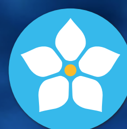
ANNUAL REPORT 2024/25



OMBUDSPERSON
BRITISH COLUMBIA

As an independent officer of the legislature, the Ombudsperson investigates complaints of unfair or unreasonable treatment by provincial and local public bodies 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.

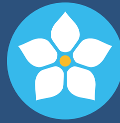
Under the *Public Interest Disclosure Act* (PIDA) the Ombudsperson investigates allegations from current and former public sector employees of wrongdoing in or relating to a public body covered by the Act as well as complaints of reprisal.

The Ombudsperson has a broad mandate to investigate allegations of wrongdoing or complaints of reprisal involving provincial ministries, provincial boards and commissions, Crown corporations, health authorities, schools and school boards, and colleges and universities. A full list of the public bodies covered by PIDA can be found on our office's website. The Office of the Ombudsperson also provides advice to those public bodies and their employees about the Act and the conduct of wrongdoing investigations.

We offer educational webinars, workshops and individual consultation with public bodies to support fairness and continuous improvement across the broader provincial and local public sector.

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

Our office is located on the traditional lands of the Lək̓ʷəŋən (Lekwungen) People and ancestors and our work extends across the homelands of the First Nations Peoples within what we now call British Columbia. We honour the many territorial keepers of the lands and waters where we work.



OMBUDSPERSON
BRITISH COLUMBIA

November 2025

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 2024/25 Annual Report to the Legislative Assembly.

The report covers the period April 1, 2024 to March 31, 2025 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

Mailing address: PO Box 9039 Stn Prov Govt • Victoria, BC V8W 9A5
Phone in Victoria: 250-387-5855 • Toll-Free: 1-800-567-3247 • Fax: 250-387-0198 • bcombudsperson.ca

CONTENTS

Message from the Ombudsperson 2

WHO WE ARE AND WHAT WE DO 4

Our role. 5

How we help 5

2024/25: Year at a glance 6

FAIRNESS IN ACTION: *OMBUDSPERSON ACT* 7

How we served people in BC. 8

Fairness across sectors 15

- Housing and affordability 16
- Health and health care 24
- Transportation, infrastructure, and environment. 36
- Local government 42
- Justice. 50
- Services for children, youth, and vulnerable adults 60
- Employment and professional associations 68
- Education 74

FAIRNESS IN ACTION: *PUBLIC INTEREST DISCLOSURE ACT* 78

Strengthening integrity in the public service 79

Five years, seven phases: PIDA implementation 80

PIDA Day. 85

Case summaries 86

2024/25: YEAR IN NUMBERS 114

Ombudsperson Act by the numbers 115

Public Interest Disclosure Act by the numbers 120

CASE SUMMARY INDEX 123

MESSAGE FROM THE OMBUDSPERSON

For more than 45 years, the Office of the Ombudsperson has been the independent voice for fair and accountable public services in British Columbia.

In times of change, when public systems can feel unpredictable or difficult to navigate, our role has remained the same: to ensure people in British Columbia have somewhere to turn if they have been treated unfairly by provincial and local public bodies. We are there to provide information, carry out impartial investigations, identify instances of public administration unfairness, propose remedies and redress, and thus ensure accountability across British Columbia's provincial and local public sector.

This past year has shown just how vital that role is. The challenges people face are increasingly complex. Rising costs continue to stretch household budgets, housing remains scarce and expensive, and health care systems are under strain. Newer forces – from the aftermath of COVID-19 and the shift to remote work, to the rise of AI and automated decision-making – are adding instability and uncertainty to the public systems people rely on every day. Too often, people are left navigating unclear services or inconsistent decisions at moments when they are most in need of help.

And in these moments, people in BC come to us. One family contacted us after going weeks without heat or hot water because of a miscommunication about an emergency benefit. Another woman living with food insecurity was told her income assistance cheque would be withheld until she produced a new identification card – a card she didn't have. And a person in custody was kept in segregation without legal authority. In each case, our intervention made the difference between hardship and relief.

More and more people are seeking our help. This year, we received 7,307 enquiries and complaints – almost 350 more than last year. Use of our online Complaint Checker increased by 60%. This online resource provides people with 24/7 guidance and allows our staff to focus on the most complex cases. Together, these numbers show the demand for our services is even greater than traditional complaint volumes alone would suggest. Meeting this need requires more than resolving unfairness in individual cases. It requires addressing the root causes of unfairness in public administration – so people don't face the same barriers from public bodies again and again.

That is why our systemic work is so important. I'm grateful that many public bodies and their employees are committed to fairness and act on the recommendations we make. But too often we see the opposite: recommendations rejected without explanation or

agreed to in principle but left unimplemented. I urge public bodies to remember that the work of an ombudsperson is not about assigning blame – instead, it's about finding solutions that make public services work better for everyone.

To strengthen this accountability, I have long called for our public reports to be automatically referred to a legislative committee for hearing, as already occurs for the reports of the Auditor General and the Representative for Children and Youth. Such hearings would give legislators the opportunity to examine our findings, hear directly from affected ministries or public bodies, and ensure that recommendations receive the attention they deserve. This practical, cost-effective step would bring increased rigour to public bodies' responses to our oversight system, increase transparency, and help ensure that when problems are identified, solutions are followed through.

Especially now, when pressures on the public sector are so acute, the people who turn to us need public bodies to engage meaningfully with our recommendations – and for legislators to have the tools to hold them accountable. By strengthening legislative oversight in this way, we can help ensure that improvements are practical, lasting, and fair.

This past year also marked the completion of the seven-phase implementation of the *Public Interest Disclosure Act* (PIDA) that started in 2019. With nearly 200 provincial public bodies now covered, more than 325,000 current employees and thousands of former employees have whistleblower protection in British Columbia. In an environment where rapid change, new technologies, and shifting workplaces can increase risks of wrongdoing, PIDA provides a safe and reliable way for public employees to speak up – strengthening accountability across the public sector at a time when it matters most.

This report reflects both the challenges people in BC are facing and the real improvements that can be made when fairness guides decision-making. In an era of constant change and uncertainty, the safeguards our office provides offer stability for both the public and public sector employees. Like carefully stacked stones that stand firm despite shifting conditions, fairness provides the balance people can rely on.

Thank you to the people of British Columbia for placing your trust in this office by bringing your concerns about the fairness of public administration to us for investigation. And thank you to the members and staff of the legislature for your ongoing support. To public bodies and public sector employees, thank you for your commitment to fairness. To the dedicated staff of this office, thank you so very much for your commitment to assisting those who need us, to upholding our key values of independence and impartiality and to holding public bodies to high standards of service excellence. The work of the office will continue with integrity and independence.

Jay Chalke
Ombudsperson
Province of British Columbia

WHO WE ARE AND WHAT WE DO

OUR ROLE

Everyone has the right to be treated fairly and equitably by their government and the public services they rely on. We provide people in BC with a way to raise their concerns when public systems aren't working as they should.

Our work is grounded in two provincial laws:

- The *Ombudsperson Act*, which empowers us to investigate complaints from the public about unfair treatment by provincial and local public bodies, conduct systemic investigations, and make recommendations to improve services
- The *Public Interest Disclosure Act* (PIDA), which protects current and former public sector employees covered under the Act who report serious wrongdoing in their workplaces

Together, these mandates ensure that everyone in BC – whether they are members of the public or public sector employees – has somewhere impartial and independent to turn when fairness is at stake.

HOW WE HELP

Each year, thousands of people contact us for help – seeking answers, solutions, and accountability from provincial and local public bodies. Through listening, early resolution, and impartial investigations, we make sure public services are delivered fairly and help public bodies fix problems before they grow.

Here's how we do that:

Listen and assess: We hear every enquiry and complaint, and help people understand their options.

Refer or resolve: If another organization is better placed to help, we connect people directly. If an issue can be resolved quickly, we work toward an early resolution.

Investigate: For complex or systemic concerns, we conduct impartial, in-depth investigations. We gather evidence, hear from everyone involved, and identify unfair practices.

Recommend change: When we find unfairness, we recommend solutions and monitor public bodies to make sure improvements are made.

2024/25: YEAR AT A GLANCE

7,307 enquiries and complaints under the *Ombudsperson Act*

390 **fairness resolutions** accepted by public bodies following our recommendations

26 **fairness workshops** delivered to 1,272 public sector employees

3 most complained about public bodies:

Ministry of Social Development and Poverty Reduction

ICBC

Ministry of Children and Family Development

303 enquiries, advice requests, and disclosure reports received under the *Public Interest Disclosure Act*

62,200 **employees** newly protected under PIDA

27 **new public sector bodies** covered by PIDA

Over 5 years of PIDA:

325,500 current **public sector employees** now have rights under PIDA

public bodies covered by the Act

FAIRNESS IN ACTION: *OMBUDSPERSON ACT*

HOW WE SERVED PEOPLE IN BC

This past year, our work under the *Ombudsperson Act* continued to be guided by the seven strategic goals outlined in our 2021/26 Strategic Plan:

1. Deepen our connection with the public
2. Enhance and modernize our services
3. Expand our investigative impact on fairness in public services
4. Help public authorities to prevent unfairness before complaints arise
5. Support implementation of whistleblower protections across the broader public sector
6. Advance and support Reconciliation through our work with Indigenous Peoples
7. Be an inclusive, supportive and engaged workplace

These goals keep us focused on outcomes that matter to people in British Columbia: better access to fair public services, stronger accountability, and lasting improvements to the way public bodies serve the people of this province.

Now in the final year of this plan, we are building on what we've achieved and are looking ahead to the next strategic framework. The following pages show how we put these goals into action in 2024/25, delivering results that respond to today's challenges while preparing us for the work still to come.

Listening and resolving quickly

Our Intake team is the first point of contact for anyone seeking help. Every call, online form, or letter is a chance to make sure people feel heard, understand their options, receive helpful referral information, or have their matter assessed for investigation.

In 2024/25, we:

- handled 12,000+ calls from people across BC
- heard and referred 1,416 enquiries to other services or resources
- handled 3,890 complaints about unfair public services
- resolved 14% of jurisdictional complaints through early resolution, helping people get answers quickly
- heard from people in a variety of ways: phone (65%), online complaint form (26%), mail (9%), and in person (1%)

Many people also start their journey with us online through our Complaint Checker, an interactive tool on our website that helps people determine if their issue is within our authority and provides guidance on next steps. In 2024/25, the Complaint Checker was used nearly 60% more often than the year before. For many people, it offers immediate answers without needing to call, and it helps our staff focus their time on the most complex complaints. The growing use of the Complaint Checker reflects a growing interest among the public in using digital tools to pursue fairness in public services.

Digging deeper to ensure fairness

When a complaint can't be resolved quickly, or a deeper look is needed, it's assigned to one of our three complaint investigation teams. Our investigators gather evidence, interview witnesses, review policies and procedures, and assess whether public bodies have met administrative fairness standards.

In 2024/25:

- 39% of complaints (1,318 in total) were assigned to investigations
- When, following our impartial investigations, unfairness was identified, we worked with public bodies to propose solutions – often resolving issues without needing formal recommendations
- We also commenced two systemic investigations, published three report updates, and are currently tracking 92 recommendations arising from 12 public reports to ensure that public bodies follow through on their commitments (further details on each report are included in the 'Fairness across sectors' section of this report, starting on page 15)

Connecting communities to fairness

Unfair services can be resolved by us only if people know we exist and trust our work. Our outreach and engagement efforts seek to ensure that people across BC – especially those who face barriers to accessing public services – know where to turn when something goes wrong.

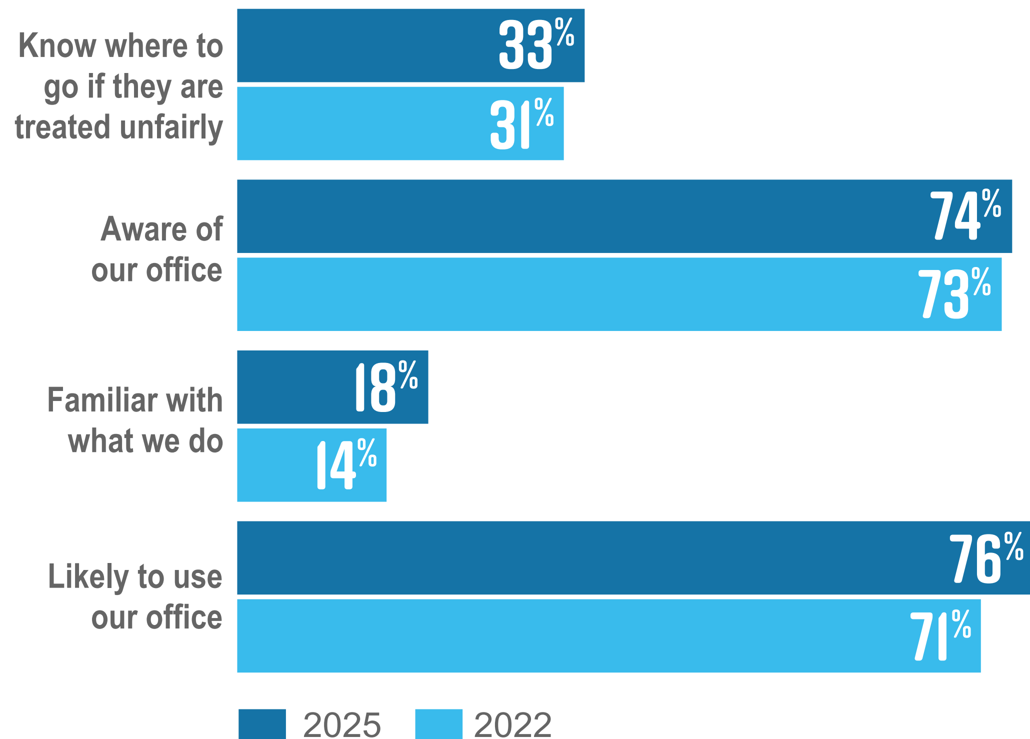
In 2024/25, we focused on building out our sustainable outreach strategy, guided by community input and research. We:

- sought input from community-serving organizations to help assess the accessibility of our Complaint Checker, brochures, website, and other public-facing resources
- connected with key audiences at events like Inclusion BC's Everybody Belongs! conference and the Housing Central Conference
- hired a dedicated community liaison to strengthen relationships and create an ongoing presence, especially in underserved communities
- engaged a social evaluation expert to help measure our impact and find ways to best reach the people who need us

Safeguarding fairness for people and families helps strengthen communities across BC.

In March 2025, we surveyed 1,503 people in BC about their awareness of our office. The survey results help us to better understand who knows about our services, how familiar they are with what we do, and where we need to raise awareness so people can access help when public systems fail.

The results show that our outreach efforts are moving awareness in the right direction. But there's more we can do to make sure people in BC – particularly those most affected by unfair decisions – know where to turn for help. Continued outreach will help to close those gaps.



Awareness is the first step toward fairness. If people don't know their rights or where to turn, they can't access help when systems fail.

Removing barriers to fairness

We are committed to making our services accessible to all people in BC. Building on our outreach efforts and guided by our Accessibility Plan, we work to identify and remove barriers so people living with disabilities can fully and equitably engage with our office. This means improving both how we deliver our services and how we design the spaces, materials, and policies that support them.

A few examples from this past year include:

- building relationships with disability-serving organizations to better understand service gaps and barriers
- delivering internal training to our staff and updating internal policies to strengthen trauma-informed service delivery for the public
- improving physical access to our office building based on recommendations from an accessibility audit
- when investigating complaints about access to public services, we consider whether the public body is subject to the *Accessible BC Act*, and any standards, commitments, or human rights considerations that are relevant in assessing whether the person has been treated fairly

Advancing Reconciliation through our work

Building trust with Indigenous Peoples, First Nations communities, and Indigenous-serving organizations is central to our mandate. Guided by our multi-phase Indigenous Communities Service Plan (ICSP), we move at the speed of trust in relationship-building and are focused on ensuring that our services are culturally safe, trauma-informed, and distinctions-based.

In 2024/25, we:

- published Phase 2 of the ICSP, outlining steps to deepen collaboration with Indigenous Peoples
- strengthened relationships by connecting with 50+ First Nations and 45+ Indigenous-serving organizations, including the First Nations Health Authority, First Nations Justice Council, BC Association of Aboriginal Friendship Centres, and First Nations Public Service Secretariat
- attended community events, including the Seabird Island Festival, Indigenous Disability and Wellness Gathering, Gathering Our Voices Conference, and First Nations Leadership Gathering
- expanded Indigenous cultural competency training across our office, ensuring culturally safe and trauma-informed services from staff
- heard 481 enquiries and complaints about public services from Indigenous people, with 81% of complaints about public bodies we can help with (compared with 66% overall)
- collaborated with the Nisga’a Lisims Government, at its request, to help enhance fairness when it receives complaints about its services or those of Nisga'a village governments

Our responsibility is to approach every connection with humility, respect and openness – ensuring that First Nations and Indigenous Peoples know they are heard and supported when seeking fairness.

Guiding public bodies toward fair practices

Preventing unfairness before it happens is a core part of our work. Through training, resources, and consultations, we help public bodies integrate fairness into their policies and practices.

In 2024/25, we:

- designed and delivered four post-secondary workshops to 200 faculty and staff across BC
- hosted 22 Fairness in Practice workshops, attended by 929 participants, with 14 workshops tailored to specific public bodies
- published seven updated fairness resources for use across the public sector
- managed 16 consultations, helping public bodies strengthen fairness in their practices

"Your handouts and resources are in a league of their own. I refer to them daily to improve our procedures, communications and mindset and approach to interacting with the people we serve."

– Public sector employee

FAIRNESS ACROSS SECTORS

Fairness concerns can arise anywhere people interact with public services. Each year, our office reviews the enquiries and complaints we receive to identify trends and opportunities for improvement across sectors – from housing and health care to education and local government.

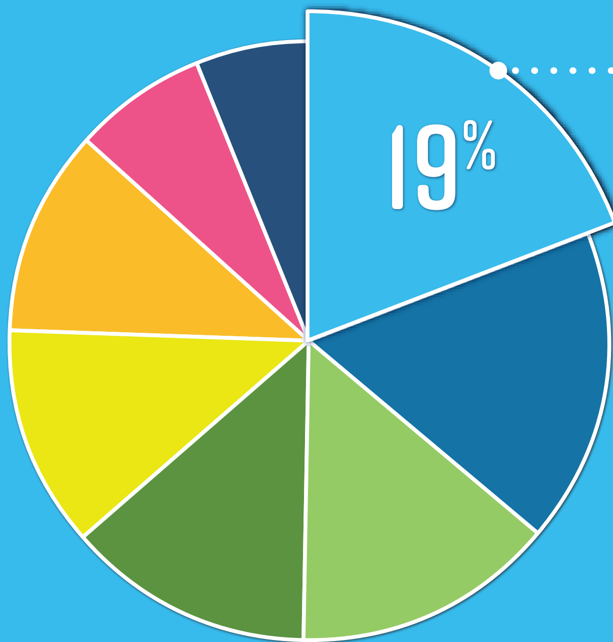
By categorizing and analyzing emerging themes, we can see where people most often experience unfairness and what those patterns may reveal about how public systems are functioning. This helps us focus our investigative work, share insights with public bodies, and recommend practical solutions that make a lasting difference.

In the pages ahead, we break down complaints from 2024/25 across eight key sectors:

1. Housing and affordability
2. Health and health care
3. Transportation, infrastructure, and the environment
4. Local government
5. Justice
6. Services for children, youth, and vulnerable adults
7. Employment and professional regulation
8. Education

Each section highlights the proportion of total enquiries and complaints received, key trends in our data, and examples of how our investigations and resolutions helped resolve issues of unfairness.

Names have been changed to protect people's privacy.
Photos are for illustrative purposes only.



HOUSING AND AFFORDABILITY

Access to housing and essential supports is critical for people in British Columbia, especially for those living on low or fixed incomes. Many of the complaints we receive are from people who rely on government programs for food, shelter and basic needs. In these circumstances, even small administrative errors, like a miscalculated subsidy or a delayed payment, can create serious disruptions, putting people at risk of losing housing or going without essentials. Responding to these issues – often in urgent situations – remains one of our highest priorities, ensuring that people who depend on these programs are treated fairly and can count on public systems to work as they should.

Highlights from 2024/25

- In December 2024, we launched an investigation into how the Ministry of Social Development and Poverty Reduction (MSDPR) distributed income and disability assistance cheques during the Canada Post strike (which began on November 15, 2024), after hearing concerns that vulnerable ministry clients could be left without funds for food and shelter.
- We offered feedback to BC Housing on its draft guidance document to help non-profit housing providers develop fair complaint-handling policies and procedures.
- We participated in the Housing Central Conference in Vancouver, connecting with community organizations, sharing information about our services, and learning more about the issues people face navigating housing and affordability programs.

Trends and data

In 2024/25, we received nearly 1,000 enquiries and complaints about housing and affordability. The four most complained-about public bodies were:

- Ministry of Social Development and Poverty Reduction: 481
- Ministry of Housing and Municipal Affairs: 192
- Ministry of Finance: 113
- BC Housing: 101

All four ranked among the 20 most complained-about public bodies last year, with the Ministry of Social Development and Poverty Reduction (MSDPR) being the single most complained-about public body overall.

Looking more closely:

- Most (189) housing-specific complaints we heard about involved the Residential Tenancy Branch, with 132 complaints from tenants and 49 from landlords.
- Complaints about BC Housing involved its registry and waiting list, as well as its rent subsidy program, particularly around how subsidies were calculated.
- MSDPR complaints reflected its role in serving the province's most vulnerable people. The most common issues involved:
  - crisis and employment supplements
  - applications and eligibility for income assistance, Persons with Disabilities benefits, and Persons with Persistent Multiple Barriers assistance
  - shelter allowance disputes
  - third-party administration issues, including service restrictions and bans

CASE SUMMARIES

The following are examples of complaints we handled in 2024/25 related to housing and affordability.

A crisis in the making

Ministry of Social Development and Poverty Reduction

The complaint: Abi, who received income assistance from the Ministry of Social Development and Poverty Reduction (MSDPR) contacted us for help when MSDPR decided to hold her income assistance cheque until she was able to provide BCeID. Abi had been receiving income assistance for several years, and believed this new requirement was unfair.

