LETTER TO THE MINISTER

October 30, 2019

The Honourable Harry Bains, M.L.A.
Minister of Labour
Room 342 Parliament Buildings
Victoria, BC  V8V 1X4

Dear Minister Bains:

In March 2019, you asked me to undertake a review of the workers’ compensation system in British Columbia with direction to assess specific issues. I conducted this review with extensive public engagement and consultation.

I am now pleased to provide you with the enclosed final report, *New Directions: Report of the WCB Review 2019*, together with my recommendations.

Yours truly,

Janet Patterson, Reviewer
WCB Review 2019

Enclosure (Final Report: *New Directions: Report of the WCB Review 2019*)
EXECUTIVE SUMMARY

This Report “New Directions: Report of the WCB Review 2019” is the result of a “targeted” Review of the workers’ compensation system of British Columbia. The Review was conducted by Janet Patterson under Terms of Reference (TOR) provided by the Minister of Labour, the Honorable Harry Bains.

The Minister had already taken some steps towards ensuring that the Workers’ Compensation Board of B.C. or WorkSafeBC (Board) was “worker centred”. In 2018, the Minister requested a policy review (the “Petrie Report”) and review of the Board’s surplus (the “Boygo Report”). This Review was asked to assess how to modernize the Board’s culture, case management and return to work (RTW) practices to reflect a worker-centric service delivery model. The Review was also asked to recommend specific steps to improve the confidence of stakeholders, including but not limited to a Fair Practices Office and amendments to the Workers Compensation Act (“Act”). The Review was to look at these matters with a GBA+ lens and also ensure that there was outreach to Indigenous communities.

The Review consulted with the public and with stakeholders, as well as with Board management and staff, the Board of Directors and external experts. Public hearings were held throughout the province and over 200 presenters, mostly injured workers and their families, presented their recommendations. In addition, the Review received detailed submissions from all compensation stakeholders as well as almost 2,000 responses to its online questionnaire. One key stakeholder, the Employers’ Forum, withdrew from the second stage of consultations. The Report sets out this consultation process in detail.

The recommendations in this Report are drawn from this extensive consultation process.

The Review sets out a context for the Report:

- About 2,000 complaints a year are made about the Board to the Provincial Ombudsperson, MLAs and the Board’s Fair Practices Office. The complaints are made mostly, but not exclusively, by injured workers and include unfair Board practices, unfair Board decisions and a lack of respect in its treatment of injured workers. A number of complaints involve complex conditions or long-standing cases.

- Following the United Nations Declaration of the Rights of the Disabled, the biopsychosocial model of disability is now widely accepted. Disabled workers can often work and workplaces must take meaningful steps to accommodate those workers.

- The “best practices” RTW guidelines require a holistic and individualized approach, active participation of the injured individual, the involvement of an expert and collaboration between all of the parties.

- The nature of work has changed and many workers now experience precarious work in the gig economy.
This Review adopted the definition of a “worker-centred” approach used in the Petrie Report. A worker-centred approach is one which allows a consideration of individual circumstances and also fully seeks to maximize an injured worker’s recovery and restore their pre-employment status as much as possible. This definition draws on the principles of the Historic Compromise which is the foundation of the Canadian compensation system.

**Assessment of Current Board Culture**

Over the last years, the B.C. Board has moved to an “insurance” service delivery model to determine and deliver “entitlements”. On the front-line, Board decision-making is largely impersonal and policy driven. The decision-making culture is influenced by the case management system which embeds disability guidelines and timeframes into each claim file. The guidelines are based on diagnosis codes and impose a “one size fits all” framework with recovery and return to work milestones for each diagnosis. Workers with simple traumatic injuries, and those who follow a predicted path of recovery, are generally satisfied with this “cookie cutter” approach.

Board compensation decisions cannot be changed, after 75 days, except on appeal to the Review Division and then to the Workers Compensation Appeal Tribunal (WCAT). Both appeal bodies have limited jurisdiction. In general, the Board’s seeks to correct decisions through appeals and may be described as having an appeal-oriented culture.

**What We Heard**

Through the Review consultation process, we heard that workers whose injuries or recover fell outside the “cookie cutter” guidelines, tended to have very negative compensation experiences and outcomes. This was particularly the experience of workers with serious or complex injuries, concussions, psychological injuries or occupational diseases. Such cases often had poor or no investigations, disregarded medical evidence or little communication with the worker before a decision was made. Workers repeatedly told the Review that they did not feel “heard” through an often adversarial compensation experience. Many reported being spoken to by case managers in hostile or dismissive ways and that they considered themselves abandoned or further injured by the compensation process. Many of these workers experienced financial hardship as a result.

Many workers had difficulty understanding the Board’s legalistic decision letters, especially if English was not their first language.

Many workers (and employers) felt that they could not navigate the appeal process without an advocate or lawyer’s assistance. Complex injuries often resulted in multiple decisions and a procedural complexity that defeated many.

In addition, many individuals, workers and employers, stated that they were not treated respectfully, that the Board was hard to communicate with and that the Board did not investigate or consider their evidence in decision-making. There appears to be almost no effective remedial avenues for stakeholders or individuals, especially injured workers.
Board decisions on medical issues were an area of particular conflict. Many felt that seriously injured workers were pre-maturely “plateaued” and forced back to work, only to experience re-injury or further disability. Both workers and employers are highly dissatisfied with the Board’s approach to Light Duties and the availability or reliability of medical evidence in such cases.

Shifting to a Worker-Centric Approach

A shift to a worker-centric delivery system must include treating all injured workers with dignity and offering effective RTW services for all stakeholders. This is an important goal especially for seriously injured workers whose work-caused injuries place a huge burden on individuals and their families. These are injured workers who are most in need of Board support and yet are, in effect, left behind by the current compensation system.

To make this shift, the Board requires improvement or change in three essential areas: communications, consideration of individual circumstances and evidence, and patient-centred medical care. The Review recommends:

1. That the Act be amended to include a Preamble and Statement of Purpose, as has been done in other jurisdictions. A statutory mandate inclusive of the principles of the Historic Compromise will assist the Board in making a cultural shift back to supporting all injured workers as an organizational goal.

2. Improved and Respectful Communications: That the Board improves its communications with all stakeholders through the use of email, plain English decision letters, and supported on-line multilingual services. It is recommended that the Act require the Board to establish a Code of Conduct for Fairness and Service to all stakeholders.

3. Improved Consideration of Individual Circumstances and Evidence: That the Act be amended to require that Board decisions be made on the “merits and justice” of the case, as is done in most other Canadian jurisdictions. Board policy should provide guidance on the use of embedded disability guidelines in this context and also for consistency in decision-making. A number of recommendations are made to improve internal Board processes for the collection and weighing of evidence including having individualized assessment and case management for concussion injuries. Policy should state that injuries from violence in the workplace cannot be dismissed as just being “part of the job” as this is not consistent with the principles of the Historic Compromise.

4. Improved Patient-Centred Medical Care: The medical model of “patient centred” care is the recommended model for revising the Board’s approach to health care services, to work towards the goal of maximum recovery for injured workers. Medical evidence must be accessible and credible and medical disputes resolved quickly, ideally through collaboration. Recommendations include:
   o Worker is treated by the caregiver of his/her choice. The carer delivers a treatment plan, minimally supervised by Clinical Services.
Clinical Services is transferred out of its current role as adjudication support and re-established as a separate division, reporting to the CEO/Board of Directors. Clinical Services will consult with Doctors of BC on systemic medical issues.

- BMA’s role within Clinical Services will be to consult and collaborate with treating physicians, claim owners and stakeholders where recovery or treatments are diverging from norms or Light Duty issues arise. BMA’s will not be involved in provided opinions on adjudicative matters.
- Medical disputes will be addressed informally first, and if needed referred to the Medical Service Office for a case conference or an Independent Medical Examination (IME).

Changing the Service Culture to Be Fair and Accessible

One of the most common complaints was the complexity of the system. A complex claim could generate multiple appeals and procedural complexity spanning years. The courts have commented that the system was “unwieldy, inefficient and cumbersome”, creating a “treadmill” of appeals and doing little to advance a worker’s access to justice. The Review again found that certain types of injuries fared the worst, and that procedural complexity combined with adversity, delay and financial hardship created a “toxic dose” which often increased a worker’s disability.

This appeal-oriented system of resolving disputes is also not compatible with RTW best practices.

The Review recommends that:

- Sections 96(2) and 96(5) of the Act be amended to allow the Board flexibility to reconsider and reopen its own decisions, as is done in other Canadian jurisdictions. As noted by the Provincial Ombudsperson in 2010 and again in 2019, section 96(2) in its present form, is administratively unfair.
- That the Review Division have wide jurisdiction to correct decisions.
- That a number of case management issues be addressed including incomplete decision making.
- That the Act be amended to provide WCAT with the statutory authority to reconsider its own decisions;
- That the Act be amended to provide WCAT with jurisdiction over issues involving the Charter and the Human Rights Code, consistent with the Review Division and a 90 day time limit, also consistent with the time limit to the Review Divison.
- That interest be paid to workers for certain types of retroactive benefits.
**Return to Work and Vocational Rehabilitation Issues**

The Report recommends that the Board adopt recognized “best practices” RTW guidelines, principles and guidelines, especially for Light Duties.

Other recommendations for an improved RTW processes include:

- Provide support for employers to conduct accommodation assessments through NIDMAR;
- Establish a process for the Board to recognize established disability management programs;
- Amend the Act to recognize the employer’s Duty to Accommodate (DTA) based on the experiences and language of other jurisdictions;
- Establish training for Board staff on DTA and disability management
- Amend the Act to provide for a specialized appeal process for DTA issues

The Report also makes recommendations for Vocational Rehabilitation (VR):

- Amend section 16 of the Act to provide a clear statutory mandate for VR
- Amend Board policy to provide for flexibility in VR plans
- Amend the Act so VR decisions are appealable to WCAT
- Initiate VR specialized programs/resources for immigrants, older workers and younger workers

**Specific Steps to Increase Stakeholder Confidence**

Given this Review, the Report considers that the following steps are critical to increase stakeholder confidence and provides detailed recommendations regarding each step.

1. That a Fair Practices Commission (FPC) be created, independent of the Board and with ombudsperson authority and resources to address both individual complaints and systemic issues. Due to the high level of complaints, it is also recommended that two Deputy Commissioners be appointed, one for Claims matters and one for Prevention and Assessment matters.

2. That a Medical Services Office (MSO) be created to provide medical services to both stakeholders and decision-makers in the system, on request. This would include non-binding medical case conferences and arranging Independent Medical Exams (IMEs) from a roster of approved physicians, replacing the IHP process at WCAT.

3. That the Act be amended to provide a more accessible process for reviewing Board policy, consistent with the supervisory powers of the court. If the WCAT Chair reviews a policy, the WCAT determination may be reviewed by court through a judicial review. If the WCAT Chair determines that a Board policy is not consistent with the Act, the Board as well as the parties will have standing to appeal the matter to court.
4. That Board governance be balanced and fair and be seen to be so. It is recommended that the Board governance structure be changed to reflect the stakeholders in the Historic Compromise, as do most other jurisdictions, using the Manitoba model of 3 employer representatives, 3 worker representatives, and 3 public interest representatives with a neutral Chair. The Review also recommends that the directors of the Employers’ Advisers Office (EAO) and Workers’ Advisers Office (WAO) be included in the BOD as non-voting members as well.

5. Other steps for improving confidence include a review at least every 5 years, and that it include stakeholder consultation and public engagement, inclusive of injured workers. Also, that the Board develop an Education Office, an Occupational Disease Advisory Committee and that both the Board and FPO support community navigators.

Other Urgent Issues

Certain issues were identified in the public consultation process as being urgent in the compensation system. The Review address some, but not all, of the raised issues.

1. **Re Activity Related Soft Tissue Disorders (ASTDs).** B.C. is alone in treating gradual onset musculoskeletal injuries (MSIs) in arms, shoulders and hands as an Occupational Disease under section 6 of the Act. This approach creates a significant barrier to the acceptance of these very common workplace injuries. Further, this barrier adversely affects women more than men. In 2017, the ASTD acceptance rate was about 60% for men and about 35% for women. This adverse impact is likely due to the gendered nature of computer work. The Board practice with ASTD adjudication is strongly resistant to accepting that repetitive computer use can be a cause of an MSI in arms or hands. In 2017, only 19 claims for computer-related ASTDs were accepted. Other jurisdictions approach these conditions as gradual onset injuries which are more easily accepted, treated and prevented.

The Review recommends that the Act be amended to specify that these MSIs be treated as personal injuries under section 5 of the Act. Board policy should then provide for an integration of the MSI Prevention guidelines into compensation policy and practice, that ASTD’s now in Schedule B have an equivalent presumption and that the Board have stakeholder consultations re additional presumptions which may be necessary for some conditions in some occupations.

2. **RE Psychological Injuries** It is recommended that section 5.1 of the Act, now termed “Mental Disorders” be renamed “Psychological Injuries” and that a short-term psychological injury could be accepted without a DSM diagnosis for up to 10 days. It is also recommended that the word “predominately” be removed from section 5.1(a) (ii) and that 5.1(c) be amended to confine the “labour relations exclusion” in certain respects. It is also recommended that section 5.1(1.1) of the Act, providing a presumption of work causation for traumatic psychological injuries, be amended to include all occupations.
3. **CPP Offset**  Another urgent issue from the consultations was the removal of the CPP deduction from the Act. This provision affects the most severely injured workers, who meet the “severe and prolonged” criteria for CPP disability and who have already had significant losses due to their disability. They are among the most disabled and financially affected workers and the most deserving of full Board support.

4. **Chronic Pain**  It is recommended that the new ICD-11 classification for chronic pain be included in the current Policy Review and that the new chronic pain policy provide for an individualized assessment of permanent impairment.

The Review made no recommendations regarding some other urgent issues raised in the consultation. The most common issue that was raised by permanently injured workers, particularly those with severe injuries, was to ask that permanent functional impairments (PFIs) be for life because their injuries were “for life”. However, this matter is outside of the Review mandate as it was covered in another report (the “Boygo Report”).

Other urgent issues were raised, but they require more data, research and consultation than was available in this Review. The Report recommends that the Board form Task Forces to address these two urgent issues by initiating the following:

1. Gathering data on the loss of earning capacity for permanently injured individuals and assess and make recommendations regarding the methods of compensation for permanent disability under section 23 of the Act; and

2. Investigating and costing the development of a workers’ system of medical clinics in B.C. similar to the Occupational Health Clinics for Ontario Workers.

**Indigenous Consultation**

The Review was also asked to encourage participation from Indigenous stakeholders. Based on presentations to the Review, it is recommended that the Board engage community navigators and develop special guidelines for VR services to Indigenous communities, taking their perspectives and the Truth and Reconciliation Commission (TRC) recommendations into account.

It was noted that workers who are injured while working for a Band, have their injuries accepted at less than half of the general accepted rate. This is an area which needs further attention.
GBA+ Review

A GBA+ lens was used throughout the Review. In addition, certain matters were the focus in this area and the following was recommended:

1. That the Act be amended to provide discretion to the determination of Average Earnings for young, casual and temporary workers’
2. That the Board develop policy and procedures to address gender and identity based discrimination and ensure a psychologically safe workplace.
3. That the Board do gender based risk assessment for RTW and develop specialized responses to reports of violent sexual assault.
4. That the Board offer specialized support to workers with cognitive impairments and temporary foreign workers and farmworkers.

Summary

The Review involved a level of public engagement around workers’ compensation which has not been seen for several decades. It paints an important picture of stakeholder concerns and levels of confidence which I have set out in detail in this Report.

The Review’s recommendations focus on shifting the Board culture to a worker-centric system, so that the Board can perform its modern role in RTW and at the same time treat injured workers with the respect and dignity that they deserve. An independent Fair Practices Commission will monitor this situation and provide an Annual Report to the Minister.
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PART I: THE FOUNDATIONS OF THE REVIEW

IN BRIEF

The Terms of Reference (TOR) for the WCB Review 2019, including the concept of a “worker-centred” compensation service, are discussed and put in the context of two key reports:

- “Restoring the Balance: A Worker-Centred Approach to Workers’ Compensation Policy” by Paul Petrie; and
- “Balance. Stability. Improvement. Options for the Accident Fund” by Terrance J. Bogyo,

The stakeholder and public consultation processes for the Review are detailed together with new developments in the world of work and the changing concepts of disability. After summarizing the key themes emerging from the consultations, the Review identifies New Directions for the compensation system in the areas covered by the TOR.

INTRODUCTION

The Minister of Labour of British Columbia, the Honourable Harry Bains, requested that I conduct a “targeted” review of the compensation system of the Workers’ Compensation Board (Board)1 under specific Terms of Reference (TOR). The complete TOR are set out in Appendix 1. Under the TOR, I am to consider the following context:

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1 The Workers Compensation Board (WCB) is the legal entity created under the Workers Compensation Act (the “Act”) and it is now operating as WorkSafeBC. I generally use the term “Board” to refer to WorkSafeBC as some still know it as the WCB, although I use the term “WorkSafeBC” when that is the term used in documents.
The *Workers Compensation Act* (Act) was born out of a compromise between British Columbia’s workers and employers in 1917, where workers gave up the right to sue their employers or fellow workers for injuries on the job in return for an employer-funded no-fault insurance system;

The last comprehensive review of the Act took place in 2002 and the last significant amendments to the Act were made in 2002 and 2003; and

There have been significant changes in workplaces, the economy and the workforce of British Columbia over the past 16 years.

Prior to this appointment, the Minister had directed the Chair of the Board of Directors (BOD) of WorkSafeBC to effect a systemic culture shift to ensure that the workers’ compensation system is more “worker centred”, that workers be treated with compassion, respect and dignity, and that the confidence of stakeholders, including injured workers, in the system is increased.

In response, the BOD initiated two reports in 2018 and 2019.

1. In April, 25, 2018, Paul Petrie completed a report entitled “Restoring the Balance: A Worker-Centred Approach to Workers’ Compensation Policy” (the “Petrie Report”). Mr. Petrie reviewed the compensation policies in the Board’s Rehabilitation Services and Claims Services Manual, Volume II (RSCM II) to determine if the policies could be amended to ensure a worker-centred approach. The Petrie Report made 41 recommendations for change. In response, the Board developed a 2019-2021 workplan to engage interested stakeholders and is addressing many of the Petrie recommendations through the usual policy consultation process.

2. A report was prepared by Terry Boygo and entitled “Balance. Stability. Improvement. Options for the Accident Fund”, (the “Boygo Report”). Mr. Boygo’s report sets out the background and options available to the Board under the Act to manage the unappropriated balance in the Accident Fund. His report was published on July 18, 2019. Stakeholders were given an opportunity through the Review’s consultation process to make separate submissions on Boygo Report, but these submissions, like the Boygo Report itself, do not form part of the Review or this Report.

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2 Under the TOR, I am to identify “urgent” compensation matters, other than those addressed in the Boygo Report and in this Review, I will not address matter which he has considered.
These two reports and the TOR for this Review highlight a new direction for the Board and for the B.C. compensation system.

The TOR required that the Review conduct a public engagement process, including the views of injured workers, and address the following specific target areas while working towards a “worker centric” system:

- the Board’s return to work (RTW) policy and practices;
- their current policies and practices through a Gender-based Analysis Plus (GBA+) lens;\(^3\)
- modernizing Board culture for a worker-centric delivery model;
- improved case management of physical and mental injuries;
- what specific steps are required to increase the confidence of workers and employers in the workers’ compensation system, including but not limited to the Fair Practices Office (FPO) and other services provided by WorkSafeBC; and
- whether or not there were any other urgent compensation issues that were not addressed in an earlier report (Boygo Report)\(^4\) to the Board of Directors.

Under the TOR, the Review was tasked with consulting with compensation stakeholders and holding public hearings in all areas of the province, including hearing from injured workers who chose to tell their stories. I was also asked to encourage general public engagement and to ensure that Indigenous people and First Nations were encouraged to participate in the Review. This public participation/engagement process was an important aspect as the last WCB Review was conducted without public consultation\(^5\).

In practice, these TOR posed a large task for this Review. The TOR, even though “targeted”, engaged key aspects of the compensation system, embedded in the wide-ranging and complex nature of the Board’s mandate and practice culture. The Review also found a broad desire by most stakeholders, including many injured workers, who wished to be heard through this Review and through its various avenues of participation. Many researchers have noted that the

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\(^{3}\) GBA+ is an analytical process used to assess how diverse groups of women, men and non-binary people may experience policies, programs and initiatives. The “plus” in GBA+ acknowledges that GBA goes beyond biological (sex) and socio-cultural (gender) differences. GBA+ also considers many other identity factors, like race, ethnicity, religion, age, and mental or physical disability. Throughout this Report, I have used gender-neutral language, where possible.


compensation system rests on the confidence of its key stakeholders\(^6\) and this confidence is built, in the first instance, by being heard.

I have carefully considered all presentations and submissions, including matters which were presented as “urgent” or as being required to improve or restore confidence.

Also, to satisfy the TOR requirement for “best practices” and “modernizing” Board culture, the Review also met with a number of experts, set out in Appendix 8, consulted with Board personnel and conducted research both within the Board (using “Information Requests” or IRs) more broadly. The research results are set out in the attached bibliography and key documents are included as Appendices to this Report.

I conducted the Review between April and October 2019, together with Jim Parker (Review Researcher and Writer), Donna Hanson (Review Coordinator) and Doreen Russell (Review Administrator). My resume and the profiles of the Review team are set out in Appendix 2.

PUBLIC CONSULTATION PROCESS

In May, 2019, EngageBC activated the Review’s public web-site with the full TOR and details of how individuals or entities could participate in the Review’s consultation process. Those wishing to participate in the Review could provide a written submission (on-line or mail-in), complete an on-line questionnaire (or later, a mail-in option) and/or make a personal presentation at a public hearing at one of 14 locations around the province between May and July, 2019. The web-site provided details of how to engage in this participation, including how to register for participation in the public hearings and the Review administrative staff were available by phone to answer questions or arrange any necessary accommodations. A full account of the public engagement process is set out in Appendix 3.

Public Hearings held in British Columbia - May to July 2019

The public hearings were held in advertised venues around the province between May and July 2019. I personally heard from 210 presenters, each making 20 minute presentations in a public forum. The presentations were recorded. Of those making public presentations, 160 were injured workers and more than 100 of these workers authorized the Review to obtained and

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\(^6\) RAND report is included among major current research noting the compensation system rests on the confidence of its key stakeholders. *How Can Workers’ Compensation Systems Promote Occupational Safety and Health? (Stakeholders Views on Policy and Research Priorities)* by Michael Dworsky and Nicholas Broten. © 2018 Rand Corporation, Santa Monica, Calif. [https://www.rand.org/pubs/research_reports/RR2566.html](https://www.rand.org/pubs/research_reports/RR2566.html)
review their WCB claim disclosure.\(^7\) Other presenters included family members, worker representatives, union officers, health care providers and employers.

Because so many injured workers participated, as well as affected family members, representatives and health care providers, the public hearing process was a rare opportunity to hear directly from the individuals most affected by injury and those who assist them. I was asked several times during the public hearing process, “when was the last time this happened?” – that is, hearing from injured workers personally. I had to say that the last time was for the Gill Royal Commission and its report on January 20, 1999 was over 20 years ago.

It became obvious that many of the presenters had carefully considered and prepared their presentations. Some had travelled long distances in order to make their concerns known. Many of these presenters had previously sought redress through the Fair Practices Office (FPO) of the Board, their Members of Legislative Assembly (MLAs) or the Provincial Ombudsperson (PO). However, in their presentations for this Review, they focused on “lessons learned” from their experiences - some very difficult - and on making recommendations to improve the compensation system. All were respectful and thankful for the opportunity.\(^8\)

I am deeply grateful to the injured workers and family members who came forward and shared their journeys with me. I consider it an honour to hear and share in their life stories.

Almost every injured worker or family member reported a range of experiences in their dealings with the Board. Many reported having positive experiences with one or several individual case managers or vocational rehabilitation consultants (VRCs). However, most reported that overall they did not have a positive experience with the Board. Some workers reported suffering and some suffered terribly, from an increased disability or burden from their injury because of individual Board officers or Board decisions, conduct or processes. Many felt betrayed. There was an overwhelming sense that these workers had turned to the Board in their time of need or crisis and either the Board was not there for them or had made the circumstances worse.

Some powerful submissions were also made by family members, often a spouse of an injured worker. Sometimes these presentations were made with the injured worker and sometimes were made on their own behalf. Many talked about the burden of disability as experienced by families and especially by children. I have enclosed one powerful written account of a wife,

\(^7\) The Review developed a special authorization process by which our disclosure request was not recorded on the worker’s claim file and the disclosure was reviewed for confirmation purposes but not retained.

\(^8\) I would like to acknowledge the important role of the Review administrative team - Donna Hanson and Doreen Russell - in helping individuals understand the Review’s focus and the short timeframe of their presentations. Several individuals called them after their presentations to thank them for their help and said that for the first time, they felt they had been “heard”.

**PART I: THE FOUNDATIONS OF THE REVIEW**
witnessing her husband’s disability journey and have set this out at Appendix 4: “In Their Own Words”.

In addition, many worker representatives took time and/or travelled to present to this Review, and their collective experience working with many injured workers over many years was invaluable. Often a worker was supported by a trusted representative and many worker representatives appeared on behalf of a worker who was unable to present themselves.

Two employers participated in the public hearings, also with a focus on “Lessons Learned”. Both were helpful and appreciated.

All of these presentations were moving and a powerful reminder that, despite reviewing a system that is large and complex, the numbers represent real people. It is essential to look beyond the numbers and at the quality of the experience of the individuals and in doing so, the efforts and contributions of injured workers and families are irreplaceable.

*Note re Board Bonus programs:*

In the public hearings, a number of workers expressed a strong belief that case managers had made negative decisions on their claims due to influence of a system of performance bonuses, paid to Board employees for limiting costs to the Accident Fund.

I have investigated this matter. In the past, the Board had bonus systems in place for both unionized employees and excluded staff and these bonus or “gain sharing” programs were based on performance measures.\(^9\) These performance measures were based on claims statistics which in turn, reflected the Board’s decisions (accepted injuries add to the injury rate, ongoing disability adds to claim duration, etc.). In these circumstances, a concern about the influence of such measures on Board decision-making is understandable.

This bonus system ended several years before this Review. At this time, there is no financial incentive for decision-makers to make negative decisions for workers. I have confirmed with the Board and with the Compensation Employees’ Union (CEU) that all forms of bonuses with any connection to claim rates ended for unionized staff in April 2013 through the CEU/WorkSafeBC Collective Agreement and for most management staff and executives by 2014.

Nonetheless, a Board program which provides Board employees with a personal financial interest in reducing workers’ entitlements potentially endangers the integrity of those entitlement decisions. It also profoundly undermines the confidence of injured workers in the workers’

\(^9\) A summary of the WorkSafeBC Gainsharing and/or Bonus Plan (WCB-IR-0064 August 6, 2019) is set out in Appendix 5.
compensation system. Impressions, especially ones that have some degree of a factual basis are hard to change and it is notable that even though the bonus plans have been eliminated for over five years, there is still a wide-spread impression that bonus plans still exist and still influence claims decisions.

The Board is now moving in a new direction and I am confident that there is no desire to return to any claim-related performance bonus system at this time.

However, given this legacy, only a Fair Practices Office which is independent of the Board will likely improve or restore workers’ confidence in the fairness of the compensation system. This recommendation is made later in this Report.

**Written Submissions to the Review**

The Review invited any stakeholder or member of the public to provide a written submissions on the TOR by July 30, 2019.\(^{10}\) The Review received 174 written submissions (over 1500 pages): 82 from workers or family members and 44 from employers. I have read all of these submissions and appreciate the depth of knowledge and engagement that they provided.

Most of the key stakeholders provided detailed submissions on the TOR, with legal and policy analysis and particular issues highlighted and researched. The Review has benefited greatly from these submissions. Most of these submissions met the Ministry criteria for posting on the website and the list of Individuals and Organizations with written submissions posted to the ENGAGE.GOV.BC.CA website is provided in Appendix 6.

The Review also received 82 submissions from individuals that did not meet the Provincial Government’s posting criteria and therefore, these individuals are not publicly identified in this Report. However, all of these submissions were appreciated and carefully read. Of particular note were the submissions received from retired Board employees and health care providers, both of whom provided important insights.

**Online Questionnaire Responses**

The Review posted an on-line questionnaire on the ENGAGE.GOV.BC.CA website for about two months. The questionnaire initially asked the respondent to identify their status as being one of seven “options” and different questions were asked for each option. The Review received almost 2000 responses to this online questionnaire. Over 1000 responses were from

\(^{10}\) The original date of July 19, 2019 was extended so stakeholders could comment on the Boygo report, released July 18, 2019.
workers or family members, over 300 from employers and over 600 from health care providers, the general public or “others”. The full response profile is set out in Appendix 3.

Many responders added comments in the space for open-ended answers and the responses were diverse and often quite frank. One individual marked the “General” category and replied:

The first question here about my connection to the topic is too presumptuous. I am interested in this because I or someone I love might need assistance one day. My concern is that help will be there and easy to access if I need it. That what I pay in on is accessible to anyone in BC with legitimate need.

The questionnaire responses contributed greatly to this Review, especially for those groups who are not always given a voice in compensation consultations. I have set out a small cross-section of responses received from each group in Appendix 7. A full record of the open-ended responses are set out in a separate document to this Report, titled “The Historical Record of Questionnaire Results, A Compendium to New Directions: WCB Review 2019”.

**Health Care Providers**

Health Care Providers do not always have a voice in compensation consultations. However, in this Review, many health care providers answered questionnaires (207), provided written submissions and made public presentations. Therefore, I would like to note some of their special concerns.

There was general agreement that the Board now paid health care professionals in a timely manner compared to the past. However, many expressed deep frustration with the Board and its actions in its “parallel” medical system; a number expressed concern for their patient’s well-being while on claim. It was expressed that the Board’s current relationship with medical professionals is fraught and that there are increasing numbers of physicians who refuse to care for patients under WorkSafeBC claims. Reasons provided include:

- The complexity of completing information for claims;
- Having opinions and medical observations rejected by the Board;
- Inability to effectively communicate and liaise with the Board; and
- Avoidance of potential need to answer patient requests for medical legal opinions.

Some of these concerns are addressed in my recommendations on medical issues.
CONSULTATIONS WITH KEY STAKEHOLDERS

Prior to the public engagement process, I met with key stakeholders to outline the TOR and discuss the overall consultation process and answer questions. At this stage, I met with the WCB’s Board of Directors (BOD) and groups organized by the following stakeholders: the Employers’ Forum\(^{11}\), the BC Federation of Labour (BC Fed), the BC Nurses Union (BCNU), the Workers’ Advisers Office (WAO), and the Employers’ Advisers Office (EAO).\(^ {12}\)

Several groups requested additional consultation and greater specificity regarding the TOR. I agreed that after the public engagement process, I would identify new or specific issues that arose from this process and then meet with key stakeholders on these issues, for more specific consultation. This approach was agreeable and most of the key stakeholders made submissions on the TOR issues through the public engagement process.

In August, I provided these key stakeholders with a list of new or specific issues arising from the public engagement process with meeting times to be arranged before mid-September. The list of new issues is set out in Appendix 3.

**Unions and Worker Representatives**

Most unions and worker representatives provided written submissions through the public process and these submissions were posted on the Review’s web-site. Many union officers and representatives also presented at the public hearings. The submissions and presentations were often detailed and I appreciate the deep engagement and expertise of those who presented them. This Report benefited greatly from this wealth of material.

Following the public engagement process, I met with the BC Federation of Labour and affiliate representatives, with the Health Services Association (HSA) and with the BC Nurses Union (BCNU) regarding the new issues\(^ {13}\), as arranged. I would like to thank all of the union officers, advocates, staff and members who participated so fully. I also met with the Workers’ Advisers Office (WAO) group for an extended consultation on the new issues. Again, I would like to thank the Advisers’ office and the individual advisers for generously giving their time and expertise to the issues before this Review, as well as providing detailed and helpful submissions.

\(^ {11}\) The Employer’s Forum is a registered society, representing over 70 employers and employer associations, with a focus on being a voice for the employer community to the Board and that the “channels of communication remain open and fair representation is maintained on all issues related to workplace health and safety.”

\(^ {12}\) Other stakeholders were invited but preferred to meet later in the consultation process.

\(^ {13}\) Other participating non-affiliated unions did not participate further: UNIFOR, Public and Private Workers of Canada (PPWC) and the Greater Vancouver Regional District Employees’ Union (GVREDU).
Employers and Employer Representatives

The Employers’ Forum:

The Employers’ Forum provided a substantive submission addressing the TOR including the issue of whether the Act should be amended to include a “Duty to Accommodate”. The Employers’ Forum also submitted that the cost of any recommendations by this Review was an automatic part of the TOR. I do not agree. The purpose of this Review is to assess Board culture and the delivery of service to affect a worker-centric compensation system. This does not include micromanaging costs even though clearly, the historic compromise requires that the Accident Fund be sustainable. After meeting with the Employers’ Forum, I met with the Board’s Actuary. I am satisfied that the Board’s financial position is sound and will remain so, whichever of the options from the Boygo Report are pursued. The BOD has financial oversight and responsibilities: the health of the Accident Fund remains their responsibility in any implementation from this Review. I take the point that costs are an important part of employer confidence in the compensation system and I address the issue further in this Report.

Public engagement by employers other than the Employers’ Forum

The Review received 44 written submissions from employers or employer representatives. Some submissions simply endorsed the Employers’ Forum submission while others provided independent submissions or additions. Most of these submissions also qualified for posting on the Review’s web-site. In addition, the Review received 313 questionnaire responses from employers or employer representatives and 2 employers presented in the public hearings.

The Review received an extensive written submission from the Employers’ Advisers Office (EAO). In my view, the EAO submission summarized many of the issues and comments made by employers in their questionnaire responses. These concerns likely represent those of medium and small employers who have different business circumstances and perhaps less experience in compensation matters than the large employers represented by the Employers’ Forum. In general, there was anger and confusion about Board decisions, how they were made, and how or why costs were allocated as they were. There was a strong feeling that the Board did not support or assist employers in RTW and/or sided with injured workers without an investigation and that doctors did not understand light duties. There were many complaints about rude treatment from Board employees.

There were also many, many submissions asking the Board to return its well-publicized surplus to employers. The issue of the surplus is addressed in the Boygo Report and therefore it is outside the mandate in this Review. As an attention point, the Board may wish to consider engaging in better communication with employers on the surplus issue, including how a surplus arises from investments by as well as premiums paid to the Accident Fund.
New Matters

Following the public engagement process, I met with the Employers’ Advisers Office (EAO) group for further extended consultation on the new issues. I met also individually with several individuals who represent employers in compensation matters, who were helpful and frank in their comments on the TOR and on new matters.

It is clear from the public engagement process and the additional consultations that the employer community does not speak with a single voice and that there are significant differences of interest between the larger employers represented by the Employers’ Forum and smaller employers concerning compensation matters, especially regarding RTW issues.

Withdrawal of the Employers’ Forum from the Review

After the new issues were identified on August 6, 2012, the Employers’ Forum publicly withdrew from participation in this Review, expressing a lack of confidence and a concern that I was biased in my selection of the “new issues” for inclusion in the consultation process.

For the record, each of the identified “new matters” was raised repeatedly by participants in the public consultation process, as were many other issues. The identified “new matters” were only those which I considered to be within my TOR, at least as “urgent” issues. I understand that these same issues are well-known and long-standing in the compensation community, of which I am a part. However, this Review provided an opportunity to address these matters in a public forum and stakeholders took the opportunity to do so. Given the TOR and the public consultation process, it was important that these issues be examined as part of the Review.

While it is unfortunate that views of the Employers’ Forum regarding the new matters was not provided, I am satisfied that I have canvassed the issues with other employer representatives and have substantive input from the Employers’ Forum and other employers on the TOR. It is unfortunate that this stakeholder group missed the opportunity to listen and/or respond to the issues brought forward by the other stakeholders, especially injured workers.

Additional and Other Consultations

Following the public engagement process, I also consulted with the Chair of the Workers’ Compensation Appeal Tribunal (WCAT) who provided a carefully researched and helpful perspective.

Finally, I met with several experts in health, research and rehabilitation outside of the Board and these consultations are set out in Appendix 8. I would particularly like to thank the Doctors of BC and the Provincial Ombudsperson and his officers for their helpful consultations.
Consultation and Research at the Board

In addition to the public consultations, I consulted extensively at the Board throughout this Review. I met with the Chair of the Board of Directors, Ralph McGuinn, and the full Board of Directors on several occasions as well as with several individual Directors at their request. I appreciate the significant time, expertise and candor provided to me in these consultations. The Acting Chief Executive Officer (CEO), Brian Erickson, welcomed the Review to the Board when we started and I then met several times with the new CEO, Anne Nasser, whose appointment commenced on July 1, 2019.

The Board appointed a dedicated liaison, Rhonda Trudeau, to schedule meetings between the Board and the Review, and to research and respond to our information requests (“Information Requests” or WCB-IRs as they are referred to in this Report). With her assistance, I was able to consult with certain Vice-Presidents, many Directors, Board Medical Advisors (BMAs), the Fair Practices Officer and the Chief Review Officer (CRO). All gave generously of their time, expertise and deep knowledge of the Board and of compensation issues. I also consulted with front-line Board staff through personal contact in sessions organized by the Compensation Employees’ Union (CEU) and through written comments provided by staff anonymously through an arranged channel. I would like to thank all participants for their very thoughtful and candid participation.

POSITIONING THE REVIEW

General Matters

As the Reviewer, I was asked to assess modernizing the Board’s service culture to reflect a worker-centric service delivery model, including return-to-work (RTW) and case management issues. During my consultations, I realized that a “worker centered approach” means many things to many people.
The Petrie Report defined a “worker-centred” approach as follows:14

A worker-centred approach for injured and disabled workers is one that takes into consideration the worker’s individual circumstances in applying policy and making decisions about benefit entitlement and rehabilitation measures. It is designed to maximize the worker’s recovery from the injury or disease and to restore as close as possible the worker to his pre-injury employment status without a loss of earnings.

I have used the Petrie definition for the purposes of this Review as I find it a useful guide for assessing the Board’s delivery system and culture and for identifying measures which may be required to achieve a worker-centric compensation system.

The Board does not have an easy mandate. As noted in the Alberta and other reviews, the workers’ compensation system is neither a private insurance scheme nor a social assistance program. It is a unique institution, arising from a historic compromise in which both workers and employers compromised.15 This unique mandate requires the Board to be a multi-faceted organization with multi-faceted capabilities and to deliver its many services in a supportive and cost-effective manner.

Today, the Board in British Columbia, like other compensation boards, bears the marks of its history. In the last two decades, certain events were particularly influential:

- The organizational and legislative changes in 2002 had an impact on the level of compensation benefits for injured workers but also on the service delivery culture at the Board. The Petrie Report’s discussion of this legacy is set out in Appendix 9.
- In 2005, the “Workers’ Compensation Board” was re-branded as “WorkSafeBC” to reflect a changed focus and mandate.
- In 2008, the Board underwent a significant change in its decision-making process when it introduced a computerized Case Management System (CMS). Some key elements of CMS, especially as they affect Board decision-making, are summarized in Appendix 10.

I recognize that the Board is now in the midst of significant change again, as it implements an ambitious policy workplan based on Petrie’s forty-one (41) recommendations under the direction of a new CEO, Anne Nasser, who began her term on July 1, 2019. In this Report, I have tried to

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note Board practices in certain areas with accuracy, but I recognize that changes at the Board may well outstrip the information in this Review.

As noted in the TOR, there have been significant changes in British Columbia’s workplaces and workforces since the last Review. In the 1990’s, there were changes, sometimes described as moving the B.C. economy from “chainsaws to keyboards”\(^{16}\). However, the last sixteen years have seen even more dramatic changes in the nature and organization of work and work relationships. The dramatic growth in contract work and the increased role for technology in the organization and distribution of work is such that many now refer to this growing sector as the “gig economy” or even the “Fourth Industrial Revolution”. Key concepts of the “gig” economy, the “sharing economy” “precarious employment” and “vulnerable worker” are defined and discussed in Appendix 11. These concepts are particularly important to the discussion of work injury, RTW and vulnerable workers.

**The Changing Concept of Disability**

Another significant change in the last 16 years is in our understanding of “disability” along with ideas and commitments about how to manage and treat disability. Although “disability” is not defined in the Act, “disability” is at the heart of the compensation system.

Today, a biopsychosocial model of disability is foundational, based on an integration of the social and medical models of disability. It forms the basis of the United Nations (UN) Convention on the Rights of Persons with Disabilities (UN 2006).\(^{17}\) On June 21, 2019, the Federal Government enacted the *Accessible Canada Act* as part of its commitment to this Convention. The key concepts in the *Accessible Canada Act* are in the definitions of a “barrier” and of “disability:

**Barrier:** mean anything— including anything physical, architectural, technological or attitudinal, anything that is based on information or communications or anything that is the result of a policy or a practice – that hinders the full and equal participation in society of persons with a physical, mental, intellectual, learning, communication or sensory impairment or a functional limitation.

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**Disability:** means a physical, mental, intellectual, learning, communication or sensory impairment – or a functional limitation – whether permanent, temporary or episodic in nature that, in interaction with a barrier, hinders a person's full and equal participation in society.

British Columbia has committed to building a more inclusive province for people with disabilities and the Province presently offers new employment services and support programs for people with disabilities through WorkBC.

This broader understanding of “disability” - as an impairment interacting with a barrier - is an important first step to effective disability management in all areas. There is extensive research supporting this view of disability and identifying effective standards and programs for disability management. Some key initiatives and resources in this area are set out in Appendix 12.

In my view, a modern worker-centric compensation system must effectively integrate a biopsychosocial model of disability and disability management with the goals of a “worker-centred approach” – to maximize the worker’s recovery and to restore his pre-injury employment status as much as possible without a loss of earnings. The two approaches are compatible and complimentary. 18 Within the TOR for this Review, the issues will be how the Board can effectively minimize a worker’s impairment and at the same time, reduce or eliminate the barriers which cause that injured worker to experience disability. In this approach, necessary supports will include, but not be limited to, financial or medical or workplace matters. Disability is a multi-faceted problem and it requires a multi-faceted solution.

Should British Columbia follow other compensation jurisdictions and incorporate a “Duty to Accommodate” into the Act and if so, how should this be done?

**WHAT WE HEARD**

This section introduces the key themes as raised by participants in the Review’s consultations. These themes are addressed in the context of specific issues in this Report and I would like to acknowledge that both the discussions and recommendations greatly benefited from the input of so many participants.

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18 Colwill v. Workers’ Compensation Board 2019 BCSC 826. May 27, 2019, Docket: S1813108, Vancouver Registry. [https://www.bccourts.ca/jdb-txt/sc/19/08/2019BCSC0826.htm](https://www.bccourts.ca/jdb-txt/sc/19/08/2019BCSC0826.htm) The court reviews of the concept of disability under the Act. Although disability is not defined in the Act, it is clear it involves a consideration of employability in light of the actual impact of the injury on the actual worker, a view consistent with the biopsychosocial approach to disability.
The main themes included:

**Listen to Workers and treat them with respect**

The dominant theme from injured workers, families, unions, health care providers and worker representatives was to listen to workers and treat them with respect. This is a major focus of this Review. A union WCB representative, described it this way:

*Over the years I have worked with quite a few of our Members who have sustained injury or illness at work. The biggest, most resounding complaint they have had, is not being treated with Respect and Dignity. This of course varied, but on the not so run of the mill Claims, the majority felt unheard and disrespected.*

*So, where we need to get to is a place where all Claimants are treated with the Respect and Dignity they deserve. Let’s remember, these individuals are in situations that they certainly didn’t want anything to do with. No one goes to work expecting to get hurt....*

*What they need is to be heard, they need those they are speaking and corresponding with at the WCB to actually hear what they are saying regarding the particulars of their Claim. They need to be able to compenetrate on getting better. …..Right from the start the worker needs the support and direction required to treat their conditions and focus on returning as close to new as possible. This includes NOT returning to work when a treating Physician is of the opinion that (for whatever medical reason) they deem the return to work too early.*

This issue is addressed throughout the Report.

**Remove Barriers to Effective and Respectful Communication with the Board**

There was almost unanimous agreement among stakeholders and health care providers in all areas and locations that the Board’s communication practices are dysfunctional for stakeholders. Communication impasses, including the “broken telephone” syndrome or “dead zones” (calls are never returned) were regularly cited as being the source of inefficiency, frustration and a factor in poor medical and RTW outcomes. This is a huge issue, perhaps greater than the Board realizes. Poor communication undermines stakeholder confidence in the system. Relationships are built on trust and trust is built on good and timely communication, inclusive of two-way communication.

Other common themes included the need for more tools and assistance to navigate a complex compensation system, especially for those who have additional barriers of language, disability or culture.
And a significant number of workers and employers reported experiencing inappropriate staff conduct in the course of their communications with the Board, including rude, hostile, suspicious, or threatening exchanges by staff. Such exchanges are significant to stakeholders and must be addressed.

**Improve Investigations and Evidence-based Decision Making.**

Many participants – workers and employers - expressed concerns about the Board not considering or seeking evidence in their decisions. In the written submissions alone, there were numerous comments about the urgent need for the Board to fairly investigate and obtain evidence to make well-founded decisions.

In assessing this issue, it was helpful to understand the Board’s decision-making process in the case management system (CMS). I appreciate the CMS training which was offered to this Review and this is summarized in Appendix 10.

The Employers’ Forum also flagged the need for “consistent, predictable and clear” decision-making.

**Improve Medical Assessments and Resolution of Disputes.**

A number of participants also expressed strong concern about how medical issues are addressed at the Board. Frequent concerns included the current role played by Board Medical Advisors (BMAs), the practice of having non-medical personnel making medical referrals, the inadequate collection and assessment of medical evidence, and the many costs and delays involved in resolving medical disputes at the Board and on appeal.

There was a call from all stakeholders for a better, expedited and fair resolution of medical disputes, especially those involving RTW and Light Duties. We heard that medical disputes took too long to resolve and that delays led to increased negative outcomes for all. We also heard from many sources that seriously injured workers were forced back to work or plateaued too early, leading to long term health consequences and/or reinjury.

The Review heard from a number of participants that they had no confidence in the independence or integrity of BMA opinions, given that there was no clinical component to the those opinions and that the BMAs themselves were accessible only to claim owners. Most striking was the message from BMAs themselves that their role within the Board had diverged from one of being clinically appropriate for physicians to one which was inconsistent with the principles of Patient-Centered Care.
The Review also heard from a significant number of workers that a claim owner (without medical expertise) had referred the worker to a rehabilitation or treatment program, without any consultation with the treating physician (AP) and at times, over an AP’s objections. A number of workers reported being injured in rehabilitation programs or suffering a setbacks.

**Administrative Unfairness and Systemic Issues**

I met with the Provincial Ombudsperson (PO) and several of his investigative staff. In addition to identifying “complaints and inquiries” about WCB, being in the “top 10” agencies which are the subject of complaints, the PO raised the question of how systemic or maladministration issues are addressed. In 2010, the Provincial Ombudsperson publicly notified the Board that section 96(5) of the Act (the “75-day rule”) created a situation of potential administrative unfairness and the legislation should be amended. [see Appendix 14] The PO noted that this issue has never been addressed. It seems that there is no mechanism which requires that systemic issues be addressed.

In this Report, I recommend that an external and independent Fair Practices Commission (FPC) be created with an ombudsperson-like authority to address, for both individual and systemic issues. This recommendation is set out in greater detail in a later section in this Report.

**RTW and Light Duties and the Duty to Accommodate and Vocational Rehabilitation**

There was a wide range of experiences and opinions in this area and these are discussed in the RTW section of this report.

**Other Issues**

The TOR asked me to identify specific steps to increase the confidence of workers and employers in the compensation system, including but not limited to a Fair Practices Office, and to identify “urgent” compensation issues that were not otherwise addressed.

A number of issues raised by stakeholders for this Review to consider, were identified as “new issues” in the August 2019 memo, attached to Appendix 3. I have addressed most but not all of these in this Review. Some of the new issues are integrated into the discussions of case management or RTW. Others are addressed in sections on increasing stakeholder confidence or on “urgent issues”.

Many stakeholders identified issues in the compensation appeal process. While an assessment of the appeal structure is beyond my mandate, I consider that amendments to the current appeal process are necessary to improve the case management of injured workers in a worker-centric system. Therefore, I have addressed some limited issues with respect to
procedure and jurisdiction of WCAT. I have also recommended alternative dispute resolution processes for medical disputes, through the creation of a Medical Services Office.

Finally, I have also applied a GBA+ lens throughout the Report, but also include a specific section on this analysis and particular issues which arise from this analysis under the TOR.

ACKNOWLEDGEMENTS

I would like to express my appreciation to the Board for providing full administrative support to this Review while demonstrating a great respect for the Review’s independence and timeline. Over seven months, the Review drew on the services of many individuals and departments at the Board and without exception, all provided exceptional support. I would especially like to thank Rhonda Trudeau, a former Board Director who returned from retirement to act as a liaison between the Review and the Board. Rhonda’s expertise, focus and ability to facilitate our many communication and research requests contributed greatly to the Review and this contribution, as well as her graciousness, is most appreciated. And thanks also to Daniel Leung and the IT Division who were able to provide excellent, personable and comprehensible technical support.

I would like to acknowledge, with gratitude, Jim Parker’s key role in and contribution to this Review. Throughout the Review, Jim attended the public hearings and consultations with me, sharing the consultation work together with his expertise, perspective and historical knowledge. Jim generously provided his considerable research background and abilities to the Review and contributed substantially to the writing of this Report. The Review and this Report reflect his huge contribution and I and the Review benefited greatly from his involvement.

I also acknowledge the brilliant administrative and front-line work by Donna Hanson as the Review Coordinator and by Doreen Russell as the Review Administrator. Both have many years of experience in compensation administration and working together, they provided this Review with exceptional administrative capacity in all areas including organization, communication, record keeping, documentation and Report production, all while presenting a professional and inclusive public face for the Review. They typified grace under pressure at all stages and the Review, and I personally, benefited greatly from their contribution.

I also acknowledge with thanks, the significant contribution of Monique Pongracic-Speier, Q.C. who expertly and patiently guided me through the complex legal shoals inherent in the compensation system and the issues particular to this Review.
I would also like to express my appreciation to the Deputy Minister of Labour, Trevor Hughes, and to the Ministry of Labour staff who guided and assisted in this complex Review at every turn. Their professionalism and non-stop work ethic greatly assisted in this task.

Notwithstanding these supports, I accept responsibility for this Report in its entirety and any errors or omissions are mine and mine alone.
PART II: ESSENTIAL ELEMENTS OF A WORKER-CENTRIC SERVICE DELIVERY - ISSUES IN BOARD CULTURE AND CASE MANAGEMENT

IN BRIEF

The workers’ compensation system is transitioning in New Directions from an “insurance” approach to a “worker-centric” model. Recommendations to progress in the New Direction include:

- A preamble and statement of purpose in the Workers Compensation Act;
- Focusing on improved communications;
- Mandating fairness through a code of conduct and improved fairness structures;
- Achieving fairness and better evidence practices in initial decision-making;
- Adopting a patient-centered care model that is complimentary to the worker-centric model, with new roles for BMAs and Clinical Services.

The Board receives about 150,000 claims from injured workers each year. For about half of the accepted claims, workers do not miss work and other claims involve straightforward, uncontested injuries which, for the most part, are processed routinely and without complications or difficulty. That is, the worker files a claim, gets good medical treatment and returns to work without complications. One worker provided the Review with a good example of this. She broke her wrist at her office job where she had a supportive employer. After a short respite, she was able to return to work wearing a cast: her wrist healed as expected and the Board and employer were supportive throughout. The strength of the compensation system handles these “simple” claims well and in considerable volume.

However, in a certain proportion of the claims, likely 15 to 25%, the injured worker does not make a routine recovery or recover as expected. This profile is similar to that noted in other jurisdictions where research indicates that 80% percent of the workers’ compensation claim

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Certain claims are accepted and coded as “health care only” claims. This can mean either the worker does not have a serious injury and is not disabled from regular duties or the injured worker can be quickly accommodated at work with light duties so there is no time loss. The latter arrangement is one of the areas often in dispute.
costs are taken up by the 20% of workers on complex and longer-term claims. Typically, these are the claims of seriously injured workers and workers most in need of Board support.

The public consultation process in this Review gave considerable insight into WHY some workers, particularly seriously injured workers, had poor or very poor experiences with the Board. Almost without exception, the workers who had the worst experiences were workers with serious or multiple injuries, head injuries or concussions, psychological injuries, older workers who may be expected to have a hard time with RTW or VR and young workers who were seriously injured, especially if they lived out of province. Most complaints were from workers with these types of injuries, rather than from workers whose claims were denied. After listening to numerous of these individuals, I believe that there is much to be learned from consulting with individual workers and their representatives. I also found the consultations with employers very helpful, especially in addressing issues in Board culture and service delivery.

The TOR included assessing issues in modernizing WorkSafeBC culture to reflect a worker-centric delivery model and issues in the improved case management of injured workers. In practice, these matters are closely linked and will be addressed thematically. The concept of workplace culture is broad and inclusive of a range of factors which systemically influence compensation services, including how services are determined and delivered. The task is to identify these key influences and then assess what must be done to modernize Board culture to reflect a worker-centric delivery model.

BOARD CULTURE

Introduction to Key Factors

One pillar of Board decision-making resides in section 99(2) of the Workers Compensation Act (Act), a provision which requires all Board decision-makers to apply relevant policy in every decision. In effect, the policies published in the Rehabilitation Services and Claims Manual, Volume II (RSCM II) have the status of “subordinate legislation”. This gives the Board a powerful tool for setting compensation rules, including a rule how this requirement meshes with the requirement to consider “the merits and justice” of a case. Board practices are also

NEW DIRECTIONS:  
WCB REVIEW 2019

strongly influenced by Practice Directives (PD) which are published by Claims Services as non-binding guidelines, separate from Board Policy.

Another pillar of Board culture resides in section 96(5) of the Act. This provision states that after 75 days, the Board cannot reconsider a decision. This “75 day” rule bestows a finality on all Board decisions after 75 days, absent an appeal, including decisions on diagnosis, medical treatments, light duties, wage loss, wage rate, age of retirement, VR plans, duration of VR plans, and pension decisions. This provision, once envisioned as a way to achieve “finality”, especially for employers in their exposure to claims costs in long term claims, it has become one of the defining features of the Board’s current form of service delivery. With this provision, the compensation service delivery system is focused on issuing binding decisions and then resolving disputes through the appeal process. This approach has resulted in a formalistic and rigid approach to service issues, service delays caused by appeals dispute resolution and a complexity of issues on appeal – procedural, jurisdictional and evidentiary - beyond the scope and resources of many stakeholders, especially injured workers.

Board culture is also deeply influenced by the directions from the Board’s Board of Directors (BOD) and leadership team. In addition to publishing policy, the BOD publishes an Annual Report in which it identifies the Board’s vision or mandate, measures past Board performance and sets goals for future performance. Today, the BOD measures performance and sets goals using certain Key Performance Indicators (KPIs) and these have deeply influenced Board operations and Board culture. The Board’s CEO and Senior Management Team implement these matters on a day to day basis.

The Board’s decision-making has been described as a “cookie-cutter” approach. In addition to Board policy and Practice Directives, the Board’s Case Management System (CMS) embeds Recovery Guidelines into each claim file, based on the accepted diagnosis for that claim. (Appendix 10) The purpose of the Guidelines is to help decision-makers make entitlement decisions about treatment and fitness for RTW with reference to average profiles and to guide claim owners through the expected milestones and decisions. The Guidelines are updated regularly based on scientific research and incorporate an algorithm of a “J curve” about the expected path to recovery. The Board’s decision-making culture is also strongly influenced by a focus on timeliness, given the timeliness targets in CMS.

The Board has always had a Clinical Services Division but its role has changed over the last decades. Formerly, Clinical Services was an independent division, focused on clinical services with BMAs performing clinical examinations at the Board.21 Today, Clinical Services are closely

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21 BMAs conducted clinical examinations of workers until several years ago. Clinical exams were referred to as AB (at Board) examinations, although the review was by a senior retired BMA that “AB” originally
integrated into the Board’s case management and claims practices. Organizationally, the director of Clinical Services, the CMO, the Chief Mental Health Officer and the director of Special Care Services all report to the vice president of Claims Services. BMAs now review files and offer medical opinions to claim owners, at their request. Claim owners describe that they are encouraged or required to accept the BMA’s opinion over that of a treating physician. In practice, the role of BMA’s role has changed from a medical/clinical role to one focused primarily on adjudication support.

The Board also now contracts its rehabilitation and RTW treatments through third party providers primarily for “packaged” program blocks such as Occupational Rehabilitation 1 or 2 (OR1 or OR2). While the programs benefit some workers, there are concerns about the referral process, the lack of oversight and the number of injuries that occur in these programs. In some cases, there are questions of the quality and integrity of the programs themselves.

Finally, it must be noted that many of the Board’s compensation categories were formulated in a previous era where there was a binary approach to disability, primarily based on the recovery path for a physical traumatic injury. Compensation services were organized on the basis that there was typically a period of temporary total disability (TTD), followed by “plateau” followed by an assessment of the permanent injury issues:

- a permanent functional impairment (PFI) assessment; and
- a return to work (RTW) or vocational rehabilitation (VR) was considered, and if necessary, a loss of earnings (LOE) pension.

In this Review, I found that there were two consistent “flash points” in case management adjudication” “Light Duties” and “Plateau” dates. In my view, neither issue is adequately addressed by the Board in part, because, the compensation system itself it does not yet incorporate a biopsychosocial concept of disability and disability management into its service delivery system.

In addition to these formal influences, an assessment must also include less formal influences on Board culture and service delivery. These are addressed below. I recognize that the Board is a very large and complex organization and that any assessment of culture is necessarily general.

referred to Board’s buildings where the exams were held. AB exams were often conducted for the purpose of declaring the worker no longer disable. Workers had a considerable degree of distrust of AB exams and this practice has virtually ceased. It was raised with the Review that, if a worker does not have a personal physician and is seen by a BMA, the BMA becomes the designated primary care physician with obligations incompatible with their current role.
Business Model of an Insurance Company vs. Historical Compromise

Behind the complexities of the compensation system, lie some basic principles. In Canada, the underlying principles are usually considered to be “The Historic Compromise”, formulated from principles set out in a report by Sir William Meredith in 1913. As noted in the Petrie Report:

The Historic Compromise which is the foundation of the workers’ compensation system is based on a balance between worker and employer interests. Workers gave up their rights to sue negligent employers in exchange for no fault compensation funded collectively by employers and administered independent of government outside the court system.

Prior to 2002, the Historic Compromise was the accepted and operational paradigm for the compensation system in B.C. A review of the Annual Reports from the 1990’s, show that the Board faced many of the same issues as today, including workers with complex injuries and the burden of increased claim duration. But the Reports also highlight that in addressing these issues, the Board worked with both workers and employers as “stakeholders” and considered that its mandate was one of “responsibility to these stakeholders” to develop effective services and expertise.

After 2002, the Board began to identify itself as a special type of insurance company created by the government. The “insurance company” model, as understood by the Board, was set out in its 2015 Annual Report, as follows:

WorkSafeBC (the Workers’ Compensation Board of British Columbia) is a statutory agency governed by a board of directors appointed by the provincial government. We provide coverage to 2.26 million workers and more than 225,000 registered employers throughout B.C. and are funded through insurance premiums paid by employers and investment returns. In administering the Workers’ Compensation Act, WorkSafeBC is accountable to the public through the provincial government, which is responsible for protecting and maintaining the overall well-being of the workers’ compensation system.

This model presents a different vision for the role of the Board and for compensation services.

Broadly speaking, the insurance model focuses on compensation services primarily as business transactions. It provides coverage for certain insured events (injury) by assessing and paying entitlements to workers for those events. This coverage is funded through insurance premiums and investment returns. There is no mention of “stakeholders” or the Board’s special mandate to work with stakeholders to meet their needs, especially the needs of injured workers. Instead, the Board identifies as a “statutory agency”, and is “accountable to the public” (not stakeholders) through the provincial government.
Absent from the insurance model is any recognition that workers and employers are stakeholders, and equal stakeholders, in a compensation system. Employers are premium paying “customers” and the system’s role is to provide “coverage” (not compensation) for insured events (injury). The obligation for oversight is for the “well-being” of the compensation system. Workers, as legitimate participants, are invisible.

In practice, the framework essentially translates the worker’s experience of injury and RTW into an entitlement matter and entitlement is determined by Board policy. There is little in the insurance model to encourage the Board to have a broader perspective to assist the injured worker to maximize recovery or rehabilitation.

Research at other compensation boards has shown that, with this insurance approach, front-line staff tend to regard employers primarily as the source of cash to the Accident Fund while workers are primarily seen as taking cash away. With this focus, front-line staff and/or leadership can easily develop attitudes of resistance, and sometimes hostility, to the “outflow” of entitlement benefits, feeling like they need to protect both the employer and the Accident Fund from workers “demands”. In this Review, there was ample evidence of this culture, with many workers reporting instances of being treated them with deep suspicion or hostility. Many many workers reported that when talking to Board staff, they were not believed, treated like they are lying or cheating, or made to feel like criminals.

There were also more than a few reports of services practices which threw up barriers to claims entitlement issues. These included:

- Prolonged “broken telephone” communication routines, where the claim owner would return calls only at times when the worker was not available, despite repeated requests for other times.
- Worker’s evidence or written requests were repeatedly ignored or misfiled or lost, including one case publicly identified by the Provincial Ombudsperson. In one case, the worker had repeatedly faxed the same information and characterized her case manager as acting like a “Squirrel hiding stuff.”

It appears that there is little remedy and little accountability for service practices which constitute maladministration.

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“Moral Hazard” Ethos: Negative Impact of Compensation Benefits

Another aspect of Board culture is its general ethos or vision regarding the role and purpose of compensation benefits.

Currently, this ethos includes the concept of “moral hazard”. This is a view that compensation benefits encourage a worker’s dependence, helplessness and prolonged disability and in doing so, create a moral hazard for the injured worker. According to this view, a worker who is injured needs to be “incentivized” to return to work and this is best done by making compensation benefits less financially attractive than a full working wage.

This view was very much a part of the 2002 legislative changes which virtually eliminated the loss of earnings pensions and reduced the PFI pensions under section 23(1) of the Act. While implementing these legislative changes, the Board reduced the discretionary vocational rehabilitation benefits by over 98%, stating:

Since section 23(1) awards provide the maximum incentive to return to work, it is expected that a worker with a section 23(1) award will return to work without any need for VR intervention.

The “moral hazard” approach is still very much a part of Board culture. A group of case managers made the following anonymous submission to the Review:

We have concerns regarding the viewpoint that worker-centric means giving workers what they want, even if this goes against policy or is actually harmful in the long run. By making workers more dependent on WorkSafeBC we create learned helplessness and become more of a social service agency than the original intention to assist in recovery and return to function. Is increased entitlement or increase service what workers need? What we really want is less disability. We have all witnessed the negative effects of disability on our workers and their families.

... Entitlement to monetary items (such as increased wage rates, LOF, VR entitlement, LOE) only reinforces severe and prolonged disability because there is a “pot of gold” at the end of the claim.

Within the “moral hazard” ethos, compensation benefits, especially monetary benefits, are seen as having a negative role. This is sometimes directly addressed with injured workers. Several workers reported that they were warned by case managers not to think that their traumatic injuries had just won them a “pot of gold.”

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23 Loss of earnings pensions have since increased significantly.
Inherent in the “moral hazard” ethos is a series of definitions and assumptions. “Disability” is effectively equated to being dependent on compensation benefits. “Independence” as a goal means being independent of compensation benefits. The Board seeks to make workers “independent” by denying benefits and when workers are more “independent”, they are “less disabled”. In this way, a “disability” is defined away, without reference to the worker’s actual experience of impairment and barriers. It is also an approach which assumes that the primary barriers for disability are within the worker’s control and primarily consist of a worker’s reluctance to return to work. According to this approach, a little financial hardship is the best medicine.

The “moral hazard” ethos is not compatible with a worker-centric service delivery because, at its core, the “moral hazard” ethos does not have a true vision of “independence” or “disability”. It is focused on reducing benefits and entitlements, discounting the views of injured workers and dismissing disability issues rather than assessing them. It positions the Board as adversarial to the needs (“demands”) of injured workers and so systemically disregards the worker’s experience of injury. This is highly unfair and disrespectful. As one long-time worker advocate put it, in 45 years of representing injured workers, not one of the them said “This is fun” or would not have traded their compensation benefits for good health and an injury-free life. The “moral hazard” ethos is also incompatible with a positive role for the Board in disability management.

ASSESSMENT OF BOARD CULTURE AND SERVICE DELIVERY

The “insurance model” (especially in concert with a “moral hazard” ethos) is not a sound foundation for a worker-centric compensation system for several reasons:

a) As a service model, it restricts the Board’s role in and responsibility for the worker’s injury, recovery and disability. Largely, the Board is kept to a narrow band of entitlement decisions, rather than engagement with the “whole worker”. Many workers, turning to the Board for help in recovery or RTW, were told “That’s not my problem”.

b) In its current form, Board decisions are often decided with reference to policy, practice guidelines or CMS guidelines rather than a worker’s (or employer’s) evidence. The single dominant theme to the Review is that workers (or employers) do not feel “heard” To a great extent, this is because under the current model, the compensation system largely does not want to hear from them. The quality of Board decisions are also adversely affected.

c) A personal Injury is a deeply personal event. In many cases, recovery and disability require some consideration of individual circumstances and a personal touch. The insurance model largely reduces service delivery to a business transaction, conducted by phone and mail. This is not sufficient service to reduce real disability.

d) The model does not envision workers or employers as stakeholders, but as “customers”. In most areas, except policy consultations, there is a striking lack of meaningful
consultation between the Board and most stakeholders. One exception is the Employers’ Forum which has developed consultation channels with the Board around some service practices. But the service model of an insurance company measures its performance in business terms (KPIs, statistics), not in terms of stakeholders needs or inputs.

As a service model, this service model excludes stakeholders in general, injured workers but also a diversity of employers. My recommendation to improve the confidence of stakeholders in the compensation system takes this into account.

A Worker-Centric Approach to Service Delivery

What is the alternative? One case manager raised an important point:

My concern is that a ‘worker-centred’ approach, such as Mr. Petrie appears to be advocating, will be misunderstood/misconstrued to simply mean “more money, more benefits” but without a vision of how this actually promotes independence.

Please do not misunderstand my underlying principle: I do not want to deny any benefits that assist our workers in working toward independence…Many of our workers, particularly the more significantly/severely injured, truly need substantial support, often for life. I do feel that we serve our injured workers… best when we help them regain as much of their former life as possible….

I agree that a worker-centric compensation system needs a vision. But the vision should be one focused on achieving true independence for injured workers and not one which defines it as an absence of compensation benefits. And it must be developed within the foundational principles of the Historic Compromise. Specifically:

- The Petrie definition of a worker-centric system gives the Board a clear vision and role: to support an injured worker to the extent of maximizing their recovery from their injury and restoring them as much as possible to their pre-injury employment status. I recommend this as a guiding vision for a renewed Board culture.

- In the modern context, this vision must incorporate the biopsychosocial model of disability, which is now the internationally accepted understanding of disability. This model includes a recognition that many barriers involved in a worker’s disability are social and beyond the worker’s control. The Board has an important and positive role in addressing each worker’s disability, and for a work-caused injury, has the responsibility to do so. It must recognized that some disabilities will truly need substantial support from the Board, often for life; and

- Return to work (RTW) is an important objective of a worker-centric compensation system, working within the biopsychosocial approach to disability. RTW issues at the
Board are assessed from this perspective and from best practices for disability management, following Guidelines set out by the International Social Security Association (ISSA) and based on the following seven principles:

- Holistic process
- Early Intervention
- Individualized Approach
- Active participation of the individual
- Collaboration
- Qualification of Experts
- Monitoring and Evaluation

This “best practices” approach to RTW calls on the Board to have a service culture with a level of agility and expertise which, at present, it does not have. In my view, to modernize and achieve its RTW objectives, the Board must develop a fundamentally different service delivery model, including how it makes, corrects and implements decisions. This service culture must be worker-centric and effective so it is done in a way which has the confidence of all stakeholders.

In particular, if RTW is simply used as a quick way to get injured workers off benefits, RTW efforts will have no credibility and will not be effective for most workers. Injured workers will correctly have no confidence in such a compensation system. But the service delivery must also be accessible, cost-effective and appropriate for all employers, including small employers to ensure employer confidence as well.

What would such a culture look like in practice? This Report provides some specific recommendations for changes to service delivery and case management in keeping with a worker-centric focus and this vision of independence. In particular, it means, as an organization, abandoning the “moral hazard” approach to compensation benefits and its attendant harms. It means supporting workers in their particular disability journeys and recognizing how difficult they are. The following vision came from an injured worker, a mental health care worker who was recovering after being badly beaten by a client:

“If you want to stop the violence, return individuals to work faster, have a successful recovery rate, then everyone who is involved needs to change the way they practice. If individuals are not treated well and continue to experience being traumatized, how can this be helpful with their recovery. The mental stress that I endured after the incident was far more damaging than the actual incident itself.… WCB needs to individualize cases, people are not automobiles we do not all come from the same mold.

I needed someone to have my back and support me. I needed someone who was completely neutral who did not have an agenda. I needed someone to stand up for me when people were being unkind. I needed someone to coordinate services.”

While this Report addresses specific issues in detail, I recommend that this new direction be supported through legislation. Specifically, I recommend that the Act be amended to include a
preamble or statement of purpose, as has been done in several other jurisdictions. A clear statement of purpose in the legislation confirms that the Board’s proper role is to assist injured workers in the recovery and rehabilitation process and that it is not harmful to the worker to do so. Such legislative statements also confirm that the Board is founded on the principles of the Historic Compromise and these principles constitute its core mandate.

It would also ensure that the Act defines its core remedial purpose (among others identified in the Historic Compromise) and that this remedial purpose is given a “fair, large and liberal construction and interpretation as best ensures the attainment of its objects” as required by section 8 of the Interpretation Act. This is a crucial first step in modernizing the service culture in the B.C. compensation system.

Finally, a preamble and statement of purpose would also assist in explaining the meaning and object of the Act to decision-makers and lead, over time, to greater consistency in decision-making and Board culture.

Having reviewed the provisions in other jurisdictions, I recommend that a preamble and statement of purpose be modeled on the language in the Yukon Act but modified for British Columbia. I have set out recommended wording for a preamble/statement of purpose in the attached recommendations, in addition to the general recommendation below.

**RECOMMENDATION #1**

I recommend that the Workers Compensation Act be amended to include a preamble and statement of purpose as set out in detail in the Attachment to Recommendation #1.

There are a few elements of service which are essential to a worker-centric service model and these are addressed below, in the context of current Board practices:

- Effective and Respectful Communication
- Effective Consideration of Individual Circumstances and Evidence
- Patient-Centered Medical Care

Improvement in Board service in these particular areas begins with a clear channel to hear and understand the experiences of injured workers with compensation services. Only by listening and fully hearing their experiences with injury and disability – what does and does not help – can the compensation system develop effective worker-centric services. I particularly thank the over 150 workers who publicly shared their experiences and recommendations with this Review.

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25 Purpose Statements/Codes of Conduct Jurisdiction (WCB-IR-0003(4))
(NOTE: Employer’s concerns about these same areas are noted throughout and their particular issues are more fully addressed in the RTW context.)

The Experience of Injured Workers is Not Heard.

The Board measures its performance in several areas, using Key Performance Indicators (KPI’s). One of the ten key KPIs is “improved injured workers’ rating of overall experience”. In 2018, this rating was based on a random survey of 800 workers conducted by a market researcher. The 2018 KPI measurements were that 79% of injured workers reported a “good or very good” “overall experience” with the Board, 7% (56 workers) said they had a “poor or very poor” experience and presumably, the remainder 14% reported an “average” experience.

I have concerns about the use of this figure to measure “worker satisfaction”. It may be a helpful snapshot if it is understood as providing limited feedback (structured response on a rating scale) on a limited random sample about a complex experience (compensation). It may well flag service attention points. However, as a KPI, the rating purports to measure worker satisfaction for purpose of assessing the Board’s delivery of compensation services to injured workers. A rating of this nature is simply not up to this task. It is a poor substitute for meaningful measures of worker satisfaction with Board such as qualitative feedback from injured workers (exit interviews, open-ended questionnaires) or meaningful consultation with worker representatives.

As a KPI, it also gives a public impression that Board performance can be measured by a simple “worker satisfaction” rating, that a level of “dissatisfaction” is to be expected from workers whose claims are not accepted and that overall rating results indicate that workers are largely satisfied with the Board’s service performance. This public stance does a disservice to the Board. It explicitly dismisses “dissatisfaction” as primarily due to “sour grapes” and masks some serious service delivery issues. Issues which are not recognized, cannot be addressed. It is also inconsistent with the high level of complaints from injured workers, which prompted this Review. In light of other measurements, it is highly unlikely that the voice of the customer measurements are fairly representative of the experiences of injured workers. A retired, long-term director of the Board wrote in his submission to the Review:

> It is absolutely ludicrous to claim that 93% of workers and/or employers today are as satisfied as the current Board proudly boasts. I am reminded of a Disraeli quote (often attributed to Mark Twain) “There are three kinds of lies: lies, damn lies and statistics”. I have met hundreds, if not thousands, of workers during my career and I seriously doubt that even 50% were reasonably satisfied”.

26 2018 Annual Report and 2019-2021 Service Plan (page 30). Publication date: May 31, 2019
In the context of the complaints below, this KPI engenders little confidence that the Board appreciates or is committed to improving service to injured workers. I recommend that it be discontinued, at least in its present form.

**Other Indicators of the Experience of Injured Workers**

Every year, there are almost 2,000 complaints made by injured workers to a combination of the Board’s Fair Practices Office (FPO), the office of the Provincial Ombudsperson (PO) and the constituency offices of Members of the Legislative Assembly of British Columbia (MLAs). A summary of these complaints and the various complaint process are set out in Appendix 13.

The public consultation process in this Review gave considerable insight into WHY some workers, particularly seriously injured workers, had poor or very poor experiences with the Board. Almost without exception, the workers who had the worst experiences were workers with serious or multiple injuries, head injuries or concussions, psychological injuries, older workers who may be expected to have a hard time with RTW or VR and young workers who were seriously injured, especially if they lived out of province. Most complaints were from workers with these types of injuries, rather than from workers whose claims were denied. After listening to numerous of these individuals, I believe that there is much to be learned from consulting with individual workers and their representatives, including the following:

- Many of the workers who presented at the public hearings made numerous complaints to various levels for many years, and often had “threat” codes on their files. To a person, their presentations to the Review were respectful, thoughtful and helpful. They just wanted to be heard. Many wrote or called afterwards to thank me. In my opinion, the Board’s attitude towards injured workers who complain is dismissive and likely exacerbates their negative interactions with the Board.

- Often at the root of a very dissatisfied worker, is either an unfair or unexplained decision or a hostile or rude interaction. The unfairness, unaddressed, can and does fester. Instead of dismissing complaints as a “part of doing business”, there needs to be an effective mechanism to hear and address complaints.\(^\text{27}\)

This assessment is based not only on the public presentations by injured workers but also on the presentations and submissions of experienced worker representatives and on my authorized review of many claim files.

\(^{27}\)While this section addresses worker complaints, it is clear from my consultations that many employers also have complaints. All are addressed in the later section on a complaint resolution.
Finally, the results of the online questionnaire are remarkable: 878 workers responded, of which 543 (about 66%) had their claims accepted. Injured workers with accepted claims provided when asked about their level of satisfaction with particular aspects of the Board process.

