Legislative Assembly of Alberta

The 31st Legislature
Second Session

Standing Committee
on
Resource Stewardship

Public Interest Disclosure (Whistleblower Protection) Act Review

Monday, January 19, 2026
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Standing Committee on Resource Stewardship

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Standing Committee on Resource Stewardship

Participants

1 p.m. Monday, January 19, 2026

[Mr. Dyck in the chair]

The Chair: Well, let's begin our meeting here, everyone. I'm going to call to order this meeting of Resource Stewardship at 1 p.m. here today, and I just want to welcome everyone in attendance. My name is Nolan Dyck. I am the chair for this committee as well as the MLA for Grande Prairie.

I would ask that members and those joining the committee at the table introduce themselves for the record. We will start to my right and then go around the table. Please introduce yourselves, and then afterwards we will go to online. While you're introducing, please turn your camera on if able as well for those joining us online.

As well, just for the record, I will mention a substitution here: Member Arcand-Paul for Member Calahoo Stonehouse. Welcome. Thank you for joining here today as well. Greatly appreciate it.

Let's start with introductions here to my right.

Mrs. Petrovic: Hi. Chelsae Petrovic, MLA for Livingstone-Macleod.

Mr. Rowswell: Garth Rowswell, MLA, Vermilion-Lloydminster-Wainwright.

Member Arcand-Paul: Brooks Arcand-Paul, MLA for Edmonton-West Henday.

Ms Sweet: Good afternoon. Heather Sweet, MLA for Edmonton-Manning.

Mr. Quirk: Adam Quirk, legal counsel.

Ms Robert: Good afternoon. Nancy Robert, clerk of *Journals* and committees.

Mr. Huffman: Warren Huffman, committee clerk.

The Chair: Excellent. Now we will go online. We will just start from those members. If we can in this order, we'll go: Member Yao, Member Al-Guneid, Member Armstrong-Homeniuk, Member Cyr, and then we will go with presenters afterwards.

Mr. Yao: Tany Yao, MLA for Fort McMurray-Wood Buffalo.

Ms Al-Guneid: Nagwan Al-Guneid, the MLA for Calgary-Glenmore.

Ms Armstrong-Homeniuk: Jackie Armstrong-Homeniuk, MLA, Fort Saskatchewan-Vegreville.

Mr. Cyr: Scott Cyr, the MLA for Bonnyville-Cold Lake-St. Paul.

The Chair: I would also like to have our LAO staff introduce themselves.

Mr. Bhurgri: Good afternoon, everyone. I'm Abdul Aziz Bhurgri, research officer.

The Chair: Then we also have Dr. Bron and Mr. Hutton. Feel free to introduce yourselves now here for the record as well.

Mr. Hutton: Hi. My name's David Hutton. I'm a senior fellow with the Centre for Free Expression at Toronto Metropolitan University.

Dr. Bron: Hi. I'm Ian Bron, also a senior fellow with the Centre for Free Expression. I'm also a researcher at Utrecht University in the Netherlands.

The Chair: Excellent. Well, thank you so very much for joining us here today. Greatly appreciate it. I look forward to your presentation here in a moment.

We do have a few housekeeping items to address before we turn to the business. Please note for all members that the microphones are operated by *Hansard* staff. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV, and the audio- and videostream and transcripts of meetings can be accessed via the Legislative Assembly website. Those participating by videoconference are encouraged to please turn on your camera while speaking and mute your microphone when not speaking. Also, members participating virtually who wish to be placed on the speakers list are asked to e-mail or message the committee clerk, and members in the room are asked to please signal to the chair, which is common practice. Please set your cellphones and other devices to silent for the duration of the meeting.

Now just for the approval of the agenda, item 2 here. Are there any changes or additions to the draft agenda? If not, would someone like to move that the Standing Committee on Resource Stewardship approve the proposed agenda as distributed for its January 19, 2026, meeting? Sure. Member Sweet. Any discussion? All in favour? Excellent. Online? Excellent. Any opposed? Excellent. That is carried.

Now we need to approve the minutes. Next we have the draft minutes of our November 24, 2025, meeting. Are there any errors or omissions to note in this? If not, would a member like to move that the Standing Committee on Resource Stewardship approve the minutes as distributed of its meeting held on November 24, 2025? Approve? Excellent. Member Rowswell. Any discussion? No discussion. Excellent. All those in favour? Excellent. Any online, those in favour? Excellent. Any opposed? None. Excellent. That is carried.

This leads us to the review of the Public Interest Disclosure (Whistleblower Protection) Act here today, which is the reason we're meeting. Looking forward to these presentations. We are doing oral presentations today. At our last meeting, on November 24, the committee agreed to invite stakeholders to provide oral presentations in relation to our review of the Public Interest Disclosure (Whistleblower Protection) Act. The committee decided that each caucus should select two stakeholders to present. The four stakeholders chosen were Red Deer Polytechnic, the United Nurses of Alberta, the Criminal Code Review Board, and the Centre for Free Expression. Unfortunately, officials from the Criminal Code Review Board and Red Deer Polytechnic are not able to present today, but we will hear from the other two presenters and officials from the two remaining organizations here this afternoon. Both organizations will have up to 10 minutes for their presentation, and afterwards members will have a chance to ask questions to these organizations.

Our first presentation is from the Centre for Free Expression, and our first presenters are Mr. David Hutton and Dr. Ian Bron from the Centre for Free Expression. They are joining us remotely today as they are based in Ontario.

Thank you so very much for joining us. Both of you guys have 10 minutes to present, to make your presentation, and then I'm sure members will be very inclined to ask questions afterwards. Please introduce yourselves once again for the record. You can begin when you're ready. I look forward to this, and I know members do as well, so thank you so very much for being here today with us.

Centre for Free Expression

Mr. Hutton: Thank you. My name is David Hutton, senior fellow at the Centre for Free Expression in Toronto. I want to thank the

committee for the opportunity to present. This is a very important subject that's close to our hearts. What I'm going to do is cover the big picture, give you some context, of course, internationally and nationally, and then Ian will drill down into much more detail into the specific law that you're looking at and provide a lot more detail if you require that.

From an international perspective there's been a very strong movement recently, in the past five, 10 years, towards countries adopting whistle-blower laws. Today there are more than 60 countries that have national laws, including all 27 EU member states, who are required by an EU directive to write laws that are really very strong. The directive sets out specifically what they have to cover, and it's a good directive.

Why are they doing this? The benefits of whistle-blower protection are so compelling. Research going back decades consistently shows that the single most effective way of finding out about wrongdoing in organizations is through tips from insiders, in other words whistle-blowers. In fact, about 42 per cent of all frauds are typically uncovered in this manner. Now, that's three times more effective than internal audit, and it's about 10 times more effective than external audit. So it's an incredibly effective tool if you want to find out what may be going wrong in the organization.

The benefit to governments is that this helps them to maintain control of the bureaucracy, the machinery of government, to maintain the integrity of that system, and to learn about internal problems at an early stage. The worst thing that any senior leader or politician wants to have happen to them is to read about some major scandal in the media that they had no inkling was going on within their area of responsibility. What whistle-blowers can do is give you the chance to know about these problems and perhaps fix them before they get out of control and before they start making headlines.

At a national level the Canadian federal system is extremely weak. In fact, it's widely recognized that we have one of the worst whistle-blower regimes on the planet, and in that respect we're way, way out of line with all the countries that we would consider our peers and would normally compare ourselves with. I'll give you a couple of examples of this. In about 19 years of operation not a single whistle-blower in the federal system has received any compensation for reprisals from the tribunal that's set up solely for this purpose, so it really does the opposite of what it's supposed to do. International comparisons done by experts give a point score of either one or zero, where most of our peer countries would be getting 15 or 16 or 17 on a 20-point scale. Sadly, when this law was written, Alberta seems to have followed the lead of Ottawa and put in place a law that has a lot of the same weaknesses.

I'm going to pass it over to Ian now, who can give you a lot more detail.

1:10

Dr. Bron: Hi. Yes. Thank you, David. I'm Ian Bron, and I'm with the Centre for Free Expression as well. I'm actually joining you from the Netherlands right now. It's about 9 p.m. here. I want to thank the committee for inviting me, and I also want to thank the Public Interest Commissioner, who has helped me in my assessment of this law.

Now, I went into great detail to examine this law basically clause by clause, as I did for every province, just to see how it was operating in practice and in theory and how well it would measure up against best practices. We at the Centre for Free Expression, David and I, developed a best practice standard which was based on other ones. I can't go through all the points in that report; all I can do is encourage you to read it or at least skim it, the major points that are in that report. But what I will do is that I'll go over some of the key issues that are contained in the law.

I'll start by looking at the enforcement. The use of the law has increased steadily over the years, and that is a good sign. The more use that a law gets, the more it suggests that the law is actually working. I know many people would like to think that too many reports is a bad thing. It's actually not. It means that the law is working properly.

Currently, when the commissioner gets a complaint, they investigate about 12 per cent, and they find wrongdoing in about 1 or 2 per cent of the times. For reprisal complaints they get about 4 per cent findings of a reprisal. Now, these may not seem great, but it's not an issue necessarily of performance of the office. What it suggests to me more is that people in the public service don't understand how the law should work and how perhaps to best make a disclosure, and maybe the law isn't working the way that it should be, that complaints and disclosures aren't being investigated in the way they should be.

As to what's happening in the departments, I really have no idea. This is fairly reasonably reported in departmental reports, larger departments, but smaller agencies just don't provide this information, so it's completely opaque how it's working there. Typically commissioners are the most professional and do the best investigations.