The investigation: Because Abi was unhoused and experiencing food insecurity, we considered her complaint urgent and contacted MSDPR. We were told Abi had an appointment for her BCeID in four days and MSDPR would release her cheque at that time. We raised fairness concerns with this response, noting the delay would leave Abi without money for food. We proposed instead that MSDPR provide her with emergency funds, called a crisis supplement, to cover the cost of food until her BCeID appointment and her full cheque was released.

The outcome: MSDPR agreed with our proposal and issued Abi a crisis supplement.

Why it matters: Administrative processes should never create unnecessary hardship. For people already struggling to meet basic needs, a small delay can mean going hungry. This case shows how flexible, reasonable solutions can prevent further harm.

When incomplete advice blocks fairness

Ministry of Finance

The complaint: Hal received a letter from the Ministry of Finance stating he was not entitled to a homeowner grant and owed $5,000. In disagreement, Hal asked the ministry if he could submit an appeal by fax or email. He never received a clear answer from the ministry and, as a result, missed the deadline to appeal.

Later, the ministry told Hal he could apply for a refund for one-year's worth of the homeowner grant. But when he tried, the ministry told Hal the refund was no longer available. Frustrated, Hal complained to our office.

The investigation: We looked into whether the ministry responded reasonably to Hal. The ministry said its letter to Hal included instructions on how to appeal by mail. But we found that when Hal asked about his options, the ministry only told him that sending his appeal by mail likely would not arrive in time. The ministry did not tell Hal he could also fax or courier his appeal. By not sharing all relevant appeal options, the ministry impacted Hal's ability to appeal the decision on time.

The outcome: The ministry agreed to train staff about how appeals can be submitted. It also issued Hal a one-year refund.

Why it matters: When people want to appeal a government decision, they must be given clear and consistent information about how to do so. If staff provide incomplete advice, people can lose their right to challenge a decision – even when they are entitled to do so. Ensuring appeal processes are clear and accessible protects fairness and accountability.

Crisis connected

Ministry of Social Development and Poverty Reduction

EARLY RESOLUTION

The complaint: Cheyanne applied to the Ministry of Social Development and Poverty Reduction (MSDPR) for urgent financial support, called a crisis supplement, to cover the cost of reconnecting her FortisBC natural gas service. At first, she was told her application was approved. But due to a miscommunication between MSDPR and FortisBC, she later learned it had been denied. After a week without heat or hot water, Cheyanne reached out to our office for help.

The investigation: Because Cheyanne was living with her daughter and four grandchildren – and the family had no heat or hot water – we asked MSDPR to urgently review her file. We also asked MSDPR to contact Cheyanne directly to explain her eligibility and discuss immediate options for reconnecting her utilities.

The outcome: MSDPR reassessed Cheyanne's application and confirmed she was eligible for the crisis supplement. MSDPR issued the requested funds to FortisBC, and Cheyanne's natural gas was reconnected and her heat and hot water was restored.

Why it matters: In urgent situations, delays or mixed messages can have serious consequences. Clear communication and timely action are essential to ensure people in crisis are treated fairly and can access the supports they are entitled to.

Accommodations are a part of fairness

Residential Tenancy Branch

The complaint: Vigo, who lives with disabilities and has low literacy, struggled to use the Residential Tenancy Branch’s (RTB) website to submit evidence and web forms. He also found it difficult to understand the dispute resolution process. When he called the RTB for help preparing for his hearing, he felt his accessibility concerns weren’t addressed.

The investigation: We reminded the RTB that it has an obligation to accommodate people with disabilities and to make sure everyone can fully participate in hearings.

The outcome: The RTB agreed to write Vigo an apology for his negative experience. It also updated its website to make the information about requesting accommodations more accessible and created a new policy on accessibility and reducing barriers to participation.

Why it matters: Fairness means recognizing that not everyone has the same needs or abilities. Public bodies must work to eliminate barriers so that people with disabilities, low literacy, or experiencing other barriers can fully participate and have their voices heard.

Delays in moving assistance put safety at risk

Ministry of Social Development and Poverty Reduction

EARLY RESOLUTION

The complaint: Meesha left an abusive relationship and was worried about the safety of her pets and the belongings she had to leave behind. She applied to the Ministry of Social Development and Poverty Reduction (MSDPR) for moving assistance but her application was delayed. Even when an advocacy agency followed up on her behalf, they did not receive a response.

The investigation: Because of the urgency of Meesha's situation, we immediately contacted MSDPR to make sure her request was reviewed.

The outcome: MSDPR reviewed and approved Meesha's request and provided her with moving assistance.

Why it matters: When people are leaving unsafe situations, delays in support can put them at further risk. Timely responses to urgent requests help people secure safe housing and move forward without additional hardship.

Setting the jurisdiction straight

BC Financial Services Authority

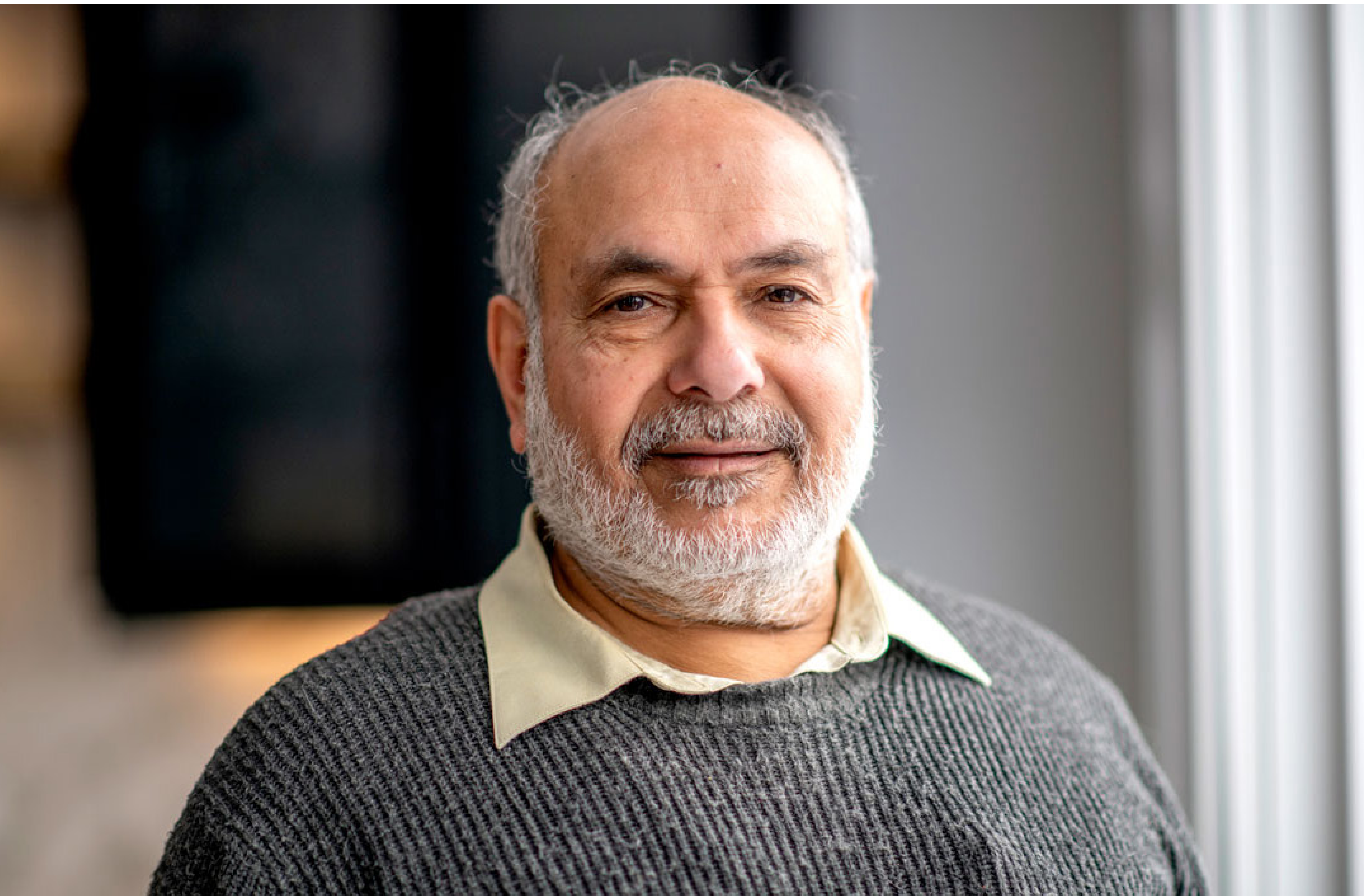
The complaint: Farid complained to the BC Financial Services Authority (BCFSA) about the developer and listing agent of a property he purchased. One of his concerns was about the listing agent's behaviour, which he said was inappropriate.

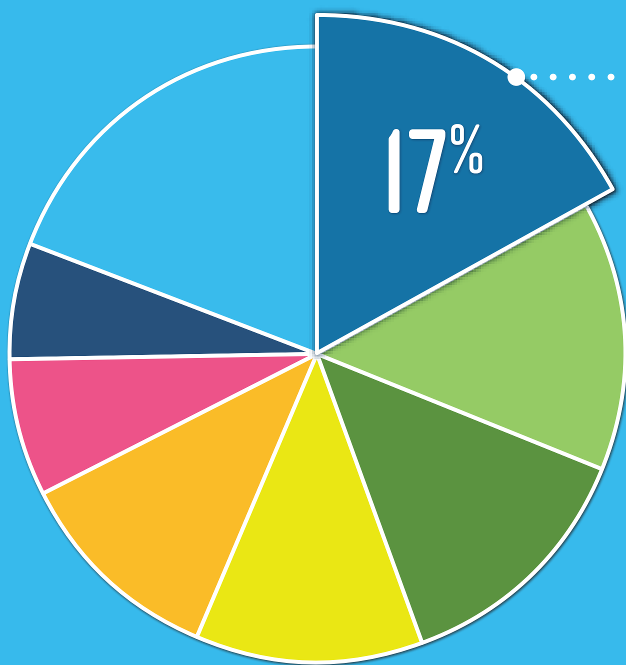
Ten months after Farid made his complaint, the BCFSA sent him a letter declining to investigate. Farid felt the BCFSA had not adequately considered the evidence he provided. He also found their explanation for not investigating to be confusing; the BCFSA had told Farid it did not investigate complaints about agents' behaviour, which Farid did not think was correct.

The investigation: We looked at whether the BCFSA's 10-month delay was reasonable and whether it gave Farid adequate reasons for its decision not to investigate. The BCFSA told us that, since Farid's complaint, it had taken steps to reduce its complaint processing times. It also explained that while it does oversee complaints about agents' behaviour, the behaviour must reach a level that is considered "unbecoming." In this case, it said the agent's behaviour did not meet that threshold. This clarification was helpful but we shared our concern that it had incorrectly told Farid it could not investigate complaints about behaviour at all.

The outcome: The BCFSA agreed to remind staff of their ability to investigate complaints about "conduct unbecoming" to ensure accurate responses in the future.

Why it matters: People rely on regulatory bodies to give clear and correct information. If staff of those regulatory bodies misunderstand their own authority, complaints risk being dismissed unfairly. Making sure staff know and accurately communicate their jurisdiction protects fairness for everyone who raises a concern.





HEALTH AND HEALTH CARE

Health care remains one of the top areas we hear about. Many of the complaints we receive involve gaps in communication, unclear decisions about care, or problems with the way policies are applied in hospitals and mental health services. Our goal is to make sure people get clear answers, resolve issues quickly, and have confidence that health authorities and ministries are treating them fairly.

Highlights from 2024/25

- In November 2024, we visited the Forensic Psychiatric Hospital in Coquitlam and St. Paul's Hospital in Vancouver to build relationships with service providers and raise awareness about how our office can help patients.
- In March 2025, we met with the Independent Rights Advisor Service (IRAS), an organization created so people detained and experiencing involuntary treatment under BC's *Mental Health Act,* understand their legal rights and how to exercise them. IRAS was established by provincial law in response to a key recommendation from our 2019 report, *Committed to Change*. Since its creation, we have built and maintained a strong, collaborative relationship with IRAS so people receiving involuntary care have access to the information and support they need.

Trends and data

In 2024/25, we received 861 enquiries and complaints about health and health care – the second most complained-about sector last year. Top public bodies mentioned were:

- Provincial health authorities: 675
- Ministry of Health: 151

The most common issues involved:

- hospital services, including acute care
- mental health and substance use services, including access to treatment
- quality of care concerns
- involuntary admissions under the *Mental Health Act*

CASE SUMMARIES

The following are examples of health and heath care-related complaints we handled in 2024/25.

Right information, too late

Vancouver Island Health Authority

The complaint: Cindi's mother went to the emergency department with signs of a stroke. She later received medication, but there was a dosage error. Her condition worsened and she passed away a few weeks later. Cindi was concerned about the care her mother received and complained to Vancouver Island Health Authority's (Island Health) Patient Care Quality Office (PCQO). She felt its response did not adequately address her concerns and contacted our office for help.

The investigation: We looked into Island Health's handling of Cindi's complaint. We learned that her mother's care had been reviewed by Island Health's Safety Committee, but those findings were not shared with Cindi because Island Health determined they were protected from disclosures under the *Evidence Act*. About a month after she made her complaint, however, an Island Health staff member informally told Cindi by email that she could take her concerns about medical misconduct to the BC College of Physicians and Surgeons and the BC College of Nurses and Midwives. Regardless of whether Island Health was able to share the results of their review with Cindi, its staff should have provided her with this referral information much earlier – and in a clear, formal way.

The outcome: Because of our investigation, the PCQO developed and documented a process for referrals when complaints include medical practice concerns. The PCQO now will:

- offer to forward the practice concern to appropriate leadership for follow up with the health professional
- tell the person about Island Health's obligation to refer serious concerns to the appropriate regulatory body for investigation
- ensure the person receives referral information early in the complaint process

Why it matters: When people raise serious concerns about medical care, they need clear guidance on where to turn. Delays or informal communication can leave families feeling dismissed at a time when they most need support. Formal referral processes help ensure people know their options.

"Thank you for this invaluable information and your care and consideration with our case. I know your office helps a lot of citizens with issues of injustice and it is truly needed and appreciated in these times of change."

– Member of the public

Time is vital

Vital Statistics Agency

EARLY RESOLUTION

The complaint: Lian applied for a birth certificate through the BC Vital Statistics Agency (Vital Statistics) after his daughter was born. Because of technical difficulties with the online system, Lian had to submit a manual application in person. Several weeks later, there was a medical emergency in Lian's family. He needed to travel internationally but without his daughter's birth certificate, he couldn't apply for her passport. Lian contacted Vital Statistics and discovered his application had been misplaced. Although it was eventually found, he was told it would still take weeks before the birth certificate could be issued. Frustrated, Lian asked us for help.

The investigation: We contacted Vital Statistics and explained the urgency of Lian's situation.

The outcome: Vital Statistics called Lian the next day to let him know that his daughter's birth certificate had been expedited and was ready for pickup.

Why it matters: For urgent, time-sensitive matters like travel for a family emergency, delays in vital records can have serious impacts. Ensuring applications are processed quickly and accurately gives families confidence they can rely on these services when it matters most.

Finding a fair path to care

Ministry of Health – Health Insurance BC

The complaint: After moving back to BC, Darius applied for health insurance. He provided his old BC health number, ID, and proof of heath care coverage from another province. However, despite these documents, Health Insurance BC (HIBC) declined to process Darius' application because he couldn't provide proof of his immigration status in Canada. Darius contacted Immigration, Refugees and Citizenship Canada for confirmation of his permanent resident status but was told the process could take nine months. In the meantime, Darius was in urgent need of a prescription refill and a doctor's care, so he contacted our office for help.

The investigation: We reviewed Darius' file and determined that the documents he submitted did not meet HIBC's requirements, even though he had previously held BC coverage. However, we also identified that HIBC can provide up to six months of temporary coverage to people who need urgent medical attention, like Darius. We asked HIBC to grant Darius interim coverage while he waited for confirmation of his permanent resident status.

The outcome: HIBC agreed to provide Darius with temporary coverage so he could access the medical care he needed.

Why it matters: When it comes to essential services like health care, fairness means using all available tools to ensure people can access the care they need. Temporary solutions can mean the difference between someone getting treatment on time or going without.

Solving a problem up front

Fraser Health Authority

The complaint: Helena's husband, Mateo, was receiving treatment in a hospital when his walker, dentures, and other personal belongings went missing. The hospital told Helena that the Fraser Health Authority (Fraser Health) would replace the walker if she contacted the Patient Care Quality Office (PCQO). Helena then reported the lost items on several occasions but never received a formal response.

The investigation: We investigated Helena's concern that Fraser Health had not responded. During our investigation, Helena eventually heard back from Fraser Health and was told about its reimbursement policy: the PCQO would not replace items directly but would reimburse her if she bought replacements herself. We found this "one size fits all" approach unfair, since it assumed everyone could afford to pay upfront for expensive items.

The outcome: Fraser Health agreed to change its approach in Helena's case. It allowed her to submit a direct invoice for the dentures and either submit an invoice for a new walker or have Fraser Health purchase one on her behalf. Helena was also invited to submit receipts for the other lost items.

Why it matters: Policies that don't account for people's financial circumstances can deepen hardship. By adapting its approach, Fraser Health recognized that fairness means offering solutions that are equitable and consider the distinct circumstances people might face.

Missing valuables, missing accountability

Forensic Psychiatric Services Commission

The complaint: When Andrej was transferred to the Forensic Psychiatric Hospital, his belongings were sealed and stored in a secure place accessible only by staff. Later, when Andrej asked to check his items, he discovered the sealed package had been opened and some of his jewelry was missing. The hospital investigated but was unable to locate the missing jewelry and offered Andrej $300 in compensation. Andrej was upset, believing the missing jewelry was worth much more than $300. Following his discharge from the hospital, Andrej complained to the Patient Care Quality Office (PCQO) about his experience. He contacted our office because he felt neither the hospital nor the PCQO had made a real effort to resolve the matter.

The investigation: We reviewed the hospital's policies for storing personal items and found they had not been followed when Andrej was transferred. Staff failed to inspect, record, list and describe his list of items, and there was no record of the jewelry he was wearing when admitted. The hospital could not explain why the sealed package was opened and why no records were made. We also found the $300 compensation offer to be arbitrary, as it was not based on evidence or linked to the value of missing items Andrej described.

The outcome: The hospital followed up with its staff to ensure personal property policies are applied consistently. It also apologized to Andrej and began discussions with him to agree on a more reasonable compensation for his lost jewelry.

Why it matters: When people are admitted to hospitals or facilities, they trust staff to safeguard their belongings. Clear policies and accurate records are essential to protect that trust. If staff fail to follow procedures, individuals risk losing not just their property but also confidence in the fairness of the system.

First, fix the mistake

Ministry of Health – Health Insurance BC

The complaint: Itsuki reached out to us after Health Insurance BC's (HIBC) denied their application for BC's Medical Service Plan (MSP). HIBC first told Itsuki they were ineligible because of an income-tax issue. Ituski resolved that issue with the Canada Revenue Agency and sent the documents to HIBC. HIBC then denied Itsuki's application again, this time saying there wasn't enough information – without explaining what was missing. Confused and without coverage, Itsuki asked us to review HIBC's decision to deny their application.

The investigation: We examined why HIBC had denied Itsuki's application and if its reasons were fair. We found that Itsuki's previous MSP coverage had been cancelled due to unpaid premiums, which created a debt. To deal with that debt, Itsuki applied for Retroactive Premium Assistance (RPA), a program that can reduce or eliminate past MSP premiums. HIBC told Itsuki it would not consider the RPA request until they re-enrolled in MSP. That advice was incorrect: people can be assessed for RPA before re-enrolling. We asked HIBC to reconsider its decision based on the correct policy.

The outcome: HIBC acknowledged the error and reassessed the file. It determined that Itsuki qualified for the maximum RPA and reimbursed them $572.54. With the debt addressed, Itsuki was able to obtain MSP coverage.

Why it matters: Administrative mistakes and unclear instructions create stress and can delay access to essential health coverage. Fairness means owning errors, giving clear information, and fixing problems quickly so people aren't left without the care or support they need.

The following case summary was reviewed by Darwyn's family. At their request, we have used Darwyn's real name. We thank the family for working with us and allowing us to share their story.

FEATURED CASE SUMMARY

Improving pediatric palliative care coordination: Darwyn's story

Ministry of Health, Ministry of Children and Family Development, and Vancouver Island Health Authority

The complaint: Darwyn was born in May 2004 and passed away at home in July 2020. Throughout his life, Darwyn experienced significant and complex health care needs. He was autistic, had Trisomy 21 (Down syndrome) and a related heart condition. He also suffered from an additional chronic heart condition requiring multiple surgeries early in his life. By 2012, his doctors decided that further heart surgery was no longer an option, and in 2018 Darwyn was referred to palliative care because his life expectancy was likely to be shortened due to his health needs.

When Darwyn's parents contacted our office in March 2022, they were deeply concerned about how fragmented and unclear the palliative care system was during the final years of Darwyn's life, which led to a lack of adequate care for Darwyn. They told us that Darwyn experienced barriers when accessing appropriate palliative care because of his disabilities, and that the pediatric palliative

care system was ill-equipped to respond when he went into medical decline. Specifically, they told us that Darwyn was not seen or cared for in a timely manner when he neared the end of his life, and that he experienced unnecessary delays receiving the pain medication he needed. They felt they were left without clear guidance or support – particularly around who was responsible for Darwyn's care.

The investigation: We investigated whether a reasonable and coordinated plan had been in place for Darwyn's care from the time he was referred to pediatric palliative care in 2018 until his death in 2020.

During this time, several public bodies and private agencies were responsible for Darwyn's care, including the Ministry of Health, Ministry of Children and Family Development (MCFD), Vancouver Island Health Authority (Island Health), Canuck Place Children's Hospice (a non-profit hospice), Nursing Support Services (BC Children's Hospital), and various primary care providers and specialists. Our investigation focused on the three overarching public bodies involved: Ministry of Health, MCFD, and Island Health.

We reviewed extensive records, and analyzed the communication, accountability, and clarity of roles among these public bodies.

The outcome: Our investigation confirmed what Darwyn's parents told us: the pediatric palliative care system in BC is fragmented and confusing in ways that can adversely impact the quality of care families receive, particularly for children with disabilities. In Darwyn's case, there was no clear understanding – by the family or even the care providers themselves – of who was responsible for what, or how the services were supposed to work together. During the last two years of Darwyn's life, this fragmentation of the palliative care system and the lack of clear accountabilities denied Darwyn's parents a clear understanding of:

- the scope of services they could expect
- how the services were integrated
- which organization they could contact if they had questions about Darwyn's end-of-life care
- which organization held responsibility and accountability for Darwyn's care
- which organization would take the lead to provide the necessary end-of-life care

This fragmentation resulted in harmful gaps in health care for Darwyn and his family when they needed it most and left his parents feeling completely abandoned.

