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VIA EMAIL: info@wcbreview.ca

WCB Review 2019
PO Box 97122 Stn Main
Richmond, B.C. V6X 8H3

Attn: Donna Hanson, Review Coordinator

Dear Reviewer:

Re: Submission to the Workers' Compensation Review

We write to provide our submission to the Reviewer. The following is based on our personal experiences with injured workers and the WCB. Some of the issues we raise deal with small procedural matters, other address large systemic problems.

We have set out our concerns briefly without going into great depth however we would be pleased to provide any further information if required.

Establishing Trust Relationship with Workers

Many workers (and healthcare practitioners) distrust the WCB and the board officers they deal with. We submit that the ideal circumstances to foster trust would see case managers having the time to meet with or at least speak on the telephone, to every worker on their caseload. Essential to creating a trust relationship is keeping their word: if a board officer says they will call a worker on a certain date, or will provide a particular adjudication, they must do so on the date stipulated.

***Above all, workers must be treated with respect*.**

It's demeaning and humiliating to a worker who is disabled from working, maybe for the first time in his or her life, to be treated like they are dishonest and untrustworthy, and trying to rip-off the system. We cannot relate the countless times we have spoken to older workers who have 25 or 30 years of a solid work record behind them, who have told us about being lectured to about "responsibility" by young case managers who don't seem to realize that they are there to serve workers. We submit that all working people take pride in doing a good job and earning a living by dint of dedication and hard work. People who are unable to work, and often fearful of losing their likelihood altogether, need support, not discouragement and condescension, often from board managers who are half their age and relatively inexperienced in the workforce themselves.

We suggest that the Board place great emphasis on treating workers with respect and invest considerable resources in providing training for board staff in this regard. We recognize that it is a large organization and that it is difficult to ensure that everyone complies with such a policy, but the amount of resources invested by the Board in achieving this goal is surely a reflection of its commitment in this regard.

Failure to copy representatives

Case managers all too frequently decline to copy decision letters to a worker's advocate or lawyer, sending copies only to the employer and their representative. This is the case even where we have represented the worker for many years and have had voluminous correspondence with the case manager over that period of time. Indeed, even in cases where the decision letter is in response to an express request of the worker's representative, it is not uncommon for the case manager to decline to copy the letter to the requester.

Sometimes, less commonly, the decision letter will indicate that the representative has been copied but no copy is ever received. The worker then assumes that their representative has seen the letter and will frequently not pick up the phone to advise us. This sometimes results in missed appeal deadline. This increases expense for all concerned and since the Review Division is so draconian in its interpretation of the onus on the worker to follow-up, there may well be no extension of time given.

While Review Division policy expressly states that omission of copying a worker's representative should be taken into consideration in extension of time applications where a deadline to file a Request for Review has been missed, we have had cases where the Review Officer declined to follow that policy.

Documents not placed on file

Sometimes documents go missing. Frequently these are letters to case managers asking for an adjudication. The requires a worker of representative to follow up, sometimes repeatedly, to get the letter placed on file. However the system functions, it has to work better. Many months can be wasted pursuing these documents and writing multiple requests.

Telephone Communications Not Logged

All communications should be logged on the file but this is not always the case. Firstly, all calls by a worker to a board officer should be logged. Calls made to a case manager's direct line are not logged. There is no evidence to corroborate a worker's statement that she has called many times and had no return call.

Second, if a worker has a conversation with a board officer, there may be no record of it. This is particularly frustrating where problems on the file have necessitated calling a Client Service Manager. A CSM may speak to a worker or their representative and yet there is no record of the conversation at all. This makes handling a file and seeking resolution to problems more fraught than it need be. Client service managers should be required to place telephone memos on the file. Similarly, it is not uncommon for telephone communications to be logged in the "Communications" section of the online file but for there to be no memo to document it. Some case managers are more prone to do this than others. For these case managers, it happens regularly. All telephone conversations should be documented by a memo to file.

Plateau Declared Too Early[1]

We have seen many cases of psychological disability in which the worker is declared plateaued much too early. While a worker is still struggling to recover from their injury and resultant condition, they don't need to have the added pressure and stress of a vocational rehabilitation consultant demanding that they embark on a return to work.

This has been the case in many firefighter claims where the worker continues to be acutely disabled, in some cases unable to even leave the house, and they are declared plateaued; then discussions start with the employer to have them returned to work, if not in suppression, then in alternate jobs.

A major problem we encounter again and again is that the worker does not understand the significance of the plateau decision. We have frequently had workers and their unions come to us well past the appeal date, because they are being pressured to return to work. They are asking for help, and not realizing that they should have appealed the decision to plateau.

A typical plateau decision letter states:

> *Medical and other information indicates that your disability is no longer temporary. Your disability is considered permanent. As a result, your wage loss benefits will end on June 10, 2018.*

We submit that plateau decision letters should explain, in plain language, what the decision means to an injured worker; not just that the condition is no longer considered temporary but that the board will be moving on to returning him or her to work.

Maximum wage rate

The board's maximum wage rate is much too low to accurately reflect what a broad spectrum of workers in BC earn. Anyone with a skilled profession is likely to earn significantly more.

[1] See also page 13.

Of note, right next door in Alberta there is no cap on earnings. Wage rate and pension are based on the *actual earnings* of the injured worker, a novel concept here in BC.

Before their act was recently amended, Alberta's maximum wage rate was $97,800. What justification can there be for such a vast discrepancy?

Failure to Adjudicate Issues

It is all too common to encounter files where the case manager should have adjudicated issues but did not, leaving the worker without decisions on matters of significance.

Most commonly, there will be a failure to adjudicate chronic pain. Thus, one might get a PFI decision in which the DAMA report expressly states that a significant symptom complained of by the worker is pain, and yet the pension award is based solely on other factors in the PDES.

In these cases a worker without a lawyer or advocate is extremely unlikely to know that this has been overlooked, and to ask the case manager to take care of it.

Of course, what needs to be done is to write the case manager and ask for an adjudication separate and apart from any appeal, since the appellate tribunals refuse to address this failure in a pension appeal. In our cases we've found that roughly 90% of cases where we make this request are granted a chronic pain award. Since it is so common to overlook this adjudication, one suspects that there must be many workers in the province who have been deprived of an award they are entitled to.

Mental Health Issues

Sometimes very small actions can have huge consequences. This is particularly true of psychological injuries.

Sending out form letters to those who suffer from disabling psychological conditions can be damaging if they are not phrased with consideration of the worker's disability. For example, sending a form letter asking the worker to list all details of their traumatic experiences, places, dates, times etc., can re-traumatize the worker.

Similarly, sending a decision letter that recites the trauma suffered when it is absolutely unnecessary to the purpose of the correspondence reflects a lack of understanding of and sensitivity to the condition suffered by the worker. For example, we have seen letters like this:

> *I have decided to accept your claim for PTSD suffered when you had to pull two young women out of a car and one of them died in your arms.*

This kind of letter should never be written.

Psychological Disability Awards Committee (PDAC)

The PDAC fails to follow internationally recognized standards and resources for measuring disability. Rather, it creates its own definitions, lingo, and methodology for determining levels of psychological disability. These standards change from time to time and often are at odds with international standards and practice.

