken by his social worker's reaction. An adult support worker who was also in attendance was similarly concerned and had tried to raise the issue with social worker's supervisor but had not received a response.

Denny felt he was not being heard by ministry staff and believed his support needs and mental health issues were not being respectfully or adequately addressed.

We investigated whether the ministry responded fairly to Denny's concerns.

We spoke to ministry staff and discussed the issues Denny had identified. In response to our investigation, the social worker's supervisor spoke with them about what had occurred during the meeting. Although it seemed there may have been a misunderstanding of what was said during the meeting, we were advised that steps would be taken to ensure that the social worker was made aware of communication expectations to ensure Denny felt acknowledged and appropriately supported. Following this discussion, the social worker spoke to Denny about the recent meeting and facilitated contact with mental health services for Denny.

The ministry also confirmed that they had spoken with Denny's adult support person about their concerns about the social worker's conduct and that a meeting was arranged for the following week to collaboratively discuss planning options.

We followed up with Denny and he confirmed he had attended the meeting and that it was a positive experience. There was now a Youth Agreement in place with the ministry and he was able to access the supports he needed. We were satisfied with the steps taken by the ministry to quickly address the concerns raised in Denny's complaint as it appeared that Denny was now feeling listened to and appropriately supported.

HOUSING

An unfair complaints process

Residential Tenancy Branch

A detailed response regarding steps taken to address a complaint is key to a fair complaints process.

Ravi complained to our office about a response he received after he filed a complaint with the Residential Tenancy Branch (RTB). Ravi felt the arbitrator was unprofessional during the dispute resolution hearing. The RTB told him it was conducting a confidential review of his complaint but due to privacy concerns the RTB would not disclose the nature or outcome of the investigation.

Ravi felt this lack of information was unfair and reached out for assistance in his case.

Through the course of our investigation, it became clear that there was an opportunity to improve information communicated to complainants following an investigation into RTB staff. Accordingly, we asked the RTB to consider whether it could disclose information about the steps taken to address a complaint without compromising personal privacy. We also asked the RTB to resolve Ravi's complaint by providing him with a clear response outlining the steps taken.

The RTB agreed to our request and committed to improving its communication to complainants. Importantly, the RTB provided Ravi with a more detailed response including the steps it took to address his complaint, the outcome of the investigation and offered him a formal apology for its earlier lack of response.

ENVIRONMENT

A flawed project

Ministry of Transportation and Infrastructure

Fairness means following through on all aspects of agreements made.

Trish lived in a small rural community and she contacted our office with concerns about what she believed to be an improperly installed culvert on private property. Trish had noticed pooling in the culvert and was worried about potential flooding and the risk of stream water infiltrating the ground and well water in the area.

In reviewing relevant documentation, we determined that most changes related to streams require approval by the Ministry of Forests, Lands, Natural Resource Operations, and Rural Development (FLNRORD) before projects begin, including culverts installed by the Ministry of Transportation and Infrastructure (MOTI). However, in Trish's rural community, the two ministries had a Memorandum of Understanding (MOU) allowing MOTI to begin certain projects without FLNRORD's pre-approval.

Our investigation revealed flaws with the culvert project. It didn't appear that the project met all the terms of the MOU. For example, an adequate environmental mitigation and monitoring plan had not been developed by the ministry prior to starting the project; changes to the width of the stream at the culvert appeared to increase the risk of sedimentation deposit and groundwater infiltration; and, it appeared MOTI delayed sharing details of the project with FLNRORD, which meant it was not audited according to the agreement.

For flawed projects such as the culvert in Trish's community, the MOU requires MOTI to propose a remediation plan to FLNRORD. In response to our investigation, MOTI proposed a plan to make changes to the stream channel at the culvert that would reduce the risk of sedimentation and groundwater infiltration thereby reducing the risk of stream water infiltrating the wells in the community. After consultation, the remediation plan was supported by FLNRORD and the work was completed.

Delays, delays and more delays

Ministry of Energy, Mines and Low Carbon Innovation

A case that led to a fair project being implemented and a new policy being drafted to ensure others don't experience similar challenges.

Tony applied to the Ministry of Energy, Mines and Low Carbon Innovation to take large mineral samples on behalf of his company. The ministry asked Tony to provide information not typically required for this type of project which meant he had to speculate on certain aspects of his project which he did not feel comfortable doing. After experiencing long delays, and concerned that his project was bring treated as a full-scale mining project and not just a sampling project, Tony contacted us.

The focus of our investigation was whether the ministry followed a fair and reasonable process in considering Tony's bulk sample application.

We reviewed records related to Tony's complaint and had numerous conversations with the ministry. Based on our review, the ministry agreed to a plan to help move Tony's project forward and provided him with clear direction on how the application process would proceed. The plan outlined, among other things, that the ministry would create an appropriate technical contract and would provide ongoing feedback as required to Tony's engineer. To prevent similar issues from occurring in the future, the ministry agreed to publish a new draft policy, an information document and a fact sheet for people like Tony who were doing large bulk samples.

A flood of concerns

Ministry of Transportation and Infrastructure

Persistence when raising complaints can significantly pay off.

For many years, the road by Walter's home and property would flood in the rainy season as a result of inadequate drainage. Walter contacted the Ministry of Transportation and Infrastructure (MOTI) on numerous occasions over the years in hopes of fixing the issue but nothing was ever done. With the floods happening more frequently and not getting answers from MOTI, Walter contacted us for assistance.

We contacted MOTI and reviewed records related to Walter's complaint and discovered that over the last 10 years, flooding on Walter's road had increased in frequency. During the last flood, the culvert was overwhelmed and the road could not be passed by vehicles.

As a result of our investigation, MOTI accelerated plans for a drainage study to assess options to mitigate the flooding. Additionally, MOTI confirmed it would conduct a sediment excavation from the existing drainage system to prevent further flooding while the drainage study options were reviewed.

TRANSPORTATION

Just be clear

Ministry of Transportation and Infrastructure

Clear, easy to understand and readily available information is important in responding to claims fairly.

Scott was out for a ride on his motorbike on a rainy day when he was in accident. He claimed the accident occurred in a work zone along a wooden bridge on a rural highway. When he filed his claim with the Ministry of Transportation and Infrastructure he indicated that he was concerned about the signage leading up to the work zone because there was nothing to alert motorists of the change in road surface from asphalt to wood. He received a letter from the ministry denying his claim. Unsatisfied with the response, Scott contacted our office.

In reviewing Scott's correspondence with the ministry, we found that there was limited information available about the review process and reasons for denying the claim. The ministry told us they had forwarded Scott's complaint to the contractor responsible for the area where the accident occurred. The contractor denied responsibility for the accident, indicating the signage met the applicable standards.