<table>
<thead>
<tr>
<th>Level of satisfaction with:</th>
<th>Very satisfied</th>
<th>Average</th>
<th>Unsatisfied/Very unsatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Process</td>
<td>25.64%</td>
<td>20.98%</td>
<td>53.26%</td>
</tr>
<tr>
<td>Board’s Communication</td>
<td>15.46%</td>
<td>16.56%</td>
<td>66.63%</td>
</tr>
<tr>
<td>Quality of Decisions</td>
<td>14.48%</td>
<td>13.01%</td>
<td>71.04%</td>
</tr>
</tbody>
</table>

I understand that workers who chose to fill out a questionnaire, like those who attend a public hearing, are not likely to be those who were satisfied with the Board, and I do not consider that these figures represent a “full picture”. But the results are strongly indicative of a serious level of discontent about the Board’s services, from workers with an accepted work injury. Overall, there is a considerable lack of confidence about the quality of the Board’s decisions in those cases.

There is no doubt that complaints about service, treatment and decisions are endemic to compensations’ difficult mandate. The question is, how should complaints be understood? In

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28 A complaints office was first recommended in 1966 by Mr. Justice Tysoe. By 1987, the BC Office of the Ombudsperson noted that about 25% of its office’s resources were devoted to handling compensation cases.
my experience, individual stories are in the nature of a “Proof of Concept” – how does the compensation system actually work or not work in the execution of its difficult mandate? The KPIs target is not helpful. It confirms the general profile but masks the problem and with it, an opportunity to correct systemic and individual areas in need of change.

Later in the Report, I recommend that an external Fair Practices Commission be established and report annually to the BOD, on both individual and systemic complaints. In my view, this type of report would assist the BOD in its understanding of stakeholder satisfaction.

#1. EFFECTIVE AND RESPECTFUL COMMUNICATION

There was a strong response by all stakeholders that Board’s communication practices and capacity should be a top priority for this Review under its TOR. Stakeholders – workers and employers – expressed concerns or dissatisfaction with Board communication practices and the responses covered a wide-range of issues from technology to staff conduct. Many emphasized the important role of communications in compensation outcomes. These many issues are discussed below, together with recommendations.

**Issues in Service Conduct by Telephone**

Teleclaim:

While there were many positive comments about Teleclaim staff, there was a general concern about the practice of using a verbal form of communication alone to provide the evidentiary basis for a claim. There were additional concerns by workers who were not fluent in English or who had difficulty accessing or speaking on the phone. As one stakeholder noted:

> The current Teleclaim process operates under the expectation that injured workers will be able to verbally provide a complete and comprehensive account of the mechanism of injury through one telephone call. This has had disastrous effects on claims from a creditability standpoint.

I recommend that the Teleclaim process be amended to the worker an optional questionnaire to provide a fuller written statement of the mechanism of injury to supplement their application.

Communication by Telephone:

Many of the communication issues identified in this Review related to phone contact (or lack thereof) between various parties outside the Board and claim owners. Workers, employers, health care providers, and representatives gave detailed descriptions of their difficulties in making phone contact with claim owners.
At the Review’s request, the Board’s provided the following call answer rates in the table below (WCB-IR-0056):

<table>
<thead>
<tr>
<th>Claim Role</th>
<th>Calls Answer Rates</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019</td>
<td>2019 (till 04/30)</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Customer Care Agents</td>
<td>95.00%</td>
<td>93.00%</td>
<td>94.00%</td>
<td></td>
</tr>
<tr>
<td>Client Service Representative - Teleclaim</td>
<td>94.00%</td>
<td>87.00%</td>
<td>91.00%</td>
<td></td>
</tr>
<tr>
<td>Entitlement Officer</td>
<td>27.82%</td>
<td>23.44%</td>
<td>26.60%</td>
<td></td>
</tr>
<tr>
<td>Service Coordinator</td>
<td>31.44%</td>
<td>24.30%</td>
<td>29.53%</td>
<td></td>
</tr>
<tr>
<td>Case Manager</td>
<td>16.55%</td>
<td>16.97%</td>
<td>16.38%</td>
<td></td>
</tr>
<tr>
<td>RTW Specialist</td>
<td>31.00%</td>
<td>26.92%</td>
<td>29.76%</td>
<td></td>
</tr>
<tr>
<td>Vocational Rehab Consultant</td>
<td>24.53%</td>
<td>24.66%</td>
<td>24.55%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Answer Rate</strong></td>
<td><strong>35.32%</strong></td>
<td><strong>43.00%</strong></td>
<td><strong>40.47%</strong></td>
<td></td>
</tr>
</tbody>
</table>

The table shows that calls to entitlement officers are answered 26% of the time and calls to case managers are answered 16% of the time. These are the figures which document the common complaint that call messages left are not directly answered or are not returned.  

The Board is aware of this problem and issued the following Problem Statement:

**Problem Statement:**

Some case managers struggle with managing telephone communication with our clients. The time it takes to listen to voicemails, return phone calls, and take repeated calls takes time away from recovery and return to work activities.

However, failure to answer calls or return calls has consistently been identified as a communication issue, while negatively impacting our VOC results.

The Board began to pilot a new model for call management but had to put this project on hold in July 2019 due to what are described as technical problems.

The low response rate may well involve staffing issues as much as technology. Claim owners told the Review that meeting the system demands for case management tasks prevents them from contacting and returning calls. As one case manager put it:

*It is very contradictory to have a “worker-centric” model yet be pressured all the time, as a CM, with metrics and statistics. CM claims are typically difficult and challenging, and interview calls, especially initial ones, can average close to an hour in duration. Calls from distressed clients or clients with mental issues also take a long time, no matter how brief we may try to keep them…. A CM gets an average of 15-20 calls per day; it is impossible to answer the phone for every one of these calls, plus listen to the many voice mails, and place outgoing calls, in addition to all other.*

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29 WCB-IR-0074 regarding WorkSafeBC’s new telephone system; specifically, features that allow tracking of staff phone call answer rates and support improved response to incoming calls.
worker required of a CM; there is not enough time in one day even based on phone call work.

Personal service is an important factor for building trust among all stakeholders. It is critical that any impediments to good personal service be effectively addressed and I note that this has been successful in other compensation bodies. I consider that the Board has sufficient resources and expertise and that the current leadership seems clearly focused on this goal.

However, even with an improved phone system, phone contact is problematic way to effectively communicate through a compensation claim.

The Review heard many examples of communication difficulties caused by the Board’s reliance on telephone communication to contact injured workers. These examples included:

- Workers working in rural locations or on shift work had difficulty making phone contact with a claim owner due to their schedules. Sometimes, their “telephone tag” would go on for weeks or even months, leading to great frustration on their claims.
- Workers who did not speak English had difficulty in initiating a call. (If the worker received a call from the claim owner, the translator with the Language Line Service was pre-arranged by the claim owner.)
- Worker with a severe larynx injury could only manage a broken or short conversation once every several days. Sometimes, she would arrange for a neighbour to call for her and leave messages and she had great difficulty in responding to a claim owner’s call.
  - These problems are inherent in telephone communication. Phone calls require both parties to be available at the same time and to speak clearly in a mutually intelligible way.
  - Phone calls are also a very problematic way to collect evidence. Many workers took issue with the claim owner’s written summaries of their exchanges, saying that claim memos were incomplete, inaccurate or misrepresented the workers’ information. These same issues were noted by some employers. These disputes are difficult and often become issues in complaints and appeals.
  - Communication modalities have changed rapidly over the last few decades and other forms of two-way communication like emails and text messaging are routinely used outside the Board.
  - Yet the Board’s relies almost exclusively on mail and telephone exchanges to communicate with stakeholders. Given the current limitations of these modes and the Board’s current level of service, I strongly recommend that the Board modernize

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30 The EAO told the Review that they have been able to put in place a system that ensures all calls have a warm transfer that results in positive actions on all calls.
and improve its communications with stakeholders by adopting additional new forms of communication, including email as set out below.

I also recommend that the Board install a system for recording phone calls for quality control purposes, such as is used in most businesses today. Such a process would have the advantage of providing a back up for both staff and stakeholders regarding the content of any particular call.

**Email – a communication option**

The Board has as a practice of not allowing email to be used as a form of electronic communication with outside parties. In answer to questions, the Board has stated that email communications are not authorized due to potential privacy concerns.

However, last year, an email pilot was conducted out of the Courtenay office for all claims, after being vetted by the Board’s Legal Services Department. In this pilot, all claim roles were able to communicate with workers, employers, worker representatives, employer representative and providers by email. The email content was permitted for transactional information. It was not permitted for sensitive personal or medical information, decisions or resumes. Workers were asked individually if they wished to participate, and those workers wishing to participate did so with informed consent. Employer participation in email communication was similarly voluntary.

The project received positive feedback from Board staff, managers, workers, and employers that included:

- Better service to workers and employers in remote areas
- No more phone tag
- Emails were answered right away, that day.
- There is better, clearer documentation of communications
- Administrative tasks and forms can be communicated with the emails.

During the term of this email pilot there were no breaches of privacy. There was no inundation of emails. The emails did not replace phone calls but anecdotally the number of incoming phone calls decreased significantly. The project also found some unexpected efficiencies. In effect, the communication purpose could be completed by each party at different times, when it was convenient and when that party had prepared an answer.

There were some challenges in integrating emails with CMS. There was no ability to email directly from a CMS file or count email communication to a worker or employer as a CMS contact. These technical problems are likely readily resolvable.
While both management and staff in the Courtenay office gave very positive reports on this pilot, this pilot does not appear to have been advanced for further consideration or be widely known at the Board. This is a concern.

**RECOMMENDATION #2**

That the Board implement the use of email in its communications with stakeholders and third parties throughout the compensation process as soon as possible.

**On-line Services**

There were a number of comments, mostly positive, that on-line services had made certain documents more accessible, especially for disclosure, claim files and certain documents for employers through the employer portal. I gather that consultations are on-going in this area.

From various responses, I would make the following comments for improved service delivery for on-line services.

- Some workers and some employers had difficulty with these on-line services. The Board’s web-site seems to require a high degree of literacy and computer literacy. I recommend that the Board provide a “Help Line” number with personal service to assist stakeholders with these on-line services.

- In some areas of the province, internet service is expensive or not reliably available or not available at all. I recommend that the Board have a communication strategy for providing better electronic access to its services in such locations. Various suggestions given to the Review included having the Board:

  - Partner with other provincial programs like WorkBC to have computer time and/or dedicated computers available for use by workers and employers in that area who do not have access to computers or internet. [Such access is currently not possible].

  - In serious cases, contribute to the cost of a cellular plan to allow injured workers access to texts, emails and phone messages with the Board and doctors. [Many farmworkers use this technology in the field.]
Other Modes of Communication – General Comments

Many stakeholders commented that some social media modes of communication are ideal for better one-way education. The Board could make more videos explaining the claims and compensation process, with closed captions in multiple languages, with overlays. These videos could be pinned on YouTube, the Board’s website or on other social media pages. I believe that stakeholders – employers and workers - would be interested in participating in the creation of these materials for their specific workplaces or populations.

Others commented that apps can offer interactive efficiencies in the compensation context and noted that several companies have developed interactive platforms which allow real-time multi-party communications for informal problem solving during a RTW.

Some doctors commented that an interactive portal for physicians would be helpful.

Servicing Many Languages and Cultures

The Board currently contracts interpretation services through “Language Line”. This allows a claim owner to arrange for an interpreter join on a scheduled phone call with a worker or employer. The Review heard from many frustrated stakeholders, especially farmworkers and their employers, that there were significant limitations involved in this approach. The common complaint was that such interpreters were not familiar with the nature of the work or compensation terminology, so there was confusion and a lack of confidence that information was clearly received or conveyed.

A Board officer made the following comments and suggestion:

Be more multilingual in our communications, information, and staff. Many BC workers’ and employers’ first language is not English. Yet, the majority of our mailings, sources, publications etc. remain in English only. Therefore, we suggest including a standard, multilingual message [sample from Metro Vancouver was provided] such that whoever receives written communication from us can better appreciate the importance and urgency of the content.…

Workers are more open and comfortable interacting with us when we speak their languages. Although we have access to a 3rd party translator/interpreter service, sometimes the important details get lost in translation or misunderstood, especially when the translator or interpreter does not have the necessary understanding of our terms and processes. Having our own multilingual staff to properly translate, interpret and communicate with injured workers would be beneficial.

This approach would make effective use of Board resources and bring the same lens of diversity and inclusiveness to Board communications as now exists in other public bodies. It would also acknowledge and promote diversity in the hiring of Board staff. I recommend this
approach to supplement the Board’s use of “Language Line” which still may be needed in many exchanges.

**Decision Letters – The Need for Plain English with Reasons**

The Review heard from many participants – workers, families, employers, third parties – that the Board’s decision letters are complex, bureaucratic and difficult to understand.

Many workers reported not only being confused by these letters but also overwhelmed, humiliated or beaten down by having important decisions about their injury delivered through bureaucratic, incomprehensible jargon.

In particular, many workers report trying to puzzle through verbatim passages of Board policy as part of the decision only to give up trying to understand the decision. It is a common experience with worker representatives and the WAO to have a worker arrive with a decision letter and inquire, “What does this mean?”

I also saw a significant inconsistency in the quality of decision letters. Some set out evidence and reasons while others contained very little information and simply stated the policy and the decision. Some decision letters still displayed the template options. Almost all cited long passages of policy.

I recommend that the practice of quoting long passages of policy be discontinued. It interferes with the clear and respectful communication of that decision and it is confuses or obscures the basis for the decision. In my view, it is essential that the Board’s written communications be done more clearly, substantively and respectfully, making the reasons for a decision are transparent.

I also strongly recommend that the Board commit to a “Plain English” approach to decision letters. If this is adopted, form letters will need to be reformatted and staff will need guidelines on how to adopt this approach in their written communications. I recommend that the Board engage a subject matter expert in “Plain English” adaption to ensure this approach is undertaken efficiently and professionally, as has been done by many other organizations.

In my view, the changes to decision letters should include:

- Decision letters should set out the decision in the initial paragraph. The letter should then briefly summarize the key evidence and the reasons (from evidence and policy) for the decision.
- The literacy standard should be whether the average worker or employer with a grade 8 education could easily understand letter, including the key decision in the letter.
NEW DIRECTIONS:
WCB Review 2019

- If a detailed reference to policy is necessary to explain a decision, the decision letter should provide a simple summary of the key policy point and note that the full policy is attached.

**RECOMMENDATION #3**

The Board commit to a “plain English” form of written communication of its decisions and develop guides and form letters to support this practice.

**Respectful Communication with all Stakeholders**

In the public consultations, one of the overwhelmingly common complaints was about disrespectful, rude, hostile or unfair verbal communication by Board officers. This matter was raised by all stakeholders, injured workers and employers, and was a dominant theme in the questionnaire responses.

All stakeholders – injured workers and employers – have a right to be treated respectfully and with respect by Board staff at all times. The Board recognizes this basic tenet of good service delivery and has recently made respectful communication an important “brand” issue.\(^{31}\) However, the recent initiative consists largely of a staff guideline, with stakeholder feedback drawn from “Voice of the Customer” (VOC) surveys. This initiative over-simplifies the complexity of the communication issues and provides no transparency or remedy for stakeholders.

Previously, the Board made a strong effort to address this issue for employer stakeholders. In 2012, it issued a public document, the Employers’ Fairness and Service Code\(^{32}\) (Employers’

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\(^{31}\) WorkSafe recently published a *Code of Business Ethics and Behaviour* (effective February 1, 2019) setting out policy and guidelines for staff conduct. While much of the Code relates to human resources issues, the Code requires staff to “behave in a manner that reflects our WorkSafeBC character – respectful, caring, fair, knowledgeable, understandable, and responsive,” (p. 10).


The Code included both basic customer service standards in plain English and a
description of the “rights” of the employer, including:

- Right to courtesy and respect
- Right to privacy and confidentiality
- Right to fair treatment
- Right to access and communication
- Right to complete, accurate, clear and timely information
- Right to pertinent advice
- Right to question our decisions

According to employer questionnaire responses from employers, these basic standards are not
being met, at least not consistently. And the standards do not apply to communication with
injured workers.

The standards set out in the Employers’ Code do not constitute a high bar. They represent a
basic standard of service delivery that should be part of a compensation tool kit and the
professionalism expected of Board staff in dealing fairly with all stakeholders.

While the Employers’ Code sets out excellent standards for respectful communication, clear
standards alone are clearly not sufficient. To be effective, service standards require full
implementation and mechanisms for accountability. Board staff often face difficult, real life
situations and they need the support, leadership and resources of the Board to consistently
achieve these goals in their day to day work. However, the Board must also establish
appropriate accountability mechanisms to monitor, correct and if necessary enforce the service
standards. It appears that the Board has some difficulties in this area and I leave this as an
attention point.

Given the many reports to this Review and the importance of this issue to all stakeholders, I
recommend that the BOD publish a Code of Conduct for Fairness and Service which sets out
the rights of all stakeholders to specific service standards. I recommend that the Code of
Conduct also include an accessible and transparent path (informal and formal) to remedy any
breaches. In my view, a formal public commitment to the Code of Conduct is the only way to
improve stakeholder confidence that a basic level of respectful communication is important to
the Board and that breaches will be addressed.

This important step should have legislative support. I recommend that the Act be amended to
include a provision requiring the Board to establish a detailed Code of Conduct for Fairness and
Service for all stakeholders. The Alberta Act is a good model for the wording of this legislative
requirement. The Act should also provide that the Code is separate from Board policy and
therefore a breach of the Code of Conduct is not an appealable Board decision but may be
addressed by the Fair Practices Commission, as recommended in this Report.

I recommend to the Board that it adopt a Code of Conduct modeled on the 2012 Employers’
Code (adapted to be appropriate for all stakeholders) and that it include both an informal and
formal complaint options. The informal option could refer stakeholders to an internal liaison or
complaints officer who will try to resolve the issue informally with the stakeholder and the Board
officer. If the matter is resolved informally, there is no record of the complaint. If the matter is
not resolved, the stakeholder may pursue the matter with the Fair Practices Commission.

RECOMMENDATION #4

That the Workers Compensation Act be amended to require the Board to develop and publish
a Code of Conduct.

That the Board develop a Code of Conduct for Fairness and Service for all stakeholders
based on the present Code for Employers and publish this Code on its website and on all
forms.

Role of Empathy and Support to Injured Workers/ Words Matter

There is a human aspect to injury that requires compensation service delivery to be different
from that of an insurance company. As one worker said, we are not like cars – just bang on a
new fender and we are good to go. Injuries, especially serious injuries, affect all aspect of a
worker’s life and impose a burden on workers and their families far beyond the worksite. This is
part of the Historic Compromise as noted in the Petrie Report:

Workers bear the heavier burden of dealing with the pain and suffering resulting
from the injury, the disruption to their lives and livelihood, and the financial stresses
that often accentuate the resulting disablement.\(^{33}\)

In addition to the visible burdens, there is the less visible journey that an injured worker (and
family) must make, in adjusting to a life with a permanent impairment. It is different for every

\(^{33}\) Page 66, Petrie Report.
worker. The changes from an injury can be profound, requiring a change of work but also of a way of life.

For many workers, their communication with a claim owner plays a key role in their adjustment to a difficult situation. The critical importance of communication at certain stages gives the Board an important (an inexpensive) tool in the recovery journey—empathy and support. But it also gives Board officers enormous potential to play a negative role, unintentionally or otherwise. In many presentations, workers highlighted the key role played by a case manager’s communication in their journeys of recovery. Their testimony confirms research findings that supportive communication with a claim owner can be an important step in rehabilitation. The opposite is also true.

Sometimes, appreciating the extent of this impact is only possible by listening to the life stories of injured workers. Attached in Appendix 4 is one such story. This unedited statement was presented at a public hearing by Kristin Thompson, the wife of an injured worker, Caley Thompson. Like so many other presenters, Kristin and Caley provided this story so the Board could learn and improve in its service to injured workers in the future. I attach this statement because it includes detailed instances of both supportive and negative interactions with claim owners and the impact of those interactions. It is also powerfully written and representative of so many of the personal accounts to this Review, presented by injured workers and/or a family member. There were many other powerfully written and/or presented cases and with greater resources, this Report would have included many other case studies as well.

The Thompson story includes the following excerpts:

*It was the caseworkers understanding and appreciation for the circumstances that gave Caley the confidence to move forward and continue on his path to returning to work as a millwright. For that I will be forever grateful.*

*The case worker that had been assigned to our file was the exact opposite from our previous case worker. She didn’t believe my husband. Because of that she wouldn’t listen to anything that he had to say and would constantly talk over him. She had a knack for leaving all the important information she needed to pass on as a message 4:30 on a Friday afternoon, so we were not able to return her call until Monday and got to stew over any bad news all weekend until we were able to get an explanation.*

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...nowhere was I able to find any documents on what is expected of the case worker. What policies are put into place to protect the employee. Even the employees advocate office [Workers Advisors] wasn’t able to help us in this scenario.

It has been the actions of the WCB and its advocates that have pushed my husband to the point that he feels the only way anyone will believe his struggles is to end his life.

If you able to take anything away from my story, please remember that how someone is treated from the beginning of any processes, can greatly affect their outcome. Lets create a tribe of people who are unbiased, not judgmental, and supportive of the situations these workers are going through. Spending a little more time listening and exploring instead of just stopping when you are not able to see an obvious solution. Not everything is black and white. People are worth the time you put into them.

Some injured workers, like Thompson, identified the positive force that words of encouragement and hope played in their recovery. Several reported that there were occasions where the understanding and compassion of a Board officer “literally saved my life”.

Others reported instances where a claim owner expressed indifference, dismissing a worker’s urgent concern by saying “Not my problem”. This indifference to the reality of the “whole worker” can be devastating, especially to a worker who is trying hard to recover and RTW. One young worker appeared before the Review with supporters. He had been injured fighting wildfires when he fell with a heavy pack. Despite an intense rehabilitation and RTW effort, he was not able to return to his chosen occupation with its comradesy, excitement and physically active outdoor way of life. He was struggling to cope when his case manager told him to stop complaining because he was “more than capable of pushing a broom”. This comment sent him into a mental tail-spin, from which he was still trying to recover.

And there were several presentations were the exact words of a claim owner, spoken with derision or hostility, were remembered as a fresh injury, years later. More than one worker reported being called a “loser” and being sworn at by a case manager. One worker reported that his case manager commented as a Board employee, he could do and say “anything he wanted” because any negative impact on the worker was “non-compensable”.

One presenter spoke from a wheelchair, where he has been since he was injured as a young man over 25 years ago. This worker successfully re-trained and has worked full-time for many years and must be considered a success story. But for “lessons learned”, he offered this:

*The quality of one’s life after suffering a minor or major injury, may be profound.*
[But] how I've been treated, to the lack of professionalism to the removal of personal choice, respect, recognition and input has been in a lot of ways harmful…

A compensation service that is worker-centric should be founded on a deep appreciation of the life adjustment that an individual with a serious injury must face and utilize the positive power of supportive and empathetic communication. Some claim owners already utilize this approach. Others do not.

I also recommend Board programs directed to adjustment issues, such as “Adjustment to Injury” counselling. I also note medical practitioners and counsellors have special training in empathetic communication. Both would be in-house resources for any staff training which may be required, going forward.

But this is likely to be one of the most difficult areas in Board culture in which to affect widespread, consistent and meaningful change. It requires a change in the organization’s definition of its role – to address the “whole worker” and issues of real barriers to RTW – and find ways to change in some entrenched service delivery practices. I make no specific recommendations in this area and leave it to the Board to find ways forward, in the context of this Report.

However, for there to be confidence that injured workers will be treated with respect, going forward, it is essential that there be injured workers be protected from abusive communication and that they, and employers, have access to an effective remedy, without retaliation, if they are belittled or threatened or humiliated by Board staff. The remedy must be sufficient to restore their dignity. In my view, only an ombudsperson type body, external to the Board and with the authority to receive and resolve such complaints can offer this assurance. Below is my recommendation for a Fair Practices Commission.

NOTE: It is apparent that once a claim owner develops an adversarial relationship with an injured worker, the claim owner’s negative views colour that claim file and the worker’s relationship with the Board through the life of that claim. And as noted above, many of the worker appearing in the public hearings for this Review, had “threat codes” on their claim files. In 2018, the Fair Practices Office raised the systemic issue that once a threat code was placed on a claim file, it was left there without review. [Appendix 13] This practice has now changed as a result of the FPO flag. I recommend that the FPO also be available to be a neutral party in cases of ongoing conflict between a worker and a case manager, and assist if a change in case assignment is requested or advisable.

Face to Face Communication

Face to face meetings were an important part of Board service in the past. While they may no longer possible in all cases, this communication tool should be encouraged, and required in all
cases where the worker has suffered a serious injury. These meetings could take place on neutral ground such as a hospital or union hall or at a worker’s home, if that is appropriate in the circumstances. (I understand that Board staff have had security concerns about home visits). Also, options offered by technology should be considered. Skype provides an excellent way to have face to face contact over distances. Seriously injured workers could be offered an IPad (on loan) for this purpose.

If the service culture at the Board is going to change and become more “worker-centric”, more Board staff will have to develop personal, supportive and compassionate relationships with injured workers. This is very difficult without at least one face to face meeting.

#2: EFFECTIVE CONSIDERATION OF INDIVIDUAL CIRCUMSTANCES & EVIDENCE

A worker-centric approach to decision-making requires that a worker’s individual circumstances be taken into consideration, the same requirement that underlies the best practices guidelines for medical care and return to work. Quality decision-making also requires obtaining and fairly weighing evidence sufficient to support a reliable conclusion. Currently, a Policy Review is assessing how to draft new policy which takes court decisions about the Board’s approach to evidence into account.

In this Review, it was striking the large number of respondents - workers and employers - who identified that the Board did not obtain and consider relevant evidence of their individual circumstances when making a decision that affected them. This included a wide range of complaints such as:

- the Board did not adequately investigate issues before deciding;
- the Board did not consider, listen to or accept evidence;
- the Board did not fairly weigh evidence; and
- when presented with contrary evidence, the officer would say “if you don't like it, appeal”.

The volume and variety of complaints about this issue suggests that there is a systemic problem with the quality of first-level decision-making. From this Review, I conclude that certain elements of Board culture and processes lead first level decision-makers to undervalue or discourage the collection and consideration of evidence. This presents a significant stumbling block to any progress towards a more worker-centric compensation system and poses a significant problem in modernizing the B.C. compensation system to include an effective RTW component.

The particular views and associated decision-making practices of concern (which appear to be fairly wide-spread) are as follows:
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• That Board decisions may be made primarily on the basis of policies and guidelines. This is considered acceptable because Board policies are binding and because the Guidelines attached to the worker’s diagnosis give a reliable framework (“one size fits all”) and the result will be “average justice”; and

• That the appeal process is the appropriate way to address additional or new evidence or correct decisions.

Two policies which are particular flash-points are addressed in later sections - the “Plateau” policy # 34.54 and the “Light Duties” policy #34.11. Issues concerning medical evidence and the role of Board Medical Advisors (BMA) are addressed in the next section on “Patient Centred Care”.

In this section I will address the more general framework regarding the role of evidence in the Board’s decision-making process.

**Merits and Justice – The Primary Principle**

The fundamental principle of a worker-centric compensation system is that cases are decided on the merits and justice of a case, a principle which has been fundamental principle in all compensation systems.

In B.C., section 99(2) of the Act requires the Board to make its decision based on the “merits and justice” of the case but in doing so must also apply Board policy. The additional requirement to apply Board policy was introduced in 2002 for the purpose of improving the quality and consistency of decision-making. Policy #2.20, which interprets this provisions, was recently revised, effective July 1, 2019, to provide clearer direction about how decision-makers are to address the “merits and justice” requirement in light of the dual requirements; that is, “merits and justice” are to be considered when Board policy is discretionary or does not apply. However, it is still the case that if Board policy is directive, the policy must apply regardless of the merits of a case.

Consistency of decision-making is one of the key concerns expressed by the Employer’s Forum. Consistency in decision-making, especially over a large range of cases, is very important as a matter of fairness and for the confidence of stakeholders, particularly employers, in the compensation system. However, consistency cannot mean making the same decisions for everyone, regardless of merit. Such an approach will necessarily be unfair to some. One size does not fit all.
While quality decision-making was a goal of the 2002 amendments, it would be hard to argue that section 99(2) of the Act has improved the quality of decision-making at the Board. As one stakeholder put it:

*What this language has done, whether intended or not, is to create circumstances in which the merits and justice are not applied to the case...It leads to strict and unbendable interpretation of policy overriding fundamental principles for decision-making.*

From the consultations to this Review, I agree. My concern is that even with the amendment of policy #2.20, Section 99(2) of the Act still imposes dual requirements on decision-makers and does not ensure that “merits and justice” will be applied in every case. There are many ways to achieve consistent decision-making in a large administrative body, without intruding, intentionally or not, on a decision-makers’ ability and willingness to collect and consider evidence or override “merits and justice” of the case.

Most other Canadian jurisdictions do not have legislation which gives Board policy any special legal status under the Act. Most compensation systems, including Ontario, have legislation which provides that cases must be decided on “the merits and justice of the case”. The Board then enacts strongly worded Board policy which requires that both the Act and policy apply. Board policy provide a clear path for decision-makers, including the use of discretion, but in the end, the Act requires that merits and justice be applied. This gives primacy to “merits and justice” at both the initial level and at the appeal level.

I recommend that the Act be amended to require that compensation decisions to be made on the “merits and justice” of the case, as the foundational principle of Board decision-making. I recommend that the Board then develop policy and appropriate oversight measures to achieve the goal of consistent decision-making. This legislative and policy framework will assist and support Board practices aimed at collecting and fairly assessing relevant evidence while being mindful of the need for consistency in decision-making. It will also assist the development of a service culture focused on communication and collaboration with stakeholders as well as on Board policy.

**RECOMMENDATION #5**

That section 99(1) and (2) of the Workers Compensation Act be combined to read “The Board may consider all questions of fact and law arising in a case and must make its decision based on the merits and justice of the case. The Board is not bound by legal precedent.”

[Section 99(3) to remain unchanged]
RECOMMENDATION #6

That subsequent to the above amendment, the Board further amend Policy #2.20 of the Rehabilitation Services and Claims Manual II to address the issue of consistency in decision-making. The Ontario policy is a recommended model.

Another major factor, yet unaddressed, is how front-line decision-makers work with the MD Guidelines within CMS (the “Guidelines” or “MDG”) within this particular legislative context.

Role of MD Guidelines

A summary of decision-making in CMS, including the role of the Guidelines is set out in Appendix 10. Sample Guidelines are set out in Appendix 15. As noted, the Guidelines “populate” each individual claim file with an expected RTW calendar based on the worker’s diagnosis code. This framework provides the claim owner with a blueprint for each worker’s recovery along with a suggested timeline for adjudicative milestones. As noted in the Guideline Introduction:

In 2012, WorkSafeBC embedded a link to MDG in the Case Management Recovery & Return to Work Planning site of CMS. This access to MDG for case managers and return-to-work specialists is intended to provide quick access to injury information, which is designed to be understood by non-clinicians. It allows claim owners to quickly learn the risk factors, symptoms, diagnostic tests, treatments, prognosis, complications, and disability duration (by job demand category) for injuries affecting the workers they serve.

MDG is a library of information only. It is not relied upon by WorkSafeBC to make entitlement decisions on a claim, nor does it replace medical evidence or opinion on individual cases. The disability duration guidelines in MDG are for information only and are not considered evidence in claim decision-making.

Although the Guidelines state that they should not be relied on or replace medical evidence in individual cases, they do more than just give information.

• Each set of Guidelines is based on a “diagnosis” code so this approach is also referred to as “one size fits all” – that is, all workers with the same diagnosis code, have the same framework of expectations.
• The Guidelines invite claim owners to make decisions on a timeline and within a framework based on averages and statistical predictors and provide little reference how to integrate these averages with medical evidence.
**Concept of “Average Justice”**

The Guidelines represent the integration of medical research with statistical analysis and algorithms; their purpose is not just to educate non-clinical staff on medical conditions, but also to attach statistically likely disability duration and RTW outcomes (with timeframes) for particular diagnostic codes. They do so with great authority. As noted in the Recovery Guidelines for Concussions [Appendix 15]:

*The WorkSafeBC Recovery Guidelines are based on an extensive review of the current clinical literature along with relevant medical, psychiatric, psychological compensation services and rehabilitation input. They are intended to provide non-clinical staff with an overview of the condition in terms of diagnosis, investigation, treatment/rehabilitation, prognosis and expected timeliness and outcomes.*

To the extent that claim owners accept the “expected outcomes” as prescriptive and use the Guidelines to determine appropriate treatments, plateau dates, and RTW dates, they guide the “average” claim to “average justice”. From this Review, it is apparent that there is strong institutional support for an “average justice” approach to claims at the practice level. Several claim owners stated that they considered “average justice” the right approach for a compensation system.

The WAO noted the advantages of CMS:

*..CMS is a comprehensive and sophisticated tool which has become an important mechanism whereby staff at the Board manage caseloads, track metrics and milestones. Measurement and metrics are certainly essential to the proper functioning of the compensation system.*

I agree. However, in its particular application of this important tool, the Board has travelled along the “average justice” path in its initial adjudication practices, without giving sufficient support to the need to collect and weigh evidence. At its extreme, it is a toxic decision-making culture if a claim owner can simply use the Guidelines to make a decision, does not seek/consider/weigh evidence of individual circumstances and then say “if you don’t like it, appeal”. At its barest, the first level decision maker does not apply, or seek to apply, the “merits and justice” of the case.

There appears to be a divide in the service culture on this matter. Some decision-makers see this “average justice” approach as “fair” and not arbitrary because it is based on research and ensures average justice to a large number of workers. Others, particularly stakeholders and most particularly seriously injured workers, see this as completely unfair and unreasonable in light of their particular circumstances.

In a worker-centered system, “merits and justice” cannot be delivered only through appeals for those privileged to engage in appeals, and simply rely on initial decisions to deliver “average
justice”. Appeals require time and resources that injured workers often do not have and should not be required to have in order to get compensation. For many stakeholders the issue becomes - how much justice can you afford? Given the rigors of an appeal process, many workers, and employers, live unhappy with “average justice”, which in their particular cases, does not feel like justice at all.

In my view, “merits and justice” must be both a fundamental principle and an operational reality in Board decision-making at the first level for all stakeholders.

I recommend below that the Board should develop policy to give decision-makers specific guidance with respect to the use of Guidelines in CMS in the context of the “merits and justice” of the case. Practice Directives could clarify that the Guidelines are not to be used as a form of “average justice” and there must be a sufficient basis in evidence for Board decisions.

Weighing Evidence

The Petrie Report noted that policy #97.00 RSCM II gives guidance for investigating claims and weighing evidence in the decision-making process generally, and policy #26.23 gives guidance for occupational disease claims. Petrie recommended that the Board consider incorporating the principles identified in recent court decisions regarding the standard of proof and the weighing of medical evidence into Board policy. During the time of this Review, the Policy Division issued an extensive Discussion Paper arising from this recommendation together with proposed options for change and conducted stakeholder engagement concluding September 23, 2019. Although the results of this policy review are not yet known, I am confident that the court’s issues be well addressed through this process. My recommendations below should be considered in light of any clarification made in this policy process.

There were several presentations related to the weighing evidence given in the reality of injured workers’ lives. Many noted that it is important to understand the medical context in which the worker is responding to questions or making statements, especially in the case of trauma and psychological conditions. Staff need expertise and alertness to interpret the effects of trauma, medication and cognitive impairment on a worker’s ability to respond and participate in the compensation system. Examples provided to the Review included:

- One worker commented that if a statement was taken before a worker is stabilized [from trauma] the worker should be entitled to go back and make amendments. He said that he spoke from personal experience as after his injury, his statement was taken “as I was being dosed by water under an emergency shower, watching the flesh being boiled my leg”.

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- One worker with complex injuries, including PTSD, was referred to a treatment program. When he did not attend, the case manager phoned him to threaten that benefits would be cut off if he did not participate. The case manager did not inquire or consider that at that time, the worker’s PTSD had worsened to the point where he was no longer able to leave the house and was in extreme distress.

Finally, it is important that decision-makers be given clear guidance from Board policy about how to weight evidence in light of Guidelines. Properly used, the Guidelines can signal cases which are outliers and which need greater attention and do so by identifying “averages” and “expectations. However, if the timelines and milestones embedded in CMS are used as “norms” or a baseline from which to weigh the significance of an individual’s evidence, the approach invests a Guideline timeline or milestone with the weight of a “rule”. The approach effectively reverses the onus and requires the worker to “prove” the exception. It may also unfairly cast doubt on the legitimacy of non-average occurrences. Such an approach is not consistent with the “merits and justice” approach to weighing evidence. “Averages” are only guidelines based on statistical formulations and have no particular significance or weight with respect to individual cases.

**RECOMMENDATION # 7**

That the Board develop policy about decision-making in Case Management System such that when a worker’s recovery is deviating from a recovery profile, the Recovery/Return to Work Guideline is removed or disregarded and the worker’s case will be adjudicated based on individual circumstances considered, including whether additional investigation is required. The Board should further develop policy to guide consistent practice in this area, especially about concussions.

**Reporting/Investigation and Evidence of Work Causation**

There is ongoing tension between the need to gather sufficient evidence and the need for a timely decision at the beginning of the claim process.

Board policy sets out the initial systematic stages of claim application, including the following:

- A worker must submit some “basic evidence” to show that there is a claim [ #97.00] and certain injuries must be reported [ #94.12]. The employer is also required to report those same injuries within 3 days, on a Form 7 [ #94.13] The Board may proceed to adjudicate a claim in the absence of an employer report but when the employer’s report is received, the Board can initiate a further investigation and reconsider the acceptance decision if necessary. The employer can also indicate on the Form 7 if further evidence of a workplace investigation of the injury will be provided. [ #94.17]
• There is a Board process to ensure that employers report claim injuries within the 3 day window. Policy #94.15 requires a Board review every six months of employers who have been late in filing their reports of injury to the Board and identify employers who should be “charged with the costs incurred on claims on which the employer is late in reporting until the overall reporting record is shown to have improved sufficiently at the subsequent six-month review.” [#94.15] I was informed that this procedure, established in 1978 to give effect to section 57(7)-(8) of the Act, is not in use. I was told that it is difficult to get employers to submit their F7 claim reports in within the 3-day window and in fact, the “3-day” requirement in section 54 of the Act is virtually “never” enforced. The average time for an employer report is over 11 days. 35 I was informed that First Aid reports are virtually never requested or produced in the normal course of business as it was difficult enough to get F7 reports.

I was informed that the Board has now discontinued its practice of requiring employers to use the Board’s First Aid report forms and that employers now own use their own forms and methods to document injuries (or not). The Board does not require the employer’s First Aid report (in whatever form) to be sent either with the F7 form or at a later date. Some employers reported that their injury documentation is now in a format that could not be easily provided to the Board.

Under the Board’s current procedures, the “best evidence” – the worker’s report to First Aid at the time of injury – remains in the hands of the employer and is not provided to the Board or the worker, unless the employer wishes to produce it. Workers who are later challenged on causation issues are essentially put in the position of having to “prove their claim” without access to critical evidence.

The requirement to produce “basic evidence” should not be the worker’s alone. Work causation is at the heart of the compensation system. First Aid reports have long been an established part of the Employer’s required documentation for a safe workplace so it would not be onerous to require the production of this documentation for compensation purposes. I recommend that the Board amend policy #94.10 to require that employer’s produce any First Aid report related to the worker’s injury as part of the employers’ duty to report the injury. Board policy can specify the format, timing and processes required for the production of these reports and also provide a transition process for employers who require this.

One union submission noted that if there was not sufficient information made through the application process, the Board’s investigation process under policy #98.00 frequently involved

only a call to the employer to get additional details. Too often, the first call to the worker was to advise that the claim was not accepted, made without further investigation or discussion with the worker. This call can be devastating for a worker, prematurely sets a response with the Board and impacts the relationship negatively from the outset.

I recommend that policy #98.00 “Investigation of Claims” be amended in light of the pending policy clarifications on “sufficient evidence”. This policy amendment should include two specifications for early claim adjudication:

- if there is evidence from an employer which suggests that a claim not be accepted, the Board must discuss this with the worker and resolve any dispute through additional investigation, prior to denying a claim; and
- the claim must be considered to be a general compensation claim and the Board must consider and adjudicate it as both a new injury and a re-opening/re-injury. A subsequent recommendation on “re-openings” may make this less onerous as an initial adjudication.

  - Finally, as recommend earlier, a worker reporting to Teleclaim should be offered forms to make a more complete statement of the mechanism of injury to be considered in the initial claims acceptance process.

There were additional procedural matters in the claims initiation process which are addressed later in the Report.

**RECOMMENDATION #8**

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<th>That the Board develop policies and procedures that facilitate and require production of the First Aid report as part of the employers’ duty to report an injury.</th>
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<td>That the Board amend policy #98 “Investigation of Claims” to include:</td>
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**Concussions and mTBI – an exception**

A Guideline inherently presents a common framework for a particular diagnosis – the “one size fits all” approach. Many presenters and representatives identified concussions and traumatic brain injuries (TMI) as a type of injury which affected individuals differently, and which by its
nature needed individualized treatment. In addition, the nature of this injury renders affected
workers among the least able to advocate for themselves. Both the WAO and the Provincial
Ombudsperson identified workers with concussions or minor traumatic brain injuries (mTBI) as
groups that did not do well in the compensation system.

We also heard from a number of workers, families and representatives about how workers, with
this type of injury, experienced the compensation system. One representative, who had
represented a number of workers with concussions and/or traumatic brain injuries (TBI)
described their experiences this way:

- They are like a boat lost at sea. Even reporting their injury to WCB, they don’t know
what to do, how to do it or if they have already done it.
- They get easily flustered and often forget what they are saying. These “memory lapses”
are often mistaken by a case manager as being “lazy” or “their injury can’t be that bad if
they are not following through.”
- The most vulnerable workers are single with no one to help them navigate the WCB
system.
- They don’t have the capacity to think of the future…they are just stuck in this present,
confused, vulnerable state.
- People with concussions often introvert…they suffer in silence.

The Recovery Guidelines for Concussions [Appendix 15] state that in general, 80-90% of mTBI
patients fully recover in less than 90 days. Another 10-20% of persons with mTBI do not
recover within 90 days and may have post-concussive symptoms and that while RTW may be
delayed, mTBI is not a “significant factor for long-term work disability.” In practice, the
Guidelines appear to be used as “norms”. One presenter to the Review had a compensable
concussion for several years. At six months, he was told that his concussion would likely
resolve and he would have no permanent injury so he was off wage loss. He accepted this and
did not appeal. His symptoms have not resolved and he remains unemployed and impaired to
this day.

In April 2019, the Board’s Evidence Based Practice Group (EBPG) issued a paper on
“Concussion Recovery Path and Past Head Traumas” that suggested a different approach to
concussions was appropriate, based on its review of scientific literature.

Concussion diagnosis and clinical management requires a multidisciplinary, but
individualized approach. Personal biopsychosocial characteristics, risk factors,
injury characteristics, and medical interventions all play a role in the patient’s
recovery. Even if most clinical symptoms resolve over time, cognitive symptoms
can become persistent and may have an impact on future psychosocial wellbeing of
the individual.
The EBPG’s recommendation for an individualized approach to the diagnosis and clinical management of concussions is a departure from the “one size fits all” approach of the Concussion Guidelines. I recommend that the Board implement an individualized approach to concussions and formalize this in Board policy.

There were also a number of presentations about a “best practices” approach to case management of head injuries. I have made recommendations for the general case management of “Cognitively Impaired Workers”, in the GBA+ section. These recommendations apply in concussion/mTBI cases as well as the comments below.

- The formation of a dedicated team of case managers assigned to head injury claims;
- Worker with a head injury is assigned to a single dedicated case manager/OT to support them through the claims process. [Note: the experience of cognitively impaired individuals in the compensation system is additionally addressed in the GBA+ section of this Report.]
- An individualized and multi-disciplinary approach to claims management including individual needs and a multi-disciplinary approach to treatment and rehabilitation including not only physicians but neurologists, ENT specialists, physiotherapists, optometrists and related specialists and psychologists.
- That in this type of injury, symptoms are often confused with conditions and vice versa with the effect that PFI awards leave out aspects of a worker’s disability. On a case by case basis, the value of a neuropsychological assessment should be considered in assessing permanent disability.

**Changing a Coded Diagnosis in CMS**

A number of worker and representatives noted that once a diagnosis was on a claim file, it was difficult to get a new diagnosis (for the same condition) added or changed. One example provided was where a worker’s foot injury was accepted as a strain but was later diagnosed as a fracture. Rather than change the diagnosis on the claim, it was suggested that a new claim be started. The same issue arose for recurrences where there was a preference for starting a new claim rather than seek a re-opening. And there were several cases where there were multiple claim numbers for a worker’s injury to different body parts but all arising from a single incident. Multiple claims are confusing and add unnecessary complexity. I am not sure why this occurs but I bring it forward as an attention point.

**Unusual Diagnoses and Chronic Conditions – Individualized Assessment**

Several workers reported injuries that involved unusual medical conditions. These unusual conditions seem to trigger systemic difficulties in the compensation system and the cases
were typified by medical disputes between treating specialists and the Board and many appeals.

One worker provided her story, along with a supportive letter from her MLA. She was injured as a care-aide at the age of 20 while transferring a patient. She developed Post Traumatic Cervical Dystonia, a neurological condition which can be caused by trauma. The Board did not accept the diagnosis and after specialists' reports, it was accepted on appeal. However, the Board's response continued to be adversarial with respect to treatment and disability issues over 14 years. Many of this worker's experiences are echoed in other sections in this Report. But her family member, who made the submission, noted the particular role played by the unusual nature of the diagnosis and made some helpful recommendations. She wrote:

*WorkSafeBC had NO idea what this neurological condition Was. Even the WorkSafeBC website had out dated information, dated 1974!* …

….perhaps employ Case Workers that have some training in the medical profession. Perhaps even set up a Team that includes the Case Worker and Medical staff and Family Doctor, employer, physiotherapist and the injured workers.

*It takes a village to raise a family and it should take a village to assist a worker to get back to work and in doing so, in a respectable manner, because that’s the end Goal. It's our hope that this review brings about a New Standard of care for those with chronic workplace injuries.*

There were other cases of Dystonia but also other unusual diagnoses, including exposure injuries. I recommend that the Board flag certain unusual diagnoses, such as Dystonia, which may need individualize attention from the medical staff from the outset and identify “best practices” case management protocol for unusual conditions. It appears that early diagnosis, acceptance and appropriate treatment play key roles in reducing a worker’s disability, especially for a young worker.

**Feedback Loop on Quality of Decision-Making**

Currently, there is no formal quality feedback loop to claim owners about the adequacy of their individual investigations or decisions when those decisions are appealed. This is a lost opportunity for learning and accountability. It would also help the Board to identify systemic issues and improve decision-making.

In changing the decision-making culture, it is important to develop processes which help decision-makers learn from decisional errors and to recognize and acknowledge good decision-makers. I recommend that the Board develop a process to use appealed decisions as a quality review tool for claim owners. Where a consistent pattern of error is identified, the Board should
identify these patterns and support enhanced staff training or other responses. I note that the Review Division and Fair Practices Office has started in this role, with some success.
RECOMMENDATION # 9

That the Board develop a process to use appeal decisions as a quality review tool for claim owners. In some cases, this may require returning the decision back to the original decision-maker. In other cases, this will not be appropriate.

Practice Directives – Key to the Service Culture

The Compensation Quality and Practices (CQP) group is responsible for drafting Practice Guidelines, also known as Practice Directives (PD). PD are non-binding guides to Board decision-makers about how to implement Board policy in compensation claims. At this time, the CQP group is not connected at an organizational level to either the Policy Division or to the Board’s appeal body, the Review Division. Nor is there a role for consultation with stakeholders. Rather, the PD’s appear to be developed separately under the direction of the Director of CQP, under the umbrella of Claims Services. The Practice Directives are a crucial piece in the decision-making culture and practice at the Board, translating policy into operational practices, yet there does not seem to be an organized feedback loop about these practices.

I recommend that when the CQP group drafts a Practice Directive, the PD should be reviewed by and with the Policy Division and then going forward, reviewed by the CQP, the Policy Division and the Review Division on a scheduled basis. These reviews should be initiated through and coordinated by the Policy Division and include a review of relevant Review Division/WCAT decisions.

This approach would have the added benefit of connecting the Policy Division to the implementation effects of different policies.

RECOMMENDATION # 10

That the development of Practice Directives remain with the Compensation Quality and Practices group but the Practice Directives, when drafted, be reviewed by the Policy Division. Going forward, the Policy Division will set a schedule to review Practice Directives together with the Quality and Practices group and the Chief Review Officer or other Quality Control person as the Board will direct, and the review will include consideration of Review Division and WCAT decisions.
**Sidebar: VIOLENCE IN THE WORKPLACE and “The Assumption of Risk”**

Acts of workplace violence are clearly on the rise. The BCGEU submission provided claims statistics for Acts of Violence 2009-2019 based on statistics provided by the Board in May, 2019. Between 2009 and 2018, the number of accepted claims from acts of violence rose nearly 80% [from 1,287 to 2,292].

One of the key principles of compensation systems is “no fault” coverage. The compensation system replaced the adversarial tort system, including its “doctrine of “assumption of risk” where the worker was assumed to have voluntarily assumed occupational risks, thereby releasing the employer from liability for the worker’s injuries. This doctrine, founded on fault-finding and dismissing coverage, was rejected by the Meredith principles and it has no place in the modern compensation system.

However, this Review heard on multiple occasions that workers were told, on reporting an injury from a violent incident, that that was “just part of the job.” This response was particularly prevalent in mental stress injuries. Representatives from many occupations involving the public – bus drivers, social workers, ER nurses, and teachers – presented that their injuries, both physical and psychological – were met with this response – its “just part of the job.” In one case, the dismissed incident was a violent riot in a jail where the worker was part of the response team.

These responses appear to be rooted in an attempt to distinguish a “normal” stressor from one that is “excessive in intensity and duration”, as set out in the Practice Directive for “mental disorder” claims.

The responses that violence is “part of the job” is highly distressing to an traumatized worker, even if the claim is ultimately accepted. It suggests that violence in the workplace is normal, that worker should expect such incidents and that the resulting injury is not compensable. This approach engenders no confidence in workers that the Board is committed to safe work or fair compensation practices. It is simply the “assumption of risk” doctrine, dressed up.

I recommend that the Board amend policy and develop Practice Directives in this area. Specifically, policy should state that workers have a right to a safe workplace and that the lack of a safe workplace may well be a significant stressor, even if violence or a safety risk has been ‘normalized” in a particular workplace. The policy should also state that when a worker is off work due to an injury from a violent incident, there must be an investigation by Prevention of the safety risks, prior to the worker’s RTW. I recommend that the Board take immediate steps to train staff in this point of practice and clarify this in the Practice Directive for mental health claims.

**Staffing for a Service Culture of Communication and Collaboration**

This Report recommends modernizing Board culture into a worker-centric compensation system through better communication and a collaborative approach to service delivery and decision-
making. This is a different way of “doing business” and it has implications for training and organization of staff.

There was a strong submission from a group of case managers that “Claim quantity and service quality are in direct competition” due to the distribution of workloads. They describe a “funnel” where the intake positions are expanded but there is no added CM staff. The group commented:

“So it is one thing to get the claims accepted faster but then there is no bandwidth in the existing number of Case Managers to take on the extra volume or provide the customer service/relationship building/quality adjudication being sought by the government.

I bring this forward as an attention point. The Board is in the best position to address these complex staffing issues in the context of the Report as a whole.

#3: PATIENT CENTERED MEDICAL CARE

One goal of a worker-centered delivery system is to maximize the recovery of injured workers. The Act provides:

\[
\text{Health Care section 21}
\text{(7) Without limiting the power of the Board under this section to supervise and provide for the furnishing of health care in every case where it considers the exercise of that power is expedient, the Board must permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner who may be selected or employed by the injured worker.}
\]

In this Review, we heard many concerns about the Board’s approach to health care services, decision-making on medical issues and the resolution of medical disputes.

What We Heard

The common themes in presentations and submissions to this Review included:

- Workers have little confidence in medical decisions made by a BMA who has never seen the worker, especially if the decision is contrary to the opinion of the worker’s treating health professional.
2. Claim owners are making decisions based on opinions from BMAs, even if there are contrary opinions from the worker’s treating professionals. Several workers reported that claim owners told them that it does not matter what the worker or his/her physician say; the BMA opinion will be followed.

3. Treating physicians have significant problems in communicating and collaborating with BMAs. One primary care physician stated that he had made a number of requests for contact with a BMA and that in his experience, the shortest response time was 3 months. Examinations of claim files confirmed that requests from general physicians on Physician Progress Reports (F11s) are often not responded to or take months to respond.

4. The focus of Clinical Services has drifted away from patient care towards assisting in claim adjudication. Both claim managers and BMAs agree that there is often a blurring of lines, between a claim owners’ request for a “medical opinion” and a BMA offering an opinion which adjudicates claim matters, although there is not necessarily agreement on why this occurs. BMAs have expressed frustration over the inability and organizational barriers to responding to requests on a timely basis and to collaborate meaningfully with worker’s physicians.

The above approach can, and does, interfere with a worker’s recovery path. Many medical and treatment decisions are taken out of the hands of the worker’s health professionals and put in the hands of either a BMA, who does not see the worker or a case manager, who has no medical training. The approach often forces workers to choose whether to attend treatment programs or RTW against the advice of their doctor or to lose the Board’s financial support while healing and/or appealing. Neither path is conducive to maximum recovery. It is, and has been, very damaging to a worker’s trust and confidence in the compensation process. It is also inconsistent with their right to choose their own health care provider.

At the same time, this approach relegates BMAs to a secondary adjudication role and does not utilize the expertise of Board doctors in treatment care. There is essentially no collaboration or discussion between BMAs and treating physicians on medical issues and, while no one looks to return to the time of “At Board” examinations36, this is a missed opportunity. And not

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36 BMAs conducted clinical examinations of workers until several years ago. Clinical exams were referred to as AB (at Board) examinations, although the review was by a senior retired BMA that “AB” originally referred to Board’s buildings where the exams were held. AB exams were often conducted for the purpose of declaring the worker no longer disable. Workers had a considerable degree of distrust of AB exams and this practice has virtually ceased. It was raised with the Review that, if a worker does not have a personal physician and is seen by a BMA, the BMA becomes the designated primary care physician with obligations incompatible with their current role.
inconsequentially, this approach has led to a considerable loss of confidence in BMAs in the worker community.

The approach sets up a decision-making process which relies on the appeal process to resolve medical disputes. It is the experience of most people involved in appeals that the delay in treatment and/or benefits during the appeal period alone impedes recovery.

In my view, the current arrangement for Clinical Services is not supportive of a worker-centric delivery system, including recovery goals for injured workers, and there is a better way.

**What is patient centered care?**

For many years, physicians, health care professionals and their organizations have considered how to achieve the maximum recovery of their patients’ health and function. My appreciation goes out to BMAs, past and present, and to the health care providers who have assisted in this model.

Central to the model is that you treat the whole person and the whole person is an active participant in their recovery. The Royal College of Physicians and Surgeons of Canada has created a framework for improving patient care named CanMEDS. The seven elements of patient centered care are summarized in the attached article from the New England Journal of Medicine.  

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37 CanMEDS is a framework that identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve. These abilities are grouped thematically under seven roles. A competent physician seamlessly integrates the competencies of all seven CanMEDS Roles are: *Medical Expert (the integrating role), Communicator, Collaborator, Leader, Health Advocate, Scholar, Professional.* The overarching goal of CanMEDS is to improve patient care. The CanMEDS model has been adapted around the world, both within and outside the health professions.

38 WCB-IR- 0050 Subject :7 elements of Patient-Centered Care, New England Journal of Medicine Catalyst, January 1, 2017. Patient- and family-centered care encourages the active collaboration and shared decision-making between patients, families, and providers to design and manage a customized and comprehensive care plan. Most definitions of patient-centered care have several common elements that affect the way health systems and facilities are designed and managed, and the way care is delivered:

• The health care system’s mission, vision, values, leadership, and quality-improvement drivers are aligned to patient-centered goals.
• Care is collaborative, coordinated, and accessible. The right care is provided at the right time and the right place.
• Care focuses on physical comfort as well as emotional well-being.
• Patient and family preferences, values, cultural traditions, and socioeconomic conditions are respected.
A synthesis of the medical literature provides the following tenets of patient centered care:

- Listen to patients to understand their values, preferences, and what they want their care to achieve
- Respect these values, preferences and aims
- Treat patients with dignity, and care for them accordingly
- Provide required information in a timely manner, and in a way the patient can understand
- Listen to patients in order to understand their fears and concerns
- Plan and co-ordinate care so that it happens when and where it is required, and it addresses patients’ concerns
- Provide collaborative care that includes the patient, their family and friends, health professionals and other caregivers.

The general goal of patient centered care is to provide the right care at the right time and in the right place. It also embraces a multi-disciplinary approach. As the article states:

Under patient-centred care, care focuses more on the patient’s problem than on his or her diagnosis. Patients have trusted, personal relationships with their doctors in patient-focused care models. Empathy, two-way communication, and eye-to-eye contact are crucial, as is the ability of the doctor to see beyond the patient’s immediate symptoms or pain. This broader look at the whole patient requires providers to offer services or referrals to services such as peer support programs, social workers, financial counselors, mental and emotional health providers, transportation and daily living assistance, and in some communities, language and literacy education. Tools range from 24/7 online portals...to wearable technology and apps....

**Patient-Centered Care as an Approach to Health Care Services**

The tenets of patient-centered care have a significant application to the Board’s approach to health care services. To work effectively towards a goal of maximum recovery for injured workers, the compensation system should be:

- Collaborative, coordinated and accessible
- Care about the emotional well-being of the worker

- Patients and their families are an expected part of the care team and play a role in decisions at the patient and system level.
- The presence of family members in the care setting is encouraged and facilitated.
- Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.
NEW DIRECTIONS:
WCB REVIEW 2019

- Respect worker and family preferences, values, cultural traditions and socio-economic conditions
- Expect workers to be part of the care team and play a role in decisions
- Share information in a timely manner so workers can make informed decisions

Role of the Physician or Treating Professional (“Carer”)

The tenets of patient-centered care strongly support the practice of minimally supervising health care and to interfere with the choices of the worker and the worker’s caregivers only in those circumstances where the direction of care is likely to delay or impede recovery. This approach is more consistent with Section 21(7) of the Act.

In the patient centered system, the care and choice in care is determined by the worker, the worker’s physicians and caregivers. This does not mean that the worker and/or worker’s caregivers are free to choose any form of treatment or no treatment at all. The Board has a role to determine what range of treatments are suitable for particular conditions. The Board should communicate with the worker and the worker’s caregivers about these treatments. The worker and the worker’s caregivers would be expected to undertake treatment that is suitable to the condition in the worker’s particular circumstances. The worker and the caregiver would be in the best position to understand the scope of the circumstances and apply the elements of patient centered care.

And where the Board requires an expert opinion that affect claim decisions, these should be provided by, and obtained from, treating practitioners.

There is also good alignment between the tenets of patient-centered care and the best practices for RTW. The Canadian Medical Association publishes and updates policy “The Treating Physician’s Role in Helping Patients Return to Work After an Illness or Injury (Update 2013). This policy recognizes the importance of a patient returning to all possible functional activities, including work, as soon as possible “provided that a return to work does not endanger the patient, his or her co-workers or society.” and that prolonged absence can have a detrimental effect. The policy endorses having the physician communicate and collaborate with a RTW coordinator to incorporate a RTW plan into the patient’s treatment plan. 39

39 The policy, brought to my attention by one of the original drafters, was developed to incorporate the foundational work of the World Health Organization and is based on the biopsychosocial model of disability.
As noted earlier, many health care professionals responded through questionnaires and it appears that the Board’s current relationship with health care professionals is fraught. If this new approach is adopted, I recommend that the Board reach out, through Clinical Services, to the Doctors of B.C. to continue to address physicians’ systemic concerns about compensation services including its forms and reporting requirements for physicians.

**New Role for Clinical Services**

In order to restore stakeholder confidence and independent medical expertise to the Board and to Board proceedings, I recommend that the Board re-locate the Clinical Services Division and constitute it as a stand-alone department or division with a reporting structure outside of Claims Services and reporting directly to the CEO or BOD. The stand-alone Clinical Services should be under the direction of the Chief Medical Officer (CMO) with the Chief Mental Health Officer (CMHO) holding a senior level position. Special Care Services provides many services under the umbrella of health care benefits and the Board may wish to consider moving Special Care Services into a stand-alone Clinical Services Division.

I further recommend that the independent Clinical Services Division be accessible to both the compensation and prevention branches of the Board and be authorized to assist in health care issues that arise in either sector.

### RECOMMENDATION #11

Clinical Services be established as a separate department from Claims services under the Chief Medical Officer reporting to the President/Chief Executive Officer.

**New Role for Board Medical Advisors (BMAs)**

In a new Clinical Services structure, BMAs would play more of a role in collaborating and coordinating care with the worker’s caregivers. As noted above, I recommend that the worker’s preferences and treating physician be given a key role in any treatment plan. The BMA would identify claims where the progress and treatment may be diverging from expected norms, a process that could be initiated in several ways including:

- Requests from the claim owner;
- Requests from the caregiver;
- Requests from the worker; and
- Requests from the employer to assist on modified light duties.

I would recommend that, as the BMA is not a practitioner selected by the worker, the BMA’s role should remain collaborative and consultative. This would mean that the BMA is not making
direct decisions regarding the care the worker receives or decisions about the worker’s fitness for work or for particular programs.

By moving away from involvement in claim adjudication, the BMA should be able to respond promptly to requests for communication, collaboration and assistance. It is the experience in other jurisdictions that formal medical disputes can be avoided by good communication and collaboration between health care professionals or carers, especially between the worker’s doctor and the BMA. It is possible that new technology could assist in this important communication. Where there is an unresolved difference of opinion, this can be documented without breaking a collaborative relationship.

I also recommend that the Board develop protocols for BMAs responding to requests for communication from health care providers. Ideally, a response should be within 24 hours (or sooner) and at the outside two business days. Timeliness has considerable value. Meaningful collaboration and consultation between BMAs and healthcare providers would benefit greatly from timeliness.

It may be possible to have special telephone communication or other modalities to facilitate this communication. As a recent proposal for Clinical Services stated:

A successful case management process should have defined milestones at which various decisions and/or assessments are made. These could include milestones for the following:

- Early clarification of the working diagnosis and treatment plan;
- Agreement for a suitable return to work plan in which all parties are engaged;
- Medical case review when there is delay in a return to work; and
- Standard medical case review to ensure optimal medical management.

BMAs could work with the worker’s physicians on these tasks on specific claims and work with the medical community to establish broader plans and procedures. They can explain medical concepts to non-medical Board staff.

The vision is to have BMAs in the new Clinical Services working collaboratively with treating physicians and health care providers to find options that would best facilitate worker recovery in a holistic approach. The BMA will be a facilitator with knowledge in work-related injury and treatment and this role, located independent from claims adjudication, will facilitate a credible, much needed change in service delivery in this area.

The current case management processes provides for claim owner requests to be addressed by BMAs. One alteration would be that requests from claim owners for BMA assistance should avoid requests for direct opinions on causation and recovery for adjudicative purposes. The
BMA can identify gaps in this medical information for adjudication and coordinate the measures needed for appropriate investigations and examinations by treating/examining practitioners. Expert reports should be obtained from the treating professional. If there is a medical dispute or the claim owner remains concerned, additional evidence (IMEs) and dispute resolution processes are available through the Medical Services Office.

Decisions regarding entitlement to Health Care Benefits would continue to be made by claim owners based on information from healthcare providers, clinical services and workers - the same as they are now, except for providing better information under patient centered care principles through more independent and robust processes. Health Care and Financial Services would continue to play the current role of paying and administering health care contacts.

**RECOMMENDATION # 12**

That the Board develop policy and practices to guide decision-makers in this new approach to health care management during the life of the claim. Workers will have a choice in their health care provider and the Board will supervise minimally and intervene only where the treatment is likely to impede or delay recovery.

**Issues re Board Treatment Plans**

As noted above, the Board contracts with third party providers for “packaged” treatment or rehabilitation programs. The proposed changes to health care decisions would improve the referral process but there remain some concerns about the current operation and oversight of these programs by the Board. The Board was unable to provide statistics on injuries in Board-sponsored programs because that information is not recorded to claim files.

The contracts with these providers often do not provide for flexibility in treatment or for a full range of possible outcomes. In several cases, a contractor was directed to have only two options as outcomes: fit to return to work with no limitations and fit to RTW with limitations. There was no option to find “not fit to RTW”. Any withdrawal by the worker from treatment resulted in the termination of the worker’s benefits.

I was told on several occasions that workers who are struggling in the program have been told “don’t worry about it. Just rest. We will just write up a report anyways.” Workers are highly reluctant to report such problems as they quite reasonably think they will not be believed.

And in some cases, the “contracted program” is preferred to a better therapeutic approach for the worker, even if it is less expensive. An example is where a worker lived in the eastern part of the province and was referred to an OR2 program in Kelowna. This referral required the
Board to pay for travel and accommodation for the six-week program. The worker was reluctant to do this as she had young children and would have to arrange for childcare during her absence. She and her treating physician asked if she could receive treatment from a local physiotherapist instead of an OR2 program. This request was denied, even though it was the worker’s preferred course with the support of her doctor and even though it was much less expensive for the Board and less disruptive to the worker and her family.

In my view, there is ample evidence that the Board is over aggressive in its referrals to third-party providers contracted to the Board when this referral is not in agreement with the treatment preferences of the worker and/or the recommendations of treating physicians. In several cases in this Review, it resulted in harm or injury to the recovering worker. The Board was unable to provide statistics on injuries in Board-sponsored treatment because that information is not recorded to claim files.

Therefore, I make the following recommendations:

RECOMMENDATION # 13
That the Board track injuries occurring in Board-sponsored treatment programs.

RECOMMENDATION # 14
That the Board provide a process for workers to anonymously evaluate the Board sponsored treatment programs for the Board, after the conclusion of their program. That within one year, the Board conduct an audit of selected treatment services and review the role of contract provisions in their performance. From this audit develop guidelines for quality oversight and supervision of these programs, and for ongoing evaluation by participating workers and treating physicians.

RECOMMENDATION #15
Clinical Services be responsible for monitoring and assessing the quality of third-party provider programs and have good communication with these programs. If a worker or a worker’s carer has concerns about a potential referral, the Board Medical Advisor will be in a knowledgeable position to help the carer to assess the appropriateness of the program.
**Improve Access to Health Care Services**

There are many workers who do not have personal physicians or easy access to medical care. This is certainly more pronounced in rural areas. I understand that it would not be wise to add to the professional obligations of BMAs by converting them to “primary care physicians”. I recommend that an independent Clinical Services Division explore what resources may be available to better meet the health care needs of injured workers around the province.

**RECOMMENDATION #16**

That the Board consider having Clinical Services partner with Health Care agencies which address issues of accessibility through innovative technology and working relationships. Regional offices could assist Clinical Services in identifying health care needs around the province which are currently not being met.

**Resolution of Medical Disputes**

In the section on “Steps to Improve Confidence”, I recommend the establishment of an independent Medical Services Office (MSO) to offer non-binding case conferences to clarify and try and resolve medical disputes and also to arrange an Independent Medical Exams (IME) at the request of the Board, WCAT, or the parties. The research and rationale behind this proposal, together with operational details, are set out in this section.

**The Key Role of Communication in Patient-Centred Care**

Patient centered care offers an excellent model for the Board’s approach to communication with injured workers and employers in general. It also incorporates an approach which aligns with a broader societal approach to RTW. The scientific literature is also supportive of this concept of respectful collaboration to support recovery by protecting the dignity of claimants during the compensation process. In highly adversarial systems, even those suffering from acute trauma as a result of obvious industrial accidents, may well be submitted to abusive contestation and suggestions of “moral hazard,” strategies that contribute to under-reporting and disability.

In order to fully understand and adopt this patient centered care model of communication, I recommend that there be training for Board staff in this form of communication. Clinical

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Services may be able to assist as this form of communication is an essential part of medical education.

**Health Care Benefits for Chronic Conditions and Permanent Disability**

A number of workers and representatives submitted that in practice, the Board does not approve health care benefits which do not result in an “improvement” in the worker’s functionality. This caused particular hardship for permanently injured workers when their permanent conditions required ongoing treatment just to maintain functionality or a reasonable quality of life.

Section 21(1) of the Act states that the Board may approve health care or treatments during the disability “to cure and relieve from the effects of the injury or alleviate to effects.” I recommend that the Board develop a policy confirming that health care benefits will be provided throughout a worker’s permanent impairment to a level that relieves from or alleviates the effects of the injury.
PART III: ADDITIONAL ISSUES IN SERVICE CULTURE & CASE MANAGEMENT

IN BRIEF

Identified issues in service culture and case management are addressed with recommendations to advance a worker-centric workers’ compensation system. Topics include:

- Plateau decisions – amendments to policy and practice
- Case management practices – continuity of claim owners and income gaps
- Incomplete Decision-Making
- Review Division jurisdiction

It is recommended that the Board be allowed to reconsider its own decisions and that there be a return to paying interest on significantly delayed benefits.

Recommendations are made to improve access to justice which include:

- harmonizing a 90-day appeal limit to apply to both the Review Division and the Workers’ Compensation Appeal Tribunal (WCAT);
- restoring the full scope of WCAT’s ability to reconsider decisions; and
- enabling WCAT to consider issues arising under the Canadian Charter of Rights and Freedoms and the Human Rights Code.

Stakeholders raised a variety of concerns about the Board’s service culture and case management practices. This section looks at some of these identified issues from a worker-centric perspective. Issues which were specific to RTW are addressed in the RTW section.

PLATEAU DECISIONS: POLICY #34.54 AND PRACTICE ISSUES

Policy #34.54 “When is the Worker’s Condition Stabilized” defines, from a policy perspective, when a worker’s medical condition, if it has not resolved, may be considered to have stabilized or “plateaued” sufficiently to be considered permanent. The policy states that where a

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41 The policy states that there is a “plateau” when the medical condition stabilizes or is unlikely to change within 12 months. In compensation, many use it interchangeably with ‘maximum medical recovery’ or MMR but the terms are not interchangeable.
condition has not yet stabilized, the decision-maker must assess the likelihood of “significant change” over the next 12 months.

The “plateau” decision is highly significant for injured workers who are still on wage loss benefits, usually due to serious injury. The plateau decision concludes the “temporary” wage loss benefits and the financial security that this benefit provides.

In case management terms, the Board’s now considers that the worker no longer has a “temporary” disability and so refers the worker to the “next stage” of adjudication – Disability Awards and/or Vocational Rehabilitation.\(^{42}\) Typically, plateau decisions also include other decisions: which permanent conditions are accepted on the claim (inclusive of restrictions and limitations) and a RTW decision i.e. whether the worker can RTW with the pre-injury employer or requires a referral to vocational rehabilitation (VR).\(^{43}\) For an injured worker on temporary wage loss, the plateau decision is a pivotal adjudication point. This decision sets out the compensable conditions and the RTW and VR parameters on which the Board’s subsequent RTW/VR decisions rest. To a great extent, the worker’s experience at the next stage after injury - be it RTW with or without limitations, RTW with accommodation, vocational rehabilitation or LOE pension adjudication – rests on the accuracy, completeness and fairness of the plateau decision.

In this Review, workers and worker representatives alike identified “plateau” decisions as an area where Board decision-making was problematic and in many cases the plateau decision was pre-mature or unfair. These included cases where injured workers were “plateaued” well before recovery, without evidence or in the face of contrary evidence and/or at medically inappropriate times. When objections were raised, the worker or representative was told “If you don’t like it, appeal it.” I have confirmed a number of these cases, including cases where workers suffered a relapse or reinjury shortly after the RTW.

Plateau decisions end the period of financial security offered to injured workers for their temporary disability. If the plateau decision is pre-mature and states that the worker can RTW, but the worker is not actually recovered or stabilized, the worker has to make a difficult choice. Some workers, at this juncture, feel forced back to work by financial need and do so, without the Board monitoring the worker’s condition or the suitability of the work. In many cases, they risk

\(^{42}\) Not all workers with an unresolved injury receive a Board decision which ends their “temporary” disability with a referral to Disability Awards, especially if the worker has RTW. The lack of a “closure” decision, with referral to DA has been identified as a systemic problem of incomplete decision-making. The recommendation to amend policy #34.54 addresses this matter.

\(^{43}\) In many cases, VR benefits do not commence until weeks or months after the plateau date. This gap is addressed below under continuity of income.
incomplete recovery, long-term disability or re-injury. The worker is “working hurt” and without support. Many workers said that it was at this point that they considered that they were “abandoned” by the Board.

Other workers, in these circumstances, elect to dispute a pre-mature “plateau” decision and face a period of time (months or years) of serious financial hardship and no employment. Even if the appeal is successful, this process can result in entrenching the worker’s disability.

Given the pivotal nature of plateau decisions, it is critical that a worker-centric compensation system which is committed to RTW get these transitional decisions right for individual workers, as well as for the compensation system. Below, I have suggested that the Board explore the option of transitioning the case management system to a “single payer” system (between TWL and VR) and staffing for this transition. This is part of a systemic change towards “best practices” disability management.

But this larger shift requires resources and consultation beyond this Review. Below, I address the concerns with pre-mature plateau decisions as they now present in the compensation system.

**Issues in Plateau Decisions**

From this Review, I would identify the following areas where plateau decision-making requires significant improvement.

a) The Scope of Evidence considered on “Plateau Decisions”

It is apparent that in practice, many claim owners rely on the discharge status set out in the OR1 or OR2 reports as the basis for a plateau decision. General issues have been raised about these programs elsewhere in this Report including that the “outcome” options for these programs are sometimes contractually limited, not all referrals are appropriate for the worker’s injury and there is effectively no oversight or remedy for quality or referral concerns. There are additional specific concerns about using the OR1 or OR2 discharge status as the basis for a plateau decision:

The discharge status can be inconsistent with the medical information in the body of the report. For example, the worker can be discharged as “fit to RTW” when the report documents the worker’s inability to participate in VR or RTW or meet the job requirements.

The discharge status is not always based on actual results. The Review heard this from several workers and one union reported:
I recommend that the plateau policy be amended to provide better guidance as to the medical evidence to be considered in making the plateau decision. Specifically, the policy should specify that a plateau decision is an adjudicative decision, to be made on the merits and justice of the case. Given the importance of this decision, it should be made on the basis of all the medical evidence, and from a “whole worker” perspective.

b) Interpretation of Policy #34.54

Stakeholders identified that in practice, policy #34.54 is often interpreted as meaning that for not-yet-stable conditions, “significant change” means that the condition will not “change on its own” in the next 12 months. There is no consideration as to whether the condition will “change after treatment, including surgery”. Thus workers are then “plateaued” and have to RTW while still in recovery.

This approach essentially sends the injury worker back to work without treatment. And in the workplace, the worker’s medical condition is considered “permanent” with the result that duties and accommodations are not necessarily appropriate to recovery.

Section 21(1) of the Act sets out the Board’s responsibility for treatment to “cure and relieve from the effects of the injury” is required during a period of disability and from a common sense point of view, treatment should be considered as part of defining that period of disability for compensation purposes. I recommend that the “significant change” in policy #34.54 should be mean no further change is likely in 12 months “with treatment”.

c) Decision Making Practices in “Plateau Decisions”

I also consider that there are two systemic issues in the Board’s decision-making practices around Plateau decisions that must be addressed:

Decision-makers appear to frequently use the recovery and RTW milestones in the Guidelines as prescriptive “norms” in their adjudication of plateau decisions including, in some cases, following these milestones despite contrary evidence. This approach appears to have the support from many Board managers. As noted earlier in this Report, this use of Guidelines as “norms” is likely a matter of general concern but it has particular significance for workers in plateau decisions. It was also flagged as a particular issue in the WAO submission:
In our experience, there have been instances where milestones may not have aligned with a worker’s recovery and durable return to work. For example, we have seen many premature plateau decisions where the very clear medical evidence on file indicates that a worker is either still in recovery or receiving medical treatment for their injuries. Negative or premature decisions can result in extreme financial hardship for workers when they are disabled from working and are forced to wait 6 to 18 months for the appeal system to correct a decision.

The previous recommendation on the use of Guidelines in fair decision-making is applicable here and I recommend that it also be referenced in the plateau policy.

The Board’s use of “RTW” outcomes as one of its 10 Key Performance Indicators (KPIs) affects, or may appear to affect, the Board’s decision-making practices for plateau decisions.