The Ministry of Health agreed there were serious gaps with the way pediatric palliative care had been organized and delivered. In response, it established a multidisciplinary working group to review and re-examine pediatric palliative care policies and processes across the province.

The working group has:

- launched a pediatric palliative advanced-care-planning initiative to identify gaps, challenges and barriers in pediatric care, which has led to a process to standardize a province-wide approach
- conducted a comprehensive consultation and engagement process with First Nations and Indigenous communities, BC Children's Hospital and BC Women's Hospital and Health Centre, Provincial Health Services Authority, BC's five regional health authorities, BC First Nations Health Authority, MCFD, Canuck Place and other public, private and contracted service providers

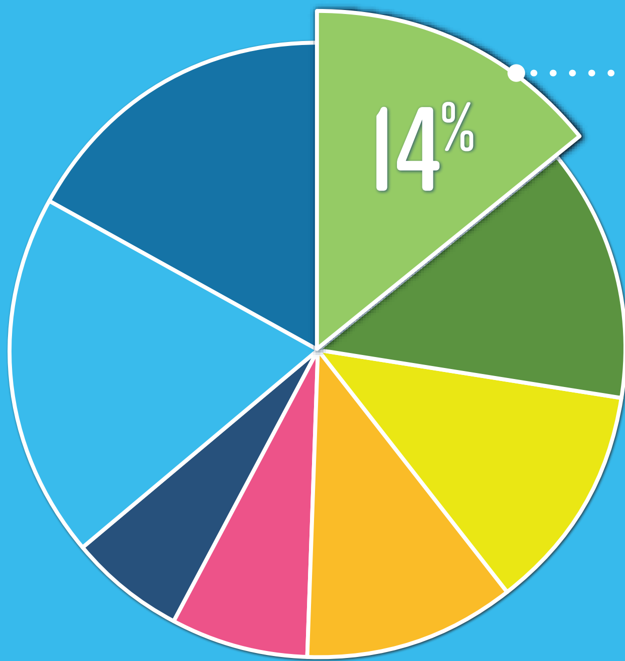
Although the working group's activities continue, its work has already led to proposals to change pediatric palliative care services, including changes to the advance-care-planning policy framework. At the time our investigation concluded, the Ministry of Health told us that it intends to implement this new framework across BC to prevent the situation that Darwyn and his family experienced from happening to others.

The Ministry of Health has also established clearer lines of communication for families and is working to clarify how responsibility for care and overall accountability are divided when multiple public and private organizations are involved in patient care.

Why it matters: Darwyn's family experienced unnecessary trauma at a time when they most needed coordinated, timely support. Our investigation showed that fragmented pediatric palliative care puts children and their families at risk of significant harm, particularly at vulnerable moments.

All children requiring palliative care deserve clear, coordinated, and responsive services that meet their complex needs. Darwyn's parents brought their concerns to us because they wanted to ensure that other children with disabilities and their families would not experience what they had. As a result, meaningful improvements were made in pediatric palliative care across BC. While these changes cannot change the difficult and traumatic experiences Darwyn and his family endured, they will help ensure that future families receive better, more compassionate end-of-life care and support.

We will continue to monitor and report on the Ministry of Health's actions to ensure the goal of reducing fragmentation and improving coordinated care delivery is achieved.



TRANSPORTATION, INFRASTRUCTURE, AND ENVIRONMENT

From road safety rules and ICBC claims to disputes over environmental decisions, the systems that manage BC's infrastructure and resources impact nearly everyone. When those systems falter – through unclear decisions, delays, or rigid policies – the impacts can disrupt people's safety, finances, and trust in government. Our office helps these complex systems operate fairly and transparently for all people in BC.

Highlights from 2024/25

- We continued to monitor implementation of the 20 recommendations from our October 2023 report, *Fairness in a Changing Climate*, which found that emergency support programs were outdated, under-resourced, inaccessible for vulnerable evacuees and poorly communicated.
- The Ombudsperson presented to 300 emergency services professionals at the Network of Emergency Support Services Teams conference on our *Fairness in a Changing Climate* findings and recommendations.
- We continued to monitor seven recommendations from our March 2024 report, *On the Road Again*, which highlighted problematic road-related legislation with real-world consequences.
- We delivered a Fairness in Practice workshop to 44 staff responsible for mining compliance with the Ministry of Energy, Mines and Low Carbon Innovation.

Trends and data

In 2024/25, we received 735 enquiries and complaints in this category; 618 related to infrastructure and transportation; and 117 were about the environment.

Top infrastructure and transportation public bodies were:

- ICBC: 476
- BC Hydro: 52
- Ministry of Transportation and Transit: 49

More than three-quarters (77%) of infrastructure and transportation complaints were about ICBC.

Of the ICBC specific complaints, more than half were about motor vehicle accidents, a trend that has continued since 2023/24. These complaints account for nearly half of all complaints about ICBC, followed by driver licensing complaints.

For the 177 environment-related complaints, the top public bodies mentioned were:

- Ministry of Forests: 29
- Ministry of Environment and Parks: 23
- Ministry of Water, Land and Resource Stewardship: 18
- Ministry of Energy and Climate Solutions: 17

Most environment-related complaints involved disagreements with decisions, unfair processes, communication gaps, or delays in obtaining critical decisions.

CASE SUMMARIES

The following are examples of complaints we handled in 2024/25 related to infrastructure, transportation, and the environment.

Keeping the lights on

BC Hydro

The complaint: Adrian asked BC Hydro for a payment plan to cover an overdue bill, explaining they would be able to pay the full amount within six weeks. BC Hydro denied their request, citing a late payment earlier in the year. Adrian felt this was unfair – the reason they were late earlier in the year was because they were applying for the Customer Crisis Fund, a financial assistance program that helps people facing temporary financial crisis to pay their overdue electricity bills.

The investigation: We looked into whether BC Hydro followed a fair process when it decided to disconnect Adrian's power. We contacted BC Hydro and it promptly agreed to review Adrian's file.

The outcome: Within three days of receiving our notice of investigation, BC Hydro contacted Adrian and agreed to a payment plan. It also confirmed that Adrian's file should not have been flagged for late payment – when a person is applying for crisis funds, any late payments should not be treated as overdue.

Why it matters: Electricity is an essential service. When payment processes are applied too rigidly, people can be left without power even when they are trying to pay what they owe. Flexible and fair approaches help ensure people can keep vital services while meeting their obligations.

"I am profoundly grateful to the Office of the Ombudsperson for your restorative justice."

– Member of the public

Agent of misinformation

ICBC

The complaint: Karla's car was damaged by an electric scooter. When she filed a claim with ICBC, she was told she would need to pay a $300 deductible to have her car repaired, even though the accident was not her fault. Karla was frustrated because ICBC staff originally told her she would not have to pay a deductible.

The investigation: We spoke with ICBC and learned the initial claims adjuster may have mistakenly treated the scooter driver as an "uninsured" party rather than a "non-vehicle road user." Electric scooters are part of a recently extended pilot program in some communities in BC. And while there are rules for where riders can ride their scooters, riders are not required to insure their scooters.

The outcome: ICBC corrected its error and provided Karla with the accurate information. It also apologized to Karla for how her complaint was handled. To avoid similar issues, ICBC agreed to amend its policy to prevent any future confusion about accidents involving non-vehicle road users.

Why it matters: Ensuring staff communicate accurate and up-to-date information prevents communications errors, like the mishap Karla experienced.

Service barriers

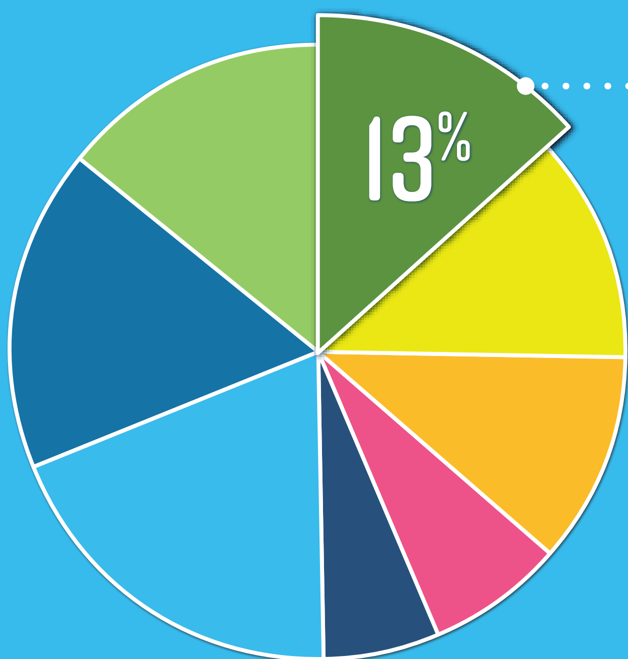
BC Transit

The complaint: Adisa applied to use HandyDART, a door-to-door shared transit service for people living with disabilities who can't readily use regular public transit. But Adisa was told by BC Transit that his Persons with Disabilities (PWD) designation was not enough to prove eligibility. Instead, he was required to undergo an assessment with a BC Transit mobility specialist. Adisa felt this was unfair and unnecessary since his PWD designation already established his disability. He was also concerned about how BC Transit had communicated with him.

The investigation: We reviewed the legislation and confirmed that Adisa should have been automatically eligible for HandyDART services because of his PWD designation. After we raised this with BC Transit, it reviewed Adisa's application and acknowledged he was indeed eligible.

The outcome: BC Transit informed Adisa that he was eligible to use HandyDART services. It agreed to update both its assessment process and information materials to reflect that anyone with a PWD designation is automatically eligible, and to communicate this change to its staff. It also said it would review its broader application process for those without a PWD designation. Finally, BC Transit said it would meet with Adisa to discuss his concerns about the local HandyDART team's communication.

Why it matters: For people living with disabilities, like Adisa, every barrier to essential services can have real impacts on daily life. Ensuring processes reflect both the letter and the spirit of the law respects people's dignity and makes access to services more equitable.



LOCAL GOVERNMENT

Local governments make decisions that directly impact people's daily lives – from bylaw enforcement to community planning and zoning. When those decisions are opaque or unfair, residents turn to us for help. Our work ensures that local governments remain accountable, transparent and fair in their decision-making.

Highlights from 2024/25

- In June 2024, we presented at the Local Government Management Association conference in Victoria, engaging directly with municipal leaders about fairness standards and practices.
- We reviewed Islands Trust's enforcement-related policies and practices, making recommendations to strengthen fairness and align its bylaw enforcement with best practices.
- In March 2025, the Ombudsperson publicly urged the provincial government to introduce legislation establishing independent and enforceable ethics and integrity oversight of local elected officials. This followed the release of two reports, one an integrity commissioner report about the Vancouver park board, and the second, a review of the Vancouver integrity commissioner's role that underscored the limitations of BC's approach to municipal integrity oversight.

Trends and data

In 2024/25, we received 667 enquiries and complaints about local government, with three-quarters of them about municipalities across BC.

The three most complained-about cities were:

- City of Vancouver: 57
- City of Victoria: 32
- City of Salmon Arm: 27

Most complaints involved:

- bylaw enforcement
- community planning, zoning and development decisions
- fees and charges
- council member conduct (includes open meetings)

CASE SUMMARIES

The following are examples of complaints we handled related to local government in 2024/25.

A fine mistake

Regional District of the Central Okanagan

The complaint: Sylvie and Andrew received a letter from the Regional District of the Central Okanagan (RDCO) about a bylaw complaint. The complaint alleged that Andrew had let one of their dogs off leash at a park where dogs are not allowed to be off leash, and that the dog had behaved aggressively. The letter included a bylaw offence notice with a fine of $125 – $175, depending on when it was paid. Sylvie and Andrew were adamant they had not been at the park on the date the alleged incident occurred. But because the letter was mailed to their rental property instead of their primary residence, they did not receive it until after the deadline to dispute the fine.

Sylvie and Andrew left multiple messages for the bylaw officer but never received a reply. Months later, they received another letter stating the $175 fine had been sent to collections. Sylvie and Andrew called several more times and emailed the bylaw officer. After finally reaching a bylaw manager, they were told the evidence supported the original officer's "charges" and the deadline to dispute the claim had passed. Frustrated, Sylvie and Andrew paid the fine and then contacted our office for help.

The investigation: We reviewed the evidence from both the RDCO and Sylvie and Andrew. We found the bylaw officer's investigation had been inadequate, relied on inaccurate information, and did not establish that Andew was responsible for the alleged incident. We were also concerned by the bylaw manager's follow-up communication, which appeared to misstate multiple facts and failed to consider the evidence Sylvie and Andrew had provided.

The outcome: The RDCO agreed to reimburse Sylvie and Andrew the $175 fine. It also sent Sylvie and Andrew a letter of apology for failing to fairly investigate the complaint and for not responding to their repeated calls and emails.

Why it matters: Thorough investigations are critical to fairness. When complaints are not properly examined, people can face unwarranted penalties. Accurate fact-finding and timely communication protect the public from unfair consequences.

A lot is wrong

Town of Creston

The complaint: Felix owned a vacant lot in the Town of Creston and was shocked to receive a $1,506 invoice from the town to clean his property. Included with the bill were before and after photos of the work done – but the problem was that the town cleaned up the wrong lot.

Felix sent an agent to town hall on his behalf to explain the mistake. When he did not hear back from the town, he assumed the matter was resolved. Months later, Felix received another bylaw notice relating to maintenance of his vacant lot. He contacted the town and was informed the earlier invoice for cleaning the wrong lot was still outstanding. When Felix tried to dispute the invoice, the town said it was too late to cancel it. He paid the invoice, with interest, but believed it was unfair since the work had been done on someone else's property.

The investigation: We investigated whether the town's enforcement of its property maintenance bylaw was fair. We learned the town had received a bylaw complaint about Felix's vacant lot and sent Felix a warning letter. The letter stated he had 14 days to clean the lot and if he failed to do so, the town would complete the work at his expense. However, Felix was working away from home and never received the letter.

The town hired a contractor to clean the property and requested before and after pictures of the work. A few days after the work was completed, the town realized the contractor cleaned the wrong lot. The contractor agreed to clean the correct lot but instead of calculating the cost for cleaning Felix's lot, the town agreed to pay the contractor's costs for cleaning the wrong lot. Because Felix was never given any evidence that the work was completed on his lot, we felt it was unfair for the cost to be calculated based on work done on the wrong lot.

The outcome: The town confirmed the cost for cleaning Felix's lot was less than the cost for the original lot. It reimbursed Felix for the difference, including the interest he had paid. It also apologized for its errors and committed to additional staff training on fair property maintenance bylaw enforcement.

Why it matters: Clear procedures and accurate record-keeping help prevent errors and ensure enforcement is applied fairly. Public bodies must take sufficient care before issuing fines or invoices.

FEATURED CASE SUMMARY

The roots of a bylaw

City of Surrey

The complaint: Blair moved into a home with a magnolia tree on his front lawn and would prune the tree periodically to keep it from growing into his porch and gutters. Blair was shocked when he received a letter from the City of Surrey that said an arborist had inspected the tree and found it had been “excessively pruned.” Because the tree was reportedly a protected tree, the city fined him $3,000 for not following its tree bylaw.

Blair contracted the city for clarification about the fine. In the city’s response it said his appeal had been reviewed and provided Blair with two options: pay the fine or apply and pay for a tree cutting permit to remove and replace the tree.

Blair felt it was unfair of the city to levy such a substantial fine for pruning a tree. Blair had not known the tree was protected. He also believed it was unreasonable for the city to offer the option of paying to remove and replace it.

Sheila was Blair’s neighbour. Like Blair, she too had a similar tree out front of her home that she pruned periodically to keep it from growing toward the sidewalk. Sheila received the same letter from the city, on the same day that Blair received his, informing her that the city arborist found her protected tree to be excessively pruned. She too received a fine of $3,000.

Sheila contacted the city and received the same response as Blair. The city reportedly reviewed her appeal and provided the same two options: pay the fine or apply and pay for a tree cutting permit to remove and replace the tree.

Like her neighbour Blair, Sheila felt she was being treated unfairly by the city and contacted us for help.

The investigation: We reviewed the city’s enforcement of its tree bylaw and found multiple fairness concerns.

We learned that the city’s tree bylaw provided several different penalty options for addressing damage to protected trees. However, the city had no policy or guidelines on how staff should decide which one to use. This meant staff had significant discretion to decide how to enforce the bylaw. Staff appeared to have proceeded directly to issuing large fines for no apparent reason and did not appear to consider other penalty options available to them.

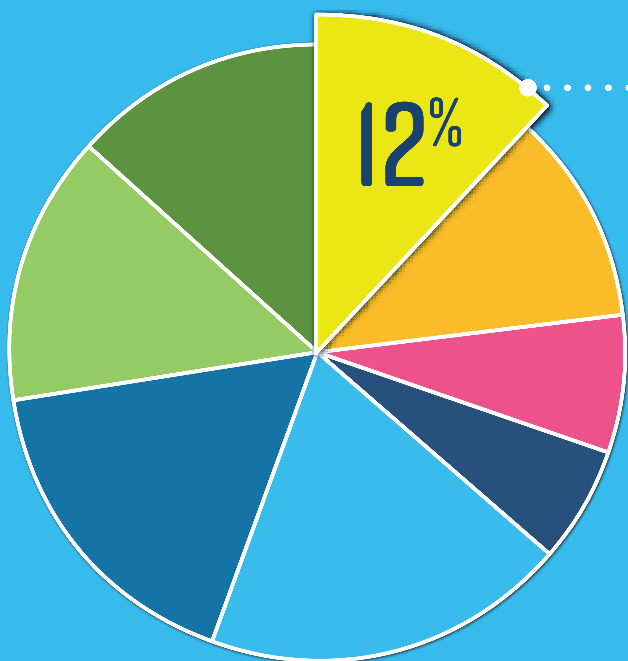
In addition, the letters sent to Blair and Sheila did not include any information about how they could appeal the fines, including their right to have city council reconsider tree matters upon request. Due to the identical nature of the letters, we were concerned the city did not consider Blair and Sheila's appeals on their merits.

It also seemed that the city's tree bylaw itself was unfair. Specifically, the bylaw did not define what was meant by "excessive pruning" making it unclear when a tree could be considered damaged by excessive pruning. It also referenced several third-party publications and standards, which were available for purchase at a substantial fee, making them inaccessible. This lack of clarity increased the risk that the public would be unaware if the bylaw was enforced randomly against residents who pruned protected trees.

The outcome: We proposed and the city agreed to:

- amend its tree bylaw to clarify what "excessive pruning" means, remove inaccessible third-party references, and explain the different enforcement options
- train staff on fair bylaw enforcement, including exercising discretion and fair appeal processes
- cancel Blair and Sheila's $3,000 fines
- send letters to Blair and Sheila informing them the $3,000 fines were cancelled and explain what is meant by a protected tree and excessive pruning
- provide Blair and Sheila with a detailed explanation of the chosen enforcement mechanism and the available appeal options if it intends to restart enforcement action

Why it matters: Without clear rules and fair processes, residents risk being fined based on inconsistent or arbitrary decisions. Blair and Sheila's cases show why bylaws must be accessible, transparent, and applied with proper discretion.



JUSTICE

People in custody or otherwise involved in the justice system often face unique challenges when policies and procedures break down. A delayed medical appointment while incarcerated, a correctional institution's disciplinary decision that is inconsistent, or a lack of access to clear or timely communication can have serious impacts in these settings. We work to make sure justice-related public bodies follow fair processes, respect rights and take action when concerns are raised.

Highlights from 2024/25

- We issued two public statements (September 17, 2024, and February 27, 2025) regarding the Ministry of Attorney General's and provincial government's unclear and slow implementation of its promised compensation for Sons of Freedom Doukhobors who were unjustly confined in New Denver in the 1950s, and ultimately its failure to follow through on a commitment to justice. Our first report about this issue *Righting the Wrong* was made public in 1999, 25 years before government's official apology on February 1, 2024.
- In July 2024, we released *Under Inspection*, an update report on the province's progress in implementing the final recommendation from our 2016 systemic report on correctional centre oversight.
- We reviewed and provided feedback on a draft compliance and enforcement policy from the Ministry of Public Safety and Solicitor General.
- We visited all 10 adult correctional centres in BC, providing opportunities to hear directly from incarcerated individuals and correctional staff. These visits offered valuable insight into how policies are implemented on the ground, and where improvements are needed.

> "Thank you so much for this feedback and thank you again for taking the time to review our draft work and meet with us to discuss it. We found the process helpful and educational, and I'm sure our end-result policies will be stronger for it."
>
> – Ministry of Public Safety and Solicitor General staff member

Trends and data

In 2024/25, we received 633 justice-related enquiries and complaints. More than half involved adult correctional centres in BC. The most complained-about public bodies were:

- Ministry of Public Safety and Solicitor General: 391
- Ministry of Attorney General: 69
- Law Society of British Columbia: 62

BC Corrections remains one of the most complained-about public bodies under our jurisdiction. Complaints from individuals in custody often involved:

- segregation and disciplinary actions
- access to health care services, including food and dietary requests
- living conditions and lack of access to phones, mail or visitation

CASE SUMMARIES

The following are examples of justice-related complaints we handled in 2024/25.

Clarity is key

Investigation and Standards Office

The complaint: Another person in custody in the same correctional centre living unit as Benji had a medical condition and his health was rapidly deteriorating. They were transferred to hospital and died three days later. Benji did not believe correctional staff and health services had acted quickly enough. He also felt the investigation into the death was incomplete because witnesses from the correctional centre living unit were never interviewed.

The investigation: When a person in custody dies, BC Corrections investigates the circumstances. The review is conducted by a team of officials, which in this case, included the Investigation and Standards Office (ISO). The ISO participated with BC Corrections' review to minimize disruption and avoid duplicating interviews and evidence reviews. However, according to policy, the ISO is considered an independent party and is to conduct its own investigation, separately from BC Corrections.

We were advised that people in custody are not typically interviewed during these reviews. Instead, the investigative team relies on staff interviews and video evidence. We found the practice of excluding people in custody from the review to be unreasonable – relevant information related to the investigation could be missed.