The language the PDAC uses to justify its awards which are often much too low, include so much jargon and circular reasoning as to be incomprehensible to the average person. We include some examples:

> *Although Dr. K. provided an overview of his symptomatology, she has not specified the symptom severity level for each unique symptom. However, even had she done so, this would not be a good guide to impairment severity. Psychological symptoms are an internal event and it is usual that the level of impairment arising from those symptoms is only imperfectly correlated with the level of symptoms. It is quite possible for an individual to be moderately depressed yet be able to fulfil their basic home and work roles despite this level of depression. As a result, impairment level is generally not presumed from either the number of symptoms or the symptom severity level. Rather, since impairment level is based upon impairments not symptoms, it is generally deduced from the psychological restrictions and limitations accepted on the file, from the assessing psychologist or psychiatrist's description of overall psychological functioning on a range of domains, and from the description of functioning contained in various psychiatric, counselling and psychological treatment progress reports*.

The PDAC does not award any PFI for somatic symptom disorder. They state that the condition is not rated itself by PDAC, "because its effects are subsumed under a combination of physical, psychological, and pain awards, as appropriate." Thus, where somatic symptom disorder is the only condition accepted under the claim, no PFI is granted.

It is our submission that that this flies in the face of recognized psychiatric practice. Somatic symptom disorder is a mental condition listed in the DSM 5 and its disabling effects are set out in that document.

It is our view that the Psychological Disability Awards Committee should not be permitted to create its own arbitrary and idiosyncratic standards that conflict with the rest of the mental health world. They should be required to adhere to accepted standards of practice in the profession.

Psychological Disability and "Non-Compensable Factors"

All too often the consequences of injury, such as unemployment, financial distress, marital discord, are discounted as non-compensable. Here is an example:

> *As noted above, Dr. Saper did not provide an opinion on causation. Dr. Feehan also noted that there were pre-injury references to anxiety. In his March 16, 2018 report, he said that the 2016 records attributed the worker's anxiety at that time to stress from non-compensable factors. With respect to these conditions, Dr. Feehan said that:*
>
> *Indirectly, it is likely that his workplace injury has added to his anxiety, as it has compromised his work history and this appears to be a stressor for him. However, the vector between injury and anxiety passes through noncompensable issues such as employment and income. That is, that the injury led to employment and income issues and that the employment and income issues, rather than the injury itself, caused the anxiety*.[2]

Psychological Disability and Temporary Wage Loss Benefits

Almost universally, when a request is made for acceptance of a psychological condition on an existing claim for physical injury, the worker may be covered for counselling costs, and may ultimately get a pension, but rarely is temporary wage loss ever considered or granted. We suggest that in each instance where a psychological condition is accepted, policy should require the case manager to determine whether it is currently disabling.

Board Medical Advisors

Board medical advisor opinions are given a disproportionate amount of deference even in areas where there may be an opposing specialist opinion, and in which the BMA is not qualified to offer an opinion.

Further, these opinions may be offered without having examined a worker, discussed the case with the worker's own physicians or even having spoken directly to the worker on the phone. Thus BMA opinions may be founded upon an incorrect understanding of the facts such as mechanism of injury of symptomatology. Again, these opinions are offered with impunity. We submit that there should be some means to calling board doctors to account when their opinions are ill-founded and at odds with accepted medical practice.

For example, in a recent case, the specialist, a physiatrist, treating a worker stated that severe right shoulder injury and resultant high dosages of opioids for pain, had prevented the worker

[2] WCAT A1802790 at paragraph 49. Of note, the Vice-chair discounted the view that the resulting anxiety was non-compensable.

from realizing that his left shoulder was also injured in his very serious accident. As the worker's drug dosages were reduced, he began to realize the degree of pain he suffered in his left shoulder.

The treating specialist is adamant that both shoulders sustained the same injury at the same time when a wall fell onto the worker from a burning building. The BMA, who is not a specialist, continues to state, categorically that:

a) There's never delay of more than 72 hours for onset of any pain, and
b) No drugs are strong enough to mask pain from an injury.

As a result, the worker's left shoulder has not been accepted. This is a perfect example of the inordinate amount of deference given to BMA opinions, to the great detriment of injured workers.

Failure to Investigate

Particularly infuriating and counter-intuitive is the refusal of BMAs to approve imaging or other tests that might establish either causation or the exact nature of an injury.

For example, a worker has multiple injuries from a fall at work. He is accepted for a knee and shoulder injury but not for low back symptomatology. The family physician requests approval for an MRI to determine what exactly is wrong with the back. A BMA opines that the back is not related and therefore she will not approve any imaging to explore it.

Alternatively, an injury may be accepted, for example, for low back strain, but it does not respond to treatment and the worker does not recover within the timeframe expected. The family physician may want to get some imaging done to determine whether there is something else going on besides a strain. Again, the BMAs often refuse imaging on the basis that "it's just a strain" and does not merit an MRI.

The practical impact this has on workers, of course, is that they may have to wait many months for imaging if it is not done under the expedited process available to the WCB.

This just does not make any sense at all. These cases may end up in years of appeals because the proper diagnosis was not in a timely way, to say nothing about the impact on the worker of delay in diagnosis. We submit that the Board should always facilitate imaging and testing where it may resolve an outstanding issue in diagnosis and treatment of a worker.

Chronic Pain Taken to a Ridiculous Extreme

Sometimes in cases where a worker is in receipt of a permanent functional impairment award for chronic pain, board medical advisors take the position that no matter how bad their pain is,

they are not entitled to a reopening because pain is pain and it's already been recognized with the pension.

Often a BMA will state that there is no "objective pathology" of a worsening, when, in fact, there never has been pathological evidence. Thus they are imposing an impossible test.

Practice Directive #C14-C3(c) states:

> *Although evidence of such a change would be ideal, the reopening criteria do not require a measurable variation in the essential nature or characteristics of the worker's compensable condition (i.e., a demonstrable change in pathology).*

While board policy also states that a worker's evidence should not be assumed to be biased (**RSCM #97.32**)

Physiotherapy

When the previous government changed the Workers' Compensation Act and system, they abruptly reduced basic physiotherapy coverage from 16 weeks to 8 weeks. They cut the provision of this service in half for purely budgetary reasons and without any consultation whatsoever with the College of Physiotherapists. It is our submission that a thorough investigation should be undertaken in order to determine whether 8 weeks is sufficient or whether the original 16 weeks of coverage should be restored.