In response to Scott's concerns about the contractor's denial, the ministry requested the contractor's records. It further sought the advice of senior engineers to confirm that the work zone signage met the applicable standards and to determine whether warning signs to alert motorists on the bridge would have been beneficial. The engineers determined the signage was sufficient.

Based on our review, we had outstanding concerns that the reasons for the denial omitted references to the policies and standards relied upon to deny the claim. As a result of our investigation, the ministry agreed to improve instructions and guidelines for how contractors respond to claims. The ministry also agreed to use plain language, reference specific maintenance standards in their decisions, provide clearer details about the Freedom of Information process and share links to the ministry's general maintenance standards available through its website.

While Scott's own outcome didn't change, the claims response process will be better for others as a result.

CORRECTIONS

The problem came into focus

Ministry of Public Safety and Solicitor General, Kamloops Regional Correctional Centre

Administrative errors can lead to reimbursement and changes to an operating procedure.

While an inmate at the Kamloops Regional Correctional Centre (KRCC), Vince's wife, Wendy, mailed him his prescription eyeglasses. When the package arrived at KRCC, it was classified as contraband and returned to the sender. Wendy, however, never received the returned package. With the package now missing, Vince called us because he felt that the centre had treated him unfairly.

The focus of our investigation was whether KRCC followed a reasonable procedure by classifying the package as contraband, refusing to accept it and by attempting to return it to the sender.

We learned that KRCC's Standard Operating Procedure classified mail without a full name or return address as contraband and provided directions on how to handle such packages. In Vince's case, the KRCC explained the package was returned because Wendy had not included her name on the package. The package did, however, have a return address. We noted that the correction's network log indicated the return address, as written verbatim on the package, stated "General Delivery Kamloops".

We contacted Canada Post directly and were informed that General Delivery Addresses are typically used for smaller communities. Kamloops is the fourth largest city in British Columbia outside the Lower Mainland. Once at the station, Canada Post sorts General Delivery mail by Addressee or sender name and asks the sender to collect their mail at the station. Because Vince's package did not include a sender name there was no way for Canada Post to identify who the sender was.

In light of the above, we asked the KRCC to revise the Standard Operating Procedure to clarify that General Delivery Addresses require a sender name and to reimburse Vince so he could purchase new prescription eyeglasses. KRCC agreed and Vince was offered $300.

Searching for a fair outcome

Ministry of Public Safety and Solicitor General, Surrey Pretrial Services Centre

Sometimes minor procedure revisions can go a long way in ensuring people are treated fairly.

Mateo was moved from his living unit to segregation as a result of a fight he was involved in at Surrey Pretrial Services Centre (SPSC). Correctional officers packed and recorded the items in Mateo's cell before moving them to storage in segregation. However, when Mateo was released from segregation, he discovered that many of his items were missing. Mateo complained to SPSC but was told that his missing items had not been recorded when his cell was packed. As such, SPSC said it would not compensate him for belongings he said were missing because there was no evidence they were in his cell when it was packed and recorded.

Frustrated, Mateo reached out to us for assistance.

We investigated Mateo's concerns and reviewed SPSC's procedure. Based on our review, it appeared SPSC had complied with the procedure as it was written at the time. However, the procedure did not address concerns identified by our investigation of Mateo's complaint.

In response, SPSC updated its procedure on its own initiative. First, it directed its staff to ensure cell items are only stored in one storage area throughout the duration of an inmate's stay in segregation. Second, it directed its staff to ensure an inmate verifies their item record as soon as possible after being moved. We later requested SPSC direct its staff to check an inmate's bedding for items, a possible factor in Mateo's case, which it agreed to do.

Given SPSC's previous procedure had not addressed concerns identified by our investigation, we asked SPSC to reassess whether it would compensate Mateo for his missing items. SPSC agreed and ultimately reimbursed him $84.

Doubtful documentation

Ministry of Public Safety and Solicitor General, Vancouver Island Regional Correctional Centre

Questioning the reasons for a decision can lead public bodies to strive to meet best practice standards.

Steve was incarcerated at the Vancouver Island Regional Correctional Centre (VIRCC). He was frustrated to learn that VIRCC had decided not to take days off his sentence that he believed he had earned. Steve felt that he was being treated unfairly because he had not been provided with the chance to address and correct the issues that led to his earned days being withheld.

Not getting answers to his questions, Steve contacted us for assistance

We reviewed the relevant sections of the *Correction Act Regulation* as well as documentation of the incidents VIRCC had cited as the reason it withheld the days. We also questioned the adequacy of the documentation of the relevant incidents. In response to our concerns, VIRCC provided additional context regarding the challenging nature of Steve's living unit, including the new staff working on the unit at the time. VIRCC agreed with our findings that the record of the incidents did not meet the standards expected. Further, VIRCC did not have procedures in place to guide staff in documenting these types of incidents or in the remission determination process.

As a result of our review, VIRCC developed a procedure that incorporated best practices regarding such determinations, briefed its staff on the procedure and reassessed that month's determinations for individuals who had been affected, including Steve. This reassessment ultimately resulted in Steve receiving additional earned days off his sentence.

A nightly need

Ministry of Public Safety and Solicitor General, Prince George Regional Correctional Centre

Gaps in procedures can create significant harm.

Damon contacted our office with a complaint that his continuous positive airway pressure (CPAP) machine did not accompany him on a transfer to a federal correctional facility. He explained that despite receiving assurances from Prince George Regional Correctional Centre (PGRCC) staff that it would accompany him, when he reached the transitory correctional centre, the machine was not provided to him. As a result, Damon spent multiple nights without it suffering from the effects of severe sleep apnea.

During our investigation PGRCC explained that it didn't receive instruction from healthcare staff to ensure that the CPAP machine accompany Damon, and therefore treated the device as it would with any other personal property by forwarding it to Damon's final destination.

We questioned PGRCC's understanding of the need for individuals prescribed a CPAP machine to use it nightly and whether it had any procedures in place to assess whether prescribed medical equipment should accompany an inmate during a transfer. In response, PGRCC acknowledged that it did not have a procedure in place and committed to creating one, which they did.

With the implementation of this procedure, inmates prescribed a CPAP machine or other medical equipment will have that equipment accompany them when transferred out of PGRCC.

WORK AND BUSINESS

Reengineering a process

Engineers and Geoscientists BC

Fairness means providing clear and meaningful reasons for decisions to allow for a thorough understanding of the process followed and how the decision was made.

Matt complained to the Engineers and Geoscientists of BC (EGBC) alleging professional and ethical misconduct by one its members. When Matt's complaint was dismissed by the EGBC without an adequate explanation of why, Matt contacted us.

When we contacted EGBC they recognized that it could have done a better job of providing Matt with reasons for its decision. The EGBC explained that it would provide additional training to the Investigation Committee and investigative staff on the importance of providing complete reasons. This training included the discussion of improved closing letters which provide greater detail and explanation of the decision to close a file. EGBC also agreed to write a new letter to Matt with a detailed explanation of why his complaint against the member was dismissed.