What you need to understand is that whistle-blowing laws, like Alberta's and the federal and all the other provinces, operate on a certain logic. The logic is that if you create a safe avenue of disclosure, then people will use that avenue to make their disclosures, and that will lead to more wrongdoing discovered and investigated. That in turn, of course, will deter more people from wrongdoing and encourage more people to report. Ultimately, you want the public to have greater trust in the government.

Unfortunately, the way the law is currently written, although it has some good points, it really can't accomplish this in the long run, I don't think. Rather than go through all the points, I will start with what is perhaps the elephant in the room, and that is that the whistle-blowing law does not put the protection of the whistle-blower front and centre.

I had once somebody I interviewed. They put it so well. They said: if the whistle-blower survives, the disclosure survives, and if the disclosure survives, the public interest is served. If the whistle-blower gets destroyed, then you can basically forget the issue.

The key problems in this protection: I can bring up six points that are the major flaws that are contained in this law and, frankly, in all laws across Canada. First of all, what can be disclosed is limited. For example, in Alberta you can't disclose unethical activity. This is important because unethical activity is quite often the tip of the iceberg. There's probably more going on underneath it, so if you can't do that – and I would argue that the public would want unethical activity to be reported and investigated.

The second thing that's wrong with the approach of this law is that the whistle-blower really after the disclosure has almost no role to play. The whistle-blower brings the issue forward, it gets taken away from them, and it gets investigated. What that does is that it gives a free hand to the implicated departments and implicated officials in particular, because we'd be naive to think that implicated officials would not lie to protect themselves.

This is why keeping the whistle-blower involved so that they can rebut the evidence that comes forward is so important. Even when the final report comes out, the department has an opportunity to, you know, comment on it and say, "Oh, there's this exigency," and "There's that thing," but the whistle-blower has no similar right to do that.

The third thing is that there's no real protection from unconventional reprisals. Reprisals can be very formal, like you get fired – that's very serious – but they can also be unofficial reprisals. For example, you stop getting invited to meetings, you get put on a blacklist, you can't get work anymore, or perhaps, you know, they go after your friends, your family that also happen to work in government if they can. These can be equally devastating.

Another major issue is the issue of reverse onus. What that means, basically, is that currently in many jurisdictions the whistle-blower must prove that any adverse action that was taken against them was solely the result of their whistle-blowing. That's often impossible to prove because departments can be very clever about finding reasons to make a reprisal.

The other thing is that there is no interim relief, and this is really important because while the whistle-blower is waiting for the whole process to go through, the implicated officials have complete freedom to make reprisals. This can be devastating. Getting some sort of redress can take years. It can take up to five to seven years, which is what I see as common. This reflects a fundamental misunderstanding of what is protection. Redress is not protection; redress is a remedy after the fact.

So this is sort of the main issue that I'd like to emphasize, that if you really want this to work, you have to focus on the whistle-blower.

The Chair: I'll give you another minute just to wrap up your thoughts there, if that's okay.

Dr. Bron: Okay. Thank you. I would repeat the fact that implicated departments at this point really have more rights than the whistle-blower does, but if a whistle-blower makes a mistake, they get stripped of any protection.

The other problem, of course, is that none of that serves the public interest, right? What you really want is to get to the root of the problem quickly and efficiently and fix it, not leave some poor whistle-blower twisting in the wind. If I were to revise the law, it would be to make that the central principle, make protecting the whistle-blower the central principle. I would also argue that the chief executive officers of the department should be made responsible for the protection of those whistle-blowers.

Thank you.

The Chair: Well, thank you for the presentation.

I will turn this over in a moment. We do have another member here that I would love to get introduced.

Mr. Ip: Nathan Ip, MLA for Edmonton-South West. Thank you, Chair.

The Chair: Excellent. Thank you so very much for joining us here, Member Ip.

We have a few minutes now with our presenters in order for us to ask some questions. As much as we can we'll go back and forth between caucuses. Okay. We will go with Member Rowswell and then Member Al-Guneid in order for questions. Please catch my eye in the future here.

Mr. Rowswell: Okay. Thank you very much. Yeah. I was going to ask you what the one most important thing is, and you kind of identify it as protecting the whistle-blower. In most working environments, if you've got a good working environment, people can bring forward issues and they get solved. So I'm assuming that people try all that first, and then when they're at their wit's end, they have to be able to report to someone and then be protected.

I guess part of my concern is this wrong or vindictive type of reporting, and I guess that's up to the commissioner to weed through that. You know, if you don't have the good working culture and you have to report to someone, how does the system protect itself that way?

Mr. Hutton: Can I ask? Are you asking: how does the system protect the whistle-blower or protect itself? It sounds as if you might be worried about inappropriate . . .

Mr. Rowswell: Accusations or something.

1:20

Mr. Hutton: Accusations. Right.

Yeah. I mean, this always comes up. It's always a concern by people looking at the possibility of whistle-blower protection. The reality is that this is very, very rare, and there are many, many other ways of dealing with it. You know, in every workplace there'll be a few people that are essentially difficult and do things like this. But we've dealt with hundreds and hundreds of whistle-blowers, and the overwhelming majority of them, almost everyone, is simply someone trying to do their job honestly, has seen something that went against their professional code of ethics or personal morals or whatever.

As you said, they typically take it up the line through their own management chain, and when they realize that's not working – I mean, they suddenly discover that things are going very badly for them in the workplace. You know, suddenly they're not a good employee anymore. Suddenly their personnel file: all the awards and so on disappeared, and it's filled with false complaints. Then that's when they reach out for help.

So the concern you have about false reporting: I think that's really not something that you should be worrying about.

Dr. Bron: I would add to that and say that having an effective whistle-blowing system is probably your best antidote to that rare event occurring. If you have a system that takes in the reports quickly and investigates them thoroughly, then it's a very, very foolish person who comes forward with a false disclosure.

Mr. Hutton: Yeah. Let me address one other thought, and that is that your aim here is due process. That means due process for the accused and for the whistle-blower. Due process protects everyone. It protects the public interest. It protects people falsely accused. It protects the whistle-blower. Due process means very quickly getting into action to make sure the whistle-blower isn't destroyed and that his or her concerns are properly investigated.

Mr. Rowswell: Okay. Thank you.

The Chair: Excellent. Follow-up, Member?

Mr. Rowswell: No.

The Chair: Okay. Excellent.

Online, next is Member Al-Guneid.

Ms Al-Guneid: Thank you. Thank you both for your presentations. I looked at your submission, and on page 16 specifically you mentioned the oversight bodies such as the office of the Public Interest Commissioner, and you name them as "specialist organizations." You're saying that the findings of this report should apply as well, and specifically I'm quoting here: "Departmental and agency processes are likely to be inferior" to those of the office of the Public Interest Commissioner. Can you tell us more? Can you add colour to that? Are they underfunded? Are there structural

deficiencies here? Is there limited independence since they are internal? I'm [inaudible] agencies and regulators, frankly, asking to be exempted of the act. What do you think of that? If you can, maybe shed some light there.

The Chair: Member, your comment just got cut off for about two seconds, but I think they probably caught the question.

Can I just confirm that you guys caught the questions?

Dr. Bron: Yeah.

The Chair: Okay. Perfect.

Dr. Bron: First, there are actually a couple of questions there. One is: do I really feel that agency processes are inferior? That is my experience and research. You've nailed a couple of the points. It's a bit of a lack of independence. In fact, there is sometimes a problem that the investigator and the recipients of the whistle-blowers can be subject to reprisals as well. This is why it's so important to have an agency above all of that that can also receive disclosures.

They also don't get quite as much training. I mean, I have to give kudos to the Public Interest Commissioner for taking on the task of providing training to these internal officers. That's usually the job of a central agency of the government, to make sure they're properly qualified. Of course, the commissioner, in this case, has stepped in to fill the breach.

As to being exempted from the law, I don't think that's a particularly helpful attitude. It suggests that the CEOs of these organizations think that there's no wrongdoing inside their organizations, which may be true at any one given point, but I would argue to them that it's far better to have somebody internal investigating the wrongdoing and that there be an opportunity for those reports that come internally to be escalated somewhere outside in case it's impossible to examine internally.

Do you want to add something to that, David?

Mr. Hutton: No. I think that's a good summary.

In many ways you cannot expect the departmental systems to work unless there's a strong oversight, which provides another pathway. That means that effectively the departments are competing with the integrity commissioner to get at the wrongdoing first so they can deal with it. If there's no oversight body that can do the job, then the sensible strategy, in many points of view, is simply to cover up because, you know, no one's going to discover it anyway.

Dr. Bron: Yeah. The evolving best practice is that there should be multiple avenues to make disclosures because any one avenue might be compromised.

The Chair: Excellent. Any follow-up, Member?

Ms Al-Guneid: A very quick follow-up. I don't want to eat all the time here. The agencies are citing that having two – like, they have their own internal process, and they're saying that the act or another process can be confusing, can be bureaucratic, can be cumbersome. How would you address that? They've had their process for 20 years, literally.

Mr. Hutton: Yeah. We hear this all the time. It happens in the corporate world. It happens everywhere. Basically, they're saying: "Trust us. We know how to do this. Don't interfere." But I think we've just explained why having an oversight body that can step in when they're not doing a job is so important.

The Chair: Excellent. Well, thank you very much.

Member Yao, please.