Selective / light employment

We often encounter workers who have been found to have unreasonably refused offers of selective/light employment where they are simply following their doctor's advice or encountering problems getting that advice. Here are some of the problems we see:

- the worker's physician doesn't write in their initial reports to the WCB that they've advised a worker not to do light duties even though they have verbally advised the worker as such
- The Board presumes that the doctor didn't advise the worker not to participate if that isn't stated in the doctor's report to the Board, and cuts the worker off
- The Board presumes a worker's refusal to participate was unreasonable because the doctor's advice isn't written out in the report. That worker's statements are disregarded.
- The process puts up various barriers to getting the worker's physician's response regarding the offer:
    - the Board's report forms (F8 and F11) don't ask the physicians whether they've reviewed an offer or whether they think it's suitable

  - The offer from the employer doesn't contain a form for the worker's doctor to fill out in response
  - The jobs are vaguely described, contain a broad range of physical and cognitive demands and/or includes work that the worker knows the employer doesn't have available, complicating a response
  - The employer doesn't offer to pay for the doctor's time in responding to the offer or filling out a form
  - The Board doesn't reimburse doctors for responding to the employer
  - The Board doesn't call the worker's physician to clarify their opinion before cutting the worker off benefits
  - attending physicians are obligated to treat the worker, complete a F8 or F11 report to the WCB and don't have time for supplementary work such as responding to selective/light employment offers

- The Board is not providing workers with alternate medical advice so that the worker can make an informed choice whether to follow the advice of his or her own doctor or a medical advisor, as Board policy and practice directive suggests the Board should.
- The Board is not intervening in real time when a worker and/or their physician disagrees with the suitability of an offer but is responding weeks later and backdating the termination of benefits.
- The Board cuts workers off for months and months of wage loss benefits even though the employer only had a few weeks of selective / light employment

We often hear from injured workers who are participating in selective/light employment that is either unsuitable or having negative impacts on their recovery, for example:

- Workers are stuck in unproductive selective/light employment such as a worker sitting in the lunchroom watching movies for month after month, and the Board declines to intervene
- Selective / light employment is being used by employers for extended durations, for example for over a year
- Harassment of workers on selective /light employment is not being investigated by the Board
- Selective / light employment is interfering with workers' access to health care treatment for their injuries
- Employers increase the worker's job demands without allowing the worker an opportunity to consult his or her physician and without reporting the increased demands to the WCB
- Employers are reporting to the WCB that the selective/light employment is lighter than the work actually available to the worker

- Employers are using selective / light employment only for WCB claims and not for other disability benefits such as short-term or long-term disability, meaning that injured workers get publicly identified as such.

Gaps in compensation

There are often long uncompensated gaps between the start of the worker's compensable disability and the start date of wage loss or a permanent partial disability, for example periods when the worker is working full hours but the compensable condition has yet to resolve or reach maximum medical recovery. This can be months or years. This delay in benefits is one reason that selective / light employment saves money for employers. Workers find this humiliating because these are periods of time when they have struggled, often the worst period of their disability.

One remedy would be to compensate all gap periods for example by payment of benefits for *temporary* functional impairment where a worker's condition is temporary but the worker is working full hours and thus not eligible for payment under section 29 or 30. This would include periods of selective/light employment.

Return to work

Here are some of the recurring problems we see injured workers encounter when returning to work:

- Deeming. When workers fail to progress through rehabilitation or return to work as expected they are cut off benefits on the basis they *should* have recovered, often in spite of the fact that they remain disabled.
- Job demands. The Board or its providers fail to get an accurate account of job demands and inappropriately deem the worker as fit to return to work. For example, the Board sees that a scaffolder can do 10 reps of lifting 50 lbs. in an OR program and deems him fit to return to work. The scaffolder's job requires repetitive heavy lifting all day. The scaffolder is unable to tolerate the work, yet the Board deems him fit because on the inaccurate job demands.
- Intransigence. Case managers and medical advisors are unwilling to change their position, for example that a worker is fit to return to work, after a worker tries and fails to tolerate the return to work.
- Discharge status. OR and RTWSS programs discharge workers as fit to RTW without limitations even though the substance of the discharge reports describes ongoing limitations that impact productivity
- Worker evidence: The Board does not accept worker's statements about their disability as evidence, even where the worker's evidence is uncontradicted. Case managers and

medical advisors are unduly suspicious about worker evidence that is supportive of their claim. This is not an evidence-based approach.

- Medical advisors. Medical advisors rarely speak with workers and presume or infer incorrect facts based on incomplete or incorrect information. They rely on paper reviews and incomplete information in team meetings.
- Subjective disabilities. The Board minimizes subjective disabilities such as pain-related limitations, as compared to objective disabilities.
- Limitations and restrictions. The Board's permanent limitations and restrictions are incomplete or inaccurate yet the vocational rehabilitation consultant has no discretion to consider the worker's additional limitations and restrictions, and must proceed to facilitate accommodation or prepare a vocational rehab plan even if the limitations and restrictions are plainly incomplete or lacking.

- Duty to Accommodate.

    - Vocational rehabilitation consultants have no power to enforce the duty to accommodate and fail to push employers in this regard even where they are clearly failing to fulfill their duty. Where the accident employer says they don't have an accommodation, the vocational rehabilitation consultant quickly starts looking at other workplaces.
    - Employers wrongly assume they only have to accommodate the disability that the WCB has accepted in its decisions and therein ignore evidence of additional disability. They do not understand—and the Board is not educating them—that they are obligated to do their own investigation and cannot rely on what the WCB says the disability is
    - Employers wrongly assume that the WCB's retraining of a worker that it says it can't accommodate constitutes (somehow) fulfillment of their human rights obligations which it does not

- Retraining. Vocational rehabilitation consultants provide retraining or job search benefits to workers on the basis that they can deem a worker of high earnings based on wage rate data and labour market information in that occupational category (and therein deny or minimize s. 23(3) compensation) not on the basis that the worker will actually get a job or earn the deemed amount over the long term. The deemed earnings can be inflated. The schools can be of poor quality, especially in relation to the deemed earnings, for example with deemed CSOs, parts person or auto service advisors. Workers often get humiliated by poor quality VR to the point that it precipitates or worsens a DSM-5 disorder.

- Competitive employability. Vocational rehabilitation consultants are deeming workers of high levels of earnings in new occupations before workers have successfully worked in that field and without actually contacting prospective employers to see if employers would accommodate someone with the worker's particular disability. Voc rehab

consultants are working backwards from the point of being able to deem the worker of a particular rate of earnings but without having first made those critical inquiries about whether the worker would be *competitively* employable in that area.

Unobtainability

For many of the most severely disabled workers, adequate benefits such as loss of earnings pensions are effectively unobtainable in the current WCB system.

Here's an example of a former client, a mill worker. In 2006 he became unable to work due to intolerable neck pain and depression from a prior work injury that had been accepted by the WCB[3]. His employer could not accommodate him any further and he became unemployable. He asked the WCB for benefits and here's what the WCB said (with the appeal results in parentheses):

1. Your neck condition is non-compensable (varied in WCAT-2011-02338).

2. Your neck condition stabilized in 2005 when you were still working and we won't look at the loss of earnings you began suffering in 2006 (referred back to the Board in R0141659 – August 9, 2012, confirmed in R0159449 – August 15, 2014)

3. We won't reopen your claim for further benefits in 2006 because your neck didn't worsen (confirmed in R0155785 – June 13, 2013, and varied in WCAT-2014-01990).

4. Your depression wasn't caused by your work injury (varied in R0155785 – June 13, 2013).

5. Your depression never disabled you and we're not paying you benefits for it (R0159449 – August 15, 2014)

6. Once again with feeling, your depression never disabled you and we're not paying you benefits for it (varied in R0192345 – September 21, 2015).