Approved, but for what?

COVID-19

WorkSafeBC

During an emergency, providing adequate notice and detailed explanations is extra important.

Pierre had been injured at work and was pursuing a retraining program through WorkSafeBC. A few days before the program was to start, Pierre still had not received final approval or financial supports from WorkSafeBC as outlined in the program. Concerned that he would miss the start of the program, Pierre reached out to us.

Shortly after contacting us, and on the Friday before the training was set to start in a city 500km away from where he lived, Pierre received approval for the training. However, he was not provided with any explanation for what expenses would be covered nor was he given detailed information about his accommodation. Frustrated with the lack of information and worried that he would be required to share a room at a home-stay during the COVID-19 pandemic, Pierre contacted us.

Through our investigation we learned that the staff member responsible for Pierre's file had not provided him with a reasonable explanation for what training was approved and what expenses would accompany the training. In our consultation with WorkSafeBC, it acknowledged the challenges Pierre was facing and committed to making sure that he was financially supported during the retraining program. WorkSafeBC also indicated that it would provide clearer and more timely communication.

At the same time the hotel and course issues were sorted out, WorkSafeBC provided Pierre with $1000 to cover initial expenses while they continued to assess his expenditure needs moving forward. This was a stop-gap measure until final decisions were made. While there were a few initial hiccups Pierre was provided acceptable accommodation and the necessary financial support to assist with his retraining program.

Fairness, a meter at a time

BC Hydro

Addressing complaints expeditiously can save both time and money.

Becky had two BC Hydro accounts with separate meters – one for her house and one for her shop. Her shop meter was broken for a period of time but BC Hydro continued to charge her for consumption. When a BC Hydro technician arrived to exchange the shop meter, she asked if an analog meter could be installed. The technician did not have an analog meter but told Becky he could come back in a week to install one. Feeling like she wasn't getting anywhere with BC Hydro, Becky contacted us.

We contacted BC Hydro and were told that while the meter display was indeed broken and had been for some time, it was still drawing energy. BC Hydro advised us that it had conducted a full review of Becky's shop account and acknowledged that it had failed to address her broken meter display in a timely manner. BC Hydro adjusted Becky's billing so she was charged the minimum daily amount from the time the meter display broke to when she refused the meter exchange. As a result, Becky was credited $3,200.

With respect to the meter exchange issue, the BC Hydro technician's notes stated that Becky refused the exchange because she wanted an analog meter, not a smart meter. BC Hydro explained that all its technicians were aware that analog meters were no longer available for exchange and that it did not have any in stock. As such, BC Hydro was not willing to further adjust Becky's billing or waive the fees. Our investigation determined BC Hydro's position on this matter did not appear to be unreasonable.

Left in the weeds

Liquor and Cannabis Regulation Branch

Sometimes delays can have far-reaching impacts on others.

Li was experiencing problems with his application for a non-medical cannabis licence application.

Although Li's application had been initially screened by the Liquor and Cannabis Regulation Branch (LCRB) within a short time, he had yet to receive notice if it had been approved or not. Frustrated, Li called our office. Li told us that another applicant was ahead of him in the local government's ranking of potential retail cannabis stores. However, the other application was delayed by LCRB, and this delay was impacting Li's ability to open a cannabis store.

In speaking with the LCRB, we learned that some applications remained outstanding because the applicant had not provided all of the required documentation. The LCRB indicated that it prioritized complete applications, or applications where no outstanding documentation or information was required. We also learned that the LCRB had started to identify applications that did not meet eligibility requirements and it was in the midst of introducing a process to bring those outstanding applications to a conclusion by cancelling them in some circumstances.

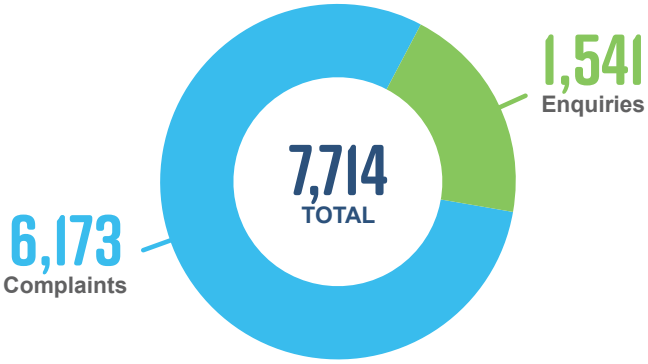
With respect of the other applicant, it did not appear that the LCRB had delayed considering the application. However, for confidentiality reasons, we were unable to share all of the details of the investigation with Li because they pertained to the other applicant.

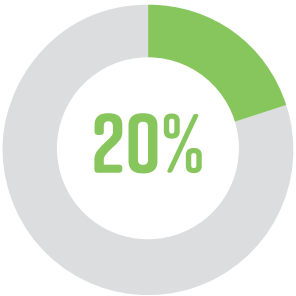
To settle the issue of potential delays in the application process, we proposed that the LCRB articulate in a written policy its process for applications that do not meet eligibility requirements because of missing, but required information. The LCRB agreed.

THE YEAR IN NUMBERS

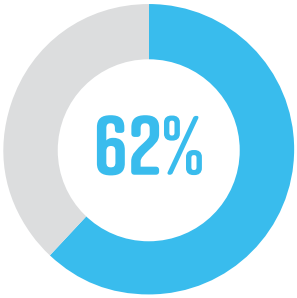
Ombudsperson Act by the Numbers

COMPLAINTS AND ENQUIRIES RECEIVED

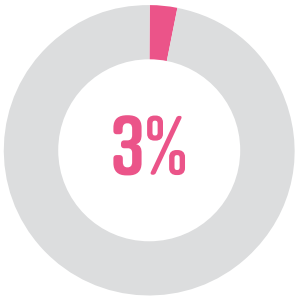




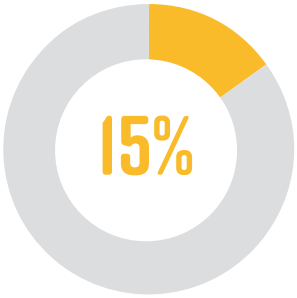
Enquiries



Complaints addressed and closed by Intake



Complaints assigned to an Early Resolution Officer



Complaints assigned to an Investigator

How We Received Complaints and Enquiries

69%

Phone

18%

Online

13%

Mail

0%

In person

(Due to COVID-19 office closure)

The Concerns People Contacted Us About

2,018
Decision or Outcome

1,453
Process or Procedure

931
Communication

685
Treatment by Staff

526
Delay

213
Review or Appeal Process

650
COVID-19

713
Other

315
Accessibility

173
Administrative Error

37
Employment or Labour Relations

Top Complaints and Enquiries by Public Authority

TOP 6 MINISTRIES

481

Ministry of Children and Family Development
(↓ **116** from last year)