The outcome: BC Corrections and the ISO met to clarify the ISO's independent role, and to ensure that role is clearly defined and consistent with BC Corrections' policy. The ISO also developed its own policies and procedures for critical incident reviews, including steps for interviewing witnesses in custody.

Why it matters: When a death occurs in custody, families and the public need confidence that the investigation that follows is independent and thorough. Ensuring policies are in place and all witnesses are interviewed strengthens an investigation.

Stamping out unfairness

Ministry of Public Safety and Solicitor General

The complaint: Eric applied to renew his security worker license, but his new license issued by the government never arrived by mail. When he contacted the Ministry of Public Safety and Solicitor General's Security Programs Division (SPD), he was told he would need to pay a $20 replacement fee. Eric felt it was unfair to be charged for a mistake that was not his fault.

The investigation: We had received three similar complaints, so our investigation examined:

- how the SPD communicates with applicants
- how it produces and mails licenses
- why it charges replacement fees for situations beyond the control of applicants
- how it develops and updates its refund policies

We learned the SPD uses the government's internal mail provider, BC Mail, to process applications and print licenses. Those licenses are then mailed through Canada Post.

An error was discovered by BC Mail that resulted in some security worker licenses not being printed in a timely manner. To fix this error, BC Mail identified applications that had not been printed, and all impacted licenses were then printed and mailed. The SPD also established new procedures to avoid similar issues in the future.

We spoke with the SPD and were informed that it had a dated policy directive indicating the minimum refund to applicants was $20. In practice, refunds under $60 were not being issued as this was the administrative cost of issuing refunds. That meant applicants like Eric had to absorb the $20 replacement fee. We asked if there were other applicants like Eric who paid $20 replacement fees. The SPD identified 53 other applicants had been impacted by the error.

The outcome: After our investigation, the SPD updated its refund policy to make an allowance to refund applicants who had paid for a replacement licence that was not issued due to either an SPD or BC Mail error. Eric and the 53 other applicants were each refunded the $20 fee they had been charged.

Why it matters: Even small fees can add up to unfair treatment if charged in error. By addressing this issue, the SPD not only resolved Eric's concern but also updated its policy and refunded dozens of others who had been unfairly charged. One complaint helped drive systemic change. This benefits past and future users of a public service.

Search for justice

Vancouver Island Regional Correctional Centre

The complaint: Sajan was strip searched when leaving the Vancouver Island Regional Correctional Centre (VIRCC) for a medical appointment. When he raised concerns about the strip search, his appointment was cancelled. Sajan hadn't been strip searched on previous medical escorts from the VIRCC.

The investigation: We reviewed the regulation that describes when strip searches can be performed, as well as the VIRCC's internal policies. We asked the VIRCC to compare its internal policy, which stated that everyone leaving for a medical appointment would be strip searched, with other correctional centres. The VIRCC agreed.

The outcome: After reviewing other policies, the VIRCC determined that its internal policy was inconsistent with other correctional centres' policies and it did not comply with the regulation on when strip searches can be performed. It stopped performing strip searches by default for medical appointments. A committee was also created by BC Corrections across all centres in the province to review and standardize strip search policies.

Why it matters: Strip searches are highly invasive and should only be used when justified. Ensuring policies align with the law protects people's dignity and upholds accountability across the corrections system.

Unfair investigation

Vancouver Island Regional Correctional Centre

The complaint: Morris was sitting at a table in the common area when he witnessed another person in custody exit Morris' unoccupied cell. They were carrying a bag with some of Morris' personal belongings. He reported the alleged theft to the Vancouver Island Regional Correction Centre (VIRCC) but believed the matter was not properly investigated. Morris contacted our office, alleging staff had not reviewed video footage and only conducted a brief cell search.

The investigation: Records showed staff searched the other person in custody's cell but did not locate Morris' missing items. However, we confirmed his concern that staff had failed to review video footage of the incident. Once the footage was checked, it supported Morris' allegation. We raised the issue with the VIRCC's deputy warden, who committed to a more thorough follow-up investigation.

The outcome: The VIRCC's second investigation confirmed staff had not adequately reviewed Morris' concerns. The VIRCC compensated Morris for his missing belongings. It also stressed the importance of thorough investigations into any allegations of theft.

Why it matters: Incomplete investigations risk dismissing valid complaints. This case illustrates the importance of thorough reviews – including available evidence like video footage – to ensure fair outcomes and accountability.

A privileged complaint

Investigation and Standards Office

The complaint: Correspondence from a person in custody to the Investigation and Standards Office (ISO) is protected by the *Correction Act Regulation*. While in custody at Okanagan Correctional Centre (OCC), Mickey wrote a letter to the ISO to raise concerns about the OCC. The ISO shared Mickey's letter with the OCC without his consent. Feeling this was unreasonable, Mickey complained to our office.

The investigation: We investigated Mickey's complaint and confirmed the ISO had shared privileged communication with the OCC without seeking his consent. This was unfair and should not have happened.

The outcome: The ISO apologized to Mickey. It also updated its policies and procedures manual to confirm that inspectors will no longer share privileged information with correctional centres unless the person in custody gives consent.

Why it matters: Privileged communications are meant to give people in custody a safe, confidential way to raise concerns. Sharing that information without consent can silence people and weaken trust in oversight. By changing its policy, the ISO reinforced that fairness means protecting confidentiality and ensuring people in custody can speak up without fear.

Segregated without authority

Surrey Pretrial Services Centre

The complaint: Darren contacted our office after being held in segregation at Surrey Pretrial Services Centre (SPSC) for more than 25 days in a row. He didn't understand why he was placed in segregation and was upset about how long it lasted.

The investigation: We investigated whether SPSC followed a reasonable process when separately confining Darren. Staff told us contraband had been discovered that threatened the security of SPSC, and Darren could not be placed back on a regular unit until the issue was resolved. While that explained the longer segregation, our review of the records showed SPSC had twice missed the legal deadlines required to extend his separate confinement. This meant Darren was kept in segregation without legal authority.

The outcome: By the time we completed our investigation, Darren had been removed from segregation. However, to improve future practice, SPSC agreed to provide additional guidance to its staff and remind decision makers about their obligations to meet timelines when extending segregation.

Why it matters: Placing people in segregation is one of the most serious measures a correctional centre can take. Missing deadlines meant Darren remained in segregation without clear authority.

A little goes a long way

Ministry of Attorney General – Criminal Justice Branch

EARLY RESOLUTION

The complaint: Lucy, who is blind, was subpoenaed as a witness in a criminal proceeding. She requested a Braille copy of the subpoena but never received it. Her husband read the subpoena, but key details – including the location of the proceeding – were missing. Lucy contacted the Crown Counsel Office and was told more information would be provided closer to the trial date. A few months later, Lucy also asked the Crown Counsel Office whether she could have a support person attend with her, but she never heard back.

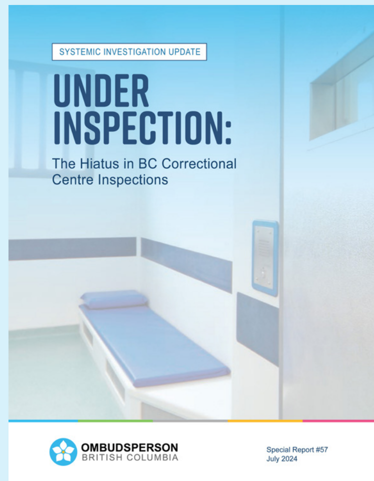
The investigation: We contacted Lucy's local Crown Counsel Office to ask about the status of the Braille subpoena and requested that staff connect with her directly to address her concerns.

The outcome: The Crown Counsel assigned to the case spoke with Lucy, provided the full details she needed about the subpoena, and addressed her request for support.

Why it matters: Accessibility requires more than simply sending documents – it means ensuring information is usable and responsive to people's needs. For Lucy, timely responses and accessible formats would have better upheld her ability to participate fully in the justice process.

FEATURE REPORT

2024 Investigation Update: *Under Inspection*



In July 2024, we released an investigative update to our 2016 report *Under Inspection: The Hiatus in BC Correctional Centre Inspections*. This report was the result of an investigation into whether the Corrections Branch was adhering to inspection obligations as outlined in the *Corrections Act.*

The 2016 investigation found that the government had not complied with the *Corrections Act* by not inspecting provincial correctional centres for 11 years, between 2001 and 2012. We also found that when inspections were reinstated, the framework was not consistent with the United Nations Standard Minimum Rules for the Treatment of Prisoners, known as the Mandela Rules. We made seven recommendations which government accepted and committed to implement.

In 2018, we published an update on the implementation of our recommendations and found six of the seven recommendations were fully implemented.

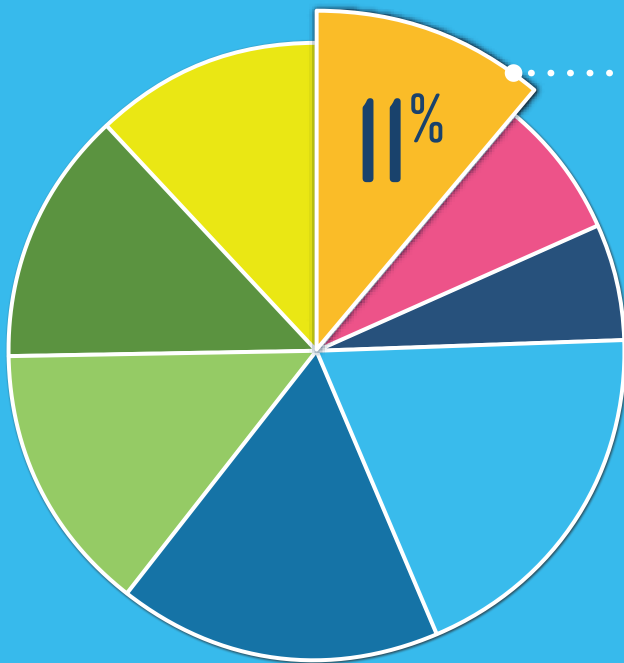
In our 2024 update, the Ombudsperson concluded that the government had only partially implemented the seventh and final outstanding recommendation: ensuring external inspections comply with the Mandela Rules.

A new model of inspections carried out by the Investigation and Standards Office (ISO) – a branch of the Ministry of Attorney General – began in 2023. In our July 2024 update, we found that the ISO had not yet included independent participants from outside government on the inspection teams, including health care professionals. Nor had it publicly reported on inspections completed.

We will continue to monitor government's progress on fully implementing the final recommendation.

"While it is encouraging to see the government improve its inspection model, it does not yet include participants from outside agencies. It is long overdue that these external eyes and ears go where the public cannot."

– Jay Chalke, BC Ombudsperson



SERVICES FOR CHILDREN, YOUTH, AND VULNERABLE ADULTS

Families caring for children, youth, or vulnerable adults must often navigate complicated systems – from child protection processes to securing supports for people living with disabilities. When those systems are slow, unclear or unresponsive, the impacts can add significant stress to already difficult circumstances. Our office provides an independent, trusted place for these families and individuals to turn to when they feel they have been treated unfairly.

Highlights from 2024/25

- In April 2024, we released an update to our 2021 report *Alone*, which found unjust and oppressive separate confinement of youth in custody centres. The update revealed that the Ministry of Children and Family Development (MCFD) had fully implemented only three of 26 recommendations, with eight partially implemented or ongoing, and no progress made on 15 recommendations. We will continue to hold MCFD accountable for implementing these recommendations.
- We visited Burnaby Youth Custody Services and the Youth Forensic Psychiatric Services In-Patient Assessment Unit. During these visits, we met directly with youth in custody, spoke with staff and toured the facilities to better understand how policies and practices impact those in care.
- We participated in Inclusion BC's Everybody Belongs! conference, connecting with organizations that serve people living with disabilities.
- The Ombudsperson took part in the kick-off celebration for BC Child and Youth in Care Week, recognizing the strength and resilience of youth in and from care.
- In January 2025, we released an update on our 2022 report *Short-Changed*, which addressed unfair practices that resulted in the withholding of federal financial support from caregivers of children living with disabilities. Three of the four recommendations have been fully implemented; no progress has been made on the fourth, which calls for the province to work with the federal government to fix systemic inequities in federal legislation. We will continue to monitor the implementation of this final recommendation.

Trends and data

In 2024/25, we received 582 enquiries and complaints about services for children, youth, and vulnerable adults. Consistent with past years, most complaints involved the Ministry of Children and Family Development.

Top public bodies included:

- Ministry of Children and Family Development: 408
- BC Family Maintenance Agency: 65
- Community Living BC: 56
- Public Guardian and Trustee: 53

Overall, the most common concerns we heard about involved:

- disagreements with decisions and outcomes
- unfair or unclear processes
- poor communication and lack of transparency
- perceived mistreatment by staff

Most complaints involving MCFD came from parents, guardians, caregivers and other third parties concerned about a child or youth's well-being. Issues ranged from child protection investigations and visitation rights to quality of care, safety plans and permanency planning.

CASE SUMMARIES

The following are examples of complaints we handled in 2024/25 related to services for children, youth, and vulnerable adults.

Tell me the whole story

Public Guardian and Trustee

The complaint: Lyle was concerned about a Public Guardian and Trustee (PGT) investigation into his late stepmother's capacity to manage her finances and alleged financial abuse by her spouse. After obtaining his stepmother's records through a Freedom of Information request, Lyle identified some shortcomings in the PGT's investigation. He expressed his concerns through the PGT review process but remained unhappy with its response, so contacted us for help.

The investigation: We investigated whether the PGT met its responsibilities to Lyle's late stepmother and whether its responses to Lyle were fair. We found that the investigation had several critical gaps, including inadequate record keeping. We also learned that the PGT itself had identified many of these shortcomings during its review but had not shared them in a transparent way with Lyle. The PGT acknowledged it had information that confirmed some of Lyle's concerns about its investigation and recognized it should have done a better job explaining its process and the basis for the decision it made.

The outcome: The PGT committed to improving its policies and procedures to strengthen oversight by its Assessment and Investigation Services division and to ensuring the team follows PGT policies. It also agreed to review and update its complaints process. The PGT apologized to Lyle for how it handled the investigation and for its response to his complaint.

Why it matters: When public bodies fall short, it undermines public trust and risks leaving people in vulnerable situations unprotected. This case shows how stronger policies, transparent communication, and accountability are essential to ensure public bodies' investigations are thorough and fair.

The riding lesson

Ministry of Children and Family Development

The complaint: Jeev was concerned that a therapeutic horse riding service (hippotherapy) had improperly billed for occupational therapy for his child who lived with a disability. During his son's session, no registered occupational therapists were on staff. Jeev believed this showed a lack of due diligence by the Ministry of Children and Family Development (MCFD) to make sure providers followed the At Home Medical Benefits Program requirements.

The investigation: We investigated whether MCFD followed a fair process for verifying provider qualifications. During our review, we determined MCFD's Frequently Asked Questions document incorrectly stated the required credentials for hippotherapy were accreditation with the Canadian Therapeutic Riding Association – and not an occupational therapist or physical therapist. This meant that Jeev's son's therapeutic riding sessions had not been carried out by a credentialed provider.

The outcome: MCFD agreed to:

- update the program's Frequently Asked Questions document for staff
- communicate the changes to staff to ensure consistent application of hippotherapy requirements
- update the program guide and other public materials to include required credentials and how services should be billed

Why it matters: Clear program requirements protect both families and public funds. They ensure services are delivered by qualified providers and families receive the supports intended for them.

Unfairly screened out

Ministry of Children and Family Development

The complaint: Mariah was offered a job with a non-profit organization that looked after children in the Ministry of Children and Family Development's (MCFD) care. Before she could start, she had to pass a screening process and police information check conducted by MCFD's Centralized Services Hub. Unfortunately, Mariah's application was denied and she was unable to start the job.

Mariah contacted our office because she believed MCFD's screening process was biased and unfair. She said MCFD staff asked her about alleged police contact that had never occurred, which she told the ministry. Further, when she asked why she was screened out, their answers were unclear and inconsistent. Mariah felt her application had been prejudged before anyone spoke to her, and that her race and previous employment in the sex industry had contributed to the way she was treated.

The investigation: We investigated whether MCFD followed a fair process when screening Mariah's application to be a caregiver.

We confirmed Mariah's account of the events and found signs of unfairness and a risk of bias throughout the screening process. Specifically, MCFD:

- did not treat Mariah with dignity and respect throughout the screening process
- appeared to have prejudged Mariah's application before she was interviewed
- asked her unfair questions about the contents of her police contact file that she had no way of knowing, then later used her inability to respond to the ministry's unfair questions as an explanation for the decision to deny her application
- gave Mariah inconsistent and unclear reasons for the decision to deny her application
- at times used language and tone that suggested bias may have negatively influenced the process
- did not adequately respond to Mariah's complaints about bias and racism

We also found that some of Mariah's experiences were not unique – at least two of the procedural fairness issues we identified were entrenched within MCFD's screening process and commonly used when screening applications.

The outcome: We worked to make sure Mariah's concerns were clearly understood by MCFD and to highlight how the risk of bias and poor processes can lead to unfair outcomes – as they did in Mariah's case.

As a result, MCFD agreed to large-scale changes to its caregiver screening process:

- changing how police information checks are handled so applicants can respond fully and fairly
- creating an appeal process for applicants who want decisions reviewed
- establishing a complaints process for concerns about screening experiences
- revising policies, procedures, template decision letters, and communications materials for clarity and fairness
- providing staff with anti-racism and trauma-informed training

MCFD also apologized to Mariah for her experience.

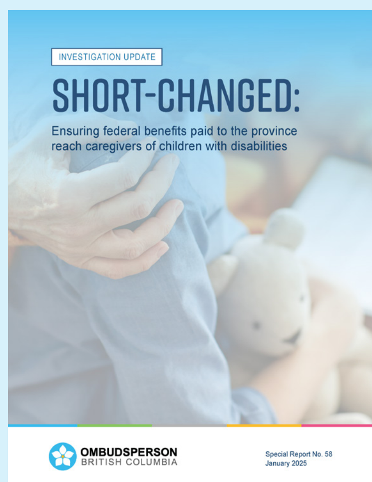
Mariah's complaint was vital to starting a process of change within MCFD's screening process.

We are pleased with MCFD's willingness to make these positive changes to address the systemic fairness issues we identified. While these changes cannot erase the impact this experience had on Mariah's wellbeing, financial stability, and trust in government, she told us that coming to our office helped her challenge the power imbalances that left her feeling dismissed. We hope MCFD remains committed to ensuring a fair and respectful experience for future applicants, and our office will continue to monitor the ministry's implementation of these changes.

Why this matters: Accurate caregiver screening is important. The purpose of the screening is meant to protect children and youth – not to unfairly exclude qualified applicants. Mariah's case shows how even well-intentioned systems can be tainted by the risk of bias. Mariah's case also shows how systems can be inadvertently set up in an unfair way, leading to systemically unfair treatment. Fair, transparent, and respectful processes are essential to building trust in public services.

FEATURE REPORT

2025 Investigation Update: *Short-Changed*



Short-Changed: Ensuring federal benefits paid to the province reach caregivers of children with disabilities was published in 2022 and detailed the case of grandparents caring for their granddaughter, an Indigenous child who lived with mental and physical disabilities, under a kinship care court order. Despite following the required steps, the grandparents did not receive the federal Child Disability Benefit, a monthly payment intended to support families caring for children living with disabilities. Our 2022 report found that under the kinship care order, the benefit was being paid to general provincial revenues. The province's failure to pass on the benefit to the grandparents was unjust, and the Ministry of Children and Family Development (MCFD) knew about the issue but did not try to resolve it. We made four recommendations to address the unfairness we found.

In January 2025, we released an update report that found three of the four recommendations made had been fully implemented, resulting in significant improvements for caregivers and their families, including payments of more than $1 million to kinship caregivers.

The province has made no progress on the fourth recommendation: to work with the federal government to address inequities in federal legislation that denies some caregivers access to additional benefits meant to support children living with disabilities.

We will continue to monitor government's progress on the remaining recommendation.

"I am pleased at the significant progress the province has made to correct this issue, including retroactive payments of over one million dollars to the caregivers of children with disabilities."

– Jay Chalke, BC Ombudsperson

FEATURE REPORT

2024 Investigation Update: *Alone*

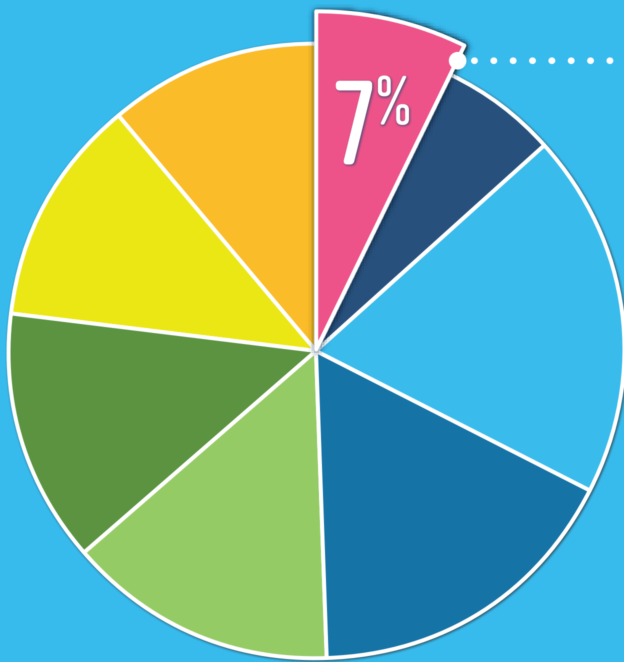
Our 2021 report *Alone: The prolonged and repeated isolation of youth in custody*, we found that the use of separate confinement was unjust and oppressive. Prolonged isolation was commonly used to respond to youth who were self-injuring or suicidal and was almost exclusively experienced by Indigenous and racialized girls. The 2021 report also found that youth who were separately confined had limited and inconsistent access to educational, mental health, and cultural support. We made 26 recommendations aimed at protecting youth in custody from exposure to the harm caused by prolonged and repeated isolation, all of which the Ministry of Children and Family Development accepted.

In April 2024, we released an update report which found that the ministry had fully implemented only three of the 26 recommendations. The ministry had partially implemented or had undertaken work on an additional eight recommendations. Most concerningly, we found that the ministry had made no progress on the remaining 15 recommendations, including law reform that would prohibit the use of separate confinement for particularly vulnerable youth.

We will continue to monitor the ministry's implementation of the remaining 23 recommendations.