The KPI for RTW defines “…success is when an injured worker is able to return to work within 26 weeks..., the return to work is voluntary (the worker does not object) and it is safe and durable (with no subsequent inability to work for 30 days after return...” As noted in the 2018 Annual Report, the 26-week milestone for return to work is used as a key statistical measure because the Guidelines indicate that the majority of injuries show recovery within six months. The 2020 KPI target is to improve this number from 81.2% (the 2018 result) to 83% in 2020. In the case management system, the “duration of disability” is measured by the number of days that a worker receives TWL. When the plateau decision effectively ends TWL, the claim owner enters a “RTW event”. It is this measurement which underlies the KPI; there is no independent tracking or reporting of actual successful RTW outcomes or long term RTW outcomes (past 30 days) despite many requests for this to occur.

In a worker-centric compensation system, there is no RTW success unless injured workers succeed in returning to safe and durable work. Effectively the KPI is a measurement of the Board’s success at ending TWL on a statistical “norm” of recovery. Too many workers report being forced back to work “hurt” for there to be confidence in this measurement is a meaningful measure.

Further, the Review heard from many Board sources that the KPI has, in effect, supported the use of the statistical “norm” for claims adjudication. I understand that front-line workers receive increased scrutiny from managers and senior leadership as TWL claims approached the RTW target dates in CMS and many expressed deep concern about the pressure that they received to issue “plateau” decisions in serious cases as the worker’s claim reached CMS milestones. Claims which went beyond this date were intensely watched so as not to exceed 240 days.

44 An “accepted RTW event” at plateau can mean that the worker has returned to work, with or without objection, or is deemed to have returned to a specific job. Presumably, the KPI figure is drawn from the “accepted RTW” events for workers who return without objection.
(another target) and “keeping the 240 bucket low” was an explicit target in offices. These reports are consistent with the concerns expressed above.

Given this, I recommend that the Board discontinue the practice of using the RTW KPI as a measurement of Board performance. It creates practices and perceptions which are not consistent with a worker-centred approach and substantially undermines stakeholder confidence in the fairness and quality of RTW decisions. The removal of this KPI would also help change the service culture at the Board to one focused on realistic RTW successes.

**RECOMMENDATION #17**

That the Board discontinue its use of RTW or other “duration of disability” statistical measurements as a Key Performance Indicator (KPI).

**RECOMMENDATION #18**

That the Board amend policy item #34.54 to provide:

1. That in assessing whether or not a condition has stabilized or if there is a likelihood of change, the Board must take into account the changes that would be possible with treatment and consider the potential for change “with treatment”.

2. That the Board will determine whether or not the worker’s condition may be considered “stabilized” after reviewing the medical evidence as a whole and based on a “whole worker” approach. The Board may seek a medical assessment on this issue but the decision is an adjudicative one.

3. That even if the worker is not receiving temporary wage loss benefits, the Board is required to issue a decision when it considers that the worker’s temporary disability has ceased and include one of the following decisions:
   a) The worker is fully recovered; or
   b) The worker’s condition is now considered to have plateaued, leaving a permanent impairment. This decision must identify the accepted permanent conditions and referred the case to Disability Awards for the worker to be assessed under sections 22 and 23 of the Act.

**Does a modern compensation system need “plateau”?**

This concept “plateau” like much of the compensation system, was developed when compensation benefits were structured around a binary system of disability, divided by the “plateau” decision:
• a period of temporary disability, with temporary wage loss (TWL), when a worker was off work;
• then recovery or the “plateau” point when the worker went off TWL, the permanent disability was assessed, and the RTW/VR/pension issues proceeded.

Today, the approach to disability and disability management has changed dramatically from these foundational concepts. In my view, compensation categories need to be updated and modernized to better adjudicate the issues involved with the new concept of disability, disability management and worker-centric goals. I recommend that the Board investigate going to a “single pay” system in which there is no adjudicative distinction necessary between “temporary disability” (section 29 or 30) and “vocational rehabilitation”; RTW can be achieved at any point in this spectrum.

This approach can be implemented without any additional claims costs for individual employers as all charges on the account remain the same. There are also no direct financial implications for injured workers who will receive wage loss payments from a single account, rather than transitioning at plateau from a “TWL” benefit to a “VR” payment. This would eliminate gaps in the Board’s financial support during this “handoff” and support better RTW success.

There would still be a need to define a point at which the Board could assess a permanent condition. This is best defined as when the worker reaches Maximum Medical Recovery (“MMR”), defined as a medical concept. But other than triggering a PFI assessment, a worker reaching MMR would not determine benefits.

Most seriously injured workers would need a ‘basket” of benefits (including VR benefits) long after MMR. The “basket” would terminate when an RTW or VR arrangement could be considered durable or suitable or until the worker is awarded an LOE pension. The goal would be an actual successful RTW and the Board’s “success” could rightfully be measured on this score.

In my view, this approach would encourage practices and programs supportive of effective disability management including:

• The RTWS or VRC could get involved early in the claim and not wait for a “hand off” form the claim manager. The RTWS or VRC could work with the claim owner at all stages of the claim, to coordinate efforts and use resources effectively. It would also introduce personal contact with the worker very early in the recovery process.
• For seriously injured workers who are in recovery for a long time, the recovery time could be combined with appropriate VR training or upgrading. In any event, if the worker is not returning to the pre-injury employer, it will be expected that the VR plan has either started or will start before MMR.
CASE MANAGEMENT PRACTICES

Continuity of Claim Ownership

Both workers and employers identified a frequent change in claim owners as a negative factor in effective case management. This was particularly negative for workers in recovery. Many said that the new case manager (CM) would ask them to repeat information or in a number of cases, did not seem to know information on the claim file before making decisions. Others said that they were just getting to know and trust their CM, when a change was made. And the changes in claim owners seemed not only to break a knowledge chain but also in many cases, led to distrust and a loss of confidence in the Board. One family member who had helped with several claims said:

They all said the same thing…whenever they felt they were getting somewhere their file was given to another worker and they had to start all over again.

The WAO noted in their submission:

Frequent reassignment of files to different Case Managers leads to lack of continuity in decision-making, increased errors, other service issues, and frustration among workers who do not know who to talk to or who is making decisions on their file. Additionally, Case Managers who cover for others who are away can be reluctant to make decisions on a file, which leads to further frustration arising related to delays.

In some stages of a claim, the change in claim owners may be due to the Board’s model of case management called “entitle and rotate”. This model necessarily involves the worker’s file being handled by numerous decision-makers in the early stages of the claim. When there is time loss claim, about 80% of workers tell their story to two or three people at least.45

However, others indicate that certain staffing issues may be a factor contributing to changes in claim ownership later in a claim, including:

- Workload issues: it is a Board practice to smooth out CM workloads by moving caseloads to desks around the province;
- The system may be understaffed in some areas as sometimes, the Board has difficulty hiring sufficiently qualified candidates for CM positions;
- Vacation coverage: Claim owners frequently did not have vacation coverage so matters waited for their return. But if assigned, the covering CMs often did not have knowledge of the claim files and were reluctant to make new decisions.

45 WCB-IR-0067
As noted in research and in many presentations to this review, an attached supportive connection can be an important factor in the recovery of an injured worker. And of equal importance, the lack of continuity in claim ownership can be a major factor in disrupting, and even derailing, a worker’s recovery. Continuing in claim ownership also supports a better knowledge base for decisions and better service to all stakeholders. Several submissions from workers and employers referenced how helpful it was to have industry-specific case managers at all stages of a claim.

I recommend that the Board embed the value of a continuity of claim ownership in its approach to service delivery. I leave it to the Board to address any staffing issues that affect this aspect of service to stakeholders.

One suggestion made to the Review was staffing in teams rather than by a single claim owner may assist in both coverage and continuity issues. A team could combine a front-line worker such as a Return to Work Specialist (RTWS) or Vocational Rehabilitation Consultant (VRC) with a claim owner such as an EO or CM. This team approach would ensure that the worker and the employer have good on-going contact with one front-line worker and provide some vacation coverage, while at the same time allowing some flexibility in the workload of adjudicators.

Another suggestion was that Board could consider the past practices of having lower classifications as entry level positions for on-the-job training such as a “case officer” 1 and 2.

**RECOMMENDATION # 19**

I recommend that the Board review its staffing model and best ways to achieve continuity of care. I leave this to their expertise in this complex system. However, I recommend that the Board embed the value of providing a single personal and continuous relationship between a claim owner, an injured worker (particularly those with a serious or traumatic injury) and the employer during return to work.

**Incomplete Decision-Making**

A number of stakeholders and presenters raised the issue that there was often incomplete decision-making on a claim file, and certain types of incomplete decision-making were repeatedly identified:

- CM did not address or adjudicate compensable conditions or compensable consequences unless specifically requested to do so, even in the face of clear medical evidence and even if flagged by the treating physician in the F11 reports.
• CM did not address all aspects of a disability as indicated in the medical evidence, especially for concussions.
• If the worker had RTW, the CM did not issue a closure letter identifying the accepted permanent conditions with a referral to Disability Awards.
• CM did not adjudicate an injury under all applicable categories, resulting in jurisdictional issues on appeal. Common problems were whether an injury was a new injury or a re-opening/recurrence and adjudication of ASTDs under both section 5 and 6 of the Act. A number of workers had experienced the appeal “treadmill” based on this issue alone.

Examples also included cases where case managers simply refused to adjudicate a matter for reasons outside of Board policy. This included examples of a refusal to adjudicate a soft tissue injury because there was no ASTD diagnosis (one is not required under policy) or because while there was some medical evidence, more was needed and the “onus” was on the worker to obtain medical evidence. (onus is not on the worker).

It is hoped that many of the decision issues will be resolved by the recommendations in this Report and the Board’s new direction to a worker-centric compensation system. In particularly, these issues are assisted by a “whole worker” approach, good communication and resolution by collaboration rather than by appeal. But should an appeal to the Review Division be necessary, I make the following recommendation.

**Review Division – Wide Remedial Jurisdiction**

I recommend, as did several stakeholders, that the Review Division exercise a broad jurisdiction to monitor the quality and completeness of Board decision-making. This was the original intent of the Core Review in establishing the Review Division and it is needed now, more than ever. As noted in the Core Review:

> The subject matter of the internal review should not be limited to what the initial decision-maker actual dealt with in the four corners of the decision letter. Rather, the review would encompass any issue which the Review Manager believes should have reasonably been dealt with by the initial decision-maker in his/her letter. My reasoning for this broader scope is to avoid the delay and frustration which will often arise when the matter is referred back to the initial decision-maker to determine the additional issues(s), which could then become the subject of a further application for internal review. (p. 28-29)

I particularly recommend that the Review Division endorse the remedial principle in the Interpretation Act and provide for a more holistic approach to the appeals process in the appropriate circumstances in order to avoid the appeal “treadmill” that now occurs. I recommend that the Review Division track (or continue to track) incomplete decision-making and identify any systemic issues in this area, for quality review.
Continuity of Income

A number of stakeholders and health professionals identified certain gaps where the case management system left injured workers without financial support due to system delays. The most frequent gap is the one between the plateau decision and the commencement of VR benefits. As one union submission noted:

This is very unfair to most workers. Once a worker is deemed no longer temporarily disabled and cannot return to his or her pre-injury job, section 29 benefits are concluded. A Case Manager will then refer the worker to Disability Awards and VRC to install Vocational Rehabilitation benefits, the worker is left with no income. Since Worksafe managers work at a snail’s pace, this could take weeks or months. Case Managers will tell you that he of she is not responsible for Continuity of Income and the VRC will not install VR benefits until the worker starts participation. This has caused many workers hardship and should be amended.

I recommend that the Board ensure, through policy or practice, that the injured worker has a continuity of income after a Board decision ends TWL and refers the worker to Vocational Rehabilitation, even if the commencement of VR services is delayed.

Injured workers who cannot work also experience financial hardship when appealing a Board decision which terminates benefits. This occurs when worker disagrees with the Board that an injury has “resolved” or that the worker can “RTW” or that certain Light Duties or a VR plan is suitable. During an appeal, the worker has no financial support and this, together with the lengthy, adversarial and complex appeal process are often circumstances from which the worker does not recover, even if the appeal is successful.

Clearly, the burden of correcting a premature, unsupported or incorrect decision falls on the injured worker. It is a heavy price to pay, in addition to injury and disability.

It is hoped that evidence-based decision-making, a “whole worker” approach and dispute resolution by either collaboration or the Review Division’s wide remedial jurisdiction will reduce the frequency and duration of such events. But given the impact of wrong decisions, it is important that the Board have incentive to arrive at quality decisions in the first instance. This is one policy reason, among several, for the recommendation that the Board pay interest on retroactive entitlement amounts that were found to be owning to a worker, after an appeal. This matter is addressed further below.

Intake Process for Compensation Claims

Various issues arose about the Board’s system for the intake and processing of new compensation claims.
One service issue that arose frequently was the amount of time that lapsed between the acceptance of the claim and the first payment of benefits. At present, the first payment usually occurs at 20 days which many workers find creates financial difficulty. In the period in which the claim is waiting for adjudication, workers may be off work, in financial distress and in need of medical treatment. The Board can and does informally offer support and financial assistance to workers with meritorious cases when there is financial hardship. I commend this practice but also encourage the Board to find a more systemic solution to this delay in benefits.

Several stakeholders identified problems in the Board’s intake process, where claims may be “gated” and held until sufficient information is obtained.

Numerous employers complained that they were given little information about a claim or opportunity to address a claims issue, especially if the worker did not report the injury. At the same time, it appears that some delay in the adjudication time frame is due to employer’s not sending in the F7 within 3 days (or even the 11 days during which a time loss claim may be gated, awaiting the F7). This is a systemic “catch 22”.

The EAO made many helpful suggestions on this particular issue, including:

- At the time of registration, get the employer to provide the contact name and number of the person handling compensation matters;
- Notify the employer when a claim is made (through employer portal, email, phone).

A group of Entitlement Officers (EO) noted that there were systemic delays in requesting and obtaining documentation during the “gating” process and that the “gated” time period is often not productive. One recommendation was all the relevant documentation should be requested with the first receipt of information to start a claim. For example, when notifying the employer of the new claim, the Board could provide the time limit for providing the F7 and the First Aid report.

Board policy provides that provisional decisions may be made in certain circumstances. I recommend that the Board be given explicit authority in the Act for such decisions prior to the acceptance of a claim. I further suggest that this power be provided for both certain urgent circumstances which were previously identified by the Board and also as a general authority to address process issues in case management, prior to the acceptance of a claim.
RECOMMENDATION # 20

The Workers Compensation Act authorize the Board to issue provisional decisions prior to the acceptance of a claim in the following two circumstances and any other circumstances that the Board, in its discretion, defines in policy:

a) where a work-related traumatic event has occurred and an affected a worker makes a claim for a psychological injury arising from that event, the Board will provide the worker with immediate psychological treatment and health care benefits while assessing the worker’s claim; and

b) where there is a delay in the Board’s determination of a claim’s eligibility, the Board may provide expedited medical treatment if it is required to avoid a significant deterioration in the worker’s condition.

If a worker’s claim is denied, the costs associated with the provisional decision will be charged against the Accident Fund.

I also note that the Board has recently staffed EO’s in a special Mental Health Unit with guidance on getting information from a worker with a psychological injury. While this is new territory, I am satisfied that the Board is now aware that asking an injured worker to repeat an account of a trauma can have a negative impact, including re-traumatization. I recommend that this practice continue and that there be a quality audit in one year to assess the consistency and effectiveness of this practice.

RECOMMENDATION # 21

I recommend the practice of placing EOs in a special mental health unit with guidelines on intakes processes for workers with psychological injuries. I recommend that there be a quality audit in one year to assess the consistency and effectiveness of this practice.

Reconsiderations and the Culture of Appeals

As noted, the Board has a strong decision-making culture that poor decisions are best corrected through the appeal process. This approach was recommended by the 2002 Core
Review as a companion to another key recommendation, that Board decisions, once made, should be final except for an appeal i.e. “no reconsideration” of Board decisions. Although the Core Review tempered this “no reconsideration” recommendation with a concern for fairness and changed circumstances, the resulting legislation did not do so. Today, section 96(5) of the Act states that after 75 days, the Board may not reconsider one of its own decisions.

This “75 day” rule is without precedent in Canada. Most Canadian jurisdictions, including Ontario, Manitoba and Alberta, have no time limit to confine a Board’s jurisdiction to reconsider its own compensation decisions. B.C. did not, prior to 2002. Those jurisdictions which do provide a time limit, have one greater, usually much greater, than 75 days.

The “75 day” rule has had a dramatic effect on service culture at the Board and on the experience of stakeholders with Board service. It is difficult to imagine that a worker-centric service culture could evolve at the Board with this provision in place.

**Background:**

Today, as a result of section 95(5), the Board approaches each compensation decision as a discrete matter, which the “decision” renders final after “75 days” and which can be changed only on appeal. The jurisdiction of appeal bodies is restricted to the matters in the formal “decision”.

This rule bestows a finality on all Board decisions including decisions on diagnosis, medical treatments, light duties, wage loss, wage rate, age of retirement, VR plans, duration of VR plans, and pension decisions. Once envisioned as a way to achieve “finality”, especially for employers in their exposure to claims costs in long term claims, it has become one of the defining features of the Board’s current form of service delivery. Some of the consequences include:

- The “75 day” rule is administratively unfair. This was noted by the Provincial Ombudsperson who publicly called for legislative change of this provision in 2010

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47 The “75-day rule” was not a recommendation of the Core Review. The Core Review proposed that there be a balance between the need for “finality” and “the ability of the worker's compensation system to respond to new circumstances”, with a 90-day time frame for the Board to reconsider its own decision and a power of “Reinquiry”, where the Board could reconsider its own decision “when new evidence is presented…”

48 Seven jurisdictions have no time limits on reconsiderations in their Acts; several have policy guiding how officers should use this discretionary authority.
One issue of importance is that our Office has identified system concerns about WorkSafeBC’s inability to correct its own errors after the 75-day reconsideration is over. While WorkSafeBC had expressed a willingness to advocate for changes to the Workers’ Compensation Act to allow it to correct its own errors past the 75-day limitation period, since we commented on this issue publicly in our 2010 annual report, there have been no such revisions to the Workers’ Compensation Act. When a mistake is made and acknowledged by all the parties, WorkSafeBC should be able to resolve the resulting unfairness for the worker on its own initiative.

- The 75 day rule brings particular unfairness to seriously injured workers who must address binding compensation decisions while in the midst of major medical and life-altering matters. There were several cases of this presented to the Review. One family member described how her son was seriously injured in a logging accident in 2004. The employer under-reported the worker’s earnings and the Board then issued an erroneous long term wage rate (LTWR) decision while the worker was in acute recovery. The decision was not appealed in time and an EOT request was denied. This seriously injured worker has lived with an incorrect and uncorrectable low wage rate since 2004; it has negatively affected his every benefit and his every interaction with the Board.

- But the impact of the “75 day” rule goes far beyond casting unfair decisions in stone. It has deeply affected how compensation matters of substance are addressed in original adjudication and on appeal.

- The “75-day” rule does not support quality decision-making in the first instance. It is an invitation to decision-makers to decide – any decision – and move the case along the case management system and off the claim owner’s desk. And while the disputed matter is on appeal, there is no progress on that matter. This is particularly a problem when RTW or VR issues are under appeal.

- The 75 day rule vests every matter in a decision with a legal status of a “determined matter” and appeal bodies are restricted to addressing on those “determined matters”. Individuals often have little or no knowledge of the significance of matters in a “decision”, it is a familiar scenario to the WAO, the EAO, the Provincial Ombudsperson and most representatives that the decision-making process, and the jurisdictional complexity that results.

- The 75 day rule brings requires stakeholders to understand and address the matters in every Board decision within 75 days. After that time, the only avenue for change is an appeal, and the stress, delay and expense of that remedy. This creates problems for all stakeholders, especially injured workers.

Many compensation matters do not lend themselves to a single legal formal distinction, set at one period in time. The approach is particularly egregious when different legal characterizations
or diagnoses can apply to the same injury. Workers may appeal a denial of a new injury, only to be told that it should have been decided as a “re-opening” (or vice versa). Or an activity-related soft tissue disorder (ASTD) is denied as a section 6 occupational disease only to be told by WCAT many months later, that the worker may seek a “decision” for the same condition under section 5 of the Act. This is particularly problematic for workers whose injuries have been misdiagnosed, or where the diagnosis has changed.

Appeal bodies spend a great deal of resources addressing issues of procedure and jurisdiction. As set out in a noteworthy WCAT decision, WCAT-2004-04309, a WCAT panel has many options when faced with a different diagnosis on appeal than that before the original decision-maker. The options available include the appeal tribunal accepting or not accepting jurisdiction over a different diagnosis than the specific diagnosis in the original decision and sending the matter back for new adjudication at different possible stages.

Recently, the British Columbia Supreme Court commented:

_The process is a lengthy, complex and inefficient one, which is striking when considered in contrast to the lofty goal of compensating injured workers fairly in a timely and efficient manner, seemingly established by the Act, the Board’s RSCM and the WCAT’s MRPP._

In 2018, another court commented:

_While these separate inquiries may be logical, the fact remain that, in combination, the overall scheme is unwieldy, inefficient, and cumbersome. This is particularly so when one considers that the Act is intended to serve injured workers. …_  

_There is much discussion and concern in the current case law about access to justice, judicial efficiency, proportionality, and like issues…. These important objects should apply with equal force to administrative bodies. Accordingly, they apply to the Act and to the decision-making process under the Act. Those decision-making processes …appear to do little to advance these various objects._

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49 WCAT-2004-04309 [https://www.wcat.bc.ca/search/decision_search.aspx](https://www.wcat.bc.ca/search/decision_search.aspx)
50 Ibid page 13
52 Shamji v. Workers’ Compensation Appeal Tribunal 2016 BCSC 1352 [https://www.bccourts.ca/jdb-txt/sc/16/13/2016BCSC1352.htm](https://www.bccourts.ca/jdb-txt/sc/16/13/2016BCSC1352.htm) affirmed by Shamji v. Workers’ Compensation Appeal Tribunal 2018 BCCA 73 [https://www.bccourts.ca/jdb-txt/ca/18/00/2018BCCA0073.htm](https://www.bccourts.ca/jdb-txt/ca/18/00/2018BCCA0073.htm). The Court of Appeal affirmed the BCSC decision in Shamji which was that he was not entitled to an LOE assessment. The relevant comment in the BCCA decision is, [67] I certainly appreciate the observations of the reviewing judge. As this case demonstrates, the compensation system in the Act can be slow, cumbersome and frustrating to workers. However, part of this stems from the nature of a process that evaluates a worker’s disability, provides vocational rehabilitation where appropriate, and assesses what losses have resulted from an
In summary, the 75 day rule has created, in its wake, a complex, byzantine legalistic decision-making regime [court commentary], an appeal “treadmill” and a host of fairness and access to justice issues, especially for injured workers. This is a service model which simply cannot provide the type and quality of adjudication needed in a more agile compensation system.

A change in decision-making culture is required to achieve a worker-centric service delivery system, consistent with fairness and RTW objectives. There must be a shift from “producing decisions” to working with stakeholders to achieve specific goals. In my view, this requires a change in both the legislative structure and the culture of Board service and staff.

And given that the complexity of the compensation system was identified as problematic across a wide spectrum of stakeholders, I believe this step is also necessary to improve the confidence of all stakeholders, most especially injured workers. I understand that there will be a concern by finality by those accustomed to the present compensation model. But again, most jurisdictions in Canada have no time limit to restrict when a compensation Board may reconsider one of its own decisions. Finality is best achieved by a good and fair decision.

Re-Openings

A related topic is whether a worker’s condition is a new injury or a recurrence/re-opening of a former compensable injury. The Core Reviewer agreed that a “reopening” of an accepted claim did not question the validity of the previous decision but merely recognized the reality of medical conditions. To do otherwise, would be “arbitrary and contrary to medical science.” However, he recommended that re-openings be limited to “a significant change in the worker’s compensable condition” and this recommendation was the basis for the current section 96(2) of the Act.

Section 96(2) limits the circumstances in which the Board may re-open decided matters. This mainly affects severely injured workers with long-term injuries and those with chronic conditions or re-injuries where there must be documentation and discussion about every change in a long term compensable medical condition. The injury is not “final”; only the liability of the Board for compensation. In my view, this evades the Board’s long-term responsibility for work-caused injuries that it has accepted.
Most other jurisdictions have no statutory limitations on re-openings and leave the matter to Board policy, as did the previous version of the Act. I recommend that both the Act and Board policy follow this model.

**RECOMMENDATION #22**

That sections 96(2) and 96(5) of the Workers Compensation Act be rescinded and replaced by a provision which allows the Board to re-open and re-consider its decisions. Section 17 of the Alberta Act is a model.

**RECOMMENDATION #23**

That following this amendment, the Board develop policy to address the “re-opening/re-injury” issue similar to the former policy on this matter.

**RECOMMENDATION #24**

That the Board develop policy and practices to promote quality decision making based on evidence including a requirement to consider new evidence after a decision has been made when reconsideration is possible under the Act. Appealing a decision is a last resort.

**APPEAL PROCESS – IMPROVING ACCESS TO JUSTICE**

The Review heard from many participants, especially injured workers, that the appeal process was complex and difficult, especially without an advocate or lawyer. Some of the greatest frustrations expressed to this Review concerned the appeal process at the Workers Compensation Appeal Tribunal (WCAT). Participants were often frustrated by WCAT’s limited remedial jurisdiction of appeal bodies and the time and expense of obtaining new evidence, together with WCAT’s restrictive policies on the reimbursement of appeal expenses. Some of these issues are beyond the mandate of this Review.

It is hoped that some of the recommendations from this Review will encourage the early and informal resolution of disputes. However, when an appeal is necessary, I make the following recommendations towards have improved access to WCAT adjudication, including providing jurisdiction sufficient to ensure accessible and fair adjudication of compensation matters.
90-Day Appeal Limit to WCAT

There is lack of consistency between in the time limit to appeal a Board decision to the Review Division (90 days) and the time limit to appeal to WCAT (30 days). This often causes confusion, especially for unrepresented parties. A 90-day appeal period would make the timelines consistent and would not add significant delay. Consistency in time limits for appeals would make the appeal process more user friendly and should reduce the number of applications for extensions of time that workers and employers file with the WCAT every year.

A 90-day appeal period would also give appellants more lead time to obtain new evidence and organize their appeals. This would increase fairness in more complex appeals and should reduce evidence-related delays in bringing appeals to hearing.

RECOMMENDATION # 25

That the appeal period to file an appeal to Workers’ Compensation Appeal Tribunal (WCAT) be 90 days instead of 30 days. This requires an amendment to section 243(1) of the Act.

WCAT Reconsider Its Own Decisions

Prior to 2014, it was considered that WCAT’s had authority to reconsider one of its own decisions on one of three grounds: the ground of new evidence (under section 256 of the Act), the ground of procedural fairness and the ground of a patently unreasonable error of fact, law or discretion (“common law errors”). These latter grounds were not specified in the Act but were seen as matters of inherent jurisdiction for the compensation tribunal, and had been relied upon for years.

In 2014, the British Columbia Court of Appeal (BCCA) decided that, absent explicit statutory authorization, WCAT did not have the authority to reconsider its own decisions for patently unreasonable errors. WCAT applied for and was granted standing to oppose this interpretation before the Supreme Court of Canada (SCC) but the BCCA decision was upheld. It should be noted that the whole issue was introduced by the BCCA on its own motion, not by the parties.

Before 2014, WCAT’s reconsideration powers for common law errors helped ensure that its decisions meet the legal standards of reasonableness and fairness, without putting an onerous burden of judicial review on parties who are little able to bear it. This is an important safeguard.

53 Fraser Health Authority v. Workers’ Compensation Appeal Tribunal, 2014 BCCA 499.
Between 2003 and 2014, WCAT reconsidered almost 1,000 cases. WCAT informed me that since the BCCA decision, the number of judicial reviews of WCAT decisions has greatly increased.

A reconsideration power for common law errors is helpful to both the compensation appeal tribunal and the compensation system generally - it increases the confidence of stakeholders that the appeal bodies provide access to justice; it reduces legal costs and court involvement in workers’ compensation matters; and it contributes to higher quality decision-making at the WCAT.

Seven other jurisdictions in Canada provide their appeal bodies with the authority to reconsider decisions for common law errors.

I recommend that the Act be amended to provide WCAT with statutory authority to reconsider decisions in completed appeals for decision-making errors, including patently unreasonable errors of fact, law and discretion; “true” errors of jurisdiction; and to remedy procedural unfairness in the conduct of an appeal.

**RECOMMENDATION #26**

That the Workers Compensation Act be amended to authorize Workers’ Compensation Appeal Tribunal to reconsider its own decisions on common law grounds.

**Consistency in Appeal Jurisdiction**

At this time, WCAT does not have jurisdiction to decide legal issues arising under the *Canadian Charter of Rights and Freedoms*(Charter) and the *Human Rights Code* (HR Code). It is precluded from doing so by section 245.1 of the Act incorporates certain provisions of the *Administrative Tribunals Act* (ATA) which remove a tribunal’s jurisdiction in these matters. However, the ATA does not apply to the Review Division and so the Review Division has jurisdiction to apply the Charter and the HR Code in matters where WCAT does not.

This creates inconsistency and complexity in the appeal process. If a worker or employer wishes to raise an issue relating to the Code or the Charter (as happens with some frequency) they must do so at the Review Division and then proceed to judicial review on those issues, even while having to proceed to WCAT on compensation issues. This inconsistency creates further difficulty for the court and the parties on judicial review. A court may consider a Charter or HR Code issue, which may arise on the courts own motion from a WCAT decision, but the matter cannot be referred back to WCAT for lack of jurisdiction.

Finally, these inconsistencies between the appeal jurisdictions will become more troublesome as the compensation system proceeds with “duty to accommodate” issues during RTW.
For all of these reasons, I recommend that section 245.1 of the Act be amended to remove that section’s incorporation of sections 45 and 46.3 of the ATA. This amendment would provide WCAT and the Review Division with the same jurisdiction to interpret and apply these fundamental sources of law in workers’ compensation matters.

**RECOMMENDATION #27**

Reinstate the Workers’ Compensation Appeal Tribunal’s jurisdiction to consider issues arising under the *Canadian Charter of Rights and Freedoms* and the *Human Rights Code*. This requires an amendment to section 245.1 of the Act.

*Flexibility In Appeal Bodies to Grant an Extension of Time (EOT)*

Most jurisdictions either have no time limit for appeals or give their appeal bodies a wide discretion under the legislation to allow for extensions to appeal deadlines. Given that the Review Division and WCAT are well established bodies, guided by published rules, it is recommended that they be provided with the discretion to determine when to allow EOTs to appeal rather than have statutory restraints. This will create an expedited and less legalistic approach to EOTs.

**RECOMMENDATION #28**

That section 243(3) and section 96.2(4) be amended to read that that on application the chair (or the chief review officer) may extend the time to file a notice of appeal even if the time to file has expired.

*Payment of Interest on Retroactive Awards*

I recommend that the Act be amended to provide for the payment of interest on certain types of retroactive benefits where injured workers have done without financial support to which they were entitled. This is an important step towards fairness and accountability in the decision-making culture.
**Background re Payment of Interest:**

Prior to 2001, the Board had a policy (policy #50.00) that required the Board to pay interest on certain types of retroactive awards. Typically, this situation arose when an appeal body or the Board found that a worker was entitled to benefits which they had not received. In 2001, the Board changed this policy to provide that interest would be paid only where it is determined that a blatant Board error necessitated the payment. The result of this change was the virtual elimination of interest being paid on delayed benefits to workers.

This issue has a technical and contentious history both before and after policy #50.00 changed in 2001. This history, the policy discussions and legal proceedings are set out in detail in Appendix 16 – Interest History. The primary source of legal pursuit to the question of whether the Board’s Interest Policy is supportable under the Act was Mr. Johnson and on September 26, 2007, Madame Justice Gray concluded that section 5 of the Act requires that interest be paid where those benefits are delayed.

There ensued further legal proceedings which again, are carefully summarized in the Appendix and which were ultimately, unsuccessful for technical reasons. This protracted legal dispute illustrated several aspects of the policy challenge under section 251, which makes this process unreasonable as a legitimate way to assess the legality of Board policy.

The frustrations and challenges of the debate of interest on delayed compensation and the eventual unsuccessful outcome support a conclusion that there should be an expressed provision in the Act to resolve this issue.

**Re Merits of Interest Payments:**

From the many proceedings, three general principles were presented for the payment of interest on delayed benefits.

- Interest may be justified on the basis that delayed compensation payments are similar to overdue business accounts on which the Board, as a corporation, pays interest.
- Interest may be justified on the basis that it is compensation for the loss of advantage accruing from funds at the time they were originally payable.
- Interest may be justified on the basis that it is remedial - it places a person in the same position in which they would have been had the benefit been allowed in the first place.

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54 See policy item #50.10 of the Rehabilitation Services and Claims Manual as of April 2000. Interest was paid on pension lump sum payments. Effective November 26, 1981, interest was extended to retroactive wage-loss payments.
Interest remedies the expenses associated with borrowing money or expensing personal resources while awaiting the payment of benefits initially denied or over-looked.

Considered together, it is reasonable that interest payments should be paid on retroactive benefits to compensate the worker or employer for being denied the opportunity to have immediate access to money.

There is a strong practical element of fairness as well. As we heard repeatedly in this Review, when workers are denied benefits for a significant period of time, they will deplete savings and, in many cases, add debt which may often be consumer (credit card) debt or cash in hard-earned assets like their houses. We heard from several workers who lost assets, including homes, boats and cars, as a result of delayed benefits.

Throughout the legal proceedings on this issue, there was much discussion on the rate of interest to be paid. Other jurisdictions pay interest for any delay under the rates in the Courts of Justice Act. However, I recommend that paying interest at the Board’s rate of return, as used to be done in B.C., would make the economic impact of the retroactive payment neutral for the Board. If interest were paid at some lower rate, there would be an economic advantage to the Board to delay benefits and this should be avoided in terms of restoring worker’s confidence in the Board.

Next, interest should not be paid on short delays. The amount of interest paid on a short delay would not be significant even though a worker may incur significant consumer debt as a result of delay. There must be a balance in the payment of interest and it also provides incentive for the Board to correct its own decisions in a timely way. A delay of 180 days or greater is clearly excessive but I consider that interest should not be paid earlier than that date. The interest should be payable from the date the payment was owing once there is a delay of 180 days or greater.

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Finally, interest accumulates against a person on a compound basis and accrues to the accident fund on a compound basis. I consider it suitable that compound interest should be paid on that basis.

**RECOMMENDATION # 29**

I recommend that the Workers Compensation Act be amended to provide that interest will be paid on overdue wage loss and permanent disability benefits greater than 180 days, based on the Board’s return on investments, at compound interest as of the date the benefits would have become payable.
PART IV: POLICIES AND PRACTICES THROUGH GBA+ LENS

IN BRIEF

The Review was charged with looking at policies and practices through a GBA+ lens and all sections are include this perspective.

This section looks at certain groups of vulnerable and precarious workers and their experiences within the workers’ compensation system. The goal is to recognize what assistance is needed to recognize and address their challenges, particularly in VR and RTW. This section looks at:

- Average Earnings calculations for young, casual and temporary workers
- Psychological Violence and Discrimination based on Identity Factors
- Gender Issues in RTW, sexual harassment and sexual assault
- Assisting workers with cognitive impairments
- Temporary Foreign workers and farmworkers

A gap in claim suppression is identified and recommendations to close the gap are made.

I was asked to assess the matters under review and my recommendations of this Review through a “GBA+” lens.

GBA+ is an analytic process using “Gender Based Analysis” where gender includes both biological (sex) and socio-cultural (gender) differences and where the “plus” refers to other identity factors such as race, ethnicity, religion, age and mental or physical disability. The process is designed to assess how these various groups experience policies and programs and the potential impacts of these programs on the diversity of Canadians.

Diversity emerged as a legal concept when it was recognized that four designated groups – women, aboriginal peoples, persons with disabilities and members of visible minorities – faced discriminatory employment barriers resulting from historical disadvantage and could benefit from measures to make workplaces more inclusive. The concept of diversity has now expanded and now includes age, sexual orientation, immigration status and other areas of disadvantage. The Provincial and Federal governments now incorporate a GBA+ analysis into all of their policy development, with the goal of supporting inclusive workplaces. Further information about the GBA+ analysis process is set out in Appendix 17.

56 Diversity was recognized in the Employment Equity Acts (1986 and 1995).
The GBA+ analysis is particularly important in a compensation review, given that the Board’s mandate includes helping workers with permanent impairments overcome barriers to their employment. A GBA+ analysis recognizes that diverse workers may experience compensation policies and practices differently. The Board’s policies and practices need to be inclusive in the exercise of this mandate and not raise further barriers to future employment. In addition, the Board is well-positioned to lead in the area of supporting inclusive workplaces.

A GBA+ lens has been applied throughout this Report. The RTW section assesses RTW policies and practices as they are experienced by immigrants, older workers and young workers. The “Urgent Issues” section notes that compensation policy and practices regarding Activity Related Soft Tissue Injuries (ASTDs) result in men having significantly higher claims acceptance (about 60%) than for women (about 35%). And the accepted claims rate for Indigenous workers working on reserve is about half of the rate of that for claims acceptance as a whole.

In this section, I will address certain additional issues which require a more in-depth GBA+ discussion regarding the impacts of certain policies and practices as experienced by particular groups of workers.

INTRODUCTION TO PRECARIOUS WORK AND VULNERABLE WORKERS: THE NEW ECONOMY IS A NECESSARY CONTEXT

Today, any review of compensation issues using a GBA+ lens must acknowledge the changing world of work and how these changes have affected historically disadvantaged workers.

The new economy includes the emergence of both the “gig” economy (characterized by temporary or flexible work arrangements or “gigs”) and the “sharing economy” (characterized by work exchanges which are organized through the internet or apps). Both concepts are further discussed in Appendix 11. This section acknowledges the research work done in other jurisdictions as they address the changing nature of work and its impact on regulatory systems and vulnerable workers, particularly women, minorities, immigrants and people with disabilities.

A recent study of the working age populations in the U.S. and Europe found that workers in the “gig economy” could be divided into two groups:

a. Those who wanted independent work on either a full time or part time basis; and
b. Those who make their primary living from independent work but would prefer traditional jobs, and those who did supplemental work (second or third jobs) out of financial necessity.

“Precarious work” identifies a certain type of independent work (which may or may not be voluntary) which is defined by certain characteristics. The Law Commission of Ontario defined it as follows:

Precarious work is characterized by lack of continuity, low wages, lack of benefits and possibly greater risk of injury and ill health... Measures of precariousness are level of earnings, level of employer-provided benefits, degree of regulatory protection and degree of control or influence within the labour process... The major types of precarious work are self-employment, part-time (steady and intermittent) and temporary.

“Vulnerable workers” are defined as those individuals who have both precarious work and an employment vulnerability due to their “social location” in one of the following groups. This definition is used because it is well documented that these groups suffer a disproportionate degree of hardship in the labour market and are over-represented in precarious employment.

- Women and single parents
- Racial Minorities
- Newcomers to Canada and Established Immigrants
- Temporary Migrant Workers
- Aboriginal Persons
- Persons with Disabilities
- Youth and new workers
- Older workers
- Non-status workers

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59 Vulnerable Workers and Precarious Work, p. 11.
Precarious work has been related to both increased workplace injuries\textsuperscript{60} and reduced health and safety regulation.\textsuperscript{61} This is further discussed in Appendix 17.

I recognize that not all workers in GBA+ identified groups have precarious employment and that many are working full-time in secure employment. However, many or most workers in precarious employment fall within a GBA+ analysis. To a great extent, the definition of a vulnerable worker coincides with groups identified as having a historical disadvantage for the purpose of a GBA+ assessment, but with the added disadvantage of precarious work.

From this perspective, I review the following compensation policies and practices:

- The calculation of “Average Earnings” (AE) for new, temporary or casual workers or the self-employed (Precarious Work)
- VR assessments and plans for vulnerable workers.
- Status Issues in Precarious Employment
- Psychological Violence and Identity Based Discrimination
- Gender Issues in RTW
- Sexual Harassment and Violent Assault
- Practices Re Individuals with Cognitive Impairments
- Practices related to Temporary Foreign Workers (TFW)
- Claims Suppression
- Employment in the Federally Regulated Private Sector
- Diversity at the Board
- GBA+ going forward

While the broader issue of Claims Suppression is an issue of concern to all workers, its prevalence in cases of vulnerable workers suggests that it is helpful to include it in this section.

**The Calculation of Average Earnings (AE) for Precarious Work**

The Act defines how “Average Earnings” (AE) will be calculated for different types of workers. This is important because each worker’s wage rate is based on the AE calculation and this affects all compensation benefits.\textsuperscript{62} Section 33 of the Act specifies one set of rules for workers


\textsuperscript{62} The policies for AE calculations are set out in Chapter 9 of the Rehabilitation Services and Claims Manual, Volume II (RSCM II). Since the AE calculation is the basis for a worker’s wage rate (set at 90% of
NEW DIRECTIONS:
WCB REVIEW 2019

with regular work patterns and another set of rules for groups with patterns more like precarious work. For both groups, the AE calculation is supposed to be made with reference to both “the average earnings and the earning capacity of a worker”.

The general rule for most workers is that the AE amount is “based on the worker’s gross earnings…for the 12 month period immediately preceding the injury.” [Section 33.1] For regular workers, the decision-maker has discretion to consider “exceptional circumstances” where the application of the AE rules would be “inequitable.” Section 33.4(1) reads:

If exceptional circumstances exist such that the Board considers that the application of section 33.1(2) would be inequitable, the Board’s determination of the amount of average earnings of a worker may be based on an amount that the Board considers best reflects the worker’s loss of earnings.

The Act stipulates a different set of rules for calculating AE calculation for workers with short-term, temporary or casual employment or the self-employed i.e precarious employment. These rules are set out in separate sections of the Act:

- Section 33.2 – AE rule for Apprentices or Learners
- Section 33.3 – AE rule for workers employed for less than 12 months
- Section 33.5 – AE rule for casual workers
- Section 33.6 – AE rule for a person covered under section 2(3) of the Act [ i.e. an independent operator who has POP coverage and therefore is deemed to be a “worker” for compensation purposes under s. 2(3) of the Act.]

In addition to these different but firm rules, the Act does not allow a decision-maker to consider “exceptional circumstances” in these cases. [ section 33.4(2)] In effect, the Board has no discretion to assess whether the legislated AE rules are “inequitable” in particular cases or whether they fairly estimate a worker’s “earning capacity” as required under section 33(1), the standard used for workers in more traditional work arrangements.

The absence of discretion in cases of precarious employment is a concern. In these categories, employment patterns are varied and they present a challenge for arriving at a fair assessment of an individual’s earning capacity. The current Act requires that for traditional workers, discretion be applied in some cases to avoid inequities. Yet this discretion is denied in those very cases where the work is most variable and where a firm rule is most apt to result in inequities, where it is least likely that “one size fits all”.

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net average earnings), the AE calculation affects all aspects of the claim including compensation benefits and RTW supports.

PART IV: POLICIES AND PRACTICES THROUGH GBA+ LENS
A number of participants in the Review identified these legislative AE rules have having a very negative impact on young, new or casual workers and others when they were injured in this type of employment.

One group that is particularly affected are seasonal workers, including farmworkers. The Review heard from their representatives that this group tends to report only very serious and disabling injuries, which typically result in permanent impairment. However, the low wage rates for seasonal workers resulting from the AE calculation under the set rules, means that their PFI pensions are so low that these disabling injuries cause great financial hardship. There is no discretion to consider their long-term employment patterns and a fair assessment of their “earning capacity”.

Another group that is affected are young workers. One family member told us about her 16 year old daughter who experienced a serious knee injury during a part-time minimum wage job. It will have a lifelong impact on her ability to work, but her compensation did not in any way reflect this. In another case, a young worker was engaged as a full-time trucker but was badly injured on his first run. His wage rate was based on an AE for new workers, rather than reflect his earning capacity over what would have been a long and well-paid job.

A GBA+ analysis must assess whether section 33.4(2) has an adverse impact on historically disadvantaged groups. In my view, it does. They are denied the opportunity to have the Board consider “inequities” that result from the application of the statutory AE rules, although this is authorized for traditional workers. And an inequitable AE calculation negatively affects a worker in many ways that affect employment barriers– less compensation benefits, less access to rehabilitation and re-employment supports and lower pensions for permanent disabilities. These impacts are experienced by groups that historically are treated unfairly.

In my view, the discretion provided to AE calculations in section 33.4(1) of the Act should be applied to all workers; equity is a principle that is needed by all.

I recommend that the wording of section 33.4(1) of the Act be amended, so it refers inclusively to all AE rules set out in Section 33, rather than just to section 33.1(2). I further recommend that section 33.4(2) of the Act be removed. I anticipate that should these legislative changes be accepted, that the Board will develop additional policies for Chapter 9, and the application of “exceptional circumstances” to precarious work. I leave that as a further matter, to be addressed through the Policy Division with stakeholder consultation. But I do note that as vulnerable workers and those with precarious work tend not to have an active consultative voice, that additional efforts should be made to ensure that representations are made on their behalf in these consultations.
RECOMMENDATION #30
Amend section 33.4 to allow exceptional circumstances to apply to all workers, where the application of the usual rules would be inequitable.

RECOMMENDATION #31
It is recommended that section 33.4(2) be removed as an unfair restriction of the application of the “exceptional circumstances” discretion to a group of vulnerable workers.

VR Plans and VR Resources for Vulnerable Workers

When a worker from a historically disadvantaged group suffers a permanent injury, a realistic RTW/Vocational Rehabilitation path should take their identify factors into account. Many of these issues are addressed in the RTW section. However, as a general principle, it should be recognized that prior to a work injury, such workers have likely experienced barriers to employment and that to RTW, they will need VR plans which realistically address the impact of that injury to that particular worker. The Board is encouraged to use its special expertise and resources to develop and address recurring VR issues related to these issues and to utilize creativity and collaboration in seeking to restore such workers to employment status as much as possible.

RECOMMENDATION #32
That the Vocational Rehabilitation (VR) plans take into account that special barriers to reemployment exist for disabled vulnerable workers and alleviate those barriers to the greatest extent possible. VR plans could regularly include language and education components to enhance employment opportunities and in appropriate cases and at the worker’s request, VR plans could include start-up grants or training for self-employment.

RECOMMENDATION #33
That the Loss of Earnings assessment for a vulnerable worker take into account the special barriers to employment faced by that disabled worker by assessing the employability of similarly vulnerable individuals.
Status Issues In Precarious Employment

One Board practice which is potentially harmful to vulnerable workers in the gig or sharing economy is the misclassification of a worker as a “self-employed contractor” rather than as a “worker”. In general, this issue is beyond the TOR for this Review so I bring it forward as an attention point for the Board and provide a fuller discussion in Appendix 11. However, to the extent that a misclassification has a significant impact on all compensation issues for vulnerable workers, I make the following recommendation as part of this Review.

RECOMMENDATION #34

It is recommended that Board policy provide that a determination of “worker” or “independent operator” status by the Assessment Department is a provisional determination which may be reconsidered and redetermined by the Board for compensation purposes, regardless of whether the individual has acquired POP coverage.

PSYCHOLOGICAL VIOLENCE AND IDENTIFY GENDER BASED DISCRIMINATION

The Review heard from workers who had experienced threats, humiliating conduct, or race or gender based harassment in the workplace. Some workers had addressed these situations through the Board’s bullying and harassment provisions; others made a claim for a psychological injury under section 5.1 of the Act. It was striking how often, when the claim was made by a woman working in a male-dominated workplace, the worker was told “What can you expect working in that environment?” In the earlier section of this Report, I confirm that there is no “Assumption of Risk” doctrine in the compensation system and this example should be included in the recommended policy and Practice Directive.

There is now a standard for a Psychological Health and Safety in the Workplace and the Board has engaged a Chief Mental Health Officer (CMHO). The Board is advancing in its programs to prevent workplace violence (including psychological violence) as an occupational risk in some sectors.

It is clear from the presentations and research that psychological violence, and sometimes sexual violence, can be embedded in the culture of a particular workplace. Women, workers of colour and LBGTQ workers are especially vulnerable. When individuals are targeted for harassment on the basis of sex or gender (or any other identity factor), the workplace is unsafe for that worker, especially if she or he is vulnerable in other respects. Workers who are so

63 Canadian Standards Association 2013
targeted often fear that reporting make the harassment or violence worse, or result in retaliation. Some of these matters are addressing in the section on Claims Suppression below.

Much of the research on this topic highlights the key role that prevention plays in identifying and addressing gender-based risks in the workplace. As noted in another article by K. Lippel:

*A key factor in reducing exposure to psychological violence, including bullying and harassment, as well as sexual harassment is to find ways to make these behaviours unacceptable in the workplace. This is achieved not just by posting policies declaring them to be unacceptable but by changing the workplace culture so that there is a shared perception that such behavior, that may have been prevalent and accepted years ago, is no longer tolerated either by management or by workers and their unions.*

Because such harassment tends to be workplace specific, and the targets of such harassment are highly vulnerable, I recommend a case by case approach to this issue, integrating both a compensation and prevention perspective. The approach should have the capacity to address all types of harassment and psychological violence, including gender, race or identity based bullying and harassment. I recommend the following:

**RECOMMENDATION #35**

That the Board extend the mandate of the Chief Mental Health Officer (CMHO) to include Prevention matters with a particular focus on the creation of psychologically safe workplaces with a GBA+ lens. In particular, I recommend the CMHO, in consultation with Prevention, establish the following:

- a process whereby a vulnerable worker can confidentially report a situation of sexual or identity based harassment or violence and receive counselling and support for a period of time without starting a compensation claim.
- Outreach programs for a workplaces or employer to promote a safe work environment for women or other vulnerable workers; and
- Make recommendations for how to address workplaces with ongoing issues of harassment and discrimination.

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**RECOMMENDATION #36**

That Board policy and practice directives on bullying and harassment specify that all workers are entitled to a psychologically safe workplace.

That Board policy provide that where a worker is targeted or otherwise made psychologically unsafe in a workplace, inclusive of bullying and harassment based on gender or other identity factors, this should be considered as a significant workplace stressor when assessing a psychological injury.

**GENDER ISSUES IN RETURN TO WORK (RTW)**

The GBA+ analysis prompts questions about the assumptions and impacts of compensation policy and practice around RTW given the realities sex and gender factors in the workplace.

This issue has a particular historical footprint in the compensation system. OH&S Regulation and compensation evolved in the context of preventing and treating traumatic injuries to men who were working in hazardous occupations like mining, fishing, forestry and construction. As women’s participation in the workforce increased, OH&S regulations were extended to them in a “gender-neutral” way. In addition, many health and occupational guidelines were developed for “all” workers but were based on male experiences or research cohorts, so the results were not necessarily reflective of the occupational risks, injuries and paths to recovery for women.

The “gender-neutral” approach has been reviewed through a type of GBA+ lens in other jurisdictions, resulting in profound impacts on OH&S regulation and health research. As early as 2011, the World Health Organization’s *Building Healthy and Equitable Workplaces for Women and Men: A Resource for Employers and Worker Representatives* noted that women and men face different risks and health problems, have different domestic and unpaid responsibilities and have different experiences on RTW. The global study also noted:

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66. For example the report “Does sex and gender matter in post-traumatic stress injury?” Canadian Institutes of Health Research, March 21, 2019 concludes most research into the neurobiology and stress response of PTSI has been conducted on all male samples while most of the research on “emotional vulnerability” in PTSI has been done on all female samples. There is a high prevalence of PTSI in transgender people which is understudied.

When women do experience a work-related health problem, they are less likely than men to be diagnosed, recognized, compensated or be offered rehabilitation. In some cases, return-to-work options are largely underprovided. 

Some of the gender-specific risks are particularly important for RTW and disability management. Attached at Appendix 18 is a publication, Principles for Labour Inspectors: With Regard to Diversity-Sensitive Risk Assessment, Particularly As Regards Age, Gender, and Other Demographic Characteristics. This publication offers a very practical way to assess individual differences in the workplace and do a holistic risk assessment (consistent with a biopsychosocial approach to disability), with particular guidelines for risk assessment with an age and one with a gender perspective. This would be an excellent guideline to consult in RTW plans for women and vulnerable workers.

As noted above, it may also be necessary to conduct a “gender-related risk assessment” of the workplace prior to the worker’s return to that location. This should identify both physical risks (e.g. working alone) but also “invisible risks” to that worker such as harassment, discrimination, threats and violence at work. A guideline to a “gender-related risk assessment” is included in the Guidelines for Labour Inspectors in Appendix 18.

I also heard from a number of women that were offered residential treatment programs or RTW options that were rendered difficult or impossible because of the conflict with their family responsibilities.

A biopsychosocial approach to disability requires that there be a realistic assessment of a worker’s barriers to particular employment opportunities, as well as an assessment of “impairment”, before the disability can be reduced or managed. For a successful RTW to be developed with a GBA+ lens, the “barriers” to be assessed for a RTW plan must include factors that affect women, even if these factors have not been perceived as “barriers” to a RTW by men. This includes a consideration of their unpaid role in family responsibilities, the impact of changed hours of work and a changed work environment which may include exposure to harassment, discrimination or danger in working alone. Enclosed in Appendix 19 is a checklist from the World Health Organization about ways that the psychosocial work environment can be modified to reduce such hazards.

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70 Principles for Labour Inspectors, European Commission, page 19. [Appendix 18]
RECOMMENDATION #37

That the Board develop policy and practice directives that specify that return to work plans must include consideration of the worker’s disability and an assessment of the workplace duties from a GBA+ perspective.

Resources are also being developed specifically in the B.C. context and as noted in a Board publication, Professor Mieke Koehoorn was awarded a Chair from the Institute of Gender and Health to investigate the differences in occupational diseases, injuries and outcomes related to sex and gender over the next five years. Professor Koehoorn’s research may assist issues of treatment and compensation, as well as prevention, over the next years.

Sexual Harassment and Assault

I have used the following resource as a guide recommendations in these sections and recommend it for further development in this area of policy: Addressing Occupational Violence: An Overview of Conceptual and Policy Considerations viewed through a gender lens. This publication identifies that women are disproportionately exposed to sexual violence in the workplace, including sexual harassment, sexual assault and poisoned work environments of a sexist nature. They are also disproportionately exposed to psychological violence, including bullying and harassment and physical violence. A review of the literature suggests that occupational violence can be "normalized" and this contributes to its trivialization. In some hospitality workplaces, sexual harassment is seen as part of the job. Lippel suggests that hazard specific legislation is helpful to make these risks visible, such as the Board’s tool to address violence to which homecare workers may be exposed in a private setting.

Sexual harassment in the workplace is well recognized in human rights law as a form of discrimination in employment. It is also an issue of workplace safety and if injured, an issue for compensation. In this Review, I heard stories from women who were sexually harassed and/or assaulted in the workplace, one violently. It was also clear from participants and from the

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73 Ibid, page 18.

74 Ibid, page 25.
research that immigrant women are at particular risk of harassment and assault, especially in the hospitality sector.

The Board now has a specialized intake practice for claims which involve sexual harassment or assault. The CSR takes basic information and encourages the worker to save detailed information for the case manager so she/he does not have to tell the story twice. The claim is then moved to a case manager in the Sensitive Claims area and is coded for Sexual Assault/Harassment. I commend the Board’s respect for the sensitive information involved in such cases. I note that the Board has also taken steps to give special case management attention to workers who are the victims of physical violence in the workplace and this has also had a very positive impact.

However, I recommend that a different approach be used for cases which involve a violent sexual assault, particularly if the worker is still in the workplace at the time of reporting. Now, if the Sexual Assault involves threats or violence or significant physical harm, the CSR will tell the assaulted worker to call the police and then call back and report the claim which is then treated as a “sensitive claim.” The Review heard from workers who had this experience, that this response was inadequate to the ongoing threat to their safety in that workplace. A violent sexual assault in the workplace is analogous to a physical critical incident in the workplace. At the time that it occurs, there is both a seriously injured worker in need of urgent treatment, and an unsafe workplace. The Board has a responsibility to react to both and the usual claims reporting process is not adequate.

In cases of violent sexual assault, the worker is likely in crisis and may need help in arranging a safe exit and/or calling the police. The Board also needs to assess to assess the immediate safety of the workplace, for the assaulted worker and other workers and while criminal charges may well apply, the workplace needs further investigation by a Prevention officer.

I recommend that violent sexual assaults be treated as critical incidents and that the Board develop the following practices and processes:

- That on the Board’s website, sexual assault be identified as a critical incident that may be reported on Prevention’s 24-hour crisis line or other available crisis line arranged through a partnership with the Board;
- Upon reaching this crisis line, the worker is immediately assessed as to her situation, urgent needs and the available resources, including getting to safety, urgent medical help and trauma counselling. The Board may wish to partner with or have training by other organizations which have crisis lines with counseling and support for victims of sexual assault; and

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75 WCB-IR 103.
• After the worker is safe and able to report her experience and injuries, the Board performs a risk assessment of the workplace and provides this risk assessment as part of the worker’s counselling and before a RTW.

This recommendation assumes that the 24 crisis line is well resourced and if not, that the Board partners with another crisis line service for 24 hour coverage of sexual assaults. One worker reported reaching the crisis line and being told to leave a message. He did so but never received a call back response.

**RECOMMENDATION #38**

That the Board practices, upon being notified of a sexual assault in the workplace, be revised to include a crisis line, reporting and counselling and follow up regarding support for the claim and an investigation of the worksite. The protocols for a workplace investigation where a criminal matter may be involved should be followed.

**WORKERS WITH COGNITIVE IMPAIRMENTS**

In this Review, we heard from many people - workers, family members, representatives, health care providers and public advocates – that workers with cognitive impairments are poorly treated by and have poor experiences in the compensation system. They are often unable to meet the complex demands of the claims process. The Provincial Ombudsperson, the Workers’ Advisors and the Fair Practice Office all describe this group as forming a regular part of their intake and support work, with workers sometimes just needing help to communicate with the Board or understand Board decisions. And for some presenters to this Review, no help was available and they fell by the wayside.

One presenter, who had represented a number of workers with concussions and/or traumatic brain injuries (TBIs) described the worker’s condition including some of the following:

• They are like a boat lost at sea. Even reporting their injury to WCB, they don’t know what to do, how to do it or if they have already done it.

• They get easily flustered and often forget what they are saying. These “memory lapses” are often mistaken by a case manager as being “lazy” or “their injury can’t be that bad if they are not following through.”

• The most vulnerable workers are single with no one to help them navigate the WCB system.
• They don’t have the capacity to think of the future…they are just stuck in this present, confused, vulnerable state.
• People with concussions often introvert…they suffer in silence.

At this time, the Board does not provide special services or assistance for workers with cognitive impairments. Yet it is clear that without special services or help, workers with cognitive impairments do not and cannot participate meaningfully in the compensation system or access many of its services. In this group, I would include workers with minor or major brain injuries (pre-existing or compensable), concussions, developmental disabilities or other psychological or physical conditions which lead to cognitive impairment. The issue is the same whether the cognitive impairment arises from the work injury or is a pre-existing condition.

In my view, the Board’s current practice holds these impaired workers to the same standard as an “average person” with respect to their the ability to navigate a complex compensation system. From a GBA+ perspective, this practice needs to change. It is an organizational response which effectively interacts with their cognitive impairment (a barrier) to hinder their full participation in the compensation system. This is a classic definition of creating a disability, rather than managing or accommodating it. Critically, this response effectively disables or prevents workers with cognitive impairment from participating in a system meant to help them address the many employment barriers that they will face.

I strongly recommend that the Board establish a non-adjudicative support team, inclusive of a social worker, for workers with cognitive impairments. The goal is to communicate with and support these individuals and help them navigate the compensation process. This includes being available to explain the claims process, Board decisions and answer questions. It is not intended that this team provide advocacy services but to identify when representation would be useful and assist the worker to make the appropriate contacts. The team should also help the worker utilize whatever medical services or resources may be available to in their community for their particular conditions. Ideally, the team would coordinate with Clinical Services to assist claim owners in identifying these individuals at an early stage in their claims. This is an important step in treating the worker’s compensable disability from a biopsychosocial perspective and in a way which accounts for the individual’s specific needs.

And while these comments are made in the context of injured workers, the same services should be available to any employer with cognitive impairment who requests this support.
RECOMMENDATION #39

That the Board establish a support team for cognitively impaired injured workers to assist them in a manner which allows them to participate in the compensation system in a fair and reasonable way. This support service should be provided to all cognitively impaired workers, regardless of the cause or nature of their impairment.

TEMPORARY FOREIGN WORKERS (TFW) and FARMWORKERS

In 2017, British Columbia hosted almost 17,000 Temporary Foreign Workers (TFW) through the federal Temporary Foreign Worker Program; it is second only to Ontario in the number of TFW in the province.\(^{76}\)

About 7500 (44%) of the TFWs entered as farmworkers through the Seasonal Agricultural Worker Program (SAWP) and arranged through the Mexican Consulate. The other TFW (about 56%) enter into occupations where a Labour Market Impact Assessment (LMIA) had established a labour shortage. These other occupations include other high-risk jobs, especially construction.

*Agriculture and Farmworkers*

For historical reasons, the majority of workers in B.C.’s agricultural sector are either Punjabi-speaking B.C. residents of East Asian descent or Spanish speaking TFW, arriving through the SAWP program. This section will address both groups of workers as part of the occupational group of “farmworkers”, recognizing that farm work is a high-risk occupation.

The health and safety issues for all farmworkers has long been an issue. In 2007, a van carrying farmworkers crashed, killing 3 women and injuring 14 others. In the wake of this accident and a coroners inquest, the Board funded a study, published as *Farmworker Health and Safety: Challenges for British Columbia*\(^{77}\). This publication and a detailed report from the Institute for Work and Health in February, 2009\(^{78}\) provide a detailed assessment of the systemic barriers facing agricultural workers in making a claim, pursuing a claim and engaging in RTW.

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These same barriers exist for many employers in this sector as well. These publications and their detailed recommendations are attached as Appendix 20. I recommend that the recommendations from these studies be reviewed and considered in a special project for compensation services to farmworkers.

I note that the Board has currently engaged in outreach to the Mexican SAWP workers by

- providing publications in multiple languages
- having the Mexican Consulate present the Board's information to workers while they were still in Mexico.

One employer who supports his Mexican workforce commented:

> Communication, it’s a big obstacle for most of the foreign workers that comes to Canada through the Temporary Foreign Program. When the worker calls to workers compensation office to confirm the injury report, communication is often difficult because there are no available translators. We will highly recommend to have translation available or better translation system when dealing with foreign workers. Other than the communication barrier the program works very well, all claims and reports were process.

This view was repeated by a number of presenters and I regard language barriers as a significant issue for all non-English speakers in participating in the compensation system. While this recommendation is made in this section on farmworkers and has a particular significance for this group, the recommendation is intended for the compensation system as a whole.

### RECOMMENDATION #40

That the Board utilize Board officers with other language capabilities, especially in Spanish and Punjabi, to communicate with agricultural workers and employers about both claims and Health and Safety. These officers should be given training and be aware of the special issues and systemic barriers in this sector.

Both groups of farmworkers - Spanish-speaking TFW and resident Punjabi-speaking farmworkers - identified other systemic barriers as well, including remote locations and the complexity of the compensation system. Given the high risk nature of farm-work, this is significant. In my view, farmworkers cannot fairly participate in the compensation claims system without additional support. From a GBA+ perspective, this group already experiences significant employment disadvantages and additional barriers to employment services should be addressed.
I note that both of the communities of workers involved in farm work have well-established advocacy communities. I recommend that the Board partner with these community organizations and fund both Navigators and special compensation advocates to provide farmworkers with effective access to the compensation system in the event of injury. I also recommend that the Board assess the need for similar support for the employers in this sector together with the EAO.

**RECOMMENDATION #41**

That the Board provide funding for the training of compensation Navigators and Advocates within the established advocacy groups for farmworkers, and fund them on an ongoing basis for case work support for injured workers who make claims. I recommend this, in addition to the Workers Advisers Office, due to the systemic barriers that this population faces: including that many of the workers live remotely, on the employer's premises, are only available to meet after long working days and do not speak English.

Finally, I was also informed that the Board has partnered with other Provincial initiatives to provide information sessions to B.C. employers who employ TFW. However, these outreach programs have focused almost entirely on health and safety issues which do not assist a worker through a compensation claim. I recommend that these excellent outreach project incorporate information on compensation.

**Temporary Foreign Workers in Sectors other than Agriculture**

In addition to farmworkers, there are about 8500 TFW in other occupations in B.C.

B.C. recently passed the Temporary Foreign Workers Protection Act, requiring employers to register when they hire foreign worker and WorkBC has a detailed website about Employer Rights and Responsibilities for TFW.

Given the dispersed nature of TFW and their integration into many occupational groups, including high-risk ones like construction, I make the following recommendation.

**RECOMMENDATION #42**

That the Board, together with the Employers’ Advisers Office and Workers’ Advisers Office, develop a partnership with WorkBC around a simple comprehensive information package – for workers and for employers – which can be accessed on the WorkBC website. It should be in several languages and phone numbers given to contact the Board, including an option to speak to someone in a preferred language.
CLAIM SUPPRESSION

“Claims suppression” refers to employer practices which are meant to discourage a worker from filing a compensation claim or which retaliate against a worker for filing a claim. A number of workers and worker representatives identified claims suppression practices in their workplaces and the problem created by the absence of any Board prohibition or remedy to this practice.

There is no protection in the Act for employer conduct around claims suppression. This is not obvious at first glance. Section 177 of the Act seems comprehensive, stating that an employer must not attempt to prevent “by agreement, threat, promise, inducement, persuasion or any other means, seek to discourage, impede or dissuade a worker …from reporting to the Board…”

However, the enforcement provision in section 151 (“No Discrimination”) applies only to employer conduct against workers reporting safety issues under Part 3 of the Act. WCAT panels have consistently found that the statutory protection of section 151 does not apply to workers filing compensation claims under Part 1 of the Act. 79 And although the Board has tried novel ways to interpret the Act to invoke this protection, this was not successful. 80

In the Workers’ Compensation Appeal Tribunal (WCAT) Decision #2015-03765, the panel considered a case where the worker had been terminated for filing a compensation claim. The WCAT panel concluded that the employer did not violate section 151 of the Act. In this decision the panel stated at para 47:

> I recognize the worker’s concern that if the filing of a compensation claim does not amount to the exercise of a right protected under section 151 of the Act, then workers do not have adequate (or arguably, any) protection from an employer who takes discriminatory action against them for that reason. In my view, this result may well be the result of an error or oversight in legislative drafting. I recommend that the Board consider this if and when it makes recommendations to the legislature for considering revisions to the Act. The Office of the Workers’ Advisers may also wish to consider recommendations to the legislature for revisions to section 151 of the Act. (emphasis added)

79 WCAT 2010-00781, WCAT 2015-03765 and Worker Complaint of Discriminatory Action |Decision CD2013033|

80 The Board argued that in informing the Board or employer of an injury, the Act creates an obligation on the employer to investigate the injury under section 173 regardless of whether or not the worker raised an obvious health and safety issue. This is a sufficient safety issue to invoke protections against discriminatory action under section 151 of the Act. The WCAT panel in 2015-03765 did not agree.
Subsequent WCAT decisions on claim suppression/discriminatory action have followed this reasoning.

The issue of claims suppression was raised repeatedly in this Review, by workers who were experiencing a repressive workplace culture around safety and compensation and by vulnerable workers. Several unions offered examples where the worker would be told that he would be “taken care of” by the employer, if he did not file a claim. In one such case, the worker sought medical help but when the claim was filed by the doctor, the employer protested the claim on the basis that the injury did not occur at work. The “frivolous” protest resulted in a prolonged appeal which impacted the worker personally and financially.

Another union talked eloquently about the strong suppression effect on workers if they reasonably believe filing a compensation claim would adversely affect their employment or that of their co-workers. Some workplaces would offer an additional benefit for the whole workforce if there were no “reported” injuries over a period of time.

The Board has only recently begun to investigate this issue. Manitoba led the way by researching and documenting the level of claims suppression and passing legislation both prohibiting this practice and providing administrative penalties as an enforcement provision. The November 2013 Manitoba WCB Claim Suppression report indicated that “claim suppression is a material and germane factor” and their findings are consistent with research into other compensation systems.

Data provided for BC claim suppression under Information Request WCB-IR-0035 found the following:

<table>
<thead>
<tr>
<th>CLAIM SUPPRESSION STATS</th>
<th>YEAR</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Field Investigations</td>
<td>73</td>
<td>150</td>
<td>230</td>
<td>304</td>
<td>98</td>
<td>(as of May 2019)</td>
</tr>
</tbody>
</table>

Of the totals above, approximately 5 claims per year have been referred from Investigations to Legal Services for review and/or action. One of the contributing factors to the low volume of referrals has been difficulty securing evidence – it is not uncommon, in investigation of a complaint that a worker will refuse to provide an affidavit/statement; and, it is often the case that there is little evidence other than conflicting statements from a worker and employer.

81 Claim Suppression in the Manitoba Workers Compensation System: Research Report November 2013
The process for investigation of potential claim suppression cases is currently undergoing revision at WorkSafeBC. In response to Recommendation #20 of the Petrie report - Restoring the Balance: A Worker-Centered Approach to Workers’ Compensation Policy (2018), WorkSafeBC is adopting a new process in which any/all allegations of claim suppression are investigated and referred to the Board’s Legal Services Division for review and direction. The new process, scheduled for implementation August 1, 2019, will be supported by staff training developed by the Compensation Practice and Quality department.

While this policy process may be helpful, I accept the recommendation which is implicit in the WCAT 2015-03765 decision, that protection from retaliatory action for filing a claim is a legislative matter and is best addressed through revisions to the Act. Also, in the absence of effective protection for workers from employer retaliation, it is unlikely that formal investigations will either reveal or remedy these situations.

I recommend that the Act be amended to provide protection to individual workers who wish to report their injuries and file a claim and an individual remedy to the worker if employer conduct, of the nature identified in section 151, impedes this reporting. The remedy should be analogous to that which is now in place for workers reporting safety issues. The amendment to the Act should also include particular disincentives for employers not to engage in this conduct.

I also recommend that in cases where the worker has been terminated from employment due to filing a compensation claim, that the remedy be an election by the worker - either reinstatement or a “make whole” remedy. I make this recommendation because many workers who are fired for filing a compensation claim are vulnerable workers or workers in precarious employment and for these workers, reinstatement is an empty remedy.

Finally, I recommend that there be an education campaign for employers and workers around the issue of claims suppression and what constitutes claim suppression, with a posting in every workplace. The goal of the campaign would be ensure that the full reporting of workplace injuries is encouraged and is also supported by the workplace culture.

I recommend the following:

- That the text and section (a) of section 177 of the Act be imported into Part 1 under the heading “No Claims Suppression”;
- That the wording in section 19.1(1) of the Manitoba WCA be added to describe the prohibited actions and administrative penalties;
- That a remedy provision for be added to this provision in Part 1, based on sections 151 and 153 of the Act, with the addition of the following:
Where claims suppression is found to have occurred, any delay in reporting the claim will be presumed to have resulted from the claims suppression unless the contrary is proved;

- If the worker’s claim is accepted, the Board shall determine what additional amount is required to remedy the worker’s loss due to the discriminatory and can order the employer to pay these remedial amounts to the worker;
- If the worker’s claim is not accepted, the Board may order a remedy under section 153(2) to restore the worker’s loss due to discriminatory action and
- Where the worker’s employment has been terminated due to the filing of the compensation claim, the remedy shall include (but not be limited to) reinstatement or a “make whole” remedy without reinstatement, at the worker’s election.

I also recommend that section 74 provide that the Board may charge the entire claims costs against the employer in egregious cases of claims suppression.

**RECOMMENDATION #43**

That the Workers Compensation Act be amended to provide protection to and remedy for a worker facing retaliation for filing a compensation claim (claims suppression) as noted in the Report.

**EMPLOYMENT IN THE FEDERALLY REGULATED PRIVATE SECTOR**

In the Federally Regulated Private Sector (FRPS), there are a few large companies (with 100 or more employees), employing about 87% of the employees, in industries including banking, telecommunications and road transportation. However, about 85% of the employers in the FRPS employ 20 or less employees. The Canada Labour Code only covers employees but does not define “employees”, and many are considered or consider themselves “self-employed”. This is a group that is at risk for non-reporting of work injuries.

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82 A portrait of the federally regulated private sector, April 4, 2019, paper prepared by the Secretariat to the Expert Panel on Modern Federal Labour Standards.
RECOMMENDATION #44

The Board create a profile of Federally Regulated Private Sector (FRPS) workplaces and that there be a targeted information program to educate workers and employers (large and small) in this sector about the compensation process. I recommend that at least one senior management person be tasked with being informed and knowledgeable about the FRPS sector and coordinate with the relevant authorities about injuries, claim reporting and claims suppression in these particular sectors, especially for large employers.

DIVERSITY AT THE BOARD

Board culture is a broad concept. The Board is involved in service delivery and on the front-line, this is a service delivery by workers, to workers. The attitude of Board staff, especially front-line staff, to diversity, is critical to service delivery which helps workers over employment barriers rather than reinforce them. There is an important diversity initiative at the Board where a formal joint management/union committee raises this issue and conducts education and awareness initiatives\(^{83}\). The general staff composition profile reflects that of the general population for women and visible minorities but persons with disabilities and aboriginal people are underrepresented\(^ {84}\).

However, these areas of historical disadvantage can persist and embed themselves in an organization in unexpected and unrecognized ways. As part of a healthy and diverse staff culture, I recommend that the Board establish a formal and confidential process and body, independent of the Board’s management and HR department, to receive, investigate and resolve staff complaints regarding harassment and bullying, including (but not limited to) sexual harassment, racial harassment and harassment on the grounds of sexual orientation.

Such a process can only be developed by agreement between the Board and the CEU. There are many successful models found in other institutions and there is a wide range of choice. It is my view that a clear, fair and accessible process to address this issue, should it arise, is critical to ensuring that diversity is respected and protected in the Board’s own workplace. This is necessary if there is an expectation of staff that they will also respect diversity in their service delivery.

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\(^{83}\) The Joint Diversity Committee (JDC) is a joint management/union (Compensation Employees Union) initiative which sponsors inclusive education and awareness initiatives.

RECOMMENDATION #45

The Board set up an independent process to counsel, investigate and resolve issues of discrimination and harassment among Board staff.

Finally, I note that with many aspects of Board policy have not been subjected to a GBA+ analysis. I recommend that the Policy Division undertake a long-term project to do so, in consultation with the research in this jurisdiction and across Canada.

One urgent item for this Review is the application of compensation and prevention policies to pregnant workers. One case raised forcefully before this Review is the risk posed by “Fifth Disease” to pregnant workers, primarily teachers. Fifth Disease is an infectious rosella type virus that is largely benign for children and adults but in some cases, poses a serious risk to fetuses if the mother contracts the disease. The issue is whether pregnant teachers should be taken off work, as it is unsafe to be in the classroom during an outbreak. At the moment, such “prophylactic” (avoidance of risk) measures are not in place.

RECOMMENDATION #46

That the Board’s policy division undertake a review of Board compensation policy as a whole from a GBA+ lens.
PART V: RETURN TO WORK

IN BRIEF
New models and guidelines are identified to lead improvements for RTW. There are separate challenges: modified selective duties; Disability management before and during transition to MMR and accommodations for permanent disabilities.

There are recommendations to:

- Improve processes to facilitate safe and productive early RTW;
- Recognize the duties of workplace parties to accommodate RTW;
- Develop policies that support the DTA process;
- Work with other established organizations in the field of human rights; and
- Provide assistance that results in positive, durable outcomes

INTRODUCTION AND GENERAL PRINCIPLES
In this section, I will identify some best practices in return to work (RTW) before assessing the Board’s policies and practices. In my view, the Board’s approach in this area needs redirection.

Best Practices in Return to Work
The International Association of Industrial Accident Boards and Commissions (IAIABC) represents most worker compensation systems in the United States, Canada and internationally. In its recent paper Return to Work: A Foundational Approach to Return to Function85, IAIABC adopts the biopsychosocial approach to disability and the view that the difference between a significant impairment and the degree of disability lies in the societal approach to the return to function. More importantly, the paper identifies guidelines from the

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International Social Security Organization (ISSA) and ICF Classifications as important to compensation RTW practice.