419

Ministry of Public Safety and Solicitor General
(↓ **21** from last year)

301

Ministry of Health
(↑ **13** from last year)

286

Ministry of Social Development and Poverty Reduction
(↓ **297** from last year)

203

Ministry of Attorney General
(↓ **11** from last year)

164

Ministry of Finance
(↑ **56** from last year)

TOP 3 NON-MINISTRIES

491

ICBC
(↓ **43** from last year)

231

City of Vancouver
(↑ **135** from last year)

176

Fraser Health
(↑ **46** from last year)

Top 20 Authorities in 2020/2021

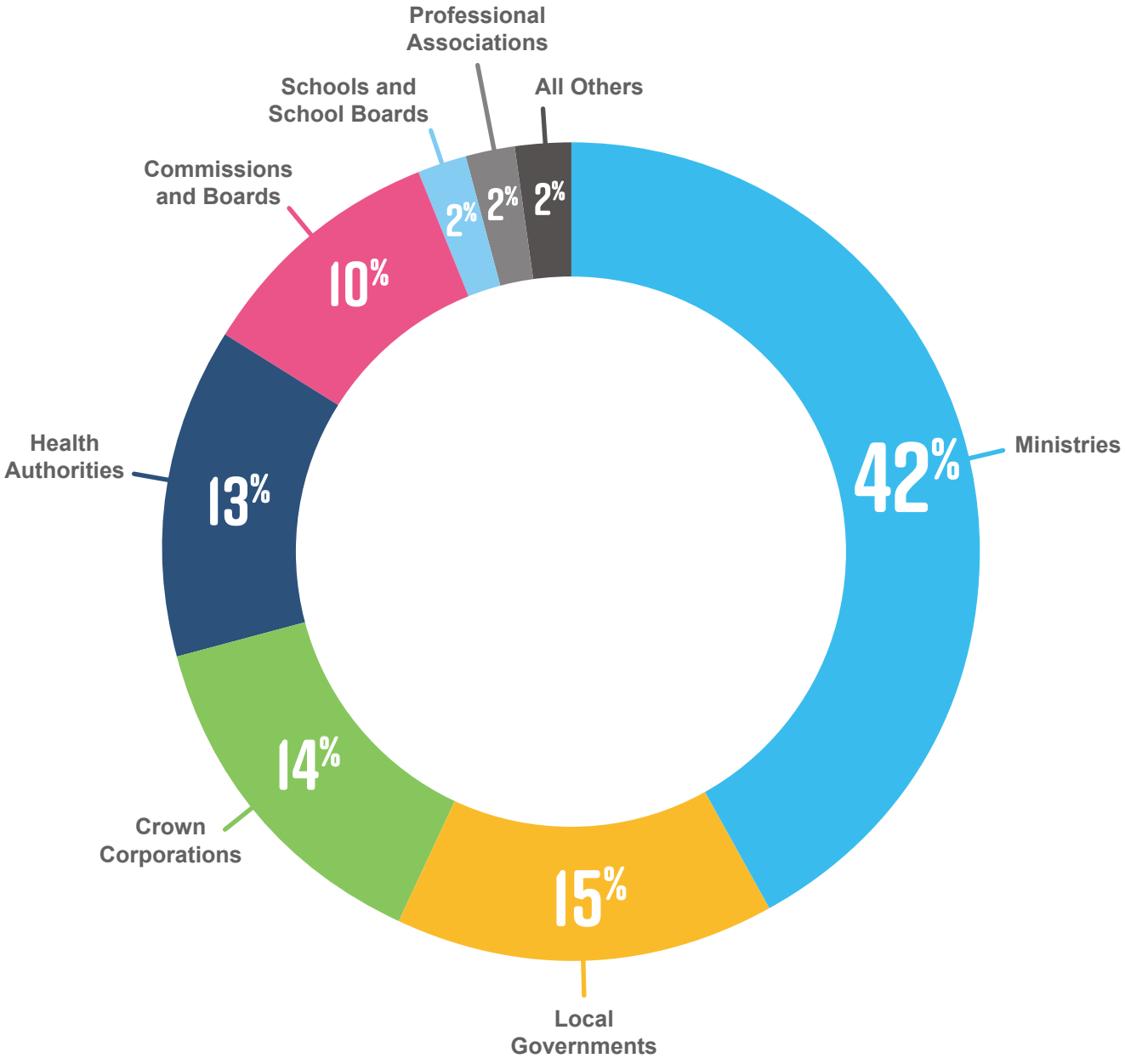
By Complaint and Enquiry Volume

Authorities	Complaints and Enquiries Received
ICBC	491
Ministry of Children and Family Development	481
Ministry of Public Safety and Solicitor General	419
Ministry of Health	301
Ministry of Social Development and Poverty Reduction	286
City of Vancouver	231
Ministry of Attorney General	203
Fraser Health	176
Vancouver Coastal Health	168
WorkSafeBC	165
Ministry of Finance	164
Island Health	140
BC Hydro and Power Authority	102
Provincial Health Services Authority	97
Interior Health	89
BC Housing	82
Ministry of Municipal Affairs	78
Public Guardian and Trustee	63
Law Society of British Columbia	53
Ministry of Education	43
Ministry of Forests, Lands, Natural Resource Operations and Rural Development	43
Total	3,875

COMPLAINTS AND ENQUIRIES RECEIVED ABOUT THE TOP 20 AUTHORITIES REPRESENT **50%** OF ALL COMPLAINTS AND ENQUIRIES RECEIVED

Jurisdictional Complaints and Enquiries Received

By Authority Category



Jurisdictional Complaints and Enquiries Received – By Authority Category

Ministries (42%)	
Children and Family Development	481
Public Safety and Solicitor General	419
Health	301
Social Development and Poverty Reduction	286
Attorney General	203
Finance	164
Municipal Affairs	78
Forests, Lands, Natural Resource Operations and Rural Development	43
Education	43
Other Ministries	163

Local Governments (15%)	
City of Vancouver	231
City of Victoria	31
District of Lantzville	25
City of Surrey	23
City of Burnaby	14
Regional District of Nanaimo	13
City of Prince George	12
City of Maple Ridge	11
Other Local Government	414

Crown Corporations (14%)	
ICBC	491
BC Hydro and Power Authority	102
BC Housing	82
Community Living BC	32
BC Assessment	18
Other Crown Corporations	16

Health Authorities (13%)	
Fraser Health	176
Vancouver Coastal Health	168
Island Health	140
Provincial Health Services Authority	97
Interior Health	89
Northern Health	23

Commissions and Boards (10%)	
WorkSafeBC	165
Public Guardian and Trustee	63
Human Rights Tribunal	27
Civil Resolution Tribunal	24
Legal Services Society	23
Motor Vehicle Sales Authority of BC	20
Workers' Compensation Appeal Tribunal	21
Coroners Service	19
Real Estate Council	19
TransLink	19
Other Commissions and Boards	118