Mr. Yao: Thank you so much, Chair. Appreciate that. Thank you, gentlemen, for presenting to us. I'm just going to get some clarity on your submission. You recommend proactive whistle-blower protection informed by risk assessment with chief officers accountable for failure. Can you just explain a little bit more about the proactive protection, what that would look like in a workplace setting, and what actions the chief officers would be required to make once the disclosure is made?

I just want to expand on this a little bit. There's always a concern about things getting weaponized, systems like this. I think we all recognize that the intent of a whistle-blower act is to protect people so that they can identify the wrongdoings, but, like with anything, things can be used in an irresponsible fashion and literally become weaponized. How do we walk that line of a responsible system that doesn't get abused?

Mr. Hutton: Okay. I'll have a go at that. I think that what the proactive protection would look like is very different than what typically happens, which is to immediately identify the whistle-blower as being someone who's at risk and to have a conversation with them. A lot of systems rely purely on confidentiality, and that's a very, very thin shield. It's very easily penetrated. You know, the wrongdoers can find out who raised the complaint. What it would look like is conversation with that person, figure out in what ways they're vulnerable, who they fear, and go through a laundry list of things that could be done to avoid that. Ian may want to expand a little bit on what other jurisdictions do.

The point about irresponsible use of the system and weaponizing it: again, we really don't see that happening, and part of the reason for that is that stepping forward to blow the whistle on something is an extremely risky thing to do. Someone who's trying to weaponize this: there's almost no upside. I mean, without the strong, first of all, protection systems, you're going to lose your career. You're going to be out of there. You're going to lose not just your job but your livelihood. So someone who is going to do that is clearly a bit deranged, and no system is going to protect against that.

As Ian said, having a good whistle-blower system is your best antidote because you can act quickly, find out if there's any substance to the allegations, and it will immediately come clear whether the allegations were made on the basis of, you know, reasonable knowledge or just made up or even vindictive. You'll know very quickly.

Dr. Bron: Many acts will include some sort of clause that says that an abuse of this process will result in disciplinary action. In my opinion, that's unnecessary because automatically, you know, lying about something like that would be a disciplinary issue right away. I'm familiar, like David said, with the argument that people are concerned that there's a legitimate job action that needs to be taken against an individual but that person is using the whistle-blowing act to prevent it from happening right away. It's essentially a delaying action, but as my colleague David said, it's not going to work in the long term.

1:30

As to specific measures, it can be tricky. You don't want to identify the whistle-blower necessarily by going to their supervisor and saying: hey, this person is blowing the whistle. You can't do that; you can't do anything against them. But if it's really obvious and the person really needs protection, it can mean moving them to another job for a while so that they can't be attacked. It can be just

a general caution to people in the office: there's an investigation going on; don't take any untoward actions against individuals.

Mr. Hutton: Yeah. It could also be as simple as just giving them a job back. You know, sometimes the reaction is very quick and even illegal, you know, depriving people of their livelihood instantly. Proactive protection would include reversing inappropriate measures that have already been taken.

The Chair: Excellent. Thank you for that.
Up next we have Member Sweet.

Ms Sweet: Thank you, Mr. Chair. I'd like to go back and speak to the comments that you've made about putting the whistle-blower first and the comments that you had indicated around the whistle-blower having no right to rebut evidence within the organization. Currently in Alberta if you are within the government and you are a whistle-blower, it will be referred back to the department for internal review and an assessment. I'm just wondering, with your research, if that is the best course to be taken, and then how do we ensure that if it is going into the department for review, we are protecting that whistle-blower, putting them first, and ensuring that they have the ability to rebut that evidence?

Dr. Bron: I'm not quite sure what you're referring to here. Are you referring to the report getting sent back to the department or the initial disclosure being sent back to the department?

Ms Sweet: Currently in the disclosure once it has been sent to OPIC, they will send it back to the department to start the investigation. That is done internally, with the report then going back once it's completed.

Dr. Bron: Oh, so the department does the investigation and then sends the report to the OPIC?

Ms Sweet: Correct, yeah.

Dr. Bron: Okay. I wasn't aware of that practice. It's something that you should – well, I've heard of it happening even in Alberta, but I wasn't aware that it's a common practice. Certainly, the departments have perhaps more leeway to conduct these investigations because it's an internal matter, and having the commissioner looking over their shoulders is not necessarily a bad thing at all because it ensures that the process is at least being done honestly.

Of course, there's always the danger that the internal process then goes awry. If that happens, I do have reasonable confidence that the commissioner would take interest because they have in the past. They have investigated a process or a disclosure that was made and then investigated in the department as well. But, yes, I mean, there's always a little danger with internal investigations, but it certainly doesn't suggest that internal investigations can never be done properly. They certainly can. It just depends on, I would argue, who's implicated and how serious the wrongdoing is.

Ms Sweet: Okay. Then just for a follow-up: we've had some significant restructuring within some of our departments, specifically our health departments, and now we're seeing that we're going to have public-sector workers working within public agencies that are also public dollars being put into private agencies, so we may have staff that are working within two different sectors of the same department. I'm just wondering, through your research and looking at other jurisdictions that have that public-private health care delivery system, if you have any areas that we should be watching or be aware of to ensure that whistle-blowers are protected.

Dr. Bron: This is sort of a broad, almost a philosophical problem. Should public money always be subject to public scrutiny? I would argue yes. I mean, if public money is being spent, then there should be some avenue to investigate wrongdoing. Now, both David and I will argue immediately that whistle-blowing law should apply to all sectors, public and private. Everything should be covered, but if we're just going to cover the public sector, then it should be that anything that public money goes into and anybody investigating it should have the authority to go into the private sector and demand evidence if that's where the trail leads.

Mr. Hutton: Yeah. I'd reinforce that. I mean, it's one of the great many, many serious weaknesses of the federal law, that the commissioner can't actually conduct any investigation that involves the private sector. You know, our view is that they ought to be able to follow the money, to use that expression, and have the full powers to do so to compel evidence, and so on, to go on-site, to confiscate evidence. In my view, that should also apply to where there are policy decisions being made that are effectively the private sector influencing policy.

Ms Sweet: Thank you.

The Chair: Excellent. Thank you so much for that.
Next up we have Member Cyr online.

Mr. Cyr: Yes. Again, thank you for your responses, and thank you for your presentation before us. I'm going to build on Member Sweet's question. That actually is very relevant to where I wanted to go. What are the most common real-life scenarios where these excluded groups are currently most likely to encounter wrongdoing but are the least protected under Alberta's current act? I guess, opening this up, you're saying that it's all workers that you're hoping to be included, but this includes our contractors, our interns, volunteers, and job applicants, so you're actually just including everybody under the sun. Can you give me some real-world or real-life examples of potential wrongdoing?

Dr. Bron: Well, on excluded groups one that immediately caught your attention was job applicants, for example. I mean, it's going to be a pretty rare job applicant that's going to detect some wrongdoing in the workplace and then report it, but it can happen, and they shouldn't be negatively assessed and not get the job because of that. It's the same with people who are, say, interns or who are, you know, on probation and not to full employee yet. They should be protected because they are particularly vulnerable. The type of person that can observe wrongdoing and report it is certainly not just limited to paid employees. As to what type of wrongdoing they would see, I would suggest that that depends on the department or the function that they're in.

Do you want to add to that, David?

Mr. Hutton: Well, I'd just say that, you know, you said that we're covering everybody under the sun. Well, in our view, it would be a good idea. But beyond that, if you look at the research I referred to about the effectiveness of whistle-blowing, it also shows that many of these tips that uncover wrongdoing come from completely other sources: customers, suppliers, citizens. Many, many people might be in a position to see something going on which is a red flag, which they should report.

The reason we tend to focus on employees and the like is that they are so vulnerable, that they're under the direct – not to say that

these other people aren't vulnerable in some ways, too, but the people who are directly connected with an organization, employees or whatever, are the most vulnerable and the most likely, to be honest, to see wrongdoing. That's why the laws tend to focus on them.

Dr. Bron: I have come across cases where outsiders in the organization have been punished as well. You know, if you are, for example, somebody dependent on the services of – well, I can give you a very specific example – Veterans Affairs and you fall afoul of Veterans Affairs, suddenly your benefits are very much at risk. I would suggest the same is true of somebody who needs health care and those who whistle on health care or long-term care. You might be a family member of somebody in long-term care who then observes and reports wrongdoing and suddenly – say it's your parent that's being taken care of in this long-term care facility and is getting badly treated. That should also be covered.

1:40

The Chair: Thank you very much.

I'm just going to ask for all our – we have four people left on the list, so we're going to make sure we have everybody on the list able to ask their questions if we can just tighten up our questions and maybe our answers a little bit. We've got about 10 minutes left. We're going extend our Q and A period by about 10 minutes if that's okay with everyone. We have a little bit of wiggle room here.

Up next we have Member Ip, and then Armstrong-Homeniuk afterwards.

Mr. Ip: Thank you, Mr. Chair. Just a high-level question, Dr. Bron. You had mentioned that there are some, frankly, common problems or some problems that are sort of common with many whistle-blower protection laws across the country. I'm just wondering: are there jurisdictions internationally or perhaps within Canada that have particularly strong whistle-blower legislation that models some of the best practices that you've outlined in your submission?

Dr. Bron: Well, as David has observed, the whistle-blowing directive in the European Union is quite thorough and comprehensive. It has many of the best practices. As to specific jurisdictions, Ireland is often held up as a good jurisdiction, and you'll be surprised to know that Serbia also has quite good protections. What these do is that they, for example, in Serbia, require training of anybody who hears a whistle-blowing case. They require specialist training before they can hear that case. That made a real difference to the outcome for whistle-blowers because many jurors don't understand the kind of imbalance of power between the whistle-blower and the institution that they're pitted against.