"The ministry's inaction continues to expose vulnerable youth in its care to the risk of significant harm from separate confinement, especially Indigenous youth."

– Jay Chalke, BC Ombudsperson



EMPLOYMENT AND PROFESSIONAL ASSOCIATIONS

Workers and the public rely on public bodies like WorkSafeBC and regulatory bodies to protect their livelihoods. When these systems are rigid, slow, or unresponsive, people come to us for help. Our office makes certain that public body decisions affecting people's work, benefits, and professional standing are handled fairly, transparently, and in line with established processes.

Highlights from 2024/25

- The Ombudsperson delivered the keynote address at the Law Foundation's Provincial Legal Advocates Conference, speaking to advocates about the importance of fairness in employment and professional oversight systems.

Trends and data

This category includes enquiries and complaints received about professional regulatory bodies such as the College of Physicians and Surgeons of BC, the BC College of Nurses and Midwives, and Forest Professionals BC, as well as other public organizations including WorkSafeBC, the Workers' Compensation Appeal Tribunal, the Labour Relations Board, and the Ministry of Labour.

In 2024/25, we received 362 enquiries and complaints about employment and professional organizations and associations. More than half involved WorkSafeBC, with the rest spread across licensing bodies and labour agencies.

The three most complained-about public bodies were:

- WorkSafeBC: 223
- College of Physicians and Surgeons: 33
- Ministry of Labour: 30

CASE SUMMARIES

The following are examples of complaints we handled in 2024/25 related to employment and professional services.

The building blocks of fairness

Engineers and Geoscientists BC

The complaint: Raj applied to be a professional engineer, but his application was rejected by Engineers and Geoscientists BC (EGBC), which told him he needed 12-months of Canadian work experience. After gaining that experience, Raj re-applied. His second application was also rejected for the same reason. When Raj appealed, his appeal was denied. Raj was concerned EGBC had not properly considered his new work experience and did not clearly explain why his applications were rejected or what else he needed to do to qualify.

The investigation: We investigated whether EGBC gave Raj adequate reasons for its decisions and whether it responded reasonably to his questions. We reviewed its decision letters, the criteria for professional engineering applications, and spoke with EGBC about Raj's concerns.

The outcome: EGBC agreed to provide Raj with a more detailed letter explaining its decision and committed to training staff on the importance of giving clear reasons for decisions. During our investigation, EGBC also approved Raj's application to be a professional engineer.

Why it matters: Clear reasons are essential to fairness. They show people how their information was considered, guide them on what to do next, and ensure regulatory decisions are transparent and accountable.

More reasons for reasons

College of Applied Biologists of BC

The complaint: Shawna complained to the College of Applied Biologists about what they believed was unprofessional behaviour and illegal activity of a member. A year later, Shawna received a one-page letter from the college dismissing their complaint and closing the file. Shawna felt the college had not fully reviewed their concerns before dismissing them and that it had not provided adequate reasons for its decision.

The investigation: We investigated whether the college's response was reasonable, including the reasons it gave for dismissing Shawna's complaint. The records we reviewed showed that the college assessed Shawna's complaint in detail, but it did not fully explain the reasons for its decision to Shawna.

The outcome: The college agreed to provide Shawna with additional reasons for its decision. It also updated its letter template to ensure it provides adequate reasons for its decisions going forward.

Why it matters: Fairness requires more than reviewing a complaint – it also requires a public body to clearly explain its decisions. Providing full reasons helps people understand the process, see that their concerns were considered, and know what to expect moving forward.

Triage troubles

BC College of Nurses and Midwives

The complaint: Myles complained to the BC College of Nurses and Midwives about a triage nurse's behaviour at his local hospital. He was surprised when the college told him it could not investigate because the nurse was not registered with the college at the time the incident occurred, unless the person had falsely represented themselves. Myles confirmed with Vancouver Coastal Health Authority (VCH) that the individual who attended to him on the day of the incident was, in fact, a registered nurse.

The investigation: Our review confirmed Myles' account: the college had told him the nurse was not registered at the time of care and so could not investigate, and had advised him to follow up with the hospital for the correct name of the staff member who provided his care. However, the college realized it had made an error in its initial response to Myles – the name of the nurse Myles provided was in fact the correct person and a registered nurse. We also learned that VCH had later sent Myles a letter confirming the nurse's name he provided was correct and that they were a triage nurse. Based on this information, it was unclear why the college would not investigate Myles' complaint about the nurse's behaviour.

The outcome: The college contacted Myles to apologize for its error and offered to investigate his complaint about the nurse's behaviour.

Why it matters: Oversight bodies play a critical role in protecting the public. When errors occur, admitting the mistake and correcting it quickly is essential to maintaining trust.

"You are admirable. I’m delighted with the outcome.
Totally unexpected how quick it worked."

– Member of the public

You do not have authority

WorkSafeBC

The complaint: Jackson complained to our office about a decision made by WorkSafeBC, which cancelled some of his benefits. He felt this decision was unfair and retaliatory, and that his personal circumstances had been ignored.

The investigation: While reviewing WorkSafeBC's decision, as well as the *Workers Compensation Act*, we became concerned that it did not have the legal authority to cancel Jackson's benefits. After discussing our concerns with WorkSafeBC, it agreed its decision lacked legislative authority, was made in error, and agreed to reinstate Jackson's benefits.

The outcome: WorkSafeBC rescinded its original decision, retroactively reinstated Jackson's benefits, and wrote to him with an explanation and apology.

Why it matters: Public bodies must act within the authority given to them by law. When they step outside those boundaries, decisions risk being arbitrary and unfair.

Avoiding a costly delay

Employment Standards Branch

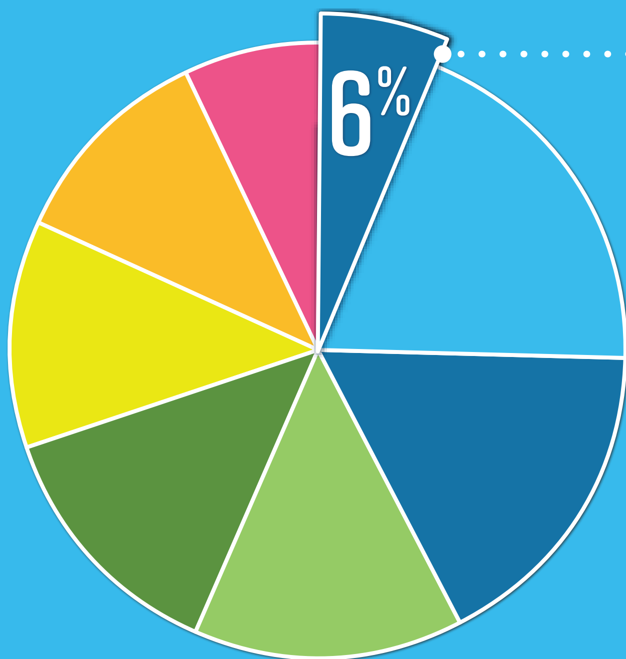
EARLY RESOLUTION

The complaint: Brodie filed a complaint with the Employment Standards Branch (ESB), alleging her employer owed her a year of wages. A year later, she still had not received a decision. Brodie tried to escalate her concerns about the delay, but her request was denied. Worried that her employer might go bankrupt before the matter was resolved, Brodie contacted our office for help.

The investigation: We asked the ESB to review Brodie's file and explain reasons for the delay. We also requested that it give her an estimate of when she could expect a decision.

The outcome: Within days, Brodie received a decision in her favour. The ESB also provided her with information on how to pursue collections if her employer did not pay the wages owed.

Why it matters: For workers, long delays in wage claims can create financial uncertainty and real hardship. Fairness requires not only a correct decision but also one delivered in time to make a difference.



EDUCATION

Students, families, and educators rely on fair and consistent practices in BC's public education system. When exclusions, fees, or unclear policies disrupt learning, those impacts can add stress to already challenging circumstances. Our office helps ensure public K–12 schools and post-secondary institutions uphold fairness, so students can focus on learning rather than navigating barriers.

Highlights from 2024/25

- In January 2025, we publicly launched an investigation into situations where BC's K–12 public schools ask or direct students not to attend school. We are examining whether these practices are fair and respect students' rights, especially for those with diverse abilities who may be left at home with little or no support, teacher time, or connection to their classmates.
- We designed and delivered four post-secondary-specific workshops to approximately 200 faculty and staff across BC. The sessions were a great opportunity to spread the word of fairness across the post-secondary sector.

Trends and data

In 2024/25, we received 291 education-related enquiries and complaints, a significant increase over the previous year. This growth is likely linked to the launch of our investigation into fairness across K–12 public schools.

Of those enquiries and complaints, half (144) were about school districts and 81 involved public post-secondary institutions. The remaining 66 enquiries and complaints were about the Ministry of Education and Child Care and Ministry of Post Secondary Education and Job Skills.

The most complained-about school districts were:

- School District 36 (Surrey): 9
- School District 39 (Vancouver): 8
- School District 27 (Cariboo-Chilcotin): 8
- School District 68 (Nanaimo-Ladysmith): 8

Top issues included:

- student safety concerns
- special education supports
- enrollment and registration processes
- suspension and exclusion practices

Top concerns at the post-secondary level were related to academic programs, and tuition and fees.

CASE SUMMARY

The following is an example of education-related complaints we handled in 2024/25.

A route to unfairness

School District 27 (Cariboo-Chilcotin)

The complaint: We received several complaints from families upset about a decision made by School District 27 to stop providing bus service for their children. Many were left without an alternate way to get their children to school – the highway lacked sidewalks, winters were extremely cold, and dangerous wildlife was often present along the route. Families told us they were not given the opportunity to provide input or appeal the decision.

The investigation: We investigated how the school district made and communicated its decision. We learned it had hired a contractor to review bus routes, who suggested the school district could significantly reduce its transportation costs if it modified the routes.

The school district sent a letter to families stating that bus routes were being reviewed and changes would take affect the following September. The letter invited feedback by email or at a meeting the following month.

A few weeks later, the school district emailed families acknowledging it could have done a better job communicating information about the changes to bus services.

The outcome: Following our investigation, the school district acknowledged it did not provide adequate communication to families impacted by its proposed bus route changes. It accepted responsibility for its communication gaps, agreed to update its policies to better inform families in the future and held a public consultation to gather further community feedback.

Ultimately, the school district reconsidered its decision and reinstated several bus stops in response to concerns expressed by families.

Why it matters: School transportation decisions affect more than budgets – they shape families' routines and children's safety. Fairness means giving families both information and a voice in the process.

"Thank you for this invaluable information and your care and consideration with our case. I know your office helps a lot of citizens with issues of injustice and it is truly needed and appreciated in these times of change."

– Member of the public

FAIRNESS IN ACTION:
PUBLIC INTEREST DISCLOSURE ACT

STRENGTHENING INTEGRITY IN THE PUBLIC SERVICE

Whistleblowers play a vital role in maintaining trust and integrity across BC's public sector. The *Public Interest Disclosure Act* (PIDA) gives current and former public servants a safe, confidential way to report serious wrongdoing, with protections for speaking up.

Our office carries out four key functions under PIDA:

1. **providing advice** to current and former public sector employees about their rights and the disclosure process
2. **receiving and investigating disclosures of wrongdoing**, where the disclosures meet the requirements of the Act and an investigation is appropriate
3. **receiving and investigating allegations of reprisal** against employees who have sought advice, made disclosures or cooperated with investigations
4. **assisting public bodies** in implementing PIDA by advising on policies, investigations, and best practices

FIVE YEARS, SEVEN PHASES: PIDA IMPLEMENTATION

This past fiscal year, another 27 organizations and 62,000 employees were brought under PIDA. In June and December 2024, current and former employees of post-secondary educational institutions in BC – colleges and teaching and research universities – as well as Health Quality BC and WorkSafeBC gained access to the protections of PIDA and the ability to report serious wrongdoing. With the last phase completed, employees of 197 public bodies, some 325,500 current public sector employees and thousands of former employees are now covered by the Act.

Five years of progress

Since 2019, our office has:

- fielded 235 requests for advice about how to safely disclose wrongdoing
- received 382 disclosures of wrongdoing and completed 44 disclosure investigations
- issued 19 recommendations, with 18 accepted, 7 fully implemented and 11 still being monitored
- assessed 38 allegations of reprisal, conducted 7 reprisal investigations
- provided training to 3,628 public employees who enrolled in our *Speaking Up Safely* online course
- published *Hire Power*, our first public report containing a finding of wrongdoing

Five-year statutory review

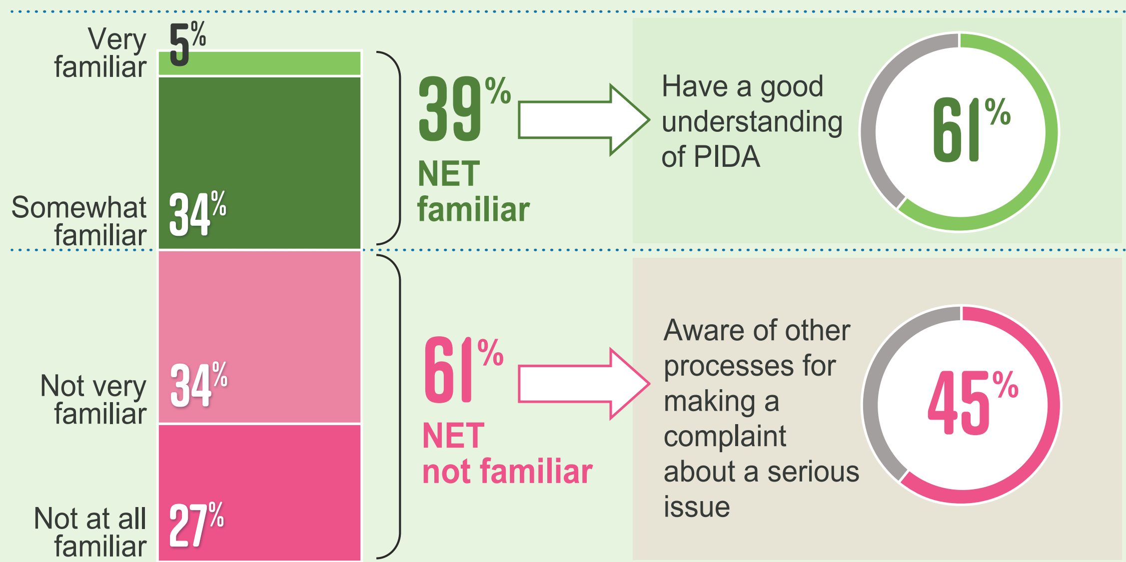
Under the Act, a special committee of the Legislative Assembly must review PIDA every five years. In 2024/25, we prepared for a May 2025 presentation to this committee, sharing our insights from five years of implementation and operation – including trends, challenges and recommendations to improve the Act. This review is critical to ensuring that PIDA continues to function effectively and supports a culture of integrity across the public sector.

Measuring awareness and confidence

In preparation for the five-year review, we commissioned a market research company to conduct an online survey of provincial government employees to understand their awareness of PIDA, its protections and their comfort in using it.

Familiarity with PIDA is low

Slightly more than one-third (39%) of employees surveyed are familiar with PIDA. Positively, among those familiar with the Act, 61% said they have a good understanding of it and know where to find more information. Among those not familiar with PIDA, nearly half (45%) said they are aware of other ways to make a complaint. Unfortunately, this means that about one-third of employees are unfamiliar with PIDA and not aware of other processes to raise a serious workplace concern.



PIDA training is preferred but online resources are also useful

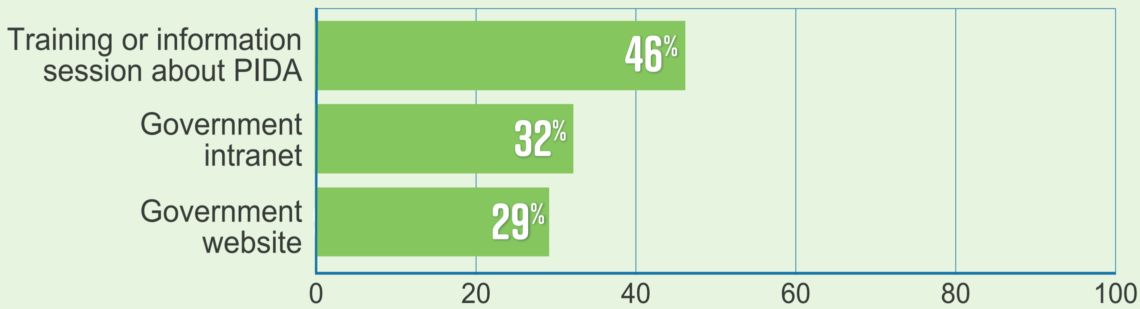
Online training is a key method for raising awareness about PIDA among both those familiar and those not familiar with the Act.

- Among those familiar with PIDA, nearly half (46%) indicate they learned about PIDA through a training or information session offered by their employer.
- Among those not familiar with PIDA, 68% would prefer to learn about it via online training or an eLearning course.

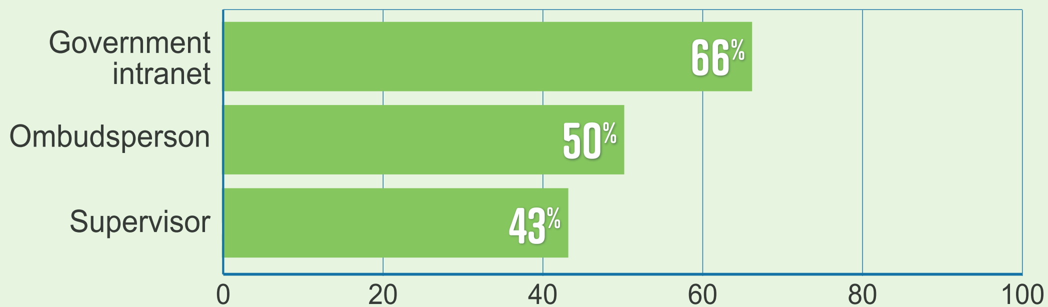
While training is key, a solid secondary source of information about PIDA for employees is the government's intranet.

- 32% of employees who are aware of PIDA said they learned about it on the intranet.
- 66% of employees would use the intranet to learn more about the Act.

Percentage of employees who became aware of PIDA through...



Percentage of employees who said they would learn more about PIDA through...



Employees know who they would make disclosures to

Among those familiar with PIDA, fully one-third (33%) would make a disclosure under PIDA to their designated officer, 29% to their supervisor and 28% to the Ombudsperson.

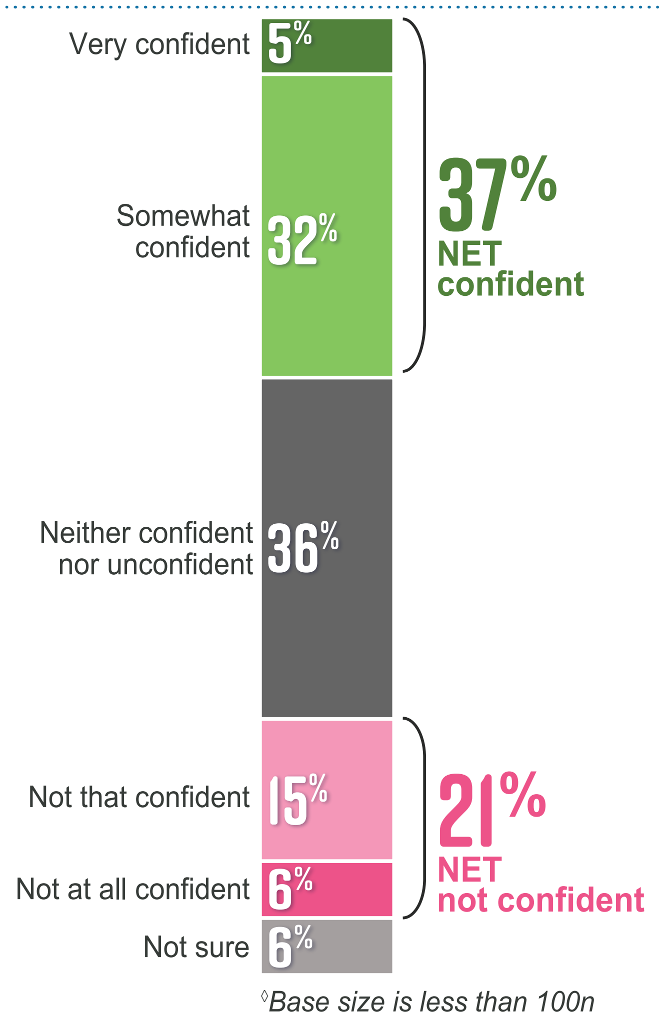
Of those not familiar with PIDA, 43% would turn to their supervisor to make a disclosure, with a similar percentage likely to turn to their designated officer (22%) and the Ombudsperson (20%).

Who to make a disclosure to	Familiar with PIDA	Not familiar with PIDA
Designated officer	33%	22%
Supervisor	29%	43%
Ombudsperson	28%	20%

Trust in PIDA is linked to awareness

Encouragingly, the more familiar employees are with PIDA and its provisions, the more likely they are to trust or have confidence in the Act.

Among those familiar, 61% trust their identity will be protected, 60% trust their employer to deal with disclosures professionally, 59% believe the legislation provides adequate reprisal protection, and 54% believe they will not be retaliated against. However, only 37% are confident in an effective resolution.