ISSA has provided guidelines for workers’ compensation schemes (among others) to assess whether their organization’s legislation and policy is in line with internationally developed best practices. In the case of workers’ compensation specifically, ISSA’s Guidelines for Return to Work and Reintegration (2013) (ISSA Guidelines) utilize the ICF concepts as part of building a legal framework for RTW. The guidelines also acknowledge several expert contributions, including from NIDMAR, Pacific Coast University and the International Disability Management Standards Council (IDMSC). We understand that CSA Guidelines for RTW will be developed by next year, too late to be included in this Report.

The ISSA Guidelines’ policy and programs are based on seven principles:

- Holistic process
- Early Intervention
- Individualized Approach
- Active participation of the individual
- Collaboration
- Qualification of Experts
- Monitoring and Evaluation.

The ISSA Guidelines are consistent with the recommendations made by this Review including individualized assessments and early intervention in VR. It is also consistent with the approach recommended by several employer stakeholders with wide experience in RTW.

I also note that other jurisdictions are more collaborative in their approach and specify an early role for a RTW specialist. One example is the model used in Ontario which highlights the importance of the coordination and collaboration role and considers it a key principle that “Someone has the responsibility to coordinate RTW.”

The coordination role involves:

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86 International Social Security Association. ISSA’s Guidelines for Social Security Administration consist of recognized professional standards and form part of its Centre for Excellence in Social Security Administration.


88 The ISSA Guidelines are also founded on the UN Declaration of the Rights of the Disabled.

89 The CSA Guidelines will rely on the work of NIDMAR as well.


• Providing individualized planning and coordination that is adapted to the worker’s initial and on-going needs;
• Ensuring that the necessary communication does not break down at any point; and
• Ensuring that the worker and other RTW players understand what to expect and what is expected of them.

The Board’s Return to Work Policy and Practice

The Board’s general approach to RTW is set out in both the policy and practice for light duties (policy item #34.11 of the RSCM II) and the RTW practices after plateau. The Practice Directive for Light Duties was just revised to incorporate some Petrie recommendations 92 and I will use it as an example.

1. For light duties, the Board intervenes only when there is a disagreement between the worker, their physician and the employer about light duties (#34.11). It refers to a temporary work alternative typically offered at or soon after an injury and often before a Board officer is involved.

2. If the Board is involved, the general approach does not specifically include consulting the worker in developing a RTW plan. Instead, the plan is developed by the Board and the employer according to certain criteria. If the worker refuses the plan, the issue is whether the refusal is reasonable. If the Board determines that the plan is not reasonable, the worker receives no further benefits unless the decision is changed on appeal. This is illustrated on the Board’s “Injury Management Road Map” is for employers to manage an injured worker’s RTW.93 The education materials are addressed to employers only, about how they may structure a RTW as a process independent of the Board.

3. If the worker is not able to return to the pre-injury employer (for whatever reason), a VRC typically gets involved after “plateau”.94

This approach leaves RTW as primarily an employer exercise; the Board only enters the RTW arena when there is a dispute. Once the worker has RTW, the file is closed. This approach leaves the parties on their own, with little guidance and then is dispute and appeal oriented.

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94 One staff member estimated that VR gets involved with a claim before plateau only about 20% of the time.
Numerous stakeholders, workers and employers, identified this RTW process as very unsuccessful.

For workers, the approach is problematic, especially for vulnerable or seriously injured workers. Injured workers are left to navigate the difficult task of aligning light duties with an injury, with an employer, to arrive at a suitable temporary work arrangement. Evidence may be scanty or not shared. Further, the process requires the injured worker to formally “object” to an offer of light duties and then “prove” the reasonableness of the objection with medical evidence which may or may not be available and which may or may not be accepted. This is at a time when the worker is injured and vulnerable medically and vocationally. A number of workers stated that in the RTW period, they felt abandoned by the Board or forced to RTW because the Board rejected the view of themselves or their physicians’ views that they were not ready.

Employers too, expressed deep frustration at the lack of timely notice or information about the claim or assistance in developing appropriate light duties. Most expressed frustration with the absence of communication with the Board officer, although there were notable exceptions in several cases.

The Employers’ Advisers Office (EAO) made this submission about the impact of such an approach on the BC compensation system:

> Overall, there is a need for a culture-shift in current WorkSafeBC processes to take an inclusive, holistic approach regarding RTW services. Education initiatives about the benefits of timely RTW; comprehensive reporting and sharing of a worker’s limitations and abilities; improved access to health care; access to a dedicated, front-end RTW services team; robust decisions and claim monitoring to provide the right information to the right people at the right time; and ongoing problem-solving and timely dispute resolution are some of our suggestions to improve the RTW system. In short, we believe robust information-sharing coordinated by an RTW team would go a long way to reflect a worker-centric delivery model that streamlines case management to ultimately improve confidence and satisfaction for all stakeholders.

I agree. In fact, a “culture shift” regarding RTW is exactly what is set out in the ISSA Guidelines and endorsed by IAIABC in *Return to Work: A Foundational Approach to Return to Function*.

Properly implemented, these detailed guidelines set a new direction for compensation boards. I recommend that the Board revise its service delivery and RTW policies to follow the ISSA Guidelines for best practices to achieve a culture-shift in RTW to holistic inclusive practices for RTW in keeping with a worker-centric model.
RECOMMENDATION #47

I recommend that the Board revise its Return to Work (RTW) policies and delivery service to accord with the International Social Security Organization (ISSA) International Guidelines for RTW and the Seven "Principles" for Successful RTW which are the recognized best practices in return-to-work. Given that policies are well developed by the ISSA Guidelines and in other jurisdictions, I recommend that the revision of RTW services begin immediately and as much as possible within the current policy structure.

I also recommend that:

RECOMMENDATION #48

As the Board develops Return to Work (RTW) policies and practice directives, that they consider following the model used in Alberta and other jurisdictions, which use policy to address many areas in RTW and provide options and guidance to the parties.

RECOMMENDATION #49

The Board look at resources which help empower different players in the Return to Work (RTW) process. I particularly note the use of "wallet cards" setting out the RTW parameters for the worker and direct supervisor (Alberta) and the inclusion of the supervisor in RTW planning, along with consideration of the impact of the RTW on co-workers.

RECOMMENDATION #50

The Board develop an intensive educational outreach to all affected parties, including health care providers and representatives, about the new approach.

LIGHT DUTIES – POLICY ITEM #34.11

Issues in the Application of Light Duties Policy

The above approach will be a “culture shift” but in the meantime, policy item #34.11 of the RSCM II and “Light Duties” has been a flash point for both workers and employers.

Workers stated that modified duties were often offered generally and at a time when the employer had no information about the worker’s injury (i.e. before the worker saw a doctor or while being treated in the First Aid room). The worker had no opportunity to review the light
duties with a doctor or, if so, the physician’s recommendations were not followed. Often, there was no RTW plan discussed with the worker.

Employers offering light duties often felt they had inadequate notice of the medical nature of the injury. If the Board accepted that light duties were suitable and did not further investigate, the issues would arise on appeal.\(^95\) One union represented that their “overturn” rate on light duties’ appeals is about 90% due to the inadequacies of the investigations.

Some large employers have already developed disability management plans in their sector or industry, which effectively deal with these matters, but which are parallel to the Board process. The issue for these parallel disability management plans is how they are affected by the Board’s processes, particularly any delays in claim acceptance or in obtaining medical evidence.

The EAO noted that the Board’s process is also deeply problematic for small and medium-sized employers, who likely don’t have a disability management plan and are overwhelmed by the complexity of the process and documentation required.

There are several factors which cause Light Duties to be a particular flashpoint.

1. Large employers are the most capable of offering light duties and many already have functioning disability management plans. In addition, due to the size of their payrolls, even one day of time loss on a claim has a significant impact on their experience rating.\(^96\) If a worker is able to return to work the day following the accident, the employer has a huge financial benefit and may be able to offer a suitable work arrangement. However, as the Board is not involved and the worker’s doctor may be supporting rest as treatment, the employer makes a “call” which is assessed retroactively. This is the gist of the high-level overturns on appeals.

2. The Board finds it difficult to respond immediately because, in effect, it does not have jurisdiction to guide a light duty arrangement until a claim is accepted, even if it was inclined to do so. The expected time frame for claim adjudication is 11 days for a time loss claims and 28 days for a health care claim, although there are many exceptions in both directions.

3. As noted above, there tends to be difficulties in the collection of evidence in the early stages of a claim so it can result in claims being accepted, even when the employer has not filed an F7 or where evidence is supportive but minimal.

\(^95\) In a 16-month period, there were about 300 requests a year to the Review Division on policy #34.11 alone with approximately a 35% overturn rate for inadequate investigation or documentation.

\(^96\) One research estimates fourfold
4. The “Light Duties” issue tends to arise in different contexts:
   a. With larger employers wanting to establish a Light Duty arrangement on the first day of an injury, that will meet the criteria of #34.11; and
   b. With smaller employers wanting to establish a Light Duty arrangement after the claim has been accepted.

This suggests that there are two issues: the light duties process itself and how to address the “pre-adjudication” use of this process, which clearly affects large employers and their workers.

**Light Duty Process – Best Practices**

Many stakeholders offered specific suggestions about how the process could be improved. My impression is that to some extent, a successful formulation and integration of light duties is industry and workplace sensitive although some general principles along with guidelines and options are helpful.

1. In many situations, there are competing interests and needs between the employer and the worker. The return to work process needs to be individualized and coordinated by a specialist, often called an RTWS or RTW co-ordinator.

2. In this situation, the worker is returning to work before full recovery (i.e. before “maximum medical recovery” (MMR) when the worker’s health and recovery are important factors in the consideration of a suitable light duties). The definition of “suitable” before MMR may be different than for a stabilized condition.

In this Review, I heard from a number of workers who either faced various barriers in light duties and just quit or were re-injured while performing light duties. This is a difficult time in an injured worker’s health and recovery, and the light duties process needs to help workers address these matters for a RTW to be successful.

There is another concern. If an employer offers light duties on the same day of the injury and the worker accepts, the worker’s compensation claim is coded as a HCO or “Health Care Only” claim, even if the injury is quite serious. As an HCO claim, the claim is “owned” by the system although there is a follow up review 4 weeks later. While this may be appropriate in some cases, it is not in others, particularly if the injury is serious and the employer does not have a functioning disability management program. Such workers are vulnerable to changes in the employer’s self-made accommodation.

After reviewing material in this area, I recommend that the Board adopt the following principles from the *Best Approaches: Recognizing Time to Heal- Assessing Timely and Safe Return to*
Work guide and put them into a RTW policy and guidebook. The full guide is set out in Appendix 21 with sample cases and assessment tools.

**The RTW Principles for RTW before MMR:**

- An injured worker’s ability to return to work beginning the day following the accident is to be determined based on an assessment of all relevant information. This includes information from the worker, the employer and the treating health practitioner(s).
- It is recognized that there are cases where “rest” is an appropriate form of treatment and required in order to speed recovery and facilitate a successful return to work. This should be determined based on an assessment of the nature and degree of the injury in each case.
- The decision-maker must be convinced on a balance of probabilities that:
  1. the job or duties offered by the employer is/are suitable in that they are within the worker’s physical and/or psychological and vocational capacity to perform and will not pose a safety risk to worker or others or impede the worker’s recovery, and,
  2. the job and the job duties have been clearly communicated to the injured worker prior to the worker beginning the job or job duties.
- In assessing the appropriateness of the return to work situation, the decision-maker must have regard for any collateral issues that may pose an obstacle to the worker. This includes such issues as the impact of the injury on the worker’s ability to travel to and from the worksite or the impact of medication on the worker’s capacity to perform work in a safe manner.

It is inherent in this model that there be an individual assessment in each case and especially in cases of serious injury, whether or not there is a recorded time loss at the time the claim is made. The approach that “Return to Work is Good Therapy” cannot be applied as a blanket statement. In some cases, it is not.

One employer presented a concern that the Board “blindly follows” a physician’s recommendation for the worker to “rest”, even when the physician does not know the possible duties.

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NEW DIRECTIONS:
WCB REVIEW 2019

Many workers talked about the “straw jobs” offered to injured workers at the time of injury. These are essentially jobs where workers are paid to sit around, sometimes even in the lunch room, rather than be on time loss on a compensation claim.

It is expected that with the early intervention of a RTWS, such issues can be addressed including that all parties, including physicians, have sufficient information and that workers are not asked, or expected to perform, token or demeaning work.

RECOMMENDATION #51

The principles in the Best Approaches: Recognizing Time to Heal – Assessing Timely and Safe Return to Work [Appendix 21] be the standard for assessing whether a return to work before maximum medical recovery is suitable for an injured worker.

Job Description and Job Duties

One of the principles in RTW is that it requires a good description of job duties and job description. This has different implications for different types of employers. Some employers or groups of employers have significantly invested in creating workplace culture such supports effective disability management. Two examples include:

- The Enhanced Disability Management Program (EDMP) was jointly negotiated and developed between the Health Employers’ Association of BC (HEABC) and the Health Authority Bargaining Associations. The introduction of the EDMP allowed for enhanced collaboration between the parties.

- In 1998, the Board funded a Physical Demands Analysis for a combined municipal group (cities of Burnaby, Richmond and Vancouver) as part of a Municipal Initiative to Enhance Early Return to Work. It was premised on the view that although the cities are different legal entities, the positions are similar.

In both cases, the employers were supported by the Board in the initial stages. One notes:

Accommodating disabled workers and ensuring the safe return-to-work of injured workers is a difficult task not only for management but for all involved in the process. A clearly understanding of the physical demands of the tasks can assist with the decision process.

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The National Institute for Disability Management and Rehabilitation (NIDMAR), partnering with Pacific Coast University (PCU) has developed assessment tools and resources to assist employers to construct disability management programs. As noted earlier, NIDMAR is a resource used by both the ISSA Guidelines on RTW and in the pending CSA standards for RTW.

**RECOMMENDATION #52**

The Board start an initiative to provide support, including financial support, to employers who wish to conduct appropriate assessments through National Institute for Disability Management and Rehabilitation (NIDMAR) and/or Pacific Coast University (PCU).

I note that there are different levels of assessments, including self assessment for small businesses. I make this recommendation as it is clear from the experiences above and research, that an assessment, PDA or disability management initiative is a positive step towards building a “culture of accommodation” in the workplace and this, in turn, will ease any application of Light Duties and RTW.

As part of this approach, it is recommended that “Light Duties” and RTW be part of a new worker’s orientation and that that the Board assist small businesses with resources and educational materials for this purpose.

Finally, it is very common for a disabled worker returning to a workplace to experience stigma from co-workers, supervisors and management. As one person said, the workplace is not a rehab center. It is important that the Board provide leadership in this area and concrete assistance to both workers and employers as part of the RTW process, to address the difficulties in any particular workplace regarding possible stigma and discrimination.

**Light Duties Before Claim Acceptance**

As noted above, for many employers, especially large employers, there is a significant financial incentive to avoid a single day of time loss for each claim, regardless of circumstances. This means that there is a powerful incentive to affect a “next day” RTW [which may be negative for the worker] and the rushed result may not be accepted by the Board or the Review Division (RD) [negative for the employer].
On the other hand, the Board’s intake process is not nimble, and it usually takes several weeks (at best) to address the RTW issue.

And as noted in “Best Lessons” principles for a worker’s RTW before MMR, this needs to be done carefully, with individual assessments and “quarterbacked” by a RTWS.

In this situation, it is unlikely that one size fits all. I recommend the following:

1. That the Board establish a registry of employers with certified disability management programs. When there is a worker with an injury who is employed by a “registered employer”, and
   - that employer submits the F7 within 3 days of being notified of the injury; and
   - the employer is willing and able to offer Light Duties and engage in the Light Duty process

   then;

   a) that employer will be assigned an RTWS on a provisional basis who can begin to assist the parties before claim adjudication; and
   b) that employer will be relieved of claims costs for that particular claim for the period of time between the date of injury and the date of a determination by a RTWS regarding suitable Light Duty arrangements (whether or not such duties can be arranged), unless the claim is denied; and
   c) any Light Duty arrangement is provisional.

It must be recognized that in keeping with the Best Lessons principles, not all workers will be able to RTW or perform Light Duties.

2. The Board may establish what is meant by “certified disability management programs” and the process by which employers may apply for Board support to implement this type of program.
RECOMMENDATION #53

That the Board establish a registry of employers with certified disability management programs. When there is a worker with an injury who is employed by a “registered DM employer”, and

- that employer submits the Form 7- Employer’s Report of Injury (F7) within 3 days of being notified of the injury; and
- the employer is willing and able to offer Light Duties and engage in the Light Duty process

then

a) that employer will be assigned an Return to Work specialist (RTWS) on a provisional basis who can begin to assist the parties before claim adjudication; and
b) that employer will be relieved of claims costs for that particular claim for the period of time between the date of injury and the date of a determination by a RTWS regarding suitable Light Duty arrangements (whether or not such duties can be arranged), unless the claim is denied.

RECOMMENDATION #54

The Board may establish what is meant by “certified disability management programs” and the process by which employers may apply for Board support to implement this type of program.

My further recommendation is that, on request, the Board provide the services of a RTWS to an employer or worker prior to claim acceptance to work out a provisional “Light Duty” arrangement to employers who do not have a “certified disability management program”. The Board may wish to create guidelines to establish consistency in its practice about these requests but the grant of a provisional RTWS is not a “Board decision” and is not appealable.

RECOMMENDATION #55

That the Board provide that employers who do not have a “certified disability management program” may request the early assignment of a Return to Work Specialist to assist them with the creation of a Light Duty option on a provisional basis and the Board has discretion on this matter. The Board may wish to create guidelines to establish consistency in its practice about these requests.
Light Duties – the Board’s Role

Any Light Duty arrangement must still be adjudicated on the merits once the claim is accepted, but the RTWS can help expedite accurate medical and vocational and disability information to the parties to construct a better arrangement, than could be done on their own.

With a culture shift to early and deep involvement with the parties in a RTW, the Board’s role and staffing will change. My understanding is that there are RTWS already, some with nursing degrees and some with Occupational Therapist certifications. In addition, many institutions including Pacific University are developing specialized training for RTWs positions. If the Board considers that there is a shortage of qualified candidates for the new demands for this position, I suggest that the Board consider partnering with the University of British Columbia’s OT program to provide additional seats and job training.

Again, technology may assist in providing this provisional service to small employers and workers in remote locations.

Reporting and Information Sharing

As noted in the Best Approaches document, an individualized assessment involves speaking to the employer, the worker and the treating physician. Early and accurate information sharing is critical to an early RTW. In their submission, the EAO made several recommendations for reporting and sharing information at an early stage. As these are quite technical, I recommend that the Board consult with the EAO about the reporting and information sharing process and the EAO’s particular recommendations.

Two suggestions from the EAO were:

- Create a robust Functional Abilities Form (FAF) similar to that used in Ontario which may be completed by any treating health professional, including a nurse, and have the FAF form completed at the request of the worker or the employer and paid for by the Board. This is similar to the proposal in the Petrie Report and I support it.

- Create a Physical Demands Information Form that employers can use to identify suitable RTW activities. (One model is Ontario’s Physical Demands Information Form). This would greatly assist small employers who did not have a pre-injury PDA.
**Monitoring Light Duties**

In this Review, I heard many stories of “Light Duties gone wrong”. This includes:

- Supervisor or co-worker not being informed of or accepting of restrictions and limitations;
- The evolution of light duties into other unsuitable duties;
- The clam ending without an assessment of the worker’s permanent condition.

I recommend that all light duty arrangements be in writing (or on a form) with a date for review. Where the light duties result in a substantial change in the worker’s regular duties or in their conditions of employment, the light duties should be termed, as it is in other jurisdictions, a Temporary Work Assignment (TWA). This terminology signals to the worker, co-workers and supervisors that this is a temporary arrangement for one stage in the worker’s recovery.

The light duties or TWA form should be a simple form and process. There should always be a “time trigger” when the RTWS, employer and worker (and physician if necessary) will review the accommodation. As the worker recovers (or not), it is likely that the accommodation will change, and all changes should be documented on the TWA form.

I recommend as a matter of policy that all RTW before MMR be in writing with a specified time for review. I also recommend that the worker and employer have ready access to the RTWS in the event there is a breakdown in the accommodation.

When the worker’s condition reaches MMR, the RTWS and the parties may have to re-evaluate what is needed by way of a permanent accommodation given the worker’s stabilized medical condition.

This re-evaluation will also have to be done in the context of the employer’s duty to accommodate under the Act.

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**RECOMMENDATION #56**

All Light Duties’ arrangements be in writing and specify a time for review by the return to work specialist. If the Light Duties result in a substantial change in the worker’s duties or conditions of employment, a Temporary Work Assignment (TWA) form should be used.
Medical Disputes

Given the earlier recommendations, it is expected that throughout the RTW process, the worker will be treated by a health professional of his choice. If at any point there is a dispute, the RTWS, the worker or the employer may follow one of the following paths depending on the nature of the dispute:

- Ask the Medical Services Office to resolve a medical issue in dispute with a non-binding case conference;
- Ask that an Independent Medical Exam (IME) be conducted.

In each case, the medical evidence needs to be trusted and accepted by all the parties. There also needs to be good evidence concerning the light duties and the workplace.

Return to Work After Maximum Medical Recovery (MMR)

At the point that the worker reaches MMR, he may already be at work or be re-training for other occupations. Therefore, many issues that arise now in RTW will be addressed in different phases of the claim process.

However, when a worker reaches MMR and is possibly left with a permanent impairment, Board policy should ensure that he/she is referred for an assessment of all of his/her compensable permanent conditions.

DUTY TO ACCOMMODATE

In February 2018, the Supreme Court of Canada (SCC) issued the Caron Decision. In this decision, the SCC held that the employer’s duty to reasonably accommodate someone with a disability as “a core and transcendent human rights principle” and that the duty to reasonably accommodate disabled employees is “a fundamental tenet of Canadian labour law”. The SCC also found that workers’ compensation legislation does not function as a code that excludes employers from the duty to accommodate under human rights law.

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100 Ibid, paragraphs 20 and 22.
101 Ibid, paragraph 4.
At the time of the decision, B.C. was one of only two jurisdictions\(^{102}\) which did not give injured workers a statutory right to return to work after an injury or a re-employment duty on employers. Instead, in B.C., the Act provides discretion to the Board to aid workers getting back to work.\(^{103}\)

After the Caron decision, it was clear that the issue of whether a duty to accommodate should be addressed in this Review. From consulting on the issue, I understand that there is ambivalence among the worker community about this inclusion and that the Employers’ Forum has the following significant concerns:

1. There is a concern about overlapping jurisdictions which could result in both multiple proceedings and divergence of views in how this legal duty is interpreted and applied. There is also a concern for how to mesh this duty with current provisions in Collective Agreements.

2. The two regimes have different purposes. As the Employers’ Forum noted: “In particular, the human rights regime has developed the specialized understanding, knowledge and expertise to address any duty to accommodate issues which may arise involving a disabled worker – which, in our view, the workers’ compensation regime does not have.”

3. Given two regimes, one employer may have to address a similar injury in two different workers under different regimes, depending on the cause of the injury.

4. There would be complex jurisdictional questions arising from situations where multiple workers had intersecting accommodation needs under the two different regimes.

As I understand the Caron decision, the issue now is whether the “fundamental tenet” of human rights law – the employer’s duty to accommodate a disabled worker – is made explicit in the Act or whether it remains an implicit term to be applied by the Board and Review Board on a case by case basis, commensurate with other aspects of the Human Rights Code which are also applied.

This situation is further inflected by the SCC decision in *British Columbia (Workers’ Compensation Board) v. Figliola* 2011 SCC 52. In that case, the SCC determined that where one administrative body such as the Review Division makes a determination on an issue under the Code, then the Human Rights Tribunal (HRT) should decline jurisdiction over the same matter. Given the Caron decision, I believe that the duty to accommodate is now squarely

\(^{102}\) The other exception is Nunavut.

\(^{103}\) Section 16 of the Act.
within the jurisdiction of the compensation system when it arises in compensation cases. I agree that this development is accompanied by all the above concerns.

In my view, it is wiser to address these concerns directly through explicit legislation and policy responses than leave them unaddressed, for parties to resolve through the burden of litigation. A legislative response also allows for some better outcomes, given we can learn from the experiences in other jurisdictions.

Therefore, I recommend that the Act be amended to explicitly acknowledge the duty to accommodate as that duty is defined in human rights jurisprudence. I have provided an outline of preferred statutory language in the attached recommendation but set out the basis principles, largely drawn from other jurisdictions, below:

1. In most compensation Acts specify when the worker’s “right to return to the pre-injury employment if the worker’s disability does not prevent it”. I recommend the “triggering” provision set out in sections 97(1) and (2) of the Nova Scotia statute – that is, “when the worker is able to perform the essential duties of the pre-injury employment.” This wording protects workers with psychological disabilities more than the wording in other Acts.

2. The Act should set out the conduct expected of employers and workers. The Acts in Alberta, Ontario and the Yukon are almost identical, and I recommend this wording for the Act in British Columbia.

3. The Act should specify the content of the duty to accommodate. I recommend the language in the Manitoba and Ontario Act (almost identical) which confirm the worker’s right to return to suitable alternative employment where disability prevents a return to a pre-injury job.

4. The B.C Act shall include a definition of “suitable” employment by incorporating the definition of “suitable” now found in Policy #40.12 RSCM II. This will give continuity to the compensation system’s treatment of this issue and also specificity.

5. I recommend that particular classes of workers are exempted from the application of the return to work provisions, including:
   a. Worker employed by “smaller” employers with 20 or fewer workers as provided in the Ontario Act\textsuperscript{104}, and
   b. Workers who are declared or deemed to be “workers” under the Act.

\textsuperscript{104} In B.C. in 2019, there are over 245,000 employers; over 90% are employers with less than 20 full-time workers. WCB-IR-0026
I recommend that section 96 provide that the Board has exclusive jurisdiction to determine the number of workers an employer has for the purpose of this new provision.

6. Many Acts exempt construction workers from the application of the DTA under a compensation Act. These provisions predate Caron. I recommend that there be further consultations with the stakeholders in the construction industry before including such an exclusion in the Act.

7. The Act should specify that the Board is empowered to determine the fitness of a worker to RTW or to take suitable work and to make a determination on its own motion or at the worker’s request as to whether an employer is meeting the duty to accommodate.

8. The Act should indicate the duration of the accommodation. There is significant variety among the jurisdictions on this issue. I recommend the language of the Alberta Act which does not specify a particular date.

9. I recommend that the Board have certain enforcement provisions, including penalties and payment to the worker, and a rebuttable presumption that if an accommodation or an accommodated worker is terminated by an employer, the employer is presumed to have not complied. The language of the Ontario Act is recommended.

10. As provided in many Acts, this DTA is a floor, not a ceiling, and that if a collective agreement provides a greater reinstatement provision, the agreement prevails. The language of the Alberta and Ontario Acts are recommended.

11. Many jurisdictions provide for dispute resolution mechanisms around the issue of a “suitable accommodation”. Given that the importation of this DTA will have some impact on the nature, complexity and number of disputes about this matter, I recommend a “made in B.C. approach” for an expeditious and expert dispute resolution process. In summary, where a dispute arises about whether the Board’s determination that an accommodation is “suitable”, the worker or the employer or the Board may request an informal dispute resolution process prior to the Board issuing a decision confirming the accommodation. If there is a request, the Board shall refer the matter to the Labour Relations Board (LRB) to conduct a non-binding investigation and mediation with a Settlement Office appointed by the LRB. If the dispute is not resolved, the Settlement Officer will issue a report and the Board will issue a decision taking that report into account.
In this process, the duty to accommodate, as the concept is developed under the Code, would apply to compensation matters, including that accommodation is an individualized process and its purpose is to enable a worker who can work to do so. The duty to accommodate is not unlimited but is only to the point of “undue hardship”. Also, an employee must cooperate with an employer’s reasonable suggestions. I recommend that these provisions not be imported explicitly into the Act and that the Act remain “skeletal” so the legal obligations of the parties can develop in tandem with the jurisprudence of the HRT and at the same time, be included in an informal dispute resolution process.

**RECOMMENDATION #57**

That the Workers Compensation Act be amended to recognize the employer’s duty to accommodate and the related legal issues as set out in detail in the Attachment to Recommendation #58 regarding statutory language.

There should also be a recognition in Board policy, that a worker who returns to the pre-injury employer in an accommodated position still has a permanent compensable injury. The re-opening policy of the Board should provide that in the event that the accommodation is discontinued, the worker is entitled to have his claim re-opened for further vocational re-training to restore his employment status in the open market.

**RECOMMENDATION #58**

That the Board develop policy that specifies that if a worker has returned to an accommodated position with a pre-injury employer through the Board’s Duty to Accommodate process and the accommodation ends, the worker is entitled to additional Vocational Rehabilitation benefits to restore the worker’s capacity for suitable employment in the labour market.

The issue of “two cultures”, “two jurisdictions” and confusing results is well taken. However, given the decisions in *Caron* and *Figliola*, I think this is now the challenge for the compensation system, here and in other jurisdictions. I accept the suggestion of the Employers’ Forum on the need for Board training.
RECOMMENDATION #59

WorkSafeBC should work with the recently established BC Human Rights Commission to develop a training program for first level Board Officers who deal with claims involving the return to work of injured workers, and in particular the Board’s Vocational Rehabilitation Consultants, regarding the human rights concepts and principles associated with the obligations on Employers, disabled workers and other workplace participants in accommodating the return to work of disabled workers.

In addition to the informal dispute resolution process in the initial stages of an accommodation dispute, I also recommend that a specialized appeal process for a Board DTA decision be included in the Act. The Employer’s Forum has suggested that this be developed as an administrative process between the Board, the Human Rights Tribunal (HRT) and the HR Commission. While these bodies certainly must be involved and consulted, I consider that more than an administrative process is required for this systemic change.

I note that the Act would have to provide such a specialized appeal process with sufficient jurisdiction and authority to develop the expertise, procedures and capacity sufficient to fairly decide DTA issues in the larger population of compensation cases that is usually considered by the HRT. There are several models for such specialized appeal adjudication. One model is that upon receiving an appeal which is inclusive of a DTA issue, the WCAT appeal will be heard by a 3-person panel consisting of which at least one member must be a member of the HRT.

RECOMMENDATION #60

That there be discussions between the Board, WCAT and the Human Rights Tribunal about a preferred appeal process including, the option of having WCAT appeals with a DTA issue, heard by a 3-person panel of which one is an HRT member. I recommend that the Act be amended to provide for this specialized WCAT appeal process for DTA issues.

VOCATIONAL REHABILITATION

Vocational Rehabilitation (VR) benefits are discretionary benefits provided under section 16 of the Act. The Board’s discretionary expenditure on these benefits reflect the impact of the 2002 legislative changes and the resulting restrictive provisions placed on loss of earnings (LOE) pensions. The effect was immediate. Vocational Rehabilitation (VR) expenditures went from approximately $130 million in 2002 to about $1.5 million in 2005, a reduction of 98.81%.

The reduction in VR benefits and LOE pensions was often due to an analytic process called “deeming”. The process of deeming involves a conclusion that some particular occupation is suitable and available\textsuperscript{106} to the worker and that the worker would be capable of earning a certain amount and so would not suffer a loss of earnings from the injury. As one workers’ group put it, “deeming” permits the assumption of employment when in practice injured workers have not secured any employment and will remain unemployed. \textsuperscript{107}

I note that in CMS, the term “deeming” is not used in this usual sense. In CMS, only a Case Manager can code for a “deemed” RTW and only does so when a worker is actually offered a position and does not RTW in this position. The general use of the term “deeming” is more descriptive of the Board’s coding when a VRC determines that a particular type of job is “suitable and reasonably available” to a worker and codes RTW event, even though the worker does not have a job or reasonable prospect of a job.

There are several court decisions\textsuperscript{108} that influenced VR plans and deeming. Two decisions of note, Young and Amos, found the plans made by Board VRCs did not properly consider the evidence on whether the occupations in Board plans were suitable and available. Since then, VR expenditures slowly regained some of its priority, with the latest figure for VR expenses being about $100 million or 76.80\% of the 2002 level.

More importantly, the Board created a framework for Quality Decision Making\textsuperscript{109} in response to Court decisions. This initiative looks to place emphasis on a collaborative process and worker participation. I agree that a more collaborative approach and improved worker participation is needed, especially in VR.

There also needs to be a change in Board practice. As suggested by the ISSA Guidelines, VRCs should be involved early in the claim and may be working with the case manager even while the worker is still in treatment. This is particularly important when there is a serious injury and even more important when with a young worker.

\textsuperscript{106} Policy item RSCM II #40:12 sets out criteria to determine if work is suitable and available for the worker

\textsuperscript{109} Vocational Rehabilitation Training Toolbox, November 2017
Section 16(1) of the Act has long provided the Board with wide discretion to make expenditures that it considers “necessary or expedient” to get injured workers back to work or to assist in lessening or removing a resulting handicap. However, given this history and the importance of VR today with RTW as a core function for the Board, I recommend that the VR mandate is mandatory and that the VR principles be specified in the Act, while still allowing wide discretion with respect to decision-making.

**RECOMMENDATION #61**

That section 16 of the Workers Compensation Act clarify the Board’s mandate regarding vocational rehabilitation (VR) as follows:

- The worker has a right to be an active participate in return to work and VR plans;
- The goal of VR is to return an injured worker to safe, productive and durable long-term employment as much as possible and in doing so, incorporate the principles of a duty to accommodate as much as possible;
- Where the worker is not able to return to their pre-injury job, the Board shall provide VR and support the worker in a return to safe and durable long-term employment as much as possible.
- Where a worker’s entitlement to VR is increased after an appeal, the worker shall be provided with retroactive VR benefits.
- If there is a Board decision that a worker is able to adapt to a suitable occupation, the Board will follow up with the worker in two years and document the worker’s employment outcome. This information will be provided to the Fair Practices Commission on an annual basis.
- The Board may consider additional factors for Indigenous workers.

*More than one Vocational Rehabilitation plan*

VR decision-making can be challenging and VRCs need greater flexibility to “do what is necessary” to get injured workers back to a realistic vocational path. Sometimes this involves trial and error. VR policy should encourage an early, proactive and goal-focused approach and VR plans that are realistic and focused on “future proofing” the disabled individual for a job market where, as a disabled worker, they are likely to have a competitive disadvantage.
RECOMMENDATION #62

Vocational Rehabilitation plans should be informal agreements which can be adapted to changing circumstances, including changing medical conditions. There is no formal restriction on the number of plans although they do have to be realistic for the worker and have a reasonable probability of achieving and sustaining the vocational goal over the long term.

Because this type of VR decision, whether coded as “deemed” or not, has such an impact on the workers’ future employment status, I recommend that it should follow the process suggested by the Alberta review:

Equally important is the need to flip the process around so that the deeming of earnings is a by-product of the [rehabilitation] process rather than a driver of the process. Right now, the deeming process appears to be premised on targeting a certain level of earnings for the worker and then identifying a job profile that achieves this level. Instead, the deeming process should be premised on identifying an occupation that realistically exists in Alberta’s labour market and for which the worker would be suited given an assessment of their training, experience and capabilities. Once a suitable occupation has been identified, the income that realistically be earned from that occupation should be assessed and used to adjust the worker’s benefits.¹¹⁰

Vocational rehabilitation decisions are the fundamental decisions underlying the pension decisions on loss of earnings. I recommend that VR decisions be appealable to WCAT so that factual matters about employment and deemed employment can be fully reviewed at an earlier stage of a worker’s claim.

RECOMMENDATION #63

Section 239(2) of the Workers Compensation Act be amended to provide that vocational rehabilitation decisions may be appealed to the Workers’ Compensation Appeal Tribunal.

Vocational Rehabilitation Consultant (VRC) Resources

VRCs are often the face of the Board for seriously injured workers or vulnerable workers, who cannot return to their pre-injury employment. There are many tools which would assist VRCs to help workers adapt to the new economy. The Board has put some effort into this area already. I have had many practical suggestions including but not limited to:

- Job Demands Analysis
- Job Placement
- Job Shadowing
- Supernumerary position placement
- A resource library where VRCs could share resources and tips
- Provide VRC’s with access to information on employers

I suggest that VRCs be provided with additional financial resources to design realistic programs for difficult cases.

There are also many specialized challenges for certain types of workers returning to the workforce and seeking new employment. I recommend that there be a review of the realistic labour markets facing for the following groups:

Immigrants: As noted above, immigrant workers often have language barriers but they may also have unrecognized transferrable skills. Upgrading can be a good investment in their future.

Older Workers: HRSDC Consultations with Older Workers and Employers: Summary of What we Heard. With the changing economy, manual and semi-skilled workers who are injured when they are older, may have a difficult time adjusting to both the change in their lives and the changed nature of work. I suggest that the Board consider a special program for such workers, to assist them to adjust with dignity, and that the Board consider this a special group for whom suitable employment may be limited or not available. A loss of earnings pension may be necessary in these cases.

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111 I note the VR Toolbox, November 2017
Younger Workers: Future-proofing young Canadians with disabilities for the changing labour market. Workers who are seriously injured when young should be given the greatest support to try and re-tool for the new economy. The technological advances may remove barriers to employment for disabled people as we go forward.

RECOMMENDATION #64

That the Board conduct special Vocational Rehabilitation reviews and establish special programs and resources for the following groups:
- Immigrants
- Older Workers
- Younger Workers.

Tracking and Follow Up for Vocational Rehabilitation Outcomes

There remains a serious gap in the VR knowledge base. There is a lack of any reliable data on the long-term outcomes of VR activities. We have heard from many workers that they were unable to obtain new employment that would mitigate significant losses despite VR plans and assistance in some cases. We heard from workers that despite plans the work was never suitable for them or despite diligent attempts to obtain employment they were not competitively employable against a backdrop of more qualified and less disabled workers competing for the same employment. There are many such stories that are supported by claim file reviews, appeal decisions and other information. The Review heard from workers that failed VR plans left them with severe financial losses for them and their families.

There is a study from Ontario Poverty Status of Worker Compensation Claimants with Permanent Impairments, Peri J. Ballantyne, Rebecca Casey, Fergal T. O’Hagan & Pat Vienneau, published online 17 March 2015 that was referenced in submissions to the Review. This is a study that has not been as widely referred to or circulated in the compensation community. The critical conclusion was:

We describe the depth and proximity to poverty of the sample members, illustrating that 46% of this diverse sample of permanently impaired injured workers live in or close to LIM-poverty, and 9% live in deep poverty.

There were a number of workers and families that came forward to the Review whose situations fit these unfortunate circumstances.

There is a research project underway in BC that aims to provide insights into labour market participation and earnings in the five-year period post-injury, for workers with permanent work-related injuries. This two-year study is in the early development phase, with no status updates expected until August 2019. Expected completion of the study and final report are scheduled for January 2021. Currently, information on claims labour market participation and earnings ends with the VR process. Accurate data is needed to evaluate and make decisions on VR services. The Board gathers a great deal of information and sets out a number of key measures.

**RECOMMENDATION #65**

It is recommended that long-term post-injury earnings and labour market participation become a key measure to track and guide action on Vocational Rehabilitation assistance.
PART VI: SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS

IN BRIEF

In the TOR, the Minister directed me to identify "what specific steps are required to increase confidence of workers and employers in the workers’ compensation system, including and not limited to the Fair Practices Office…." I recommend the establishment of an Independent Fair Practices Commission including basic principles for the Commission to operate under. Recommendations are made for “Navigators” to assist certain categories of workers.

Recommendations are made to establish an Independent Medical Services Office modelled similar to systems in other jurisdictions to provide assistance on resolving medical disputes. A recommendation is made to investigate options for a Workers’ Clinic system.

A change in the process to determine consistency of Board policy with the Act is recommended. A new balanced structure for the Board of Directors is recommended. The re-establishment of an Occupational Disease Advisory Committee is recommended. There had been a gap in publication of discriminatory action complaint decisions. I affirmed the value of published decisions and recommend this gap be closed. Finally, in this Part VI, I recommended that a gap in survivor benefits created by past legislative changes be closed.

In the Terms of Reference (TOR), the Minister directed me to identify "what specific steps are required to increase confidence of workers and employers in the workers’ compensation system, including and not limited to the Fair Practices Office…." This was part of a general need to need to improve fairness for workers and supports a “worker-centric service delivery model” with a focus on injured workers who need care, compassion and respect while they recover.

After hearing the participants, particularly from injured workers in public hearings, I believe that this is an important task. This section contains my recommendations for these important steps.
STEP #1: ESTABLISH AN INDEPENDENT FAIR PRACTICES COMMISSION

**Ensuring Fairness, Impartiality and Respect in the Workers’ Compensation System**

It has long been recognized that a viable compensation system requires a specialized disputes resolution mechanism\footnote{In Canada, one was first recommended by the Honourable Mr. Justice Tysoe in his 1966 report *Commission of Inquiry, Workmen’s Compensation Act Report of the Commissioner*. In 1987, the BC Ombudsman noted that 25% of its investigative resources were devoted to compensation cases and an internal WCB Ombudsman was created in 1996. As noted above, the name of this office changed to the Complaints Office in 2002 and in 2010.} and today, every compensation Board in Canada has one. There are two essential types: a “complaints resolution” model (now used by British Columbia and New Brunswick) and an “ombudsperson” type disputes resolution model (used by all other jurisdictions).\footnote{Ombudsman, Province of British Columbia. *Fair First. An OmbudsAudit of the WCB Ombudsman*. Public Report No. 37, December 1998, to the Legislative Assembly of British Columbia. ISBN 0-7726-3744-X, (page 8). https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2037%20Fair%20First%20An%20Ombuds%20Audit%20of%20the%20WCB%20Ombudsman.pdf} The “complaints resolution” model operates internal to the Board and is focused on the resolution of specific complaints. An “ombudsperson” model may be internal or external to the Board and typically has wider scope and authority to resolve disputes.

As noted by the former Ombudsperson in her 1999 Report:

> The WCB has an enormous task to fulfil. It is inevitable in an institution as large and complex as WCB that there will be numerous complaints from the public who seek service. It is essential that there be an office where those who are dissatisfied with the services received from the WCB can go to seek redress for their grievances. The mechanism chosen by the WCB must be highly effective or it will be considered as a "twin cousin" of the very organization it is intended to monitor and investigate.\footnote{WCB-IR 0002 FPO Report at page 3-4 contains an item regarding “2018, a systemic issue related to the management of workers’ claims where there are communication and contact restrictions in place was identified after receiving approximately five complaints within a three-month timeframe. The Fair Practices Office will initiate requests to Corporate Security to review these restrictions if appropriate when investigating a complaint. In some instances, these restrictions have been found to no longer be required upon further investigation and have been removed."}

The current Fair Practice Office (FPO) is internal to the Board's administration, reporting through the Chief Review Officer (CRO). This reporting relationship inhibits the ability of the FPO to address systemic issues of fairness, although they have attempted to do so at least on one occasion.\footnote{WCB-IR 0002 FPO Report at page 3-4 contains an item regarding “2018, a systemic issue related to the management of workers’ claims where there are communication and contact restrictions in place was identified after receiving approximately five complaints within a three-month timeframe. The Fair Practices Office will initiate requests to Corporate Security to review these restrictions if appropriate when investigating a complaint. In some instances, these restrictions have been found to no longer be required upon further investigation and have been removed.”}

The FPO also has a limited jurisdiction and remedial authority, and this together with a real and/or perceived lack of independence undermines the confidence of workers and employers in the FPO’s ability to effectively resolve individual complaints.
The Board has recently started a new Client Relations project which will report out in November 2019. This project, together with a review of the complaints to the FPO, PO and MLAs is set out in Appendix 13.

In my view, there is an urgent need for an effective dispute resolution mechanism, especially for injured workers. In the last decades, the offices of the FPO, the Provincial Ombudsman and constituency offices of MLAs have received literally thousands of complaints, most of which could not be adequately redressed because the limited scope of redress available. And without effective resolution, there is no closure for those aggrieved by unfair decisions or conduct or what is known as “maladministration.”

The current Client Relations project has taken over claim management of about 37 claims, to better address some of the complex issues in these few cases. This is welcome but a very exceptional solution to a small number of cases.

There is also an urgent need to develop an effective avenue to address systemic issues. This has been sorely lacking in past years and it leaves critical issues to be addressed through appeal, the courts or the media. It is critical to establish a credible complaints body which has the mandate and authority to identify systemic issues, to make recommendations to the Board of Directors (BOD) and to encourage systemic, comprehensive change within the Board. It is the BOD who have the final authority to resolve systemic fairness issues in the system and it is to the BOD that systemic fairness concerns must ultimately be addressed. There should also be a public accountability and an annual report to the Minister identifying the systemic investigations and outcomes, as is done with the Provincial Ombudsperson.

I recommend that in British Columbia, a complaints body be established with a wide mandate on the “ombudsperson model” and that this ombudsperson body be external to the Board. I understand that the term “Ombudsperson” is reserved for the Provincial Ombudsperson Office so the new body should be termed the “Fair Practices Commission” (Commission), to distinguish it from the Provincial Ombudsman.

I also recommend that the Commission have enough resources and expertise to address complaints in the area of assessments and prevention as well as compensation. In this Review, I heard many complaints about Board practices in these areas, although these were beyond my mandate. My impression is that there are too few avenues for workers or employers to pursue concerns about Board practices in these areas. A Commission that could address such matters would be a significant step in increasing the stakeholder confidence in the compensation system.

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Finally, I have included guidance on the specific steps I believe are required to establish a worker-centric Commission, one with the capability to receive and resolve both individual complaints and systemic concerns by workers, dependents and employers. The focus of this Commission will be related to the Board’s administration’s primary responsibility to carry out its statutory obligations and its day to day decision-making in a fair, impartial and respectful manner.

Such a Commission would be separate from and external to the Board and presented in a way that it is not perceived as simply a “twin cousin” of the Board.

**RECOMMENDATION #66**

**Establish An Independent Fair Practices Commission**

1. A complaints body be established with a wide mandate on the “ombudsperson model” and that this ombudsperson body be external to the Workers’ Compensation Board.
2. It should have enough resources and expertise to address complaints in the area of assessments and prevention as well as compensation.
3. The focus will be related to the Board’s administration’s primary responsibility to carry out its statutory obligations and its day to day decision-making in a fair, impartial and respectful manner.

In making these recommendations, I have considered a comprehensive Audit by the Provincial Ombudsperson of a previous internal WCB internal dispute resolution program. The Audit found that the Board’s program at that time fell short of the standard required for an effective “ombudsperson” dispute resolution model, but then offered detailed recommendations about how to set up a viable comprehensive WCB Ombudsperson office. I have updated and adapted many of these recommendations to give specific steps for the establishment of an external Commission in British Columbia today.

The former Ombudsperson strongly stated that the complaints mechanism must have particular characteristics to ensure its effectiveness as a fair and adequate remedy including:

a. A clearly articulated mandate provided for in law or an existing administrative procedure;

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120 Between 1999 and the present, the term “Ombudsman” was made gender neutral and became the term we use today – “Ombudsperson”. When directly quoting historical reports, I use the term used in the quoted section.
NEW DIRECTIONS:  
WCB REVIEW 2019

b. Policies, procedures and practices that demonstrate a respect for and are consistent with its legislative authority or administrative procedure;

c. Absence of bias;

d. Competence and capacity to receive complaints and conduct thorough reviews, investigations or appeals;

e. Power to order or recommend corrective action to the public body;

f. Commitment to the principles of administrative fairness and the rules of natural justice.

I agree that these should form the basic principles of the office.

In order to establish a worker-centered Commission which can resolve both individual complaints and systemic fairness concerns by workers, dependents and employers in accordance with these principles, I recommend that the Fair Practices Commission be constituted as follows:

RECOMMENDATION #67

The Workers Compensation Act (Act) be amended to establish the Office of the Fair Practices Commission (Commission) and appoint a Fair Practice Commissioner (FPC) by the Lieutenant Governor in Council independent from the Workers’ Compensation Board’s (Board’s) administration and reporting directly to the Board of Directors (BOD).

The Lieutenant Governor in Council appoint two Deputy Fair Practices Commissioners, one with expertise in issues related to workers’ compensation legal and medical issues and one with expertise in assessment and prevention issues. The FPC may delegate investigation of fairness issues involving those specialized issues to the appropriate Deputy.

The remuneration of the FPC and all costs and expenses required for the administration of the Commission shall be determined under the BC Public Service Act and regulation and paid out of the Accident Fund as approved by the Minister responsible for the Board.

The FPC to have full authority to conduct thorough investigations and make recommendations to the BOD and the Workers’ Compensation Appeal Tribunal (WCAT) on issues relating to systemic fairness.
RECOMMENDATION #67 cont’d

The BOD or the chair of WCAT may refer an issue of systemic fairness to the FPC and the FPC will provide a timely response to the referral. The FPC may also initiate an investigation into a systemic fairness issue on his or her own initiative by giving notice to the BOD or WCAT that such an investigation is under way.

Where issues of systemic fairness relating to statutory provisions arise the FPC have full authority to undertake investigations and make recommendations to the Minister responsible for the applicable statute.

The Minister may refer an issue of statutory unfairness to the FPC and the FPC will provide a timely response to the referral. The FPC may initiate an investigation into an issue of statutory unfairness on his own initiative by giving notice to the Minister responsible that such an investigation is under way.

Where specific disputes arise relating to a specific worker, dependent or employer, the FPC or his or her staff have full authority to make recommendations to the applicable department of the Board's administration or the chair of WCAT. The FPC does not have the authority to direct the Board's administration or WCAT to change a decision but may recommend that the Board’s administration or WCAT reconsider a decision within the terms of the Act for such reconsideration.

The Board’s administration and the chair of WCAT may refer a fairness issue to the FPC and the FPC will provide a timely response to that referral.

The FPC have the authority to establish programs to provide advice, assistance and advocacy services to workers and employers including but not limited to the administration of the Workers’ Advisers Office (WAO) and the Employers’ Advisers Office (EAO). It is recommended that the established WAO and EAO offices be retained as separate from each other but report through the FPC and offer separate services to each of their communities.

The FPC have the full authority to establish an education program to provide workers, dependents, employers, the Board's administration and the general public on the hallmarks of administrative fairness and the rules of natural justice as they apply to the workers’ compensation system.

The FPC shall within 7 days of receiving a complaint, or within a longer period determined by the FPC, advise the worker, dependent or employer who has raised the fairness issue, that the appropriate avenue to resolve the dispute is through the review and appeal systems and conclude the investigation on that basis. Where the determination of the appropriate avenue to resolve the dispute is delayed beyond seven (7) days, the additional time period to make that determination shall extend the period for filing a review or appeal by that same period, so long as no party is prejudiced by that extension. The FPC may continue an investigation of an issue in dispute including an issue of systemic fairness while a review or appeal involving that issue proceeds.
**RECOMMENDATION #67 cont’d**

Within six (6) months of his or her appointment the FPC shall establish a Code of Rights and Conduct under the Act in consultation with representatives of workers and employers and endorsed by the BOD and the Provincial Ombudsperson.

The FPC may make specific recommendations regarding the adherence or failure to adhere to the Code. The practices and procedures carried out by the FPC and the Fair Practices Commission shall adhere to the Code and systemic failure to do so may constitute just cause for removal by the Minister on the recommendation of the BOD.

The Board shall continue the current Fair Practices Office (FPO) for six (6) months or a longer period as determined by the BOD, to ensure an orderly transition to the new disputes resolution program administered by the FPC and the FPO shall report to the BOD through the FPC during that period.

The FPC shall provide an annual report to the BOD and to the Minister and may also provide interim reports on time sensitive issues. In addition, the FPC will issue a separate annual public report.

The foregoing recommendations are designed to provide specific steps to establish a system of dispute resolution to increase confidence of workers and employers in the workers’ compensation system. I attach the highest priority to enactment of the statutory changes necessary to establish the Commission to support the Board’s administrative responsibility to carry out its statutory obligations and its day to day decision making in a fair, impartial and respectful manner.

In making these recommendations I would like to emphasize that first and foremost it is the Board's primary responsibility to minimize disputes and, where they arise, to resolve them where possible before there is a referral to the Commission. It is expected that, as the Commission establishes a high standard of fairness in the workers’ compensation system, the level of disputes referred to the Commission will diminish over time.

With this in mind:

**RECOMMENDATION #68**

I recommend that the Provincial Ombudsperson carry out an audit of the Fair Practices Commission (Commission) after five (5) years to make recommendations to improve the efficiency and effectiveness of the Commission.
STEP #2: NAVIGATORS (INTERNAL AND COMMUNITY)

Throughout this report, I have repeatedly mentioned that communities of workers and employers would benefit from navigators who can guide them through the requirements of a complex compensation system. I recognize that there are many individuals and bodies who have informally played this role inside and outside the Board. I would like to acknowledge their efforts which often have gone unrecognized or have added to regular workloads. These efforts have greatly assisted individuals and have contributed to fairness in this complex system.

I recommend that the value of a supported navigator role in the compensation system be formally recognized and its value acknowledged. Experience shows that a helping hand can reduce disputes, disability and distress for stakeholders who are located outside big institutions, especially ones who have challenges or barriers to participation in the compensation system.

I make the following recommendations to develop a “navigator” role in a cost-effective manner:

1. that the Board establish an internal navigator desk, separate from the call centre, at the Board to act as a liaison between inquiries and the Board resources. In my view, the current FPO could easily evolve into this role and continue to take inquiries from the public or referrals for inside assistance from the Fair Practices Commission (Commission), WAO, EAO and PO. These types of inquiries require insider knowledge and form a significant portion of the calls to the FPO and PO. The number of inquiries in the first year should be tracked and this service evaluated. Also, the FPO has already established connections to the mental health unit for crisis calls and may be well situated to take on this role. In addition:
   a) If FPO transitions to the insider navigation role, I would recommend that the FPO change its name to the “Inquiries Office” to avoid confusion with the Commission. The Inquiries Office should refer any complaints to the Commission and not get involved with complaints resolution unless requested to do so by the Commission. Likewise, the Commission can refer appropriate inquiries to the Inquiries Office.
   b) The Inquiries Office should be available to worker / employer representatives seeking information about Board processes or resources. The Inquiries Office should establish an accessible communication link (phone or email) to assist stakeholders with compensation inquiries which do not involve a complaint.
   c) The Inquiries Office should identify and approach Board staff who have second language abilities. In concert with management and the Compensation Employees’ Union (CEU), the Inquiries Office should develop the capacity at the Board to utilize these staff abilities to assist in inquiries made to the Inquiries Office or to other Board staff on an “as needed” basis to communicate with stakeholders. I heard many times that outside translators simply do not have the knowledge base to provide effective translations on compensation matters (as happened in one of the
public hearings). Officers skilled in more than one language are an untapped resource within the Board which could improve delivery service to stakeholders, particularly in the areas around the province where there are distinct linguistic communities. Ideally, there is, or there can be, sufficient diversity in Board staff to offer compensation services in several languages. This will greatly improve stakeholder confidence in the compensation system, and it is also an important aspect of fairness.

d) That the Inquiries Office should inform the FPO of areas in community education which requires attention.

**RECOMMENDATION #69**

The Workers’ Compensation Board establish an internal navigator desk to act as a liaison between inquiries and the Board resources in a cost-effective manner.

The Fair Practices Office change its name to the Inquiries Office to avoid confusion with the Fair Practices Commission.

I recommend that the Fair Practices Commission (Commission) set up a formal process to designate and train Community Navigators (CN) and support them as follows:

a. CNs should be respected individuals in the community who can help others find and use established compensation resources, and support them in a compensation claim, medical issues and RTW. In some communities, there will be individuals who are already known for this role. Where communities approach the Commission for a CN and there is no individual able to perform this role, the Commission will work with the community to develop a plan for navigation. This will be particularly helpful in communities which are isolated or where barriers to participation exist, including language, culture or literacy.

b. CNs may be offered an introductory WCB course developed and offered through the Commission, other appropriate background resources or training, and other support that the Commission finds appropriate to ensure fairness.

c. The Commission should have the discretion to recognize, decline to recognize or revoke a CN. Where the Commission recognizes a CN, the Approved Community Navigator (ACN) may perform certain functions in the community and receive compensation for this role, as set out below.
d. The Commission will develop recognition and compensation for different levels of involvement and service to different communities. The compensation can range from an honorarium (e.g. where the ACN is available for occasional phone calls from the community) to an hourly rate for specific services. These services will all be at the discretion of the Commission.

e. The CN roles will be evaluated no later than one year after implementation to assess the value of this role.

It is recommended that the initial CNs be immediately established for temporary foreign workers through one or more established advocacy groups. I also recommend that the Commission meet with the EAO and WAO to consider what other communities, if any, should develop a CN.

I recommend that the Commission coordinate with the Ministry and with the Board (both the CEO and BOD), to develop an overall plan for CNs for Indigenous groups and, at the same time, receive requests for CN from established groups.

The Approved Community Navigator (ACN) role is meant to support other advocacy groups in the identified communities, not replace or compete with them. Ideally, an existing community advocate, community leader or elder can take on a CN or ACN role. An ACN is not meant to be, and cannot be portrayed, as being able to advise in compensation matters. Their role is to assist workers and employers who are unfamiliar or daunted by the compensation system, connect with the right resources, and support them in their journey.

Neither is the ACN meant to replace or interfere with the excellent navigational work of the WAO and EAO. An ACN may simply help a worker or employer with limited access, knowledge or capability get in touch with these bodies. I heard many times in this review that a worker did not file a claim because he did not know about the compensation system. This lack of knowledge about compensation is particularly striking in certain communities including new immigrants and indigenous workers. In these communities, there are often passionate and skilled advocates who would be excellent ACNs with a little more knowledge of the compensation system and who could assist the worker or employer in their contacts with the WAO or EAO.

With Commission approval, a qualified ACN could take a longer or more supportive role for an injured worker who was struggling with injury and disability and link them to Board or community resources. This greater support would be decided on a case by case basis.

The ACN role is also separate from the Commission mandate to develop a public education program.

Typically, an ACN will live and work in the community and be a guide for questions about how to access the compensation programs and resources.
RECOMMENDATION #70

That the Fair Practices Commission (Commission) set up a formal designation called Community Navigators (CNs) and Approved Community Navigators (ACNs) and support them.

The initial CNs be immediately established for temporary foreign workers through one or more established advocacy groups.

The Commission meet with the Employers’ Advisers Office and Workers’ Advisers Office to consider what other communities, if any, should develop a CN.

The Commission should coordinate with the Ministry and with the Workers’ Compensation Board (both the Chief Executive Officer and the Board of Directors) to develop an overall plan for CNs for Indigenous groups and, at the same time, receive requests for CN from established groups.

STEP #3: ESTABLISH AN INDEPENDENT MEDICAL SERVICES OFFICE

In the proposed patient centered care model, treating practitioners would have a primary role in determining treatment and medical care for an injured worker and Board Medical Advisors (BMA) would:

1. help to identify objective issues with treating practitioners’ observations, information, opinions and treatment direction/choice
2. work in a collaborative approach with treating practitioners to resolve difference, explore options and find consensus on medical issues
3. inform claim owners when there are unresolved issues or inability to obtain sufficient opinion/direction from treating practitioners in order to engage processes to obtain more complete medical opinion/expertise.

However, medical disputes will inevitably arise. In my view, in keeping with a worker-centric approach to compensation, it is best if medical disputes can be resolved informally and in a timely way. If not, injured workers should have their issues resolved with fairness and good evidence.

The Petrie Report noted that, after 2002, only WCAT had authority to request an IME\(^\text{121}\) and that a process for resolving medical disputes, similar to the WCAT process, was not in place at any other level of the system. He recommended that an independent medical examination process

\(^{121}\) Under section 249 of the Act, a WCAT panel may refer a medical issue to an independent health profession for an expert opinion. This is known as the “IHP” process.
be established to assist in resolution of medical disputes and left it to the Board to determine where this should be located. This recommendation is currently in progress by Worker and Employer Services/ Clinical Services. To date, the proposals do not indicate that a Board directed IME process would be sufficiently independent of the claim management process.

An independent, credible and accessible IME process available at all levels, and to all stakeholders, is essential to improving the confidence of stakeholders in this workers’ compensation system. Good, timely and accessible medical evidence is the foundation for fair compensation decisions and essential to injured workers believing their lives and livelihood are being treated with respect. Seven of the other 12 Canadian jurisdictions have access to some form of independent medical evidence or IME system. ¹²²

I note that many compensation Boards operating in a variety of environments have developed systems for IMEs and dispute resolution mechanisms to resolve medical disputes.

In Quebec opinions of treating physicians are binding on some issues. In both Ontario and Quebec there are processes that engage treating physicians in medical evidence processes for causation and RTW/functional ability issues. Ontario has a process for more complicated expert opinions, particularly on occupational disease, to be obtained from the independent Occupation Health Clinics for Ontario Worker (OHCOW). Alberta has a Medical Panels office that provides an examination/RTW Occupational Injury Service (OIS).

Several persons we have consulted with in BC, including physicians and researchers, have worked with and presented positive opinions in regard to Washington State Centers of Occupations Health and Education (COHE) a community-based program designed to ensure timely, effective, and coordinated services for injured workers. COHEs improve injured worker outcomes and reduce disability by training providers and coordinating care. California has a system for Independent Medical Reviews (IMRs). The California system utilizes a contract service provider as the independent medical review organization to conduct all IMR.

Having reviewed these other models for IMEs and medical dispute resolution in compensation systems, I make the following recommendations. The recommended model has some features from these other jurisdictions but designed to fit the needs of the BC workers’ compensation system.

¹²² WCB-IR 0063 - Medical Evidence and Independent Medical Examination/Review Jurisdictional Scan Summary
RECOMMENDATION #71

An independent Medical Services Office (MSO) be established on the following basis:

- A Medical Services Commissioner (MSC) be appointed by the Lieutenant Governor in Council for the purpose of carrying out the business and affairs of the MSO. The MSC appointment should be in accordance with the Public Service Act.
- The MSO will be provided with the resources from the Accident Fund to provide the specified services, including the hiring of support staff and administrative services. The MSO shall report to the Fair Practices Commissioner (FPC) and share administrative arrangements with the office of the Fair Practices Commission (Commission).
- The MSO will administer and arrange the following services, set out in detail below:
  - Medical Case Conferences to work to resolve medical disputes (non-binding)
  - Medical-Legal Assistance and Reports
  - Arrange Independent Medical Examinations (IMEs) at the request of workers, employers, the Board or WCAT.
- The MSC, in consultation with the FPC and the Minister, will develop and publish policy, procedure and rules for requesting and obtaining an IME, a medical report, assistance with medical-legal requests, and case conference procedures. The MSC will also identify the treatment of records and confidentiality in this assistance.
- A key function of the MSO and MSC is to develop a roster of physicians with the capacity and expertise to provide guidance and expert evidence in a timely way, on medical matters in the compensation system.
- The MSO will be funded from the Accident Fund. Costs for tests, assessments, medical reports and IMEs will be charged under the claim for which they are conducted.
- The MPO will issue an Annual Report that will be provided to the FPC and the Minister.

RECOMMENDATION #72

The Fair Practice Commission (Commission) operate as an umbrella oversight organization for the Independent Medical Services Office (MSO), Workers’ Advisers Office (WAO) and the Employers’ Advisers Office (EAO). The organizations under the Commission umbrella will function independently but may collaborate and coordinate actions to improve stakeholder confidence in the system.
Medical Case Conferences

The purpose of the medical case conference is to clarify and try and resolve medical disputes through an informal case conference. Medical case conferences would involve the worker, the worker’s practitioner, the Board claim owner with respect to the issue, a Board Medical Advisor (BMA) and a MSO physician/expert. The purpose of the medical case conference would be to clearly as possible set out the issue(s) in dispute, the medical and non-medical facts, the reasonable options and try to assist the parties to an agreed course of action. Medical case conferences would be non-binding and the opinions of participants are heard without prejudice.

The process can be modelled on the Alberta MPO Case Conference process. The primary difference for the medical case conference model proposed for BC is that there may be active involvement, engagement and participation of the claim owner and the BMA from Clinical Services to try to collaboratively resolve disputed medical issues.

Issues to address through an informal case conference are:

- Suitability of modified light duties
- Fitness to RTW including own duties and modified duties
- Suitability of recommended medical investigations or treatment

Medical-Legal Assistance and Reports

The MSO would offer different types of assistance to parties seeking to make a medical-legal request to a physician.

I would anticipate that this particular MSO service would primarily be requested by workers and worker representatives. The service would also be available to employers; however, the MSO would need to develop policies and procedures around these requests to ensure that in each case there are no conflicts of interest. I recommend that this be done by the MSC in consultation with the director of the EAO.

The MSO services for medical-legal requests should include:

1. **Assistance in drafting a medical-legal request**: When a request is received, the MSO would review the claim file, identify the medical issues, compile a listing of the relevant documentation and evidence on the issue and provide suggested questions that may be put before a treating practitioner in order for the medical practitioner to provide an opinion on the medical issue. This would present an alternative to an IME that may prove faster and less expensive than the full IME process. It would also ease the workload of the WAO when assisting workers with medical-legal requests and representation.
2. **Arranging for the pre-payment of a medical-legal request**: Where a worker is seeking a medical opinion for the purpose of a WCAT appeal and requests financial assistance, the MSO could pre-approve expenses for medical opinions from treating practitioners. This would improve the ability of workers to obtain quality medical opinions for appeal processes. This would assist the appeal process and instill worker confidence in the compensation system. Workers face unique challenges in obtaining medical evidence/opinion and consider barriers to quality medical evidence create injustices in their case. Having a fair opportunity to provide good evidence is vital to worker confidence in their recovery and in the system. This medical assistance would help to alleviate this problem and minimize resource expenditure.

The MSO would draft criteria for Medical Issue Assistance in consultation with the FPC, and reports which meet these criteria should be paid by the Board out of the Accident Fund, the same as an expense under section 7 of the Workers’ Compensation Appeal Regulation. The MSO would negotiate rates for consultations, opinions and IME’s with the Doctors of BC in the same manner that WorkSafeBC negotiates rates for services with the Doctors of BC.

3. **Services to the Workers’ Advisers Office (WAO)**: The WAO handles a large volume of worker appeals and currently, each adviser has a limit on expenditures which they may incur, a limit which is considerably less than the Board’s fee schedule for one medical/legal opinion. This limit effectively precludes the WAO from obtaining expert medical evidence/reports or clinical notes. This is an unreasonable restriction on the advocacy assistance that advisers require to provide to injured workers. This is especially critical when the Board itself has not actively investigated a claim and the worker does not have the resources or ability to get medical evidence themselves.

- In one case, a worker injured his back while working as a landscaper, an occupation he chose because he had a pre-existing brain injury from a prior accident. His claim was accepted as a “back strain” but when he did not recover as expected, his claim was terminated. On seeking help with the WAO, they helped him draft medical questions, but the worker had to find and pay for his own medical report or the WAO could not assist him in his medical appeal. The worker did not have a doctor and, without compensation, was not able to pay for a report. He felt utterly humiliated and hopeless by these demands which he could not meet, and he now faced the future with a combined disability and no vocational or medical assistance.

- The WAO should be able to obtain medical legal opinions that are pre-approved for payment under the Accident Fund. The request and opinion would need to meet the
same criteria for an opinion request drafted by the MSO and for the content as per agreement between the MSO and the Doctors of BC.

- Injured workers have little knowledge or resources to obtain expert evidence. In comparison, the Board has considerable resources to obtain expert evidence. Facilitating the acquisition of relevant quality expert evidence will assist the system significantly.

**Independent Medical Examinations:**

The MSO would arrange an independent medical examination (IME) when an objective third-party expert medical opinion is required. Physicians specially trained to conduct IMEs are selected from a roster with the appropriate specialty. An IME may be requested by a worker, an employer, the Board or WCAT. The IME physician will be provided with relevant documentation. The IME physician will examine the patient and provide an expert opinion regarding the medical issue. IME opinions will not be binding but should be afforded considerable weight as independent expert evidence. The MSO process could replace the IHP process for WCAT under section 249 of the Act and follow a similar process.

**STEP #4: JUDICIAL REVIEW OF BOARD POLICY**

Section 251 is the section of the Act provides the process by which the legality of a Board policy may be challenged and determined. In that process, a party to a WCAT appeal (worker or employer) may question whether the policy is consistent with the Act. If the vice chair finds that the policy is inconsistent, the matter is referred to the chair of WCAT. If the chair agrees, the chair implements the process under section 251, which sets out how the policy must be referred back to the BOD for consideration.

Since 2003, the chair has referred four (4) matters to the BOD and the BOD has changed the impugned policy two (2) times. There were six (6) referrals by the chair that were withdrawn. Withdrawn appeals include ones in which the impugned policy became a moot issue to the particular claim under appeal.\(^{123}\)

\(^{123}\) WCAT-2013-00551 is an example of a decision in which the panel found the policy applied was not supportable under the Act. In the interim the Board concluded to accept different facts that averted the use of the impugned part of the policy making the appeal moot for the worker but leaving the impugned policy issue unaddressed.
Section 251 has been tested in several judicial reviews, with the appeals arising at different stages of the section 251 process. The definitive case is Jozipovic v. British Columbia (Workers’ Compensation Board), 2012 BCCA 174. Speaking for the court, Groberman J.A.,

I would not give effect to the claims of the WCB and the WCAT that they alone are charged with determining the reasonableness and validity of policies established by the WCB’s board of directors. Accepting such a proposition would be an abdication of the supervisory role of the superior courts vis-à-vis administrative tribunals. Indeed, it is not an exaggeration to say that to accede to all of the arguments presented by the appellant would be to deny the constitutional role of the Supreme Court of British Columbia in maintaining the rule of law in this Province.

Then, at paras. 56 et seq. Groberman J.A. said:

The internal appeal and review provisions of the Workers Compensation Act are convoluted, and in some respects bizarre. They appear, on their face, to give the WCAT a very limited function in reviewing policies of the board of directors of the WCB, but a function that in many ways closely resembles the traditional role of the superior courts on judicial review.

[58] The proposition put forward by the appellant in this case is extraordinary. It suggests that the judicial review function ordinarily exercised by the Supreme Court of British Columbia has been vested exclusively in the WCAT by provincial legislation.

[59] Supervisory jurisdiction over inferior tribunals is a core function of a superior court. Any attempt to remove that function in respect of a particular tribunal would violate s. 96 of the Constitution Act, 1867. In Crevier v. A.G. (Quebec), 1981 CanLII 30 (SCC), [1981] 2 S.C.R. 220, the Supreme Court of Canada considered the degree to which a province may, through the use of a privative clause, insulate an administrative tribunal from judicial review. It held that while privative clauses may validly restrict courts from reviewing tribunal decisions for errors of fact and law, they may not oust the power of superior courts to review tribunal decisions for errors of jurisdiction.

... 

[63] In finding judicial review for “error of jurisdiction” to be part of the irreducible core of functions entrusted to a superior court under s. 96 of the Constitution Act, 1867, Crevier stands for the proposition that no administrative tribunal can have the power to finally determine whether an interpretation of a statute is “so patently unreasonable that its construction cannot be rationally supported by the relevant legislation”.
As recently as May 26, 2019, the court commented in *Colwill v. Workers’ Compensation Board*, 2019 BCSC 826:

*The nature of the s. 251 process (described by Groberman J.A. in Jozipovic (C.A.) as labyrinthine, convoluted, unwieldy and bizarre) gives rise to concerns about proportionality, efficiency, costs, and convenience, all of which weigh in favour of directly reviewing the policy once the views of the administrative tribunal are known through a WCAT decision that squarely addresses the point.*

The courts are clearly offended by the Board’s repeated argument that the courts have no jurisdiction to review Board policy, a view at the heart of the section 251 process.

It is fundamental to the legitimacy and cohesion of the compensation system that Board policy be consistent with the Act. The Act delegates a great deal of discretion to the Board to create policy, and the Board invests a great deal to create good policy through a fair process. In the end, it is a legal issue to be determined by the courts as to whether or not Board policy is consistent with the Act and this is done best, and most credibly, by the courts. Section 251 creates a path to this judicial determination that is “labyrinthine”, “bizarre” and inaccessible to most stakeholders. This does not engender confidence, particularly when in May of this year, a court stated that the interests of “proportionality” weigh in favour of a direct judicial review of Board policy.

It is an urgent matter that section 251 of the Act be amended and that the compensation system be provided with a reasoned proportional process for reviewing Board policy, consistent with the supervisory powers of the court.

**RECOMMENDATION #73**

The section 251 process remain the same until a policy question is referred to the chair of Workers’ Compensation Appeal Tribunal (WCAT). However, an amended version should provide:

a) If the chair of WCAT approves the policy, the chair’s decision (on policy alone or together with the original appeal) may be the subject of a judicial review by either party to the appeal; and

b) If the chair concludes that the policy is not lawful, then the Board, in addition to the parties, has standing to refer the matter to judicial review within the 60 days specified in the *Administrative Tribunals Act*. In those 60 days, the Board may elect to seek a judicial review, change the policy or let the policy lapse. If the matter is not referred to judicial review by the Board or either party within the 60 days, then the impugned policy is of no force and effect, effective the 61st day after the WCAT chair’s decision.
STEP #5: BALANCED AND EFFECTIVE GOVERNANCE

A Common Vision

In virtually all past reviews on governance, reviewers have noted the importance of a common vision in ensuring effective governance. In B.C., it has been left to the Board to issue its “Vision” or “Mandate” and as a result, the vision shifts with changing leadership. For example, the current “Goal and Objective” as set out in the BOD manual includes improving “overall customer service” and ensuring stakeholders receive their full legal entitlements. These are objectives directly drawn from the insurance and business model and are part of a different vision than one for a worker-centric compensation system.

In order to achieve effective governance, there must be a common vision. Five other jurisdictions provide a statutory “Statement of Purpose” or “Preamble” to their Act. As noted earlier in this Report, I strongly recommend that a preamble or statement of purpose be added to the Act.

Board Structure

Governance is an issue identified by key representatives as an issue that needs to be addressed in order to improve confidence in the system. There have been many studies on this issue in B.C., and a detailed history with summaries and documentation is attached in Appendix 22.

As will be seen from this history, there were three broadly consultative reviews of WCB governance between 1988 and 1999. Each recommended that the primary stakeholders of workers and employer representatives make up a majority of the Board. Despite those recommendations, the 2002 legislative changes brought the current BOD structure where a single member from each stakeholder community was appointed along with public interest and special interest representation.

A single stakeholder representative, who participates on a part-time basis, can easily be overwhelmed in governance responsibilities, especially when faced with a larger number of directors that do not share or understand the interests of the stakeholder community. In the past two decades, there is no confidence that workers, as stakeholders in the historic compromise, have a voice at this table.

\footnote{124 WorkSafeBC Board of Directors’ Manual (Tab 2, page 2)}
\footnote{125 Purpose Statements/Code of Conduct Jurisdiction Table (WCB-IR-003(4)), Appendix 22}
Further the current governance model brings together individuals from diverse backgrounds into a complex structure without a clear statutory mandate, resources or a knowledge base about day to day operations. This structure is likely to, and in my view has, delegated a great deal of responsibility to the CEO and management. At the same time, the BOD is isolated from its historical stakeholders. Skilled and knowledgeable individuals have served on the BOD with dedication, but the structure does not support effective, systemic oversight of compensation.

The overriding principle is that the core stakeholders, employers and workers, should have sufficient and equal representation to proficiently and responsibly carry out the governance on behalf of their communities. It is striking that this system of multiple key stakeholder directors has worked so well in other Canadian Jurisdictions. At the same time, it is prudent to recognize the lessons of history in B.C.

Manitoba has a governance model that includes 3 worker representatives, 3 employer representatives, 3 public interest representatives, a neutral chair and the CEO. I believe this governance structure, together with the recommendations below, would provide a governance structure that is stable, well-informed and gives full voice to the diversity in both the employer and worker communities. Only by having such a direct voice in the future compensation path, can the key stakeholders work together to carry out a fair historic compromise.

Given the history, I have added some specificity to the recommendations.

### RECOMMENDATION #74

I recommend that the Workers Compensation Act be amended to provide that the Board of Directors will consist of:

- 3 employer representatives
- 3 worker representatives
- 3 public interest representatives of which one should be an actuary and one a healthcare representative
- a neutral Chair
- president and chief executive officer remain a non-voting member of the Board of Directors.