7. We're not paying you a loss of earnings pension for your compensable neck disability and depression because we think there are jobs at your mill that you could have done all along (referred back to the Board for further investigation in R0210749 – December 28, 2016.)

In the above case, it took the worker eight years and all those appeals until the WCB finally recognized, in April 2017, that he was competitively unemployable and entitled to a 100% loss of earnings pension. None of that would have come close to happening without tremendous

[3] The work injury occurred in 1994. He fell 30+ feet at work breaking his neck, eventually returned to work with the support of the WCB.

support from his union and his family. Unfortunately, it's not uncommon for the most disabled injured workers to face such an endless (and humiliating) string of adverse decisions and appeals. It's simply unobtainable for many.

It is common to see workers being found unemployable because of their work injuries by other agencies, for example by private insurance companies for LTD and the federal government for CPP Disability benefits, but the WCB will only accept unemployability after years of appeals, if ever and usually multiple failed VR plans.

Representation

In order to navigate such a system, injured workers with reduced long-term employability often need a representative who can provide full representation including assessing what decisions are important and what aren't, correspond with the Board and seek new adjudication, suspend appeals, pursue multiple appeals at the same time, and be able to fund expert opinions, often expensive opinions. A model that won't work effectively in this situation is the workers' advisers office model where the representative is closing files after each review and appeal, requiring the worker to come back for each new review or appeal, potentially with a new adviser, putting the onus on the worker to seek new adjudications, address delays, and seek new medical reports, and having an inadequate budget to fund opinions from specialists/experts.

Head injuries

Workers with head injuries including post-concussion syndrome need to be provided with additional support to navigate the WCB system including making sure they are attending health care appointments, navigating review and appeals process and following until they recover. A lot of these workers aren't able to navigate the system due to their injury, and many don't realize the extent of their injuries and aren't adequately assessed. The long-term effects of their injuries aren't getting accepted because they don't have anyone reconnecting them with the WCB and the WCB isn't taking the initiative to follow up.

Plateau decision letters

These can have a significant effect on the amount of a worker's permanent partial disability award, but the decision letters contain no warning in that respect. For example, a plateau decision letter might say we find your compensable tendinopathy is not permanent and we are accepting chronic pain, and referring chronic pain to Disability Awards. That is in effect a denial of range of motion PFI award, but the worker reading that would never know, and it's common that the worker receiving that won't seek advice until after 90 days have elapsed when they receive their 2.5% disability award. In fairness to the worker there needs to be a big warning stamped on that decision letter.

Appeal expenses

Appeal representatives are getting highly inadequate reimbursement of expert reports. There's a fee code for medical legal reports and opinions with the Doctors of BC. The Board itself rarely uses it in practice. It's not a reflection of a market rate. It is primarily used by worker representatives and functions, based on the Board's and WCAT's policies, as a means to shift the costs onto workers. We ask experts to stick to the schedule rate and they don't because we're not the WCB or WCAT and it's not a market rate.

Discrimination

One of the ways in which the WCB discriminates against certain types of disabilities is diagnosis, in particular pain conditions. A worker with a diagnosis of mechanical low back pain will typically receive significantly less PFI as a worker with another back diagnosis such as DDD even though they have the same level of disability and permanent functional impairment.

Another example of discrimination is certain kinds of psychological injuries, for example the predominant cause threshold for mental disorders related to significant stressors under s. 5.1 of the Act.

Clinical records

The Board treats contemporaneous health care records as complete accounts of a worker's history when they aren't, and disregards worker's statements that address gaps or errors in those records. This is not an evidence-based approach.

Section 5 and 6

A lot of compensable occupational diseases are first getting adjudicated and denied as a personal injury and aren't getting adjudicated under section 6 until months or years later when the Board is pushed to make that adjudication. Workers without advocates don't know to make this request. Policy should require that adjudications be made under both ss. 5 & 6 where there is any possible overlap.

New Injury vs. Reopening

Similarly, board policy used to require that an adjudication be provided for both a new injury and a worsening or recurrence of an old injury where the injury was in a part of the body, or was a condition, that had been accepted before. This was removed from policy in the early 200s and should be replaced.

Retaliation

Workers in construction trades and other sectors that work temporary jobs are often terminated after they return to work in retaliation for filing wage loss claims. Work is still available, but the injured workers are singled out for lay-off. A lot of construction tradespeople aren't filing claims for fear of losing their job or risking future employment with that company or other contractors. A common question we get from construction trades that work temporary jobs is how they might delay filing a claim until the point that they know whether it's a serious or permanently disabling injury.

Hard work

You want a compensation system that doesn't interfere with people working hard. One of the comments we hear repeatedly from injured workers is this: 'If I had known I was going to be treated like garbage, I never would have gone out of my way for my employer in the first place.'

Sufficient evidence

The Board has a duty to investigate claims but so often the Board simply denies based on "insufficient" evidence or inadequate investigation, putting the onus and cost on the worker via the appeal system. This seems to a greater problem in claims that are the most work for adjudicators such as bullying and harassment claims, repetitive strain and occupational exposure claims, and other claims with complex mechanisms of injury.

Reopening

The Board should compensate significant changes in the status of a worker's disability not significant changes in the status of a worker's "condition" as worded in section 96(2). Significant changes in a worker's disability are most often unaccompanied by significant changes in the worker's "condition". The changes that occur with the most frequently disabling symptom—pain—often don't match up with changes in the underlying condition itself. Pain conditions and other subjective conditions should not be treated as any less real and disabling than other conditions and the criteria for reopening of such conditions should be no higher than other conditions.

Similarly, workers may experience changes in their careers or working conditions that should make them eligible for reopening. For example, a worker had returned to work with a permanent disability. He managed to return to his pre-injury job and had been doing it for several years when the employer advised him that they no longer felt he was safe, and they moved him to another area of the workplace where they felt he was safer but which paid $5.00 an hour less. The employer provided him with a letter explaining that this was the case and that it was purely due to his compensable injury. Yet, the worker was unable to seek a

reopening as there had been no change in his condition. If a permanent disability resulting from a compensable injury causes a worker to lose income, he should be compensated.

Jurisdiction

There is a lot disagreement between and amongst adjudicators at different levels of the appeal system over questions of jurisdiction, the scope of a decision, and finding of fact vs. entitlement decisions. A common problem arises when we ask a case manager to address an issue they failed to address in past decisions, which they then say they can't address because it's already addressed. It isn't until 5 months later when we get a Review Division confirming that the issues are indeed unadjudicated that we can then get the case manager to move on the adjudication.

Diagnosis

Often a diagnosis is unclear or disputed by different doctors. Many at the WCB and appeal system have wrongly imposed an onus on the worker to clarify diagnosis as a prerequisite to compensability, even though policy is clear that this is not correct. It is the disability that should be the focus.

Long-term Wage Rates

It is not uncommon for the wage rate officer to rely only on the accident employer's reported employment earnings when setting the long term rate and not speak with the worker at all or not adequately before issuing the long-term wage rate decision, therein undercalculating the worker's wage rate, for example by not realizing that a worker has earnings from a second job or has had a significant irregular absence in the 12 months prior to injury.