That said, there is no perfect jurisdiction. There is always somebody who's trying to poke a hole in the existing law, which is what makes a process of review and improvement so important. This is actually one of the strengths of the Alberta law, that you're required to review it every five years, and if it's working well, the law will be continuously improved.

Mr. Ip: Thank you.

The Chair: A follow-up?

Mr. Ip: No follow-up. Thank you.

The Chair: Excellent. Thank you, Member, for that question.

We're going to go online to Member Armstrong-Homeniuk.

Ms Armstrong-Homeniuk: Thank you, Chair, and thank you for the presentations. They've been fantastic so far. I will keep my question short. Gentlemen, you note that the workers lack a meaningful mechanism to escalate disclosures to the public or other channels if internal handling fails. In your view, what is the appropriate balance between confidentiality and accountability, and when, if ever, should public disclosure be protected under Alberta's regime?

Thank you.

Dr. Bron: That's a tricky one. You're right. There does have to be a balance, and this is why most national security laws are exempted from whistle-blower protections. They're required to have their own internal mechanisms, of course, but that's to maintain secrecy. In general it's accepted now internationally that if it's a major public interest issue outside of the sphere of national security or police matters, the whistle-blower should have a right to take the issue up to the public if it's clearly not being dealt with internally.

In fact, in Britain they have a system whereby you are first to make it internally or try to make it internally unless it's obviously unsafe internally. Then the next thing you can do is take it to a regulator unless that, too, doesn't work and is unsafe. Then the third avenue is that you could take it to public. Not everybody thinks that's the best way. Some people say that you should be able to try to take it externally right away. I suppose it depends on the individual circumstance, whether there's a great urgency in it. If lives are threatened immediately, most laws will allow you to go forward with that. The only danger to that is that if you make a mistake and take an issue public, your decision will be judged afterwards and by people who are potentially implicated.

Do you want to add to that, David?

Mr. Hutton: Yeah. I think that it's a really important issue. Australia has done a lot in the whistle-blowing arena by having many states simultaneously developing whistle-blower laws in different ways. Then the researchers would study these like a bunch of different test tubes, if you like, and see what worked and what didn't.

One of the surprising things that came out of that research done by Professor A.J. Brown was that some of those that didn't actually seem that good on paper were working quite well, and they traced it back to a provision a bit like this, which basically said that if the official system isn't working or taking too long or is ignoring the issue, then you go public. That made a big difference because the default strategy of a bureaucracy that is, you know, worried about a problem in a whistle-blower complaint is delay, and delay always punishes the whistle-blower and favours the wrongdoers, so this strategy really turned the tables and put pressure on the bureaucracy to deal with the issue properly and quickly, because the alternative was that it might go public.

Also, I have the point that, you know, the media are a lot more responsible, I think, than – certainly the mainstream media, the regulated media, are really quite responsible, and they just don't publish any nonsense that gets presented to them. They have their own system of due diligence. They want to avoid liability and lawsuits, so it's not such a big hazard. You know, someone who's vindictive and telling lies is probably not going to get any publicity at all, I would say; very rare.

The Chair: Excellent. Thank you for that.

Next up on the list we have Member Arcand-Paul. Please go ahead.

Member Arcand-Paul: Thank you, Mr. Chair, and thank you, Mr. Hutton and Dr. Bron, for being here today and for your submissions and for joining us. My questions are related to the 2020 Federal Court of Appeal decision Desjardins and Canada, Attorney

General, and the 2024 Alberta Court of King's Bench Campbell and Alberta Public Interest Commissioner. My question is: is there remedy in legislation anywhere in Canada or anywhere across the world that would protect confidentiality of whistle-blowers when it comes to disclosure in judicial review, obviously very carefully balancing the independence of the judiciary as well? Broad question, then I have a follow-up following that.

Dr. Bron: Well, the first thing I would say to that is that this precise issue has been legislated in Quebec, and the decision went the other way. For those who aren't familiar, confidentiality was stripped from whistle-blowers because the person who was implicated sought a judicial review, and in two cases they won that review and were able to expose the people who had spoken out against them. I would say that there is a remedy in law. You just write the law in a way that protects them from exposure in this way. It certainly seems possible to me because it occurs in other types of cases. For example, you know, child victims: they're not required to expose their identities. It seems to me absurd that we couldn't do something similar for people who are whistle-blowers.

Member Arcand-Paul: Thank you.

My follow-up question is that you highlight a major concern about the public service not knowing how the law should work generally. Are there any other examples crossjurisdictionally in which there have been best practices put in place for these types of classes of employees to understand what their protections are and what they're entitled to under these different laws?

Dr. Bron: Are you asking about jurisdictions where they provide good training to the staff on how . . .

Member Arcand-Paul: Yeah.

Dr. Bron: You know, it's a good question. I haven't actually looked at the training jurisdiction by jurisdiction, so I'm not really aware of which jurisdictions do a good job of training, but I would say that your best indicator would be that the system is well used and appropriately used. That means that when somebody comes forward with a disclosure, it's not something frivolous. Investigation finds things that, you know, reasonably can be classified as a covered wrongdoing. But, yeah, it's certainly – I don't know if you're aware of any jurisdictions that do that well, David.

Mr. Hutton: Well, let me jump in. I think I'll make two points here. One is that you have lots of questions, I'm sure, that we may not be able to answer on the spot, but our hope is that this is not a one-off event and we never hear from you again. You know, our mission is to help organizations like you put in place effective systems, and we have considerable expertise. We have links to everyone on the planet who has real expertise in this area. We've also helped found an international organization called WIN, the Whistleblowing International Network, headed by Anna Meyers, a support organization for NGOs like ours all across the planet. So if you're looking for, you know, best practice, particular jurisdictions that are good at something, we're your go-to place to get that information even though we might not be able to instantly tell you right now during this meeting.

1:50

Dr. Bron: Well, David speaking has actually triggered my memory. It's the Serbian system, for example, where they do require training for jurors in these kinds of cases. That results in better findings. Many jurors will resist this training, saying that it impinges on their independence.

Mr. Hutton: In Serbia they've actually removed a judge from one of these panels because they discovered he hadn't gone through the training. The result in Serbia has been that whistle-blowers can pretty much count on getting immediate relief from the reprisals within weeks with a very high success rate. If you imagine the effect of this on wrongdoers, it's extremely powerful because they now realize they cannot simply silence and crush these people and keep them tied up in the courts or whatever for years. They're going to stay alive, they're going to stay in their jobs, and they're going to be able to contribute to the investigations and so on.

One other point I'd like to make that came from previous questions is that you can look at whistle-blowers not just as witnesses to some kind of wrongdoing, but they're very often subject matter experts in the area that you need to know about in order to detect the wrongdoing. You know, a lot of wrongdoing is well hidden, and you need to be quite smart to see what's going on. These are the people that have been able to spot the clues and have the subject matter knowledge to be able to see what's going on.

Dr. Bron: If we look at what's actually happening typically in the jurisdictions that I've looked at, usually there is some training at the beginning or at the hiring process and maybe once or twice in a person's career on what to do when they see unethical action or they see a wrongdoing happening, and that is clearly inadequate. It should be considered a form of training that needs to be refreshed every year or two, I would argue.

The Chair: Excellent. I appreciate that.

Our final question or questions will be coming from Member Petrovic. Please go ahead.

Mrs. Petrovic: Well, thank you both for your presentation. I just want to touch briefly, and you have kind of throughout your presentation – I want to talk about whether the reform worked, as you could say. From your perspective, what concrete indicators should this committee track going forward to assess whether PIDA reforms are improving whistle-blower confidence, worker protection, and deterrence of wrongdoing? What, exactly, to you guys would success look like over the next three to five years, and what structural or procedural changes would most improve the independence, consistency, and credibility of investigations under PIDA?

Mr. Hutton: I'll have a quick go at the first one. There are several questions in there, Chelsae. Regarding things that you can measure that will tell you how effective you've been, there's a host of things, and if you look at our criteria, then it lists a lot of those. One of the key things that you should be looking at is what happens to the whistle-blowers and what they feel about how they've been treated, whether they're still employed, what their career trajectory has been. Almost, you know, none of that happens in Canada. There's no interest in what happened to the whistle-blowers.

You can also measure things like perceptions in the federal workplace, perceptions of how common wrongdoing is – that's very important – perceptions of how they feel whistle-blowers are being treated. You can also measure other things like – oh, gosh, there are lots more examples in our criteria.

I'll pass that over to you, Ian.

Dr. Bron: You've done a good job already.

I would just like to emphasize that when you're looking at how things went for the whistle-blower, you have to look over years. You have to follow them for at least two to three years. As one whistle-blower told me – he's an Australian. He says, "They lie waiting in the long grass," meaning that the people who have been

implicated aren't just going to go away. They're going to wait for their opportunity to make a reprisal. That's why it's important to keep an eye on how that's going.

And yes, most governments in Canada now send out a survey already on things like ethics and how the workplace is functioning. All you need to do is add a few questions about observed wrongdoing and how freely they feel to speak up about issues. That's one of the big things. When people feel comfortable in a system, they will speak up routinely about concerns to the point that it actually doesn't feel like they're doing anything unusual anymore. They're just raising an issue. This is why so many whistle-blowers are surprised when they face a reprisal. They say: "Well, I was just doing my job. I was just pointing out that there was a problem here, and suddenly all my responsibilities were stripped from me." So that's a key factor.