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126 See Appendix 24 table from WCB-IR-0003(3a)
I also recommend that the director of the Workers' Advisers Office and the director of the Employers' Advisers Office be included in the Board of Directors as non-voting members.

It would be expected that the representatives for worker and employer interests bring significant policy, OH&S and regulatory knowledge to the table. I recommend the inclusion of the WAO and the EAO as they will bring a perspective from stakeholders who typically are not heard from in the usual compensation governance structure (i.e. non-union workers and small employers).

I believe this structure will draw together the appropriate mix of knowledge-skilled experience to provide governance of the Board and build on the strengths of each group.

**Board Resources**

The WorkSafeBC Board of Directors' Manual\(^{127}\) (BOD Manual) provides the directors with guidance. I recommend the following:

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**RECOMMENDATION #76**

Subsequent to any change in the Board of Directors’ structure, the current *WorkSafeBC Board of Directors’ Manual* be revised and updated.

In this BOD Manual, I note what key role is given to the director, Governance (Tab 14). The director, Governance connects many compensation pieces.

1. Is the conduit between the BOD Chair, CEO and administration
2. Is the first level of review of matters to go to the BOD
3. Acts as liaison between the BOD and stakeholders
4. Acts as liaison between the Board and the Ministry

The BOD needs the resources and capacity to carry out its duties and its mandate for governance independently from senior management. This is seriously compromised if the director, Governance is a member of senior management as is the case at the time of this Review.

**RECOMMENDATION #77**

The position of director, Governance be selected by the Board of Directors (BOD) and be independent of the management of the Board. Ideally, the individual would know the Board operations very well.

The BOD develop, through the director, Governance or through another avenue, a Directorate dedicated to serve the BOD, provide research, expert evidence and ask the “big questions” in terms of compensations’ difficult mandate. This work should be done at arm’s length from the management of WorkSafeBC but with consultation and when appropriate, collaboration.

Finally, I would note that the BOD is in a unique position to monitor the health of this complex system, in a way that the day to day operations cannot.128

**Relationship Between the Board, the Ministry and Other Bodies**

The relationship between the BOD and the Ministry is set out in sections 81-88 of the Act. Section 82.1(2) of the Act requires that the Board deliver its service plan to the Minister and the Minister “must promptly lay the plan before the Legislature”. This legislation seems more restrictive of the Ministry’s oversight role than that recommended by the Core Review129 and much more restrictive than the previous Act, which provided that the Minister might “hold the system accountable”.

Clarity about roles and responsibilities is an important part of good governance. Some other jurisdictions develop “Mandate Agreements” between bodies to clarify and direct the relationship between the government and agencies.130 The documents are developed collaboratively and are non-binding. In my view, such Mandate Agreements would assist in clarifying roles,

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128 I note that in the 1990’s, the BOD would request different reports like the “Administrative Inventory Reports” requested by J. Dorsey.
responsibilities and communication lines between the Board, the Ministry and any new bodies such as the Fair Practices Commission.

I mention this as an attention point.

**Systemic and Targeted Reviews of the Compensation System**

There is no doubt that 17 years is too long between reviews. On the other hand, reviews take valuable resources and should not be done lightly or simply according to a formula. Based on my experience in this Review, I recommend the following:

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**RECOMMENDATION #78**

The Workers Compensation Act be amended to provide:
- A review of the compensation system may be systemic (a review of the whole system) or targeted (review of specific topics or aspects);
- the Board of Directors (BOD) may request that the Minister appoint a review, and in this request, specify whether the review should be systematic or one which targets specific areas;
- the Minister may initiate a review at any time but the interval between reviews must be no greater than 5 years.
- The terms of reference for all reviews must include a clear and transparent consultation process with stakeholder consultation and public engagement inclusive of injured workers; and
- The resources for the Review should be made from the Accident Fund.

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**STEP #6: EQUALITY OF STAKEHOLDER EDUCATION**

The Employers’ Forum Claims Committee developed an excellent educational approach and program for their members. They arranged to have senior management members make presentations to their group on pre-arranged topics three or four times a year.

I have reviewed the materials offered at several of these sessions. The materials are excellent and helpful to any representative. However, the practice of one-sided education does not support worker confidence in the system, especially when the materials are offered to employers alone and are not public.
I recommend the following:

**RECOMMENDATION #79**

The Workers’ Compensation Board (Board) develop a Stakeholder Education office and that it follows the practice developed by the Employers’ Forum’s consultations with the Board. The Education Office would:

- Consult with stakeholders on a regular basis about what areas of interest they have about current Board practice
- Based on these consultations, develop half-day sessions with presentations and reports from senior management about these areas, with time for Questions and Answers, and open discussion about these topics
- Hold these Professional Development (PD) sessions for stakeholder representatives 3 or 4 times a year
- Both employer and worker representatives attend the same PD sessions and ensure the roster for invited representatives is continually updated.
- The PD sessions be limited to stakeholders or their direct invitees.
- The Education Office will be the arbiter in this process.
- The Education Office consider an on-line presence and post the materials developed for the PD sessions or some appropriate version of these materials.
- Legal Services, together with the Education Office, consider developing a course for a law school on “WCB and the Law”.

I also recognize that these PD sessions are for “stakeholders” and that at various times, there may be questions about who is or is not a “stakeholder”. These PD sessions are not merely for information but are also an opportunity for worker and employer representatives to engage and discuss on common topics of interest. This is the model used for Policy Discussions and in law practice by the labour bar. Therefore, I recommend that these PD sessions be limited to stakeholders or their direct invitees. The Education Office, like the Policy Division, will be the arbiter in this process.

In the meantime, I note the paucity of accurate compensation information in the general community. I recommend that the Education Office consider having an on-line presence and posting the materials developed for the PD sessions or some appropriate version of these materials.

I also recommend that Legal Services, together with the Education Office, consider developing a course for a law school on “WCB and the Law”.
STEP #7: OCCUPATIONAL DISEASE ADVISORY COMMITTEE

Occupational disease is a specialized area, with specialized issues. Many of these issues did not get fully addressed in this Review. I note that this occurred as well in the Core Review, and that the Reviewer also recommended a separate review of compensation practices around occupational disease.

In my view, this and more needs to be done. I recommend the following:

**RECOMMENDATION #80**

That the Board establish an “Occupational Disease Advisory Committee” with a mandate to conduct an inventory of Board practices in this area and recommend specific attention points for a targeted review or legislative change.

This Committee be provided with the resources to retain the services of an “Independent Occupational Disease Specialist” to advise on medical practices and current scientific research and issues in this area.

**Diseases with Long Latency Periods**

The present wording of the Act provides that workers who are disabled or die from a recognized occupational disease will not receive compensation if they are no longer employed at the exposure site. This specifically excludes the most serious occupational diseases which typically have long latency periods. Section 6(1) and 6(3) are complex provisions and we recommend that this be an urgent matter for review by the ODA. At this time, I recommend that the wording of section 6(3) of the Act be amended to remove the requirement that the worker be employed “at or immediately before the date of disablement” as a presumption of causation so at least the presumption will apply to workers disabled by ODs with long latency periods.

**RECOMMENDATION #81**

That section 6(3) of the Workers Compensation Act be amended to read “If at the date of disablement, the worker is or had been employed in a process or industry mentioned in the second column of Schedule B…. the presumption will apply.”
STEP #8: OTHER ISSUES

Publication of Discriminatory Action Complaints

In the course of the Review, Discriminatory Action (DA) complaints were reviewed. We noted a gap in decisions published to a Board external website in 2015/2016. The Review made an information request to the Board that revealed 436 decisions had not been published in 2014 to 2016. The information request response provided the 436 decisions in an identifier redacted format.

Publishing decisions provides parties with information on what has been considered in other decisions, what has been considered relevant and makes for potential guidance to parties. This process has worked well in other DA complaints as well as Review Division and WCAT processes. While appellate decisions and DA decisions do not set precedent, it is reasonable to request that where applicable reasoning in previous decisions be adopted and applied.

RECOMMENDATION #82

I recommend that the unpublished Discriminatory Action decisions be published and made available on the Board’s external website and that the principle of publishing decisions be affirmed and supported.

Legislative Change to Section 17 in its Application to the Former Act

There is an unusual dichotomy between survivor benefits between the former Act and the Current Act. In 2003, Bill 37 amended the WCA and how survivor benefits were calculated, to extend and rationalize them in accordance with recommendations by the Royal Commission. The BOD amended WS policies (resolution #2003/11/19-04) to reflect these legislative changes. Whether intended or not, when the amendments in Bill 37 were made retroactive to June 30, 2002, the amendments apply only to the current Act. Survivors of workers who were injured before June 30, 2002 are calculated under the former legislation, which was considered discriminatory. It is recommended that the amendments in Bill 37 be applied to the former WC Act and that in implementation, these changes should apply to those currently affected (as was done with the implementation of the Cowburn decision, 2006 BCSC 722).

RECOMMENDATION #83

That the Workers Compensation Act (Act) be amended to provide that Bill 37 applies to all survivors under the Act, including those claims which arise from workers injured prior to June 30, 2002.
IN BRIEF

This section addresses item 1(f) of the Terms of Reference (TOR) regarding whether there are any other urgent compensation issues that were not addressed in the final report to the Board of Directors (BOD) of WorkSafeBC (Board) on how to manage the unappropriated balance in the Accident Fund. The recommendations include;

- Move ASTDs from Occupational Diseases under section 6 of the Act to Personal Injuries under section 5. Develop ASTD policy which recognizes gender gaps and the presumptions for certain ASTD conditions now in Schedule B and initiate stakeholder consultations for additional presumptions.
- Amend section 5.1 of the Act to treat psychological injury more in line with how workers with physical injuries are treated and so remove the stigmatization and inequities around these injuries.
- Remove the CPP Disability benefit offset
- Incorporate the diagnostic criteria, categories and evaluation of impairment for chronic pain in the ICD-11 version of the International Classification of Diseases into the new policy being developed for Chronic Pain
- Amend policy so that post-injury evidence may be considered in assessing retirement dates.

Despite compelling arguments to change to compensation wage rate, I have not done so due to giving priority to other urgent and pressing matters.

In the next Part, I recommend a Task Force to do necessary investigations on changes to the compensation approach to permanent disability, which are beyond the mandate and resources of this Review to resolve.

It has been 17 years since the last compensation review and many issues were raised in the stakeholder and public consultations. This section addresses some of the urgent matters.

However, not all raised matters could be addressed. It is my hope that some of the Review’s recommendations will result in better remedial channels in the future, with better stakeholder consultation, an independent Fair Practices Commission and a requirement for regular reviews of the compensation system.
ACTIVITY RELATED SOFT TISSUE DISORDERS (ASTD’s)

Many stakeholders raised concerns about ASTD policy and practices. Some concerns were specifically from a GBA+ perspective:

- Women are more at risk for ASTD type injuries. Medical research has confirmed that occupational risk factors for women are different and have lower thresholds, so the application of non-gendered risk factors in ASTD claims can create a bias against the acceptance of women’s claims, even though many of the risk factors are higher for women by virtue of inherent biological factors.

- The current ASTD policies and practices effectively bar all computer-related ASTDs. and this practice disproportionately affects women, who have a concentration in occupations requiring prolonged computer usage.

These GBA+ issues are addressed in this section. However, the Board’s ASTD policies and practices are problematic in ways which affect all workers, so I have addressed the ASTD matters in this “urgent” section.

Background:

Board policy treats certain types of gradual onset musculoskeletal Injuries (MSI) in hands, arms, shoulders [tendonitis, etc.] - as Activity Related Soft Tissue Disorders (ASTD) and Occupational Diseases under section 6 of the Act. The following is some helpful background to MSIs and the Board’s policies and practices for ASTDs.

Musculoskeletal injuries (MSIs),[^131] can occur suddenly, from trauma or have a gradual onset, from repetitive motions or even both. An MSI can affect the upper limbs including the neck but the term also includes low back pain and conditions. In compensation systems, MSIs are often separated into those affecting the back and lower back and those affecting the upper extremities. MSIs are wide-spread and in many countries, constitute a major portion of work-related conditions or diseases.[^132]

[^131]: MSIs, also known as “musculoskeletal disorders” (MSD) include a wide range of inflammatory and degenerative conditions affecting muscles, tendons, ligaments, joints, nerves, blood vessels or related soft tissue.

The B.C. compensation system adjudicates personal injuries under section 5 of the Act and Occupational Diseases under section 6 of the Act. Board policy divides the adjudication of MSI’s as follows:

1. MSIs of the back (typically due to heavy lifting) are treated as injuries under section 5 of the Act, whether they are traumatic or have a gradual onset. Traumatic MSIs of the upper extremities are also treated as injuries under section 5.

2. Many gradual onset MSIs of the upper extremities are recognized in policy #27.00 as a specific ASTD and Occupational Disease under section 6 of the Act. The adjudication of each recognized condition (e.g. tendonitis) is given specific risk factors through policy and numerical “thresholds” for each risk factor are set out in the corresponding Practice Directive. A review of the ASTD conditions and policies is set out in Appendix 25.

British Columbia stands alone in its treatment of these MSIs as ASTD’s and as Occupational Diseases (OD) under section 6 of the Act.

**Board Policy and Practice re ASTDs**

It is generally accepted that gradual onset MSIs/ASTDs are multi-factorial. For an ASTD claim, the case manager makes a job-site visit to identify the worker’s risk factors at work. The fairness and accuracy of these assessments if often questioned as they are often assessing another worker (not the injured worker) in a different work set up. The case manager then applies the PD guidelines to identify the applicable work risk factors, before referring the claim to a BMA for a “causation” opinion.

In practice, the Board is known to have a “hard application” of the PD guidelines, using the PD numerical levels as firm and separate pre-conditions for the acceptance of each risk factor, prior to adjudicating the ASTD. The Board’s use of this Practice Directive has been found to pose a significant barrier to the compensability of gradual onset MSIs, particularly from computer work. This practice is regularly criticized in ergonomic reports from professional ergonomists, when these experts are called on appeals.

There is clear evidence that Board policy, together with the Board’s application of the Practice Directive erects a barrier to the acceptance of ASTDs as compensable work injuries. The table

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133 Practice Directive C4-2
below\(^{136}\) shows that acceptance rates of ASTD injuries are usually below 50%, well below the general rate of acceptance (about 90\%)\(^{136}\).

The table also shows that this barrier adversely impacts women. Workplaces are still highly gendered, and many of the repetitive strain injuries (or MSIs) to the arms, neck and hands are experienced by women often from extended computer use. The table below also shows that there is a dramatic difference between the acceptance rate of ASTDs by gender. In 2017, about 46\% of over 3,000 ASTD claims were accepted and, while women made slightly more claims than men, fewer of their claims were accepted. About 60\% of men had their ASTD claims accepted while just over 35\% of women did.

Activity-Related Soft Tissue Disorder Claims by Gender (WCB-IR-0104)

<table>
<thead>
<tr>
<th>Claim Registration Year</th>
<th>Worker Gender</th>
<th>Total</th>
<th>Allowed</th>
<th>Disallowed</th>
<th>% Allowed</th>
<th>% Disallowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Total</td>
<td>19,064</td>
<td>9,192</td>
<td>9,872</td>
<td>48.2%</td>
<td>51.8%</td>
</tr>
<tr>
<td>2014</td>
<td>Female</td>
<td>1,708</td>
<td>548</td>
<td>1,160</td>
<td>32.1%</td>
<td>67.9%</td>
</tr>
<tr>
<td>2014</td>
<td>Male</td>
<td>1,378</td>
<td>802</td>
<td>576</td>
<td>58.2%</td>
<td>41.8%</td>
</tr>
<tr>
<td>2014</td>
<td>Unknown</td>
<td>51</td>
<td>19</td>
<td>72</td>
<td>20.9%</td>
<td>79.1%</td>
</tr>
<tr>
<td>2015</td>
<td>Total</td>
<td>3,351</td>
<td>1,522</td>
<td>1,829</td>
<td>45.4%</td>
<td>54.6%</td>
</tr>
<tr>
<td>2015</td>
<td>Female</td>
<td>1,703</td>
<td>622</td>
<td>1,161</td>
<td>34.9%</td>
<td>65.1%</td>
</tr>
<tr>
<td>2015</td>
<td>Male</td>
<td>1,498</td>
<td>881</td>
<td>617</td>
<td>58.8%</td>
<td>41.2%</td>
</tr>
<tr>
<td>2015</td>
<td>Unknown</td>
<td>70</td>
<td>19</td>
<td>51</td>
<td>27.1%</td>
<td>72.9%</td>
</tr>
<tr>
<td>2016</td>
<td>Total</td>
<td>3,557</td>
<td>1,732</td>
<td>1,825</td>
<td>48.7%</td>
<td>51.3%</td>
</tr>
<tr>
<td>2016</td>
<td>Female</td>
<td>1,826</td>
<td>662</td>
<td>1,164</td>
<td>38.3%</td>
<td>61.7%</td>
</tr>
<tr>
<td>2016</td>
<td>Male</td>
<td>1,679</td>
<td>1,053</td>
<td>626</td>
<td>62.7%</td>
<td>37.3%</td>
</tr>
<tr>
<td>2016</td>
<td>Unknown</td>
<td>70</td>
<td>19</td>
<td>51</td>
<td>27.1%</td>
<td>72.9%</td>
</tr>
<tr>
<td>2017</td>
<td>Total</td>
<td>3,373</td>
<td>1,561</td>
<td>1,812</td>
<td>46.3%</td>
<td>53.7%</td>
</tr>
<tr>
<td>2017</td>
<td>Female</td>
<td>1,841</td>
<td>654</td>
<td>1,187</td>
<td>35.5%</td>
<td>64.5%</td>
</tr>
<tr>
<td>2017</td>
<td>Male</td>
<td>1,532</td>
<td>898</td>
<td>604</td>
<td>58.8%</td>
<td>41.2%</td>
</tr>
<tr>
<td>2017</td>
<td>Unknown</td>
<td>52</td>
<td>17</td>
<td>35</td>
<td>32.7%</td>
<td>67.3%</td>
</tr>
<tr>
<td>2018</td>
<td>Total</td>
<td>3,522</td>
<td>1,800</td>
<td>1,722</td>
<td>51.1%</td>
<td>48.9%</td>
</tr>
<tr>
<td>2018</td>
<td>Female</td>
<td>1,865</td>
<td>755</td>
<td>1,110</td>
<td>40.5%</td>
<td>59.5%</td>
</tr>
<tr>
<td>2018</td>
<td>Male</td>
<td>1,657</td>
<td>1,036</td>
<td>621</td>
<td>63.6%</td>
<td>36.4%</td>
</tr>
<tr>
<td>2018</td>
<td>Unknown</td>
<td>50</td>
<td>9</td>
<td>41</td>
<td>30.0%</td>
<td>70.0%</td>
</tr>
<tr>
<td>2019</td>
<td>Total</td>
<td>2,084</td>
<td>1,208</td>
<td>876</td>
<td>58.0%</td>
<td>42.0%</td>
</tr>
<tr>
<td>2019</td>
<td>Female</td>
<td>1,156</td>
<td>553</td>
<td>603</td>
<td>47.8%</td>
<td>52.2%</td>
</tr>
<tr>
<td>2019</td>
<td>Male</td>
<td>924</td>
<td>603</td>
<td>271</td>
<td>70.7%</td>
<td>29.3%</td>
</tr>
<tr>
<td>2019</td>
<td>Unknown</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

The gender divide in the acceptance rate is likely due, to a large extent, to the Board’s firm position that extensive computer use is not causally related to an ASTD. As seen in the table

\(^{135}\) Table was provided through WCB-IR-0104.

below, less than 2% of the accepted ASTD claims are from computer use. In 2018, over 5,000 ASTD claim applications were made: 23 were accepted as being caused by computer use.

<table>
<thead>
<tr>
<th>Registration year</th>
<th>Total ASTD Apps</th>
<th>Allowed</th>
<th>Denied</th>
<th>Other*</th>
<th>% of ASTD Apps Accepted</th>
<th>Computer-related (CR) ASTDs accepted*</th>
<th>Cumulative CR ASTDs accepted</th>
<th>% of accepted ASTDs that are CR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>4762</td>
<td>1354</td>
<td>1533</td>
<td>1875</td>
<td>28%</td>
<td>21</td>
<td>21</td>
<td>1.5%</td>
</tr>
<tr>
<td>2011</td>
<td>4824</td>
<td>1557</td>
<td>1637</td>
<td>1630</td>
<td>32%</td>
<td>28</td>
<td>49</td>
<td>1.7%</td>
</tr>
<tr>
<td>2012</td>
<td>4931</td>
<td>1589</td>
<td>1855</td>
<td>1496</td>
<td>32%</td>
<td>18</td>
<td>67</td>
<td>1.1%</td>
</tr>
<tr>
<td>2013</td>
<td>4925</td>
<td>1736</td>
<td>1763</td>
<td>1426</td>
<td>35%</td>
<td>19</td>
<td>85</td>
<td>1%</td>
</tr>
<tr>
<td>2014</td>
<td>4916</td>
<td>1409</td>
<td>1851</td>
<td>1656</td>
<td>26%</td>
<td>15</td>
<td>101</td>
<td>1%</td>
</tr>
<tr>
<td>2015</td>
<td>4961</td>
<td>1494</td>
<td>1907</td>
<td>1560</td>
<td>30%</td>
<td>23</td>
<td>124</td>
<td>1.5%</td>
</tr>
<tr>
<td>2016</td>
<td>5112</td>
<td>1706</td>
<td>1783</td>
<td>1623</td>
<td>33%</td>
<td>19</td>
<td>143</td>
<td>1.1%</td>
</tr>
<tr>
<td>2017</td>
<td>5121</td>
<td>1603</td>
<td>1804</td>
<td>1714</td>
<td>31%</td>
<td>19</td>
<td>162</td>
<td>1.1%</td>
</tr>
<tr>
<td>2018</td>
<td>5491</td>
<td>1845</td>
<td>1848</td>
<td>1798</td>
<td>34%</td>
<td>23</td>
<td>185</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

One union whose membership is primarily women noted:

*The current application of this policy effectively bars all computer-related ASTDs since they do not have the requisite force that the Board requires to accept these claims. Yet, year after year, our members develop ASTDs due to prolonged computer use.*

The Board’s firm resistance to recognizing MSI’s arising from computer use relies primarily on a 2007 literature review which concluded:

*…it can be concluded that at present, given the literature at hand, there is no evidence of any cause-effect association between computer related work activities and upper extremity disorders.*

In 2010, a professor of public health at Harvard University submitted an expert report to WCAT, reviewing the Board’s 2007 literature review in the context of published scientific literature and concluded that prolonged computer work could not be ignored as a significant risk factor for upper extremity disorders, especially for the hand and forearm.

Notably, in the 1990’s, there was enough epidemiological evidence linking physical ergonomic exposures at work with upper limb MSDs to develop prevention guidelines for computer work. The Board developed sections 4.46 - 4.53 of the *Occupational Health and Safety Regulation*

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137 Table was provided through a Freedom of Information request.
139 Ibid, page 2.
(OH&S Regulation) which set out Ergonomic Requirements for MSDs [known as “MSI”s or “musculoskeletal injury”].

Assessment of the Board’s Practices re ASTDs

In my view, the Board’s ASTD policy and practices cannot be supported, particularly in light of the following:

1. British Columbia appears to be unique among all Canadian jurisdictions in classifying ASTDs as occupational diseases rather than an RSI arising out of and in the course of employment which is the test for physical injury.141

2. In other jurisdictions, MSIs, including from RSIs from computer work, constitute one of the largest categories of work-related injuries. The emphasis is on prevention and early intervention as seen in Ontario which has a “RSI Awareness Day” every year.

3. The data shows that this policy has an adverse impact on the acceptance of this type of injuries and an adverse impact on women injured at work.

4. The Practice Guidelines are not consistent with current medical evidence and good ergonomic practice.

5. Neither the Board nor WCAT accept the Prevention guidelines as relevant guidelines in assessing ASTD injuries so there is a serious disconnect between the Board’s two approaches. It is difficult to imagine that there is much confidence in the prevention ergonomic guidelines when injuries due to poor ergonomics are regularly denied as compensable injuries. I note that the Petrie Report recommended that the Prevention guidelines be used in amending Board policy and made several other recommendations to amend policy item #27.00. The Board has placed amendment of this policy on its workplan for 2019-2020.

6. While an amendment of Board policy would assist consistency, there are other problems embedded in the process of adjudicating ASTDs as “occupational diseases”. One employer submission was helpful on this point and I have quoted longer selections from this submission as I consider that it provides an important insight.

141 WCB-IR-0066 A Jurisdictional Scan Summary: No other Canadian jurisdiction deals with ASTDs (repetitive strain disorders in the same manner as BC. Some other jurisdictions will have a very limited listing of occupational diseases with presumptions the same as BCs Schedule B. These jurisdictions include: Alberta; Saskatchewan; Manitoba, Ontario; Quebec; and Nova Scotia.
Compass Group Canada is a large national foodservice and support services provider with over 2,000 locations and over 32,000 employees throughout Canada. As we are a national organization, we have experience with all workers’ compensation schemes across all jurisdictions in Canada.

In our opinion, the current WCBC adjudication practice of ruling on “Section 6” cases (ASTD claims) results in significant decision-making delays. These cases often require setting up a “job site visit” with a WSBC Case Manager to review and observe the worker’s job tasks in order to make a determination regarding the work-relatedness of the injury. WSBC is the only jurisdiction in Canada that employs this practice, and, in our experience, it results in significant delays. Due to decision and treatment delays, the worker is negatively impacted.

...The current “ASTD Questionnaire”, which is used to determine eligibility for benefits should be reviewed, as it contains several irrelevant questions...

The review may also wish to consider implementing practices to support immediate or early access to physiotherapy for assessment and treatment within 24-48 hours. Delays in adjudication, in our opinion, are one of the significant barriers to workers gaining access to early treatment. WSBC and other boards across Canada are currently providing a Direct Access to Physiotherapy (DAP) program in conjunction with the return to work program, which falls under the costs of the claim by the board and not the employer. WSBC would be best suited to expand this program to all employers.

In my view, consistency in the Board’s approaches to RSI, together with an integration of processes compensation and prevention, would encourage a stronger pro-active preventive response in the workplace, by employers and by OH&S committees.

In light of the above and the many submissions on the Board’s practices around gradual onset upper extremity MSIs, I make the following recommendations:

1. That the Act be amended to provide that all MSI injuries, including upper extremity gradual onset injuries, be adjudicated as under section 5 of the Act in keeping with other jurisdictions. Such an amendment would confirm the causation test for MSIs to be one of “causative significance” under section 5 of the Act.

2. That the Board develop new policy for the adjudication of MSI as personal injuries in the following context:

   a. That there be an updated medical review of the risk factors for MSI injuries in computer work;

   b. That a new Practice Directive be developed which is consistent with the Prevention guidelines and that it be reviewed by an external expert;
c. that the Board formulate a policy from a GBA+ perspective that does not create gender barriers for the compensability of this injury. The policy should clarify that individuals may have different personal risk factors and the issue is whether the work activity had “causative significance” for the MSI for that particular worker.

d. That the Board develop policy and practice to integrate the prevention and compensation approaches to RSIs. For example, when a worker develops RSI symptoms, the workplace may be assessed for risk factors by a qualified professional (OT or ergonomist) and the employer may be assisted to make any corrections. If the symptoms continue, the worker may be referred for physiotherapy under the DAP program prior to filing a claim. If a claim is filed, this prevention record is copied into the claim file for adjudication purposes.

I recognize that if these changes are made, more ASTD claims will be accepted. This is similar to compensation practices in other jurisdictions and it is also appropriate given the modern nature of work and the pervasiveness of these injuries. However, a “floodgate” concern does not necessarily arise for claims costs. Gradual onset MSIs are largely preventable and are often signaled well before the condition becomes disabling.

I note that moving RSI/ASTDs out of section 6 presents a possible problem for the Schedule B recognition of bursitis, tendinopathy and hand-arm vibration syndrome. Therefore, I recommend that if the Act is so amended, that the Board draft policy for Chapter 3, RSCM II which provides for a similar rebuttable presumption of work-causation for any MSI condition which is now in Schedule B as an ASTD condition.

I also recommend that as part of the ASTD policy review, the Board request submissions from stakeholders about MSI conditions for which they consider there is strong evidence supporting inclusion in Schedule B, such as workers employed as medical radiation technologists and diagnostic medical sonographers who develop a tendinopathy of the hand-wrist, elbow or shoulder. I leave it to the usual policy consultation process for all stakeholders to comment on the merits of each inclusion.

In the meantime, I recommend that that the section of the ASTD Practice Directive setting numerical values as a pre-condition for “work-relatedness” be discontinued and that a holistic approach to an ergonomic analysis, in keeping with the Prevention guidelines, be adopted. I recommend that the Board ensure that ergonomic assessments are conducted by qualified professionals to ensure that confidence in the Board’s approach to ASTDs is fully restored.

Finally, I recommend that the Board engage an expert to help create a training program (perhaps an online program) for the better education of treating physicians in the treatment of

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142 Practice Directive C4-2, Appendix 1
MSIs. This is an area of ongoing research and medical specialization\(^{143}\) and I understand that Board support in this area would be welcomed by the medical profession.

### RECOMMENDATION #84

**That the Workers Compensation Act (Act) be amended to provide that gradual onset musculoskeletal injuries (MSIs) will be treated as personal injuries under section 5 of the Act and that Board policy then be amended to provide:**

- for the adjudication of MSIs as personal injuries;
- a GBA+ perspective as discussed;
- an integration with the Prevention guidelines for MSI injuries
- that Activity-Related Soft Tissue Disorder conditions now specified in Schedule B would have an equivalent rebuttable presumption of work causation for the designated occupations but as a personal injury.

### RECOMMENDATION #85

**That, in the meantime, Appendix 1 of Practice Directive C4-2 be retired and that the PD be updated to include the current Prevention guidelines and a process to integrate prevention and compensation approaches.**

In light of any new policy, I recommend that a new Practice Directive be reviewed by an expert external ergonomist who is accepted as credible by the key stakeholders.

### RECOMMENDATION #86

**That Board policy and practice provide a process for a worker, the union, the employer or the OH&S committee to intervene when a worker is developing Musculoskeletal Strain Injury (MSI) or Repetitive Strain Injury symptoms and request Board assistance or resources to reduce the risk of an MSI for that worker.**

### PSYCHOLOGICAL INJURY

Concepts on psychological injury have evolved over the last several years and will continue to evolve. The underlying principle is that psychological injury should be treated in a manner that is not discriminatory on a comparative basis to physical injury. This principle is set out in Charter Rights and has been articulated in *Plesner v. British Columbia Hydro and Power Authority*, 2009.
BCCA 188. The BC Court of Appeal found that Mr. Plesner was discriminated against under section 15(1) of the Charter by way of differential treatment by a high causation threshold. The court of Appeal concluded:

the criteria contained in s. 5.1(1)(a) and Policy 13.30 are extreme. As earlier stated, they impose an exclusionary threshold which is difficult, albeit not impossible, for those suffering purely mental work-related injuries to meet. 144

The Court made clear that the decision was only regarding section 5.1(1)(a) read together with policy item #13.30. The concerns and principle likely apply to other provisions in section 5.1 and the related policy. These concerns have been articulated to include:

- The requirement for a DSM diagnosis by a psychiatrist or a psychologist;
- The requirement that a predominant cause test be applied for significant work-related stressors;
- Exclusion from compensability of a decision of the worker's employer relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the worker's employment; and
- The denial of claims on the basis that the work-related stressor that is considered to be part of the normal pressures and tensions at work which are associated with the duties and interpersonal relations connected with the worker’s employment.

In 2011, amendments to the Act in Bill 14, Minister MacDiarmid spoke of the government’s “commitment to ensuring that BC’s workers’ compensation system remains responsive to the needs of both workers and employers.” She cited the bravery and willingness of individuals such as Olympian Clara Hughes, Romeo Dallaire and Margaret Trudeau to talk about their experiences to help, “decrease the stigma that has too often surrounded mental illness.” The Minister said on introducing Bill 14:145

Our government recognizes that we need to treat mental disorders that arise from the workplace in the same way we treat physical disabilities, and that’s why we are making these amendments.

The Minister on behalf of the government had the recent Plesner decision in mind, as well as the changing attitudes towards psychological injury and mental disorders. There have been other decisions including an April 2014 Ontario appeal tribunal decision146 that found limiting a

worker’s stress claim to an acute reaction to a sudden and unexpected traumatic event violate the equality guarantee in s. 15 of the Charter of Rights and Freedoms.

The concepts of removing stigmatization and treating psychological injury the same as physical injury has outpaced the law and policy. There remains stigmatization regarding psychological injury. The causation barriers for psychological injury are in many respects much greater than those for physical injury.

In reviewing the psychological injury/mental disorder policies in other jurisdictions it is apparent that less onerous causation tests have been set. These causation tests in some cases are essentially equivalent to the out of and in the course of employment tests applied to physical injuries. The tests under BC’s section 5.1 and policy item #13.30 remain considerably more onerous than those that apply for physical injury.

A major factor in stigmatizing psychological injury is in recognizing and compensating only for DSM diagnoses. Physical injuries can be accepted without a specialist diagnosis. The requirement for a psychologist’s or psychiatrist’s diagnosis of a DSM-5 diagnosis treats those suffering work-related psychological injury in a differential manner from those workers suffering physical injuries. A psychological injury should not necessarily require a DSM-5 diagnosis.

In a June 2017 decision the Supreme Court of Canada stated:

*While, for treatment purposes, an accurate diagnosis is obviously important, a trier of fact adjudicating a claim of mental injury is not concerned with diagnosis, but with symptoms and their effects put simply, there is no necessary relationship between reasonably foreseeable mental injury and a diagnostic classification scheme.*

This points out the difficulty and disparity in relying on a specific diagnosis classification system for psychological injury that is not applicable to physical injury. The entire concept of relying on diagnostic classification to accept any condition under the broad category of psychological injury has been found to be an incorrect application for adjudication of mental injury. There is justification to removing the diagnostic requirements for mental injury entirely. We are not saying that the conclusions on the diagnostic requirements should be entirely tossed or maintained at this point. What we are recommending is that the scope of psychological (mental) injury be expanded to include conditions that do not require DSM diagnosis. Policy should set out that

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147 WCB-IR-0003 provided the policies for mental disorders in all Canadian jurisdictions Appendix 26
148 The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) published by the American Psychiatric Association is a current version referenced under section 5.1 of the Act. The Manual is the recognized reference but is not without controversy.
short-term psychological injury may be accepted without a DSM diagnosis and long-term disabilities would be expected to have expert evidence on DSM diagnosis and causal factors.

In Alberta, a full psychological or psychiatric evaluation may not be required for short-term claims for psychological injury. It is understandable that experiencing a traumatic, disturbing or shocking work-related event could result in a short-term stress and disability from work for a few days without resulting in a DSM-5 mental disorder. Some workers with such conditions are discouraged from making claims for such disability due to fear they would be stigmatized as suffering from a mental disorder.

A full psychological or psychiatric assessment as well as the related adjudication resources would likely require resources much greater than the acceptance of a short-term claim. Short-term psychological injury claims should be able to be accepted when there is sufficient evidence to make a sound decision with confidence that work-related events out of and in the course of employment were likely causative of a short-term disability. Such a short-term disability should be able to be medically confirmed, including by a general practitioner, under the same rules that apply to physical injuries in policy item #95.31.

**RECOMMENDATION #87**

That section 5.1(1)(b) be deleted from the Workers Compensation Act. The term “mental disorder” is inappropriate and should be replaced by the term “psychological injury”. A mental disorder is a potential subset of psychological injury, but mental disorder does not capture all psychological injury.

**RECOMMENDATION #88**

The title of section 5.1 of the Workers Compensation Act should be changed from “Mental Disorder” to “Psychological Injury”.

**RECOMMENDATION #89**

A short-term psychological injury may be accepted for a disability not to exceed ten (10) working days without a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis by a psychiatrist or a psychologist. Policy should set out a general requirement that longer-term psychological injury is expected to be supported by expert opinion on DSM diagnosis and causal factors.

The general causative requirements for psychological injury should be equivalent to the causative requirements for physical injury. The requirement is that, on the balance of possibilities, it must be at least as likely as not that the work is a significant cause of the disability. Section 5.1 of the Act currently separates mental disorders into two major categories. The first of those categories are reactions to traumatic events under section 5.1(1)(a)(i).

If the cause is traumatic by definition the causation test is otherwise the same as for physical injuries. If there is no dispute on the definition of traumatic, we are satisfied there is no issue on the causation test for this category of psychological injury.

The second category under section 5.1(1)(a)(ii) is significant work-related stressors must be predominantly caused by the work. Applying a predominant cause test is a causation test that is not applied to physical injury or even to traumatically caused psychological injury. This results in differential treatment from workers with physical injuries and even workers with traumatic psychological injury. This is discriminatory in our view in a way that offends Charter rights.

I understand the concerns that it may be challenging to separate out the background of psychological conditions in society from those that result from employment. The science and medical literature have advanced significantly on these issues in recent years. Included in these advances is the CSA standard for mental health identifies the factors relevant to mentally healthy workplaces. There are opportunities to connect the prevention side of mental health with the claims side. I believe that strides in creating and improving psychologically healthy workplaces will advance the prevention of mental illness both occupationally and non-occupationally.

There should be an intermediate level between the more than trivial and not necessarily the most significant cause test and the predominant cause test. For the purposes of significant mental stressors, the test should be that the disability was not likely to occur but for the work-related stressors. I see no reason to deny a claim if the disability would not have occurred if not for the work-related stressors. In those circumstances the work-related stressors are causative of the disability and the condition should be compensable even if the work-related stressors are not the predominant cause of the condition.

I note the causation tests as articulated in other jurisdictions including Alberta, Saskatchewan and Manitoba is much more aligned with the causation tests for physical injuries arising out of

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151 The definition of traumatic has been the subject in recent decisions including, Atkins v. British Columbia (Workers’ Compensation Appeal Tribunal), 2018 BCSC 1178. https://www.bccourts.ca/jdb-txt/sc/18/11/2018BCSC1178.htm. The general rules are that there must be objective evidence that the traumatic event was experienced by the worker and subjective evidence that the worker experienced the event as traumatic.

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Part VII: OTHER URGENT ISSUES
and in the course of employment. This indicates that applying the test in this manner to psychological injury is reasonably practicable.

**RECOMMENDATION #90**

The word “predominantly” should be removed from section 5.1(1)(a)(ii) of the Workers Compensation Act.

The Meredith Report noted that the assumption of risk rule was abrogated.  

_The rule is based upon the assumption that the wages which a workman receives include compensation for the risks incidental to his employment which he has to run. That is, in my judgment, a fallacy resting upon the erroneous assumption that the workman is free to work or not to work as he pleases and therefore to fix the wages for which he will work, and that in fixing them he will take into account the risk of being killed or injured which is incidental to the employment in which he engages._

The assumption of risk has crept into and been applied in psychological injury cases. This is present where an analysis is applied regarding whether the stressors are in excess of the normal pressures and tensions at work which are associated with the duties and interpersonal relations connected with the worker’s employment. This language is not present in the Act but has been part of policy and practice. Policy and practice need to clearly articulate that there is no assumption of risk. Psychological injury is not an accepted part of any job.

Finally, the exemption in section 5.1(1)(c) should be limited to situations in which the condition is caused directly by an employer’s decision regarding the worker’s employment that has been made for a legitimate labour relations decision. The current language and policy include matters that could include decisions to change the work to be performed or working conditions.

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152 Manitoba WCB Policy 44.05.30 provides that, Claims for psychological injury will be adjudicated in the same way as for physical injuries. The WCB will determine whether:
- there has been an accident arising out of and in the course of employment;
- the worker has suffered an injury; and
- the injury was caused by the accident.


154 For example, bus drivers are often told that threats or violence are an expected part of their occupation so any psychological injury from these encounters is non-compensable. This is not consistent with a worker-centric approach where injury is not an acceptable part of any job.
creates a potential to include very broad work-related stressors in the exclusion that are not
directing resulting from a reaction to the employer’s decision but are the result of the stressors
in the work environment that are part of the employment environment. The exclusion should be
limited to reactions directly resulting from employer’s legitimate employment related decisions
such as decisions to terminate or discipline.

The Alberta Board policy 03-01 Part II sets that hiring and firing, performance evaluations and/or
performance corrective actions and normal work fluctuations are not considered to be traumatic
as their route of dealing with this type of exclusion.

Saskatchewan Policy Injuries – Psychological (POL02/2017) at items 12-14 “Incidents –
Workload and Interpersonal” sets out reasonable and practicable practices for addressing what
would not be considered compensable and what would arising from management of
workplaces.

The policies in place in Alberta and Saskatchewan should be referenced to model new policy on
where the boundaries should be for employer labour relations decisions versus employment
related stressors. In my view the boundary is between a decision of the employer rather than
the actual effect of the work stressor. For example; an employer could decide to quadruple the
workload of a worker or group of workers. As long as that was not bullying and harassment, the
decision and a worker’s reaction to the decision would not be compensable. If though, a worker
attempted to do the work and the worker developed a mental disorder due to stressors from the
work rather than the decision, those stressors and the disability resulting from the stressors
would not be exempted and considered in adjudication of the claim on the merits.

**RECOMMENDATION #91**

Section 5.1(1)(c) of the Workers Compensation Act should be amended to read:

- (c) is not directly caused by a decision of the worker’s employer relating to the
  worker's employment, including a decision to change the work to be performed or the
  working conditions, to discipline the worker or to terminate the worker's employment.
- Corresponding policy similar Saskatchewan Policy Injuries – Psychological
  (POL02/2017) at items 12-14 “Incidents – Workload and Interpersonal” should be
  used to model new policy.

The Review heard from a number of workers who experienced traumatic events firsthand, along
with other workers who were in “eligible occupations”. One group was given the benefit of the
presumption and the other was not, for the same event. These events are not common but are
traumatic and we believe that the presumption should apply to all workers that experience work-
related traumatic events. Other jurisdictions, including Alberta, Manitoba, apply the presumption
for traumatic psychiatric or psychological injury to all workers exposed to a traumatic event or events.

The specific legislative action would be to remove “in an eligible occupation” from section 5.1(1.1) and remove the definition of “eligible occupation” and related provisions from section 5.1(1.1)(4).

RECOMMENDATION #92

That section 5.1(1.1) of the Workers Compensation Act be amended to apply to all workers who experience a traumatic event or a series of traumatic events in and out of the course of work.

CPP OFFSET

There is a current requirement for the Board to deduct 50% of a CPP Disability Award from a permanent disability benefit. Many stakeholders considered this unfair as it creates financial hardship for the most severely injured workers.

Section 34(2) of the Act provides:

Subject to sections 7(4.1), 22(2) and 23(4), the Board must deduct, from the amount of a periodic payment of compensation paid to a worker under section 22(1) or 23(1) or (3) for an injury, an amount equal to 50% of any disability benefit that the worker is paid in respect of the injury under the Canada Pension Plan.

Policy item #36.20-36.22 provides further direction that the Board deducts applicable Canada Pension Plan (“CPP”) disability benefits from a worker’s permanent disability award where the injury occurs on or after June 30, 2002. When a worker is disabled because of the work injury and there is evidence that leads the Board to determine that the disability benefits being issued under CPP are only related to the injury, 50% of the entire CPP disability benefits paid to the worker will be deducted from the worker’s permanent disability award payable by the Board. If a portion of the disability for which CPP Disability benefits are being paid as a result of the work injury, the Board determines the percentage that is attributable to the work injury and deducts 50% of that percentage from the CPP disability benefits.
The requirements to qualify for CPP Disability benefits are high. A disability must be both "severe" and "prolonged," and it must prevent the worker from being able to work at any job on a regular basis. Both the "severe" and "prolonged" criteria must be met simultaneously at the time of application. The interpretation of these requirements is clear from both cases and policy:

- Severe means that you have a mental or physical disability that regularly stops you from doing any type of substantially gainful work.
- Prolonged means that your disability is long-term and of indefinite duration or is likely to result in death.

In addition, the applicant must also be between 18 and 65 years of age and have met the contribution requirements to CPP. The eligibility and amount received is based on CPP contribution requirements. There must be contributions to the CPP by the worker and the worker’s employer to meet the minimum for payment of benefits of four of the last six years or three of the last six years if the worker has contributed for at least 25 years.

In other words, a worker must be disabled from any gainful employment in order to be eligible for CPP Disability benefits. This designation is equivalent in compensation terminology for competitively unemployable. If an equivalent level of disability were applied between CPP and the Board permanent disability awards, the Board award would need to be 100% and very few offsets of CPP pensions meet that criteria.

In fact, the Board does not apply this lens or require that the Board has accepted a permanent disability to the extent required to receive CPP Disability benefits. Many permanently disabled persons who the Board has done a CPP offset on their claims the Board PPD awards are less than 75%. See Table 1 in Appendix 27 from WCB-IR-0087. In 2018, 533 of 646 claims with offsets were rated at under 75% disability. Only 65 of 646 claims were rated 100% which would be equivalent to the CPP Disability qualification requirement of incapable of any gainful employment. About 90% of the CPP Disability offset is taken from workers the Board has not accepted disability to the degree required to qualify for the CPP Disability benefit.

There is an element of proportionality in the degree to which the deduction of 50% of the CPP Disability benefit affects the compensation system compared to how this deduction affects those workers to which it applies. See Table 2 in Appendix 27 from WCB-IR-0087.

In 2018, the Board deducted an average $463.45 from 646 claims for a reduction of $3,124,392.12 paid out by the accident fund on permanent disability claims. The Board paid out

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$650,789,000.00 in long term disability claims in 2018. The CPP offset amounts to 0.48% of long-term disability (LTD) benefits paid. This is slightly less than ½ of 1% of the Board’s LTD expenses. For the workers that experience this deduction they must have severe and prolonged disability from any gainful employment. They have no employment income. A reduction in benefits averaging $463.45/month will have significant impact on the vast majority of those severe and prolonged disabled persons. The comparative or proportional effect those disabled persons and the Board’s accident fund is substantially greater to the disabled person experiencing the offset.

There is a strong argument that CPP Disability should not be deducted from a Board disability award unless the Board accepts the worker’s compensable disability to the same level required to qualify for the CPP Disability benefit. This is a very small number of workers and about 90% of the disabled persons the Board deducts CPP Disability benefits from are not accepted to have the level of disability that qualified them for CPP Disability benefits.

Workers that qualify for CPP Disability benefits as a result of their compensable injuries are among the most-disabled, financially affected persons. In my view, there is disproportionate hardship to the small total number of workers that qualify for CPP Disability benefits compared to those that do not. There is little financial impact to the compensation of less than ½ of 1% of the LTD benefits compared to significant financial impact from the offset to the permanently disabled persons the benefit is deducted from.

Lastly, CPP Disability is paid from a different contribution pool than the Board accident fund. It is a benefit that is paid for by contributions from workers and their employers. The CPP Disability offset uses this direct contribution for different benefits, to reduce costs to the accident fund, resulting in part, in workers with CPP Disability making a direct out of pocket contribution for the costs of their disability that is not paid by other workers. This violates a fundamental principle of the Historic Compromise that workers will not be required to pay into the compensation system for benefits.

Given all of the above, I recommend that the Act be amended to remove the offset requirement.

**RECOMMENDATION #93**

Section 34(2) of the Workers Compensation Act (Act) be deleted so that there is no offset of Canada Pension Plan disability benefits from awards under sections 22 and 23 of the Act.
CHRONIC PAIN

Participants submitted that chronic was an urgent issue in the compensation system.

The Petrie Report noted that the Act is silent on chronic pain and the condition is adjudicated under policy items #C3-22.20 and policy item #39.02. These policies provide that a worker with permanent chronic pain is awarded 2.5% PFI, without assessment or consideration of individual circumstances. The Petrie Report made two recommendations which are now being considered by the Policy Regulation & Research Division (PRRD) as part of its chronic pain policy review which has been in progress for several years now. The two recommendations from the Petrie Report are:

- That the BODs consider Policy addendums to ensure all necessary treatment to maximize the worker’s ability to return to safe and durable work is carried out before referral to Disability Awards.

- That in more serious cases of chronic the condition is so exceptional that the Board may consider the claim under section 23(3) of the Act.

Recently, there has been some remarkable developments in the scientific understanding and classification of chronic pain. The International Association for the Study of Pain (IASP) issued a June 3, 2019 Press Release that the World Health Organization (WHO) has adopted ICD-11, the latest revision of its International Classification of Diseases, including a new classification system for chronic pain. The decision was made at the World Health Assembly on 25 May 2019. The new ICD-11 coding will allow for differentiation between different types of chronic pain, improve patient outcomes by facilitating multimodal treatments and provide the ability evaluate impairment of functioning resulting from chronic pain diagnoses.

It appears that the science has advanced to a degree that some of the problems and issues with chronic pain in the compensation system will be transformed through the recognition and standardization provided by the ICD diagnoses. The advancements present the ability to differentiate between different types of chronic pain; to focus treatment on specific types of chronic pain and to rate permanent functional impairment resulting from chronic pain.

156 Chronic Pain as a Symptom or a Disease: the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD-11). Item 4.2 Exhaustiveness “Chronic pain may be a symptom of an underlying chronic condition, but it frequently outlasts the normal healing process and often no other underlying disease can be identified.”
https://journals.lww.com/pain/Fulltext/2019/01000/Chronic_pain_as_a_symptom_or_a_disease___the_IAS P.3.aspx

Given this development, I recommend that the Policy Review process incorporate the ICD-11 developments into a new chronic pain policy and that any new policy include a range of impairment findings based on an individual assessment.

In the meantime, I recommend that the Board draft a Practice Directive, effective immediately, initiating the practices recommended in the Petrie report concerning health care interventions prior to a determination of permanent chronic pain and a loss of earnings assessment for those with serious permanent chronic pain conditions. I also recommend that workers with permanent chronic pain conditions, which were previously assessed by the Board, be provided with health care benefits on a permanent basis, if they have not already done so.

RECOMMENDATION #94

The Chronic Pain Policy Review currently in progress with the Policy Regulation & Research Division should include consideration of the ICD-11 Version of the International Classification of Diseases, Including New Diagnostic Codes for Chronic Pain in the development of updating chronic pain policy. The new policy should provide for an individual assessment and a range of possible permanent impairments.

It is recommended that the Board develop a Practice Directive, effective immediately that:

- for workers with chronic pain, that all necessary treatment to maximize their ability to RTW will be carried out before a referral to Disability Award; and
- for workers with serious permanent chronic pain, the Board may consider the claim under section 23(3) of the Act.

DATE OF RETIREMENT & EVIDENCE

One of the issues that had the strongest input to the Review was about termination of permanent functional impairment (PFI) pensions at age 65 or another presumed age of retirement. We heard from multiple workers that their disability does not end at age 65 or retirement, so why should their disability award on this date? In old age, they still had the pain and limitations and medical needs but no financial support. This issue was raised not only by workers and worker representatives but also by several employers. One presenter who made a vivid case for this passed away shortly after his public presentation to this Review.

However, as the Bogyo Report addressed this matter and presented Option 3 to increase the presumed retirement age to age 70, I am precluded from addressing the presumed age of retirement under the Act.

There is still the matter of the evidence needed to determine a date of retirement. Section 23.1 (b)(ii) of the Act permits the Board to apply a date later than the presumed date (currently age 65) if the Board is satisfied the worker would retire after that date. Policy #41.00
“Duration of Permanent Disability Periodic Payments” sets out certain requirements for “independent and verifiable” evidence that may support a worker’s statement that he or she would have worked past age 65. The policy goes on to state:

When determining whether a worker would retire after age 65, the circumstances under consideration are those of the individual worker as they existed at the time of the injury.

The effect of this policy is to restrict the evidence considered in the date of retirement decision to the worker’s intended retirement age at the date of injury (DOI). There are inherent problems with this restriction and even the concept of basing the retirement date on intent at DOI.

This policy is inequitable as it significantly disadvantages some workers, depending on when an injury occurs in a life. This may be reasonable for a traditional worker who is injured near retirement age and has a clear concept and/or plan for retirement. However, many workers are injured years before retirement and have not yet planned retirement. It is an impossible bar for a young worker who is highly unlikely to have considered retirement at all. And even if a person at, for instance, age 25 had formed some general intent about when to retire there are so many events, not taking a compensable injury into account, that would change those plans.

It is also clear that injury changes everything. A compensable injury may reduce earnings and contributions to retirement benefits and not at all compensate for pension contributions or other ancillary benefits. Retirement plans get altered due to compensable injuries for other reasons as well. The Review heard from several workers that had intended to retire but were unable to because due to the financial hardship due to the effects of a compensable injury. This included having to sell assets or losing equity in property or running up credit card debt, with interest, during “gaps” in benefits.

Compensation benefits are intended to compensate for the lost earning capacity resulting from the injury. The earning capacity is not fixed at the date of the injury. The Board regularly examines what the worker is able to earn in a suitable and available job many years after the DOI. I agree with the reasoning of the Petrie Report and recommendations #29 and #30, and recommend that policy #41.00 be amended.

RECOMMENDATION #95
Policy item #41.00 should be amended to allow consideration of all relevant evidence regarding the actual impact of the injury on the workers likely retirement date, including evidence after the date of the injury.
RATE OF COMPENSATION

Many participants requested that the rate of compensation be increased to 100% of net.\textsuperscript{158} Prior to the 2002 changes, the rate was 75% of gross earnings. For many workers this was effectively 100% of net. The change to 90% of net has had a substantial impact on injured workers. This is undoubtedly a matter that required consideration by this Review.

The primary argument made against raising the compensation wage rate to 100% of net is that 90% of net matches the highest rate in all other jurisdictions. Rates in some other jurisdictions are lower. Cross-jurisdictional comparisons should be an important part of any review. They are an important aspect of this Review. We have done comprehensive cross-jurisdictional comparisons on a wide range of issues including wage rates. The fact that 90% of net is currently the highest wage rate in Canadian jurisdictions is not the reason why I am not recommending a change.

Cross jurisdictional comparisons are useful to see what is achievable and the impacts of certain measures. We know that 100% of net is achievable because the 75% of gross is roughly equivalent.\textsuperscript{159} This rate was in place for claims up to July 2002 and remains in place for former provision claims.

I have also taken into account certain options in the Boggo Report in consideration of wage rate changes and the overall picture of scale of compensation. Specifically:

- Option 2, Increase the maximum insurable and assessable earnings to $100k per year.
- Option 4, Provide a one-time adjustment to restore the value of currently paid pensions to their purchasing power in 2002 or more recent year when the pension was established
- Option 5, Revise the cost of living provision of the legislation by altering the current CPI-1% such that full CPI would apply unless the Accident Fund falls below the established fully funded level.

Given the Boygo recommendations and the substantial issues within my other TOR, I decline to address this issue in this Review. This issue will undoubtably be a subject of future reviews.

\textsuperscript{158} Sixteen (16) written submissions requested that wage rates be increased to 100% of net or similar.
\textsuperscript{159} Compensation benefits are not taxable or subject to CPP or EI deductions. Net pay estimates deductions for taxes and deducts an amount equal to CPP and EI deductions to arrive at net pay. For persons at or near the Board maximum wage rate deductions would generally be 25% or greater. As a result, 75% of gross in most cases would be roughly equivalent to 100% of net. There would be variations in either direction that results on 75% of gross may be greater or less than 100% of net.
PERMANENT DISABILITY AWARDS

The Review has gathered considerable information and had discussions with stakeholders and experts, both internal to the Board and external regarding the manner in which the Board compensates for permanent disability. The cross-jurisdictional comparisons show that BC compensates for permanent disability in ways that are substantially different from all other Canadian jurisdictions. There are problems with the way permanent disability awards are calculated and made. These problems in some cases severely affect permanently disabled workers. There are broad impacts on the system including to employers. The permanent disability provisions impact case management, return to work, and the confidence in the compensation system.

I do not believe that there is enough information, nor has there been sufficient discussion with stakeholders and experts to make a well-informed recommendation for legislative and/or policy changes. There are several important pieces of new relevant information that will be available soon but are not available in time for this Review. In examining the issue, this is one that will likely require legislative changes, particularly if there is to be consistency with other jurisdictions and if there is to be meaningful actions to address the problems identified with the current permanent disability system.

This is not a matter than can or should wait for a future Review of the system. As a result, I will be recommending in a later section that a Task Force be established to examine this issue and make recommendations under a specified time frame.

There is one focused exception that applies to Permanent Disability in which I am making a recommendation and that is regarding the “so exceptional” clause for Loss of Earnings awards. That recommendation is found earlier in this section.
PART VIII: CONSULTATION WITH INDIGENOUS COMMUNITIES

IN BRIEF

The Review heard from a number of Indigenous workers, representatives and VRCs regarding Indigenous workers with injuries from off reserve employment. The Review retained a consultant about on-reserve employment and assessed injury rates.

The Board is developing a corporate response to the Truth and Reconciliation Commission. In the meantime, I recommend:

- That guidelines be developed for VRCs, to incorporate an Indigenous perspective into VR plans for Indigenous workers.
- Develop community navigators and a Board liaison for Indigenous workers and employers
- Retain an expert for Internal development and cultural sensitivity training
- Investigate the low acceptance rate for Indigenous workers on reserve

I was asked to ensure that BC’s Indigenous people were encouraged and supported, in their various capacities, to participate in this Review. In preparation for this consultation, I reviewed certain initiatives of the Province, WCAT and other communities arising from the recommendations of the Truth and Reconciliation Commission (TRC). These important initiatives are summarized in Appendix 28.

Several Indigenous workers and service providers participated in the public hearings and provided detailed and helpful recommendations. I attach these comments and recommendations in Appendix 29.

GENERAL COMMENTS

Based on this consultation, we conclude that the Board is effectively absent from many Indigenous working communities, on and off reserve. This absence is more pronounced for compensation than for occupational health and safety issues.

We canvassed this issue with the Board. With respect to safety, the Board’s ILS Youth Group has engaged in annual safety projects with Indigenous communities for a number of years. These initiatives don’t seem to have broadened or been incorporated into a more community-
based approach as was suggested in the Board’s 2008 research paper *Working Safe in Aboriginal Communities*.\(^{160}\)

General research shows that Indigenous workers have a higher risk of injury than other workers.\(^{161}\) The Board does not currently ask workers or employers to self-identify as Indigenous so data about this matter could not be obtained.

The Board’s involvement in OH&S issues on reserve is complicated by jurisdictional issues. Part III of the Act only applies to workers and employers “within the jurisdiction of the Provincial government”\(^{162}\) and since band employment can be either Federal or Provincial, there is often a difficult question of fact to assess when or if the Board has jurisdiction to enforce safety regulation in a band enterprise. The EAO reports assisting and guiding many Indigenous employers who struggle with their role under the Act (Appendix 30).

We understand that the Board is preparing to develop a corporate strategy to develop a response to the TRC’s “Call to Action”. The Board has many resources to draw on, including the Joint Diversity Committee’s report on the TRC recommendations\(^{163}\) and the many current initiatives by the Province, particularly those with the First Nations Health Authority (FNHA), which could be a possible partner in the delivery of health care services to injured Indigenous workers.

A helpful submission from the WAO noted that the Indigenous population is young and growing and is anticipated to comprise a significantly larger proportion of the Canadian labour market in the next decade. The compensation system would benefit from a better understanding of the systemic barriers in order to make the compensation system, and VR programs in particular, more effective for Indigenous people.

**INDIGENOUS WORKERS, WORKING OFF RESERVE**

From the presentations, it was clear that even when an Indigenous person is working off reserve or was non-status, their ties to their Indigenous community remain strong. All indigenous participants spoke of their strong familial, tribal and status ties to their community and a strong connection to the land.

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\(^{161}\) WCB-IR-0004(2) - Information from Industry and Labour Services (ILS), WorkSafeBC, May 3, 2019

\(^{162}\) Section 108(1)(b) of the Act.

There were several strong presentations about the need to consider these factors while formulating vocational rehabilitation plans. Participants offered many detailed recommendations (summarized in the Appendix 29) about the Board’s VR practices. These echoed the presentation to the Board by Dr. H. Harder on how to formulate “Indigenous Perspectives within Vocational Rehabilitation”\(^\text{164}\). Again, the Board has many resources to draw on, including present staff who are Indigenous.

**RECOMMENDATION #96**

That the Board develop guidelines for VR practices and the development of specialized resources to assist in the vocational rehabilitation plans for workers who self identify as an Indigenous person, whether status or non-status. The presentations and recommendations made to this Review are summarized in Appendix 29 and should be considered in the development of these guidelines. I recommend that the guidelines include that in such cases, the Relocation Policy should not be applied.

It is also recommended that VRCs who self-identify as Indigenous be included in the development of these guidelines, as well as the WAO and the EAO who have been working with Indigenous workers and employers on a case by case basis.

INDIGENOUS WORKERS AND EMPLOYERS ON RESERVE

As noted above, no data was available about work injuries for Indigenous workers. Further, no on-reserve Indigenous worker attended the public hearings or completed a questionnaire\(^\text{165}\).

Therefore, to review this aspect of Indigenous work, I initiated two proceedings:

1. While the Board has no data on Indigenous workers, it does have data regarding Aboriginal bands who are registered as employers. I reviewed the claims profile of registered band employers (who give preferential hiring to on reserve members)\(^\text{166}\). The acceptance rate for compensation claims made by band employees is about 35% - half the rate for claims acceptance as a whole. This data and comparison are set out in Appendix 31. This is an area which demands further attention.

\(^{164}\) WCB-IR-004(2) *Indigenous Perspectives within Vocational Rehabilitation*, Dr. Henry Harder, Presentation to WorkSafeBC, 2019.

\(^{165}\) Everyone who identified themselves as Indigenous on the questionnaire stated that they resided off reserve.

\(^{166}\) In July 2019, there were 153 registered bands.
2. I engaged the services of an Indigenous worker, Pauline Henry, who was working off reserve but lived on reserve and had a long work history of working on reserve in administration.

In summary, Ms. Henry stated that, outside of band offices on reserve employment generally arises when the band gets a contract with the Federal or Provincial government, or a third party, to perform work in a specified time. Typically, the work is seasonal and involves some physical labour. Firefighting, construction, forestry and fishing are the common areas of employment. The Federal contracts often have additional funding for skills training and virtually all of the contracts provide that the band may hire band members before others are employed. It is her experience that in band offices, there is very little information or knowledge about compensation especially in locations where the Board does not have jurisdiction over safety. Ms. Henry suggests that this lack of knowledge, together with many systemic barriers (like those identified by the TRC) likely result in work injuries being underreported.

Her suggestions for better contact with on reserve workers include:

- Engage Indigenous community navigators to assist in starting a relationship between band employers and the Board. This approach would be focused on how to help support workers and employers in the case of injuries (e.g. how to support a culturally appropriate claim process) but it could include safety issues where the Board has jurisdiction, or safety advice when it does not.\(^{167}\)
- Partner with Provincial outlets, like WorkBC, to distribute Board information by pamphlet and posters; these are more accessible to rural communities and remote locations.
- Approach Federal government to get provisions added to Federal contracts for support and information for injured workers.

RECOMMENDATIONS:

We heard common themes in the many suggestions made from different sources, including public participants in the Review. The detailed suggestions are summarized in Appendix 29. I agree with these summaries and make the following recommendations:

\(^{167}\) In Manitoba, the WCB partnered with others to create MAHSI or the Manitoba Aboriginal Health and Safety Initiative. MAHSI developed on-line learnings tools, developed materials and resources for culturally appropriate workplace health and safety.
RECOMMENDATION #97

Designate an Indigenous liaison desk for “one stop shopping” for Indigenous employers and workers. The liaison desk could coordinate a Board response regarding OH&S, compensation and Return to Work issues. It may be helpful to coordinate this with the Employers Advisers Office and/or Workers’ Advisers Office, who often handle these inquiries.

RECOMMENDATION #98

Retain one or more Experts in Indigenous matters to help Case Managers (CMs) and Vocational Rehabilitation Consultants (VRCs) build relationships in their communities, recognize successes, build a knowledge base, advise on research, job development and economic development for communities, recognize racism as a barrier to re-employment and provide support and fund established third party providers who can provide services and have the trust of the community. Suggestions for the role include:

a. Work with Employers’ Advisers Office re registration and assessments of Indigenous employers;
b. Work with Prevention to develop culturally sensitive safety programs;
c. Work with Workers’ Advisers Office re handling claims by Indigenous workers;
d. Work with claims to develop traditional and western-based health care treatments (see “Prevention and Treatment strategies” in WS 2012 Safeguarding Indigenous Fire Crews);
e. Arrange or conduct cultural sensitivity training for WorkSafe staff – based on BC cultural competencies – to help staff to develop culturally sensitive Disability Management and Return to Work (RTW) programs;
f. Initiate provincial community outreach re WCB issues for the Indigenous community;
g. Educate the Board re Indigenous community identity & central role of Indigenous community in wildfires;
h. Assist the Board to partner with other agencies re outreach, research, treatment and prevention resources for this community;
i. Develop a claims form – option to self-identify as Indigenous or if employer is Indigenous, with copy sent to Indigenous liaison desk;
j. collect Data and conduct research on injuries and outcome by Indigenous status;
k. Research Project on RTW options and strategies in Aboriginal community;
l. Advise the Board on outreach to Metis and Inuit communities.
RECOMMENDATION #99

Develop, train and pay community navigators in Indigenous communities, particularly in bands with high project employment. Navigators should be members who live in the community and are trusted by the community. They can be trained by the Board to support and assist Indigenous workers to make claims and support the claims process with assistance from community resources as well as the Board.

The Board should also reach out to the Metis community and establish a community navigator with an established advocacy organization for this community.

Band employers clearly operate in a specialized environment and may have special sensitivities about compensation jurisdiction. Also, based on Ms. Henry’s information, there are different areas of responsibility within bands, Tribunal Councils and territories. I highly recommend that the Board coordinate outreach to particular communities with other Provincial initiatives, including the First Nations Health Authority.
PART IX: FUTURE TASK FORCES

IN BRIEF

The Review recommends that Task Forces be created to address two critical issues which require more work than is possible in this Review.

1. That the Board gather data on the earning capacity of permanently injured workers at 2.5 years and 10 years after a RTW and assess whether the B.C. method of evaluating permanent disability under section 23 is fair and in keeping with other Canadian jurisdictions.

2. That the Board investigate and cost out the option of creating a separate system of medical clinics based on Ontario’s OHCOW model, in British Columbia.

There are a small number of issues that require action, but the require more work than what was available for the Review. These are critically important issues for the delivery of fair and balanced compensation and the confidence in the system. We are therefore recommending that Task Forces be appointed to investigate, consult and make recommendations on these matters. The specific issue is:

1. Permanent Disability
2. Establishment of Medical Clinics on (Occupational Health Clinics for Ontario Workers (OHCOW) model

It is recommended that the government appoint Task Forces to investigate the issues and report back with recommendations within a specific time frame. The time frame to conduct the necessary investigations, information gathering, and consultations should be less than two years. The establishment of these Task Forces should set a process for bringing key stakeholders together with the Board\(^{168}\) and external experts together to gather information, set out established facts and make recommendations. The issues identified for Task Force actions are matters that would require legislative action. The Task Forces should be appointed by the Minister of Labour and report out to the Minister of Labour.

\(^{168}\) Internal Board experts would be included in the Boards’ involvement in the process
TASK FORCE RE COMPENSATION FOR PERMANENT DISABILITY

There are two sections of the Act that address compensation for permanent; sections 22 and 23. Permanent total disability is addressed in section 22 of the Act. There are a relatively small number of claims that fall under this section. A worker with a permanent disability will be compensated for total loss of earning capacity. There are no issues for claims under this section.

There are significant issues for claims under section 23 of the Act for permanent partial disability.

BC uses a schedule that supposedly estimates impairment of earning. Sections 23(1) of the Act requires the Board to:

- estimate the impairment of earning capacity from the nature and degree of the injury,
- pay the worker compensation that is a periodic payment that equals 90% of the Board’s estimate of the loss of average net earnings resulting from the impairment.

All Canadian jurisdictions have similar provisions in their Acts to compensate for impairment of earning capacity. This is a principle set out in the Meredith Report that has been reflected in all Acts including BCs since establishment of the Acts and systems.

Section 23(2) allows the Board to use a Permanent Disability Evaluation Schedule (PDES), which is set out in Appendix 4 of the (Rehabilitation Services and Claims Manual II (RSCM II). This is a rating schedule of percentages of disability for specific injuries or mutilations. This PDES was developed in the 1960’s by Dr. Bell in consultation with compensation Boards across Canada. All Canadian compensation Boards adopted the recommendations of Dr. Bell to create PDESs to rate permanent impairment. The problem with these PDESs, as was recognized by Dr. Bell and others, is that they measure functional impairment and not impairment of earning capacity as is required under the Act. Using functional impairment PDESs results in arbitrary awards that have no relationship to the impairment of earning capacity, either on an individual basis or on a global basis, for all workers experiencing the same nature and degree of injury. This problem was addressed and resolved to some degree by the “Dual System” first established in Commissioners’ Decision No. 8 for back injuries and subsequently expanded to all types of permanent injuries in subsequent Commissioners decisions. It is notable that in Decision No. 8, the Commissioners concluded it was not possible to gather the information

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necessary to determine what the impairment of earning capacity is for particular degrees of injuries and mutilations.

There are permanent injuries that are not specifically referenced in the PDES. These are addressed by what are called unscheduled awards. Unscheduled awards are addressed by extrapolation of items in the PDES and/or referenced to other materials such as the AMA guides to Permanent Impairment. Unscheduled awards also measure functional impairment and do not reflect impairment of earning capacity.

The “Dual System” worked well for decades to resolve the inability of the PDES to compensate for impairment not earning capacity. When the PDES does not adequately compensate for impairment of earning capacity an assessment of the actual impairment of earning capacity was done for the worker and the award was based on the higher of the two. This balance was altered with the “so exceptional” clause introduced in 2002 that drastically reduced the number of permanently disabled workers that received an award for the impairment of earning capacity they actually experienced under section 23(3) for a Loss of Earnings (LOE) award. The LOE legislative changes in 2002 made “functional” awards the mandatory method to compensate for permanent impairment. In only rare (so exceptional) cases would a worker be eligible to receive compensation based on impairment of earning capacity.

In the interim through the 1980s and 1990s all other Canadian jurisdictions moved away from use of PDESs as primary measures of permanent impairment. They use a system of non-economic and economic awards. All permanent impairments receive a non-economic award to compensate based on the loss of function resulting from the injury. If a worker has a loss of earning capacity due to the permanent injury the worker is also compensated for that loss of earning capacity.

It has been pointed out in several submissions as well as in discussions with internal policy experts with WorkSafeBC that the BC reliance on a very outdated PDES is inconsistent with the Act in not having any relationship to impairment of earning capacity and is inconsistent with the practices in place in all other Canadian jurisdictions. There is now the capacity to create a PDES that is based on impairment of earning capacity resulting from specific injuries that was not present in 1972 at the time of Decision No. 8. There is a research project under way that should result in providing substantive information on post injury earning capacity for persons with PPD. This creates the possibility of development of a PDES that has reasonable and

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170 Nunavut/NWT is an exception in that they use a schedule as the primary method of compensating for PPD. The Nunavut/NWT compensates at comparatively much higher rates and has other provisions that ensures it is much less likely that a worker would be under compensated for impairment of earning capacity than a worker in the BC system.

171 Submissions received from BC Federation of Labour (SUB-0125) and BC Nurses’ Union (SUB-0133) posted at https://engage.gov.bc.ca/workerscompensationreview/stakeholder-submissions/
reliable accuracy in rating impairment of earning capacity resulting from the nature and degree of injuries. It may be more prudent to take the path of all other Canadian jurisdictions and move to a system of economic and non-economic awards. The issues of an assumed retirement age and whether permanent partial disability (PPD) awards should be for life, as was requested by many submissions, public hearing presenters and survey responses to the Review, further complicates the issue.

Many parties have identified a lack of knowledge of long-term RTW outcomes as a problem in both the assessments of PPDs and determining what RTW measures including legislative requirements for RTW are needed. The Board does not gather information on the long term RTW results for persons with permanent disability. Clear and accurate knowledge of the real results for persons with compensable permanent disabilities would provide valuable assistance in determining what measures are needed to compensate suitably for PPD and to achieve the best results for RTW and prevent/minimize impairment of earning capacity. As a result, we are recommending that, on an ongoing basis, the Board will gather and compile data on the earnings capacity of permanently disabled workers at 2, 5 and 10 years after the conclusion of the RTW process on their claims.

I have considered whether the “so exceptional” clause of section 23(3.1) of the Act should be recommended for removal. Initially, for several years after enactment in 2002 very few workers were accepted for loss of earnings or VR assistance as a result of the “so exceptional” clause. Many workers that suffered significant LOEs were unfairly denied benefits. In recent years the numbers of LOE awards per year have approached the numbers prior to 2002. That number is approximately 1000 LOE awards per year. This demonstrates the high level of variability possible by the way the legislation can be interpreted.

I believe the interpretation in the years immediately following 2002 were excessively restrictive. That situation has changed and raises the question of whether this clause is needed at all given the current application of LOE criteria. The application could though, return to the restrictive application of the past. This bodes for removal of the clause. The awarding of LOEs is tied inextricably with the overall compensation for permanent disability.

I have recommended that a Task Force examine the system to compensate for permanent disability. It would be appropriate for the Permanent Disability Task Force to include all aspects of LOE awards including the “so exceptional” clause in consideration of how to compensate for permanent disability. I would decline to make a recommendation to remove section 23(3.2) based on the current application and that this is a matter that should be included in a comprehensive review of permanent disability awards.
RECOMMENDATION #100
The Board will gather and compile data on the earnings capacity of permanently disabled workers at 2, 5 and 10 years after the conclusion of the Return to Work process on their claims on an ongoing basis.

The method of evaluating PPD is of enormous importance to the system including fairness of the system. This is a complicated issue that requires significant additional information that is not available to the Review during the term of the Review. This is a matter that has significant impact to stakeholders and the Board. It is recommended that the Ministry establish a Task Force to investigate and make recommendations on the methods of compensation for permanent disability under section 23 of the Act and that the Task Force should present its findings and recommendations not more than 24 months from appointment.

RECOMMENDATION #101
The Ministry establish a Task Force to investigate and make recommendations on the methods of compensation for permanent disability under section 23 of the Workers Compensation Act. The Task Force should present its findings and recommendations not more than 24 months from its appointment.

TASK FORCE ON THE ESTABLISHMENT OF MEDICAL CLINICS ON OHCOW MODEL
In the course of this Review, there were also numerous public presentations requesting an accessible system for Independent Medical Examinations (IMEs), including recommendations for a workers’ clinic system similar to Occupational Health Clinics for Ontario Workers Inc. (OHCOW) in Ontario.

I consider it beyond the mandate of this Review to establish a separate system of clinics. However, I recommend that such an option be investigated and costed in the British Columbia context as it has many advantages, especially for workers outside of large urban centers.