Schools and School Boards (2%)	
School District 39 (Vancouver)	10
School District 36 (Surrey)	8
School District 43 (Coquitlam)	8
School District 44 (North Vancouver)	8
School District 62 (Sooke)	8
Other Schools and School Boards	51

Professional Associations (2%)	
Law Society	53
College of Physicians and Surgeons	25
College of Nurses and Midwives	12
Other Professional Associations	36

All Others (2%)	
Universities	46
Colleges	29
Parks Boards	6
Libraries	1

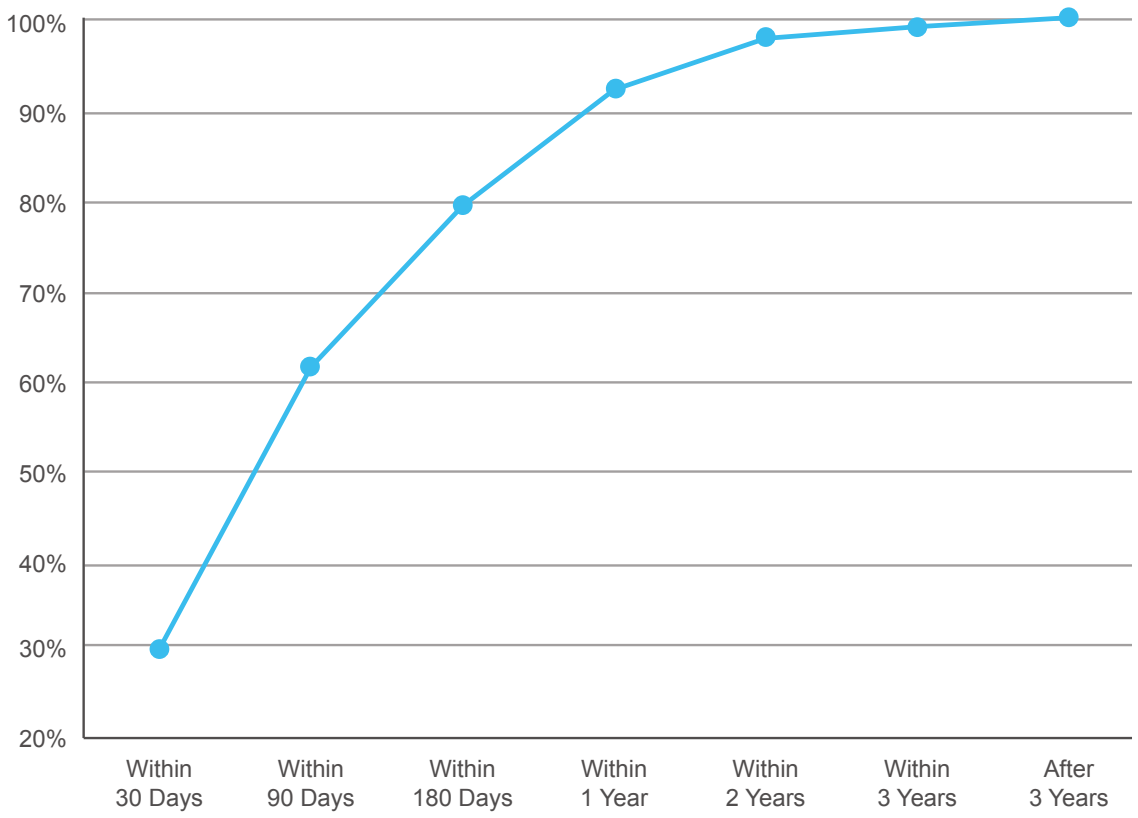
Complaints and Enquiries Received

By Electoral District

#	Electoral District	Received
1	Abbotsford South	41
2	Abbotsford West	21
3	Abbotsford-Mission	34
4	Boundary-Similkameen	114
5	Burnaby North	32
6	Burnaby-Deer Lake	31
7	Burnaby-Edmonds	40
8	Burnaby-Lougheed	23
9	Cariboo North	33
10	Cariboo-Chilcotin	20
11	Chilliwack	57
12	Chilliwack-Kent	31
13	Columbia River-Revelstoke	34
14	Coquitlam-Burke Mountain	21
15	Coquitlam-Maillardville	43
16	Courtenay-Comox	59
17	Cowichan Valley	80
18	Delta North	22
19	Delta South	25
20	Esquimalt-Metchosin	52
21	Fraser-Nicola	35
22	Kamloops-North Thompson	55
23	Kamloops-South Thompson	94
24	Kelowna West	61
25	Kelowna-Lake Country	52
26	Kelowna-Mission	41
27	Kootenay East	32
28	Kootenay West	60
29	Langford-Juan de Fuca	58
30	Langley	26
31	Langley East	48
32	Maple Ridge-Mission	36
33	Maple Ridge-Pitt Meadows	69
34	Mid Island-Pacific Rim	69
35	Nanaimo	52
36	Nanaimo-North Cowichan	41
37	Nechako Lakes	20
38	Nelson-Creston	59
39	New Westminster	60
40	North Coast	10
41	North Island	76
42	North Vancouver-Lonsdale	46
43	North Vancouver-Seymour	26
44	Oak Bay-Gordon Head	29
45	Parksville-Qualicum	78
46	Peace River North	29
47	Peace River South	22
48	Penticton	78
49	Port Coquitlam	95
50	Port Moody-Coquitlam	42
51	Powell River-Sunshine Coast	55
52	Prince George-Mackenzie	54
53	Prince George-Valemount	33
54	Richmond North Centre	11
55	Richmond South Centre	14
56	Richmond-Queensborough	19
57	Richmond-Steveston	23
58	Saanich North and the Islands	74
59	Saanich South	105
60	Shuswap	51
61	Skeena	29
62	Stikine	16
63	Surrey South	33
64	Surrey-Cloverdale	13
65	Surrey-Fleetwood	22
66	Surrey-Green Timbers	22
67	Surrey-Guildford	20
68	Surrey-Newton	15
69	Surrey-Panorama	84
70	Surrey-Whalley	57
71	Surrey-White Rock	31
72	Vancouver-Fairview	46
73	Vancouver-False Creek	61
74	Vancouver-Fraserview	28
75	Vancouver-Hastings	56
76	Vancouver-Kensington	30
77	Vancouver-Kingsway	33
78	Vancouver-Langara	25
79	Vancouver-Mount Pleasant	104
80	Vancouver-Point Grey	43
81	Vancouver-Quilchena	27
82	Vancouver-West End	46
83	Vernon-Monashee	59
84	Victoria-Beacon Hill	79
85	Victoria-Swan Lake	54
86	West Vancouver-Capilano	24
87	West Vancouver-Sea to Sky	54
	Total	3,862

Note: These numbers do not include enquiries and complaints where the electoral district could not be obtained.