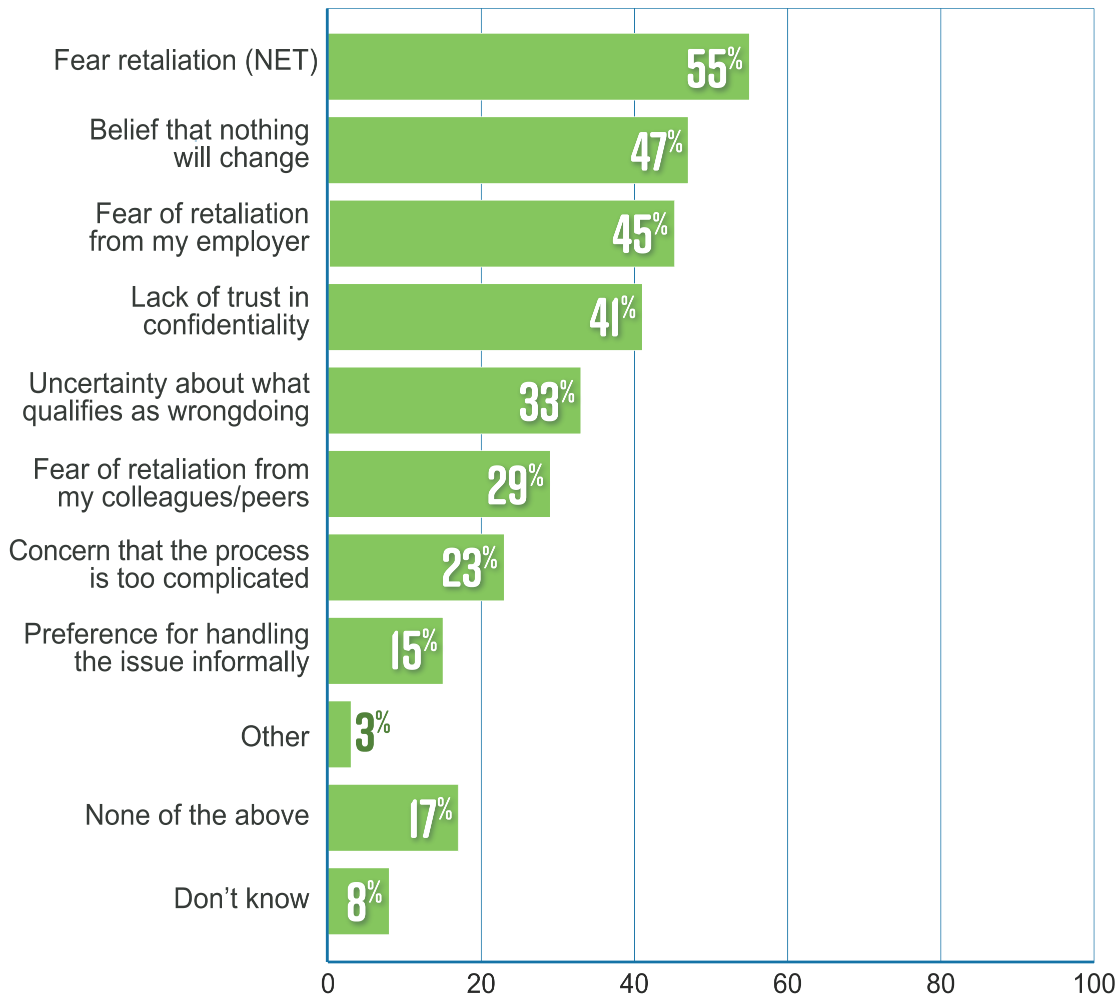


Key barriers to reporting wrongdoing are evident

The overarching barrier to reporting wrongdoing is a fear of retaliation from either the employer or colleagues with more than half (55%) of employees indicating any fear of retaliation would discourage them from coming forward. Some employees identified multiple barriers to disclosing wrongdoing.

Nearly half (47%) believe that nothing would change if they reported wrongdoing, and 41% lack trust in the confidentiality provisions of the Act.

Even among those aware and with a good understanding of the Act, fear of retaliation and lack of trust are significant concerns.



PIDA DAY

In October 2024, we hosted the sixth annual Public Interest Disclosure Conference, bringing together approximately 120 attendees from across Canada to share knowledge and strengthen whistleblower protections. Topics included:

1. public sector integrity: protections and incentives
2. engaging employees on PIDA
3. investigating whistleblower reports: current practices and legislation
4. the human impact of reprisal: mental health, ostracism and recovery
5. public interest and accountability: lessons from the Nisga'a Lisims Government

Almost all attendees who participated in the follow-up survey were satisfied with facilitators, speakers, and presenters (94%) and agreed that PIDA Day was well organized (99%) and informative (97%).

"Asking many experts from different fields to share their knowledge ... That richness makes us understand the Act's complexity and how it affects the many people involved. That was amazing."

– PIDA Day attendee

CASE SUMMARIES

The following section includes summaries of some disclosure investigations completed by the Ombudsperson that resulted in recommendations to public bodies covered by PIDA to address identified concerns. Under PIDA, the Ombudsperson may make recommendations following an investigation regardless of whether wrongdoing was found. To review public body responses to our recommendations, please see our *PIDA Special Report #4: Operational Review*.

Contracts in legal cases

The alleged wrongdoing

We received a disclosure under PIDA alleging that the Ministry of Children and Family Development (MCFD) misused public funds when engaging in legal proceedings under the *Child, Family and Community Services Act and the Family Law Act*. The discloser alleged that MCFD acted contrary to government financial directives by:

- establishing contracts for expert witness and court transcript services without obtaining required approval from the Ministry of Attorney General (MAG)
- coding the invoices and payments for these transactions improperly
- paying excessive witness fees higher than the amount allowed by MAG

Our investigation focused on whether MCFD seriously misused public funds under section 7(1)(c) of PIDA.

The investigation

Establishing contracts for expert witness fees and court transcripts without approval

Our investigation found that MCFD was authorized to establish contracts for court transcripts under the *Child, Family and Community Services Act* and the service level agreement between MCFD and MAG that was in place at the relevant time.

However, we also found that in family law cases, MCFD did not have authority to establish contracts for more than $700 without prior MAG approval. In 2019, MAG reiterated to MCFD that all contracts should go through MAG.

In this case, MCFD had contracted with outside legal counsel rather than using the legal counsel normally supplied by MAG. This outside legal counsel, who was involved in engaging the witnesses and obtaining transcripts, did not follow the appropriate procedures established by MAG because they were not familiar with them.

Coding for the invoices and payments improperly

Our investigation found that financial coding practices within MCFD allowed staff discretion, and there was no single correct set of coding practices for most transactions. MCFD's cost-management practices directed staff to code transactions as closely as possible to the description of the actual activity the transactions represented.

MCFD confirmed that its staff, who have delegated expense authority, are permitted discretion to spend budget dollars in their areas of responsibility. MCFD further maintained that variation in financial coding practices between different staff had no meaningful impact on its overall financial reporting because the different expenditures would be added to the same financial reporting line.

Paying excessive witness fees

We also found that the expert witness fees in one family court process exceeded the amounts allowed under the applicable MAG policy by approximately $6,000. The MAG policy in question stated that charging a higher rate was prohibited.

MCFD's records did not show consideration or discussion of the fee amounts and the records we reviewed showed that MAG staff:

- received a specific witness fee estimate in advance of the witness' testimony
- reviewed the invoices after the testimony in question
- requested additional information, and an opportunity to review before payment
- did not receive further information
- did not pay anything because MAG was not provided with an invoice at the proper rates for approval

Was it wrongdoing?

We consider an act to be a serious misuse of public funds under PIDA if the use of public funds was irregular or outside of what is normally expected in the circumstances, and that irregular use was serious in terms of the amount, the frequency, or because the misuse was in bad faith.

We found that there was no serious misuse in relation to either the court transcripts or the expert witness fees and therefore, no wrongdoing.

We determined there was no misuse of public funds in the direct contracting for court transcripts because the specific transactions in question were approved by a MCFD executive within the scope of their authority under the *Child, Family and Community Services Act*, and the funds were used as intended. The evidence also supported that the financial coding of the invoices in question was within the range of accepted practice and aligned with MCFD's agreement with MAG on appropriate coding.

Similarly, our investigation found that the transactions for payment of witness fees did not involve a serious misuse of public funds. While the direct contracting with expert witnesses was not authorized, and the fee amounts did not comply with the applicable MAG policy, the evidence indicated the contracted legal counsel was not familiar with the correct procedure. Our investigation identified that the contracting practices in this case reflected errors by MCFD staff and outside counsel, and perhaps a lack of oversight by MAG personnel. However, this was not a serious misuse of funds as would be required by PIDA for a finding of wrongdoing.

It was evident that these transactions arose in the context of complex and contentious proceedings. Furthermore, while we recognized the dollar value of the amount paid to the expert witness was excessive compared to MAG guide rates, it was within the range of similar service contracts. The use of expert witnesses in proceedings is part of MCFD’s usual practice in fulfilling its mandate. Therefore, the evidence did not support a finding of serious misuse of public funds. However, we did find the applicable MAG policy should be reviewed and updated to provide clearer guidance.

The Ombudsperson's recommendations

Despite our determination that the ministries' actions related to direct contracts and witness fees were not wrongdoing under PIDA, we considered it appropriate to make recommendations under section 27(2)(c) of PIDA to ensure MCFD and MAG addressed the issues we identified.

Recommendation 1: MAG update the 2010 Billing and Reporting Guide to expressly address the question of what is to be done when outside counsel retain expert witnesses at amounts in excess of the guide without government approval. We recommended that this update be completed in consultation with the Office of the Comptroller General and other BC government ministries including MCFD.

Recommendation 2: MCFD train relevant staff on the guide and the resulting ministry procedures once the guide referred to in Recommendation 1 was updated.

Follow-up on the recommendations

MAG and MCFD both accepted our recommendations and we worked with each to ensure the recommendations were fully implemented. As of the date of this report, we understand that the following work has taken place:

Status of Recommendation 1: The Ministry of Attorney General Billing and Reporting Guide was updated, in consultation with the Office of the Comptroller General, in February 2022.

Status of Recommendation 2: Following the update to the guide, MCFD's intranet was updated to provide information in line with the guide. The intranet states all contracts with ad hoc counsel or expert witnesses for case-specific purposes must go through the Legal Services Branch and MCFD staff should not initiate ad hoc contracts with legal counsel or expert witnesses.

The Ombudsperson considers the recommendations fully implemented.

Safe activities

The alleged wrongdoing

We received a disclosure under PIDA alleging that a small public body failed to fulfill its mandate to ensure the safety and integrity of certain activities involving members of the public. Our investigation focused on whether there was gross or systemic mismanagement in relation to the public body's mandate, contrary to section 7(1)(d) of PIDA.

The investigation

Section 40(6) of PIDA requires that we exclude from a public report any information that would:

(a) unreasonably invade a person's privacy

(b) reveal the identity of a discloser, or

(c) reveal the identity of an individual who was the subject of an investigation

Given this provision and considering the nature of the allegation and the small size of the public body, we cannot publicly release the details of this investigation.

Providing details about the nature of the disclosure or the investigation would reveal the identify of the individual who was the subject of the investigation and may reveal the identity of the discloser.

Was it wrongdoing?

Our investigation resulted in no finding of wrongdoing.

The Ombudsperson's recommendations

While we did not find any wrongdoing, based on the evidence gathered during the investigation, the Ombudsperson recommended the public body make changes to its policy and establish an appropriate system to ensure that the activities it oversees are properly monitored and safe for those involved.

Follow-up on the recommendations

The public body agreed to the recommendations. It redeveloped its policy and established a system to undertake the necessary monitoring of the activities in question.

The Ombudsperson determined the public body has fully implemented the recommendations.

Use of a government vehicle

The alleged wrongdoing

We received a disclosure under PIDA alleging that a former Commercial Vehicle Safety and Enforcement (CVSE) officer used their assigned patrol vehicle for extensive personal use.

CVSE is a branch of what is now known as the Ministry of Transportation and Transit (MOTT) and promotes compliance with safety regulations for heavy trucks and other commercial transport to increase road safety and protect public health, transportation infrastructure, and the environment.[1]

Personal use of a CVSE vehicle could undermine trust in a public institution, result in additional wear or damage to a public asset, and cause public safety issues if the vehicle is mistaken for being involved in enforcement activities.

We investigated whether this conduct was a serious misuse of a public asset under section 7(1)(c) of PIDA.

The investigation

Authorized use of the patrol vehicle

Our investigation determined that the officer was hired to work in a stationary position at a specific commercial vehicle scale and was only permitted to use their patrol vehicle to travel to and from the scale, and to and from pre-authorized training or meetings. We also learned that, due to organizational changes and the remote location of the officer's posting, the officer's supervisor informally assigned the officer increased enforcement activities and permitted use of the vehicle for that purpose.

However, we received conflicting accounts from CVSE management regarding the nature of the approved enforcement activities, including whether the officer was allowed to conduct mobile enforcement and inspection, and allowed to work alone while doing so. Our investigation determined that the informal expansion of the officer's role caused confusion for the officer, their supervisors, and other CVSE staff.

[1] Province of British Columbia, Commercial Vehicle Safety and Enforcement, "Key Facts".

Unauthorized work use

Our investigation also showed that the officer did not inform their supervisor when they were working alone and undertaking patrol activities. In addition, contrary to CVSE procedures, the officer had travelled outside of the province without first receiving their supervisor's permission. We could not determine whether the officer's travel outside of the province was solely related to their work. However, this only occurred once. We found that the officer's supervisor was not always aware of the officer's location even when working in the province and did not address this with the officer. This put the officer and the public at risk because CVSE would not have been able to provide backup or assistance when the officer was alone and in remote areas without cell service.

Personal use

The records we reviewed showed that the officer did not consistently inform their supervisor of their travel plans when working. Further, the supervisor did not request additional information from the officer to ensure accurate reporting and compliance with CVSE procedures. Based on the limited information available, we could not determine how much of the officer's vehicle mileage was due to authorized work activities, unauthorized activities, or for personal use.

Was it wrongdoing?

We consider several factors in determining whether conduct constitutes a serious misuse of public assets under PIDA:

- Was the asset public?
- Was the asset misused?
- Was the misuse serious?

In this case, we confirmed the patrol vehicle was a public asset and it was used in an unauthorized way – the officer did not consistently follow CVSE procedures for working alone or travelling out of the province.

However, we could not conclude that the misuse was serious. This was because we could not determine whether any unauthorized use was due to the officer's failure to follow procedures for working alone, the lack of clear direction from their supervisor, or a result of the supervisor's failure to address the unique work situation of the employee. Most of the instances of possible misuse were work-related.

In addition, the informal expansion of the officer's role contributed to confusion for other CVSE staff regarding the officer's use of the patrol vehicle and enforcement activities. For these reasons, we determined that the officer's unauthorized use of their patrol vehicle was not serious misuse of a public asset and therefore, there was no wrongdoing.

The Ombudsperson's recommendations

Despite finding the use of the vehicle was not wrongdoing under PIDA, we considered it appropriate to make recommendations under section 27(2)(c) of PIDA to ensure MOTT addressed the issues we identified.

Recommendation 1: Through the SafetyAware application, or by other means, MOTT consider tracking and monitoring CVSE officer use of its vehicle fleet while off-duty.

Since this case, CVSE had started using a GPS application called SafetyAware to track officer locations. However, SafetyAware only works when officers use it. We were concerned that officers may still use patrol vehicles off duty or for personal use without engaging the SafetyAware application. Therefore, we recommended that MOTT track and monitor CVSE officer vehicle use while off duty through SafetyAware, or other means.

Recommendation 2: MOTT improve tracking of CVSE officer training and communicate training to new supervisors to support officer transitions.

This case highlighted concerns with CVSE's practices for assigning new supervisors and tracking officer training and experience. In this case, the gap may have led to the officer conducting enforcement activities beyond their training or experience. Therefore, we recommended that MOTT improve its tracking and communication of CVSE officer training.

Follow-up on the recommendations

MOTT accepted both recommendations and we are continuing to work with it to ensure our recommendations are fully implemented. As of the date of this report, we understand that the following work has been completed:

Status of Recommendation 1: MOTT does not currently have a GPS tracking program in place. The provincial government's existing fleet management services contract expires January 31, 2026. We have been informed that staff at the Ministry of Citizens' Services are tendering documents for a new contract that will include provisions for GPS tracking for fleet management.

Meanwhile, CVSE officers continue to be required to follow the government's core policy and procedures when operating government vehicles, in addition to CVSE's vehicle usage policy.

Status of Recommendation 2: MOTT is developing a Learning Management System to house and facilitate CVSE training. While being developed, CVSE has used monthly management and supervisor meetings to discuss officer course requirements and completions, refresher training, and where more support may be needed.

CVSE is also working with the BC Public Service Agency to enter all CVSE-specific training completed by officers into its MyLearning system to ensure supervisors can easily view all training completed by staff.

Culvert engineering

The alleged wrongdoing

We received a disclosure alleging the Ministry of Transportation and Transit (MOTT) routinely failed to ensure that large culvert replacements met the requirements of the *Water Sustainability Act* and the *Water Sustainability Regulation* (the Regulation).

Culverts are large pipes often installed under roads to prevent flooding, to channel water past an obstacle, or to provide for effective drainage. As part of its highway infrastructure, MOTT constructs culverts to allow for streams to cross under roads.

The disclosure alleged that on three creeks where culverts were installed, MOTT did not follow these legal requirements:

- culverts must allow fish to swim through unimpeded
- large culverts (2 meters to 2.9 meters in diameter) must be designed by an engineer

A failure to properly construct these large culverts could endanger public safety or result in damage to private property.

This allegation raised concerns of wrongdoing under PIDA that could be:

- an act or omission that creates a substantial and specific danger to the life, health or safety of persons, or to the environment, other than a danger that is inherent in the performance of an employee's duties or functions
- gross or systemic mismanagement

The investigation

For the first creek, based on MOTT's records and interviews with staff, we were unable to conclude whether the culvert allowed fish passage. However, the culvert was 1.8 meters in diameter and was not required to be designed by an engineer.

For the second creek, the evidence showed that the culvert would enable fish passage and the structural design documents were also stamped by an engineer. However, we were unable to determine whether engineers conducted a site-specific assessment of the creek in support of the culvert's design. As such, we could not conclude that MOTT met the legal requirement to involve an engineer in designing the culvert.

For the third creek, MOTT's records showed it had paid special attention to enabling fish passage during the culvert installation. However, there was no evidence that an engineer was involved in an assessment of the drainage basin, the site-specific conditions of the stream channel, or in determining whether the

culvert had sufficient hydraulic capacity for the flow of the stream. Therefore, we found that MOTT did not meet the legal requirement to involve an engineer in designing the culvert.

Was it wrongdoing?

PIDA considers conduct a wrongdoing if an act or omission creates a substantial and specific danger to the life, health or safety of persons, or to the environment, other than a danger that is inherent in the performance of an employee's duties or functions.

The culverts at issue did not present either a substantial or specific danger to life, health or safety. Even though MOTT did not involve an engineer in the design of the third creek, the location of the culvert and the evidence received did not support a conclusion that there was a substantial danger of harm from potential failure of the culvert. Further, MOTT involved the appropriate environmental consultants during the culvert projects and representatives from MOTT's environmental management branch weighed relevant factors to determine what action would be best for the aquatic environment during culvert installation.

We consider conduct to be gross or systemic mismanagement under PIDA if the mismanagement was of a public resource, and that mismanagement was serious, longstanding or widespread. While in one case, MOTT's failure to involve an engineer in the culvert's design was contrary to the Regulation, staff attempted to ensure the appropriate operation of the culvert in the stream. We did not have evidence of any existing negative impact resulting from the violation. Therefore, we concluded that MOTT's actions did not reach the threshold to be considered gross or systemic mismanagement under PIDA.

The Ombudsperson's recommendations

While we did not find that the conduct of staff represented a wrongdoing, the failure to involve an engineer as required remained a significant concern. For this reason, we made two recommendations under section 27(2)(c) of PIDA to ensure MOTT addressed the issues we identified.

Recommendation 1: MOTT employ an engineer to assess the culvert installation on the third creek to ensure it was appropriate.

We made this recommendation to mitigate the potential for future harm caused by the culvert by having it examined in accordance with the regulatory requirements.

Recommendation 2: MOTT ensure that the installation of all culverts with a diameter of 2 metres and larger follow the design of an engineering professional.

We made this recommendation to align MOTT's practices with the Regulation and to ensure MOTT's climate change adaptation commitments are met. MOTT acknowledged that culverts between 2 metres and 2.9 meters carry significant amounts of water and deficiencies in these culverts can have disastrous consequences for the aquatic environment, private property and for those downstream relying on the stream for clean water.

Follow-up on the recommendations

MOTT accepted both recommendations. We worked with staff to monitor its progress and ensure the recommendations were fully completed.

Status of Recommendation 1: MOTT retained an external engineering firm to undertake the inspection necessary to assess the culvert installation and capacity. The engineer's report confirmed that the culvert is appropriately sized for the channel.

Status of Recommendation 2: MOTT created a new position, Water Permitting and Authorizations, to assist ministry operations, project delivery and engineering staff with water matters, including the *Water Sustainability Ac*t and the Regulation, as well as with drainage related issues in connection with MOTT's infrastructure. The position is intended to add additional skilled resources to MOTT's operations. Its goal is to bring an additional layer of oversight, skill, knowledge and expertise in the conduct of these operations.

The Water Permitting and Authorizations team have been carrying out training sessions for MOTT staff on when to engage professionals regarding work conducted in and about water bodies.

MOTT is updating the Standard Specifications for Highway Construction document to provide greater clarity on the document's purpose as a construction guide. In particular, the updates are anticipated to provide guidance for when professionals are to be hired to provide design requirements. It is expected that appropriate communications and training of staff will coincide with, or follow the updating of this guide.

MOTT's chief engineer led the development and implementation of a guidance document regarding culvert requirements, which will be published once review processes are complete.

MOTT is also preparing a best practices guide to clarify for operations staff what would constitute an emergency culvert replacement.

The Ombudsperson considers the recommendations fully implemented.

FEATURE REPORT

Hire Power

The alleged wrongdoing

We received a disclosure alleging the wrongful hiring of two ministerial assistants into roles with the Ministry of Social Development and Poverty Reduction (MSDPR) immediately following their time as ministerial assistants to the minister. The discloser alleged the ministerial assistants were hired by MSDPR at the request of the minister without following the applicable processes, and once hired, they received preferential treatment during internal promotion opportunities.

We investigated the disclosure to determine whether gross or systemic mismanagement occurred in or relating to MSDPR.

During our investigation, we reviewed evidence that showed the BC Public Service Agency (the PSA) was not correctly applying the relevant hiring policy to ministerial assistants who are Order in Council (OIC) appointees. We expanded the investigation by looking into whether the PSA's process for managing OIC appointees applying to competitions which they were not eligible for could constitute systemic mismanagement in or relating to the PSA.

Specifically, we investigated whether there was a failure by the PSA to ensure compliance with section 9.1 of the Terms and Conditions for Excluded Employees, which prohibits OIC appointees from applying to internal temporary assignment competitions.

The investigation

MSDPR investigation

Based on records and interviews with MSDPR and PSA staff, we found that MSDPR followed public service-wide practice regarding eligibility of ministerial assistants, or political staff, to public service assignments. But the public service-wide practice was inconsistent with written government policy.