Mrs. Petrovic: Chair, can I just have one quick follow-up?

The Chair: Absolutely.

Mrs. Petrovic: Thank you. You both touched on it, I think, to quote: perceptions in the workplace and follow them up for years as they're waiting in the tall grasses, as you said. My question is, essentially: is legislation enough? When we look at legal change and this cultural change that you guys continue to touch on, it's not just law that determines whether people feel safe for speaking up. In practical terms what can legislation reasonably accomplish to drive a cultural change, and where should policy-makers be cautious about expecting laws alone to solve some of these issues?

Dr. Bron: I can see we're both eager to answer that question. This, to me, is the big old debate. Is it culture first or is it law first? Different people have different perspectives on it. My personal perspective after researching this is that first the law has to change, and the law has to be effective and it has to be enforced effectively. I think it's unrealistic to expect incumbents who are used to a certain way of doing business to change the way they do business just because there's a law in place, particularly if it's not enforced, or because there's a policy in place.

David may not agree with me. I'm not sure how he felt about that.

Mr. Hutton: No. I agree a hundred per cent. This is something that gets talked about a lot, and some people offer a different view, but if you want to change behaviour, which is what we're looking for here, there have to be consequences to, you know, desired or undesired behaviour, and the law is a very powerful way of doing that.

You know, I throw out an example. In the U.K. there was a case where the CEO of one of the major banks was the subject of a whistle-blower allegation that he had done something wrong, which was investigated very properly. They ended up by saying that there wasn't enough evidence to say that he had actually done anything wrong, so he was exonerated. He then went on to take extreme steps to try and identify the whistle-blower, and that's illegal, and he was fined hundreds of millions of dollars personally. You can look up the number. I can't remember the number, but it was literally: he hit a personal fine of several hundred million dollars. I think I've got that right, Ian. Now that, I think, will change the behaviour of banking CEOs when they see something like that.

The Chair: Excellent. Thank you so very much for your time here this afternoon. I think it's been valuable to hear your guys' presentation, and I do want to thank you on behalf of this committee for your time. We will be transitioning here in the next couple of minutes to the next presenter. Gentlemen, you are welcome to stay and listen. Please just mute your mics on that, and I would ask you to turn your cameras off, too, as well if you are interested in sticking around.

We will just pause for a couple of minutes. We will invite the presenters from the United Nurses of Alberta to join us at the table, and we will continue on in hearing presentations. I believe we have a couple of people here to present. Love to see you here at the table right away.

2:00

Excellent. Well, thank you so very much for joining us here at committee and taking the opportunity to come and present. I look forward to your presentation. We will be hearing from Ms Heather Smith and Ms Donna Lynn Smith from the United Nurses of Alberta. What we have scheduled for you here today is about a 10-minute presentation. You don't have to take up the whole time, but feel free to. Then afterwards we will ask questions for the record. So 10 minutes or so for you guys to present, but I would love for you guys to introduce yourselves for the record here today. We will start on my right if you wouldn't mind. Go ahead.

Ms H. Smith: Hello. I'm Heather Smith. I'm president of United Nurses of Alberta. I am a Registered Nurse.

Ms D. L. Smith: Good morning. Can you hear me all right?

The Chair: Absolutely.

Ms D. L. Smith: My name is Donna Lynn Smith. I work with the United Nurses of Alberta as a staffperson, supporting nurses who speak up about their concerns about safety of the patients. But I'll just add that in my previous career I was, for about 30 years, an administrator in the health system and also worked in the Alberta public service, so I do bring to this discussion a bit of a perspective, and I must say I very much appreciated the previous presentations. Thank you.

The Chair: Excellent. Well, thank you both for being here again today. Really looking forward to this presentation. I'm going to open the floor for you to present. You have 10-ish minutes. We will go from there, and then afterwards we will turn this over to the members to ask questions.

United Nurses of Alberta

Ms H. Smith: Good afternoon, Mr. Chair and members of the committee. I have already introduced myself. I'm very pleased to be here, and I echo Donna's comments. The previous presentation was incredibly informative and certainly gave me a lot to think about. I had downloaded the Dr. Bron's report and stuff, so I'm really pleased to put it into perspective and identify a whole lot more questions on public disclosure whistle-blower needs.

United Nurses of Alberta represents approximately 35,000 mostly registered nurses but also registered psychiatric nurses and a few allied personnel, licensed practical nurses and others in smaller sites. I want to start by framing why this legislation is so critical to the members of the United Nurses of Alberta. For a nurse, blowing the whistle isn't just a policy mechanism; it's an ethical obligation. Nurses are bound by a code of ethics and standards of practice. When they witness wrongdoing, and especially when they see something that endangers the life, health, or safety of a patient, they are required to speak up.

But we must be honest about the reality of their situation. Speaking up against an employer, a superior, or a systemic failure is very intimidating. It can carry serious personal and professional

risks. For nurses to fulfill their duty to Albertans, they need to know that the system has their back. They need to know that effective structures exist to protect them from reprisal, and they need to have the necessary knowledge and awareness of those structures in order to use them. PIDA, the Public Interest Disclosure (Whistleblower Protection) Act, is one of those structures. Its existence is fundamental in enabling nurses and other health care workers to speak up and maintain the public trust in our health care system.

Donna mentioned that she advises in terms of safety. She's what we call a professional responsibility adviser. I raise that because professional responsibility is something that, actually, nurses here in the province went on strike twice to secure in terms of their ability to identify and bring forward concerns about incidents that threaten public safety, patient safety.

We encourage the adoption of the recommendations from the 2020-2021 review. We applauded the changes made to the legislation in 2018. Another review was initiated in 2020, which led to important recommendations from Alberta's Public Interest Commissioner. Unfortunately, those recommendations have yet to be adopted.

Our message to you today is straightforward. It is time to finish that work. Certainly, with what we just heard in terms of how important protection of whistle-blowers is, I think it is imperative that we move forward. We are encouraging this committee to review and implement the recommendations from the commissioner's November 2020 report as well as new evidence that has emerged since then. There are recommendations from the commissioner's 2020 report that are vital for the health sector. Currently there are gaps in the legislation that leave huge swaths of health care workers and vulnerable patients unprotected.

Recommendation 1 calls for enacting a regulation to include contracted service providers of public entities. Contracted supportive living accommodations, long-term care facilities, and home-care service providers are not currently covered under the act. For example, a nurse employed by and working in a health care facility operated by Alberta Health Services is covered by PIDA. A nurse working in a private contracted long-term care facility is not. The office of the Public Interest Commissioner has explicitly reported having to decline investigations into complaints from these sectors because of the lack of jurisdiction, a very dangerous blind spot. We are talking about nursing homes and seniors' lodges and whatever else we have in this changing world of continuing care. These are high-risk environments with vulnerable patients. If a nurse in a contracted senior care facility sees negligence or wrongdoing, they should have the same protection as a nurse in a hospital. Patient safety in a publicly funded facility should not depend on whether it is privately or publicly operated.

We ask for evidence-informed legislation. Nurses are required to support decisions with evidence-informed rationale. We are not the experts on whistle-blowing legislation or best practice, but we can look to experts to provide guidance in this area. I think we heard some of that today.

Beyond the commissioner's report we must look at the recent independent analysis by the Centre for Free Expression, which released a comprehensive review of PIDA in February 2025 authored by the very man we heard today, Dr. Ian Bron. I'm going to continue to read my notes. Dr. Bron noted that while Alberta has many best practices, they are overshadowed by the critical weaknesses. In fact, I would suggest that his comments today suggest we have – I'm not so sure we have many best practices. UNA strongly endorses the six recommendations in Dr. Bron's report, including strengthening protection against reprisal, improving the quality of investigation, enhancing the data to evaluate and guide future changes.

Finally, I want to address the invisible barrier to this act, the lack of awareness. I think this was also raised by Dr. Bron. The best legislation in the world is useless if nobody knows it exists. Dr. Bron's report cited a 2024 survey by the commissioner's office. The numbers are very concerning. Two-thirds of public-sector employees were unaware the office existed. Only 5 per cent could actually name the office. Over half did not know how to report wrongdoing.

Currently PIDA does not set standards for employee training, another thing that just came up. A 2025 systematic review of why nurses blow the whistle found that a positive ethical climate is a key factor. We call it just culture. Nurses speak up when they trust their organization and have awareness of the tools and mechanisms that enable them to do so. I'd suggest to you that the most powerful tool we have is our professional responsibility committee and process.

2:10

We cannot build trust and awareness in the dark. Therefore, we are asking that minimum standards for awareness and training be written directly into the act. Every health care worker should know the safety net is there before they need to use it.

Concluding my formal remarks, strengthening PIDA should not just be a bureaucratic exercise. It is about ensuring that the nurses and all health care workers who care for your constituents in both public and privately operated facilities can report wrongdoing without fear of reprisal and have awareness of the mechanisms that enable them to do so.

We urge this committee to adopt the recommendations from the Public Interest Commissioner and Dr. Ian Bron, including expanding the scope to contracted providers. By doing this, you protect nurses but more importantly you safeguard the health and safety of all Albertans.

Thank you for your time today.

The Chair: Thank you so very much for the presentation. Greatly appreciate it.

We're going to open this up for questions here. We've got about 10 minutes or so, so we'll see where we kind of go. We can extend the meeting, but we would require unanimous consent in about 10 minutes. We'll see where the questions go. If we want to extend, I just want to give everybody the heads-up that that would be the result of that.