RECOMMENDATION #102
Investigation and costing be performed on a workers’ clinic system similar to Occupational Health Clinics for Ontario Workers Inc. (OHCOW) in the British Columbia context.
RECOMMENDATIONS: COMPLETE LIST

L* = Legislative Changes  
P* = Policy Changes  
O* = Operational Changes

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<td><strong>PART I: – FOUNDATIONS OF THE REVIEW</strong> [NB: There are no recommendations in Part I]</td>
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<td><strong>PART II: – ESSENTIAL ELEMENTS FOR WORKER-CENTRIC SERVICE DELIVERY ISSUES IN BOARD CULTURE AND CASE MANAGEMENT</strong></td>
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| **Recommendation #1:**  
I recommend that the Workers Compensation Act be amended to include a preamble and statement of purpose as set out in detail in the Attachment to Recommendation #1. | ✓ | | |
| **Recommendation #2:**  
That the Board implement the use of email in its communications with stakeholders and third parties throughout the compensation process as soon as possible. | | ✓ | |
| **Recommendation #3:**  
The Board commit to a “plain English” form of written communication of its decisions and develop guides and form letters to support this practice. | | ✓ | |
| **Recommendation #4:**  
That the Workers Compensation Act be amended to require the Board to develop and publish a Code of Conduct.  
That the Board develop a Code of Conduct for Fairness and Service for all stakeholders based on the present Code for Employers and publish this Code on its website and all forms. | ✓ | ✓ | |
| **Recommendation #5:**  
That section 99(1) and (2) of the Workers Compensation Act be combined to read “The Board may consider all questions of fact and law arising in a case and must make its decision based on the merits and justice of the case. The Board is not bound by legal precedent.”  
[Section 99(3) to remain unchanged] | | ✓ | |
| **Recommendation #6:**  
That subsequent to the above amendment, the Board further amend Policy #2.20 of the Rehabilitation Services and Claims Manual II to address the issue of consistency in decision-making. The Ontario policy is a recommended model. | | ✓ | |
### PART II: ESSENTIAL ELEMENTS FOR WORKER-CENTRIC SERVICE DELIVERY ISSUES IN BOARD CULTURE AND CASE MANAGEMENT (cont’d)

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<td><strong>Recommendation #7:</strong>&lt;br&gt;That the Board develop policy about decision-making in Case Management System such that when a worker’s recovery is deviating from a recovery profile, the Recovery/Return to Work Guideline is removed or disregarded and the worker’s case will be adjudicated based on individual circumstances considered, including whether additional investigation is required. The Board should further develop policy to guide consistent practice in this area, especially about concussions.</td>
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<td><strong>Recommendation #8:</strong>&lt;br&gt;That the Board develop policies and procedures that facilitate and require production of the First Aid report as part of the employers’ duty to report an injury.</td>
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<td><strong>Recommendation #9:</strong>&lt;br&gt;That the Board develop a process to use appeal decisions as a quality review tool for claim owners. In some cases, this may require returning the decision back to the original decision-maker. In other cases, this will not be appropriate.</td>
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<td><strong>Recommendation #10:</strong>&lt;br&gt;That the development of Practice Directives remain with the Compensation Quality and Practices group but the Practice Directives, when drafted, be reviewed by the Policy Division. Going forward, the Policy Division will set a schedule to review Practice Directives together with the Quality and Practices group and the Chief Review Officer or other Quality Control person as the Board will direct, and the review will include consideration of Review Division and WCAT decisions.</td>
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<td><strong>Recommendation #11:</strong>&lt;br&gt;Clinical Services be established as a separate department from Claims services under the Chief Medical Officer reporting to the President/Chief Executive Officer.</td>
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<td><strong>Recommendation #12:</strong>&lt;br&gt;That the Board develop policy and practices to guide decision-makers in this new approach to health care management during the life of the claim. Workers will have a choice in their health care provider and the Board will supervise minimally and intervene only where the treatment is likely to impede or delay recovery.</td>
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<td><strong>Recommendation #13:</strong>&lt;br&gt;That the Board track injuries occurring in Board-sponsored treatment programs.</td>
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## PART II: – ESSENTIAL ELEMENTS FOR WORKER-CENTRIC SERVICE DELIVERY ISSUES IN BOARD CULTURE AND CASE MANAGEMENT (cont’d)

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<td><strong>Recommendation #14:</strong> That the Board provide a process for workers to anonymously evaluate the Board sponsored treatment programs for the Board, after the conclusion of their program. That within one year, the Board conduct an audit of selected treatment services and review the role of contract provisions in their performance. From this audit develop guidelines for quality oversight and supervision of these programs, and for ongoing evaluation by participating workers and treating physicians.</td>
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<td><strong>Recommendation #15:</strong> Clinical Services be responsible for monitoring and assessing the quality of third-party provider programs and have good communication with these programs. If a worker or a worker’s carer has concerns about a potential referral, the Board Medical Advisor will be in a knowledgeable position to help the carer to assess the appropriateness of the program.</td>
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<td><strong>Recommendation #16:</strong> That the Board consider having Clinical Services partner with Health Care agencies which address issues of accessibility through innovative technology and working relationships. Regional offices could assist Clinical Services in identifying health care needs around the province which are currently not being met.</td>
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### PART III: – ADDITIONAL ISSUES IN SERVICE CULTURE AND CASE MANAGEMENT

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<td><strong>Recommendation #17:</strong></td>
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<td>That the Board discontinue its use of RTW or other “duration of disability” statistical measurements as a Key Performance Indicator (KPI).</td>
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**Recommendation #18**

That the Board amend policy item #34.54 to provide:

1. That in assessing whether or not a condition has stabilized or if there is a likelihood of change, the Board must take into account the changes that would be possible with treatment and consider the potential for change “with treatment”.
2. That the Board will determine whether or not the worker’s condition may be considered “stabilized” after reviewing the medical evidence as a whole and based on a “whole worker” approach. The Board may seek a medical assessment on this issue but the decision is an adjudicative one.
3. That even if the worker is not receiving temporary wage loss benefits, the Board is required to issue a decision when it considers that the worker’s temporary disability has ceased and include one of the following decisions:
   a) The worker is fully recovered; or
   b) The worker’s condition is now considered to have plateaued, leaving a permanent impairment. This decision must identify the accepted permanent conditions and referred the case to Disability Awards for the worker to be assessed under sections 22 and 23 of the Act.

**Recommendation #19**

I recommend that the Board review its staffing model and best ways to achieve continuity of care. I leave this to their expertise in this complex system. However, I recommend that the Board embed the value of providing a single personal and continuous relationship between a claim owner, an injured worker (particularly those with a serious or traumatic injury) and the employer during Return to Work.
## Recommendation #20
The Workers Compensation Act authorize the Board to issue provisional decisions prior to the acceptance of a claim in the following two circumstances and any other circumstances that the Board, in its discretion, defines in policy:

a) where a work-related traumatic event has occurred and an affected worker makes a claim for a psychological injury arising from that event, the Board will provide the worker with immediate psychological treatment and health care benefits while assessing the worker’s claim; and

b) where there is a delay in the Board’s determination of a claim’s eligibility, the Board may provide expedited medical treatment if it is required to avoid a significant deterioration in the worker’s condition.

If a worker’s claim is denied, the costs associated with the provisional decision will be charged against the Accident Fund.

## Recommendation #21
I recommend the practice of placing EOs in a special Mental Health Unit with guidelines on intake processes for workers with psychological injuries. I recommend that there be a quality audit in one year to assess the consistency and effectiveness of this practice.

## Recommendation #22:
That sections 96(2) and 96(5) of the Workers Compensation Act be rescinded and replaced by a provision which allows the Board to re-open and re-consider its decisions. Section 17 of the Alberta Act is a model.

## Recommendation #23:
That following this amendment, the Board develop policy to address the “re-opening/re-injury” issue similar to the former policy on this matter.

## Recommendation #24
That the Board develop policy and practices to promote quality decision making based on evidence including a requirement to consider new evidence after a decision has been made when reconsideration is possible under the Act. Appealing a decision is a last resort.

## Recommendation #25
That the appeal period to file an appeal to the Workers' Compensation Appeal Tribunal be 90 days instead of 30 days. This requires an amendment to section 243(1) of the Act.
Recommendation | L* | P* | O*
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**PART III: – ADDITIONAL ISSUES IN SERVICE CULTURE AND CASE MANAGEMENT (cont’d)**

**Recommendation #26**
That the Workers Compensation Act be amended to authorize the Workers’ Compensation Appeal Tribunal to reconsider its own decisions on common law grounds. 

**Recommendation #27**
Reinstate the Workers’ Compensation Appeal Tribunal’s jurisdiction to consider issues arising under the *Canadian Charter of Rights and Freedoms* and the *Human Rights Code*. This requires an amendment to section 245.1 of the Act.

**Recommendation #28**
That section 243(3) and section 96.2(4) be amended to read that that on application the chair (or the chief review officer) may extend the time to file a notice of appeal even if the time to file has expired.

**Recommendation #29**
I recommend that the Workers Compensation Act be amended to provide that interest will be paid on overdue wage loss and permanent disability benefits greater than 180 days, based on the Board’s return on investments, at compound interest as of the date the benefits would have become payable.
### PART IV: – POLICIES AND PRACTICES THROUGH GBA+ LENS

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| Recommendation #30  
Amend section 33.4 to allow exceptional circumstances to apply to all workers, where the application of the usual rules would be inequitable. |✅ |    |    |
| Recommendation #31  
It is recommended that section 33.4(2) be removed as an unfair restriction of the application of the “exceptional circumstances” discretion to a group of vulnerable workers. |✅ |    |    |
| Recommendation #32  
That the Vocational Rehabilitation (VR) plans take into account that special barriers to reemployment exist for disabled vulnerable workers and alleviate those barriers to the greatest extent possible. VR plans could regularly include language and education components to enhance employment opportunities and in appropriate cases and at the worker’s request, VR plans could include start-up grants or training for self-employment. |✅ |    |    |
| Recommendation #33  
That the Loss of Earnings assessment for a vulnerable worker take into account the special barriers to employment faced by that disabled worker by assessing the employability of similarly vulnerable individuals. |✅ |    |    |
| Recommendation #34  
It is recommended that compensation policy provide that a determination of status by the Assessment Department is a finding of fact. Policy now allows for back-dating and cancelation of Personal Optional Protection (POP) if there is evidence the Board is no longer liable for work-related injuries “for legal reasons”. I recommend that this assessment policy be amended so POP can also be cancelled if there is evidence that a “self-employed” worker (under POP) was actually a worker for another employer. |✅ |    |    |
**Recommendation**

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<td>That the Board extend the mandate of the Chief Mental Health Officer (CMHO) to Prevention matters with a particular focus on the creation of psychologically safe workplaces with a GBA+ lens. In particular, I recommend the CMHO, in consultation with Prevention, establish the following:</td>
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<td>1. a process whereby a vulnerable worker can confidentially report a situation of sexual harassment or violence and receive counselling and support for a period of time without starting a compensation claim.</td>
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<td>2. Outreach programs for a workplaces or employer to promote a safe work environment for women or other vulnerable workers; and</td>
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<td>3. Make recommendations for how to address workplaces with ongoing issues of harassment and discrimination.</td>
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**Recommendation #36**

That Board policy and practice directives on bullying and harassment specify that identity issues may create vulnerability or inequities in the workplace and this should be considered in identifying workplace stressors contributing to a psychological injury.

**Recommendation #37**

That the Board develop policy and practice directives that specify that return to work plans must include consideration of the worker’s disability and an assessment of the workplace duties from a GBA+ perspective.

**Recommendation #38**

That the Board practices, upon being notified of a sexual assault in the workplace, be revised to include a crisis line, reporting and counselling and follow up regarding support for the claim and an investigation of the worksite. The protocols for a workplace investigation where a criminal matter may be involved should be followed.

**Recommendation #39**

That the Board establish a support team for cognitively impaired injured workers to assist them in a manner which allows them to participate in the compensation system in a fair and reasonable way. This support service should be provided to all cognitively impaired workers, regardless of the cause or nature of their impairment.
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<td><strong>PART IV: – POLICIES AND PRACTICES THROUGH GBA+ LENS (cont’d)</strong></td>
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<td><strong>Recommendation #40</strong>&lt;br&gt;That the Board utilize Board officers with other language capabilities, especially in Spanish and Punjabi, to communicate with agricultural workers and employers about both claims and Health and Safety. These officers should be given training and be aware of the special issues and systemic barriers in this sector.</td>
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<td><strong>Recommendation #41</strong>&lt;br&gt;That the Board also provide funding for the training of compensation Navigators and Advocates with established advocacy groups for these two communities, and fund them on an ongoing basis for case work support for injured workers who make claims. I recommend this, in addition to the Workers’ Advisers Office, due to the systemic barriers that this population faces: including that many of the workers live remotely, on the employer’s premises, are only available to meet after long working days and do not speak English. This may be coordinated with the Province’s funding and programs for particular community groups.</td>
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<td><strong>Recommendation #42</strong>&lt;br&gt;That the Board, together with the Employers’ Advisers Office and Workers’ Advisers Office, develop a partnership with WorkBC around a simple comprehensive information package – for workers and for employers – which can be accessed on the WorkBC web-site. It should be in several languages and phone numbers given to contact the Board, including an option to speak to someone in a preferred language.</td>
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<td><strong>Recommendation #43</strong>&lt;br&gt;That the Workers Compensation Act be amended to provide protection to and remedy for a worker facing retaliation for filing a compensation claim (claims suppression).</td>
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<td><strong>Recommendation #44</strong>&lt;br&gt;The Board create a profile of Federally Regulated Private Sector (FRPS) workplaces and that there be a targeted information program to educate workers and employers (large and small) in this sector about the compensation process. I recommend that at least one senior management person be tasked with being informed and knowledgeable about the FRPS sector and coordinate with the relevant authorities about injuries, claim reporting and claims suppression in these particular sectors, especially for large employers.</td>
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### Recommendation

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<td><strong>PART IV: – POLICIES AND PRACTICES THROUGH GBA+ LENS (cont’d)</strong></td>
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<td>Recommendation #45</td>
<td>The Board set up an independent process to counsel, investigate and resolve issues of discrimination and harassment among Board staff.</td>
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<td>Recommendation #46</td>
<td>That the Board’s policy division undertake a review of Board compensation policy as a whole from a GBA+ lens.</td>
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<td><strong>PART V: - RETURN TO WORK</strong></td>
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<td>Recommendation #47</td>
<td>I recommend that the Board revise its Return to Work (RTW) policies and delivery service to accord with the International Social Security Organization (ISSA) International Guidelines for RTW and the Seven “Principles” for Successful RTW which are the recognized best practices in return-to-work. Given that policies are well developed by the ISSA Guidelines and in other jurisdictions, I recommend that the revision of RTW services begin immediately and as much as possible within the current policy structure.</td>
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<td>Recommendation #48</td>
<td>As the Board develops Return to Work (RTW) policies and practice directives, that they consider following the model used in Alberta and other jurisdictions, which use policy to address many areas in RTW and provide options and guidance to the parties.</td>
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<td>Recommendation #49</td>
<td>The Board look at resources which help empower different players in the Return to Work (RTW) process. I particularly note the use of “wallet cards” setting out the RTW parameters for the worker and direct supervisor (Alberta) and the inclusion of the supervisor in RTW planning, along with consideration of the impact of the RTW on co-workers.</td>
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<td>Recommendation #50</td>
<td>The Board develop an intensive educational outreach to all affected parties, including health care providers and representatives, about the new approach.</td>
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**RECOMMENDATIONS**
### PART V: RETURN TO WORK (cont’d)

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| **RECOMMENDATION #51**  
The principles in the *Best Approaches: Recognizing Time to Heal – Assessing Timely and Safe Return to Work* [Appendix 21] be the standard for assessing whether a return to work before maximum medical recovery is suitable for an injured worker. | ✓ | | |
| **RECOMMENDATION #52**  
The Board start an initiative to provide support, including financial support, to employers who wish to conduct appropriate assessments through National Institute for Disability Management and Rehabilitation and/or Pacific Coast University. | ✓ | | |
| **RECOMMENDATION #53**  
That the Board establish a registry of employers with certified disability management programs. When there is a worker with an injury who is employed by a “registered DM employer”, and  
  • that employer submits the Form 7 – Employer’s Report of Injury (F7) within 3 days of being notified of the injury; and  
  • the employer is willing and able to offer Light Duties and engage in the Light Duty process  
then  
  a) that employer will be assigned a Return to Work specialist (RTWS) on a provisional basis who can begin to assist the parties before claim adjudication; and  
  b) that employer will be relieved of claims costs for that particular claim for the period of time between the date of injury and the date of a determination by a RTWS regarding suitable Light Duty arrangements (whether or not such duties can be arranged), unless the claim is denied. | ✓ | ✓ | |
| **RECOMMENDATION #54**  
The Board may establish what is meant by “certified disability management programs” and the process by which employers may apply for Board support to implement this type of program. | ✓ | | |
| **RECOMMENDATION #55**  
That the Board provide that employers who do not have a “certified disability management program” may request the early assignment of a Return to Work Specialist to assist them with the creation of a Light Duty option on a provisional basis and the Board has discretion on this matter. The Board may wish to create guidelines to establish consistency in its practice about these requests. | ✓ | | |
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<td><strong>PART V: - RETURN TO WORK (cont’d)</strong></td>
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<td><strong>Recommendation #56</strong>&lt;br&gt;All Light Duties’ arrangements be in writing and specify a time for review by the return to work specialist. If the Light Duties result in a substantial change in the worker’s duties or conditions of employment, a Temporary Work Assignment (TWA) form should be used.</td>
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<td><strong>Recommendation #57</strong>&lt;br&gt;That the Workers Compensation Act be amended to recognize the employer’s duty to accommodate and the related legal issues as set out in detail in the Attachment to Recommendation #58 regarding statutory language.</td>
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<td><strong>Recommendation #58</strong>&lt;br&gt;That Board develop policy that specifies that if a worker has returned to an accommodated position with a pre-injury employer through the Board’s Duty to Accommodate process and the accommodation ends, the worker is entitled to additional Vocational Rehabilitation benefits to restore the worker’s capacity for suitable employment in the labour market.</td>
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<td><strong>Recommendation #59</strong>&lt;br&gt;WorkSafeBC should work with the recently established BC Human Rights Commission to develop a training program for first level Board Officers who deal with claims involving the return to work of injured workers, and in particular the Board’s Vocational Rehabilitation Consultants, regarding the human rights concepts and principles associated with the obligations on Employers, disabled workers and other workplace participants in accommodating the return to work of disabled workers.</td>
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<td><strong>Recommendation #60</strong>&lt;br&gt;That there be discussions between the Board, WCAT and the Human Rights Tribunal about a preferred appeal process including, the option of having WCAT appeals with a DTA issue, heard by a 3-person panel of which one is an HRT member. I recommend that the Act be amended to provide for this specialized WCAT appeal process for DTA issues.</td>
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## Recommendation #61
That section 16 of the Workers Compensation Act clarify the Board’s mandate regarding vocational rehabilitation (VR) as follows:

- the worker has a right to be an active participate in return to work and VR plans;
- the goal of VR is to return an injured worker to safe, productive and durable long-term employment as much as possible and in doing so, incorporate the principles of a duty to accommodate as much as possible;
- Where the worker is not able to return to their pre-injury job, the Board shall provide VR and support the worker in a return to safe and durable long-term employment as much as possible.
- Where a worker’s entitlement to VR is increased after an appeal, the worker shall be provided with retroactive VR benefits.
- If there is a Board decision that a worker is able to adapt to a suitable occupation, the Board will follow up with the worker in two years and document the worker’s employment outcome. This information will be provided to the Fair Practices Commission on an annual basis.
- The Board may consider additional factors for Indigenous workers.

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### PART V: - RETURN TO WORK (cont’d)

**Recommendation #65**  
It is recommended that long-term post-injury earnings and labour market participation become a key measure to track and guide action on Vocational Rehabilitation assistance.

### PART VI: - SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS

**Recommendation #66**  
Establish An Independent Fair Practices Commission  
- A complaints body be established with a wide mandate on the “ombudsperson model” and that this ombudsperson body be external to the Workers’ Compensation Board.  
- It should have enough resources and expertise to address complaints in the area of assessments and prevention as well as compensation.

The focus will be related to the Board’s administration's primary responsibility to carry out its statutory obligations and its day to day decision-making in a fair, impartial and respectful manner.

**Recommendation #67**  
The Workers Compensation Act (Act) be amended to establish the Office of the Fair Practices Commission (Commission) and appoint a Fair Practice Commissioner (FPC) by the Lieutenant Governor in Council independent from the Workers’ Compensation Board's (Board’s) administration and reporting directly to the Board of Directors (BOD).

The Lieutenant Governor in Council appoint two Deputy Fair Practices Commissioners, one with expertise in issues related to workers’ compensation legal and medical issues and one with expertise in assessment and prevention issues. The FPC may delegate investigation of fairness issues involving those specialized issues to the appropriate Deputy.

The remuneration of the FPC and all costs and expenses required for the administration of the Commission shall be determined under the BC Public Service Act and regulation and paid out of the Accident Fund as approved by the Minister responsible for the Board.

The FPC to have full authority to conduct thorough investigations and make recommendations to the BOD and the Workers’ Compensation Appeal Tribunal (WCAT) on issues relating to systemic fairness.
Recommendation #67 (cont’d)
The BOD or the chair of WCAT may refer an issue of systemic fairness to the FPC and the FPC will provide a timely response to the referral. The FPC may also initiate an investigation into a systemic fairness issue on his or her own initiative by giving notice to the BOD or WCAT that such an investigation is underway.

Where issues of systemic fairness relating to statutory provisions arise the FPC have full authority to undertake investigations and make recommendations to the Minister responsible for the applicable statute.

The Minister may refer an issue of statutory unfairness to the FPC and the FPC will provide a timely response to the referral. The FPC may initiate an investigation into an issue of statutory unfairness on his own initiative by giving notice to the Minister responsible that such an investigation is underway.

Where specific disputes arise relating to a specific worker, dependent or employer, the FPC or his or her staff have full authority to make recommendations to the applicable department of the Board's administration or the chair of WCAT. The FPC does not have the authority to direct the Board's administration or WCAT to change a decision but may recommend that the Board's administration or WCAT reconsider a decision within the terms of the Act for such reconsideration.

The Board's administration and the chair of WCAT may refer a fairness issue to the FPC and the FPC will provide a timely response to that referral.

The FPC have the authority to establish programs to provide advice, assistance and advocacy services to workers and employers including but not limited to the administration of the Workers' Advisers Office (WAO) and the Employers' Advisers Office (EAO). It is recommended that the established WAO and EAO offices be retained as separate from each other but report through the FPC and offer separate services to each of their communities.

The FPC have the full authority to establish an education program to provide workers, dependents, employers, the Board's administration and the general public on the hallmarks of administrative fairness and the rules of natural justice as they apply to the workers' compensation system.
Recommendation #67 (cont’d)
The FPC shall within 7 days of receiving a complaint, or within a longer period
determined by the FPC, advise the worker, dependent or employer who has
raised the fairness issue, that the appropriate avenue to resolve the dispute is
through the review and appeal systems and conclude the investigation on that
basis. Where the determination of the appropriate avenue to resolve the dispute
is delayed beyond seven (7) days, the additional time period to make that
determination shall extend the period for filing a review or appeal by that same
period, so long as no party is prejudiced by that extension. The FPC may
continue an investigation of an issue in dispute including an issue of systemic
fairness while a review or appeal involving that issue proceeds.

Within six (6) months of his or her appointment the FPC shall establish a Code of
Rights and Conduct under the Act in consultation with representatives of workers
and employers and endorsed by the BOD and the Provincial Ombudsperson.

The FPC may make specific recommendations regarding the adherence or
failure to adhere to the Code. The practices and procedures carried out by the
FPC and the Fair Practices Commission shall adhere to the Code and systemic
failure to do so may constitute just cause for removal by the Minister on the
recommendation of the BOD.

The Board shall continue the current Fair Practices Office (FPO) for six (6)
months or a longer period as determined by the BOD, to ensure an orderly
transition to the new disputes resolution program administered by the FPC and
the FPO shall report to the BOD through the FPC during that period.

The FPC shall provide an annual report to the BOD and to the Minister and may
also provide interim reports on time sensitive issues. In addition, the FPC will
issue a separate annual public report.

Recommendation #68
I recommend that the Provincial Ombudsperson carry out an audit of the Fair
Practices Commission (Commission) after five (5) years to make
recommendations to improve the efficiency and effectiveness of the
Commission.
### Recommendation 69
The Workers’ Compensation Board establish an internal navigator desk to act as a liaison between inquiries and the Board resources in a cost-effective manner.

The Fair Practices Office change its name to the Inquiries Office to avoid confusion with the Fair Practices Commission.

### Recommendation 70
That the Fair Practices Commission (Commission) set up a formal designation called Community Navigators (CNs) and Approved Community Navigators (ACNs) and support them.

The initial CNs be immediately established for temporary foreign workers through one or more established advocacy groups.

The Commission meet with the Employers’ Advisers Office and Workers’ Advisers Office to consider what other communities, if any, should develop a CN.

The Commission should coordinate with the Ministry and with the Workers’ Compensation Board (both the Chief Executive Officer and the Board of Directors) to develop an overall plan for CNs for Indigenous groups and, at the same time, receive requests for CN from established groups.

### Recommendation 71
An independent Medical Services Office (MSO) be established on the following basis:

- A Medical Services Commissioner (MSC) be appointed by the Lieutenant Governor in Council for the purpose of carrying out the business and affairs of the MSO. The MSC appointment should be in accordance with the Public Service Act.
- The MSO will be provided with the resources from the Accident Fund to provide the specified services, including the hiring of support staff and administrative services. The MSO shall report to the Fair Practices Commissioner (FPC) and share administrative arrangements with the office of the Fair Practices Commission (Commission).
- The MSO will administer and arrange the following services, set out in detail below:
  - Medical Case Conferences to work to resolve medical disputes (non-binding)
  - Medical-Legal Assistance and Reports
  - Arrange Independent Medical Examinations (IMEs) at the request of workers, employers, the Board or WCAT.
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<td>PART VI: - SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS (cont’d)</td>
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<td><strong>Recommendation #71 (cont’d)</strong></td>
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<td>The MSC, in consultation with the FPC and the Minister, will develop and publish policy, procedure and rules for requesting and obtaining an IME, a medical report, assistance with medical-legal requests, and case conference procedures. The MSC will also identify the treatment of records and confidentiality in this assistance.</td>
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<td>- A key function of the MSO and MSC is to develop a roster of physicians with the capacity and expertise to provide guidance and expert evidence in a timely way, on medical matters in the compensation system.</td>
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<td>- The MSO will be funded from the Accident Fund. Costs for tests, assessments, medical reports and IMEs will be charged under the claim for which they are conducted. The MPO will issue an Annual Report that will be provided to the FPC and the Minister.</td>
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<td><strong>Recommendation #72</strong></td>
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<td>The Fair Practice Commission (Commission) operate as an umbrella oversight organization for the Independent Medical Services Office (MSO), Workers’ Advisers Office (WAO) and the Employers’ Advisers Office (EAO). The organizations under the Commission umbrella will function independently but may collaborate and coordinate actions to improve stakeholder confidence in the system.</td>
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<td><strong>Recommendation #73</strong></td>
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<td>The section 251 process remain the same until a policy question is referred to the chair of Workers’ Compensation Appeal Tribunal (WCAT). However, an amended version should provide:</td>
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<td>a) If the chair of WCAT approves the policy, the chair’s decision (on policy alone or together with the original appeal) may be the subject of a judicial review by either party to the appeal; and</td>
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<td>b) If the chair concludes that the policy is not lawful, then the Board, in addition to the parties, has standing to refer the matter to judicial review within the 60 days specified in the Administrative Tribunals Act. In those 60 days, the Board may elect to seek a judicial review, change the policy or let the policy lapse. If the matter is not referred to judicial review by the Board or either party within the 60 days, then the impugned policy is of no force and effect, effective the 61st day after the WCAT chair’s decision.</td>
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<td><strong>PART VI: - SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS (cont’d)</strong></td>
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| **Recommendation #74**  
I recommend that the Workers Compensation Act be amended to provide that the Board of Directors will consist of:  
- 3 employer representatives  
- 3 worker representatives  
- 3 public interest representatives of which one should be an actuary and one a healthcare representative  
- a neutral Chair | ✓ |    |    |
| president and chief executive officer remain a non-voting member of the Board of Directors. |    |    |    |
| **Recommendation #75**  
I also recommend that the director of the Workers’ Advisers Office and the director of the Employers’ Advisers Office be included in the Board of Directors as non-voting members. | ✓ |    |    |
| **Recommendation #76**  
Subsequent to any change in the Board of Directors’ structure, the current WorkSafeBC Board of Directors’ Manual be revised and updated. | ✓ |    |    |
| **Recommendation #77**  
The position of director, Governance be selected by the Board of Directors (BOD) and be independent of the management of the Board. Ideally, the individual would know the Board operations very well. The BOD develop, through the director, Governance or through another avenue, a directorate dedicated to serve the BOD, provide research, expert evidence and ask the "big questions" in terms of compensations’ difficult mandate. This work should be done at arm’s length from the management of WorkSafeBC but with consultation and when appropriate, collaboration. | ✓ |    |    |
## Recommendation #78

The Workers Compensation Act be amended to provide:
- A review of the compensation system may be systemic (a review of the whole system) or targeted (review of specific topics or aspects);
- the Board of Directors (BOD) may request that the Minister appoint a review, and in this request, specify whether the review should be systematic or one which targets specific areas;
- the Minister may initiate a review at any time but the interval between reviews must be no greater than 5 years.
- The terms of reference for all reviews must include a clear and transparent consultation process with stakeholder consultation and public engagement inclusive of injured workers; and
- The resources for the Review should be made from the Accident Fund.

## Recommendation #79

The Workers’ Compensation Board (Board) develop a Stakeholder Education office and that it follows the practice developed by the Employers’ Forum’s consultations with the Board. The Education Office would:
- Consult with stakeholders on a regular basis about what areas of interest they have about current Board practice
- Based on these consultations, develop half-day sessions with presentations and reports from senior management about these areas, with time for Questions and Answers, and open discussion about these topics
- Hold these Professional Development (PD) sessions for stakeholder representatives 3 or 4 times a year
- Both employer and worker representatives attend the same PD sessions and ensure the roster for invited representatives is continually updated.
- The PD sessions be limited to stakeholders or their direct invitees.
- The Education Office will be the arbiter in this process.
- The Education Office consider an on-line presence and post the materials developed for the PD sessions or some appropriate version of these materials.

Legal Services, together with the Education Office, consider developing a course for a law school on “WCB and the Law.”
### PART VI: SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS (cont’d)

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<tr>
<td><strong>Recommendation #80</strong>&lt;br&gt;That the Board establish an “Occupational Disease Advisory Committee” with a mandate to conduct an inventory of Board practices in this area and recommend specific attention points for a targeted review or legislative change. This Committee be provided with the resources to retain the services of an “Independent Occupational Disease Specialist” to advise on medical practices and current scientific research and issues in this area.</td>
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<td><strong>Recommendation #81</strong>&lt;br&gt;That section 6(3) of the Workers Compensation Act be amended to read “If at the date of disablement, the worker is or had been employed in a process or industry mentioned in the second column of Schedule B….” the presumption will apply.</td>
<td>✔</td>
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<td><strong>Recommendation #82</strong>&lt;br&gt;I recommend that the unpublished Discriminatory Action decisions be published and made available on the Board’s external website and that the principle of publishing decisions be affirmed and supported.</td>
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<td><strong>Recommendation #83</strong>&lt;br&gt;That the Workers Compensation Act (Act) be amended to provide that Bill 37 applies to all survivors under the Act, including those claims which arise from workers injured prior to June 30, 2002.</td>
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### PART VII: OTHER URGENT ISSUES

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| **Recommendation #84**<br>That the Workers Compensation Act (Act) be amended to provide that gradual onset musculoskeletal injuries (MSIs) will be treated as personal injuries under section 5 of the Act and that Board policy then be amended to provide:  
• for the adjudication of MSIs as personal injuries;  
• a GBA+ perspective as discussed;  
• an integration with the Prevention guidelines for MSI injuries  
• that Activity-Related Soft Tissue Disorder conditions now specified in Schedule B would have an equivalent rebuttable presumption of work causation for the designated occupations but as a personal injury. | ✔ |  |  |
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<td><strong>PART VII: OTHER URGENT ISSUES (cont’d)</strong></td>
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<tr>
<td><strong>Recommendation #85</strong></td>
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<td>That, in the meantime, Appendix 1 of Practice Directive C4-2 be retired and that the PD be updated to include the current Prevention guidelines and a process to integrate prevention and compensation approaches.</td>
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<td>In light of any new policy, I recommend that a new Practice Directive be reviewed by an expert external ergonomist who is accepted as credible by the key stakeholders.</td>
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<td><strong>Recommendation #86</strong></td>
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<td>That Board policy and practice provide a process for a worker, the union, the employer or the OH&amp;S committee to intervene when a worker is developing Musculoskeletal Strain Injury (MSI) or Repetitive Strain Injury symptoms and request Board assistance or resources to reduce the risk of an MSI for that worker.</td>
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<td><strong>Recommendation #87</strong></td>
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<td>That section 5.1(1)(b) be deleted from the Workers Compensation Act. The term “mental disorder” is inappropriate and should be replaced by the term “psychological injury”. A mental disorder is a potential subset of psychological injury, but mental disorder does not capture all psychological injury.</td>
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<td><strong>Recommendation #88</strong></td>
<td>✓</td>
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<td>The title of section 5.1 of the Workers Compensation Act should be changed from &quot;Mental Disorder&quot; to &quot;Psychological Injury&quot;.</td>
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<td><strong>Recommendation #89</strong></td>
<td>✓</td>
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<td>A short-term psychological injury may be accepted for a disability not to exceed ten (10) working days without a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis by a psychiatrist or a psychologist. Policy should set out a general requirement that longer-term psychological injury is expected to be supported by expert opinion on DSM diagnosis and causal factors.</td>
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<td>✓</td>
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<td><strong>Recommendation #90</strong></td>
<td>✓</td>
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<td>The word “predominantly” should be removed from section 5.1(1)(a)(ii) of the Workers Compensation Act.</td>
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<tr>
<td><strong>PART VII: - OTHER URGENT ISSUES (cont’d)</strong></td>
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| **Recommendation #91**  
Section 5.1(1)(c) of the Workers Compensation Act should be amended to read: | | | |
|  
- (c) is not directly caused by a decision of the worker's employer relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the worker's employment.  
- Corresponding policy similar Saskatchewan Policy Injuries – Psychological (POL02/2017) at items 12-14 “Incidents – Workload and Interpersonal” should be used to model new policy. | ✓ | ✓ | |
| **Recommendation #92**  
That section 5.1(1.1) of the Workers Compensation Act be amended to apply to all workers who experience a traumatic event or a series of traumatic events in and out of the course of work. | ✓ | | |
| **Recommendation #93**  
Section 34(2) of the Workers Compensation Act (Act) be deleted so that there is no offset of Canada Pension Plan disability benefits from awards under sections 22 and 23 of the Act. | | ✓ | |
| **Recommendation #94**  
The Chronic Pain Policy Review currently in progress with the Policy Regulation & Research Division should include consideration of the ICD-11 Version of the International Classification of Diseases, Including New Diagnostic Codes for Chronic Pain in the development of updating chronic pain policy. The new policy should provide for an individual assessment and a range of possible permanent impairments.  
It is recommended that the Board develop a Practice Directive, effective immediately that:  
- for workers with chronic pain, that all necessary treatment to maximize their ability to RTW will be carried out before a referral to Disability Award; and  
- for workers with serious permanent chronic pain, the Board may consider the claim under section 23(3) of the Act. | | ✓ | |
| **Recommendation #95**  
Policy item #41.00 should be amended to allow consideration of all relevant evidence regarding the actual impact of the injury on the workers likely retirement date, including evidence after the date of the injury. | | | ✓ |
### PART VIII: - CONSULTATION WITH INDIGENOUS COMMUNITIES

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<th>Recommendation</th>
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<tr>
<td><strong>Recommendation #96</strong></td>
<td>That the Board develop guidelines for VR practices and resources when the worker self identifies as an Indigenous person. It is recommended that VRCs who self identify as Indigenous be included in the development of these guidelines.</td>
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<tr>
<td><strong>Recommendation #97</strong></td>
<td>Designate an Indigenous liaison desk for “one stop shopping” for Indigenous employers and workers. The liaison desk could coordinate a Board response regarding OH&amp;S, compensation and Return to Work issues. It may be helpful to coordinate this with the Employers Advisers Office and/or Workers’ Advisers Office, who often handle these inquiries.</td>
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<tr>
<td><strong>Recommendation #98</strong></td>
<td>Retain one or more Experts in Indigenous matters to help Case Managers (CMs) and Vocational Rehabilitation Consultants (VRCs) build relationships in their communities, recognize successes, build a knowledge base, advise on research, job development and economic development for communities, recognize racism as a barrier to re-employment and provide support and fund established third party providers who can provide services and have the trust of the community. Suggestions for the role include:</td>
</tr>
<tr>
<td>a.</td>
<td>Works with Employers’ Advisers Office re registration and assessments of Indigenous employers;</td>
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<td>b.</td>
<td>Works with Prevention to develop culturally sensitive safety programs;</td>
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<td>c.</td>
<td>Works with Workers’ Advisers Office re handling claims by Indigenous workers</td>
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<td>d.</td>
<td>Works with claims to develop tradition and western-based health care treatments (see “Prevention and Treatment strategies” in WS 2012 <em>Safeguarding Indigenous Fire Crews</em>);</td>
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<td>e.</td>
<td>Cultural sensitivity training for WorkSafe staff – based on BC cultural competencies – to help staff to develop culturally sensitive Disability Management and Return to Work (RTW) programs;</td>
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<td>f.</td>
<td>Provincial Community Outreach re WCB issues for the Indigenous community;</td>
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<td>g.</td>
<td>Educate the Board re Indigenous community identity &amp; central role of Indigenous community in wildfires;</td>
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<td>h.</td>
<td>Partnering with other agencies re outreach, research, treatment and prevention resources for this community;</td>
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<td>i.</td>
<td>Develop a claims form – option to self-identify as Indigenous or if employer is Indigenous, with copy sent to Indigenous liaison desk;</td>
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<td>j.</td>
<td>Collect Data and conduct research on injuries and outcome by Indigenous status;</td>
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<td>Research Project on RTW options and strategies in Aboriginal community.</td>
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</table>
## PART VIII: CONSULTATION WITH INDIGENOUS COMMUNITIES

**Recommendation #99**
Develop, train and pay community navigators in Indigenous communities, particularly in bands with high project employment. Navigators should be members who live in the community and are trusted by the community. They can be trained by the Board to support and assist Indigenous workers to make claims and support the claims process with assistance from community resources as well as the Board.

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<td><strong>PART VIII: CONSULTATION WITH INDIGENOUS COMMUNITIES</strong></td>
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<td><strong>Recommendation #99</strong></td>
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## PART IX: FUTURE TASK FORCES

**Recommendation #100**
The Board will gather and compile data on the earnings capacity of permanently disabled workers at 2, 5 and 10 years after the conclusion of the Return to Work process on their claims on an ongoing basis.

**Recommendation #101**
The Ministry establish a Task Force to investigate and make recommendations on the methods of compensation for permanent disability under section 23 of the Workers Compensation Act. The Task Force should present its findings and recommendations not more than 24 months from its appointment.

**Recommendation #102**
Investigation and costing be performed on a workers’ clinic system similar to Occupational Health Clinics for Ontario Workers Inc. (OHCOW) in the British Columbia context.

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<td><strong>PART IX: FUTURE TASK FORCES</strong></td>
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<td><strong>Recommendation #100</strong></td>
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<td><strong>Recommendation #101</strong></td>
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<tr>
<td><strong>Recommendation #102</strong></td>
<td>✓</td>
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RECOMMENDATIONS: LEGISLATIVE CHANGES ONLY

PART I: – FOUNDATIONS OF THE REVIEW [NB: There are no recommendations in Part I affecting Legislative Changes]

PART II: – ESSENTIAL ELEMENTS FOR WORKER-CENTRIC SERVICE DELIVERY ISSUES IN BOARD CULTURE AND CASE MANAGEMENT

<table>
<thead>
<tr>
<th>Recommendation #1:</th>
<th>I recommend that the Workers Compensation Act be amended to include a preamble and statement of purpose as set out in detail in the Attachment to Recommendation #1.</th>
</tr>
</thead>
</table>
| Recommendation #4: | That the Workers Compensation Act be amended to require the Board to develop and publish a Code of Conduct.  
That the Board develop a Code of Conduct for Fairness and Service for all stakeholders based on the present Code for Employers and publish this Code on its website and all forms. |
| Recommendation #5: | That section 99(1) and (2) of the Workers Compensation Act be combined to read “The Board may consider all questions of fact and law arising in a case and must make its decision based on the merits and justice of the case. The Board is not bound by legal precedent.”  
[Section 99(3) to remain unchanged] |
| Recommendation #6: | That subsequent to the above amendment, the Board further amend Policy #2.20 of the Rehabilitation Services and Claims Manual II to address the issue of consistency in decision-making. The Ontario policy is a recommended model. |
### Recommendation #20
The Workers Compensation Act authorize the Board to issue provisional decisions prior to the acceptance of a claim in the following two circumstances and any other circumstances that the Board, in its discretion, defines in policy:

- **a.** where a work-related traumatic event has occurred and an affected a worker makes a claim for a psychological injury arising from that event, the Board will provide the worker with immediate psychological treatment and health care benefits while assessing the worker’s claim; and
- **b.** where there is a delay in the Board’s determination of a claim’s eligibility, the Board may provide expedited medical treatment if it is required to avoid a significant deterioration in the worker’s condition.

If a worker’s claim is denied, the costs associated with the provisional decision will be charged against the Accident Fund.

### Recommendation #22:
That sections 96(2) and 96(5) of the Workers Compensation Act be rescinded and replaced by a provision which allows the Board to re-open and re-consider its decisions. Section 17 of the Alberta Act is a model.

### Recommendation #25
That the appeal period to file an appeal to the Workers’ Compensation Appeal Tribunal be 90 days instead of 30 days. This requires an amendment to section 243(1) of the Act.

### Recommendation #26
That the Workers Compensation Act be amended to authorize the Workers’ Compensation Appeal Tribunal to reconsider its own decisions on common law grounds.

### Recommendation #27
Reinstate the Workers’ Compensation Appeal Tribunal’s jurisdiction to consider issues arising under the *Canadian Charter of Rights and Freedoms* and the *Human Rights Code*. This requires an amendment to section 245.1 of the Act.

### Recommendation #28
That section 243(3) and section 96.2(4) be amended to read that that on application the chair (or the chief review officer) may extend the time to file a notice of appeal even if the time to file has expired.

### Recommendation #29
I recommend that the Workers Compensation Act be amended to provide that interest will be paid on overdue wage loss and permanent disability benefits greater than 180 days, based on the Board’s return on investments, at compound interest as of the date the benefits would have become payable.
### PART IV: – POLICIES AND PRACTICES THROUGH GBA+ LENS

<table>
<thead>
<tr>
<th>Recommendation #30</th>
<th>Amend section 33.4 to allow exceptional circumstances to apply to all workers, where the application of the usual rules would be inequitable.</th>
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<tr>
<td>Recommendation #31</td>
<td>It is recommended that section 33.4(2) be removed as an unfair restriction of the application of the “exceptional circumstances” discretion to a group of vulnerable workers.</td>
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<td>Recommendation #43</td>
<td>That the Workers Compensation Act be amended to provide protection to and remedy for a worker facing retaliation for filing a compensation claim (claims suppression).</td>
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<td>Recommendation #45</td>
<td>The Board set up an independent process to counsel, investigate and resolve issues of discrimination and harassment among Board staff.</td>
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### PART V: - RETURN TO WORK

| Recommendation #53 | That the Board establish a registry of employers with certified disability management programs. When there is a worker with an injury who is employed by a “registered DM employer”, and  
• that employer submits the Form 7 – Employer’s Report of Injury (F7) within 3 days of being notified of the injury; and  
• the employer is willing and able to offer Light Duties and engage in the Light Duty process then  
  c) that employer will be assigned a Return to Work specialist (RTWS) on a provisional basis who can begin to assist the parties before claim adjudication; and  
that employer will be relieved of claims costs for that particular claim for the period of time between the date of injury and the date of a determination by a RTWS regarding suitable Light Duty arrangements (whether or not such duties can be arranged), unless the claim is denied. |
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<tr>
<td>Recommendation #57</td>
<td>That the Workers Compensation Act be amended to recognize the employer’s duty to accommodate and the related legal issues as set out in detail in the Attachment to Recommendation #58 regarding statutory language.</td>
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<td>Recommendation #60</td>
<td>That there be discussions between the Board, WCAT and the Human Rights Tribunal about a preferred appeal process including, the option of having WCAT appeals with a DTA issue, heard by a 3-person panel of which one is an HRT member. I recommend that the Act be amended to provide for this specialized WCAT appeal process for DTA issues.</td>
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### PART V: RETURN TO WORK

**Recommendation #61**
That section 16 of the Workers Compensation Act clarify the Board’s mandate regarding vocational rehabilitation (VR) as follows:

- the worker has a right to be an active participate in return to work and VR plans;
- the goal of VR is to return an injured worker to safe, productive and durable long-term employment as much as possible and in doing so, incorporate the principles of a duty to accommodate as much as possible;
- Where the worker is not able to return to their pre-injury job, the Board shall provide VR and support the worker in a return to safe and durable long-term employment as much as possible.
- Where a worker’s entitlement to VR is increased after an appeal, the worker shall be provided with retroactive VR benefits.
- If there is a Board decision that a worker is able to adapt to a suitable occupation, the Board will follow up with the worker in two years and document the worker’s employment outcome. This information will be provided to the Fair Practices Commission on an annual basis.
- The Board may consider additional factors for Indigenous workers.

**Recommendation #63**
Section 239(2) of the Workers Compensation Act be amended to provide that vocational rehabilitation decisions may be appealed to the Workers’ Compensation Appeal Tribunal.

**Recommendation #65**
It is recommended that long-term post-injury earnings and labour market participation become a key measure to track and guide action on Vocational Rehabilitation assistance.
**PART VI: - SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS**

**Recommendation #66**
Establish An Independent Fair Practices Commission

i. A complaints body be established with a wide mandate on the “ombudsperson model” and that this ombudsperson body be external to the Workers’ Compensation Board.

ii. It should have enough resources and expertise to address complaints in the area of assessments and prevention as well as compensation.

The focus will be related to the Board’s administration's primary responsibility to carry out its statutory obligations and its day to day decision-making in a fair, impartial and respectful manner.

**Recommendation #67**
The Workers Compensation Act (Act) be amended to establish the Office of the Fair Practices Commission (Commission) and appoint a Fair Practice Commissioner (FPC) by the Lieutenant Governor in Council independent from the Workers’ Compensation Board's (Board’s) administration and reporting directly to the Board of Directors (BOD).

The Lieutenant Governor in Council appoint two Deputy Fair Practices Commissioners, one with expertise in issues related to workers’ compensation legal and medical issues and one with expertise in assessment and prevention issues. The FPC may delegate investigation of fairness issues involving those specialized issues to the appropriate Deputy.

The remuneration of the FPC and all costs and expenses required for the administration of the Commission shall be determined under the BC Public Service Act and regulation and paid out of the Accident Fund as approved by the Minister responsible for the Board.

The FPC to have full authority to conduct thorough investigations and make recommendations to the BOD and the Workers’ Compensation Appeal Tribunal (WCAT) on issues relating to systemic fairness.

The BOD or the chair of WCAT may refer an issue of systemic fairness to the FPC and the FPC will provide a timely response to the referral. The FPC may also initiate an investigation into a systemic fairness issue on his or her own initiative by giving notice to the BOD or WCAT that such an investigation is under way.

Where issues of systemic fairness relating to statutory provisions arise the FPC have full authority to undertake investigations and make recommendations to the Minister responsible for the applicable statute.

The Minister may refer an issue of statutory unfairness to the FPC and the FPC will provide a timely response to the referral. The FPC may initiate an investigation into an issue of statutory unfairness on his own initiative by giving notice to the Minister responsible that such an investigation is under way.

Where specific disputes arise relating to a specific worker, dependent or employer, the FPC or his or her staff have full authority to make recommendations to the applicable department of the Board's administration or the chair of WCAT. The FPC does not have the authority to direct the Board's administration or WCAT to change a decision but may
**PART VI: SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS**

*(cont’d)*

**Recommendation #67 (cont’d)**

recommend that the Board’s administration or WCAT reconsider a decision within the terms of the Act for such reconsideration.

The board's administration and the chair of WCAT may refer a fairness issue to the FPC and the FPC will provide a timely response to that referral.

The FPC have the authority to establish programs to provide advice, assistance and advocacy services to workers and employers including but not limited to the administration of the Workers’ Advisers Office (WAO) and the Employers’ Advisers Office (EAO). It is recommended that the established WAO and EAO offices be retained as separate from each other but report through the FPC and offer separate services to each of their communities.

The FPC have the full authority to establish an education program to provide workers, dependents, employers, the board’s administration and the general public on the hallmarks of administrative fairness and the rules of natural justice as they apply to the workers’ compensation system.

The FPC shall within 7 days of receiving a complaint, or within a longer period determined by the FPC, advise the worker, dependent or employer who has raised the fairness issue, that the appropriate avenue to resolve the dispute is through the review and appeal systems and conclude the investigation on that basis. Where the determination of the appropriate avenue to resolve the dispute is delayed beyond seven (7) days, the additional time period to make that determination shall extend the period for filing a review or appeal by that same period, so long as no party is prejudiced by that extension. The FPC may continue an investigation of an issue in dispute including an issue of systemic fairness while a review or appeal involving that issue proceeds.

Within six (6) months of his or her appointment the FPC shall establish a Code of Rights and Conduct under the Act in consultation with representatives of workers and employers and endorsed by the BOD and the Provincial Ombudsperson.

The FPC may make specific recommendations regarding the adherence or failure to adhere to the Code. The practices and procedures carried out by the FPC and the Fair Practices Commission shall adhere to the Code and systemic failure to do so may constitute just cause for removal by the Minister on the recommendation of the BOD.

The Board shall continue the current Fair Practices Office (FPO) for six (6) months or a longer period as determined by the BOD, to ensure an orderly transition to the new disputes resolution program administered by the FPC and the FPO shall report to the BOD through the FPC during that period.

The FPC shall provide an annual report to the BOD and to the Minister and may also provide interim reports on time sensitive issues. In addition, the FPC will issue a separate annual public report.
### Recommendation #71
An independent Medical Services Office (MSO) be established on the following basis:

- A Medical Services Commissioner (MSC) be appointed by the Lieutenant Governor in Council for the purpose of carrying out the business and affairs of the MSO. The MSC appointment should be in accordance with the Public Service Act.
- The MSO will be provided with the resources from the Accident Fund to provide the specified services, including the hiring of support staff and administrative services. The MSO shall report to the Fair Practices Commissioner (FPC) and share administrative arrangements with the office of the Fair Practices Commission (Commission).
- The MSO will administer and arrange the following services, set out in detail below:
  - Medical Case Conferences to work to resolve medical disputes (non-binding)
  - Medical-Legal Assistance and Reports
  - Arrange Independent Medical Examinations (IMEs) at the request of workers, employers, the Board or WCAT.
- The MSC, in consultation with the FPC and the Minister, will develop and publish policy, procedure and rules for requesting and obtaining an IME, a medical report, assistance with medical-legal requests, and case conference procedures. The MSC will also identify the treatment of records and confidentiality in this assistance.
- A key function of the MSO and MSC is to develop a roster of physicians with the capacity and expertise to provide guidance and expert evidence in a timely way, on medical matters in the compensation system.
- The MSO will be funded from the Accident Fund. Costs for tests, assessments, medical reports and IMEs will be charged under the claim for which they are conducted.

The MPO will issue an Annual Report that will be provided to the FPC and the Minister.

### Recommendation #72
The Fair Practice Commission (Commission) operate as an umbrella oversight organization for the Independent Medical Services Office (MSO), Workers’ Advisers Office (WAO) and the Employers’ Advisers Office (EAO). The organizations under the Commission umbrella will function independently but may collaborate and coordinate actions to improve stakeholder confidence in the system.

### Recommendation #73
The section 251 process remain the same until a policy question is referred to the chair of Workers’ Compensation Appeal Tribunal (WCAT). However, an amended version should provide:

a. If the chair of WCAT approves the policy, the chair’s decision (on policy alone or together with the original appeal) may be the subject of a judicial review by either party to the appeal; and
b. If the chair concludes that the policy is not lawful, then the Board, in addition to the parties, has standing to refer the matter to judicial review within the 60 days specified in the Administrative Tribunals Act. In those 60 days, the Board may elect to seek a judicial review, change the policy or let the policy lapse. If the matter is not referred to judicial review by the Board or either party within the 60 days, then the impugned policy is of no force and effect, effective the 61st day after the WCAT chair’s decision.
<table>
<thead>
<tr>
<th>Recommendation #74</th>
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<tbody>
<tr>
<td>I recommend that the Workers Compensation Act be amended to provide that the Board of Directors will consist of:</td>
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<tr>
<td>- 3 employer representatives</td>
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<td>- 3 worker representatives</td>
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<td>- 3 public interest representatives of which one should be an actuary and one a healthcare representative</td>
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<td>- a neutral Chair</td>
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president and chief executive officer remain a non-voting member of the Board of Directors.

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<thead>
<tr>
<th>Recommendation #75</th>
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<tr>
<td>I also recommend that the director of the Workers’ Advisers Office and the director of the Employers’ Advisers Office be included in the Board of Directors as non-voting members.</td>
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<table>
<thead>
<tr>
<th>Recommendation #78</th>
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<tbody>
<tr>
<td>The Workers Compensation Act be amended to provide:</td>
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<tr>
<td>- A review of the compensation system may be systemic (a review of the whole system) or targeted (review of specific topics or aspects);</td>
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<tr>
<td>- the Board of Directors (BOD) may request that the Minister appoint a review, and in this request, specify whether the review should be systematic or one which targets specific areas;</td>
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<td>- the Minister may initiate a review at any time but the interval between reviews must be no greater than 5 years.</td>
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<tr>
<td>- The terms of reference for all reviews must include a clear and transparent consultation process with stakeholder consultation and public engagement inclusive of injured workers; and</td>
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<td>The resources for the Review should be made from the Accident Fund.</td>
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<tr>
<th>Recommendation #81</th>
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<tr>
<td>That section 6(3) of the Workers Compensation Act be amended to read “If at the date of disablement, the worker is or had been employed in a process or industry mentioned in the second column of Schedule B….” the presumption will apply.</td>
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<tr>
<th>Recommendation #83</th>
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<tr>
<td>That the Workers Compensation Act (Act) be amended to provide that Bill 37 applies to all survivors under the Act, including those claims which arise from workers injured prior to June 30, 2002.</td>
</tr>
</tbody>
</table>
# PART VII: OTHER URGENT ISSUES

**Recommendation #84**
That the Workers Compensation Act (Act) be amended to provide that gradual onset musculoskeletal injuries (MSIs) will be treated as personal injuries under section 5 of the Act and that Board policy then be amended to provide:

- for the adjudication of MSIs as personal injuries;
- a GBA perspective as discussed;
- an integration with the Prevention guidelines for MSI injuries
- that Activity-Related Soft Tissue Disorder conditions now specified in Schedule B would have an equivalent rebuttable presumption of work causation for the designated occupations but as a personal injury.

**Recommendation #87**
That section 5.1(1)(b) be deleted from the Workers Compensation Act. The term “mental disorder” is inappropriate and should be replaced by the term “psychological injury”. A mental disorder is a potential subset of psychological injury, but mental disorder does not capture all psychological injury.

**Recommendation #88**
The title of section 5.1 of the Workers Compensation Act should be changed from “Mental Disorder” to “Psychological Injury”.

**Recommendation #89**
A short-term psychological injury may be accepted for a disability not to exceed ten (10) working days without a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis by a psychiatrist or a psychologist. Policy should set out a general requirement that longer-term psychological injury is expected to be supported by expert opinion on DSM diagnosis and causal factors.

**Recommendation #90**
The word “predominantly” should be removed from section 5.1(1)(a)(ii) of the Workers Compensation Act.

**Recommendation #91**
Section 5.1(1)(c) of the Workers Compensation Act should be amended to read:

- (c) is not directly caused by a decision of the worker's employer relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the worker's employment.
- Corresponding policy similar Saskatchewan Policy Injuries – Psychological (POL02/2017) at items 12-14 “Incidents – Workload and Interpersonal” should be used to model new policy.

**Recommendation #92**
That section 5.1(1.1) of the Workers Compensation Act be amended to apply to all workers who experience a traumatic event or a series of traumatic events in and out of the course of work.
PART VII: - OTHER URGENT ISSUES

**Recommendation #93**
Section 34(2) of the Workers Compensation Act (Act) be deleted so that there is no offset of Canada Pension Plan disability benefits from awards under sections 22 and 23 of the Act.

PART VIII: - CONSULTATION WITH INDIGENOUS COMMUNITIES  [NB: There are no recommendations in Part VIII affecting Legislative Changes]

PART IX: - FUTURE TASK FORCES

**Recommendation #101**
The Ministry establish a Task Force to investigate and make recommendations on the methods of compensation for permanent disability under section 23 of the Workers Compensation Act. The Task Force should present its findings and recommendations not more than 24 months from its appointment.
RECOMMENDATIONS: POLICY CHANGES ONLY

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<td><strong>PART I: – FOUNDATIONS OF THE REVIEW</strong> [NB: There are no recommendations in Part I affecting Policy Changes]</td>
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**PART II: – ESSENTIAL ELEMENTS FOR WORKER-CENTRIC SERVICE DELIVERY ISSUES IN BOARD CULTURE AND CASE MANAGEMENT**

**Recommendation #4:**
That the Workers Compensation Act be amended to require the Board to develop and publish a Code of Conduct.
That the Board develop a Code of Conduct for Fairness and Service for all stakeholders based on the present Code for Employers and publish this Code on its website and all forms.

**Recommendation #7:**
That the Board develop policy about decision-making in Case Management System such that when a worker's recovery is deviating from a recovery profile, the Recovery/Return to Work Guideline is removed or disregarded and the worker's case will be adjudicated based on individual circumstances considered, including whether additional investigation is required. The Board should further develop policy to guide consistent practice in this area, especially about concussions.

**Recommendation #8:**
That the Board develop policies and procedures that facilitate and require production of the First Aid report as part of the employers’ duty to report an injury.

**Recommendation #12:**
That the Board develop policy and practices to guide decision-makers in this new approach to health care management during the life of the claim. Workers will have a choice in their health care provider and the Board will supervise minimally and intervene only where the treatment is likely to impede or delay recovery.
PART II: – ESSENTIAL ELEMENTS FOR WORKER-CENTRIC SERVICE DELIVERY
ISSUES IN BOARD CULTURE AND CASE MANAGEMENT

Recommendation #18
That the Board amend policy item #34.54 to provide:

1. That in assessing whether or not a condition has stabilized or if there is a likelihood of change, the Board must take into account the changes that would be possible with treatment and consider the potential for change “with treatment”.
2. That the Board will determine whether or not the worker’s condition may be considered “stabilized” after reviewing the medical evidence as a whole and based on a “whole worker” approach. The Board may seek a medical assessment on this issue but the decision is an adjudicative one.
3. That even if the worker is not receiving temporary wage loss benefits, the Board is required to issue a decision when it considers that the worker’s temporary disability has ceased and include one of the following decisions:
   a) The worker is fully recovered; or
   b) The worker’s condition is now considered to have plateaued, leaving a permanent impairment. This decision must identify the accepted permanent conditions and referred the case to Disability Awards for the worker to be assessed under sections 22 and 23 of the Act.

PART III: – ADDITIONAL ISSUES IN SERVICE CULTURE AND CASE MANAGEMENT

Recommendation #23:
That following this amendment, the Board develop policy to address the “re-opening/re-injury” issue similar to the former policy on this matter.

PART IV: – POLICIES AND PRACTICES THROUGH GBA+ LENS

Recommendation #34
It is recommended that compensation policy provide that a determination of status by the Assessment Department is a finding of fact. Policy now allows for back-dating and cancelation of Personal Optional Protection (POP) if there is evidence the Board is no longer liable for work-related injuries “for legal reasons”. I recommend that this assessment policy be amended so POP can also be cancelled if there is evidence that a “self-employed” worker (under POP) was actually a worker for another employer.

Recommendation #36
That Board policy and practice directives on bullying and harassment specify that identity issues may create vulnerability or inequities in the workplace and this should be considered in identifying workplace stressors contributing to a psychological injury.
**PART IV: – POLICIES AND PRACTICES THROUGH GBA+ LENS**

<table>
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<tr>
<th>Recommendation #37</th>
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<tr>
<td>That the Board develop policy and practice directives that specify that return to work plans must include consideration of the worker’s disability and an assessment of the workplace duties from a GBA+ perspective.</td>
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<thead>
<tr>
<th>Recommendation #46</th>
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<tr>
<td>That the Board’s policy division undertake a review of Board compensation policy as a whole from a GBA+ lens.</td>
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**PART V: - RETURN TO WORK**

<table>
<thead>
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<th>Recommendation #47</th>
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<tr>
<td>I recommend that the Board revise its Return to Work (RTW) policies and delivery service to accord with the International Social Security Organization (ISSA) International Guidelines for RTW and the Seven ‘Principles” for Successful RTW which are the recognized best practices in return-to-work. Given that policies are well developed by the ISSA Guidelines and in other jurisdictions, I recommend that the revision of RTW services begin immediately and as much as possible within the current policy structure.</td>
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<th>Recommendation #48</th>
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<td>As the Board develops Return to Work (RTW) policies and practice directives, that they consider following the model used in Alberta and other jurisdictions, which use policy to address many areas in RTW and provide options and guidance to the parties.</td>
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<th>Recommendation #53</th>
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<tr>
<td>That the Board establish a registry of employers with certified disability management programs. When there is a worker with an injury who is employed by a “registered DM employer”, and</td>
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<td>• that employer submits the Form 7 – Employer’s Report of Injury (F7) within 3 days of being notified of the injury; and</td>
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<tr>
<td>• the employer is willing and able to offer Light Duties and engage in the Light Duty process then</td>
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<tr>
<td>a. that employer will be assigned a Return to Work specialist (RTWS) on a provisional basis who can begin to assist the parties before claim adjudication; and</td>
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<tr>
<td>b. that employer will be relieved of claims costs for that particular claim for the period of time between the date of injury and the date of a determination by a RTWS regarding suitable Light Duty arrangements (whether or not such duties can be arranged), unless the claim is denied.</td>
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</table>
### PART V: - RETURN TO WORK

**Recommendation #56**
All Light Duties’ arrangements be in writing and specify a time for review by the return to work specialist. If the Light Duties result in a substantial change in the worker’s duties or conditions of employment, a Temporary Work Assignment (TWA) form should be used.

**Recommendation #58**
That Board develop policy that specifies that if a worker has returned to an accommodated position with a pre-injury employer through the Board’s Duty to Accommodate process and the accommodation ends, the worker is entitled to additional Vocational Rehabilitation benefits to restore the worker’s capacity for suitable employment in the labour market.

**Recommendation #62**
Vocational Rehabilitation plans should be informal agreements which can be adapted to changing circumstances, including changing medical conditions. There is no formal restriction on the number of plans although they do have to be realistic for the worker and have a reasonable probability of achieving and sustaining the vocational goal over the long term.

### PART VI: - SPECIFIC STEPS TO INCREASE THE CONFIDENCE OF WORKERS AND EMPLOYERS

**Recommendation #80**
That the Board establish an “Occupational Disease Advisory Committee” with a mandate to conduct an inventory of Board practices in this area and recommend specific attention points for a targeted review or legislative change.

This Committee be provided with the resources to retain the services of an “Independent Occupational Disease Specialist” to advise on medical practices and current scientific research and issues in this area.

### PART VII: - OTHER URGENT ISSUES

**Recommendation #91**
Section 5.1(1)(c) of the Workers Compensation Act should be amended to read:

- (c) is not directly caused by a decision of the worker’s employer relating to the worker’s employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the worker’s employment.
- Corresponding policy similar Saskatchewan Policy Injuries – Psychological (POL02/2017) at items 12-14 “Incidents – Workload and Interpersonal” should be used to model new policy.
### PART VII: OTHER URGENT ISSUES

#### Recommendation #94
The Chronic Pain Policy Review currently in progress with the Policy Regulation & Research Division should include consideration of the ICD-11 Version of the International Classification of Diseases, Including New Diagnostic Codes for Chronic Pain in the development of updating chronic pain policy. The new policy should provide for an individual assessment and a range of possible permanent impairments.

It is recommended that the Board develop a Practice Directive, effective immediately that:

- for workers with chronic pain, that all necessary treatment to maximize their ability to RTW will be carried out before a referral to Disability Award; and
- for workers with serious permanent chronic pain, the Board may consider the claim under section 23(3) of the Act.

#### Recommendation #95
Policy item #41.00 should be amended to allow consideration of all relevant evidence regarding the actual impact of the injury on the workers likely retirement date, including evidence after the date of the injury.

### PART VIII: CONSULTATION WITH INDIGENOUS COMMUNITIES

[NB: There are no recommendations in Part VIII affecting Policy Changes]

### PART IX: FUTURE TASK FORCES

[NB: There are no recommendations in Part IX affecting Policy Changes]
PREAMBLE AND STATEMENT OF PURPOSE

Preamble
Whereas the workers’ compensation system has benefited injured workers in British Columbia since 1917 and continues to serve both workers and employers well;

And recognizing that the historic principles of workers’ compensation, namely the collective liability of employers for workplace injuries, guaranteed, no fault compensation for injured workers, immunity of employers and workers from civil suits, should be maintained;

And also believing that improvements to the workers’ compensation system are desired to ensure that the workers’ compensation system continues to meet the changing needs of workers and more adequately reflects the true costs, in both human and economic terms, of injuries arising out of the workplace and enable a holistic approach to the rehabilitation of injured workers;

And whereas it is important to advance efficient strategies for the prevention of workplace injuries;

And whereas the government has confidence in continuing to delegate to the Workers’ Compensation Board the trusteeship of the compensation fund to manage it in the best interests of its main stakeholders, namely workers and employers;

And whereas the commitment exists to promote a greater understanding of this legislation, all efforts have been made to make this Act more readable.

Purposes

1 The purposes of this Act are:

(a) to provide for an open and fair system of guaranteed, adequate compensation for all workers or their dependents for work-related injuries;

(b) to promote recovery from workplace injuries through early return to work, appropriate health care as well as vocational rehabilitation, where required;

(c) to maintain a solvent compensation fund managed in the interest of workers and employers;

(d) to provide for fair assessments on employers;

(e) to provide an appeal procedure that is simple, fair, and accessible, with minimal delays;
(f) to combine efforts and resources for the prevention of workplace injuries, including the enforcement of health and safety law and regulation;

(g) to establish a board of directors, with equal representation from workers and industry and a neutral chair to administer workers’ compensation, health and safety for all industries; and

(h) to ensure that workers, dependents of deceased workers, and employers are treated with compassion, respect, and fairness.
ATTACHMENT to RECOMMENDATION #58

STATUTORY LANGUAGE FOR THE DUTY TO ACCOMMODATE PROVISIONS IN THE WORKERS COMPENSATION ACT.

These are suggested models for amendments to the Workers’ Compensation Act to provide for the duty to accommodate.

2. That the Act set out the condition which triggers the worker’s right of return. I recommend that language similar to that of sections 97(1) and (2) of the Nova Scotia statute be used as this wording protects workers with psychological disabilities more than the wording in other Acts. For greater specificity, this section is set out below.

**Nova Scotia**

s.97 Duty of employer on receiving notice

(1) The employer, immediately upon receiving actual notice, or notice from the Board pursuant to Section 96, that a worker is able to perform the essential duties of the worker’s pre-injury employment, shall offer to reinstate the worker in the position the worker held on the date of the injury.

(2) Where the Board is satisfied that the employer is unable to reinstate the worker pursuant to subsection (1), the employer shall offer to provide the worker with alternative employment with the employer.

3. The Act should set out the conduct expected of employers and workers. The Acts in Alberta, Ontario and the Yukon are almost identical, and I recommend this wording for the Act in British Columbia. For example:

**Alberta**

88.1 Obligation to return injured workers to work

(17) The employer of an injured worker shall cooperate in the early and safe return to work of the worker by

(a) contacting the worker as soon as possible after the accident occurs and maintaining communication throughout the period of the worker’s recovery and impairment,

(b) attempting to provide suitable employment that is available and consistent with the worker’s functional abilities and that, when possible, restores the worker’s earnings payable to the worker on the date of the accident,

(c) giving the Board such information as the Board may request concerning the worker’s return to work, and

(d) doing such other things as may be prescribed by the Board.

(18) The worker shall cooperate in the worker’s early and safe return to
work by
(a) contacting the worker’s employer as soon as possible after the accident occurs and maintaining communication throughout the period of the worker’s recovery and impairment,
(b) assisting the employer, as may be required or requested, to identify suitable employment that is available and consistent with the worker’s functional abilities and that, when possible, restores the worker’s earnings payable to the worker on the date of the accident,
(c) giving the Board such information as the Board may request concerning the worker’s return to work, and
(d) doing such other things as may be prescribed by the Board.

4. The Act should specify the content of the duty to accommodate. I recommend the language in the Manitoba and Ontario Act (almost identical) which confirm the worker’s right to return to suitable alternative employment where disability prevents a return to a pre-injury job. For example:

**Manitoba**

49.3(4) Duty to Accommodate
The employer must accommodate the work or the workplace to the needs of the worker to the extent that the accommodation does not cause the employer undue hardship.

5. The B.C Act shall include a definition of “suitable” employment by incorporating the definition of “suitable” now found in Policy #40.12 RSCM II. This will give continuity to the compensation system’s treatment of this issue and also specificity.

6. I recommend that particular classes of workers are exempted from the application of the return to work provisions, including:
a. Worker employed by “smaller” employers with 20 or fewer workers as provided in the Ontario Act\(^ {172}\), and
b. Workers who are declared or deemed to be “workers” under the Act.

Similar provisions are contained in other jurisdictions. For example:

\(^{172}\) In B.C. in 2019, there are over 245,000 employers; over 90% are employers with less than 20 full time workers. IR 26
Ontario

41(2) Exception
This section does not apply in respect of employers who regularly employ fewer than 20 workers or such classes of employers as may be prescribed. 1997, c. 16, Sched. A, s. 41 (2).

I also recommend that section 96 provide that the Board has exclusive jurisdiction to determine the number of workers an employer has for the purpose of this new provision.

7. Many Acts exempt construction workers from the application of the DTA under a compensation Act. These provisions predate Caron. I recommend that there be further consultations with the stakeholders in the construction industry before including such an exclusion in the Act.

8. The Act should specify that the Board is empowered to determine the fitness of a worker to RTW or to take suitable work and to make a determination on its own motion or at the worker’s request as to whether an employer is meeting the duty to accommodate. For example:

Manitoba

49.3(7) If the worker and the employer disagree about the worker’s fitness to return to work, the board must determine

(a) if the worker has not returned to work with the employer, whether the worker is medically able to perform the essential duties of the worker’s pre-accident employment or to perform suitable work; or

(b) if the board has previously determined that the worker is medically able to perform suitable work, whether the worker is medically able to perform the essential duties of the worker’s pre-accident employment

9. The Act should indicate the duration of the accommodation. There is significant variety among the jurisdictions on this issue. I recommend the language of the Alberta Act which does not specify a particular date. For example:

Alberta

88.1(16) An employer is obligated under this section until the date on which the worker declines an offer from the employer to reinstate the worker that, in the opinion of the Board, complied with this section.
10. I recommend that the Board have certain enforcement provisions, including penalties and payment to the worker, and a rebuttable presumption that if an accommodation or an accommodated worker is terminated by an employer, the employer is presumed to have not complied. Such provisions would include the following:

a) The Board’s power to monitor the accommodation:

| Ontario 40(5) | The Board may contact the employer and the worker to monitor their progress on returning the worker to work, to determine whether they are fulfilling their obligations to co-operate and to determine whether any assistance is required to facilitate the worker’s return to work. 1997, c. 16, Sched. A, s. 40 (5). |

b) Presumption of non-compliance, if employer discharges an accommodated a worker

| Ontario 41(10) | If an employer re-employs a worker in accordance with this section and then terminates the employment within six months, the employer is presumed not to have fulfilled the employer’s obligations under this section. The employer may rebut the presumption by showing that the termination of the worker’s employment was not related to the injury. 1997, c. 16, Sched. A, s. 41 (10). |

c) Penalty and payment to worker:

| Ontario 41(13) | If the Board decides that the employer has not fulfilled the employer’s obligations to the worker, the Board may,
(a) levy a penalty on the employer not exceeding the amount of the worker's net average earnings for the year preceding the injury; and
(b) make payments to the worker for a maximum of one year as if the worker were entitled to payments under section 43 (loss of earnings). 1997, c. 16, Sched. A, s. 41 (13). |

11. As provided in many Acts, this DTA is a floor, not a ceiling, and that if a collective agreement provides a greater reinstatement provision, the agreement prevails. The language of the Alberta and Ontario Acts are recommended. For example:
**Alberta**

88.1(15) If the employer’s obligations under this section provide the worker greater reinstatement terms than does a collective agreement that is binding on the employer, this section prevails over the collective agreement except that this subsection does not operate to displace the seniority provisions of the collective agreement.

12. Many jurisdictions provide for dispute resolution mechanisms around the issue of a “suitable accommodation”. Given that the importation of this DTA will have some impact on the nature, complexity and number of disputes about this matter, I recommend a ‘made in B.C. approach” for an expeditious and expert dispute resolution process. In summary, where a dispute arises about whether the Board’s determination that an accommodation is “suitable”, the worker or the employer or the Board may request an informal dispute resolution process prior to the Board issuing a decision confirming the accommodation. If there is a request, the Board shall refer the matter to the Labour Relations Board (LRB) to conduct a non-binding investigation and mediation with a Settlement Office appointed by the LRB. If the dispute is not resolved, the Settlement Officer will issue a report and the Board will issue a decision taking the report into account.
## LIST OF APPENDICES

### PART I: THE FOUNDATIONS OF THE REVIEW

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APPENDIX 1: TERMS OF REFERENCE

Whereas the Workers Compensation Act (the Act) was born out of a compromise between BC’s workers and employers in 1917, where workers gave up the right to sue their employers or fellow workers for injuries on the job in return for an employer funded no-fault insurance system;

And whereas the last comprehensive review of the Act took place in 2002, and the last significant amendments to the Act were made in 2002 and 2003;

And whereas there have been significant changes in workplaces, the economy and the workforce of British Columbia over the past 16 years;

And whereas the Premier’s July 2017 mandate letter to the Minister of Labour includes the following direction:

Review and develop options with WorkSafeBC to increase compliance with employment laws and standards put in place to protect the lives and safety of workers.

And whereas the Confidence and Supply Agreement from May 2017 contains the following commitment at Section 2 (d):

Improve fairness for workers, ensure balance in workplaces, and improve measures to protect the safety of workers at work so that everyone goes home safely and that workers and families are protected in cases of death or injury.

And whereas the Minister has directed the chair of the Board of Directors of WorkSafeBC to effect a systemic culture shift to ensure the workers’ compensation system is more “worker centred”, that injured workers be treated with compassion, respect and dignity, and that increases confidence in the system;

And whereas the Minister has supported this systemic culture shift by:

4. Refreshing the Board of Directors of WorkSafeBC, including a new chair.
5. Clearly articulating the needed culture change within WorkSafeBC itself to improve services, with a focus on injured workers who need care, compassion and respect while they recover.
6. Directing the WorkSafeBC Board to remind employers of their responsibilities and accountability to reduce workplace injuries and death under the Act and the Occupational Health and Safety Regulation (OSHR).
7. Directing the WorkSafeBC Board to review its Rehabilitation and Claims Services policies to determine if there are policies that could be amended to ensure a worker-centred approach which resulted in a report published on April 25, 2018 by Paul Petrie entitled “Restoring the Balance: A Worker-Centred Approach to Workers’ Compensation
Policy”. The report contains 41 recommendations for change which has led to the development of a workplan to engage interested stakeholders in a process to implement as many of the recommendations as possible. Stakeholder consultation is underway on the 2019-2021 workplan.

8. Amending legislation (Bill 9-2018) to add a presumption for first responders who experience trauma as a result of their work and which results in a diagnosed mental health injury/disorder.

9. Considering development of a regulation to expand coverage for the Bill 9 presumption to other occupations, including nurses and dispatchers (and call-takers) who support first responders.

10. Directing the WorkSafeBC Board to prepare a report on the background and options available to WorkSafeBC under the WCA to manage the unappropriated balance in the Accident Fund.

11. Leading a cross-ministry working group, with involvement and input from WorkSafeBC, to better protect people and the environment from the dangers of asbestos. A report for consultation and input was released December 19, 2018.


13. Working to support WorkSafeBC’s implementation of a 5-year prevention strategy as part of its Strategic Plan to reduce workplace injury, disease and death and have BC become the safest jurisdiction in Canada for workers.