In terms of the content of the decision letters, what would work better is if the decision letter adequately explained to workers what employment earnings are to be considered and the rules that apply, so that they can be adequately advised of the right to appeal, for example that employment earnings from a second job are to be included, and significant irregular absences are to be excluded. It is inadequate for the decision letter to refer the worker to the policy manual. It is not uncommon for workers to have erroneously low wage rates because they were never advised that secondary employment earnings are to be included, i.e. they didn't realize it was an appealable issue.

Pension Wage Rate

The long term wage rate decision should be made appealable when the permanent disability award is granted, as with claims falling under the former provisions. A lot of workers are

seeking advice only after the permanent disability and are shocked to find out they've missed their appeal deadline on an important issue. If the decision letter must be made earlier than the permanent disability award, then the Board should at minimum warn the worker of the significance of the long term wage rate decisions that it can't be remedied after the permanent disability award no matter how inaccurate it is, that if the worker is eligible to VR the worker will only get VR to restore that rate and if the worker suffers a loss of earnings the Board can only compensate up to that rate.

Name of the Board

We submit that the organization should once again be called the Workers' Compensation Board. The psychological impact of changing the name of WorkSafeBC is that workers feel there is a lessening of the responsibility of the employer and of the board to keep workers safe. Rather, the emphasis in the new name is that workers should "work safe". Let us return to an organization that emphasizes the responsibility of all parties in the workplace.

Further Review Thoughts

General Overall- we submit that the report should expressly state recommendations apply to Current and Former Act where indicated.

General Overall– Clarify Policy - Do Search of RSCM I and RSCM I for use of "Significant Cause" or similar wording (direct cause, actual cause) and replace with Causative Significance.

Section 5 – Personal Injury

<u>S.5(4) Presumption:</u>

<u>Problem</u>- There are only a few presumptions in the Act. Where they exist, they should be given full meaning and effect.

The Board routinely ignores the presumption in s 5(4) in its initial adjudication of injury claims.

Policy item #C3-14.20 provides very little guidance.

Worse yet, staff are told to consider the presumption only as a last resort. Practice Directive #C3-4-S.5(4) Presumption states:

1. *Consider eligibility under section 5(1) before applying section 5(4)*

WorkSafeBC Officers should begin their analysis by considering eligibility under section 5(1) of the Act. It is not necessary to perform a section 5(4) analysis in every case involving an accident. The following are examples of situations involving accidents where a section 5(4) analysis is unnecessary.

- If the evidence is sufficiently complete to confidently conclude that the injury arose both out of and in the course of employment, the claim may be accepted and there is no need to consider section 5(4).

- If the claim is barred by another applicable law or policy, the claim may be denied without consideration of section 5(4). For example, if an accident was caused purely by horseplay instigated by the worker, RSCM II Policy item C3-17.00 applies and the worker's behaviour may be considered a substantial deviation from employment.

The examples provided may or may not be valid. That is not the point. The point is that the presumptions should still be considered in every case where an accident has occurred. This direction is essentially to ignore this section of the Act. It is frequently seen that a claim will be denied where a clear accident has occurred without consideration of s5(4) at all.

Solution– Amend policy and Direction to Staff to ensure consideration of the presumption in every case where an accident has occurred.

Pre-Existing Condition Policy:

Problem — Item # C3-16.00 – requirement for an exceptional strain or circumstance of the employment activity. Even though the policy refers to causative significance test, this element of the policy is being applied restrictively. For example, worker with repetitive work activity over time resulting in injury (physiological change) is seen not to have shown an exceptional circumstance. In *essence, a higher standard of proof is being required.*

Solution– Removal of exceptional circumstance wording. In addition, policy needs clarifying to indicate examples other than the extreme example of a worker moving a 300-pound weight as indicative of an exceptional circumstance.

Compensable Consequence Policy

Problem– For RSCM I and injuries prior to July 1, 2010, the significant wording policy continues to require clarification. It is not settled that it means the same as causative significance in decisions Board is issuing.
Solution– apply current policy to RSCM I and for injuries prior to July 1, 2010.

Problem– the policy can be seen to refer in places to a higher standard than causative significance:

#C3-22.00:

B. *Aggravation Due to Subsequent Non-Compensable Incidents*-If a worker's condition resulting from the compensable injury is aggravated by a subsequent non-compensable incident, the Board does not consider the subsequent non-compensable incident to form part of the compensable injury, or that the increased level of disability is compensable. This is true regardless of the fact that the subsequent non-compensable incident would not have been as significant if the condition that resulted from the compensable injury had not existed.

The only exception to this is if the condition resulting from the compensable injury actually causes the fall or other non-compensable incident that brings about the aggravation – *WCAT 2013-00739* discussed different interpretations of compensable consequence policies.

C. *Compensable Consequences of Treatment*- Where a further injury, increased disablement, disease, or death arises as a direct consequence of treatment for a compensable injury

#C3-22.40 - If the compensable injury was a significant cause of the subsequent disease or condition, then the subsequent disease or condition is sufficiently connected to the compensable

injury as to be considered to arise out of and in the course of the employment, and is therefore also compensable.

Solution– same as above - Do Search of RSCM I and RSCM I for use of "Significant Cause" or similar wording (direct cause, actual cause) and *replace with Causative Significance*

Section 5.1 Mental Disorder Claims

Problem - why is a diagnosis required and then only from a certain specialty of psychiatrist or psychologist. This seems onerous.

Problem- Lack of clarity on whether the presumption applies to the exclusion provisions set out in s5.1(1)(c).

Problem– Lack of clarity on the causation test pertaining to the exclusion provisions in s5.1(1)(c) - the section says only "caused by". Does this mean the same test of causative significance when considering exclusion where the facts pertain to a traumatic event and then the predominant cause test where the facts pertain to a significant stressor test?

Solution – Clarify these sections of the Act.

Section 6-Occupational Disease

Problem- Requirement that a worker be "thereby disabled from earning full wages" creates inequity between section 5 and section 6.

Policy-#26.30 Disabled from Earning Full Wages at Work --No compensation other than health care benefits are payable to a worker who suffers from an occupational disease (with the exception of silicosis, asbestosis, or pneumoconiosis and claims for hearing loss to which section 7 of the Act apply) unless the worker "is thereby disabled from earning full wages at the work at which the worker was employed".

Solution-Amend section 6 to remove requirement for disability. Apply the amendment to the Former and Current versions of the Act.

Problem: Section 6(3) includes requirement for "immediately before the date of disablement". The Board used to interpret this section of the Act broadly. As noted in the History of policy item #26.21 - June 1, 2004 – Statements adopting a broad interpretation of the phrase "immediately before" have been deleted. The requirements since that policy change are stricter and those workers who may suffer from occupational diseases with certain latency periods have been required to meet that stricter test.