Length of Time to Close Investigative Files

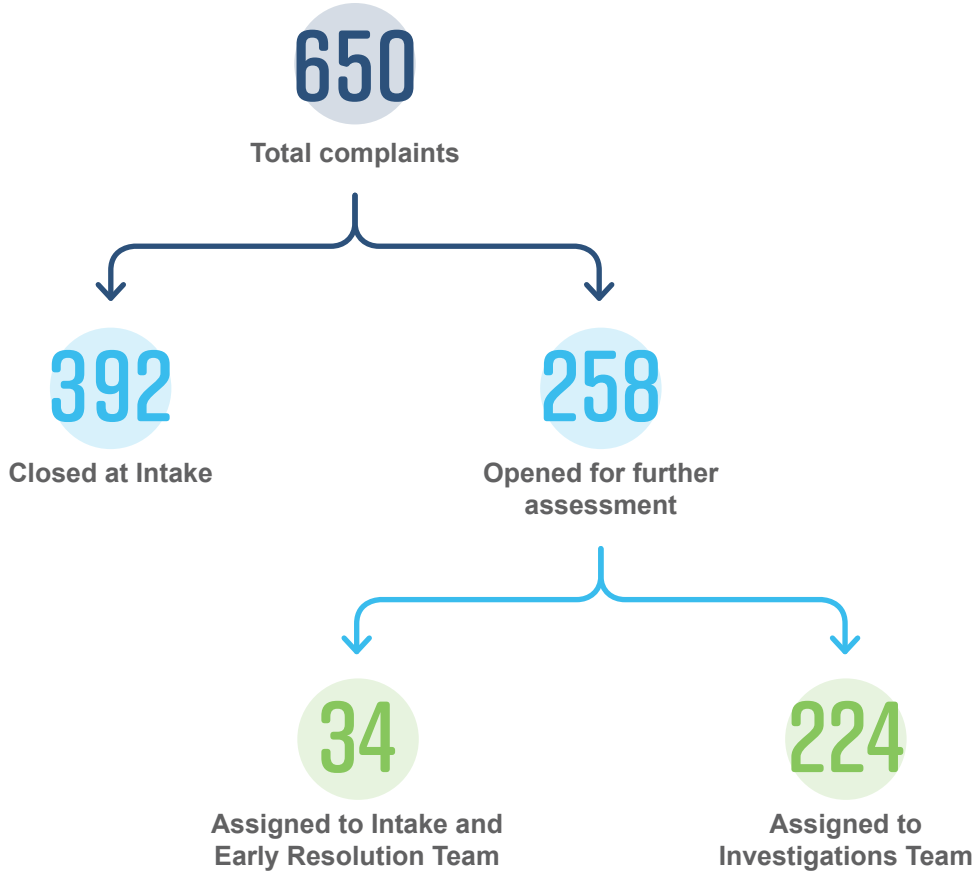


	2020/2021*		Cumulative Closures %
Closed in 30 Days	281	30%	30%
Closed in 31 to 90 Days	295	31%	61%
Closed in 91 to 180 Days	168	18%	79%
Closed in 181 Days to 1 Year	122	13%	92%
Closed in 1 to 2 Years	53	6%	98%
Closed in 2 to 3 Years	13	1%	99%
Closed in more than 3 Years	9	1%	100%

* *Elapsed time does not include time before a matter is assigned to an investigator*