Right now the list is online first. Member Cyr, then Member Ip right afterwards. Member Cyr, please go ahead.

Mr. Cyr: Well, thank you, and thank you for your presentation. I know that for myself I do want to make sure that my seniors, especially those that are vulnerable, are getting the adequate care that I myself would want when I'm their age and in their delicate position.

You've already mentioned it, but your submission emphasizes expanding the PIDA coverage to contracted home-care and continuing care workers. From UNA's perspective, what specific patient safety risks arise when contracted providers are excluded from this PIDA coverage? It's kind of good to have a full understanding, if you will, of exact examples where the private and the public, I guess, would differ from each other and how that could put my seniors at risk.

Ms H. Smith: Well, again, a real concern is that those in the private market world don't have the levels of protection, particularly if they're not unionized, that we have in our public system. As I mentioned, Donna is a professional responsibility adviser. Professional responsibility and reporting is part of our provincial agreement. As I said, we went on strike twice to achieve it. That

process and the collective agreement protections that it brings with it are not available in the private sector, particularly if they're not unionized but even in the unionized environments in terms of private for-profit and private not-for-profit long-term care facilities that we represent. It is often very, very difficult to attempt to achieve the kinds of provisions we have in our hospitals in terms of professional responsibility.

You know, I see three tiers to it in terms of the best we have now, in terms of a unionized environment, which is what we have been able to negotiate into the provincial hospital agreement. The second best is what we have been able to negotiate into some of the long-term care contracts. The third and the worst is where there is no such protection at all. Just on that, in terms of what we've been able to negotiate outside of the hospitals, again, even private not-for-profit long-term care facilities tend to be easier to negotiate protection like the professional responsibility process than the private for-profit, so there are sort of steps in terms of that.

Again, the fears that employees have are one thing, the concerns that employees have, but of greater concern are the fears that family and, as they call them, residents – I call them patients – in long-term care environments feel. It is absolutely that they are afraid to speak up for fear of reprisals.

I don't know if that fully answers your question, but in terms of protecting and ensuring safety a concern for United Nurses of Alberta is, of course, that we see more and more drifting into private delivery. I'm a strong advocate of public delivery, not just public funding, but we are seeing more and more drift into private. For profit, not for profit: same to us.

You know, the words that Dr. Bron mentioned I strongly echo in terms of following the money and the ability to follow any public dollars, but it shouldn't just be about following public dollars. Every individual in this province and every family in this province should have the same ability to speak up and defend themselves and their family.

The Chair: Thank you for that.

Member Cyr, do you have a follow-up question as well?

Mr. Cyr: Right. Thank you for all of that, and again thank you for your response there. But what specific patient safety risks arise by being excluded for the contracted continuing home-care and home-care providers? Can you give me specific patient safety risks?

Ms D. L. Smith: I'll answer that one. At least, I'll start. I'll start by saying that the safety risks to the residents or the patients, wherever they might be in the health system – and this could also be at home care. It could also be in supportive living. It could be in any place where people receive health or human services, and the risks are the same no matter where you are. The culture, the conditions, the organizational climate, what's sometimes called tone at the top, meaning how the leaders behave and model, influence this, but in fact the same issues and risks are there in every environment. It's an excellent question. It's the most compelling reason why the legislation should cover everything, every site, every place where services are given, because the same risks are there.

As the previous presenters mentioned, one of the concerns in the long-term care sector – and this is not particularly Alberta; it's everywhere – is reprisal against the family member or the volunteer, who might be well intentioned, even a nursing student. I used to teach nursing. Students are very earnest and conscientious in talking about what they feel might be wrong, and the fear is that they will be unable to express those concerns and that those concerns wouldn't be followed up. I hope that helps with that second part.

The Chair: Thank you for that, and thank you for the question.

I'm just going to set the stage here. We've got a couple of questions left, and I'm assuming there might be a few more. I do want to offer the committee some extended time here, and I would need unanimous consent in order to extend the time, so I'm looking for unanimous consent to add some extra time onto the clock for us to get through the rest of the questions. I will ask – and I believe it's just quiet. Do I need to . . .

Ms Robert: How much time about are you asking for?

The Chair: I'm probably looking for about 15 minutes of extra time onto the clock. We were scheduled to end at 2:30, and we probably need to add another 15 minutes, to about 2:45.

I'm looking for unanimous consent on this. If anybody opposes this, please state that you're opposed to that. All right. Excellent. We're going to add 15 minutes onto the clock. Thank you so very much for that, committee.

Next person up for this is Member Ip.

Mr. Ip: Thank you, Mr. Chair, and thank you, Ms Smith, for both your submission and also your testimony today. To both of you, in fact. Both Ms Smiths.

Ms D. L. Smith: We're not related.

2:20

Mr. Ip: I wanted to follow up on what you've outlined in recommendation 1 and the fact that contract service providers are not covered by PIDA. There is obviously a significant gap in oversight. I'd like to understand – certainly, in your answer to the previous question you've outlined some of the risks and challenges there, but I'm hoping that you can add a bit more colour to the impact for the front-line workers. What pathways of recourse currently are available to workers or to perhaps families with these service providers that are not covered? What are you hearing from front-line workers? I think that sort of context would be really helpful.

Ms H. Smith: I can't speak to front-line workers, obviously, in environments that we don't represent. In terms of challenges, you know, the biggest thing is fear of reprisal, overt or covert reprisal. I think Dr. Bron touched on this as well, right? It could be overt kind of denial of opportunities and stuff. It could be just sort of silent whatever. But I think that the reprisals would be the biggest fear, Donna.

If you don't have a process that you can trust to bring forward concerns, that causes a lot of moral distress, and with moral distress – we're experiencing some of that right now – ultimately may come a loss of personnel in terms of people who work in environments where they do not feel supported, do not feel it's a just culture, and do not feel supported by their immediate management. Certainly, again, where they don't even have a union to support or protect them, I think you see a lot of turnover simply because people can't sustain moral issues, moral discomfort for long periods of time. I think you see a lot of moving on. You may have people, maybe an environment that attracts people who perhaps – no, I won't go into it. Yeah. Donna, do you have . . .

Ms D. L. Smith: If I may add just one international example, which is really quite an important one. Some years ago in the United Kingdom there was an episode in one of the hospitals. It wasn't the biggest hospital. It was kind of out in the country, the Stafford hospital. It was investigated in an inquiry conducted by Robert Francis. In that inquiry one of the things that was found was that

many, many people had tried to speak up, and this was a situation where hundreds and hundreds of people died or were injured or had problems happen to them in this hospital. What Robert Francis found in the inquiry that was conducted was that as people tried to speak up, there were terrible reprisals to doctors, to nurses, and to others.

In fact, as a result of that inquiry, which is publicly available, the United Kingdom implemented something called the office of the National Guardian and required all health regions – they would call it trusts – to have a separate guardian's office. In a way, that's the function of the act that you're considering now.

The point that I want to make is that Francis, as he conducted the inquiry, saw that there had been so much reprisal that they conducted another inquiry called the fear of speaking up inquiry. That report is also publicly available. We could certainly help you get that. It tells the stories of people who did speak up, and they spoke up about the kinds of things that, as Mr. Cyr mentioned, you know, if it happened to your mother, you'd be very upset. You'd be concerned. Couldn't somebody do something? And that would be: you'd talk to the first person, the manager, the nurse that you saw, whatever, and it would go up.

There are terrible stories of what has happened to people who report. I don't know any from Alberta, but I bet there are some.

Mr. Ip: Just a quick follow-up.

The Chair: Real quick. Real quick.

Mr. Ip: A very quick follow-up. You talk about how OPIC will decline investigations into complaints because it's sort of due to the lack of jurisdiction. Of course, you're not necessarily lawyers, but based on your experience are there other sort of pathways available to complainants to be able to – or are they completely without protection, having not been covered by PIDA?

Ms D. L. Smith: Are you asking: are there other pathways available to the person in an organization that's not covered?

Mr. Ip: Correct. Like, labour standards or something.

Ms D. L. Smith: Well, theoretically, there are. For example, there's something called the Protection for Persons in Care Act, and there is a reporting mechanism there – right? – and there are other things like that. But I would say, from my experience, that these don't really work that well either. They sometimes result in reprisals, too, so I think, as we heard in the previous expert presentations, the best system is one where people feel very free to report and it's not negative to report. When you come to your manager and you say, "I'd like to express a concern," the manager says: thank you for coming in and telling me about this. That's the culture that we want and the culture that, hopefully, this legislation would help to create in the system. I hope that helps.

Mr. Ip: Yes. Thank you.

The Chair: Excellent. I currently have four people on my speakers list: Member Petrovic, Member Al-Guneid, Member Armstrong-Homeniuk, and then Member Sweet. At this point if we can keep our questions concise, that would be great. We will try as members and as politicians to do so, so thank you for that.

Member Petrovic, you're up.

Mrs. Petrovic: Thanks, Chair. I'm already going to apologize ahead of time. Thank you, guys, for being here today. It's a known fact that I was a nurse before I was a politician, so this legislation and speaking with you guys means a lot. I apologize in advance. Please bear with me.

I just want to speak about some of the public-sector employees. I know we've touched on the private sector and the gaps that are there, but I do want to chat about this just a little bit, mostly because I worked in the public sector for 13 years before I headed into politics and I, too, wasn't aware of the office of the Public Interest Commissioner. I know that, based on the survey data referenced in Dr. Bron's report, you guys have highlighted particular findings that show low awareness of the office of the Public Interest Commissioner among the public sector's employees, and I can attest to this.