The amendments were made in *BOD Resolution 2004/05/18-02 – Re: Statutory Presumption and Diseases with Long Latency Periods.* The policy used to extend the meaning of "immediately before" in section 6(3) of the Act to include situations where medical evidence has established that there is a long latency period between exposure to the process, agent or condition of employment and the time the disease first becomes manifest. The policy stated that individual judgment must be exercised in the circumstances of each claim to determine the meaning of "immediately before" having regard to the medical and other evidence available. The example was provided of a claim filed by a worker who suffers from a recent onset of a cancer listed in Schedule B but who has not worked in the process or industry described opposite such cancer for a number of years. Policy stated it may be appropriate to conclude that such worker was employed in such process or industry "immediately before the date of disablement" by virtue of the long latency period which is known to exist with respect to such a cancer.

Solution: Amend Section 6(3) to remove this wording and/or return policy to the broad interpretation in place before the June 2004 amendments. Apply the amendment to the Former and Current versions of the Act.

Problem – Chapter 4 does not include mention of causative significance test. Certain policy items continue to set in place significant cause test. Decision makers continue to take the wording of

these policy items to require a higher standard of causation or to establish entitlement to a permanent disability assessment or a permanent disability award.

Policy Examples:

#26.50 - whether a particular occupation had any significant effect in advancing the pace of degeneration …. the evidence must establish that the work activity brought about a disability that would probably not otherwise have occurred, or that the work activity significantly advanced the development of a disability that would otherwise probably not have occurred until later.

#26.55 - Evidence that the pre-existing disease has been significantly accelerated, activated, or advanced more quickly than would have occurred in the absence of the work activity, is confirmation that a compensable aggravation has resulted from the work…. This must be distinguished from the situation where work activities have the effect of drawing to the attention of the worker the existence of the pre-existing disease without significantly affecting the course of such disease.

#27.20 - The compensability of a claim for an ASTD listed in Schedule B where the presumption does not apply depends on whether or not the employment activities (the employment-related exposure to risk factors) played a significant role in producing the ASTD. The employment-related exposure need not be the sole or even the predominant cause; it simply needs to have been a significant cause.

#27.36 - The Board generally accepts that plantar fasciitis can be related to significant unusual strain placed on the plantar fascia. Similarly, the Board generally considers that workers are at an increased risk for developing plantar fasciitis when they are exposed to direct trauma to the bottom of the foot through an accident, or when there is a significant unaccustomed physical strain or impact to the bottom of the foot.

#28.00 - The nature of the employment created for the worker a risk of contracting the disease significantly greater than the ordinary exposure risk of the public at large.

#29.20 - A pre-existing asthma condition is not compensable unless such underlying condition has been significantly aggravated, activated, or accelerated by an occupational exposure. A worker is not entitled to compensation where his or her pre-existing asthma condition is triggered or aggravated by substances which are present in both occupational and non-occupational settings unless the workplace exposure can be shown to have been a significant cause of an aggravation of the condition.

… Where workplace exposures to a sensitizing agent have caused the worker to develop asthma and the worker's acute symptoms resolve following removal from the workplace, the Board may consider the worker to have a permanent impairment where: • the worker is left with a significant underlying allergy or sensitivity;

#30.50 - A pre-existing contact dermatitis condition is not compensable unless such underlying condition has been significantly aggravated, activated, or accelerated by an occupational exposure. A worker is not entitled to compensation where his or her pre-existing condition is triggered or aggravated by substances which are present in both occupational and non-occupational settings unless the workplace exposure can be shown to have been a significant cause of an aggravation of the condition…. the Board may consider the worker to have a permanent impairment where:
• the worker is left with a significant underlying allergy or sensitivity

Solution– See above recommendation to search and replace such wording. Also include explanation of this causative significance test regarding occupational diseases.

Section 17-Fatality Benefits

All workers deserve the utmost consideration under the Act. Where a worker's death is compensable, there should be no question that the survivors receive the same considerations. This is not happening under the current legislative scheme.

A. Higher Standard of Proof for Dependants of Deceased Workers-Oversight or Intended?

Problem: The provisions of section 250(4) of the Act do not expressly state that this section of the Act is to apply to the dependants of a deceased worker.

Result: In order to obtain benefits the dependants need to meet a higher standard of proof than workers who managed to survive their injuries or occupational diseases. This is unfair on so many levels.

Solution: Amend this section to expressly state that it applies to dependants of deceased workers. Apply the amendment to the Former and Current versions of the Act.

Examples as Background:

WCAT-2011-00659:

What is the applicable burden of proof?

[60] We have considered section 250 of the Act which provides at subsection (2) that WCAT must make its decision on the merits and justice of the case, and provides at subsection (4) that if WCAT is hearing an appeal respecting the compensation of a worker and the evidence supporting different findings is evenly weighted, WCAT must resolve the issue in a manner that favours the worker.

[61] Subsection 250(4) refers to a "worker," but not to a "dependant." On its face that subsection does not apply to the claims of dependants, unless one wants to contend that the word "worker" must be taken to include a worker's dependants. However, the statute has different definitions for a worker and a dependent, indicating that the terms were

meant to be used exclusively. Further, the statute contains many instances where the word "worker" cannot be taken to include "a dependant."

[62] A clear example of that is subsection 6(10) of the Act which clearly indicate the claims of workers and dependants are subject to the restrictions found in subsection 6(8). If the claims of workers were considered to include those of dependants, there would be no need to refer to both workers and their dependants.

[63] Thus, it appears the word "worker" may not include a worker's dependants.

WCAT-2015-02924:

[63] In addressing that issue and the appeal in general, I remind myself of the applicable burden of proof.

[64] Section 250 of the Act provides at subsection (2) that WCAT must make its decision on the merits and justice of the case, and provides at subsection (4) that where evidence supporting different findings is evenly weighted WCAT must resolve the issue in a manner that favours the worker.

[65] Subsection 250(4) refers to a worker, but not to a dependant. On its face, this subsection does not apply to the claims of dependants, unless one wanted to contend that the word "worker" must be taken to include the worker's dependants. Yet, the statute contains many instances where the word "worker" cannot be taken to include a dependant. A clear example of that is subsection 6(10) of the Act. That subsection clearly indicates that the claims of workers and dependants are subject to the restriction found in subsection 6(8). If the claims of workers were considered to include those of dependants, there would be no need to refer to both workers and their dependants.

[66] I find the civil standard of proof on a balance of probabilities is applicable to this appeal. It is not sufficient for the evidence to be evenly weighted (sometimes referred to as "the balance of possibilities"). I find the outcome of the appeal would not change were I to apply the low standard of a balance of possibilities.

[67] Thus, this appeal can only succeed if the evidence establishes it is more likely than not that the worker's employment was of causative significance regarding his death.

B. Incomplete Implementation of Recommendations of the Royal Commission's Reports on Workers' Compensation-Oversight or Intended?