Now, therefore, the Minister directs that a review of the workers’ compensation system be undertaken as follows:

1. Subject to further direction from the Minister of Labour, the review will assess the following specific issues:

   a. The policy and practices used in the workers’ compensation system relating to supporting injured workers return to work.
   b. An evaluation of current WorkSafeBC policy and practices through a Gender-based Analysis Plus (GBA+) lens.
   c. Modernizing WorkSafeBC’s culture to reflect a worker-centric service delivery model. This model should incorporate a best practices, research-supported approach to managing physical and mental injuries caused by the workplace.
   d. Recommendations dealing with issues related to the improved case management of injured workers.
   e. What specific steps are required to increase confidence of workers and employers in the workers’ compensation system, including but not limited to the Fair Practices Office, and in the other services provided by WorkSafeBC.
   f. Whether there are any other urgent compensation issues that were not addressed in the final report to the Board of Directors of WorkSafeBC on how to manage the unappropriated balance in the Accident Fund.
2. A report will be provided to the Minister by September 1, 2019 and may include recommendations for amendments to the Act.

3. The review will be undertaken by an individual (Janet Patterson) with expertise in the workers’ compensation system, who is appointed by the Minister and who will approach the review in an independent, impartial, and balanced manner.

4. The funding for the review, including the reviewer’s compensation, will come from WorkSafeBC and will be administered by the Minister of Labour. WorkSafeBC will provide administrative and research support to the review.

5. The reviewer will determine their own procedures, including the format for reporting out to the Minister and communications with stakeholders. It is expected that the review will engage in consultations with and receive submissions from interested employer and union/worker stakeholders from all regions of the province, including hearing from injured workers who choose to come forward to the reviewer. The reviewer will work with the Ministry to design the stakeholder consultation process.

6. The reviewer will provide a draft of the final report to the Minister of Labour to review and provide input on prior to finalizing the report. The Minister of Labour will make the final report public after a reasonable period of time to review and consider it.

Given under my hand this 4th day of March, 2019.

______________________________
Honourable Harry Bains, Minister of Labour
APPENDIX 2: Resume and Review Team Profiles

Janet Patterson, Reviewer

Janet Patterson has been practicing law in the B.C. workers’ compensation system context for more than 17 years.

Janet was an adjudicator at the Public Service Appeal Board in the 1990s. In 2001, she joined the Appeal Division of the Workers’ Compensation Board as an Appeal Commissioner. She was appointed Vice Chair of the newly created Workers’ Compensation Appeal Tribunal and served as a Vice Chair and Deputy Registrar from 2003 to 2005.

In 2005, Janet joined the law firm of Rush Crane Guenther, where she represented workers in complex compensation appeals at all levels and in a variety of related proceedings, including discriminatory actions, section 257 applications, arbitration, disability appeals and Canada Pension Plan appeals. She was the co-chair for the 2016 Continuing Legal Education session on workers’ compensation.

Jim Parker, Review Researcher and Writer

Jim Parker has worked as a worker representative in the workers’ compensation claims and appeal system for over 25 years. Jim was a forest industry trades person in the 1980s when he added to his experience first aid attendant then safety committee chair. He then moved up to safety director and representative on provincial and national bodies.

Jim has been active in the development and consultation on OH&S and compensation regulation and policy as well as OH&S education and training. Jim moved to the public sector healthcare field in 2003 where he is a representative of workers in claims and appeals. Jim has been actively engaged in compensation policy prior to working with the WCB Review 2019 in April 2019.

Donna Hanson, Review Coordinator

Donna has worked within the workers’ compensation appeal system for 32 years, commencing with the Appeals Administration Department in 1987. The Appeal Division was formed in 1991 due to the recommendations made within the Munroe Report. Donna provided executive support to the Appeal Division Manager, the Deputy Chief Appeal Commissioner and then the Chief Appeal Commissioner until 2003 when the appeal structure changed again – this time due to the implementation of the Winter Report. The Workers’ Compensation Appeal Tribunal (WCAT) formed in 2003, and Donna served as the Senior Executive Assistant to the Chair until 2006. Now, she serves as a WCAT Appeal Coordinator. Donna is thankful to Janet Patterson for the invitation to work on this important and timely Review of the workers’ compensation system, and to WCAT for allowing the opportunity to do so.
Doreen Russell, Review Administrator

Doreen began her career in workers’ compensation field in June 1989. She worked in Disability Awards Department and the Compensation Services Division until January 1992 when she became the Administrative Assistant for the Secretariat for Regulation Review. In 1998 she transferred to the Appeal Division as a Secretary. Shortly after joining the Appeal Division she became an Appeal Officer. In 2003, when the Workers’ Compensation Appeal Tribunal came into being, Doreen transferred to the tribunal and continued working as an Appeal Coordinator until her retirement in December 2016.
The Terms of Reference (TOR) established by the Minister of Labour for this Review set out:

It is expected that the review will engage in consultations with and receive submissions from interested employer and union/worker stakeholders from all regions of the province, including hearing from injured workers who choose to come forward to the reviewer. The reviewer will work with the Ministry to design the stakeholder consultation process.

- To meet the mandate for wide public consultation, the WCB Review 2019 (Review) held early information meetings with key stakeholders and then launched a public website with Engage BC on May 24, 2019. The website provided the dates and registration process for public hearings, an online questionnaire, and a process for making written submissions before the close of public engagement on July 19, 2019. This process is summarized below.

One of the TOR was to identify “urgent issues” in the compensation system which were not otherwise addressed by the Bogyo Report. At an early stage, the Review determined that new matters could well arise in the public consultation which would be “urgent” but may not have been clear to stakeholders at the outset. Therefore, it was determined that after the public consultation concluded on July 19, 2019, there would be a second round of consultations for key stakeholders on “new issues” which arose in the public process.

There was also an additional opportunity for stakeholders to comment on the Bogyo Report, once it was released.

Part I: Public Consultation (May 24 to July 19, 2019)

Public Hearings

Hearings were originally scheduled in 14 locations between June 14 to July 19, 2019. The locations and dates were:

---

173 The November 6, 2018 report “Balance. Stability. Improvement. Options for the Accident Fund” (Bogyo Report) prepared by Mr. Terrance J. Bogyo was referenced as part of the TOR for this Review but was not available to stakeholders until July 18, 2019.
<table>
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<tr>
<th>CITY</th>
<th>DATE(S)</th>
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<tbody>
<tr>
<td>Surrey</td>
<td>Friday, June 14, 2019</td>
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<td></td>
<td>Saturday, June 15, 2019</td>
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<tr>
<td>Castlegar</td>
<td>Monday, June 17, 2019</td>
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<td></td>
<td>Tuesday, June 18, 2019</td>
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<tr>
<td>Nanaimo</td>
<td>Thursday, June 20, 2019</td>
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<td>Campbell River</td>
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<td>Vancouver</td>
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<tr>
<td>Chiliwack</td>
<td>Thursday, June 27, 2019</td>
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<tr>
<td>Williams Lake</td>
<td>Tuesday, July 2, 2019</td>
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<td>Wednesday, July 3, 2019</td>
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<tr>
<td>Kamloops</td>
<td>Thursday, July 4, 2019</td>
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<tr>
<td>Cranbrook</td>
<td>Monday, July 8, 2019</td>
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<tr>
<td>(Conducted via teleconference)</td>
<td>Tuesday, July 9, 2019</td>
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<tr>
<td>Kelowna</td>
<td>Wednesday, July 10, 2019</td>
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<td>Victoria</td>
<td>Thursday, July 11, 2019</td>
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<td>Monday, July 15, 2019</td>
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<td>Tuesday, July 16, 2019</td>
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<td>Prince George</td>
<td>Wednesday, July 17, 2019</td>
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<tr>
<td>Terrace</td>
<td>Thursday, July 18, 2019</td>
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<tr>
<td>(Conducted via teleconference)</td>
<td>Friday, July 19, 2019</td>
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Participants were asked to register before the hearing and were given a specific hearing time slot of 20 minutes. They could use the hearing time to make their presentation, share the time with others, and/or provide written submissions. All public hearing presentations were digitally recorded and are part of the Review record.

In some circumstances, some participants were given an opportunity to participate in the public process by teleconference when in-person participation was not practicable. In these cases, the
teleconference was recorded and if practicable, held in the scheduled public venue. In two locations (Cranbrook and Terrace), the hearing slots were all conducted by teleconference due to low registration numbers.

In total, the Reviewer heard 210 public presentations, all of which were digitally recorded and are being held as part of the Review record. The participants were in the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
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<tbody>
<tr>
<td>Workers</td>
<td>160</td>
</tr>
<tr>
<td>Family Members</td>
<td>10</td>
</tr>
<tr>
<td>Union / Representatives</td>
<td>30</td>
</tr>
<tr>
<td>Employers</td>
<td>2</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
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Of these 210 public presentations, 172 participated in person and 38 presented by teleconference.

In addition, the Review heard from 10 participants who asked for, and were granted, anonymity, according to agreed criteria. These presentations were not recorded.

**Questionnaires**

The Review consulted with individuals who conducted questionnaire surveys as part of their stakeholder consultation during the recent Alberta Workers’ Compensation Review.¹⁷⁴ These individuals generously provided advice, guidance and “lessons learned”. The Review then worked with the Ministry and a consultant with expertise in questionnaire design to develop a single questionnaire for multiple stakeholders. Between May 24 and July 19, 2019, 1980 questionnaires were completed with the responses received from the following categories:

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<tr>
<th>Category</th>
<th>Number</th>
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<tr>
<td>Workers</td>
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<td>Family of Injured Worker</td>
<td>140</td>
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<tr>
<td>Family of Deceased Worker</td>
<td>8</td>
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<tr>
<td>Employer</td>
<td>313</td>
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<tr>
<td>Self-Employed</td>
<td>28</td>
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<tr>
<td>Health Care Professional</td>
<td>207</td>
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<tr>
<td>Concerned Citizen</td>
<td>216</td>
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<tr>
<td>Other</td>
<td>190</td>
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**TOTAL** | **1980**

Written Submissions

In the public consultation process, the Review received 174 written submissions (totaling 1,535 pages). The breakdown of the written submissions, by source, is outlined as follows:

- Workers: 75
- Family of Worker: 7
- Worker Representative: 30
- Employer and/or Representative: 44
- Other: 18

Part II: The Bogyo Report (July 18 to 30, 2019)

A number of stakeholders raised questions about the December 6, 2018 report “Balance. Stability. Improvement. Options for the Accident Fund” (Bogyo Report) prepared by Mr. Terrance J. Bogyo, as this report was referenced in the Review’s TOR. Since the Bogyo Report was not publicly released until July 18, 2019, key stakeholders were provided with an opportunity to make a submission on the Bogyo Report, on the understanding that the Review would simply forward these submissions to the Ministry and not otherwise comment.

Part III: Key Stakeholders and “New Issues” (August 8 to September 11, 2019)

- As agreed, the Review provided key stakeholders with a list of “new issues” which arose in the course of public consultations. The list was originally provided on August 6, 2019, and then amended on August 8, 2019 to correct some items on the list as they had already been addressed in the Bogyo Report. The amended August 8, 2019 version of the “new issues” is attached (Attachment 1).

This list was provided to the following key stakeholders: Board of Directors of WCB; BC Federation of Labour; participating non-affiliated unions (BC Nurses’ Union, UNIFOR, Public and Private Workers of Canada (PPWC), Greater Vancouver Regional District Employees’ Union (GVREDU) and Christian Labour Association of Canada (CLAC)); Employers’ Forum; Workers’ Advisers Office; Employers’ Advisers Office; and the Workers’ Compensation Appeal Tribunal (WCAT).

- On August 14, 2019, the Employers’ Forum withdrew from participation in the Review for reasons it set out in an August 14, 2019 public letter.

The Review held stakeholder consultations with the other key stakeholders as agreed.
NEW DIRECTIONS: WCB REVIEW 2019

WCB Review 2019
Janet Patterson, Reviewer

To: Key Stakeholders in the British Columbia Workers’ Compensation System
Copy to: Ralph McGinn, Chair, Board of Directors – WorkSafeBC
Andrew Pendray, Chair, WCAT

From: Janet Patterson, Reviewer, WCB Review 2019
Date: August 6, 2019 (Amended August 8, 2019 – changes noted)

RE: Selected Issues for further Stakeholder Consultation
(August 6 - September 11, 2019)

INTRODUCTION

The following issues were identified as important or urgent issues in the course of the WCB Review 2019’s (Review’s) public consultation process and as such, are within the scope of this Review.

These issues are likely well known to key stakeholders, as are the views and concerns of other stakeholders. Some issues have already been reviewed in other venues. Therefore, I would like to commence this next consultation process by meeting with each stakeholder group for a frank discussion about both the issues and what type of further consultation process (if any) is indicated within the Review’s timeframe. Please contact Donna Hanson at the Review office to set up this meeting.

The list below does not represent the full scope of this Review. Many issues identified in the Terms of Reference (TOR) were well canvassed in the public process and do not

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APPENDIX 3: PUBLIC CONSULTATION PROCESS – OVERVIEW AND PUBLIC HEARING SCHEDULE
require additional consultation (return to work (RTW) process, the duty to accommodate (DTA), Fair Practices Office, Board service to and communication with Stakeholders). Other matters relate to internal Board processes or are integrated with the matters below, and so are not listed separately.

Finally, some matters are beyond the scope of the Review, including those addressed in the Accident Fund Report: Balance-Stability-Improvement Bogyo December 2018 ("Bogyo Report"). All submissions made to the Review on the Bogyo Report were forwarded to the Minister of Labour for consideration.

ISSUES FOR CONSULTATION

The issues are set out in three sections:

A. Proposed changes to the Workers Compensation Act (Act) and/or policy;
B. Proposals to assist disadvantaged groups (GBA+ lens); and

A. Proposed changes to the Workers Compensation Act (Act) and/or policy:

1. Add a Preamble to the Act, setting out the statutory purpose of the legislation and confirming its commitment to the Meredith Principles. In addition to setting out the statutory purpose a preamble could clarify issues that arise from the legal name of the Workers’ Compensation Board and branding as WorkSafeBC.

2. Include a statutory requirement for periodic reviews.

3. Amend section 99(2) to read "the Board must make its decision based on the merits and justice of the case" (with a companion amendment for WCAT in section 250(2). That is, take the requirement for binding policy out of the Act.

4. Include a duty to fairly investigate and obtain enough evidence to make a well-founded decision.

5. Include a different process to review a policy’s consistency with the Act. Several court decisions have commented negatively on the section 251 process.

6. Include a Code of Conduct to help set a service standard.

7. Include a provision to provide protection and/or a remedy to injured workers who face negative consequences or retaliation intended to prevent them from making a claim, or as a result of making a claim (Claims Suppression).
8. Amend section 96(5) to allow the Board to re-open and reconsider its own decisions at any time.

9. Amend 96(2) to require that, under this provision, the Board must adjudicate the changed condition as a reopening, a re-injury or a new injury and in doing so, must consider each possibility. On appeal, the appeal body has the jurisdiction to consider the matter differently without returning the matter to the Board for new adjudication.

10. Amend section 95 and policies and practices on disclosure to better protect workers’ privacy issues in the compensation context.

11. Include a provision to address compensation for permanent chronic pain.

12. Amend section 6(1) to remove the requirement that the worker must be “disabled from earning full wages” to be eligible for compensation for a work-related occupational disease (OD), and remove section 6(2) from the Act. Matters of timeliness for making an OD claim would be addressed in section 55.

13. Amend 6(3) to include an exception to the “immediately before” requirement for a presumption as follows:

   An exception to this is where the medical and scientific 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.

14. Amend the Act to specify that repetitive strain injuries (now referred to as ASTD’s) are adjudicated under section 5 as gradual onset injuries. Schedule B would need to be amended to reflect this change.

15. Amend the Act to provide for the payment of interest at the Board rate for retroactive compensation awards to workers.

16. Amend the Act to provide for greater adequacy of benefits to workers, including:
   a. Wage rate is based on 100% of net;
   b. No offset for CFP Disability awards from compensation awards to seriously injured workers; and
   c. Index pensions at CPI rate. *(Addressed in Bogyo Report)*

17. Amend section 33 to provide for flexibility in setting wage rates for young and casual workers and other special circumstances.
18. Provide both appeal bodies (Review Division and WCAT) with broad discretion to grant extension of time (EOT) relief.

19. Include a new provision to provide WCAT with power to reconsider its own decisions on common law grounds.

20. Amend the Administrative Tribunals Act (ATA) to provide WCAT with jurisdiction over Charter matters and the Human Rights Code. This will be important to address duty to accommodate (DTA) issues.

21. Include a new provision to grant Review Division broad remedial discretion.

22. Amend provisions for benefits to family survivors.

23. Amend section 5.1 to remove predominant cause and not require DSM diagnosis for short-term psychological disability (emphasis on treatment), so psychological injuries are treated consistently with other section 5 claims. Alternatively, delete section 5.1 and adjudicate mental disorder claims under the same criteria of “arising out of and in the course of employment” for personal injury claims.

24. At the same time, address special issues that arise in the management and RTW for mental stress claims including:
   a. Training staff and setting service standards for Board’s role in mental stress injuries;
   b. Identify special RTW issues and processes for mental stress claims, including a psychological safe workplace. Specialized Board staff to support RTW plans.

25. Change presumption language for PTSD claims to apply to all occupations equally, consistent with DSM criteria.

26. Add provisions respecting vocational rehabilitation – this would involve several parts of the Act:
   a. Change language in section 16 to clarify the VR mandate;
   b. All VR decisions, including DTA decisions, be appealable to WCAT;
   c. Provide a statutory requirement for a duty to accommodate, with special provisions and supports for small employers – may be based on Ontario language; and
   d. Provide a process for expedient non-binding mediation for VR and DTA disputes, prior to a formal decision.
NEW DIRECTIONS: WCB REVIEW 2019

APPENDIX 3: PUBLIC CONSULTATION PROCESS – OVERVIEW AND PUBLIC HEARING SCHEDULE

ATTACHMENT 1

27. Amend the Act to authorize diagnostic and prophylactic treatment prior to claim acceptance. *(Addressed in Bogyo Report)*

27. Confirm the right of workers to choose their own practitioner under section 23(7) with possible refinement of the definition of a practitioner.

28. Modernize the language of section 55 to reflect that most claim applications are made by Teleclaim or on an electronic form.

29. Amend section 23.1 to provide that the Board must assess whether the worker would retire at the statutory date (now age 65) or at a later date and in doing so, must consider evidence from both before and after the injury and the impact of the injury on a retirement date. *(Addition)*

30. Amend section 23(3) and (3.1) and (3.2) to provide that the Board must conduct a loss of earnings assessment when the worker’s compensable loss of earnings is, or is likely to be, greater than the PFI pension amount and after the assessment, award the higher of the two pensions. *(Addition)*

B. **Proposals to assist disadvantaged groups (GBA+ lens)**

There are several issues and recommendations for remedying barriers or negative impacts for vulnerable and precarious workers.

1. Special services to vulnerable workers:
   
   a. Navigators
   b. Ambassadors
   c. Identifying and addressing special compensation issues – Task Force.

2. Relationship building with Indigenous stakeholders - develop cultural sensitivity and cultural competencies, especially in VR.

3. Renew inter-jurisdictional agreements to address gaps, inconsistencies and barriers for workers who are inter-provincially mobile.

4. Special provisions to address claims and compensation barriers for temporary foreign workers.

5. Special compensation supports for small employers.

6. Process for addressing “self-employed” decisions by the Assessment Department, where the individual is found to be a “worker” in a claims matter.
C. **New Concepts in BC Compensation**

The concepts below have evolved from many discussions inside and outside the Board and research, and from concerns repeatedly raised by participants.

1. **Develop New Category of “Pre-injury Risk Management” in Prevention.**

Where a worker is developing symptoms of a physical injury, OD or psychological condition but is not yet disabled, the worker may be designated as a “worker at risk”. This allows for Board resources to be utilized for intervention (“pre-injury” risk management) before onset of disability. Resources could be available at the employers’ or workers’ request and could cover what is needed to head off injury (ergonomic assessment, counselling, investigation) and keep the worker and workplace safe. If no injury develops, then there are no claims made and no claims cost to the employer. If injury develops, then all material from risk intervention evidence becomes part of the worker’s claim without delay and without gaps in service. [Model of Critical Incidence Counselling - useful for RSI and developing Mental Stress Injuries.] The goal is for the worker to stay at work and avoid injury or, if injured, quick adjudication, treatment and RTW. This could be developed in conjunction with the concept of psychological safe workplaces, with education and training and resources provided by the Board’s Chief Mental Health Officer.

2. **Develop and support a capacity for independent medical evidence and effective resolution of medical disputes.**

This approach has two parts:

* Internally, set up a Clinical Services Division within the Board, with Board medical advisors (BMAs) able to liaise with treating physicians, advise Claims and Preventions, refer workers to treatment programs, advise the Board, etc.;

* Externally, set up an independent medical service model, based on either the Alberta Medical Services Panel (MSP) or Washington State COHE, to provide reliable and expedient IME’s and health services.

For medical disputes, there would be an informal process to resolve these matters between the BMA and the treating physician. If these were not resolved informally or where there was another type of medical conflict (e.g. between an employer and the worker’s doctor in a RTW or light duties situation), the Board, the worker or the employer could request for an IME. The IME process can also be used by the appeal bodies and parties before appeal bodies.
3. New Pension Framework for “non-economic” loss (of function) and LOE awards, where there is a LOE after VR.

British Columbia is only one of two jurisdictions in Canada that does not treat the functional award as an award for non-economic loss. It is proposed that British Columbia adopt the following model and provide for a transition plan to change its pension awards.

i) Change the “PFI” award to a “non-economic” loss lump sum award, based on a common scale, and awarded as a lump sum award at the time of MMR; and

ii) Everyone who suffers a LOE after attempting a RTW, within the framework of a DTA and VR, is assessed for a LOE at that time, with a follow-up assessment after 2 years.

Yours truly,

Janet Patterson, Reviewer
WCB Review 2019
First, I would like to take this opportunity to thank you for inviting me to speak before you today. I truly believe that we don’t know what we don’t know. The only way to create change is to listen to the people affected by any system.

Each situation, each person, each family has their own dynamics. Their own special circumstances, and their own identity. One program or schedule might not be the right fit for each person. However, I for one can appreciate how important it is to have procedures in place. Procedures assist with expectations and consistency. The one thing that procedures cannot assist with is compassion and empathy.

With any position dealing with a demographic of people in not ideal circumstances can be challenging. I can only imagine how hard it is for each case worker not to take on the problems of each case.

I would like to tell you about my husband, the love of my life and the father of my children, Caley Thompson. This picture of him was taken on our wedding day! It is my favourite picture not because it was on our wedding day but because his smile reaches his eyes which reaches his soul. He has the kindest heart and he wears in on his sleeve. He isn’t afraid to tell you if he is mad, sad, angry, hurting, happy, elated or sorry. He owns his emotions and is accountable for every action he takes.
This is a picture of me and my kids last year at my brothers wedding. Caley isn’t in this picture. Caley isn’t in a lot of our family pictures anymore. My children’s memories are filled with pictures that do not have their father in them. There is a lot of different reasons why he isn’t in the pictures. But first I would like to tell you more about Caley.

Caley is a third-generation millwright. Something that he is very proud to say. Something that he worked very hard for. He honestly loves his job. He takes pride in the fact that he can fix big machines, increase production, or save a project/mill from complete failure. Each day after work he would come home and tell us some grand story from that day. It was all about the machines he fixed and what gear, cog, compressor, hoist, belt, blade, hydraulic, motor or bearing he had to replace, fix, repair or patch together to save the day. I’m a bookkeeper and I don’t have stories that sound that exciting.

Even though Caley’s WCB records may not show it, Caley is very safety conscious. I have seen him turn down jobs in mills because they weren’t safe, or someone wasn’t doing their lock outs properly. He was never afraid to speak up about safety procedures and if he felt they weren’t being followed.
Caley’s first WCB claim happened in 2007. He was working in an ore mine. He was loosening a bolt on a flange that he had a snipe bar on. He put the bar on his shoulder to try and apply more force to the bar and separate his ACL in his right shoulder. Besides timing, this was the best experience that we had with WorkSafe BC.

He attended physio therapy, with no avail. WorkSafe got him into a surgeon fairly quickly. The surgeon removed a portion of his clavicle bone on the right side. This was to stop the impingement of the tendons in his shoulder. More physio therapy followed and eventual and second surgery to repair the ACL and Rotor Cuff.

Unfortunately, during the time that Caley was away from work due to the injury, there was a mass lay off at the mine. Our WCB caseworker was amazing. She took the time to listen to Caley’s concerns. Coming back from an injury, still an apprentice at the time and trying to find a new job wasn’t easy. She met with him several times. Discussed back to work idea’s, discussed modified tools and provided a person to help him revamp his resume. She provided information about return to work rebate plans for the employers and gave him amazing opportunities to assist him to get back to work. We were well into the downturn of the economy in 2008 during this time providing a further hurdle. However, with her help and Caley’s determination he was able to find some camp work that allowed him to get back to the job and onto the tools again.

It was the caseworker understanding and appreciation for the circumstance that gave Caley the confidence to move forward and continue on his path to returning to work as a millwright. For that I will be forever grateful.

At the end of 2010, early 2011, Caley was working in a coal mine. We were very grateful that early that year, he had found a permanent position in our home town. We had just welcomed our daughter into the family. Life was good.

Caley was working underground, jumped off a piece of machinery and landed in some thick mud. As he started to walk away, his boot was stuck in the mud and he twisted his left knee. As soon as he was at the surface, he sought out the first aid attendant who took the time and inspected his knee. The first aid attendant wrote out his report, mentioned that there may be meniscus damage and suggested that Caley take it easy and ice his knee as much as possible. For two months Caley took it easy, iced it as much as possible and continued to work. He did as much light duty that was available but working in a coal mine, there isn’t a lot of that. Finally, one night at home, he blew out his knee.

The next year and a half, at the time, was the hardest times we had been through.

The case worker that had been assigned to our file was the exact opposite from our previous case worker. She didn’t believe my husband. Because of that she wouldn’t listen to anything that he had to say and would constantly talk over him. She had a knack for leaving all the important information she needed to pass on as a message 4:30 on a Friday afternoon, so we
were not able to return her call until Monday and got to stew over any bad news all weekend until we were able to get an explanation.

It wasn’t until we were able to obtain a copy of the first aid attendants report our self and submit it to her, that his case was finally accepted. For whatever reason, she had either not received it from the employer or had not acknowledge it the first time it was sent.

Even before the injury had been accepted, Caley had attended physio therapy. We had tried everything that we could to aid the recovery of his knee. Once the case was accepted, he was able to see a specialist right away. From there, three knee surgeries followed. Each one trying to remove and repair the damaged meniscus. By the time his knee healed from the third surgery, there was nothing else they could do for him. Replacing his knee was not an option at his age.

Caley has epilepsy. He has had this most of his adult life. It is controlled with daily medication. With epilepsy medication, there is a lot of counteraction with other medications. One of them being ibuprofen and NSAID’s. Both of those would be prescribed to you after injuries and surgery to help reduce swelling. Caley is not able to do this. So, the doctors prescribed icing his knee as much as possible and Percocet. With each new surgery the Percocet dose got higher and higher.

After the case worker decided there was nothing else that she could do for Caley, she cancelled his claim.

With a knee brace, ice packets and a Percocet prescription to get him through the pain on his off days, Caley was forced to go back to work. However, Caley’s employer was unable to accommodate a lighter duty for him, Caley was forced to quit.

With this claim there was no one available to watch out for the rights of my husband. He did not receive any support or explanation as to what he should do with a knee that still wasn’t even operating 50% of the time. He was bullied to go back to work, and he was bullied into quitting his job.

I personally have been through the WCB Bullying and Harassment training. While preparing for this session, nowhere was I able to find any documents on what is expected of the case worker. What policies are put into place to protect the employee. Even the employees advocate office wasn’t able to help us in this scenario.

It was also this injury that I became glaringly aware that there was no support for the families of the injured workers. With only my small maternity leave income and the little I made working from home, there wasn’t extra money for babysitters. Babysitters that would have come in handy when I had to pick Caley up from the hospital, or councillors to talk to about how hard it is to have an injured person at home. Or home care to come and cook meals for him because he had to stay in the downstairs of our upstairs living house because he couldn’t make it up the
stairs. Or taxis to take him to and from his doctor’s appointments because he couldn’t drive. None of this support was there. We were not able to submit receipts for any of this. This became an extra burden on me and my very young family.

It’s worth saying that this is still an injury that plagues Caley today. Not only is his left knee still a main source of pain, his right knee is also giving him grief due to compensating for the other side. He is currently doing physiotherapy and waiting for a referral to an orthopedic surgeon.

With a family of five to support, we made the decision to move. Caley was able to get a position in a sawmill in Vanderhoof. This position was better for him as it wasn’t underground, there was stable footing and there was enough tools and trades that he wouldn’t be working alone.

Caley enjoyed his position at the sawmill. For the most part, he had a great group of co-workers and enjoyed the appreciation that the company provided to their employees.

Towards the end of December 2012, Caley had underestimated the weight of a roll of belting and had attempted to pick it up. He heard a pop and then instant pain. What would follow is now going on the hardest 7 years of our lives. Our meaning my FAMILY. My husband, my children, my in-laws, my parents and my life. This has affected us all in so many different ways, I fear that there will be a ripple effect that will haunt us forever.

The day after the injury occurred, it was obvious that something had happened. He was in so much pain. The best way he describes it, is that someone is kicking him in the crotch over and over again. He wasn’t able to urinate properly and couldn’t stand up straight. Caley went to our doctor. The doctor checked him for a hernia, dislocated discs, joints, cough due to cold, even STD’s!

It wasn’t until a week had past that he suggested that some imaging be done. An ultrasound was conducted. Showing nothing out of the ordinary.

Caley’s employer had provided light duty for him at work, which he was able to do most of the time. There were times that he had to call in sick because the pain was too much. Finally, the doctor advised him that he shouldn’t return to work. The doctor sent him to physiotherapy here in Prince George. He worked endlessly with the physiotherapist. During one of the exams at the physiotherapist Caley was telling her that he was still in so much pain. He was able to do a lot of things but would pay for it by not being able to move for three days after. She didn’t believe him. She did his exam and reported back to WCB that he was no longer injured. Finally, in September on 2013, the caseworker sent Caley to Vancouver for more imaging. This was nine months after the injury.

Nine months after the injury the MRI came back clear. Prior to the MRI and in desperate search to figure out what was actually going on, Caley had also been seen by a urologist. Between the urologist and our GP, they speculated that he had torn his abductor muscles away from his
pelvic bone. This is something that a woman’s body is built to do, not a man’s. This would explain the pain, not being able to stand up straight and the fact that still to this day, he is not able to urinate properly and will be on medication for the rest of his life. Yet this part of the injury was denied by WCB. So, nine months after the injury only seemed right that the MRI had not shown any damage, the muscles had healed. So why was he still in so much pain? Yet no matter how much we asked this question, WCB decided there was nothing else they could do, and that Caley must be faking it and cancelled our WCB coverage.

We were fortunate to have been involved with a union and to have been able to go on long term disability. There was no way that Caley was able to go back to work in the state that he was in. He would go days on end not being able to get out of bed due to pain. On the days the pain wasn’t so bad, he helped out around the house. But after that he paid for it with another three days of crippling pain.

During this time our general practitioner continued to prescribe him pain medication. He had tried a few different ones, but they were always narcotics. As the years went on the doses got stronger.

The pain got so bad that Caley started to talk about how all he wanted to do was stab himself in the stomach so he would be rushed to the hospital and they would be forced to look into what was wrong. Luckily this didn’t happen. What did start happening is almost as bad. Caley started to cut. He would cut his arm or his leg, sometimes deep enough that he needed stitches. He did this so he could avert his focus to a different pain, to have a different problem. At first, I had no idea what was happening. But as the hospital visits increased, I knew something was wrong.

Early in 2014, after many discussions between us and his doctor, Caley started to talk with a counsellor. Caley was hospitalized for the first time in April of 2014. Still off work, still in pain, still no answers. He was in the hospital for two weeks. It was a humbling experience for him. He was put on medication to help with the depression that was creeping in. His mood started to lift.

Upon discharge though, our broken medical system proved to us that you need to be your own advocate. There was no follow up from any psychologist, no counsellor called. And no matter how much I begged him to call the office to book an appointment with his counsellor he wouldn’t. He felt that they didn’t want to see him because they never called to reschedule an appointment. This feeling of neglect just pushed him further down.

It took a lot of energy to consistently reassure him that we would find the answer. We had started the process with our union hall to appeal the decision of the WCB claim. He had been referred to the pain clinic in Prince George by our GP, many months before. Holding out hope we waited.
The next several months were a delicate balance act of keeping Caley safe, reassuring him everything would be ok, trying everything we could just to find some relief. Chiropractor, more physio therapy, acupuncture, homeopathic remedies. We would try anything we could.

Finally, in November of 2014, we were able to get in to see the pain specialist. After an hour-long conversation, he had answer! What Caley has is called Chronic Regionalized Pain Syndrome or CRPS for short. This occurs when an injury heals but the nerves don’t. The nerves still tell the brain that there is an injury. Holy Smokes! We have an answer. What the doctor was able to do is inject a needle into three to different places in Caley’s back. He freezes the band of nerves that run along the side of his hip and into his groin. He told us that the hope was after a couple of treatments, the brain would start to recognize that there wasn’t an injury anymore and the pain would slowly go away.

We were floored. After all of this time, someone believed Caley. Someone was willing to help him.

Caley’s first treatment lasted three hours. But according to Caley it was the best three hours every. For the first time in two years the pain was at a point he could actually think straight. He wasn’t clouded by what was happening in his groin.

His next few treatments continued to get better and better. We were now to a point were Caley was able to go a few months without crippling pain. The nerve blocks don’t take the pain away completely, but it defiantly muted it.

Now the pain medication. There wasn’t a need for them anymore. Caley tried to stop the taking the pain medication on his own. He detoxed in our house for three days. I have never seen a person go through so much trauma than this. And I have seen Caley have grand mal seizures.

He finally contacted the detox clinic and checked himself in. After 5 days in there, he was off the pain meds. This was all done on his own accord. There was no help or guidance from the doctors. Once again, the broken medical system had failed us. They had prescribed narcotics but had not tried to help get him off.

Also, during this time, our WCB appeal had escalated to WCAT hearings. The employers advocate had resorted to calling Caley a druggy after receiving a copy of his medical records. This assumption would seem obvious just looking at the records. However, Caley never took the pain medication while at work. He knew that this would alter his state and would not provide a safe environment for himself or coworkers. This was the employers advocates only argument. With the employers sitting next to him in the hearing, they had nothing to say except that. When Caley was hired, he had a drug test, provided prescription information and was upfront with all prescriptions.
With bi-monthly nerve blocks, Caley was now in a position that we were able to think about returning to work. However, considering that Caley was now labelled a druggy at work, it was not a comforting place to return to. Caley resigned from his position and found a job in Prince George.

With regular nerve blocks, Caley was able to work successfully. We scheduled his blocks on his days off. These blocks also require me to take time off work to transport Caley to and from the hospital. As he is put under for the treatment and not able to drive for a period of time after.

His job was going well. What wasn’t going well was his depression. The WCAT hearing was still going on and even though the claim had been denied, the employers advocate was still resorting to name calling. Caley has mentioned to me many times that this is the worst injury he has ever had and now he is struggling to prove it. The feelings of not being believed, being called a druggy and having to prove an injury that has no visible damage proved to be too much.

February 2017, Caley’s doctor put him on stress leave. His depression had gotten worse, the cutting had started again and now Caley was having suicidal thoughts. He was now seeing a psychiatrist weekly, trying different medication and trying to elevate the depression that had seized his life.

Over the next year, he was hospitalized for a total of six months. April 2017 – July 2017 and then September 2017 – November 2017. They tried everything. During his second stay ECT treatments were started. This is where they attach electrodes to your temples and induce a seizure. This is supposed to jump start your brain to heal itself. It is horrible to think that your spouse is being electrocuted on a weekly basis.

Due to medicine changes, one started to interfere with his epilepsy. For the month of December, Caley suffered from over 40 petit mal seizures a day. He wasn’t able to watch our kids, drive and could barely walk down the hallway.

April 2018 brought on another hospital stay for a month. This stay proved once again that our medical system is broken. However, that is for a Northern Health Review panel.

August 2018 to October 2018 brought on another round of ECT’s. This time Caley’s short-term memory was affected. This is a side effect of the ECT’s. After the first round, his memory returned after a few months. We are still waiting for it to come back after this round. Short term memory is a struggle for Caley. We now relay on iPhone alarms, post it notes and many reminder text messages throughout the day.

During this time, the WCAT hearing is still progressing. Many hearings had to be postponed due to Caley’s hospital stays. We finally received the approval that I could stand in for him in an evidence-based process instead.
In October 2018, after five years of appeal’s we won our case. Caley’s CRPS was finally accepted into the claim. However once again, there is no support for the families. I was told that I wasn’t able to claim any of my time (upwards of two hours) for the transportation of Caley to and from his nerve blocks. I am not about to send my husband in a taxi to get a procedure done. But we won!

As wonderful as that win felt, our battle is far from over. After a suicide attempt, Caley was hospitalized again, this time in Vancouver’s UBC neuro-psych department for seven weeks. His depression is still very strong, and his suicidal thoughts are still there.

We have been denied our request to add his severe depression to our WCB claim. This appeal is still ongoing.

One of the most hurtful things I have had to experience, is seeing one of the employer’s advocates attend a forum on Mental Health and Safety in the Construction industry. How can the same person, sit and assist an employer belittle, fight against and deny my husband of any of his feelings, mental or physical, be present at a form about mental health.

It has been the actions of WCB and its advocates that have pushed my husband to the point that he feels the only way anyone will believe his struggles is to end his life.

According to a study that the Mental Health Commission of Canada published alongside of Morneau Shepell, https://www.mentalhealthcommission.ca/English/news-article/13522/canadian-employees-report-workplace-stress-primary-cause-mental-health-concerns, 70% of workers claim that their work experience impacted their mental health. I wonder what the percentage of workers who have had to go through any appeal process with WCB would say impacted their mental health.

Not only has this process impacted Caley’s mental health, but mine and my families as well. My children have witnessed that you can’t not relay on the people that are supposed to be there to protect you.

Caley’s depression has kept him away from our lives. He isn’t able to often participate in family outings, vacations, sporting events or watch our children’s school plays. If I were to take his picture, his smile doesn’t reach his eyes or his soul.

If you are able to take anything away from my story, please remember that how someone is treated from the beginning of any processes, can greatly affect their outcome. Let’s create a tribe of people who are unbiased, not judgemental, and supportive of the situations these workers are going through. Spending a little more time listening and exploring instead of just stopping when you are not able to see and obvious solution. Not everything is black and white. People are worth the time you put into them.

Most recently, Caley told me that he hopes to have a good last summer.
APPENDIX 5: WorkSafeBC Gainsharing and/or Bonus Plan (WCB-IR-0064)

2019 WCB Review
Subject: WorkSafeBC Gainsharing and/or Bonus Plan

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<tr>
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<td>Rhonda Trudeau</td>
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<tr>
<td>Completed by:</td>
<td>Nancy O’Kraffka, Director, Human Resources Rhonda Trudeau, Senior Policy Advisor, Policy, Regulation &amp; Research</td>
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REQUEST DETAILS
The Reviewer requests information regarding whether WorkSafeBC has a gainsharing or bonus plan for staff and/or management.

REQUEST RESPONSE:

WorkSafeBC no longer has a gainsharing or bonus plan for staff and/or management. Some details about past programs is provided below:

1. A gainsharing plan was introduced in collective bargaining in 2002 for Compensation Employees’ Union (CEU) members and was subject to PSEC approval.

2. The gainsharing plan was based on measurement of three key metrics - injury rate, short-term disability (STD) duration and claims inventory. Payout was not to exceed 2% of total payroll.

3. The gainsharing plan was paid out in 2003, 2004 and 2005 for CEU members. Goalsharing was not included in the 2006-2009 collective agreement.

4. A plan similar to the CEU goalsharing plan was adopted, effective January 2005, for management staff and was referred to as the Bonus Plan.

5. An Agreement between WorkSafeBC and the CEU, signed January 1, 2012, implemented a new gainsharing program which ran from April 1, 2011 to March 31, 2013. This program was based on the serious injury rate, voluntary return-to-work results, and customer service. This program is no longer in effect.

6. The Bonus Plan for management staff was discontinued, as per the Public Sector Management & Executive Compensation (PSEC) salary freeze policy. In 2014, the calculated average payout of 8% was rolled into salaries for all management staff, with 4% for exempt support staff.

7. The Bonus Plan for Executives (VPs and President/CEO) was replaced by a "holdback" of 10% of salary, based on 9 corporate KPIs. The holdback was discontinued and was rolled into salaries, effective October 1, 2018.
APPENDIX 6: SUBMISSIONS POSTED TO ENGAGE.GOV.BC.CA

(SEE “GUIDELINES” ON NEXT PAGE)

Arrow Transportation Systems Inc.
Baillie & Associates Consulting Ltd
BC Agriculture Council (BCAC)
BC Care Providers Association
BC Chamber of Commerce
BC Council of Forest Industries (COFI)
BC Federation of Labour
BC Ferry & Marine Workers’ Union
BC Government Employees’ Union (BCGEU)
BC Greenhouse Growers’ Association
BC Hotel Association
BC Maritime Employers Association (BCMEA)
BC Nurses’ Union (BCNU)
BC Pork Producers Association (BCPPA)
BC Poultry Association
BC Rapid Transit Company Ltd. (BCRTC)
BC Road Builders and Heavy Construction Association
BC Teachers’ Federation (BCTF)
Boilermakers Lodge 350
Business Council of BC
Canada West Ski Areas Association
Canadian Centre for Policy Alternatives (CCPABC)
Canadian Federation of Business (CFIB)
Canadian Pacific Railway
Canadian Union of Postal Workers (CUPW), including Columbia River Local
Canadian Union of Public Employees (CUPE)
CMAW Local 2300
Coast Mountain Bus Company
Community Legal Assistance Society
Compass Group Canada
Construction Maintenance and Allied Workers (CMAW) Locals 1998 & 2300
Council of Construction Associations (COCA)
Doctors of BC/WorkSafe Liaison Committee/ and Projects and Innovations Committee
Employers’ Advisers Office

Employers’ Forum
Federation of Post-Secondary Educators of BC (FPSE)
Greater Vancouver Board of Trade
Harrison O’Leary Lawyers LLP
Health Sciences Association
Hebert, Rick
Hershler, Dr. Cecil
Hospital Employees’ Union (HEU)
ILWU Ship & Dock Foremen Local 514
Independent Contractors & Businesses Association
Int’l Longshore & Warehouse Union, Local 500
Judith C. Lee Law Corporation
Lisa Jennings
Mechanical Contractors Association / ESC Automation Inc.
Morgan Creek Tropicals Ltd.
Morneau Shepell, Workers’ Compensation Services
Movement of United Professionals (MoveUP)
NBM Group
Office of the Ombudsperson
Paul Petrie
Profloral Express Ltd.
Progressive Contractors Association of Canada (PCA)
Randhawa Farms
Retail Council of Canada (RCC)
Sofina Foods Inc.
UNIFOR, including Locals 592, 2301 and 3000
Union of BC Performers/ACTRA
United Steelworkers (USW) District 3, Local 2009
Vancouver Regional Construction Association
Workers’ Advisers Office
GUIDELINES FOR FORMAL SUBMISSIONS

All British Columbians, including employers, employees, organizations, professionals, and Indigenous communities, were invited to make written submissions to info@wcbreview.ca before July 19 at 4:00 pm.

Written submissions in Word or PDF were requested to include:

- The name and purpose of the organization (if applicable).
- The connection to the workers’ compensation system.

Only submissions that met the following criteria were posted publicly:

1. Does not contain profanity or content that is defamatory, threatening, hateful, personally disparaging, harassing, indecent, vulgar, obscene, illegal, immoral or sexually explicit (partially masking profanity or other unacceptable language by substituting asterisks or other symbols into a word is not acceptable if the word remains recognizable);
2. Does not appear to, or actually, infringe the copyright, trade-mark, right of privacy, right of publicity or any other intellectual property or other proprietary right of any third party;
3. Does not contain information about, or images (e.g., photographs, videos or illustrations) of, any person other than the person submitting the content;
4. Does not advertise any product, person or organization, or direct attention to another website for personal gain;
5. Does not provide links to, or information about, other sites that contain unlawful, objectionable or inappropriate content;
6. Does not make unproven or unsupported accusations against individuals, groups or organizations;
7. Does not appear to be spam-like messaging, a repeat posting or a template letter writing campaign; and
8. Is not far off-topic.

All submissions were read and considered as part of the review. Please note individual or personal submissions were not posted publicly to ensure that the confidential nature of the topic is maintained.
APPENDIX 7: SUMMARY OF QUESTIONNAIRE RESPONSES

Question 69 of the survey asked, “What are your primary concerns or comments about workers’ compensation in B.C.?“ The following is a condensed summary of some randomly selected responses received from each of 6 stakeholder categories:

- General
- Health Care
- Injured Workers
- Self-Employed
- Employers
- Family or Friend of Deceased Worker
- Family or Friend of Injured Worker

[NB: All responses have been reproduced as written.]

GENERAL PUBLIC:

456 Not enough random inspections of worksites, not enough investigation to verify a worker is truthful, big corporation paperwork drowning the reality of onsite worker training

486 WCB exists to ensure works are safe on the job, and compensated when workplace injuries occur. However, it appears to be an entity with a vast surplus of funds due to the rigid and unfair policies it adheres to, at the expense of injured BCers.

846 I think the system is fair and that the public tends to hold misconceptions about how it works. I hold WorkSafeBC in high regard.

1561 Investigations should be implemented more on injured workers at the worksite, and accommodation (staying in a camp) health and wellness of employees as employers ignore the state of accommodation at the worksite.

2496 I am deeply concerned that the current workers compensation system is a box check, a legally required system but not a meaningful safety net. Workers Compensation should be a comforting protection that allows us to feel secure, but instead it just feels like a morally grey operation solely designed to protect from liability and to save as much money as possible. I fear getting injured or developing an occupational disease not because of the pain and suffering it may cause, but because of the legal and psychological pain that dealing with workers compensation may cause.

2536 It often feels like worksafe only exist for liability reasons and not as a safety net for employees. I fear dealing with the psychological and legal repercussions of workers compensation even more than the physical pain an occupational disease or physical injury would cause.

3256 The need to investigate fraudulent claims and employees that take advantage or make false claims and still are able to be compensated from WCB

3671 Many employers are not knowledgeable about the Workers Compensation Act and the obligations employers have to employees. Even those who might be knowledgeable have little regard for the Act, or employees. This is especially true in retail, restaurant, fast food, cleaners, most small, non-unionized industries.
The Workers Compensation Board is far too willing to bend to employers needs. Exemptions are often given out and past BC governments have defunded WCB to the point of failure. WCB could start bringing back workplace protections for late night workers instead of supporting a set of rules that only protect money and merchandise.

1. Limit Excessive overtime, it is cheaper to work more hours then higher more workers or overtime has no benefits associated to wage. There is an increase in mental health problems and no rest is a factor.
2. Provide history behind WorkSafeBC rules to provide context, for work safe officers and public (training)
3. Stricter rules with Multi employer worksites, to protect both parties.

The first question here about my connection to the topic is too presumptuous. I am interested in this because I or someone I love might need assistance one day. My concern is that help will be there and easy to access if I need it. That what I pay in on is accessible to anyone in BC with legitimate need.

It’s 100% arbitrary Workers Compensation in BC unlike many other jurisdictions are the judge, jury and executioner!

I believe the additional changes ongoing to further accept claims with less and less supportive evidence-proof of employer responsibility is getting out of hand. Yes employers are responsible for the safety of all their employees in the course of their employment/on employer grounds, but like all things these days we are going too far 'left'. We are no longer taught personal responsibility, self-awareness or general common sense, now everything is someone else’s fault - most especially if we can benefit from the occurrence.

Needs to be clear about who should contact, when to contact, why to contact. Prompt response times. Ability to have an advocate assist if needed.

I would say that BC workers Compensation has always followed a reactive than proactive attitude when it comes to concerns and benefits of working employees. This is merely financial or you would be of the opposite mind. The saying goes in All insurance place "its cheeper if your dead than if you alive". Safety should be first in all aspects, if you job entails possible conflict or violence, more should be done to protect and cover for mental stress.

As a bus driver to find out violence is just part of our job is ridiculous. Every work in this province should not have to put up with violence.

The burden of proving the injury occurred at work lays on the worker. If a claim is rejected by WCB medical billing should automatically get paid by MSP rather than going back to the worker to pay. Injury generally is difficult to prove. WCB has stated that pain is not an injury and pain by itself is no reason not to go back to work.

Violence should not be considered "normal" for a bus driver.

That the adjudicators have way to much control, they should not be able to over ride Doctors. Work safe should be protecting workers not causing them to be bankrupt because they were injured at work.

The denial of an injury claim for bus drivers after assault. There should be a claim for bodily injury as well as mental injury. Assault should not be considered a part of any job no matter what the position.
They should really believe the person's primary care physician.

I am concerned about workers who experience violence at the hands of the public. I am concerned about workers who experience PTSD. I am concerned about workers who experience harassment and sexual harassment at work, which is more common for women, people of colour, people with disabilities, and people who are LGBTIAQ2+

When the workers are hurt, they should be fairly compensated for it.
HEALTH CARE PROVIDERS:

1401 I am in a position where I observe the interaction of injured workers by Worksafe health care providers. Medical decisions are being made without first speaking with the worker. The opinion of family members & the physician are dismissed. GRTWs are being created without collecting the full medical background. If I behaved in this manner, I would lose my licence to practice as a provider.

1951 There is no oversight of the power imbalances between the injured worker and workers compensation. I am aware of many people who were denied compensation and it destroyed their lives. Medicating frustrated and depressed workers because they are unable to return to their former employment has been great for the drug companies and salaries of worker compensation employees but devastating to the families whose lives are affected.

5871 I have heard repeated stories about how the WCB is not client centered, client's symptoms of anxiety and stress often worsen when dealing with WCB instead of improving, clients express that the process of dealing with WCB can "be a full time job" with very little help and understanding on WCB's end. Client's feel as though it is them "versus WCB" when trying to receive compensation for a claim. Two separate clients expressed wishes that they had gone to a lawyer before submitting a WCB claim and state that they "felt duped by employers who are just covering their own interests." I have heard positive results from the Brain injury rehab program however.

6951 I think the staff need a better understanding of trauma-informed care. I've had claims denied because they did not understand the impact of a traumatic incident at work or why there was a delay in submitting a claim - sometimes trauma is minimized at first or it takes a while for the symptoms to develop. They are more accepting of physical injury claims and need to learn more about psychological injuries.

10141 Having medical proof of injury thru diagnostics being blatantly ignored by WCB. And not believing medical opinion or facts.

12506 Assessments of injured workers are often only from paper reviews or one assessment. Patients have never had freedom of access to the services most appropriate for them and I have experienced several times that patients are denied alternative care, or are told they are fit to return to work without an independent assessment. Workers compensation limits care and patients have no legal representation to dispute their decisions.

13616 It seems that for certain diagnosis, some patients are approved and some are not. If I write a specific letter as to why I think a worker should be covered by WCB, with detailed medical information about the work and the disease, it doesn't seem to make a difference or be considered. It causes me frustration because although these cases are rare, they do happen, and I think my specialist medical opinion should matter. Also, there seem to be delays in approval for surgery, which pushes me outside the 40 day window, and then WCB refuses to pay the uplift. So I have to bring patients in for followup that is unnecessary just to show that the surgery was done within 40 days of my last interaction with the patient. Lastly, patient often travel to see me. Some of them are more than 6 hours away. WCB does not allow telephone followup which is unfortunate.

13716 For physicians, payment delays and refusals. This doesn’t make the physicians want to work with WSBC For patients, the too frequent change in their caseworker. This has improved but for complicated cases this is detrimental. Staff help and attitude has improved over the years.
I have had several patients with repetitive strain injuries who are disregarded by WSBC. They require long periods of time off which is financially crippling. I realize it is difficult to determine the actual injured from the charlotans but it has been frustrating for my patients.

Need more communication between physicians and the medical advisors, will improve community physician education on WCBC medical resources etc. Recommend having a “WCB Race Line”

I am a Physiatrist. My primary concerns revolve around the lack of training of case workers. The lack of case summaries from case workers for patient whom are referred to me; the lack of interaction with case workers in complex cases that need series visits to clarify the diagnosis and treatment plan, the lack of responsibility that the case workers take for their decisions and their general ignorance of my recommendations while trying to accelerate the return to work process. I have never had a case worker ask for my advise, call me regarding a case or re-visit a case with me.

I spent over 20 years in BC treating injured workers with MSK problems (the 10 years before in another province). Overall I was not pleased with the change from the MRP to the MARP as I felt we went from a treatment model to more of a medicolegal model. Also as the programs became more multi-discipline the physician became the least consulted member of the team. Also the change from an injured workers’ claim being handled in their community to one of the case manager being assigned an industry may have been good for the employer but I don’t believe it helped the worker. We got away from local solutions to dealing with a CM in the lower mainland, etc. and this did not help. There were no accommodations for the North. Workers travelled long distances over winter roads for 1 assessment; with some warning the worker could have been accommodated with more appointments. I would say 75% of the case managers and medical advisors were easy to work with.

As a FFS Emergency Physician I find little direction as to who needs a form filled out and who doesn’t. I also find there is no direction regarding needlestick injuries and extra forms and whether these are worksafe or not. There should be a transparent way for us to real time check to see if an initial Form was already filled out as there is no need to duplicate work. If the claim is rejected it should be automatically switched to MSP and no need for resubmission on our part. Would like to see a greener option instead of these letters re denied or accepted claims. Surely an email could be sent out regarding claims instead of paper.

The amount of paper/computer work, charting, submitting claims. Getting reasonable payment for the time required as a family physician and walk-in physician. And having my payment claims either rejected or held because employers are disputing or not completely their requirements. And having patients tell me that their employer has told them that they are not to say their injury occurred at work. Workers injury’s are often very complex to treat comprehensively. The time required to see WCB claimants is very onerous.

I have communicated my concerns about medical decision making. The board will often seek a second opinion about a treatment decision I have made with a full history and physical having been performed, and in the area of my subspeciality training. I am in full active practice, operate 2-3 times per week and teach. I am on trauma call. The board will hire a retired surgeon with no subspeciality training to review the chart (no history and physical) and override my decision. This is a real disservice to patients. In a recent case my decision was over ruled. The patient eventually underwent MSP funded surgery through a regular 6 month wait, and after being off work for over a year returned to work 3 months after surgery. A similar case occurred in 1998 -
with a patient waiting 3 years off work - they were denied surgery by the boards expert who did not do a history and physical - the patient returned to work 2 months after surgery. if the board reviews a case it should be done by an equivalently trained specialist in active practice with a history and physical - then the review would have credibility. Without it it is not relevant.
INJURED WORKERS

There is no way to challenge your appeal tribunal decisions if you believe they were made in error. WCB is their own entity and makes their own rules. They can’t be challenged by anyone outside. That needs to change. They need to be accountable to decisions that they make. These are real peoples lives that they’re affecting. Long term, legitimate claims need to have more consideration. Personally the amount of a pension I get I can’t survive on, it wouldn’t even pay rent anywhere, much less food or living expenses. There was a decision made to cut me off benefits because I couldn’t work (even dr said I wasn’t ready or able) when they forced me back that made me hire a lawyer. He got me enough money to pay for him and reinstated my benefit payments. Another decision came after that and I didn’t receive it for a couple years, then when I tried to appeal it they said it was mailed (I never got it) and it was my fault for not appealing on time and denied. This appeal would have gotten me more money on my pension to actually live on. “more consideration for long term claims” “Dont just deny everything and cut off payments” “be accountable outside of wcb for decisions”.

Being injured again by the system Delayed treatment, services and compensation Not listening to the professional medical personnel that WorkSafeBC request and having doctors that have never met me make decisions based on case manager opinions

Because of my personal three year ordeal with worksafe my son who was seriously injured at work will not file or fight a declined claim. Now at 21 he has no help and without back surgery he will be hurting physically and financially his whole life. He watched me fight, be constantly bullied and eventually win my case through tribunal hearing. This process took too much financially physically and mentally out of my family and he is not willing for us to go through that all over again and I don’t blame him because even after winning my hearing work safe is still dragging their heels. I am emotionally financially and physically exhausted!

Lack of understanding my illness, unwilling to be reasonable, unprofessional ism, lack of resources available to me once application was submitted.

That Worksafe BC protects the employer and not the employee. It acts like a typical insurance agency and denies, denies, denies. It has processes and language on paper, however when it comes time to implement these rules, no one bothers until it’s too late.

I must first of all state that I am truly thankful for my pension. I desperately hope the pension benefits will become lifetime benefits. My disability doesn’t get better at 65. I’m also hoping that the pay rate will go back to 90% of gross earnings. I’m barely making it on 75% of net. The anxiety I feel over the ending of my pension and day to day finances has caused problems.

WCB should be really supporting clients who are injured. Injury is not something any of us want. Having to lose your ability to support our families is the hardest thing, and can lead to suicide, depression and loss of self worth.

It is a broken system linked to our equally broken medical system! I understand that WCB as been abused by many, but a better filtration system would allow those in real need of help to get the help they deserve. A badly injured worker like myself with a brain injury shouldn’t have to worry about how to pay his/her mortgage. Furthermore a known brain injury should trigger help with paper work and application process. I feel that WCB took advantage of my lack of brain function to fast track me and now make me appeal their decision.
Their are so many hoops to jump through to prove you have a valid serious injury that has changed your lifestyle and capability to function without pain. The person is treated as if they have the plague and not a valued worker with issues and concerns. WCB should be there to accommodate the workers and not to try and disapprove claims for the benefit of the employer. There is no consistency as to why some people are turned down and others seem to be able to use the system to their benefit. Overall it is unfortunately that workers often don't file a claim as it is too overwhelming and demeaning.

It entails a lot of requirements which include documentation. Since my injury is psychological so it is difficult to prove or document and they would not accept GP doctor certification. I will take a year or so before your case will move.

That the process takes far too long to be of any use. I was injured in Dec 2018 and my claim was only accepted in 2019 April when I had been back at work for months already.

When my claim was finally accepted, the treatment recommended was punitive. I was physically and mentally incapable of attending a physical rehabilitation program away from home. The program was a generic program for anybody on a WCB claim, not specialized for brain injuries. When my GP vetoed my attendance, I was threatened that my claim could be cancelled. Eventually, we found a local alternative. It still felt like punishment. I was declining physically and could not continue the rehabilitation: at that point I was given an ultimatum, continue rehabilitation against my GPs advice, return to work or retire. Essentially, I was forced to retire in order to maintain some type of reduced income. The WCB process seemed punitive and not in my best health interests. The stress the process caused has negatively impacted my recovery.

It was suggested by my physiotherapist and doctor that I continue to do physiotherapy and the request for further coverage for this was denied so I had to pay out of my pocket for my additional sessions.

It's set up and adjudicated to decline all claims as much as possible, even when it's clear to the employer that it was work caused and should qualify.

Too many false claims are allowed yet honest people are penalized

Even family physicians do not accept patients with a WorkSafeBC claim. They do not like to deal with them. I did try to get a doctor while my went on maternity leave. No doctor was taking a WorkSafeBC claim. I have been treated so unfairly by WorkSafeBC. Nonsense combining of medical opinions always in their favor to deny the claim, falsely twisting words to make the decision in their favor. The entire system is such a waste of time. A WCAT decision takes over 3 years to implement after calling WorkSafeBC on regular basis. A serious change needs to make this body for effective.

Medical advisor and return to work nurses are a “joke”. I was send to a specialist chosen by WCB. He made a diagnosis and linked my condition directly to my work. The WCB medical advisor, in his wisdom said my chest wall repetitive strain as diagnosed by a specialist was likely caused by hiking (!!??). While interviewing me, The return to work nurse, spent most of the interview time blaming me for my injury, trying to imply that I am deliberately injuring myself. This is despite the fact that I had tried to keep working with my injury for several months.

They wanted to send me straight back to work against my doctors recommendation. I reinjured my shoulder and ended up being out of commission longer then I would have been had they not forced me.
The fact that it took 8 weeks from assault to claim acceptance. I was already in counselling immediately after the assault but got caught up in the work counselor vs worksafe counselor. Had I waited 10 weeks to see the worksafe counsellor I would have NEVER recovered to the point I have. Then, once I felt I was failing my return to work and reached out for help, I waited another 10 weeks to hear if I could get back into worksafe counselling. Meanwhile-I quit my job, took another, took a pay cut, altered my work hours, etc. This has been a horrific experience while being in such a vulnerable state.

I imagine case managers are loaded down with claims but I feel that a head injury should go down a different path than the general return to work let's get this guy going. Claims managers should be people experienced with head injuries to deal with head injuries.

Process is difficult to navigate, especially when it’s your first time dealing with an injury. I felt penalized because I didn’t know to do certain things and when to do them. The system is very geared towards cut-and-dry incident type injuries, so for anything that doesn’t fit into that box is much harder to claim support for.

I do not believe they help the people who are truly disabled. because when you are in a great deal of pain you do not make good decisions nor do you answer questions well because your pain is extreme. the people who are not hurt as bad are able to think clearly and answer correctly when required to do so.

The fact they treat paramedics different than other first responders. Please look at the facts of how many fire fighters, police officers and paramedics even if all on the same call, the paramedics are denied a worksafe injury. It is tragic and costing lives.

After 20 years of being a front line worker and care aide, I have been hit punched kicked spit on, roughed up and psychologically abused many times, this has all played a part in the situation I am in now, to have worked so hard to remove the stigma attached to mental health issues, i am appalled that i have to fight to get services and to get help. I want to be back to work but i also want to be back to work safely. Not a shell of the person i once was.

Workers who have been affected by PTSD and/or mental health related situations are not treated the same or viewed as important as those who have been physically injured. Having worked related PTSD made it difficult to live a normal life for many months and I was not compensated for this by WCB and treated unfairly by them.

I lost so much of my life and my potential to earn and thrive. The maximum income compensation thresholds and wage loss was barely enough to allow my family and I to hold our lives together while I stumbled through a chaotic rehabilitation where I was too injured to advocate for myself and my family within wcb. Anyone with a head injury should automatically be assigned a 3rd party liaison from the claims review division to help them access medical personal, treatment, navigate the wcb forms and evaluations processes.

My primary concerns are basic respect as a human being. A second check of case workers to make sure the claim was categorized correctly; quality control of human error follow ups. In conjunction, after being referred to the disability awards area, again no follow up with the worker, no site visit to determine fair amount of compensation after a life changing injury. I will now have to continue with this ongoing issue again in addition to daily pain, wrecked home life, added stresses. I just want to be done with it, and I think that is what mainly is wanted from the other side is individuals giving up. Not me, not today.
NEW DIRECTIONS:
WCB Review 2019

10116 We need a complete overhaul of the whole system, I believe we need to get rid of all the administrators and start fresh with people that are there for the workers. At present it is not there to protect the workers they are only concerned about protecting their money.

11066 There was little follow up. I was encouraged to push through head pain and delayed cognitive process, told it wouldn’t cause more brain injury. It definitely delayed my healing and increased anxiety.

11886 During the period of acceptance, my case manager was just beyond amazing. I couldn’t have asked for a better worker and team behind me. BUT it just takes way too long.

12326 Education on how the system works. Professional and educational support for the workers and financial security as we don’t know how long it takes for our claims to be accepted or when we are able to go back to work and will we be able to return to full duties. Can I pay my bills? When is the money expected? Will I be penalized for being off? What if I am still hurting after my grtw is finished?

12591 That I might commit suicide as my life sucks now. I lost my job as a tradesman now work part time at a refuse station. I don’t like to use the word hatred but it is the only word I can think of to use to describe how I feel about the WCB.

13976 The workplace health call centre. The hours are so MASSIVELY limiting. Having "bankers hours" for a system that is 24/7 is pretty ridiculous. Make it at least 7 days a week and from 0700-2000. That would cover anyone coming off nights at 0700 and also those working a 0700-1900 dayshift. The vast majority of nurses work extended 12-hour shifts, so the current hours and working massively understaffed each and every shift make it very hard to report. This is a system to report issues to try and improve the safety for all, yet the available hours are so far below what is needed. Please address this.

14731 my concerns don’t relate to my claim I am concerned that youth who are injured or at risk of injury at work have no idea about worksafe and their rights. Many adults are also unaware. More public and workplace based education is needed.

15926 If you want injured workers to recover, return to work and be self sufficient, then offer adequate treatment, training and financial compensation. And if a worker acquires a permanent disability as a result of a work related injury, then compensate workers with a life time pension, like Federal govt employees receive. Why should WCB be allowed to treat injured workers differently. In 2002 - 2003, the Liberal govt made changes to the WCB act aimed at reducing costs of BC’s WCB system; unfortunately, the costs were being reduced on the backs of injured workers! Money over injured workers pain and suffering!! If I could sue my employer I would to compensate for a life time of pain and suffering and inadequate financial compensation. I was totally self sufficient and earning a good income up until my work related injury; now, it's all I can do to get through my day. If that isn't enough hardship, my employer insurance benefits have been denied and I have to "prove" I'm unable to return to work; causing more frustration, stress and financial hardship. Clean up your act WCB and treat injured workers with care, compassion, fairness; and, if necessary, a life time disability pension. WCB owes a duty of "good faith" to workers and their families.

16741 I honestly wish that I never had to experience dealing with wcb ever!!! It has been the toughest and most depressing time in my life!!!
SELF-EMPLOYED:

331 The regulatory environment without accountability specifically for workers. As an employer you may direct an employee to do something required, they choose not to and the only recourse is verbal warning, written warning, punitive values and release. The problem is that there are few workers out there so much of the option is toothless. An officer should be able to directly write a ticket to a non compliant worker not just access the employer.

826 They are a pain. We are going to discontinue having coverage, as our accountant told us that it's optional. WCB did not present things that way, and we have been paying into it for so many years when we didn't have to.

7391 That the rules are getting very difficult to reasonably follow. I would have employees, but find myself unwilling to submit to the insurance companies policies. I would love to see more onus on the individual to decide there level of comfort with risks associated with the job. It is far to easy for work safe to keep adding more and more safety regulations without any "checks and balances."

11011 Want to be sure that Workers Compensation acts as an independent broker between employer and employee and treats both in a fair manner. I recommend Workers Compensation be more proactive in monitoring those people that are scamming the system. Also concerned about the frivolous mental anguish claims that seem to be more supported by government agencies. An example would be a claim made for time off or compensation from someone who lost their fiance (wife or girlfriend) and claims they are suffering mental anguish because of it and the employer has to pay out of his pocket or provide time off for that person. Workers Compensation should be used for people that are legitimately hurt on the job and be a fair deal for both employers and employees not a free ride for some that are always thinking of ways to use the system for their own benefits.

12651 Work safe is hording "OUR" money. Paying too much for nothing in return. Lining the pockets of the white color office chair hallway racers is not what this money is for. It is for the employers and employees. 153%...too insane

17756 Weird, sick, twisted rules at odds with Canadian common law, highly subjective assessments by self-apptd experts, who are free to ignore substantive evidence and simply prefer one expert over another just cuz. Ludicrous judgments and protracted litigation for the wealthy who can afford lawyers.
EMPLOYERS:

306 That it is currently well over funded and that there will be a lot of regulatory burden put on employers. I’m also concerned that there will be the erosion of any accountability on the employee to ensure they are following safe practices and that all of the safety will fall completely to the owners. Safety has to be a two way street and both parties need to understand the importance of maintaining safety.

676 Wcb should continue to work closely with on site supervisors to insure they are better educated. We see way to many accidents on other projects, where supervisors are sending workers into harms way.

701 The staff at WSBC have been very helpful in getting me the information I need.

2626 As an occupational therapist and employer I have for many years been concerned about the conflict of interest between insurance (wanting employee to be back to work as soon as possible to save money) and the actual process for each individual client to promote successful return. The plans are often prescriptive. There have been some improvements in understanding mental health but mostly the focus is on physical injury. There is little evidence of a clear foundational knowledge regarding how to support employees with mental illness/psychological trauma in return to work. When the brain is impacted by mental illness or acquired brain injury, the processes often do not meet clients/employers needs for success.

3036 Claims management can be inconsistent when it comes to injured workers. We have two cases where we have been trying to have the workers return on Modified duties and have gone through multiple case managers on each case.

4016 Need more representation, advice and services to employees. Always have a hard time having staff understand OHS and WSBC, or no motivation at all to learn the legislation. WSBC always says they are available, but when requested they do not have the time to pay a visit for advice, guidance, etc.

4626 Over the past couple of years we have noticed a shift in claims adjudication to be more worker centric. We have noticed more claims accepted with a lack of objective medical information supporting disability and/or lack of evidence of work causation.

5741 Pros: interested in prevention and education good training resources try to be balanced between employer and worker Cons: bureaucracy & silos rate increases rigidity highly politicized organization esp. between labour and management

6916 I am concerned with the ability to speak to case managers regarding specific claims for specific employees. It is always a challenge to get a hold of a case manager, constantly playing telephone tag. This makes it very frustrating especially when trying to facilitate a RTW plan.

7861 Our primary concern is when employees return to work on a RTW program and do not follow the recommendations, we provide verbal warnings to them and they still do not follow the recommendations and then proceed with written warnings for not following the RTW program and then the workers going on further disability leave. Not sure what else we can do to ensure they follow the program.

7891 The return to work or modified duties feels rushed. Sometimes the best thing for an injured worker is to stay home and recover. Asking an employee who is active and works outside to
return to a modified duty inside job creates frustration and can impede healing. Then when an employer doesn't have the worker return to modified duties the employer is 'punished' through an increase in premiums. Although WSBC believes that all injuries and accidents are preventable, some are not; especially when working outdoors. I believe that for the most part employers and employees do their best to prevent injuries.

8016 Workers claims of injury are fully accepted by WCB even before a proper medical assessment has been undertaken. This leaves the system open to fraud. It has occurred in the past, that a worker will claim injury at the end of a busy season, knowing that shorter hours, less shifts, or even layoffs are possible in the near future. Secondly, injuries sustained outside of work can be claimed as work related. For instance, heaving lifting on the weekend will result in a sore back, which is then claimed as a work injury. When challenging the acceptance of a claim for either of the above reasons, WCB has, in our experience, always ruled in favor of the worker and accepted the claim without question.

8086 Evidently there is an unnecessary surplus as a result of collecting more premiums that is required over-and-above a fund for fluctuations. Return the excess to employers as this is our money that you do not need to administer WorkSafe BC.

The online platform is excellent. I love how I can manage our WorkSafe BC account simply and quickly. Bravo for it's design. It literally makes tasks like reporting and paying premiums a 10-minute job.

8306 Doctors giving a blanket 'off work' for several weeks, without follow up. I feel that Dr's think this is what the employee wants, to be off work. The employee can return in another capacity, until the injury is healed.

11446 More expertise on the education side of things when it comes to the education sector. Lots going on and nobody seems to have a real understanding of it. Too much comparing to construction.

11951 It is expensive and we are penalized for very little use of it. We did not feel involved with some of the claims and we had no say in what we thought the cause of the injury was. The employer's voice is often ignored or drowned out.

11956 I don't like that the BC government controls insurance like this in any way. I dont believe that they should be making the revenue off of the employers or injured workers. Although I agree that employers need to have the insurance it should be more fiscally responsible to both employers and employees, with the possibility of employees contributing to the funding as well especially if they choose to work in higher risk industries.

12006 We spend massive amounts of time and money ensuring our crew are properly trained, (with written documentation), in safe-work procedures, but when a worker chooses not to follow their training and injures themselves, we the employer we are penalized. The Act should be modified to allow employers who can provide evidence of proper & ongoing training that demonstrates that the worker failed to adhere to their signed training agreement, and exemption to increases in their claim rated scale. Otherwise, there is no consequence to a worker who chooses to take risks that we as an employer and the Act don't allow.

12056 Largest complaint is the WSBC accepting of a claim. Claims have been accepted without proof of mechanism of injury and WCB does very little to investigate potentially fraudulent claims. The best an employer can hope for when a claim is made (fraudulent or otherwise) is cost relief after 10 weeks. This places the entire fiscal burden, of all forms of claims, directly on the employer.
regardless of the validity of the claim. A claim should not be accepted before mechanism of injury is investigated beyond dispute and Dr clinical notes support the claim.

12171 The current system is a totally employee based system with no account or regard for the employer or the business, fines penalties no education or working with the employers. I feel like we are the looked as as enemy not someone providing a safe work environment and a job for our employees.

12276 That smaller employers are reasonably able to provide services without being overburdened by regulation.

12386 Communication has been horrible. We have had claims that sit for months without any follow up from wcb and the workers have not complied with doctors orders or reporting to wcb or the employer. As the employer, we are having to chase down the wcb rep for answers and information about worker claims. The amount of money that is wasted by paying for claims that should never have lasted as long as they did is a concern. We had an employee that was off and paid by wcb for 2 months and yet had never attended one doctors appointment or physical therapy appointment. No one was following up on her case so she just kept getting paid and not being held accountable to return to work. we have offered return to work for several claims and we don't get any cooperation from wcb, employees, or doctors. This system is terrible.

12396 WCB was made mandatory many years ago with the PROMISE that it was for the employer's protection against lawsuits and prolonged entanglements with legal claims. This as apparently has been forgotten. Many stories exist on how employees have 'milked' the system and stayed on payment long past their injuries. While employers need to be ethical and responsible, so do the employees AND the government. Large accumulations should be reviewed. Some monies could be set aside for future needs, investment in programs to enable people to return to useful employment. The rest should be a strong signal for a call to review fee structures to reduce the overages.

12741 I believe the system is flawed in that there are no fines or responsibility put on the workers for safety violation as is done in Ontario and Alberta. I believe holding workers more accountable for their actions or lack of compliance with regulation would improve compliance as they too would have some skin in the game. As it stands right now the board treat workers as irresponsible children who are not held accountable for their actions or lack there of. We are a COR certified company with a robust safety program, we provide high level of training to our employees, proper supervision, countless dollars on safety equipment and systems, yet if an employee is found to be not in compliance the problem still comes back to us, regardless if the employees demonstrates understanding of the regulation, their responsibilities, and training. The system is frankly a joke. It's akin to getting a speeding ticket, and being able to fight it by saying I didn't understand the speed limit sign, the province should be able to prove that they trained me adequately on the speed limits and that I understood them. I am certainly not shirking a firms responsibility to provide all the components of an effective safety program, and where lacking they should be held to account, but when all reasonable measures have been taken and met by the firm and the worker still disregards the regulation there should be a sanctioned penalty to the worker. This simple step would greatly improve compliance, as proven in other jurisdictions.

14741 The communication between medical staff, employer, and WSBC is poor with decisions being made without the proper information.

14846 Streamlining communication as there seems to be a disconnect. Case load managers change frequently and being in contact with several different individuals while handling a case causes a
high frequency of repetition and frustration. We enjoy the online format as it is easy to track progress but also appreciate direct contact with case managers.

17706  There is no consistency with case managers. Recently one worker was bounced to three case manager in one day. Complex claims require a consistent case manager. Dedicated case managers to large organizations.

17716  Communication it's a big obstacle for most of the foreign workers that comes to canada through the Temporary Foreign Program. When the worker calls to workers compensation office to confirm the injury report, communication It's often difficult because there are no available translators. We will highly recommend to have translation available or better translation system when dealing with foreign workers.
FAMILY OR FRIEND OF DECEASED WORKERS:

WorkSafeBC management completely failed WorkSafeBC management did everything they could to avoid incriminating Kiewit for the cause of Sam’s death. The initial investigation produced strong clear language, and the resulting fine was probably the best they could do at the time. The appeal process is obviously meant to deter or grind down any family members that might want to fight an appeal. The WCAT decision looked to me like “the fix was in” They completely turned away from the affidavit provided by a professional with intimate knowledge of the job, and relied 100% on the testimony of the excavator operator. This operator had all the reasons in the world to distort or lie in his statement, but nobody ever questioned his story. This operator was in fact involved in accidents on that jobsite, including the incident of Feb 21, the day before Sam died. As well, he was involved in a blasting accident about one month before Sam’s death. Yet, the WCAT decision hung on his testimony. It’s not possible to disregard ALL of the Louvos affidavit. Some.. maybe” but certainly not all. When the balance of probabilities is mentioned…it escapes me how the WCAT lawyers could completely turn away from the great likelihood that two large excavators working in loose blast rock were the most likely cause of Sam’s death. This result in the WCAT decision makes it look like the appeal was destined to always go along with the wishes of management. It makes it look like someone told those on the tribunal what the results needed to be. Note, where WorkSafeBC management and the WCAT lawyers worked to reduce guilt in killing the RCMP and prosecutor’s office found grounds to bring criminal charges. That’s two very, very different outcomes. At the moment, WorkSafeBC and the WCAT system is designed to immunize big business from prosecution, plain and simple. WorkSafeBC would have never got a fair shake if his friends and didn’t blow by all the barriers placed in front of them by the WorkSafeBC bureaucracy.