I just have a couple of questions focusing on that. Do you, UNA, believe that the primary challenge with PIDA lies in the substantive design of the legislation itself or more its implementation, communication, and awareness across the public sector? And if the implementation and awareness are the dominant issue across the public sector, what specific legislative or regulatory tools would be most effective to ensure concise training and awareness without imposing unnecessary administrative burden on these public bodies? I know we have our continuing competencies every year, so what would that potentially look like for our public employees without adding those additional burdensome modules we have to do every year? And then from your guys' standpoint, what minimum awareness or training standard would show meaningful change in reporting behaviour among nurses?

Thank you.

Ms H. Smith: I think I know what you're asking. Certainly, awareness and knowledge of legislation is really important, but it is more important that it is awareness and knowledge of good legislation. Awareness of the current situation is not going to address the issues that are there and is certainly going to do nothing for the private. So, yes, you know, certainly, with AHS and with Covenant they have education modules that are mandatory. It should be part of orientation. It should be absolutely reinforced with immediate, front-line management because a lot of, you know, the issues we encounter are front-line managers who may not understand the importance of just culture and the need to encourage disclosure and threats to patient safety or things that may compromise patient safety. So, yeah, I agree totally with appropriate education, but let's get them good legislation to educate them on.

The Chair: A follow-up question, or are we moving on?

2:30

Mrs. Petrovic: No. If I can just clarify, I understand what you're talking about in terms of good legislation and when we're talking about private versus public and who qualifies under the whistle-blowers act and who doesn't. But if we can just be honest, this is still happening within our public sectors.

Then, as the parliamentary secretary for health workforce, I'm seeing this on the regular, people coming to me behind closed doors absolutely terrified to meet with me to speak about things that are happening – this is in the public sector – unaware that there are alternate avenues for them to go. Secret meetings behind closed doors because they're terrified of what's going to happen to them: I think everyone in this room can agree that that's not okay. This is where, you know, when we are looking at legislation and we are looking at this, I have these health care workers come to me from all backgrounds and all stripes of life, and they're unaware of this.

When we're talking about communication awareness across the public sector, like, is there a minimum awareness or training standard

that we should have for these front-line employees to ensure that they know what their avenues are to making sure that they aren't having fear? Like, we do have some of these protections in place for our public-sector employees, and they're still, within the culture of these areas, unaware of where to go or who to turn to. From your guys' perspective, should there be implementation of this for these individuals to have that awareness and the avenues to go down?

Ms H. Smith: Absolutely there should be implementation, and I'm not sure which health care workers you speak to. We are the only – well, I think something may have recently come into the AUPE. We've had what we call professional responsibility since 1980, when we achieved it, and we have had a constant uphill struggle, but with success, in terms of making nurses – I primarily deal with nurses – aware of how powerful a tool they have in terms of identifying patient safety concerns and even more powerful because it is supposed to be a joint tool. We have worked all these years in terms of what Sean Chilton said: turning the moment when a nurse identifies on a professional responsibility concern form a concern going from, "Oh, my God" by the manager to, "Thank you." We continue that road, that challenge, and we have made incredible steps ahead.

Not all health care workers have that. Even in Alberta Health Services we are the only ones with that. But, you know, people do take risks, and knowing that what they consider a risk to them, whether it's real or not, all depends on how their concern is responded to. If their response is, "What did you do?" or "What did you not do?" that's not the right response. A just culture is something very different than that. You know, we're not just educating nurses and the workers about what a just culture means; we are still educating employers and front-line managers in many ways.

Just as a fact, our process, you know, is very much related to a written identification of a concern. Last year there were 3,005 professional responsibility concerns identified primarily in AHS facilities. We don't really necessarily have the same process in all of our long-term care, the not-for-profits especially. But for each one of those, if there was a system outside of the workplace that they are made aware of, that will bring them support and security, I think that number would be even greater than it is.

So, yes, we love to talk to health care workers about their concerns and get them to come forward. A just culture change doesn't happen overnight, but it will happen faster if there are external supports to that change in culture. One of those supports is legislation that everybody supports and understands and respects and enforces.

The Chair: Excellent. Committee, just for awareness, we are going to do the last four questions, and then we do need to move on to other business afterwards. We are going to do: Al-Guneid, Armstrong-Homeniuk, Sweet, Arcand-Paul. After Member Arcand-Paul has wrapped up his questions, then we will move on to other business here today. We might be flexing that 2:45 a little bit, a little bit over, but we want to make sure we get all the questions in here today.

Member Al-Guneid, please go ahead.

Ms Al-Guneid: Thank you, and thank you both for being here and for the passion you're bringing today. I see in your submission that you want the implementation of recommendation 5 from the commissioner's report, which is to include all subsidiary health organizations under the act. My question is: to date, how has the exclusion of some health organizations impacted nurses and families? These are not just numbers. Obviously, we're talking about Albertans. There is a human cost here. I have the Rockyview hospital in my riding. It's a very busy hospital. I had my two kids in that hospital, so it's close to me and my riding. Are you able to share some examples, some stories here? This exclusion, to date, how has it impacted nurses and families here in Alberta?

Ms D. L. Smith: One way we could address what you've asked would be to say, as Heather just mentioned, that in the AHS facilities and those that are covered and have access to the process we've been talking about, which is in the collective agreement for nurses, there are 3,000 reports in the last year, and that's not an unusual number. It's several thousand each year over the last 12 years, when we've been collecting this information.

If you were to say, you know, percentagewise, then, how many beds and people are being cared for in the rest of the system, you could do a little numbers thing, which I can't do right now in my head, but somebody who's a farmer might be able to do it right away because they do numbers, and you'd say: well, what proportion, then, of the 3,000 might you expect to see coming from the parts of the system that are not now covered? Referencing the previous presentation, I think they alluded to the idea that if you don't have concerns being reported and people blowing the whistle, you have to worry whether there's something not very good in the culture.

We can't say exactly, but if you were to use that number 3,000, take the beds in the areas that are covered by the legislation now and then do a proportion, you'd get a number of what you might expect should be happening, should be reported from that other system that's not under the umbrella now. I hope that makes sense.

Ms H. Smith: And so many of our professional responsibility concerns relate to staffing. I think what you have to go on to imagine is that if those kinds of reports of understaffing or short-staffing proportionately happen outside of AHS, we know the implications of short-staffing in terms of work not done, care not done, whether that means that somebody in a facility is not turned, somebody is not fed, somebody is not mobilized. We came across – and this was one of your passions – by accident, actually, the rationing of diapers in long-term care.

I mean, you have to imagine if there are – and there has been. I am sure there has been any kind of proportionate lack of or understaffing, and you can pretty much imagine what's not getting done.

The Chair: Thank you for that.

Member, do you have a quick follow-up question?

Ms Al-Guneid: Considering the time, I'll pass. Thank you.

The Chair: Thank you so very much. Really appreciate that.

We're turning online to Member Armstrong-Homeniuk. Please ask your question.

Ms Armstrong-Homeniuk: Thank you, Chair, and thank you, ladies, for joining us today. Very interesting conversation and insight you have. I will be very quick with my question. My question is: have you or your organization encountered real-life cases where nurses or health workers were unable to seek protection because a subsidiary was not explicitly listed, and if yes, are you able to share more details about such cases? It's singled out in recommendation 5, which suggests that all subsidiary health corporations be automatically included.

Thank you.

2:40

Ms D. L. Smith: Well, I can think of a couple of examples, and they're not recent, so they're good ones to use because they won't get anyone

too anxious. You might remember that a few years ago there were big billboards up, and they had been put up and paid for by a man whose mother had experienced serious injuries. She had developed bedsores from not being turned and changed, and she had ulcers and so on, and this person had enough money that he could afford to have billboards and make presentations. I don't remember the facility, but it was an example, I think, of what you're talking about.

Another example I can give – and I can't tell you whether it was a subsidiary one or not, off the top of my head, but it was in central Alberta in a nursing home, and it was actually a nursing student who reported it. Actually, I think this was perhaps even in a Covenant facility, and there was an investigation, as should have happened. This was, I want to say, a positive example. There was an investigation, there was a response, and there was what you would hope would have happened, but the piece about it that I think makes it very powerful is that a student was the one – it might have been an LPN student if I'm recalling right – who reported this through her instructor, and this led to an investigation, as we would all hope would have happened.

So, although I can't bring other examples to mind right now, I think we should assume that there are many instances where people would like to have or might have tried to report in all of these other settings.

Ms H. Smith: And we get sort of some of the secondary stuff, Donna, in terms of, like, home care, for instance, where actual personal care may be contracted out, and most of it is now, and, you know, our nurses through our process may report that when they become aware of where the private agency did not send the person in. The health care aide, the whatever, never arrived, and the family may not have told them. They may not be aware that somebody did not show up.

I would think that it would be much safer for everybody if those workers in those agencies had the ability to identify their concern and, you know, make known, and it's something that could be under public scrutiny, why those individuals had not come to change the dressing or assist with mobilizing or the bath and that kind of stuff. Because it seems that it's more frequent than our nurses want to consider, but I would think that protection for those workers, those secondary workers, and their ability to raise within their employment situation their concerns about staffing would be helpful to those, you know, overall responsible in the public system.

The Chair: Thank you very much for that.

Member, do you have any follow-up questions?

Ms Armstrong-Homeniuk: No, I don't. Thank you.

The Chair: Excellent. Thank you.

Member Sweet, please carry on.