Background- What the Royal Commission Said

1997:

ROYAL COMMISSION ON WORKERS' COMPENSATION IN BRITISH COLUMBIA

REPORT ON SECTIONS 2 AND 3(a) OF THE COMMISSION'S TERMS OF REFERENCE

Judge Gurmail S. Gill Commission Chairman Oksana Exell Commissioner Gerry Stoney Commissioner

October 31, 1997

Section 17(1) Definition of CHILD

*"**child**" means*

a child under the age of 18 years, including a child of the deceased worker yet unborn;

an invalid child of any age; and

*a child under the age of 21 years who is regularly attending an academic, technical or vocational place of education, and "**children**" has a similar meaning.*

The commission believes that the object of this section should be to provide compensation to children of deceased workers until they are able to be reasonably self-sustaining. The current age limitations in the definition of "child" may not accomplish that object and in some

circumstances will prematurely end surviving children's benefits. In the modern social context, many children remain in school and pursue post-secondary education well past the age of 21. This is reflected in other legislation, such as the Canada Pension Plan Act, as well as in many extended dental and health insurance plans, where it is common to extend benefits to children up to the age of 25 if they are attending recognized post-secondary institutions.

The cessation of benefits upon attaining the age of 18 years is also inconsistent with the Infants Act, which recognizes legal capacity at age 19. The Family Relations Act also makes parents responsible for maintaining children until that age.

Therefore, the commission recommends that:

Recommendation #58:

58. (a) the reference to the age of 18 in part (a) of the above definition be changed to 19; and (b) the reference to the age of 21 in part (c) of the above definition be changed to 25.

November 6 1997 Press Release Stated

1999:

FOR THE COMMON GOOD FINAL REPORT OF THE ROYAL COMMISSION ON WORKERS' COMPENSATION IN BRITISH COLUMBIA

Judge Gurmail S. Gill Commission Chairman Oksana Exell Commissioner Gerry Stoney Commissioner January 20, 1999

Volume II Chapter 2

…A key problem with the current scheme created by Section 17(3)(c)-(e) is not that it creates distinctions between non-invalid childless surviving spouses of different ages, but that benefits for

those under the age of 40 are calculated on a totally different conceptual basis than benefits for all others. In the case of all other spouses, pensions are payable rather than the lump sum payable to those under 40. Furthermore, the pensions are calculated with some degree of reference to the deceased worker's average earnings. Unless the statutory minimums or maximums apply, the latter benefits vary depending upon the worker's actual earnings.

Thus, the system recognizes considerations of both loss and need for spouses aged 40 or older. In contrast, spouses under 40 receive a specified and unvarying flat rate pursuant to Section 17(3)(d). The amount is the same irrespective of spouse's actual losses or needs, and no account appears to be taken of either consideration.

Recommendation #155:

the Workers Compensation Act be amended such that
the age-related distinctions in Section 17 (3) (c), (d) and (e)
be repealed and replaced by a provision that states that:
a) childless non-"invalid" surviving spouses age 50 and
older at the time of the worker's death, will receive 60%
of the monthly amount which would have been payable if
the deceased worker had, at the date of death, sustained
a permanent total disability; and
b) surviving spouses below 50 years of age at the time of
the worker's death will receive 1% less than 60% for each

year of age below 50 years of age to a minimum of 30%.

<u>Problem – Implementation- What Was Done:</u>

Bill 37 – *Skills Development and Labour Statues Amendment Act, 2003*– came into effect on December 31, 2003. Amended how survivor benefits are calculated:

17 Section 17 is amended

(a) in subsection (1) in the definition of "child" by striking out "18" and substituting "19" and by striking gout "21" and substituting "25",

(b) in subsection (1) by repealing the definition of "federal benefits" and substituting the following:

"federal benefits" means the benefits paid for a dependant under the Canada Pension Plan as a result of a worker's death, other than the death benefit payable to the estate of a worker under section57 of that Act. ,

(c) in subsection (3) (a), (b), (c) and (f) (i), (ii) and (iii) by adding "50% of the" before "federal benefits",

(d) by repealing subsection (3) (d) and (e) and substituting the following:

(d) where the dependant, at the date of death of the worker, is a widow or widower who is not an invalid and is under the age of 50 years, and there are no dependent children, a monthly payment of a sum that, when combined with 50% of the federal benefits payable to or for that dependant, would equal the product of

(i) the percentage determined by subtracting 1% from 60% for each year that the age of that dependant, at the date of death of the worker, is under the age of 50 years, and

(ii) the monthly rate of compensation under this Part that would have been payable if the deceased worker had, at the date of death, sustained a permanent total disability,

but the percentage determined under subparagraph (i) must not be less than 30% and the monthly payments must not be less than $889.32; ,

(e) in subsection (3) (h) (i) and (ii) by adding "for life or a lesser period as determined by the Board" after "per month",

(f) in subsection (9) (a) by striking out everything after ";but" and substituting "monthly payments must be made in respect of that spouse and those children equal to the periodic payments due under the order or agreement; or", and

….

23 The following section is added:

Transitional -- death of worker

35.2 (1) In this section, "transition date" means the date on which this section comes into force.

(2) Subject to subsection (5), this Act, as amended by the Skills Development and Labour Statutes Amendment Act, 2003, applies to the death of a worker that occurs on or after June 30, 2002.

(3) Subject to subsections (5) and (6), this Act, as it read immediately before June 30, 2002, applies to the death of a worker that occurred before June 30, 2002.

(4) Subject to subsections (5) and (6), in recalculating compensation under section 17 (4) or (5), the Board must, if the actual date of the death of a worker was before June 30, 2002, base the recalculation on this Act as it read immediately before June 30, 2002.

(5) Subject to section 19 (2.1) of this Act, section 25 of this Act, as amended by the *Skills Development and Labour Statutes Amendment Act, 2003,*applies to compensation paid on or after the transition date in respect of the death of a worker irrespective of the date the worker died.

(6) Commencing on the transition date, for the purposes of applying subsections (3) and (4), the Board must adjust the dollar amounts referred to in sections 17 and 18 and Schedule C of this Act, as it read immediately before June 30, 2002, in accordance with section 25.2 (1), as amended by the *Skills Development and Labour Statutes Amendment Act, 2003.*

(7) In applying section 17, as amended by *Skills Development and Labour Statutes Amendment Act, 2003*, to a death that occurred on or after June 30, 2002 but before the transition date, the Board must consider payments paid before the transition date.

Resolution of the Board of Directors - #2003/11/19-04

RE: Policies Regarding the *Skills Development and Labour Statutes Amendment Act, 2003:*

Once brought into force on December 31, 2003, the amendments in Bill 37 relating to the calculation of survivor benefits, except the provisions relating to cost of living adjustments, will be retroactive to June 30, 2002.

Problem: The implementation applies only to current Act (June 30, 2002).

Result: The survivors of a worker whose benefits are calculated under the former provisions prior to June 30, 2002 do not receive the benefit of those changes. There are many active claims involving the survivors of workers who died before June 30, 2002. There are widows under 40 still receiving lump sums only and children whose lose 4 years of potential support while attending post-secondary studies.

The survivors of these deceased workers continue to be disadvantaged. The Board continues to make these decisions as it is required to do.

Solution: Amend Former Act (prior to June 30, 2002) to Completely Implement Royal Commission Recommendations. **This implementation should not have only prospective effective date but should apply to those currently affected- as was done with implementation of the decision in *Cowburn v. Worker's Compensation Board of British Columbia*, 2006 BCSC 722.**

Section 23-Permanent Disability

Problem- *s 23.1 - Termination Date versus Payable for Life*(also applies to section 22, 29 and 30) The interpretation of this section to mean that the "decision is made only once" as many workers do not realize that a decision was made until much later.