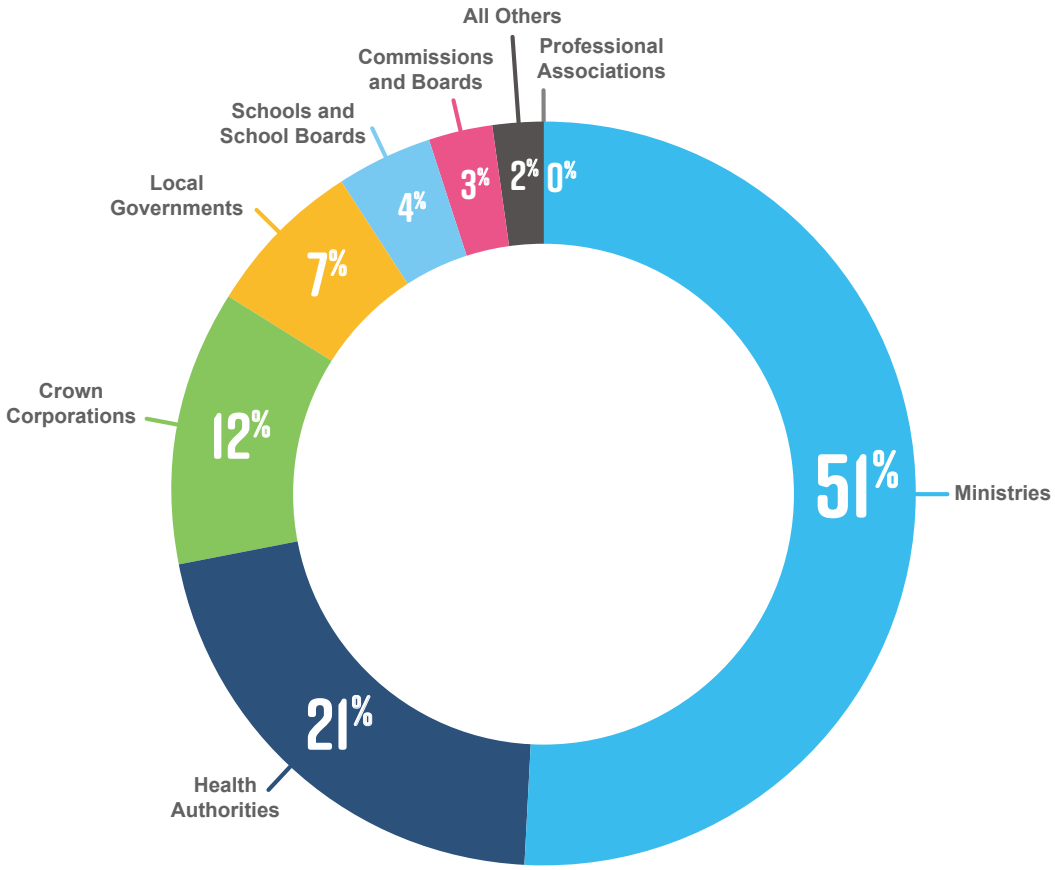
COVID-19 DATA SPOTLIGHT

COVID-Related Complaints Received in 2020/21



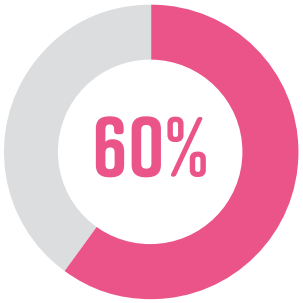
COVID-Related Complaints Received

By Authority Category

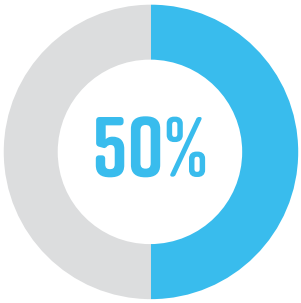


Percent of Complaints That Were COVID-19 Related

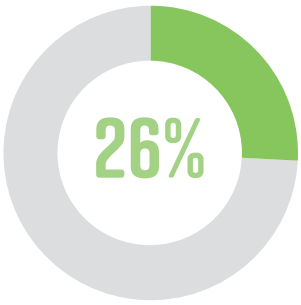
By Authority



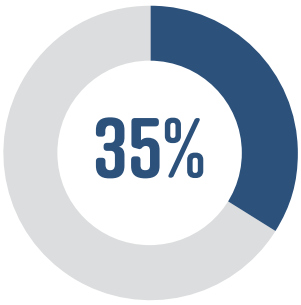
Ministry of Finance



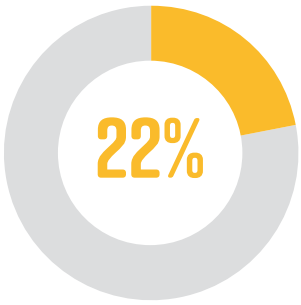
Ministry of Education



Health Authorities



Ministry of Health



Ministry of Public Safety and Solicitor General

Topics Most Complained About

By Authority

COVID-19 Issues Most Complained About by Authority or Sector

135
Health Authorities

- Residential care complaints
- Access restrictions
- Home Support

82
Ministry of Public Safety and Solicitor General

→ Adequacy of COVID-19 precautions within correctional centres

75
Ministry of Finance

→ Pandemic benefits such as the BC Recovery Benefit, Temporary Pandemic Pay and Emergency Benefit for Workers

63
Ministry of Health

- Provincial health emergency restrictions
- Vaccination plan
- Care/visit restrictions

PIDA by the Numbers

118
Enquiries and Reports Received

- **37** general enquiries
- **25** requests for advice
- **46** disclosures
- **10** reprisal complaints

58
Disclosures dealt with
46 disclosures reported this fiscal year + 12 carried forward from previous fiscal year (11 for assessment and 1 investigation)

- **20** about organizations not under PIDA
- **38** about public bodies under PIDA
  - **20** declined for investigation
    - **11** allegations did not meet threshold for wrongdoing
    - **5** allegations related to an employment dispute
    - **2** not enough information provided
    - **2** not an employee of a public body covered by PIDA
  - **10** investigations conducted
    - **2** discontinued because matters already appropriately investigated
    - **1** completed
    - **7** in progress at year end
  - **8** disclosures at year end under assessment

PIDA by the Numbers, continued

10
Reprisal reports dealt with

- **6** about organizations not under PIDA
- **4** about public bodies under PIDA
  - **3** declined because allegations did not meet threshold for reprisal
  - **1** reprisal reports at year end under assessment

Public Interest Disclosure Report for the Office of the Ombudsperson

There are two avenues for reporting wrongdoing under the *Public Interest Disclosure Act* (PIDA) – within an employee's organization or externally to the Ombudsperson.

For Ombudsperson employees disclosing wrongdoing about the Office of the Ombudsperson, that external option is the Office of the Auditor General.

PIDA requires that the Office of the Ombudsperson, as a public body covered by the Act, report the number of disclosures that it has received. PIDA also requires the Ombudsperson to report the number of disclosures received by the Auditor General about the Ombudsperson's office, if the Ombudsperson has been notified of those disclosures.

For the reporting period of April 1, 2020 to March 31, 2021, the following information was reported:

Section 38(1)	
Disclosures of wrongdoing in respect of the Office of the Ombudsperson:	0
Section 38(2)	
(a) the number of disclosures received, including referrals of disclosures:	0
and the number acted on:	0
and not acted on:	0
(b) the number of investigations commenced as a result of a disclosure:	0
(c) in the case of an investigation that results in a finding of wrongdoing	0
(i) a description of the wrongdoing,	
(ii) any recommendations, including those made by the Auditor General, and	
(iii) any corrective action taken in relation to the wrongdoing or the reasons why no corrective action was taken;	
(d) any other information prescribed by regulation	0

SPEAK UP. YOU CAN MAKE A DIFFERENCE.

STAFF AND FINANCES

OMBUDSPERSON'S LONG SERVICE AWARDS

The Ombudsperson recognizes dedication to the office each year for staff who reach milestones of service with the Office of the Ombudsperson. This year, the following staff members were recognized by the Ombudsperson with long service awards for achieving milestones during 2020/21.

5 years

Keir Bertram
Charisse Giarraputo
Anne Horan
Sarah Malan

20 years

Brad Cambrey

25 years

Jennifer Bertsch

OUR STAFF

The following were employed by the Office of the Ombudsperson as of March 31, 2021.

Agnello, Alexander
Anderson, Krysty
Andrew, Jolene
Barlow, Ross
Bertram, Keir
Bertsch, Jennifer
Biscoe, Chris
Blackman, Linda
Blakeman, Candice
Bockus-Vanin, Alycia
Bruch, Elizabeth
Byrne, Wendy
Cambrey, Brad
Cannon, Laurel
Cavers, Stewart
Chalke, Jay
Chapman, Matthew
Charles-Roberts, Rachel
Chunick, Carly
Clarke, Bruce
Closson, Yvette
Cobby, Emma
Cox, Maegan
Darling, Sara
Davis, Harrison
Devonshire, Jasmine
Downs, Dustin
Edgar, Oliver
Engbers, David
Evans, Lisa
Gardner, Victor
Garnett, Andrew
Giarraputo, Charisse
Gingras, Leoni
Gormican, Erin
Graham, Rebecca
Gray, Elizabeth
Green, Jaime
Green, Matt
Greschner, John
Haska, Christina
Henderson, Mark
Hillsburg, Heather
Hintz, Elissa
Hlady, Janice
Horan, Anne
Hunt, Lindsay
Jackson, Zoë
Jeakins, Katherine
Jones, Jennifer
Kaga, Midori
Kitt, Brittany
Lapthorne, Jonathan
Lopez Ramos, Sergio
Lyder, Róisín
Macmillan, Zoë
Mais, Julia
Malan, Sarah
Matheson, Deidre
May, Andrea
McCarthy, Jill
McMillan, Christina
McPherson, Colin
Milligan, Sarah
Morgan, Glenn
Morris, Christine
Morrison, Kathleen
Moss, Michael
Murray, David
Ogroske, Susan
Oldham, Lindsay
Osmond-Jones, Nick
Paradiso, David
Paul, Nathan
Perkey, Debora
Pollock, Julie
Presnail, Megan
Purewall, Jaspreet
Railton, Crawford
Skinner, Della
Slanina, Sarah
Sparks, John
Stewart, Megan
Thompson, Calvin
Trahan, Stacy
Van Swieten, David
Vossen, Julia
Warren, Rachel
Welsh, Megan
Wiltse, Heather
Yanisch, Carol