Ms Sweet: Thank you, Mr. Chair, and thank you again for being here today. Just real quickly, I recognize that the way that the process works for whistle-blowers can be a long process, and it can take a long time to get there, and I also want to recognize that you do have the PRC process within your organizations, that you've been able to negotiate. But that also is something that many front-line workers are saying is not responding to their concerns. It goes to their supervisor or manager and it dies, and nothing really becomes of it, so they're now finding other ways to report, whether they go to social media influencers, whether it's trying to find different mechanisms to bring issues forward.

So I guess my question to you is: given the urgency of some of the care that needs to be provided to people within Alberta, given the fact that we are more often than not now hearing of urgency within our emergency centres, within our care facilities, are there things that we need to know today that we can start acting on today to help your front-line workers as well as ensure that Albertans' health care is being protected?

Ms H. Smith: Well, that's quite a question.

Ms D. L. Smith: If you're asking what could be done right away that would start to help while you deliberate and decide what to put in the act, which I hope you'll do fast, there's a writer in the United Kingdom. Her name is Mary Dixon-Woods, and she's written extensively about quality in health care and so on. She writes that what leaders need to do is create the conditions in which workers could do the right thing. It could be done in every place tomorrow if leaders encourage the right thing to be done, and one of the right things to do is to report a concern.

Come to me if you're worried about something. Come to me if you think something is wrong. That is the behaviour, if it were enacted tomorrow, that would start this to switch, but I think, to go back to the bigger purpose of your meeting today and the act, I feel that you heard such wonderful expert evidence from the previous presenters, and they did allude to best practices. If I were on the committee, what I would be wanting to do is say: tell me more about the best practices so that we can be sure we don't overlook them as we fix our act in Alberta.

Ms H. Smith: Our professional responsibility process is not always fast, but it has been effective in many of our work sites, and as I said, increasingly understood and supported in workplaces, so, you know, this would just – better legislation, better protections would simply reinforce and strengthen it. It's not just one and one equals two. Our work and better legislation is one and one equals three or four – right? – and moves along the achieving of just culture that much faster. I'm not naive in thinking that even with new legislation things are going to go faster and improve overnight. It's going to take time even if the best possible legislation was passed tomorrow.

The question regarding, you know, educating and informing and getting that messaging out: that's going to require resources, that's going to – the government of Alberta should be sort of advertising it. "There is new legislation to protect workers in this province. Please check it out." You know, there should be mandatory in-service at workplaces, not just in health care. Yeah. It's not going to change overnight, but the first step in terms of helping us help Albertans is good legislation.

The Chair: Member Sweet, do you have a follow-up?

Okay. Member Arcand-Paul, if you can be concise in your questions, which I know you can, and ladies, if you can be concise in your answers for this one, not to hinder, because I don't want to put that pressure on, but we are coming to a pretty solid cut-off here in about two and a half minutes, three minutes. So, Member, you have a couple of minutes.

Member Arcand-Paul: Thank you, Mr. Chair, and I'll be very brief per your caution. I was born at a hospital called the Camsell hospital, which at the time had a history of intense government intervention, and there are subsequent class actions that are now being heard in this year, 2026. Whistle-blower protections did not become a conversation until about 1981, in which time that class has been identified as the cut-off period, 1981, and this was run by Indian health services, by the federal government.

Presently government interventions in health system operations in Alberta would cause us to have intense and more necessary whistle-blower protections here in the province of Alberta. With regard to private delivery versus public delivery, which you've spoken of, Ms Smith, would your reiteration of recommendation 1

from the 2020 report include a recommendation that private-delivered health care would need to be included under this legislation to cover those nurses that might not be otherwise considered under UNA? And then, I would reiterate, would you confirm that where public dollars go, this legislation should follow?

Ms H. Smith: Absolutely. It's always a good rule to follow the money, and accountability for public dollars is imperative.

The Chair: Excellent. Member, do you have a follow-up question?

Member Arcand-Paul: Nope. That's everything. Thank you.

The Chair: My man, thank you so very much. That was incredible.

Ladies, thank you so very much for coming here today and presenting and giving us a few more extra minutes of your time – greatly appreciated – as you answer our questions. I do greatly appreciate your presentation, your time, and your answers for us in this committee. You are welcome to stick around, if you would like, in the gallery, though we'll be wrapping up here, hopefully, very quickly.

2:50

That concludes our oral presentations today. Once again to the presenters online as well, thank you for your time and your perspectives on the Public Interest Disclosure (Whistleblower Protection) Act in this conversation. It is important that you share, and I want to thank you for the time.

I want to move on to next steps, into our review. There are a couple of options that the committee needs to converse with. As a reminder, we were given 12 months to complete our review of the Public Interest Disclosure (Whistleblower Protection) Act. We began our review on June 27, 2025, which leaves us approximately five months to wrap this up, to complete the review, and get our final report to the Assembly. Lots of words.

Okay. We have received both written submissions, oral presentations, and a number of research documents. Now the decisions on the table are: does the committee wish to gather further information, or are we ready to plan to begin deliberations here at our next meeting? Really, the question is: is there maybe more information that the committee might seek, or start deliberations?

We have a question. Member Petrovic.

Mrs. Petrovic: I actually have a motion.

The Chair: You want a motion?

Mrs. Petrovic: I'm just going for it, Chair.

The Chair: All right.

Mrs. Petrovic: In respect for everyone's time.

My motion

> directs the Legislative Assembly Office to prepare a consolidated summary of key issues and proposals raised through written submissions and oral presentations to support the committee's review of the Public Interest Disclosure (Whistleblower Protection) Act.

I'm dropping the gun.

The Chair: Thank you for dropping the gun.

If the committee is willing, we're just going to quickly explain next process in regard to the motion that was put on. Please just explain what next steps are in regard to this. That'll be fantastic.

Ms Robert: Thanks, Mr. Chair. Okay. I'll be very, very brief because I know everybody wants to get on with their day. The motion that the member put forward is with respect to the Legislative Assembly Office preparing a summary of issues and proposals in order to, hopefully, facilitate your deliberations on making recommendations with respect to the law.

Most of you have been involved in statute reviews before. The issues and proposals document is a fairly standard-looking document. It's four columns long. It is organized by issue, and then there's a column that sets out each specific proposal or recommendation that has been made through the written submissions or through the oral presentations we heard today. There's a column which contains notes which are contextual information on the recommendation. It might reference the crossjurisdictional. It might reference a quote from the submission that was made, anything that might help the committee kind of zero in on the proposal. And then there's also a column on the relevant sections of the act that the proposal might impact. The document also starts with an introduction on how to use the document. It includes an executive summary to help sort of make the information digestible.

The document is purely a tool for the committee. The committee is not required to use it. The committee can make whatever recommendations it wants to. It doesn't need to go through the entire thing. It can pick and choose, or it can set it aside. Totally up to the committee. It's just a tool that the Legislative Assembly Office typically will provide to the committee at its direction.

Unless there are any questions, I'll just . . .

The Chair: Member Rowswell.

Mr. Rowswell: The review of the 2020-21 review: would that be part of it? Or do we just do that on our own?

Ms Robert: I'm sorry.

Mr. Rowswell: There was reference to the . . .

Ms Robert: To the last time that this – yes.

Mr. Rowswell: . . . last review and that, you know, it wasn't implemented.

Ms Robert: Right. If the committee wanted to consider recommendations from that review, they would have to bring them forward anew. If the committee would like to see that document, if that's the will of the committee, we can certainly provide it on the internal site. That's totally fine if that is the wish of the committee.

Mr. Rowswell: I would like that myself, if everyone's okay with that.

The Chair: It looks like at least in the room there's some consensus. I don't think we need a motion for that.

Ms Robert: No. As long as everybody's fine with that, absolutely. Warren will make sure they're very clearly delineated so that you're clear on which one is which. They'll look quite similar.

Mr. Rowswell: Okay. Thanks.

The Chair: Okay. Perfect.

That leaves us to the motion at hand. Is there any more discussion on this motion? I'm not seeing any. Okay. All in favour of this motion, please say aye. Excellent. Online, please say aye if you are in favour of this motion. Excellent. Any opposed to this motion? None in the room. Online, any opposed? Excellent.

That motion is carried.

This leads us to our next meeting. We'll begin deliberations regarding any observations or recommendations the committee wishes to make with respect to its review of the Public Interest Disclosure (Whistleblower Protection) Act. We do not have a date scheduled for

that meeting yet, but I would like to remind everyone that notice requirements are in place for substantive motions. As such, I would encourage everyone to provide your motions to the committee clerk as soon as possible after reviewing the issues and proposal document, which will be posted to the committee's internal website once it's completed. The staff of the Legislative Assembly Office are available to assist with any drafting of motions. Please try to consult them through the committee clerk prior to the day that notice of motions must begin. Are there any questions on this process? None online? Perfect.

All right. On to other business. At our last meeting the committee requested that research services provide supplemental information related to the crossjurisdictional review prepared by LAO research services. That supplementary document was posted to the committee's internal site, and members were notified. Are there any other items for discussion at today's meeting? None. Okay. Excellent.

That leads us to the date of the next meeting. The date of the next meeting will be at the call of the chair, and I would now like to call for a motion of adjournment. Excellent. Member Petrovic, thank you.

The January 19, 2026, meeting of the Standing Committee on Resource Stewardship is adjourned. Thank you, members. We've got to vote for that. My bad. All in favour of adjournment? Excellent. Online? They're off. Perfect. Unanimous.

[The committee adjourned at 2:58 p.m.]

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