This section of the Act is blatantly unfair to young workers. For example, a seriously injured 18 year old who sustains a permanent disability will generally not have made retirement plans. Such a worker is at a serious disadvantage by virtue of their age alone.

Policy- The policy also sets in place a requirement for financial provisions that only workers with certain financial resources may be able to satisfy (to contemplate a plan versus living hand to mouth to pay the rent/mortgage). This could be seen as differentiating for a particular class or type of occupation or requiring a certain degree of financial or professional sophistication to produce the types of evidence preferred in Board policy and practice. Many workers do not use accountants or seek or obtain financial plans from a bank or financial institution.

Solution– Return to pre-existing June 30, 2002 provisions.

Policy– s 23(1)- Problem– the cap on chronic pain awards.
Solution– Set in place provisions for PDES type of award with a range of impairment.

Problem- *s 23(3.1) (3.2) - The Loss of Earnings Assessment Hurdle*

Solution– Return to pre June 30, 2002 provisions

Policy– **Problem-** the Board at times determines a loss of earnings (assessment and award) prematurely, as soon as a vocational plan is identified and before it can be determined to be durable. The use of the job a worker actually obtains is frequently seen as a last resort because certainly there is some other higher paying job a worker can be expected to obtain. Such expectations are often unrealistic.

Solution– Set in place a requirement in policy that vocational rehabilitation be tested and durable before finalizing for the purposes of a loss of earnings award.

For Loss of Earnings Awards: Amend policy item #40.12 to place less emphasis on deeming and more emphasis on Guideline #1-the job that the worker has actually obtained is generally accepted as being suitable, unless there is evidence that the job is transitory and jobs at another level of earnings within that occupation will be available to the worker in the near future.

As an example, policy #40.12 provides guidance regarding meaning of the term "long term" as referring to three to five years. There is no parallel guidance on the meaning of the term "near future" in Guideline #1. An inference would indicate it is less than the three to five year window, but that is vague. It is suggested that the policy be clarified. Some possibilities to consider are: completion of a probationary period specific to that employment, six months, one year, etc.

Policy– **Problem-**For Loss of Earnings Awards: the cap on loss of earnings for high-income earners.

Solution– Return to the provisions set by Terry Ison in WCR Decision #8 (extended to non-spinal injuries with WCR Decision 297). Decision 8 stated the following:

The projected loss of earnings method is a difficult one to blend with the application of the statutory ceiling. This blending could easily be accomplished if the ceiling related to the amount of compensation payable, but it is much more difficult when the ceiling relates to the average earnings to be used in the calculation. Section-24 refers to the "loss of average earnings", and Section 31 indicates that average earnings must only be calculated up to the ceiling. But suppose, taking the current ceiling of $8,600, a man is injured with the result

that his earnings drop from $15,000 to $10,000. If, following the wording of Section 24 (1) (a), compensation is to be calculated by estimating the impairment of earning capacity "from the nature and degree of the injury", he should obviously receive compensation. Under current practice, he does receive compensation based on the application of the estimated degree of disability to the statutory ceiling and the statutory percentage rate. For example, if the physical impairment of a claimant is assessed at 20% of total disability, he would receive 20% of 75% of $8,600, which is $1,290 per annum.

But if compensation is to be based on the estimated loss of "average earnings", then using that term literally as it is defined in Section 31, he should receive nothing. In other words, no compensation would be payable for partial disability unless it reduces actual loss of earnings to a point below the ceiling. But that is not a view that has ever been taken by this Board, nor by any Royal Commission studying workmen's compensation in British Columbia, nor as far as we know by any other Board in Canada. It is not a conclusion required by the terms of the Act, and we do not feel that it is a conclusion that should be reached now.

It seems to us that the only way out of this dilemma is to look at the percentage by which actual average earnings have been reduced by the ceiling, and then reduce the post-injury earning capacity for the purpose of comparison by the same percentage. This would treat earnings above the ceiling in the same manner as they are now treated by the physical impairment method. The formula for applying this principle will be illustrated below….

(e) If average earnings have been reduced by the ceiling, the estimated post-injury earning capacity would be reduced in the same ratio.

Section 33- Wage Rates

Problem- 90% Net clear cost saving measure to detriment of injured workers
Solution– Return to pre June 30, 2002 provisions

Section 96(2) – Reopening

Problem– Requirement for Significant Change sets in place onerous test.

Solution– Amend Act to remove "significant" from s 96(2) of the Act.

Policy- Problem- Recurrence of Injury policy requires consideration of intervening incident. Policy is being applied restrictively to indicate that any intervening incident, no matter how minor, breaks the chain of causation and a reopening is denied. In essence, a sole causation test is set in place.

Solution– Clarify policy to indicate expressly such an intervening incident may or may not indicate a disability has recurred and expressly state an injury can recur even with the occurrence of such an incident. The amendment should expressly refer to the causative significance test

Significant change should include changes other than just in the compensable condition. For example, a worker we represented had a PFI. He'd been back at work for two years and was managing to do the job. For reasons which were never clear, the employer decided that the worker was unsafe on the job due to his compensable injury. His condition had not worsened, but the employer simply held the view that his disability made him unsafe to work on the rail cars.

The employer wrote him a letter advising that due solely to his compensable disability, he was being moved to a job in the yard which paid $5.00 an hour less. The employer was very clear about the reason for his reduction in pay; there were no allegations of misconduct on the worker's part.

The worker had not experienced a worsening of his condition. He had no option to seek a loss of earnings pension because his physical condition had not changed, notwithstanding that his loss of income was directly attributable to his PFI. Thus, a significant change may also include working conditions or other factors that impact the worker.

Appeals

Problem–Some appeals arrive at WCAT with serious evidentiary problems. While WCAT can undertake additional inquiry, it is not generally WCAT's role to undertake initial adjudication at the final level of appeal. The risks of such an approach can deprive the appellant of the ability to participate in the Board's initial process of inquiry or at review. WCAT also does not have the same level of resources as the Board or Review Division for initial inquiry. WCAT must also be cautious from making clear recommendations on a claim. This is reflected in WCAT's *Manual of Rules of Practice and Procedure*, which states at item #17.4.1 - Due to legislative restrictions on the Board's authority to revisit previous decisions, panels will exercise caution in making recommendations. WCAT aims to provide finality but does see appeals that return after a problematic or incomplete implementation.

The transitional provisions of Bill 63, the *Workers Compensation Amendment Act*(No. 2), 2002 included that instead of making a decision under section 253 (1) of the Act, as enacted by the amending Act, WCAT may refer a matter back to the Board, with or without directions, and the Board's decision made under that referral may be reviewed under section 96.2 of the Act, as enacted by the amending Act.

Solution– Amend the Act to return those provisions to the appeal tribunal to enable WCAT to direct the manner in which the Board is to proceed with a claim, in appropriate circumstances. In addition, provide the parties to an appeal with the ability to return to WCAT if issues arise with the Board's implementation of the panel's directions.

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