One of the ministerial assistants was hired through a competitive process. The other ministerial assistant's hiring and subsequent promotion complied with the *Public Service Act*.

The evidence did not suggest any ministerial interference in the hiring of the two ministerial assistants at issue or preference towards either employee.

Rather, the evidence raised questions about the PSA-endorsed public service-wide application of section 9.1 of the Terms and Conditions for Excluded Employees. Contrary to the Terms and Conditions, OIC appointees across the public service were accessing and competing for internal temporary assignment opportunities – positions they were not eligible to apply for and which were reserved for regular public servants only. The Terms and Conditions are the PSA's policy and the PSA's responsibility to administer, amend and enforce as required. As such, we pursued this issue directly with the PSA.

PSA investigation

The evidence provided by the PSA revealed a regular and long-standing issue regarding OIC appointees applying for internal temporary assignments. The data showed that over 10 years, at least 64 eligible public servant applicants were not offered positions because they came in second to an OIC appointee. There was no mechanism for ineligible applicants to be identified and removed from the competition. OIC appointees were not informed of section 9.1 at the time of their appointments.

The evidence showed that, rather than excluding identified OIC appointees from internal temporary assignment competitions, the PSA had developed a regular informal process to manage competitions when OIC appointees were successful. If OIC appointees were successful in an internal temporary assignment competition, the PSA expected them to resign from their appointments and accept their temporary assignment on an auxiliary basis.

Was it wrongdoing?

Our assessment of MSDPR's conduct

Gross mismanagement is serious and requires conduct that is negligent, an abuse of authority, unlawful, in bad faith, or dishonest. In this case, to make such a finding, we would need evidence that there was improper and biased processes which resulted in specific ministerial assistants being appointed to their positions within MSDPR. With respect to ministerial interference, we would need evidence that the minister directly meddled in the hiring decisions made.

The evidence we found did not support the discloser's allegations or a finding of wrongdoing under PIDA in or relating to MSDPR's hiring of the specific ministerial assistants.

Our assessment of the PSA's conduct

Systemic mismanagement is broad, longstanding, or organizational in nature. It is typically recurrent, involves or impacts a broad number of people and is often known of and accepted by those with a high level of responsibility.

The evidence we found supported a finding of systemic mismanagement, a wrongdoing under PIDA.

While a small percentage of public service employees were affected by the alternative process, for those who were, the inappropriate loss of a development opportunity was a serious matter. There is the loss of the direct benefit (such as a likely increased salary) but also the long-term impact of missing out on a developmental opportunity. The latter can have an impact on the trajectory of an entire career. Missing out on developmental opportunities awarded to ineligible employees is unfair and contrary to the public service hiring principles. The PSA increased the seriousness of the wrongdoing by developing and using an alternative informal process to circumvent policy.

The alternative process demonstrated broad acceptance of regular contravention of the PSA's own policy. Rather than seeking to mitigate the practical challenges the policy posed, the PSA created an alternative and informal process, that contravened the wording and intention of the policy. The PSA allowed OIC appointees to hold positions they were not intended to be eligible for at the expense of current public sector employees. Broad acceptance of a known issue is a common feature of systemic mismanagement.

An applicant's loss of an employment opportunity to which they were otherwise entitled, due to a systemic acceptance of a policy breach, is a serious concern that damages the PSA's record of ensuring the public service is a fair and principled employer. This constitutes systemic mismanagement.

The Ombudsperson's recommendations

As a result of our determination of wrongdoing, we made the following recommendations under section 27(2)(c) of PIDA to ensure the PSA addressed the issues we identified.

Recommendation 1: The PSA update its practices to be consistent with section 9.1 of the Terms and Conditions for Excluded Employees by amending:

- existing hiring procedures and materials, including systems changes if practicable, to assist in identifying and screening out OIC appointees from a competition
- onboarding templates for OIC appointees to clearly communicate section 9.1 and the expectations for OIC appointees that flow from the policy

Recommendation 2: The PSA communicate section 9.1 to deputy ministers in writing and ensure the information was also provided to ministers' offices.

Recommendation 3: Where OIC appointees are identified as having applied for a temporary assignment, to advise the appointee that they are in breach of section 9.1 and on a second occurrence their supervisor will be advised for the purpose of follow-up with the employee.

Recommendation 4: The PSA report to the Merit Commissioner annually for the next three years, its compliance with these recommendations, in a manner the Merit Commissioner considers appropriate. The PSA may return to the Ombudsperson's office to review this recommendation if the PSA believes the manner set out by the Merit Commissioner is unreasonable.

As the independent office of the Legislature tasked with auditing and reviewing hiring competitions under the *Public Service Act,* the Merit Commissioner's expertise is well suited to monitor the PSA's progress on the recommendations.

We issued a special report in June 2024 on our investigation into this matter. *Hire Power: The appointment of ineligible candidates to temporary assignments in the public service* is published on our website.

Follow-up on the recommendations

The PSA accepted our recommendations and the Merit Commissioner will be receiving progress updates. The PSA first reported to the Merit Commissioner on its progress in implementing the recommendation in May 2025, with additional reports expected in May 2026 and 2027.

The PSA has informed us that the following work will take place:

Status of Recommendation 1: The PSA will update its recruitment system questionnaire to identify and screen out applicants who are OIC appointees, and update its offer letters to clarify the temporary assignment restriction.

Status of Recommendation 2: The PSA will send a further reminder letter out to all deputy ministers and ensure the information is also provided to ministers' offices.

Status of Recommendation 3: The PSA will exercise due diligence to notify OIC applicants that they cannot apply for temporary assignments and that if identified, their application must be withdrawn. If the PSA becomes aware of multiple applications by an OIC for temporary assignments, it will notify their supervisor.

Status of Recommendation 4: The PSA will report its compliance with these recommendations and will continue to do so until 2027.

Employment standards decisions

The alleged wrongdoing

Our office received a disclosure under PIDA alleging that the Employment Standards Branch (the ESB) of the Ministry of Labour undermined the independent decision-making of its Industrial Relations Officers (IROs). The concerns had previously been raised internally and included allegations that the ESB had been improperly deleting records that would be necessary if a judicial review application was filed contesting a decision. We investigated the disclosure to determine whether wrongdoing occurred in or relating to the ESB. Specifically, whether there was gross or systemic mismanagement as contemplated by section 7(1)(d) of PIDA.

The ESB's mandate is to promote and uphold the BC *Employment Standards Act*, which protects employees and sets minimum requirements for employers. Its IROs are responsible for mediating and adjudicating workplace complaints. If either party (employer or worker) disagrees with an IRO's decision they may appeal to the Employment Standards Tribunal, and then make an application for judicial review to the BC Supreme Court.

We assessed the disclosure and determined that the allegations, if proven, could constitute wrongdoing under PIDA. As a result, we decided to investigate the matter. Our investigation focused on whether the ESB had a practice of improperly fettering, or limiting, the discretion of its IROs.

Specifically, we looked at:

1. whether an ESB program advisor, through a "read-and-review" process, repeatedly and substantially fettered the discretion of IROs' determinations under the *Employment Standards Act* and the *Temporary Foreign Worker Protection Act*. If true, the ESB's actions would be contrary to the rules of natural justice.
2. whether the ESB had a practice of deleting records related to the "read-and-review" process that is contrary to government records requirements.

The investigation

Fettering discretion

Our investigation began by looking into the "read-and-review" process the ESB used whereby program advisors reviewed, and could change, the determinations of IROs. Early in our investigation, we learned that a lawyer from the Ministry of Attorney General's Legal Services Branch (the LSB) had already reviewed the fettering allegations. Records from a committee – comprised of Ministry of Attorney General (MAG) and Public Service Agency (PSA) executives – coordinating the response to these allegations suggested that an investigation was undertaken, findings were made, and the committee considered whether any further action was required.

Given the overlap between our investigation of the fettering allegations and the LSB lawyer's review, we attempted several times to obtain evidence to clarify the lawyer's findings, the committee's consideration of the review, and/or any subsequent steps taken. This was necessary to determine whether the matter had already been appropriately investigated. However, the substantive aspects of the records were redacted or otherwise withheld from our office by MAG, citing solicitor-client privilege.

Without more specifics about the fettering review done by LSB or the committee, we needed to interview several current and former senior executives within the PSA and Ministry of Labour, and to pursue additional documentation to help us clarify matters.

As a result, we were able to determine that the IROs' discretion could not be fettered because they do not have independent decision-making authority; they are delegates of the ESB director. However, we received evidence that suggested the fettering review may have ended prematurely.

Without the redacted and withheld information, we were unable to determine whether the review was appropriately completed.

Deleting records

Our investigation found that the ESB had deleted records – primarily created in the "read-and-review" process – which it viewed as transitory or not needed as evidence of the decision. This is permitted under the applicable legislation. The question of whether it was correct to characterize such records as transitory was less clear. The ESB said it had a legal opinion to support its perspective but the PSA and the Corporate Information and Records Management Office (CIRMO) interpreted the opinion differently. However, the PSA and CIRMO stated they were unable to definitively determine whether those records were transitory because they were not experts in the ESB's work.

The CIRMO report on the matter raised the prospect that the records were not transitory and could not be deleted because they could be considered relevant to a litigation discovery process. However, CIRMO's assessment, analysis, and conclusions were redacted from the report and they refused to share them with us, citing solicitor-client privilege.

Again, without access to the privileged information, we were required to interview several additional executives to better assess whether the ESB inappropriately deleted records.

In response to our inquiries, an executive at the ESB reviewed its processes and confirmed there was “little, if any, indication that the ESB is not in compliance with appropriate policies.” In addition, after re-reviewing CIRMO’s report on the matter, the ESB updated its policy and communicated to staff about the classification of records and its obligations.

As with the discretion issue, we were unable to determine with certainty whether the matter had been appropriately reviewed. We had outstanding questions about whether certain records were authorized to be deleted while legal processes related to the relevant files were underway.

Was it wrongdoing?

We consider a variety of factors in determining whether conduct constitutes gross mismanagement under PIDA, including whether it involves a person in a position with a high level of authority or responsibility, whether the conduct is recklessly negligent, deliberate, for an improper purpose or personal gain, or an abuse of authority. Systemic mismanagement is mismanagement that is wide spread, long standing or a part of the organization’s culture or practice.

Fettering discretion

We determined that no wrongdoing occurred related to this allegation.

Our investigation supported that the IROs are not independent statutory decision makers and the ESB’s “read-and-review” procedure was a quality assurance process to ensure staff made decisions in line with its policies, precedent, and applicable laws. Therefore, we found that on a balance of probabilities, the ESB did not improperly fetter the IROs' discretion. However, without the complete record, we had outstanding investigative questions about the process used in reviewing this matter.

Deleting records

We determined that no wrongdoing occurred related to this matter.

Our investigation found the ESB acted proactively to define its records policies and ensure compliance with records requirements. The evidence we reviewed indicated the ESB’s process was to only delete internal, operational records, and not external records that are considered public record. Therefore, we found that on a balance of probabilities the ESB’s current process complied with government records requirements. Again, however, the lack of access to privileged information left outstanding questions about whether prior practice was appropriate and whether the matter had been properly investigated or dealt with.

The Ombudsperson's recommendation

Since 1991, our office has had an agreement with MAG that it will provide us with information which may be subject to solicitor-client privilege related to investigations under the *Ombudsperson Act.* We do not consider the sharing to be a waiver of privilege, and we always maintain the confidentiality of that information. As a primary oversight body of government, we use this information to thoroughly and accurately assess how government has handled matters of concern to determine whether conduct was appropriate or reasonable. Our office has managed receipt of this information for almost 35 years. Regrettably, MAG refused to provide us with the same information when requested for investigations under PIDA.

Due to MAG's refusal to provide several pieces of information requested, we were unable to make more conclusive determinations whether what occurred was appropriate. While we were able to determine no wrongdoing occurred, we were not able to definitively clear the Ministry of Labour of all possible misdeeds. Further, this refusal required us to speak to significantly more people, including some no longer working for government, to pull several senior executives away from their core work, and to conduct a lengthier investigation overall to make our conclusions. This meant informing significantly more people of the allegations against the Ministry of Labour and specific senior executives – knowledge they would not otherwise have had. This casts an unnecessary cloud over the ministry and the individuals involved.

PIDA requires us to conduct investigations confidentially and in an expeditious, fair and proportionate manner as appropriate in the circumstances. The refusal to share privileged information frustrates these requirements and creates a process that unnecessarily involves more people and is neither expedient nor proportionate in the circumstances.

Recommendation 1: Despite our finding of no wrongdoing, we considered it appropriate to make a recommendation, under section 27(2)(c) of PIDA, that the MAG provide us with information that may be subject to solicitor-client privilege related to PIDA investigations. We believe the sharing of this information is not a waiver of privilege and ensures the appropriate operation of PIDA.

Follow-up on the recommendation

MAG did not accept our recommendation. It plans to continue its current practice of assessing our requests for information that could be subject to solicitor-client privilege on a case-by-case basis. We note that, with respect to PIDA investigations, none of the requests made to date have been approved.

Tuition fees

The alleged wrongdoing

We received a disclosure alleging that a person in a senior management position at the Ministry of Health (the ministry) had shown favouritism towards a particular employee and inappropriately reimbursed, through the Pacific Leaders Scholarship Program (PLSP), all fees associated with the employee's graduate degree program.

If true, this allegation raised concerns of a serious misuse of public funds under section 7(1)(c) of PIDA.

We investigated the disclosure to determine whether wrongdoing occurred in or relating to the ministry. We focused on three aspects of the allegation:

1. whether the reimbursement to the employee was outside guidelines, and if so, the reason for reimbursement
2. whether there were appropriate conditions attached to the reimbursement per the PLSP guidelines
3. whether there was any favouritism toward the employee

The investigation

Allegation of reimbursement outside guidelines

Based on our review of the evidence, we determined that the employee applied for and received full reimbursement for tuition fees through both PLSP (in the maximum amount of $7,500) and the ministry's employee training and course fees budget expense category. This was done despite an agreement between all ministries and the Deputy Ministers' Council (DMC) that limited tuition fee reimbursement beyond the PLSP's maximum. In accordance with this agreement, a ministry's training budget should not be used to top up funding beyond PLSP maximums.

However, limited information about the terms of the DMC agreement and the lack of clear communication from the DMC to ministries created ambiguity about the PLSP reimbursement limits. Further, in this case, the ministry provided a reasonable justification for why the employee received a full reimbursement for the program.

Considering these factors, we could not conclude that the reimbursements were clearly made outside of the DMC's guidelines.

Conditions attached to approval of the reimbursement

The employee signed an agreement with the ministry to maintain adequate grades and remain working in the public service for a specified amount of time after completing the degree, or the employee would repay the reimbursement. This agreement aligned with PLSP guidelines.

We determined that the allegation was unsubstantiated – there were in fact appropriate conditions attached to the employee's program as required by PLSP guidelines, and the employee did later repay the full $7,500 to the ministry.

Allegations of favouritism

Our review of the ministry's records and interviews with the discloser and other witnesses did not present any other specific instances of favourable treatment of the employee. In addition, the ministry had authorized full reimbursement to a second member of staff for enrollment in a similar degree program for similar reasons. Therefore, we determined that there was no favouritism evident in this case.

Was it wrongdoing?

We consider an act as a serious misuse of public funds under PIDA if the funds are public, and their use was irregular or outside of what is normally expected in the circumstances.

In this case, the ministry provided legitimate reasons connecting the full reimbursement of the degree to the employee's role. Moreover, the DMC had not provided clear direction to government ministries that the PLSP, and its funding limits, were expressly intended to replace a work unit's training budget.

We found that the use was not clearly irregular and therefore there was no serious misuse of public funds under PIDA.

The Ombudsperson's recommendations

While we did not find wrongdoing related to the allegations, our investigation identified issues with respect to the PLSP and its communication of the program. We made the following recommendations under section 27(2)(c) of PIDA to remedy these matters:

Recommendation 1: The Ministry of Health seek clear direction from the DMC about the role of the PLSP in funding training requests for university programs. If the PLSP is intended to be the only method for reimbursing university training, then expressly state this restriction.

Recommendation 2: The PSA clearly communicate the result of any DMC direction to ministries through a memorandum, policy note or other written instrument that establishes any relevant parameters for reimbursing university programs, as well as the scope of any discretion to reimburse beyond the amounts stipulated by the PLSP.

Our investigation revealed ambiguity surrounding the DMC's agreement that ministries will not "top up" applications beyond the prescribed level of funding, and the administration of training. To ensure consistency across the public service, more clarity needed to be provided to ministries.

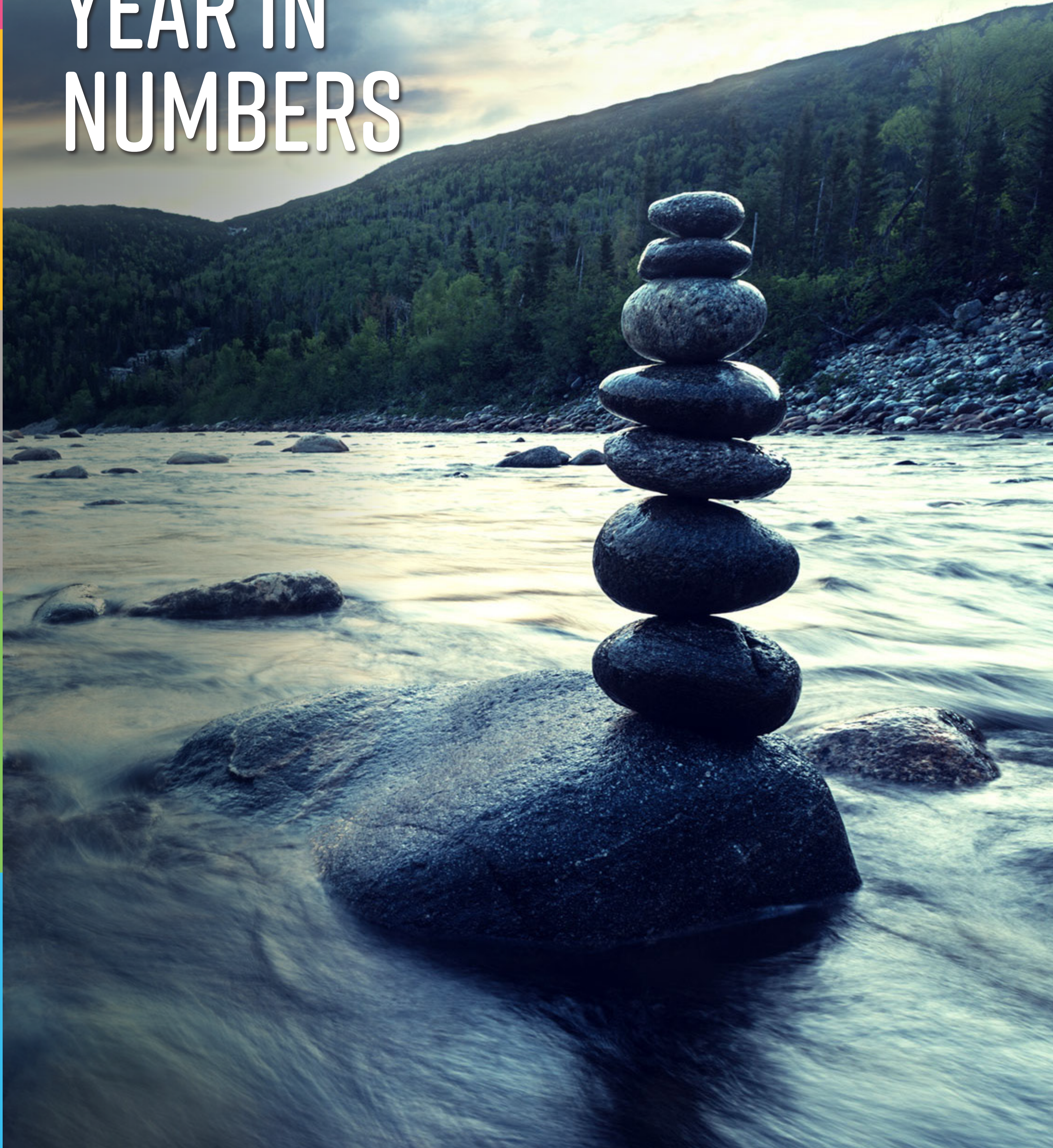
Follow-up on the recommendations

The Ministry of Health and the PSA accepted the recommendations.

Status of Recommendation 1 and Recommendation 2: The PSA is working to clearly communicate the role of the PLSP and the scope of any discretion to reimburse beyond the amounts stipulated by the PLSP.

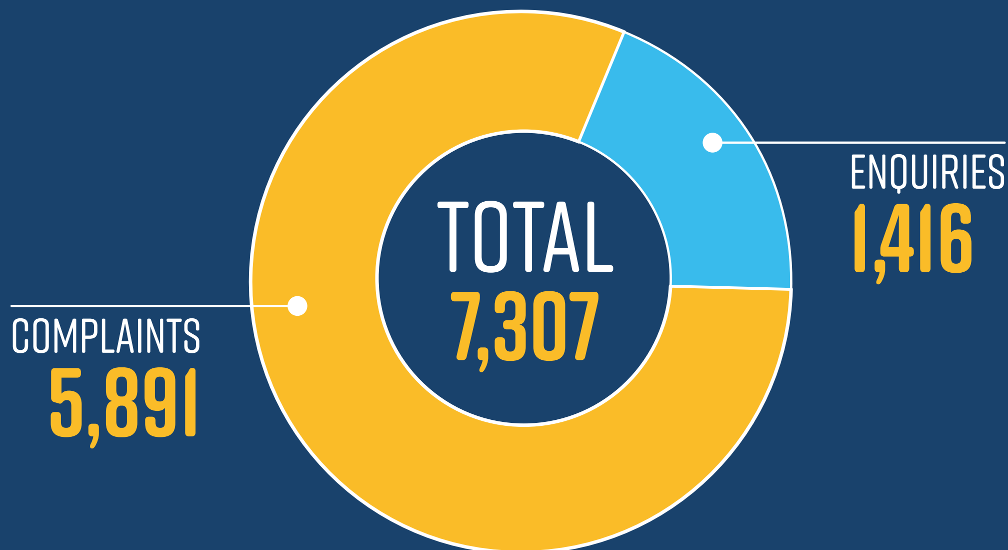
We continue to monitor the recommendations.