Co-op Students

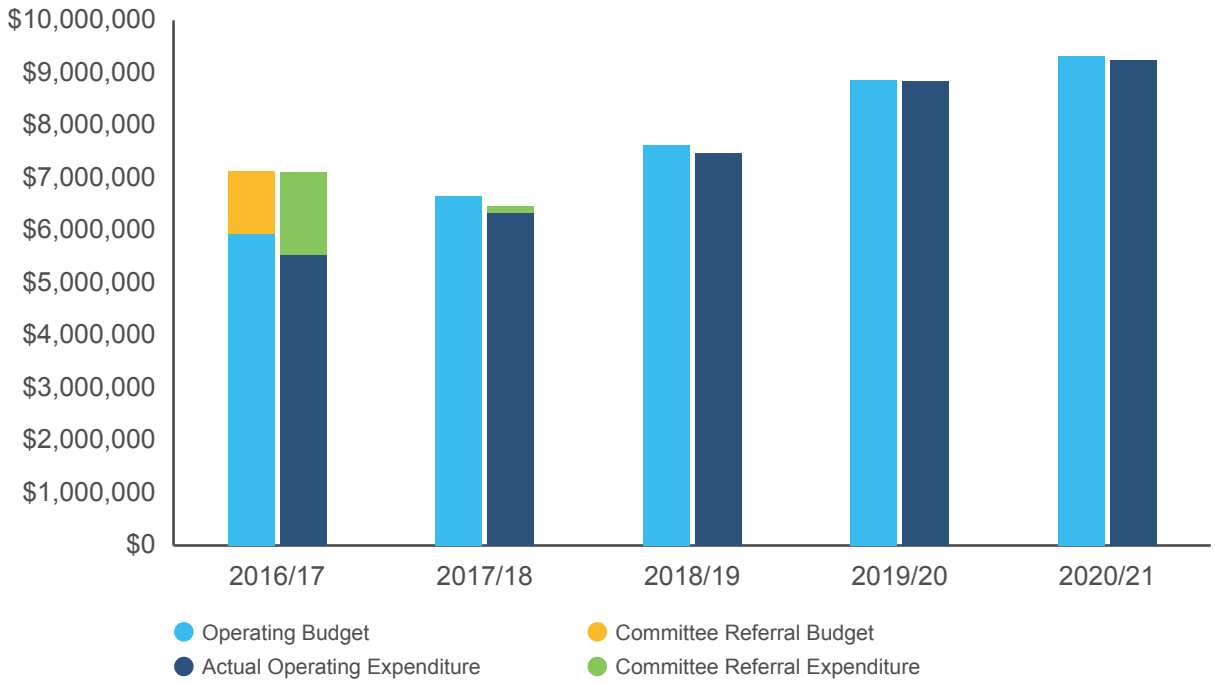
Co-op students joined the Office for four-month terms between April 1, 2020 and March 31, 2021.

Cheema, Hardeep
De Almeida, Steven
Fitzgerald, Daisy
Foster, David
Hodgins, Dorothy
Massigham, Hailey
Mjekiqi, Erza
Prosser, Andrew
Uganec, Zack

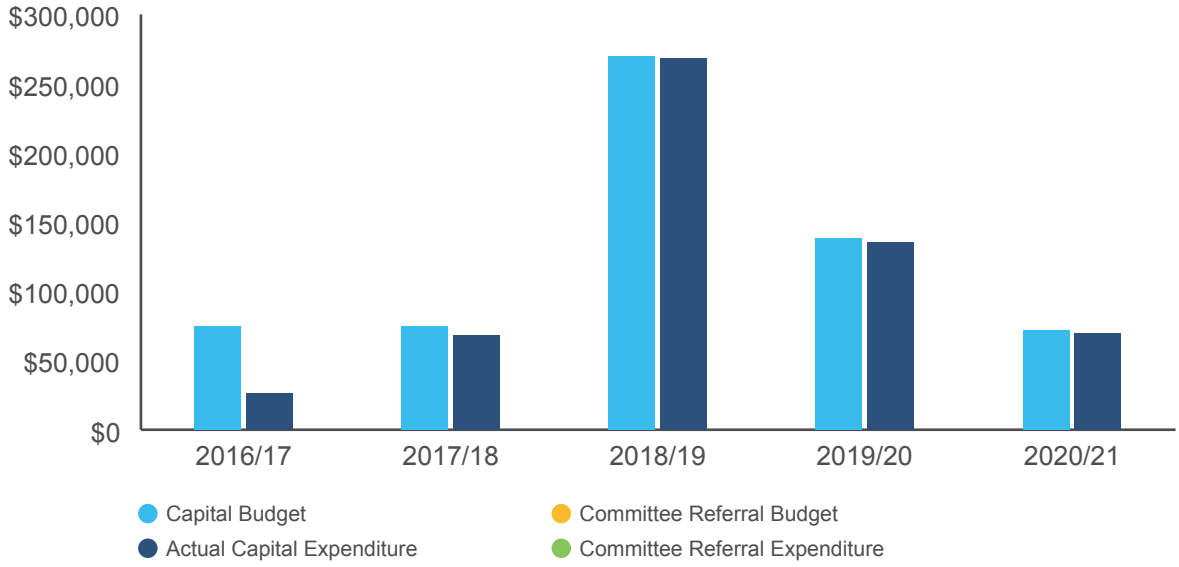
OUR FINANCES

The 2020/2021 annual operating budget for the Office of the Ombudsperson was $9,366,000.

Operating Budget to Actual Expenditures by Fiscal Year



Capital Budget to Actual Expenditures by Fiscal Year



CASE SUMMARY AUTHORITY INDEX

BOARDS AND COMMISSIONS

CROWN CORPORATIONS

LOCAL GOVERNMENTS

PROVINCIAL GOVERNMENT MINISTRIES

SCHOOLS AND SCHOOL BOARDS

HEALTH AUTHORITIES

PROFESSIONAL ASSOCIATIONS

MAIL:

PO Box 9039 Stn Prov Govt
Victoria BC V8W 9A5

TELEPHONE:

Victoria: 250.387.5855
Toll-free: 1.800.567.3247
Fax: 250.387.0198

EMAIL:

info@bcombudsperson.ca

IN PERSON:

2nd Floor • 947 Fort Street • Victoria BC

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@BCOmbudsperson
BC Ombudsperson

OMBUDSPERSON
BRITISH COLUMBIA