2024/25: YEAR IN NUMBERS



OMBUDSPERSON ACT BY THE NUMBERS

Enquiries and complaints received



The fairness concerns people contacted us about

Issues are tracked on individual complaints received and often involve more than one issue per complaint. Thus data does not equal the total enquiry and complaint volume.

- Disagreement with decision: **3,379**
- Process or procedure: **2,386**
- Communication: **1,644**
- Treatment by staff: **1,483**
- Delay: **1,106**
- Accessibility: **814**
- Administrative error: **420**
- Review/appeal process: **353**
- Employment/labour relations: **177**
- Other: **673**

Enquiries and complaints by public body

Top five government ministries

- Ministry of Social Development and Poverty Reduction: 481
- Ministry of Children and Family Development: 408
- Ministry of Public Safety and Solicitor General: 391
- Ministry of Housing and Municipal Affairs: 192
- Ministry of Health: 151

Top five non-ministries

- ICBC: 476
- WorkSafeBC: 223
- Fraser Health Authority: 160
- Vancouver Coastal Health Authority: 147
- Vancouver Island Health Authority: 144

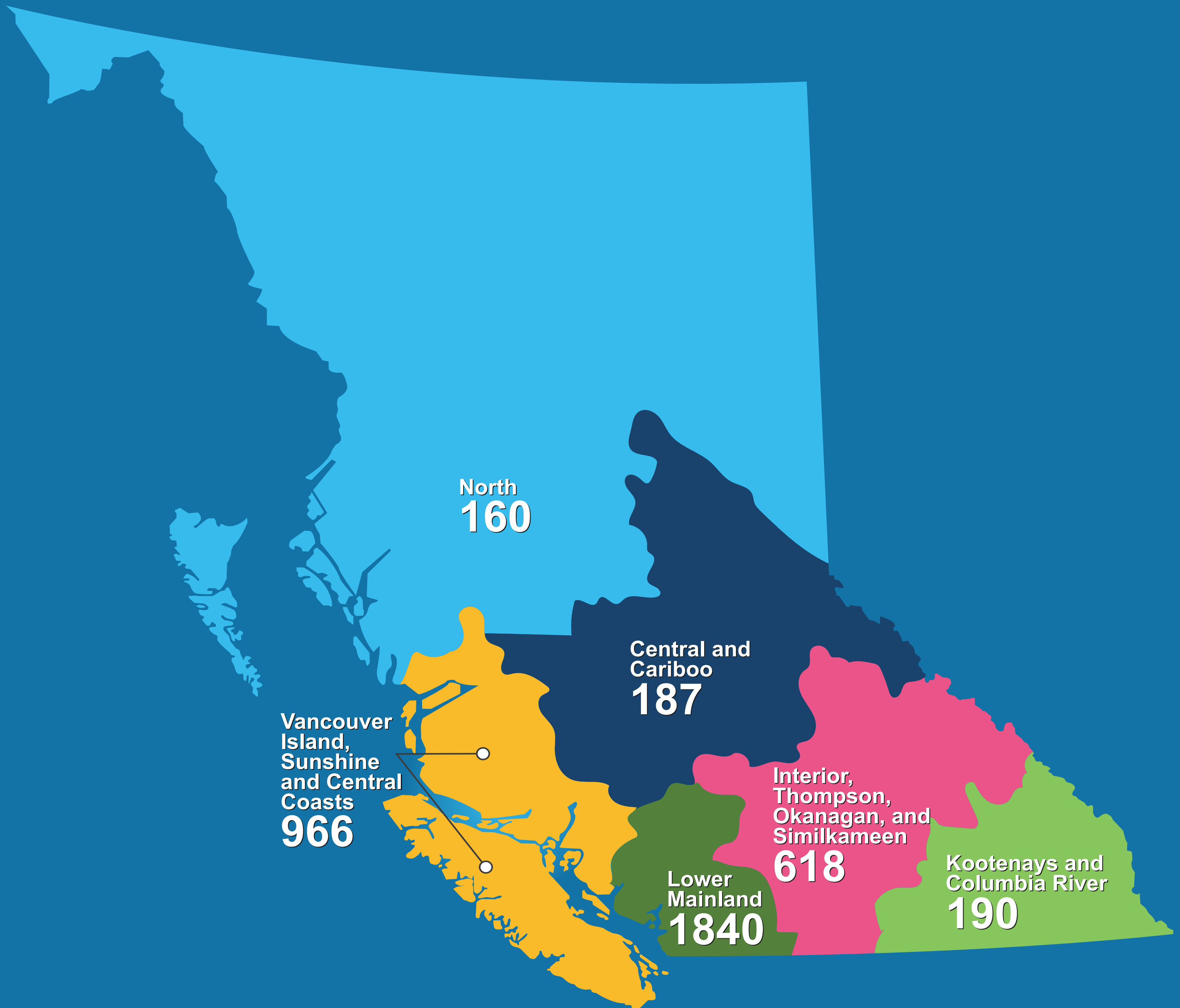
Top 20 public bodies in 2024/25

The top 20 public bodies represent **48%** of all enquiries and complaints received.

Public bodies	Enquiries and complaints received	Difference from 2023/24
Ministry of Social Development and Poverty Reduction	**481**	**+92**
ICBC	**476**	**+11**
Ministry of Children and Family Development	**408**	**+7**
Ministry of Public Safety and Solicitor General	**391**	**+27**
WorkSafeBC	**223**	**+24**
Ministry of Housing and Municipal Affairs	**192**	**-30**
Fraser Health Authority	**160**	**+16**
Ministry of Health	**151**	**+20**
Vancouver Coastal Health Authority	**147**	**+7**
Vancouver Island Health Authority	**144**	**+16**
Ministry of Finance	**113**	**+18**
BC Housing	**101**	**-19**
Interior Health Authority	**98**	**+13**
Provincial Health Services Authority	**69**	**-29**
Ministry of Attorney General	**69**	**+13**
BC Family Maintenance Agency	**65**	**+3**
Law Society of British Columbia	**62**	**+1**
City of Vancouver	**57**	**-16**
Northern Health Authority	**57**	**+9**
Community Living BC	**56**	**+16**
Total Top 20	**3,520**	

Enquiries and complaints by region*

*Data does not include complaints and enquiries where the electoral district was not obtained.



Enquiries and complaints received by authority category

Housing and affordability (19%)	
Ministry of Social Development and Poverty Reduction	481
Ministry of Housing and Municipal Affairs	192
Ministry of Finance	113
BC Housing	101
BC Assessment	26
BC Financial Services Authority	23
Other	36

Health and health care (17%)	
Fraser Health Authority	160
Ministry of Health	151
Vancouver Coastal Health Authority	147
Vancouver Island Health Authority	144
Interior Health Authority	98
Provincial Health Services Authority	69
Northern Health Authority	57
BC Emergency Health Services	12
Other	23

Transportation, infrastructure, and the environment (14%)	
ICBC	476
BC Hydro and Power Authority	52
Ministry of Transportation and Transit	49
Ministry of Forests	29
Ministry of Environment and Parks	23
Ministry of Water, Land and Resource Stewardship	18
Ministry of Energy, Mines and Low Carbon Innovation	17
Ministry of Emergency Management and Climate Readiness	13
TransLink	13
Vehicle Sales Authority of BC	11
BC Transit	7
Other	27

Local government (13%)	
Municipalities	497
Regional Districts	138
Improvement Districts	14
Islands Trust	10
Other	8

Justice (12%)	
Ministry of Public Safety and Solicitor General	391
Ministry of Attorney General	69
Law Society of British Columbia	62
Human Rights Tribunal	31
BC Coroners Service	25
Legal Aid BC	21
Civil Resolution Tribunal	17
Other	17

Services to children, youth, and vulnerable adults (11%)	
Ministry of Children and Family Development	408
BC Family Maintenance Agency	65
Community Living BC	56
Public Guardian and Trustee	53

Employment and professional associations (7%)	
WorkSafeBC	223
College of Physicians and Surgeons of BC	33
Ministry of Labour	30
Workers' Compensation Appeal Tribunal	15
BC College of Nurses and Midwives	11
Other	50

Education (6%)	
School districts	144
Universities	54
Ministry of Education and Child Care	37
Ministry of Post-Secondary Education and Future Skills	29
Colleges	27

Length of time to close files following assignment to an investigator

	2024/25	
Closed in 30 days	353	29%
Closed in 31 to 90 days	312	26%
Closed in 91 to 180 days	225	19%
Closed in 181 days to 1 year	185	15%
Closed in 1 to 2 years	86	7%
Closed in 2 to 3 years	41	3%
Closed in more than 3 years	3	0%

Complaint Checker usage

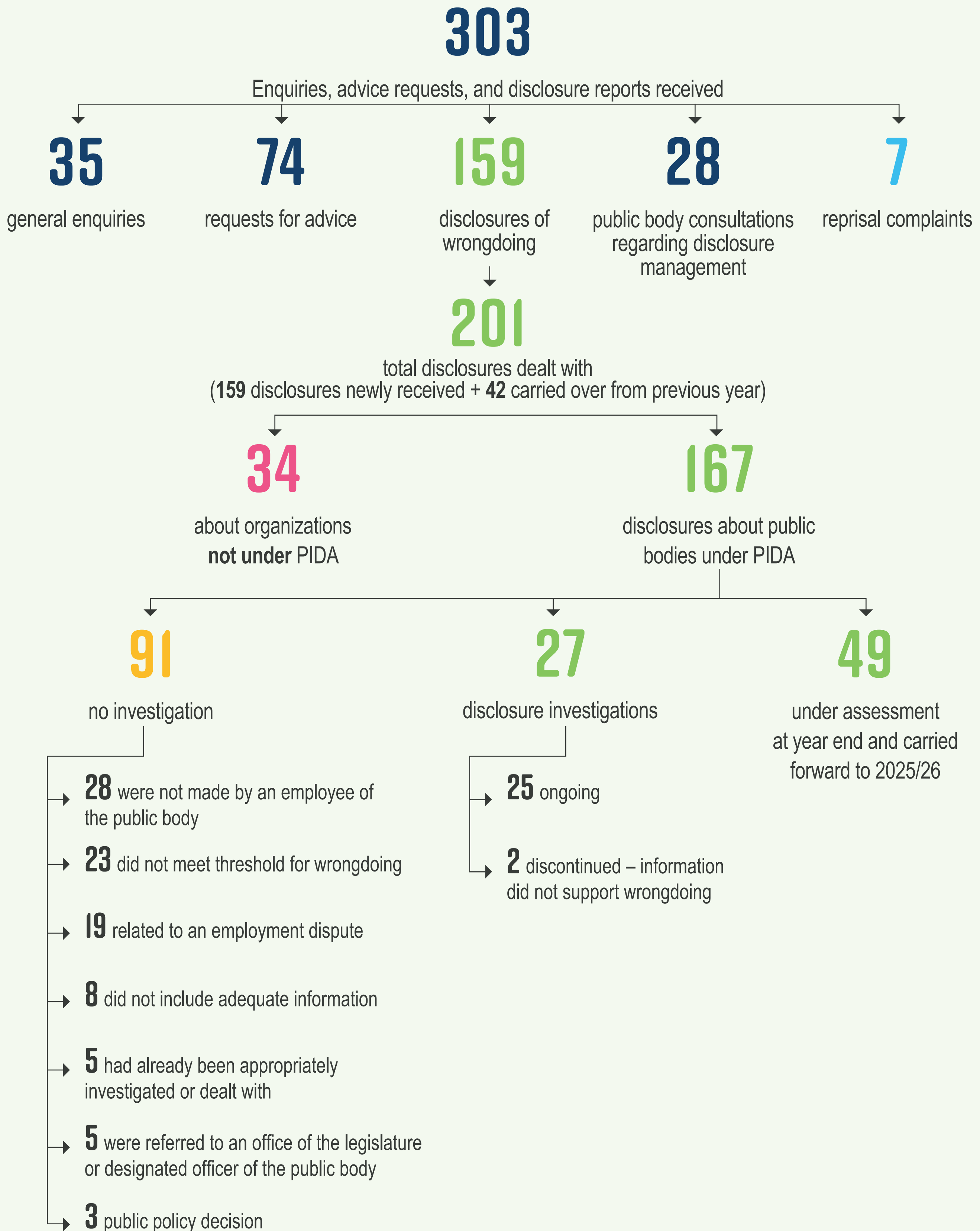
	2024/25	2023/24
Views	14,561	9,122
Active users	5,511	3,515
Event count	**59,054**	**35,861**

Views: counts how many times a user has seen a web page.

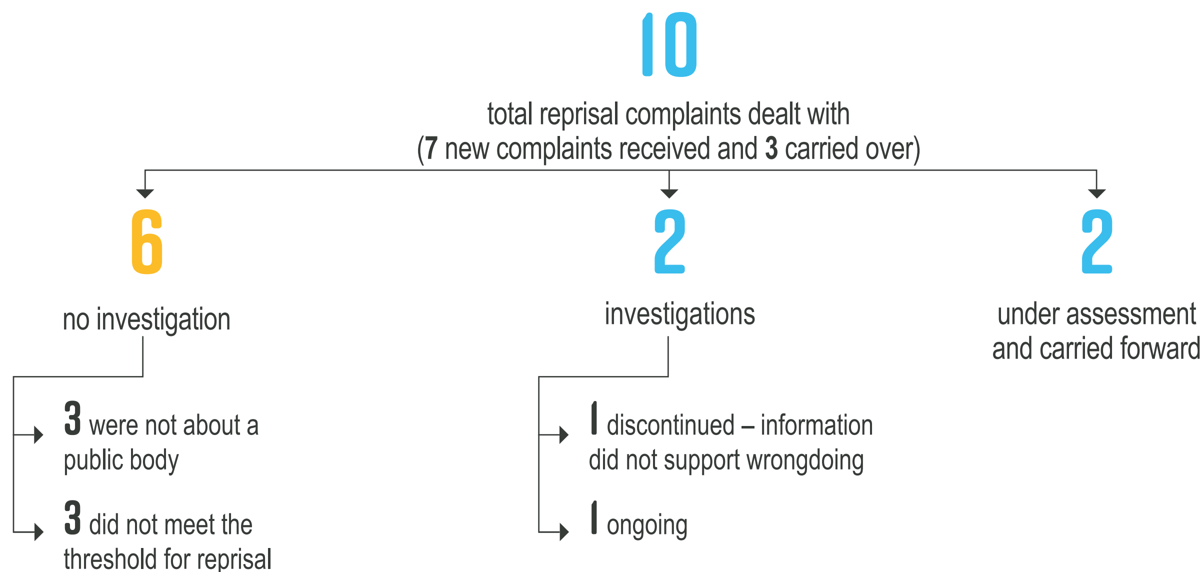
Active users: a user who spends longer than 10 seconds on the page, views two or more pages, or whose visit is their first session.

Event count: counts every event/action performed by a user visiting the page, such as clicking a link or button, scrolling down the page, etc.

PUBLIC INTEREST DISCLOSURE ACT BY THE NUMBERS



Reprisal complaints



Public Interest Disclosure Report: Office of the Ombudsperson

For Ombudsperson staff, the two avenues for reporting wrongdoing under PIDA are:

- internally to a designated officer
- externally to the Office of the Auditor General

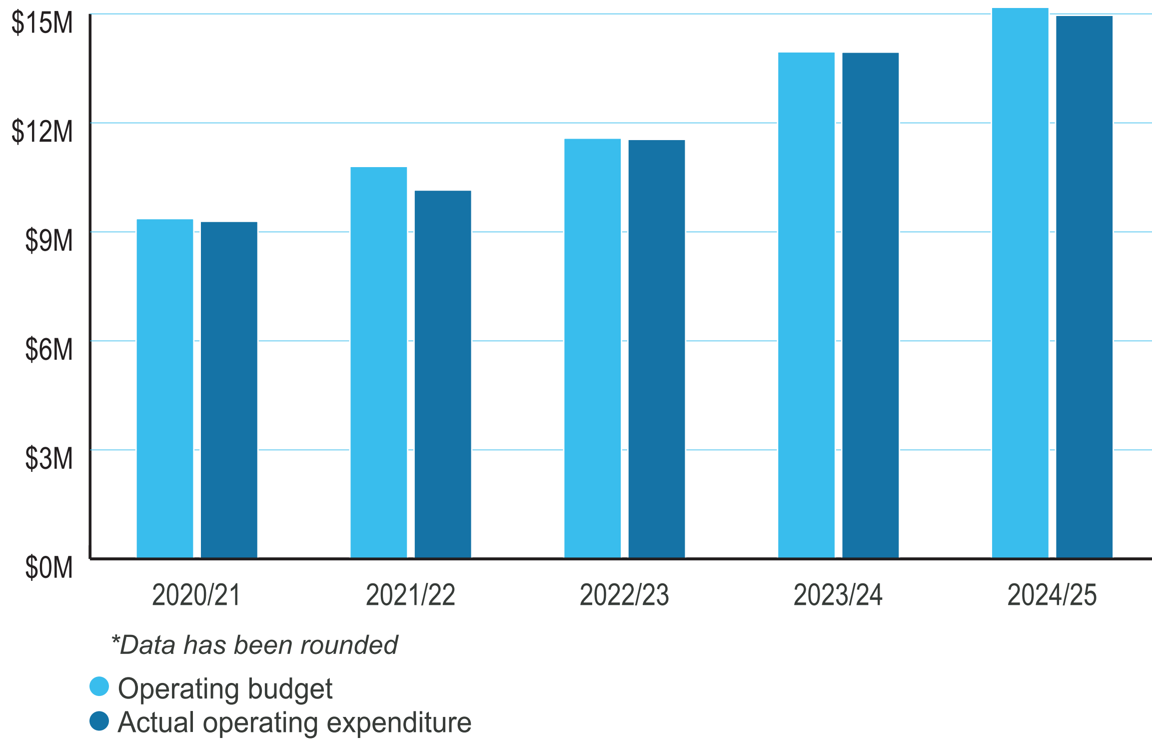
The Act requires that the Office of the Ombudsperson report the number of disclosures that it received in the year. The Act also requires the Ombudsperson to report the number of disclosures received by the Auditor General about our office, if the Ombudsperson has been notified of those disclosures.

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

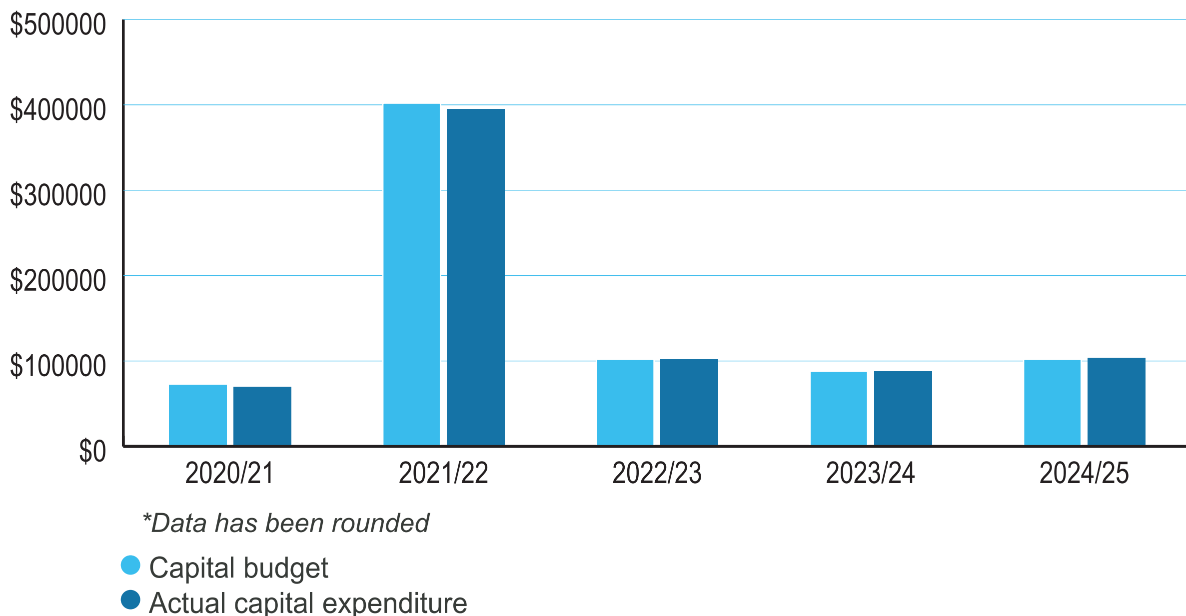
OUR FINANCES

The 2024/25 annual operational budget for the Office of the Ombudsperson was $15,181,000.

Operating budget and actual expenditures by fiscal year



Capital budget and actual expenditures by fiscal year



CASE SUMMARY INDEX

Under the *Ombudsperson Act*

HOUSING AND AFFORDABILITY

BC Financial Services Authority 23

Ministry of Finance 20

Ministry of Social Development and Poverty Reduction 21, 22

Residential Tenancy Branch 21

HEALTH AND HEATH CARE

Forensic Psychiatric Services Commission 30

Fraser Health Authority. 29

Ministry of Health – Health Insurance BC 28, 32

Ministry of Health, Ministry of Children and Family Development, and Vancouver Island Health Authority 33

Vancouver Island Health Authority 26

Vital Statistics Agency 28

INFRASTRUCTURE, TRANSPORTATION, AND ENVIRONMENT

BC Hydro 38

BC Transit 41

ICBC 40

LOCAL GOVERNMENT

City of Surrey 47

Regional District of the Central Okanagan 44

Town of Creston 46

JUSTICE

Ministry of Attorney General – Criminal Justice Branch 58

Investigation and Standards Office 52, 57

Ministry of Public Safety and Solicitor General. . . 54

Surrey Pretrial Services Centre 57

Vancouver Island Regional Correctional Centre 55, 56

SERVICES FOR CHILDREN, YOUTH, AND VULNERABLE ADULTS

Ministry of Children and Family Development 63, 64

Public Guardian and Trustee. 62

EMPLOYMENT AND PROFESSIONAL ASSOCIATIONS

BC College of Nurses and Midwives 71

College of Applied Biologists of BC. 70

Employment Standards Branch 73

Engineers and Geoscientists BC 70

WorkSafeBC. 73

EDUCATION

School District 27 (Cariboo-Chilcotin). 76

Under the *Public Interest Disclosure Act*

Employment Standards Branch 107

Ministry of Children and Family Development . . . 86

Ministry of Health 111

Ministry of Social Development and Poverty Reduction 101

Ministry of Transportation and Transit 93, 97

Small public body. 91

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 V8W 9A5

ONLINE:

bcombudsperson.ca