WSBC claims managers are not trauma informed.

I feel that the employees of WCB are overbearing, rude and condescending on the phone, they do not have the clients best interests at heart. I feel that all the employees who deal with clients should go through better education on how to communicate, and to realize that each client is different. They have to realize that these people are injured their lives have been turned upside down and they are looking for support, not to be talked down to. WCB cuts people off their compensation with no notice clients have worked all their lives and have paid into WCB, the employees who deal with clients act like it’s their money they are giving, but actually the clients are paying for the WCB employees wages.

WCB protects air taxi operators. A lawyer letter representing WCB did state in a letter that even if it was proven that the operator’s negligent maintenance caused the crash, he/she cannot be sued. WCB protects the air taxi operator and allow him to neglect repairs even knowing the aircraft is unfit for flight, is unsafe to fly and knows that Transport Canada inspectors are too busy to inspect his aircraft often enough to insure safety. The operator can deliberately and intentionally sabotage old worthless aircraft knowing it will crash and kill as many as 10 person and he will suffer no consequences. WCB protect him. That is a violation of the Canadian Charter of Rights section 15 of all the killed. When the pilot dies and he is single, his surviving family is “awarded” a pitiful $7,500. How unjust, despicable and criminal is that? That does not cover his funeral. An air taxi pilot has the most dangerous job and for his surviving family to be rewarded by a pittance is an insult. The pilot treated like dirt which is the ultimate insult. WCB, the BC government, the Canadian legislation that allow WCB to exist is inhumane. Air taxi pilots should be insured by WCB to a minimum of 5 million dollars after death while on the job. WCB does not immediately come forth and willing give compensation. WCB wait until the decedents survivors come begging. WCB has no useful purpose and most does not belong in the hair tax
sector. WCB lie when they state they instigate all accidents that have fatalities. WCB state that after an air taxi crashes TSB investigate for them because TSB are the experts in that field. TSB are as good at lying as WCB. TSB state they investigate all accidents but in other documents state they pick and choose which accidents they investigate. Many air taxi accidents are not investigated by WCB or TSB and that violates ICAO, ISASI, human rights may rules of law et al.
FAMILY OR FRIEND OF INJURED WORKERS:

1476 1) WCB suggests in literature and media to the general public that it is a government agency working primarily on behalf of injured workers. In reality it is a government agency working primarily to protect employers against injury claims filed by workers. This is grossly misleading the public.

2) I have direct experience filing and managing a WCB claim on behalf of an injured worker through to a successful appeals process and decision where the employee clearly was justified, the employer clearly breached WCB legislation and regulation and was denied acceptance of the claim until considered at appeal. This was a four year process where if the employee had to pay legal fees the claim would have dropped due to inability to fund the appeal process. WCB drags out its decisions and appeals process even when it knows the injury clearly is a compensable injury, hoping, it appears, to out-fund the injured employee.

3) It is difficult for the average worker to navigate the claims process, or to argue with WCB lawyers. The WCB Advocate is nearly as difficult to deal with. The system needs to be made easier for the average person to access and be successful with.

1646 They make it difficult to claim for longstanding tinnitus and hearing loss. Appeals are long, difficult to follow and my husband didn't get much of a say and never got to be examined by their 'experts'.

1821 Being the spouse of an injured worker offered me the opportunity to see the difference that a wcb case worker's practices and communication can make to someone. My husband suffered a second injury and serious psychological trauma when it was determined that he suffered the trauma in an initial injury that was later triggered by a new injury. His first case worker was dismissive, unkind, mistrusting and sent him back to work so rapidly after major burns sustained at work that he was barely functional. When he sustained a different injury, it was by the grace of god and his second worker that an inquiry was conducted into the determinations of the first worker (who had since been released from Employment) and my husband received the care that he needed to heal his boat and his post traumatic stress disorder.

1866 My husband has a spinal injury. We were denied help to cover cost of another vehicle as his pre injury vehicle was standard and he couldn't drive it. Pension expires at 65, how to live on cpp and oas? More people working past 65, so why does pension end? Not able to save for retirement on worksafe pension. CPPD half deducted from pension.

2046 The handling of my dad's case. Needing to show causation, in a workplace chemical exposure. With substances that are clearly described by whmis labels to have a list of impacts. Things that are accepted in many countries, about organic solvents, not being honoured here in my dads and his coworkers example. Their injuries being bluntly denied.

2821 Worksafe should allow injured workers more time off of work to heal. I understand that people need to get back to work but they also need time to heal properly. For example, my husband injured his ankle at work. Worksafe paid him for approximately 3 or 4 days and told him to go back to work when he was barely able to walk on his ankle and was in pain. Since his ankle never healed properly, he re-injured it at work a few months later. I think Worksafe paid him for approximately for 2 or 3 days off the second time and covered physio costs for approximately 6 weeks. After a few days, my husband was told to go back to work. When he said his ankle was not ready, Worksafe said he wouldn't be paid anymore by them. So, he went back to work and his ankle has not healed properly and is sometimes very painful.
3601 I think the problem with work safe is they try to get you off there case file as soon as possible. The mentality seems to be that injured workers are trying to scam the WCB. They don't recognize that serious injuries could take life times to heal and don't offer alternative training programs for workers to get them back to school and working in a less hazardous environment. My friend broke 27 bones in his body, a year later work safe said he was good to go. That summer his injury flared up again and he had to start a new claim. This guy is going to live with this injury for the rest of his life he should be given the opportunity to contribute to society in a new meaningful way.

3956 In my experience as the common law spouse of an injured worker with a long term claim (almost 8 years). My concerns:
1. Overall treatment of workers and the lack of rehabilitation offered
2. Processes available to and those that affect the worker
3. Financial "warfare" (i.e. the roller coaster of being cut off, reinstated (or not), and repeat...)
4. The insurance company's needs and financial situation is put first before a legitimately injured worker
5. Staff biases and subjectivity get in the way of claims, rather than the focus being on, in our case, the extensive medical evidence
6. False claims, use of interpreters x6 in one classroom

6656 Process of decision making is not clear for the worker. I am saying this based on observation of a friend who has gone through 3 years of assessment and attempted rehabilitation. Throughout the process he has been unsure what is happening, why it's happening, or what will happen next. He has memory and cognitive problems now so it's possible that he's been told and simply doesn't remember -- but if people are head-injured then written information would be helpful. E.g., we will try this with you; if it's successful then this is the plan; if it's not successful, then that is the plan. It doesn't seem difficult. My friend and his wife have been in limbo for 3 years not knowing what will happen, if he will lose his job, if he will be forced onto disability or whatever.

9686 They dont help the injured worker they work against them my family member was injured at work and was not treated early enough and had prolonged injury in the end the doctor did help him but at no help from wcb. who advocates for the worker .

10231 Its very disappointing that the statistics show 50% of claims are denied. My mom was injured on the job and her claim was denied, with a ton of effort and leg work she was able to prove that her injury happened at work and the employer was not providing all the supporting documentation to prove she was injured on the job. Due to the delay and appeal process she had to apply for medical EI and on top of it all pay her own benefits to the employer. This was a financial hardship on not only her but her kids as we all tried to do what we could to help her stay above water. Her benefits alone were over $400 a month and she was only getting 55% of her income on medical EI. Workers Compensation should be there to help people get back to work not force them into debt and cause more stress and undue hardship. Workers have to right to get better from work injuries, they shouldn't be subjected to abuse and neglect which can cause more health problems in the long run and add to recovery time.

10851 Work safe is a joke. Someone I know was screwed over so badly by wcb. He lost probably over $200,000 & basically became bankrupt bc of wcb's incompetent methods for calculating wages for seasonal workers. Incompetent case workers who did not provide timely communication, service & needed items. This person suffered physically, mentally, socially & financially & was even suicidal bc of the incompetence of wcb. I would recommend to anyone to only ever go through wcb if there is absolutely no way to deal with it yourself. Wcb is completely out of touch.
with reality & does not provide a system that allows for safe reporting of workplace accidents. Employers abuse & WCB does nothing to protect workers when they do.

In my experience, all people are not treated equally with WCB claims. Benefits that you may be eligible for are not explained. My spouse was injured at work and had to ask for everything, very little information was offered to him. He had to have surgery and was nearly rejected from receiving any compensation for time off because he was misdiagnosed initially and returned to work thinking his injury was not as serious as it was. This caused problems as technically he had returned to work, if only for a few days. One of his coworkers had broken a finger and had a group of people walking around the lab with him to assess his work place. This was never offered to my spouse. His case manager rarely offered him any help. It felt very much like he just wanted him to return to work so he could close the file. He was never offered any retraining program options, we learned about that by researching ourselves.

My stepson was injured on the job besides the fact that they had to redo his surgery 5 times because the doctor didn’t do it right, every time he told he has had to have a assessment he has to take a day off work and drive from Kamloops to Kelowna. I don’t understand this.

The treatment of seriously injured workers. I have had the unfortunate experience to witness two people go through the WCB process after being injured on the job (both were the fault of the employers NOT the employees). The case workers psychologically abused both of the people I know. They provided unsafe medical advice, refused to pay them. I was witness to a phone call where the women threatened the person I know to not pay him if he didn’t stop speaking up about his concerns, I witnessed manipulation by these case workers to cut people off and the complete lack of communication in regards to the steps needed to be taken to progress the claim. From what I have witnessed it is clear that WCB is there to protect the employer from being sued for unsafe working conditions and is not there for the workers safety, which is completely unfortunate.

WSBC has evolved into a very racist and intolerant organization. It is evident in its management structure where none of the Directors/ Vice-President is from the other populations WBC represents. For example, there is no Punjabi or Cantonese speaking Director or Vice- President in the company. Current Management laughs and jokes at the mention of city of Surrey or Richmond in its meetings and conference. Such strong is the bias that workers and employers are judged guilty from their appearances. WCB should intentionally promote or hire professionals who could bring cultural sensitivities and needs to the forefront. It will greatly help reduce injuries. Couple hours of cultural trainings are not sufficient. Moreover, current Directors and VPs are strongly rooted in the mandate of previous politicians who decimated the world class structure of WCB in the last 16 years. Bring up leaders who can end WCB corrupt practices. For example:
1. Currently WCB requires no background criminal checks for its upper management positions. WCB management have officials who have criminal backgrounds and strong partisan/ political affiliations to the past.
2. WCB allows its managers/ officers in Fort St John to keep and carry personal weapons in their trucks. Folks commonly see hunted animals in the WCB trucks in the northern BC. WCB needs to come of its old mould so that it can move in the new direction.

They'll keep denying your claim or come up with in skilled tactics till you either give up drop dead or commit Suicide! NEVER GIVE UP

My mother is now 82 yrs old And is suffering with pain in injured knee till today she was injured at work Hyatt Hotel never got better after Wards no one cared but she was harassed to be back to work she had to quit
## APPENDIX 8: EXPERT CONSULTATIONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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</thead>
<tbody>
<tr>
<td>Backler, Bill</td>
<td>Retired Board Employee &amp; Worker/Employer Advocate</td>
<td></td>
</tr>
<tr>
<td>Bogyo, Terrance J.</td>
<td>Researcher, Speaker, Consultant</td>
<td></td>
</tr>
<tr>
<td>Burm, Sunny</td>
<td>Workers’ Advocate</td>
<td></td>
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<tr>
<td>Chalke, Jay</td>
<td>Ombudsperson</td>
<td>Office of the Ombudsperson</td>
</tr>
<tr>
<td>Clarke, Bruce</td>
<td>Executive Director of Investigations</td>
<td>Office of the Ombudsperson</td>
</tr>
<tr>
<td>Claufton, Cathy</td>
<td>Director, Medical Panels Office</td>
<td>Alberta Review Team – (WCB Alberta)</td>
</tr>
<tr>
<td>Corwin, Lucas (and various Workers’ Advisers)</td>
<td>Executive Director</td>
<td>Workers’ Advisers Office</td>
</tr>
<tr>
<td>Entitlement Officers and RTW Nurse Advisers, Case managers and Vocational Rehabilitation Consultants</td>
<td></td>
<td>Compensation Employees’ Union</td>
</tr>
<tr>
<td>Gallant, Jacqueline</td>
<td>Workers’ Advocate</td>
<td></td>
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<tr>
<td>Gravelle, Joyce</td>
<td>Vice President Administration</td>
<td>PCU-WHS</td>
</tr>
<tr>
<td>Harink, Jorgen</td>
<td>Regional Analyst</td>
<td>Doctors of BC</td>
</tr>
<tr>
<td>Henry, Pauline</td>
<td>Consultant</td>
<td></td>
</tr>
<tr>
<td>Hulyk, Rob</td>
<td>Director of Physician Advocacy</td>
<td>Doctors of BC</td>
</tr>
<tr>
<td>Jackson, Alex</td>
<td>Vocational Rehabilitation Consultant</td>
<td>Private Sector, Vocational Rehabilitation</td>
</tr>
<tr>
<td>Koehoorn, Mieke</td>
<td>Professor</td>
<td>Partnership for Work, Health &amp; Safety, University of BC School of Population and Public Health</td>
</tr>
<tr>
<td>Kumar, Hemant</td>
<td>President and Principal Consultant</td>
<td>Alberta Review Team – (Engage First)</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Organization</td>
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<tr>
<td>Mantis, Steve</td>
<td>Advocate</td>
<td>Ontario Network of Injured Workers’ Group</td>
</tr>
<tr>
<td>McCleod, Chris</td>
<td>Associate Professor</td>
<td>Partnership for Work, Health &amp; Safety, University of BC School of Population and Public Health</td>
</tr>
<tr>
<td>Monahan, Lindy</td>
<td>Former Board Safety Officer</td>
<td></td>
</tr>
<tr>
<td>Pawluk, Lorna</td>
<td>QC &amp; Consultant</td>
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<tr>
<td>Petrie, Paul</td>
<td>Consultant</td>
<td></td>
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<tr>
<td>Picotte, Adam</td>
<td>Barrister &amp; Solicitor</td>
<td>Health Sciences Association of BC (HSA)</td>
</tr>
<tr>
<td>Ralph, Corey</td>
<td>MBA Senior Business Analyst</td>
<td>Alberta Review Team – (Workforce Development)</td>
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<tr>
<td>Rogers, David</td>
<td>Vocational Rehabilitation Consultant</td>
<td>Private Sector, Vocational Rehabilitation</td>
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<tr>
<td>Salmon, Mary-Jaye</td>
<td>Former Board Safety Officer</td>
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<tr>
<td>Stoehr, Claudia</td>
<td>Legal Advocate</td>
<td>Farm Workers Program - Abbotsford Community Services</td>
</tr>
<tr>
<td>Takaro, Dr. Tim</td>
<td>Professor, Associate Dean, Research, Health Sciences</td>
<td>Simon Fraser University Medical Evidence, Alternate Systems</td>
</tr>
<tr>
<td>Various Employers’ Advisers</td>
<td></td>
<td>Employers’ Advisers Office</td>
</tr>
<tr>
<td>Weiss, Dr. Eliot</td>
<td>Specialist, Physical Medicine &amp; Rehabilitation</td>
<td>Doctors of BC</td>
</tr>
<tr>
<td>Wilson, Trevor Glynn</td>
<td>General Physician</td>
<td>Doctors of BC</td>
</tr>
<tr>
<td>Yassi, Dr. Annalee</td>
<td>Professor, School of Population and Public Health, Tier 1 Canada Research Chair</td>
<td>University of BC</td>
</tr>
<tr>
<td>Zimmerman, Wolfgang</td>
<td>President</td>
<td>Pacific Coast University for Workplace Health Sciences PCU-WHS)</td>
</tr>
</tbody>
</table>
The Historical Context

My terms of reference direct me to assess whether the current Board benefit levels fully reflect the financial losses suffered by injured workers. To some degree Board benefit levels are determined by the provisions in the legislation and legislative considerations are not before me in this policy review. It is important to consider the degree to which the current adjudication of claims restores the financial losses suffered by injured workers in the historical context to provide some perspective on this issue.
The Historic Compromise which is the foundation of the workers’ compensation system is based on a balance between worker and employer interests. Workers gave up their rights to sue negligent employers in exchange for no fault compensation funded collectively by employers and administered independent of government outside the court system. Maintaining the balance in the workers’ compensation system that retains the confidence of both the employer and worker community is essential to the system’s long-term survival. Where system changes upset the balance of interests between workers and employers, steps must be taken to restore that balance.

Maintaining the balance in the workers’ compensation system has historically relied on periodic royal commissions to provide an independent review and to make recommendations to government to ensure the viability of the system. The last royal commission was carried out by Mr. Justice Gill who delivered the Royal Commission Report on Workers’ Compensation in British Columbia - For the Common Good - in January 1999. In that report he concluded that:

The commission determined that, while deserving praise for fiscal responsibility, the Workers’ Compensation Board of British Columbia has failed in its mandate to administer fair and equitable benefits to all injured workers, often those most in need of assistance. (page xix)

He also identified: “…severe shortcomings in leadership, lack of defined goals, poor performance evaluation and deficient accountability structures and processes.”

(page xx)

Following the Royal Commission Report, the newly elected Liberal Government commissioned a Core Services Review³ of the workers’ compensation system to review the law and policy which was carried out by Alan Winter. In addition, the government commissioned a second “Service Delivery Review” carried out by Allan Hunt from the US based Upjohn Institute⁴

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² 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

³ Core Services Review of the Workers’ Compensation Board, 2002

⁴ “Why Not the Best”, Service Delivery Review by H. Allan Hunt PhD of the US Based Upjohn Institute
The Winter Core Services Review provided the basis for Bill 49 introduced by the Liberal Government in 2002 to bring major changes to the British Columbia Workers' Compensation System. These changes were in response to strong advocacy from the employer community based on the contention that the Workers' Compensation Board had become economically unsustainable. The British Columbia economy had been through a down turn in the 2000-2001 recession, impacting the Board's investment portfolio that resulted in a projected unfunded liability.

The former government introduced Bill 49 to address the concerns advanced by employers. During the May 16, 2002 second reading of Bill 49 the Minister of Skills Development and Labour raised concerns about the financial impact on the Board of the continuation of the benefits levels then in place and outlined the following goals of Bill 49:

The goals of this bill are to restore the system to financial sustainability by bringing costs under control, to make the system more responsive and to maintain benefits for injured workers, which are among the highest and best in Canada, while ensuring fairness for workers and employers. (Hansard, Volume 8, No. 3 at page 3547)

The primary purpose of the amendments to the Act that became effective on June 30, 2002 was to reduce the costs of workers' compensation benefits to address what the government had concluded was required to achieve a more financially sustainable system in the future. Interestingly the Board had an operating surplus of $571 million in 2002.

The changes enacted by Bill 49 and subsequent initiatives included:

- A dramatic reduction in loss of earnings pensions by limiting access to only exceptional cases.

- A major reduction in resources devoted to vocational rehabilitation assistance to help workers return to work.

- A new limitation in lifetime permanent impairment pensions to age 65 unless the Board was satisfied that the worker would have retired at a later date.
NEW DIRECTIONS:
WCB Review 2019

• A reduction in compensation benefits from 75% of gross earnings to 90% of net earnings resulting in a general reduction in wage loss benefits.

• The reduction in the Consumer Price index to the CPI rate less 1% with a cap at 4%.

• Increased restrictions on the manner of determining a worker’s wage rate.

• A 75-day limit on the ability to review and re-adjudicate prior decisions even if subsequent evidence challenged the validity of that decision.

• The imposition of binding policy to limit decision makers’ ability to exercise discretion on the basis of the merits and justice of the case.

• Elimination of the Board’s Appeal Division that applied remedial jurisdiction to resolving appeals and the creation of the external Workers Compensation Appeal Tribunal that was bound by Board policy.

• Introduction of a computer-assisted case management system that focused more on the application of policy to claims adjudication and less on the merits and justice of the individual worker’s case.

In 2010 the Board again retained H. Allan Hunt to assess the Board’s progress on the recommendations he made in his 2002 review in light of the legislative changes introduced in 2002. His May 2010 report\(^5\) summarized evaluation of a range of service delivery measures including benefit adequacy, return to work outcomes and timeliness of claim processing. He noted significant problems with the launch of the computerized claims management system which he attributed to implementation challenges that would likely be resolved with time. Hunt also reviewed the Board’s progress with his prior service delivery recommendations and concluded:

WorkSafeBC has successfully transformed itself into a customer-oriented service organisation in the past decade. In my opinion, this is due primarily to the consistency of the leadership at WorkSafeBC and the unwavering focus of that leadership on the goal of service quality. The transformation may not be 100 percent complete yet, but the contrast with the organisation that I first encountered in 1991 is very striking indeed.

\(^5\) Service Delivery Core Review: A Reappraisal, May 2010, H. Allan Hunt, PhD W.E. Upjohn Institute, Michigan, USA
Hunt qualified his findings somewhat by noting that the context in which his 2010 review was carried out covered the period 2002 to 2008 when the British Columbia economy was in a strong growth phase with unemployment dropping from 8.5% in 2002 to 4.6% in 2008. During that period the Board’s operating surplus averaged approximately $500 million. However, the world-wide recession that occurred in 2008 saw the unemployment rate rise from 4.6% to 7.6% in 2009. He indicated his review concentrated mainly on the 2002-2008 period.

The Board also commissioned a series of studies with the Canadian Institute for Work and Health to review the impact of Bill 49 on benefit adequacy and equity. The study reported on post-accident earnings and benefits adequacy and equity of long- and short-term disability claims. The methodology compared the benefits injured workers received under the pre-Bill 49 policy with the benefits they would have received under the Bill 49 changes. The study looked at the impact of three changes introduced under Bill 49: the change to 90% of net earnings, the reduction in the application of CPI, and the limitation of loss of earnings pensions to only those cases considered “exceptional”. On the basis of these three factors, the authors concluded that for long term pension benefits:

Overall, the move to Bill 49 resulted in reduced benefits. For the entire sample the reduction was 15%.

The greatest impact was to injured workers in the 50-59 age bracket with the earnings replacement rate at 82% well below the target rate of 90% of their pre-injury earnings. The authors indicated this age bracket was the most vulnerable to the changes introduced in Bill 49. The authors did not factor in the impacts of the inclusion of Canada Pension Plan benefits, and the limitation of loss of function pensions to age 65. They pointed out that these impacts, especially for older injured workers, would show even greater loss of benefits.

The authors recommended a more worker-centred approach with greater consideration of individual experiences of these workers and contextual factors that affect them, since injured workers with similar impairment levels may have dramatically different earnings recovery patterns.

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6 “WorkSafeBC Study Report I: The Impact of Bill 49 on Benefits Adequacy and Equity,” July 2011; Emile Tompa et. al., Institute For Work and Health.
The Board conducts quarterly surveys of both employers and workers to gauge the level of their “overall experience” with the Board. Approximately 80% of surveyed workers rate their overall experience with the Board as good or very good. This has improved from 74% in 2011. Approximately 83% of employers rate their satisfaction as either good or very good.

These indicators suggest that the Board is meeting the expectations of a large majority of workers and employers. A majority of the claims are being handled well. However, there is still a significant percentage of both employers and workers for whom the Board is not meeting their expectations. The Board’s senior staff acknowledge that there is still a significant number of workers and employers where the Board could be doing a better job at providing the necessary supports to maximize recovery and restore the injured worker to safe, productive and durable employment.
APPENDIX 10: SUMMARY OF CASE MANAGEMENT SYSTEM (CMS) & COMPENSATION DECISION-MAKING

CMS is the computer framework for how and when decisions are made in the life of a compensation claim. It also collects, records and organizes information to form the basis for disclosure, on-line access and research requests. The basic framework involves 5 areas: Claim Registration and Information; Claim Eligibility; Short Term Disability (medical recovery and return to work); Vocational Rehabilitation and Long-Term Disability.

Given the TOR, the Review will focus on the first four stages and highlight those aspects of CMS which are discussed in the Report.

1. **Claim Registration**

A claim is initiated a worker makes an application (using form F6) or a health care provider sends in a report (F8). The most popular avenue for injured workers to register claims is through Teleclaim, in which a worker phones in and speaks to a Customer Care Agent (CCA) or a Customer Service Representative (CSR), who fills out a Teleclaim form.

2. **Information Collection.**

CMS takes key information from the initial forms (F6, F8 and/or the employer’s report, F7) or from medical reports. This initial information initiates several CMS functions to input data or resolve or flag conflicting data from a variety of sources.

3. **Injury Coding by Diagnosis before acceptance**

Before claim acceptance, the CSR will assign an “ICD9” Code to the diagnosis shown on the incoming medical reports. If the diagnosis is unclear or uncertain, the CSR will code the most common diagnosis in the same area (e.g. “back strain”). ICD9 codes are specified on an “ICD9” Crosswalk and each is used to set up:

i. Initial anticipated RTW time frame
ii. Populate the “Service Plan” template
iii. Determine the need for early intervention or eligibility for auto-claim
iv. Identify specialty claim assignments and routing guidelines.
4. **Gating the Claim**

A claim can then be held in a “holding” area while awaiting sufficient information to proceed to automation, usually key forms (F6 and F7). The “gating” ends when the forms are received or when the designated gating time has elapsed (or is ended manually). Where there is no time loss, claims can be gated for 28 days; with time loss, up to 11 days.

5. **Health Care Only (HCO) Claims & Time Loss Claims**

Where the worker has made a claim and returns to work the next day and is working full hours at full pay, the claim is processed as an HCO claim. If no medical treatment is sought, there is no adjudication but if there is medical treatment, the claim will be processed for acceptance, but no wage rate calculated. The worker is sent a letter accepting the claim with no wage loss and to contact the Board if the injury subsequently results in wage loss.

Case Managers have an option to monitor an HCO claim if the medical evidence indicates that the injury is serious. This is an exceptional occurrence.

Time Loss claims, if accepted, are “populated” with an RTW Calendar which have four event categories:

- **“Off” Event** = this monitors the date that the worker went off work and is linked to the payment of temporary wage loss under section 29 of the Act.
- **“Modified RTW” Event** = this monitors the period of modified duties and gradual return to work and is linked to the payment of partial TWL under section 30 of the Act.
- **“RTW” Event** = this event has a number of codes and is used in two different contexts:
  - By claim owners to end TWL; and
  - By VRCs to end VR benefits.
- **“Non-RTW” Event** = this event also is used by CMs and VRCs and also has a number of codes.
6. **Automated Eligibility Rules**

A small number of claims can be accepted by CMS after meeting certain eligibility rules. Other decisions including wage-loss, average earnings and anticipated RTW calendar can be automated if rules are met. The majority of claims do not satisfy these rules. In the last 19 years, about 3% of claims were accepted and paid initial wage loss by CMS.

7. **Health Care only claims**

If a claim application is made but has no time loss attached (apparent from the documents), the claim can be gated up to 28 days. If in this time, the worker does not seek medical treatment, no adjudication is done. If only the F6 and F8 are received, the claim can be gated for an additional 8 days to wait for the F7. If the F7 shows no objection, the claim has automated eligibility.

8. **Claim Ownership**

While all claims are initially opened and “owned” by the system, each is quickly assigned to a claim owner. The claim owner is primarily responsible for the management of that claim. Each claim has only one claim owner at a time but over the life of a claim, a single claim may pass through a number of owners. In general, claim ownership roles are as follows:

a. **Client Services Representative (CSR) – Initial Adjudication Unit** – A CSR adjudicates health care only and short duration claims, sets the wage rate and makes the first payment. The CSR may approve health care in some cases. The CSR will route complex claims that cannot be allowed or further adjudicated at the CSR level.

b. **Entitlement Officer (EO)** – An EO makes claim and eligibility decisions for more complex claims and then routes the claim to a Case Manager unless RTW is imminent.

c. **Return to Work Specialist (RTWS – Nurse)** – The RTWS or Nurse manages claims with high likelihood of RTW (especially sprain/strains) and focuses on early and safe RTW.

d. **Case Manager (CM)** – The CM manages claims where there is an extended period of disability, where RTW is challenging, or where there is psychological or permanent impairment. The CM also adjudicates speciality claims (ODS, ASTD,
Fatal) and coordinates any RTW plan in those cases. The CM also adjudicates any LOE decision using information from the Vocational Rehabilitation Consultant (VRC).

e. **Vocational Rehabilitation Consultant (VRC).** The VRC makes entitlement decisions about VR services, constructs and implements a VR plan and assesses the worker’s likely long term earnings and potential loss of earnings.

There are 25-30 Recovery Plan Guidelines which provide case management templates in the CMS system. These RP Guidelines are prepared by Clinical Services for claims purposes, with reference to and updated by scientific research. In CMS, each ICD9 Code is attached on one of these RP Guidelines. When a worker applies for compensation, the worker’s injury is given a diagnosis (or likely diagnosis) and the ICD 9 coding for that diagnosis imports the related RP Guideline/template into the case management of that claim. The RP Guidelines/template provide a roadmap to the claim owner of the likely pathway of recovery including milestones, treatments and reasonable light duties. They can also provide a roadmap for the RTW issues for that claim. Two examples of RP Guidelines (for Lumbar Back and Concussion injuries) are provided in Appendix 15.

Since 2012, CMs and RTWSs have also had access to “MD Guidelines” (developed by a private organization, the ReedGroup) through a link embedded in the CMS Case Management Recovery and Return to Work Planning Site. The MD Guidelines were developed to provide non-clinicians with information and allow claim owners to learn risk factors, treatments, prognosis, complications and disability duration by job category. The MD Guideline for Concussions is provided in Appendix 15.

If the worker is not improving as expected or if a health care provider asks for additional time or treatment outside the RP or MD Guidelines, the CM has several options, including seeking the opinion of a BMA, manually changing the Service Plan and/or add additional diagnoses with additional ICD9 codes to the claim file. Many of these are set out in the sample content from a CMS training session on Recovery and RTW, also provided in Appendix 15.

9. **RTW and “Non-RTW” Events in CMS**

There are two different types of RTW “events” coded into a claim file and these can be confusing when trying to assess RTW outcomes. In effect, two separate groups - claim owners and VRCs - use two separate RTW codes in CMS, for different purposes. The groups and types of RTW codes are as follows:
a. Claim owners (EO, RTWS, CM) record a “RTW event” on the RTW Calendar in CMS at the end of temporary wage loss or plateau. The RTW event is classified as one of two types:

i. An “accepted” RTW event – this code includes a voluntary RTW or “RTW under objection”; OR

ii. A “non-RTW Event”. This code is used where the worker has reached MMR but has not RTW at the pre-injury job or at any other workplace. There are 3 types of “non-RTW” events coded by claim owners:

   a. Worker is medically unable to RTW
   b. No work is available to the worker for a RTW
   c. The worker is not cooperating with a RTW

b. Vocational Rehabilitation Consultants (VRCs) will close a VR intervention period in one of 5 ways. Explanations of these five VR closure categories and the RTW events that they encompass are attached.
Q1 RTW CODES IN CMS: 5-PAGE GUIDE TO CLOSURE CATEGORIES (FROM WCB-IR-004)

Vocational Rehabilitation VR Referral - Closure Categories/Reasons

Last update: January 29, 2016

<table>
<thead>
<tr>
<th>Closure Category 1</th>
<th>Return to Work (RTW)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closure Category 2</td>
<td>Non-Return to Work (NRTW)</td>
<td>2</td>
</tr>
<tr>
<td>Closure Category 3</td>
<td>Non-Return to Work - Other/Not Possible (NRTW-Other/Not Possible)</td>
<td>2</td>
</tr>
<tr>
<td>Closure Category 4</td>
<td>Non-Return to Work Intervention (NRTWI)</td>
<td>4</td>
</tr>
<tr>
<td>Closure Category 5</td>
<td>Section 29/30 – Temp. Intervention</td>
<td>5</td>
</tr>
</tbody>
</table>

Closure Category 1: Return to Work (RTW)

<table>
<thead>
<tr>
<th>Closure Reason</th>
<th>Description</th>
<th>Examples*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Job, Same Employer</td>
<td>Worker returns to the time of injury/re-opening job, unmodified. This closure reason also includes return to unmodified self-employment/contract work if the worker was a self-employed/contract worker at time of injury.</td>
<td>Phase 1 return to work.</td>
</tr>
<tr>
<td>Modified Job, Same Employer</td>
<td>Worker returns to the time of injury/re-opening job which has been modified to accommodate the worker (Phase 2a). This closure reason also includes return to modified self-employment/contract work if the worker was a self-employed/contract worker at time of injury.</td>
<td>Phase 2a return to work involving: • adaptive technology • job or worksite modification • job redesign • minor or major equipment • other modifications or ergonomic changes.</td>
</tr>
<tr>
<td>New Job, Same Employer</td>
<td>Worker returns to an alternate job with the time of injury/re-opening employer.</td>
<td>Phase 2b return to work.</td>
</tr>
<tr>
<td>New Job, New Employer, Same Industry</td>
<td>Worker returns to a new job with a new employer in the same or related industry.</td>
<td>Phase 3 return to work.</td>
</tr>
<tr>
<td>New Job, New Employer, New Industry</td>
<td>Worker returns to a new job with a new employer in a different industry.</td>
<td>Phase 4 return to work.</td>
</tr>
<tr>
<td>Self-employed/Contract Work</td>
<td>The worker has returned to work in self-employment and/or contract work.</td>
<td>• Business Start-Up/Enhancement • Independent Contractor</td>
</tr>
</tbody>
</table>

* Examples are not exhaustive
** Closure Category Section 29/30 – Temp. Intervention refers to assistance to address the temporary disability.
### Q1 RTW CODES IN CMS: 5-PAGE GUIDE TO CLOSURE CATEGORIES (FROM WCB-IR-004)

#### Vocational Rehabilitation VR Referral - Closure Categories/Reasons

##### Closure Category 2: Non-Return to Work (NRTW)

<table>
<thead>
<tr>
<th>Closure Reason</th>
<th>Description</th>
<th>Examples*</th>
</tr>
</thead>
</table>
| Not looking for work | Worker decides to discontinue looking for work. | - Worker decides to stop seeking work.  
- Attends school without WSB sponsorship.  
- Not looking but may accept employment offer if presented. |
| Still looking for work | Worker is unemployed but still looking for work at conclusion of service/benefits. VRC decides worker is not entitled to further job search assistance or other services/benefits. | Worker is unemployed and still actively seeking work. |
| Declined suitable job opportunity | Worker refuses available employment that the VRC determines is suitable in relation to the worker’s post-injury vocational profile and applicable phase of benefit entitlement. | Worker declines actual job opportunity that the VRC decides is suitable. |
| Retired | Worker decides to retire from the workforce. | Worker has withdrawn from the workforce for purposes of RETIREMENT, instead of continuing to seek work. |

##### Closure Category 3: Non-Return to Work - Other/Not Possible (NRTW-Other/Not Possible)

<table>
<thead>
<tr>
<th>Closure Reason</th>
<th>Description</th>
<th>Examples*</th>
</tr>
</thead>
</table>
| Non-cooperation | The VRC makes a decision to suspend or terminate VR services and/or benefits based on the worker’s lack of cooperation and/or commitment to their own vocational rehabilitation. Further vocational rehabilitation assistance is not likely to be provided unless there is a significant change in the worker’s attitude and/or motivation. This closure reason does not apply in cases where there is an identifiable, non-compensable reason or barrier that is the primary reason that the worker declines or withdraws from the vocational rehabilitation process. *Should be discussed with Manager prior to closure. | The worker refuses to cooperate with their own vocational rehabilitation or the VRC decides that the worker has not demonstrated a satisfactory level of commitment. Examples:  
- The worker continues to seek medical input or treatment post maximum medical recovery despite a determination by the Case Manager that the worker has recovered or reached maximum medical recovery and Section 29 or 30 benefits have concluded.  
- No response to attempted contact by VRC  
- Adversarial situation in which further assistance is not likely without a substantial change in worker’s attitude and/or motivation  
- Worker does not cooperate in providing information required. |

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* Examples are not exhaustive  
** Closure Category Section 29/30 – Temp. Intervention refers to assistance to address the temporary disability.
### Vocational Rehabilitation VR Referral - Closure Categories/Reasons

<table>
<thead>
<tr>
<th>Conclusion that worker is unemployable</th>
<th>The primary reason for referral to VR is return to work assistance and the VRC determines that the worker is competitively unemployable for reasons related to the compensable injury or condition.</th>
<th>During the vocational rehabilitation process, the VRC determines that the worker is competitively unemployable for reasons related to the compensable injury or condition.</th>
</tr>
</thead>
</table>
| Non-compensable issue - other | There is an identifiable reason, unrelated to the compensable injury or condition that is the primary reason the worker has decided to withdraw from the workforce or from active participation in the vocational rehabilitation process. | • Psycho-social issues unrelated to the compensable injury/condition.  
• Financial problems unrelated to the compensable injury/condition.  
• Family circumstances such as child-rearing, child-care, family illness, etc.  
• Worker decides to remain in own community/decides against relocation for employment.  
• Travel out of country.  
• Incarceration.  
• Worker is deceased. |
| Non-compensable issue - medical | The worker has withdrawn from the workforce or from active participation in the vocational rehabilitation process for medical reasons, unrelated to the compensable injury or condition. | A non-compensable health or medical issue is the primary reason that the worker has decided not to participate or return to work or that prevents participation in the vocational rehabilitation process/return to work. Examples:  
• Non-compensable heart attack.  
• Non-compensable surgery.  
• Motor vehicle accident that temporarily disables worker. |
| Further medical – compensable | VRC decides to suspend VR involvement due to compensable medical treatment that precludes active participation in the VR process or return to work. | Treatment required for the compensable injury or condition interferes with the worker's ability to actively participate in the VR process or return to work. Worker continues to receive s. 29/30 benefits or the claim is re-opened for section 29/30 benefits. |
| TRPD | The worker has chosen an educational advancement or vocational ambition that exceeds what is reasonably necessary as rehabilitation for their injury. VRS has provided a partial contribution to the worker's preferred vocational plan. No further assistance from VRS is indicated; the worker continues to actively pursue his/her preferred plan and is unavailable for return to work. | Funds approved for diversion to worker's preferred formal training program have been paid out; worker still participating in preferred training plan. |

* Examples are not exhaustive  
** Closure Category Section 29/30 – Temp. Intervention refers to assistance to address the temporary disability.
### Q1 RTW CODES IN CMS: 5-PAGE GUIDE TO CLOSURE CATEGORIES (FROM WCB-IR-004)

Vocational Rehabilitation VR Referral - Closure Categories/Reasons

<table>
<thead>
<tr>
<th>Closure Category 4: Non-Return to Work Intervention (NRTWI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Closure Reason</strong></td>
</tr>
</tbody>
</table>
| EA 23 Completed | The primary reason for VR involvement is for completion of a Section 23 Employability Assessment. The VRC has completed the EA and determines that no other vocational rehabilitation services are required. | • Section 23 EA request from Review Division.  
• Section 23 EA update and EA request only.  
• VR decision – directly to deeming EA at plateau. |
| IHMA Investigation Completed | The primary reason for vocational rehabilitation involvement is completion of an Independence and Home Maintenance Allowance (IHMA) Investigation. The VRC has completed the IHMA investigation and determines no other vocational rehabilitation services are required. | • Independence and Home Maintenance Allowance investigation only. |
| Commutation Investigation Completed | The primary reason for vocational rehabilitation involvement is completion of a commutation investigation. The VRC has completed the commutation investigation and determines that no other vocational rehabilitation services are required. | • Commutation Investigation completed. |
| Other-Non-RTW Intervention | The primary reason for the VR referral is non-RTW intervention and/or the VRC decides that RTW assistance is not the primary objective of VR involvement. The VRC has completed the required VR activity and has determined that no other vocational rehabilitation services are required. | • Quality of Life Assistance.  
• Pension reassessment.  
• PTD (100%) cases.  
• Assistance to surviving spouses and dependants.  
• Fatal mesothelioma or other terminal disease claims where RTW is not the primary objective of service.  
• Implementation of appellate return where there is no ongoing VR service i.e. retroactive benefit payment only.  
• Correspondence only.  
• Review of VR entitlement and decision is made to deny vocational rehabilitation services and/or benefits (or further vocational rehabilitation assistance). |

* Examples are not exhaustive

** Closure Category Section 20/30 – Temp. Intervention refers to assistance to address temporary disability.
### Q1 RTW Codes in CMS: 5-Page Guide to Closure Categories (From WCB-IR-004)

**Vocational Rehabilitation VR Referral - Closure Categories/Reasons**

**Closure Category 5: Section 29/30 – Temp. Intervention**

<table>
<thead>
<tr>
<th>Closure Reason</th>
<th>Description</th>
<th>Examples *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-RTW intervention</td>
<td>The primary objective of the vocational rehabilitation involvement during recovery is unrelated to return to work.</td>
<td>• Immediate VR referral/catastrophic injury.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hospital visits.</td>
</tr>
<tr>
<td></td>
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<td>• Deeming Section 30 EA.</td>
</tr>
<tr>
<td>EA 30 Completed</td>
<td>The primary reason for VR involvement is for completion of a Section 30 Employability Assessment.</td>
<td>• Section 30 EA request.</td>
</tr>
<tr>
<td></td>
<td>The VRC has completed the EA and determines that no other vocational rehabilitation services are required.</td>
<td></td>
</tr>
<tr>
<td>Declined transitional work</td>
<td>Worker declines a suitable, available temporary job with either the time of injury/re-opening employer or with a new employer.</td>
<td>Worker declines an available, temporary accommodation/job opportunity during recovery (while in receipt of Section 30 benefits) that the VRC determines is suitable.</td>
</tr>
<tr>
<td>Transitional (temp) Work, Same Employer</td>
<td>Worker returns to suitable, temporary work with the time of injury/re-opening employer during recovery (while in receipt of Section 30 benefits)</td>
<td>• GRTW.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Modified job.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alternate job, same or new occupation.</td>
</tr>
<tr>
<td>Transitional work unavailable/not suitable</td>
<td>VR assistance did not result in immediately available, suitable work with either the time of injury/reopening or new employer, despite worker participation and cooperation.</td>
<td>Worker did not return to suitable temporary work following vocational rehabilitation assistance and the VRC determines that further vocational rehabilitation services are not required.</td>
</tr>
<tr>
<td>Transitional (temp) Work, New Employer</td>
<td>Worker returns to suitable, temporary work with a new employer during recovery (while in receipt of Section 30 benefits).</td>
<td>• GRTW.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Modified job.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• New job, same occupation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• New job, new occupation.</td>
</tr>
</tbody>
</table>

* Examples are not exhaustive

**Closure Category Section 26/30 – Temp. Intervention refers to assistance to address the temporary disability.**
APPENDIX 11: CLASSIFICATION AND MISCLASSIFICATION ISSUES IN THE GIG ECONOMY

THE NEW “GIG” ECONOMY

The modern economy is rapidly changing and with it, the nature of work and work organizations. This genesis of this change is largely identified as being from the sector known the “gig” or the “sharing” economy. The gig economy already makes up between 20-30% of the workforce in Canada\textsuperscript{175}; it is expected to increase up to 50% in the future. Some are calling this the “Fourth Industrial Revolution”\textsuperscript{176}.

The gig or “freelance” economy is generally defined as one in which temporary, flexible jobs (or “gigs”) is commonplace; it encompasses both skilled and unskilled work. At one end of the spectrum, skilled workers of all kinds (lawyers, engineers, accountants, IT, HR consultants, etc.) provide their services in non-traditional arrangements as “independent contractors” as part of an “agile” economy. At the other end of the spectrum, workers with less skills provide services on a temporary basis. In the past, this type of work was organized by a labour contractor or temp agency; today, it might be an application (“app”). The spread of the “gig economy” has normalized and increased these type of work arrangements.

The “sharing economy” is a related but different concept. The “sharing economy” focuses on those areas where technology is the center and driver of this change. New technology, with software platforms organized by “apps” connected through the internet, provide individuals with opportunities to start “capital light” enterprises and connect them with new markets. It also allows individuals to buy, sell, rent and exchange goods and services through “peer-to-peer” (P2P) platforms, by-passing many middle service functions on which traditional jobs are built. A good example is ride-sharing (like Uber) in which a registered Uber driver (an individual with a car) is connected to an individual wanting a ride, through an Uber app. The app connects the buyer and seller, allows the rider to pay for the ride and rate the driver; it also tracks the ride and pays the driver. To the extent that traditional terms apply, the “worker” (driver) is connected to the “employer” (Uber) on a flexible, autonomous and short-term basis. However, this alternative way of organizing work certainly challenges those categories.


Both the “gig” economy and the “sharing” economy raise issues related to the Board’s classification system for the purposes of compensation for injured workers.

1. **Determination of Status under the Act**

The Act provides that, for assessment purposes, there are three possible status designations: “worker”, “employer” and “independent operator”. A detailed Practice Directive sets out factors which may be considered when distinguishing between a worker and an independent operator and Policy provides that an “independent operator” is also an “independent firm”.

The distinction between a “worker” and an “independent operator” is significant because a “worker” is covered by the Act as a whole, while independent operator/ind independent firm may purchase Personal Optional Protection (POP) if they wish to cover possible injury to themselves. If they have employees, they must also register as an employer. If a self-employed individual has no employees and does not apply for POP, then the Act does not apply.

For compensation purposes, an “independent operator” with POP coverage is deemed to be a “worker” (a ‘deemed worker’) and as such, is statute barred from any legal action for a personal work-related injury. The deemed worker has the same compensation benefits as a full-status worker under Part I of the Act with one significant exception. For a status worker, the calculation of their wage rate is based on their actual gross earnings; for a deemed worker, their wage rate is based on the insured POP amount being the “gross earnings”. For example, someone who buys POP insurance coverage of $36,000 a year will have their net earnings calculated as $30,500 a year and their wage rate will be 90% of this net amount or $27,450 a year.

The POP policy also provides that the policy holder is subject to the OH&S obligations under Part 3 of the Act, including administrative penalties, as an employer. This includes seeing a potential increase in their individual experience rating due to their own claim costs.

The Board considers this a fair approach to POP and compensation coverage for self-employed individuals on the basis that this group has a choice (at least in theory) about

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178 Section 2(a) of the Act provides that the Board “may” direct the Act to apply to the “independent operator” as though the independent operator was a worker. Section 1 incorporates these “deemed” workers into the definition of “worker” under the Act with the result that section 10 applies to them as well.
whether to participate in the compensation system or to choose another form of disability insurance.

2. **Misclassification of Vulnerable Workers**

When an individual contacts the Board to register for POP coverage, the Assessment Department determines that individual’s classification according to Board policy and the Practice Directive i.e. whether the individual is an independent operator (“contractor”) or a worker. This classification decision is one of great significance.

If an individual who is actually a worker is misclassified as a “contractor”, that individual loses both the Board’s OH & S protection and some compensation benefits. The individual’s employer is also effectively invisible to the Board. In particular:

For the misclassified “worker”, the individual must pay for their own compensation coverage and work outside the OH & S protections of the Act, including the right to a safe workplace. If the individual is injured at work, the POP coverage may be far less than their actual earnings and there is no “employer” to offer RTW opportunities. In effect, this individual pays for their own compensation coverage but has less coverage, less RTW support and less safety protection than if that person were properly recognized as a “worker”.

For the “employer” of this misclassified worker, the business makes no assessment payments to the Board and is outside the Board’s safety regime. In effect, this employer avoids assessment costs (including any ER increases due to claims costs) , RTW obligations and compliance with health and safety standards.

While POP coverage may be a reasonable solution for self-employed individuals, it is not a fair situation for individuals who are actually “workers” with little control over their workplaces.

The integrity of the classification system depends on the fairness and accuracy of status determination between a “worker” and an “independent operator”. Currently, this classification decision is made in the Assessment department, based on the verbal information provided by an individual in a phone call. This is, as someone described it, a “soft assessment”\(^{179}\). The “soft assessment” approach leaves the determination of status open to misuse by a party who seeks one status determination over another.

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\(^{179}\) This approach to a classification decision is in contrast to the more rigorous assessment of status for the purpose of court proceedings made by WCAT in section 257 proceedings.
For example, under Board policy, one indicia of an “independent operator” vs. a “worker” is someone who has more than one employer. Apparently, this aspect of Board practice is well known in certain industries; office cleaning services were particularly identified. It appears common practice for a company to obtain a contract to clean office buildings and provide work assignments and cleaning supplies. However, before a worker (usually an immigrant) will be “hired” by the company, they must apply to the Board for “WCB number” (i.e. register as self-employed) and are told, if questioned, to say that they have more than one employer. On the basis of a phone call with this information, the worker will be classified at the Board as a “self-employed” contractor with a POP account rather than as a worker (which he/she likely is).

In other jurisdictions, the problem of misclassification has been flagged as “one of the most serious problems facing affected workers, employers and the entire economy.”\(^{180}\)

> When employers improperly classify employees as independent contractors, the employees may not receive important workplace protections such as the minimum wage, overtime compensation, unemployment insurance, and workers’ compensation. Misclassification also results in lower tax revenues for government and an uneven playing field for employers who properly classify their workers.

In 2015, the Department of Labor (DOL) in the U.S. allocated significant resources to investigating and prosecuting misclassification cases in federal court. In 2015, these investigations resulted in more than 100,000 workers receiving more than $74 million in back wages in industries such as janitorial, temporary help, food service, day care, hospitality and the garment industry.\(^ {181}\)

Given this experience in other jurisdictions, it is likely that there is a wide-spread practice of misclassification in particular industries and that it is significant in British Columbia as in other jurisdictions. And given the industries typically involved in these practices, misclassification is likely a problem which disproportionately affects vulnerable workers, particularly immigrants and women.

The Law Commission of Ontario expressed the view that the most straightforward approach is to target the practice of misclassifying employees in a way which does not impact those who benefit from real self-employment. The most effective way would be to have proactive investigations and inspections in those industries known to be high risk.


\(^{181}\) *Changing Workplaces Review*, p. 360-361.
for misclassification practices: trucking, cleaning and catering and of those industries populated by workers known to be disproportionately affected. 182

The Assessment Department may also wish to consider developing more robust processes for determining status before providing POP coverage. For example, Ontario has specialized forms for different industries and requires specific documentation and signed declarations before providing POP coverage to a “self-employed” person.

3. Classification Issues in The New Economy

There are also new classification issues with the growth of the gig economy. Many new entities, including Uber, Lyft and Skip the Dishes, consider themselves to be “on demand” companies with a business model that depends on its drivers being independent contractors. The status of these drivers has been challenged in court in several jurisdictions. Courts in both California and Ontario have found that Uber has sufficient control of the driving services that the drivers are likely to be employees. However, these decisions are being appealed and the dispute is unlikely to be settled in the courts for some time.183

Another classification issue for these new entities arises under Part 3 of the Act. Section 108(1)(b) provides that the Act applies to every “employer” and “worker” within the jurisdiction of the Provincial Government. New “on demand” companies, like Uber, do not accept that the Uber entity which organizes the Uber drivers is an “employer”. In effect, these “on demand” companies seek to be exempt from the Act and from health and safety regulations in any event.

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183 In 2018, the Supreme Court of California determined that Uber drivers should be considered employees if they perform a task that’s part of the “usual course” of a company’s business, and as such, get many of the same protections as other employees. See Dynamex Operations West, Inc. v. Superior Court of Los Angeles County 4 Cal. 5th 903 (2018), also known as the “Dynamex” case. The California Assembly passed legislation to enshrine these findings in May 2019 and the bill is now before the California Senate. In the meantime, Uber (and other “on-demand” companies) are in negotiations with certain unions, to create a “third category” for work classification, which would allow drivers to remain independent contractors but have some of the benefits of employees. In New York, similar discussions are taking place, with different players and positions. In Canada, one matter involving Uber drivers in Ontario was recently been given leave to be heard by the Supreme Court of Canada (SCC). Uber Technologies Inc., et al. v. David Heller 2019 ONCA 1 (January 2, 2019). The SCC may focus on another issue (whether an arbitration clause is unconscionable), the core of the case is whether Uber drivers are employees and entitled to the minimum standard of the Employment Standards Act.
There are larger questions than are before this Review, with respect to the gig and sharing economy and Health and Safety regulation. However, more than one researcher has suggested that there needs to be new status classes of “worker” and “employer” to meet this changing landscape. In the meantime the current categories will apply to this growing sector, and to the classification of vulnerable workers in this area of precarious employment.

As one of the key researchers in the area of precarious employment said:

...one issue stands out when reading these papers all together: that of the transfer of risk to those least capable of absorbing its consequences. …Risks are transferred to individuals, and the ability to respond collectively, be it by organized labour or by the state, is thwarted. These are the challenges to be met by OHS regulation in the 21st century.

\footnote{How Can Workers' Compensation Systems Promote Occupational Safety and Health? Rand Corporation, 2018, page 37.}
APPENDIX 12: INITIATIVES REGARDING BIOPSYCHOSOCIAL MODEL OF DISABILITY

Developments in “Workplace Disability” Policy and Legislation

- The CSA Group\textsuperscript{185} is currently developing a CSA Standard on Work Disability Prevention Management Systems (WDP-MS). The CSA Standard will include a framework for the prevention and management of work disability at an organization level.

- The Centre for Research on Work Disability Policy (CRWDP)\textsuperscript{186} coordinates, supports and initiates research across Canada. The CRWDP, along with other organizations, formed a working group for Disability and Work in Canada (DWC) and drafted a Canadian Strategy for Disability. After a year of consultations, the finalized strategy will be presented in December 2019. The Canadian Strategy is based on a vision that “Employment throughout Canada is inclusive: people with and without disabilities will have the same opportunities and choices in careers, jobs and work.”

- The government of British Columbia has committed to building a more inclusive province for people with disabilities. Initiatives relevant to this Review include the province’s programs at WorkBC which offers job options, employment services and support programs for people with disabilities to support and help them to build a career and find employment.

Developments in Disability Management Training

Increasingly, disability management is an area of expertise.

- The Canadian Society of Professions in Disability Management (CSPDM) has a mandate to establish and advocate for best practice standards in disability management.

- The National Institute for Disability Management and Rehabilitation (NIDMAR) developed a Disability Management Self-Assessment (DMSA) tool to allow organizations to conduct a basic self-assessment of their current RTW and disability management (DM) efforts, together with a “best practices” comparison to determine what areas require review or improvement. The DMSA tool was used by several employers in the health sector to develop the Enhanced Disability Management Program (EDMP) described in a separate Appendix.

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\textsuperscript{185} The CSA Group, formerly the Canadian Standards Association, is a standards group accredited by the Standards Council of Canada to develop standards in 57 areas.

\textsuperscript{186} The CRWCP coordinates, supports and initiates research across Canada in the area of workplace disability.
• The Human Resources Professional Association (HRPA) has partnered with NIDMAR and Pacific Coast University (PCU) to offer Disability Management/Return to Work Professional Development and Certification Programs. In March 2019, PCU and WorkSafeBC announced a two-year pilot project, which commits funding for scholarships, to allow 25 qualified students to transfer into PCU’s Bachelor of Disability Management Program. As noted by the PCU President, Wolfgang Zimmermann, the B.A. qualification (after a 2-year diploma) “focuses on the core competencies required to help workplaces develop a culture of accommodation and successfully maintain employment for workers who acquire a mental or physical health impairment.”

Key Research on Work Disability

• There is an ongoing Partnership for Work, Health and Safety (PWHS) between WorkSafe and the University of BC (UBC). At UBC, the Partnership Team is situated in the School of Population and Health and in the Faculty of Medicine. The Partnership also collaborates with other organizations, including CARDEX Canada and the BC Cancer Agency. The Review met with the Partnership Co-Directors of the School of Population and Health, Dr. Chris McLeod and Dr. Mieke Koehoorn. The focus of their research includes an examination of the etiology and outcomes of serious work-related injury and national and international comparisons with other jurisdictions.

Key Research on Disability Management and RTW Policy Outcomes

• In May 2019, Dr. S. Kimpson published a paper “Mapping the Canadian Work Disability Policy system (Alberta and BC)”. In this report, the author sets WorkSafe assessment, treatment and RTW efforts in the context of other disability programs in BC and Alberta.

• In February 2018, the ONIWG published Phantom Jobs & Empty Pockets: What Really Happens to Workers with Work-Acquired Disability?” based on labour market information.

• WorkSafe has initiated research to follow up workers after a deemed RTW.

\[187\] Dr. Sally Kimpson, t “Mapping the Canadian Work Disability Policy system (Alberta and B.C.), CWRDP BC Cluster Project Report, May 2019. Dr. Kimpson is a CRWDP Postdoctoral Fellow at Simon Fraser University and Co-researchers were Dr. J. Calvert, SFU and Dr. M. Koehoorn, UBC.
APPENDIX 13: RESOLUTION OF COMPENSATION COMPLAINTS RESOLUTION: AN OVERVIEW

In the Commission of Inquiry, Workmen’s Compensation Act Report of the Commissioner (1966), the Honourable Mr. Justice Charles W. Tysoe recommended a complaints department be developed. This office was created and eventually became the Workers’ Advisers Office.

In 1987, the BC Office of the Ombudsperson issued a report noting 25% of its investigative resources were devoted to handling compensation cases. In response, the Board established an Ombudsman Office internal to the Board in April 1996. This was implemented to both address the volume of complaints received by the BC Office of the Ombudsperson and to recognize the Board’s responsibility to directly address complaints arising from its service and decision-making quality. With the introduction of this office, the volume of the Board’s complaints received by the BC Office of the Ombudsperson dropped 75% from 1,717 in 1996 to 433 in 2005.

In 2002, the internal office was renamed the Complaints Office to reduce potential confusion with the BC Office of the Ombudsperson.

In 2010, the focus of the Complaints Office changed from being an internal ombudsperson model being to a complaint resolution model. The name of the department also changed to the Fair Practices Office (FPO) to better reflect its core values of fairness and impartiality.  

Fair Practices Office

Today, the Board has an internal Fair Practices Office (FPO) based on a complaints resolution model. The FPO director reports to the chief review officer (CRO). The FPO handles an average of 1500 complaints and inquiries a year. The most frequent issues sent to FPO, with the 2018 figures:

188 Source: Fair Practices Office – An Overview item 2.0 History (WCB-IR-0002)
The mandate of the FPO is primarily to “investigate and resolve complaints of alleged unfairness” in the application of the Act, Board Policy or procedure. In practice, the FPO jurisdiction is largely confined to procedural and service matters (decision delays, returned phone calls) which are usually resolved within three days. The FPO director reported that it was very common for the FPO to receive crisis calls and that the FPO and Review Division (RD) had a dedicated relationship to a mental health specialist. Also, the FPO work can handle referrals from the Provincial Ombudsperson although some workers consider this a conflict of interest. The FPO reports to the CRO and the FPO report is contained in the CRO’s report to senior management.

The FPO states that part of its role is to identify systemic issues and it reports one successful investigation in 2018. After receiving a number of similar complaints within a 3-month timeframe, the FPO flagged a systemic issue about how a worker’s claim was managed once a “threat” code had been placed on the file. However, this systemic investigation seems to be a single exception and indeed, the reporting structure of the FPO suggests little independence or ability to investigate systemic issues.

Complaints to the Board from MLAs

When a worker or employer makes a complaint about the Board to their MLAs’ constituency office, the office tries to resolve the complaint. If it is unable to do so, the MLA constituency office refers it through certain channels to the Board, which receives and handles such complaints confidentially according to a published process. Legal Services confirmed that it receives between 150 - 200 complaints a year from MLA constituency offices. There are no published results of any resulting investigations.

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189 This includes “does not understand what is being said (e.g. too much jargon and policy references) communication breakdown (e.g. refusing to speak to the claim owner) and unclear decision letters”.
190 For example, one referral involved a problem with a service provider and worker with a traumatic brain injury. The Provincial Ombudsman referred this matter to the FPO who was able to assist the worker.
Consultation with The Provincial Ombudsperson

I met with the Provincial Ombudsperson (PO) and several of his investigative staff. The office receives about 200-300 “complaints and inquiries” a year concerning WCB and describes the agency in the “top 10” agencies which are the subject of complaints.

The PO and staff confirmed that, when the PO office receives a complaint, the individual has often already been through a number of other sources which can include the FPO and/or constituency offices of MLAs. Typically, the individual is unrepresented and/or has a mild brain injury (MBI) or cognitive impairment. In many cases, the complaints arise from a lack of understanding about some matter due to the complexities of procedure, language or policy and once the issue is explained, the matter is settled. Other times, it is difficult for the individual to identify the matter under appeal and the file is referred to the WAO as “justice is unaffordable” otherwise.

The PO identified the following matters as often forming the basis for what constituted substantive complaints:

- the individual was barred by the “75-day” rule from addressing decisions that they considered were wrong;
- the many hurdles faced by an appellant in obtaining an extension of time from the Review Division for a missed deadline;
- the lack of reasons why the opinion of a BMA was preferred to the opinion of the worker’s own doctor or the adequacy of reasons for restrictions and limitations; and
- evidence which had been submitted was missing on a claim file. One such case was publicly reported in 2018.\(^\text{192}\)

The PO noted that, when the office became involved, they would “hold the worker’s hand” and work with the Board to obtain a resolution if possible. However, this was often a cumbersome process and unfair to the worker.

Client Relations Pilot Project

On January 1, 2019, the Board initiated a Client Relations Pilot and this project is expected to report out in November 2019. In this project, senior managers would provide interventions in acute situations and in some cases, transfer claim files to the Client Relations Department (CRD) to take over ongoing management of the claim. A July 2019 information request from


APPENDIX 13: RECENT HISTORY OF THE BOARD’S ADMINISTRATION’S COMPLAINTS RESOLUTION
WCB-IR-0059(1) on the CRD notes that the CRD was managing the claims of approximately 37 clients on an ongoing basis. This IR is attached, with further information on the CRD.
Attachment from Client Relations Department Pilot (page 1 of 2) (WCB-IR-0059(1))
NEW DIRECTIONS: WCB Review 2019

Attachment from Client Relations Department Pilot (page 2 of 2) (WCB-IR-0059(1))

Claims management
The CRD is managing the claims of approximately 37 clients on an ongoing basis.

Resolution durability
Of 71 resolved complaints, five were subsequently returned to the CRD to address further issues related to the complaint. This represents an approximate 93% durability of resolution.

Resolution categories
Of the 81 closed complaints, the CRD has coded each with a resolution category. The chart below shows resolution type by category and frequency. More than one category can apply to a single complaint.

Complaint channels
- WorkSafeBC Claims staff and management: 53
- Social media: 8
- Claims Call Centre: 7
- Client Relations Department: 24
- CRD: 3
- External sources: 3
Total = 95

A sample of our success stories

Case 1:
On February 4, a worker reached out to WorkSafeBC on social media requesting assistance with her claim. Client Relations spoke with the worker that same day and arranged to transfer her claim into a specialized area best suited to her needs. Client Relations provided input regarding an outstanding adjudicative matter, and in turn, the worker received appropriate entitlements and support.

Case 2:
On May 16, a worker’s representative reached out to WorkSafeBC to express concerns over communication delays related to an entitlement request. The representative noted that the worker’s relationship with WorkSafeBC was quite fractured, and that it was impacting her well-being. Client Relations spoke with the representative and then moved the worker’s claim into the Client Relations Department for high-touch support. As part of this process, the Client Relations team issued a same-day decision on the entitlement matter. Both the worker and her representative confirmed their concerns had been resolved.

Case 3:
A worker sent an email to WorkSafeBC expressing concern over her claim and the adverse impact her experience has had on her life. Client Relations spoke with the worker and then transferred her claim into the Client Relations Department for high-touch support. The team extended additional psychological treatment to the worker with a mental health counsellor of her choice. As part of this process, Client Relations worked with Health Care Services to add the counsellor to the list of preferred providers for injured workers in a region where access to mental health services is limited.
APPENDIX 14: EXCERPTS FROM THE ANNUAL REPORTS OF THE PROVINCIAL OMBUDSPERSON

https://www.bcombudsperson.ca/sites/default/files/files/201718%20OMB%20AR%20FINAL.pdf
Assessment delayed

Workers’ Compensation Board

Stacey is a single mother and a welder by trade who suffered an injury at work which caused her headaches and pain associated with exposure to bright lights. Because welding required her to work with very bright lights, even when wearing protective eyewear, Stacey believed she would never be able to weld again.

Following a number of decisions made in relation to her workplace injury claim, the Review Division of the Workers’ Compensation Board determined that Stacey should undergo additional assessment to determine whether she was able to return to welding. Once this was done, the Board indicated it could then reassess her benefits accordingly. After four months of waiting for this decision to be implemented, and not understanding the reasons for the delay, Stacey asked our Office to look into her situation.

We investigated whether the Workers’ Compensation Board was following a reasonable process when implementing the Review Division’s decision.

Stacey explained to the Board that she would require a new prescription and eyewear to take part in the assessment. On the request of the Board, Stacey’s ophthalmologist provided a copy of the exam invoice and the results of the testing. Unfortunately the Board misfiled this report as being only a copy of the invoice, and not the exam results. Without both, the Board was unwilling to pay for the exam or for the new eyewear. Without new eyewear, the Board was not prepared to move forward with the welding assessment. Without the assessment, her claim was stalled.

Understanding Stacey’s frustration and the difficult financial situation she and her children found themselves in, we went back and forth between Stacey and the Board to make sure we understood the exact cause of the delay. Through this process we led the Board to know that both Stacey and her ophthalmologist were confident that they had sent everything the Board needed to move forward with the welding assessment. In response to this, the Board explained that it would look through its records again to make sure that the report had not been misfiled. In doing this the Board discovered its error and promptly proceeded with making arrangements for Stacey to attend the welding assessment as soon as possible. As a result, the deadlock was overcome and Stacey was able to have her claim properly assessed.
From the Office of the Ombudsperson. 2010/2011 Annual Report
Case Summaries – Work and Business

We looked into whether there had been unreasonable delay on the part of the ministry in assessing the waste wood on Phil’s timber sale licenses. The process of contracting waste assessments appeared to be delayed (in this District) in 2006. The waste wood on Phil’s two cut blocks could not be assessed after snowfall brought an end to assessments in that year.

The ministry said that the leftover cut blocks were carried forward into 2007 as a priority. Field work on Phil’s licences was done by the summer, but then there were further delays in completing the assessments.

After discussion with our Office, although not in general practice, in this case the ministry agreed to pay interest for the one-year period in which it held the security deposit longer than usual. We considered that payment of interest for the period of delay in the waste wood assessment to be a reasonable outcome in this case.

Correcting acknowledged errors

WorkSafeBC

We received several individual complaints about the apparent inability of the Workers’ Compensation Board (WorkSafeBC) to correct its own errors after a 75-day reconsideration period was over. Although the individual complaints to our Office were eventually resolved, our continued concern about WorkSafeBC’s processes prompted our Office to initiate its own investigation into this area.

Generally, if WorkSafeBC makes a decision on a claim file, WorkSafeBC has a 75-day period to reconsider the decision. At the same time, the worker or employer has a 90-day time limit to appeal the decision to the Review Division. What happens, however, if a WorkSafeBC decision is incorrect, but the error is not clear to anyone until after 90 days? Under those circumstances, it seemed that WorkSafeBC was unable to correct its own error after the 75-day reconsideration period was over. If the worker/employer didn’t appeal the decision to the Review Division within the 90-day time limit (because he/she didn’t know the decision was incorrect), then there seemed to be no remedy to correct the error.

We asked WorkSafeBC to explore how an acknowledged error on the part of WorkSafeBC could be corrected. WorkSafeBC had previously suggested that an application for an extension of time to appeal to the Review Division might be an adequate remedy for acknowledged WorkSafeBC errors. However, that remedy did not allow WorkSafeBC to fix errors on its own initiative. There was also no guarantee that the extension of time application would be successful.

In order for an extension of time application to be successful, the Review Division had to first be satisfied that “special circumstances” existed that would preclude the filing of the request for review within the 90-day time period. The question of whether an acknowledged WorkSafeBC error constituted “special circumstances” was not previously contemplated by the Review Division Practice and Procedures.

As an interim solution, we asked WorkSafeBC if it would be willing to consider expanding its definition of “special circumstances” under the Review Division Practice and Procedures to include an acknowledged WorkSafeBC error.
Case Summaries – Work and Business

In response to our investigation, as of June 21, 2010, WorkSafeBC implemented procedural changes that allowed the Review Division to accept an acknowledged substantive error as grounds for granting an extension of time to request a review. In this amendment, “error” refers to a situation where the applicant is not simply disagreeing with the decision-maker’s exercise of judgment or weighing of evidence, but rather where the decision is not within the range of possible decisions allowed by the law, policy or the facts.

In addition to this interim solution, WorkSafeBC told us that it had discussed our broader concern about the apparent unfairness of the 75-day limitation that was established in the legislation and it was willing to explore a legislative resolution. We continue to monitor the success of the revised Review Division Process and Procedure and to support legislative change. We appreciate WorkSafeBC’s willingness to pursue change in this area.
APPENDIX 15: Recovery Guidelines

Back (lumbar) – sprains and strains

Concussion

MD Guidelines

Recovery and Return to Work
Back (Lumbar) – Sprains and Strains (from WCB-IR-0089(2))


<table>
<thead>
<tr>
<th>Guide Name</th>
<th>Back (Lumbar) - sprains and strains</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD Code(s)</td>
<td>T242, T245, 846, 8460, 8461, 8462, 8463, 8468, 8469, 847, 8471</td>
</tr>
</tbody>
</table>

**Injury Description**

Muscle strains and ligament sprains are the most common diagnoses made for patients with low back pain. Approximately 80% of people will experience this in their lifetime. Common causes may be attributed to incidents involving heavy lifting, uncommon exercise, awkward posturing, falls, trauma, but in many cases its cause cannot be attributed to any particular event.

Although the term sprain/strain implies a muscle or ligament injury, the actual tissue responsible for back pain is typically not known. Various synonyms for sprain include non-specific low back pain, mechanical low back pain, lumbago and many more.

<table>
<thead>
<tr>
<th>General Duration Guide</th>
<th>DURATION IN DAYS</th>
<th>Minimum</th>
<th>Optimum</th>
<th>Maximum</th>
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<tbody>
<tr>
<td></td>
<td>Job Classification</td>
<td>Sedentary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Light</td>
<td>1</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>3</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Very Heavy</td>
<td>7</td>
<td>42</td>
<td>91</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guide Content</th>
<th>Additional Information</th>
<th>Start Date Offset</th>
<th>Always Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSIS (Day 1 – 7) (History, examination results, tests to consider)</td>
<td>History of incident/truma and impact on lumbar spine and surrounding tissues. Examination for decreased range of motion, pain with range of motion testing, tenderness to palpation of involved area along with associated muscle spasm. Neurological examination is usually normal. Most patients with this diagnosis do not require any further specific testing for example X-ray, MRI, CT Scan unless the physician identifies a potential red flag condition.</td>
<td>Day 1 (A)</td>
<td>No</td>
</tr>
<tr>
<td>INITIAL MEDICAL CARE (Day 1 - 7) -Initial care</td>
<td>Activity as tolerated for 1-7 days, along with heat/ice and acetaminophen or anti-inflammatory medication. Pain medications may be used for a short period. Reassurance of the patient with a goal of early, graduated mobilization is important.</td>
<td>Day 1 (B)</td>
<td>No</td>
</tr>
</tbody>
</table>

| REHABILITATION PLAN (Day 1 – 28) | Encourage and increase level of activity during this period. Some individuals may benefit from formal treatment such as physiotherapy, chiropractic, with a focus on activation. Ensure injured worker is following health care provider care regarding activation. | Day 1 (C) | No |

| REFER TO MA Immediately: if (progressive leg weakness/numbness and tingling, bowel and bladder incontinence) (Day 1) | Evidence of Cauda Equina syndrome. | Day 1 (D) | No |

| PROGNOSIS | The prognosis for such back pain is excellent, with most individuals returning to full function within weeks, although it may take longer for the pain to resolve when function has already returned. While return to function occurs within a few weeks, resolution of back pain itself may take months, but typically does resolve. Expect most individuals to return to sedentary/light activities within days to weeks. Where back complaints and return to function do not occur, the diagnosis of back strain may ultimately be better explained by a different diagnosis. | Day 10 | No |
**NEW DIRECTIONS:**
**WCB REVIEW 2019**

**Appendix 15:** Recovery Guidelines

### Back (lumbar) – sprains and strains (from WCB-IR-0089(2) (cont’d))

<table>
<thead>
<tr>
<th>CONSIDER RISK FACTORS FOR PROLONGED DISABILITY:</th>
<th>Unique to the diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Previous disabling low back pain; prior low back surgery</td>
</tr>
<tr>
<td></td>
<td>• Neurological symptoms (numbness/tingling/pain/weakness down a leg/into foot)</td>
</tr>
<tr>
<td></td>
<td><strong>Generic Risk Factors:</strong></td>
</tr>
<tr>
<td></td>
<td>• Multiple previous musculoskeletal complaints; history of chronic pain</td>
</tr>
<tr>
<td></td>
<td>• Multiple previous claims</td>
</tr>
<tr>
<td></td>
<td>• Severity and extent of injury; severity of pain associated with the injury; treatment method; response to treatment; adherence to treatment</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric concerns (i.e. depression)</td>
</tr>
<tr>
<td></td>
<td>• Alcohol or drug use/misuse; use of opioids (prescription or street)</td>
</tr>
<tr>
<td></td>
<td>• Psychosocial issues (catastrophizing; fear of pain/avoidance; pain behaviours; perceived injustice; disability beliefs)</td>
</tr>
<tr>
<td></td>
<td>• Job requirements (occupational issues)</td>
</tr>
<tr>
<td></td>
<td>• Non-occupational activities*</td>
</tr>
<tr>
<td></td>
<td>• Pre-injury fitness level/overall health; older age (&gt;50 years)*</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Net mandatory for a team meeting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESTRICTIONS AND LIMITATIONS. (Day 1 to RTW)</th>
<th>No restrictions with respect to diagnosis. Possible restrictions related to medication. Plausible limitations, if reported, may include difficulty with heavy lifting, sustained/awkward postures, bending, twisting. Described limitations should be temporary.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 20 (A)</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RETURN TO WORK OPTIONS. (Day 1 – 28)</th>
<th>Return to appropriate work and normal life activities is generally the best rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 20 (B)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**PHYSIOLOGICAL RECOVERY EXPECTED:** for RTW/Medium duties

- Review and confirm RTW risk factors contributing to worker’s ongoing disability

**“ARRANGE TEAM MEETING”**

- If RTW is not expected in next 7 days, schedule team meeting within next 14 days.

<table>
<thead>
<tr>
<th><strong>Yes</strong></th>
<th><strong>Yes</strong></th>
</tr>
</thead>
</table>
**Concussion (from WCB-IR-0089(1))**

**Recovery Guide** ([https://new.mdguidelines.com/content/concussion-cerebral](https://new.mdguidelines.com/content/concussion-cerebral))

<table>
<thead>
<tr>
<th>Guide Name</th>
<th>Mild Traumatic Brain Injury (Concussion)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD9 Code:</strong></td>
<td>850.0, 850.11, 850.12, 850.2, 850.3, 850.4, 850.5, 850.9 (Ref #1)</td>
</tr>
</tbody>
</table>
| **Injury Description**                  | A concussion describes a sudden change in mental status after a head injury, with no immediate or delayed evidence of structural brain damage. The change in mental status may or may not be accompanied by a loss of consciousness. Concussions are very common and may occur without loss of consciousness. Concussions, like more serious head injuries, are associated with confusion or memory loss. These complaints may clear within 24 hours. The initial physical exam is normal or mildly abnormal with Glasgow Coma Scale ratings of 13 to 15. A small percentage of patients with a concussion may develop a post concussion syndrome lasting several months or more. Individuals who have sustained concussions are more sensitive to recurrent head trauma. (Ref #1)

The World Health Organization defines a mild traumatic brain injury (mTBI) as an acute brain injury resulting from trauma to the head from external forces. (Ref #2) The following criteria are taken from the Australian Motor Accidents Authority and are adapted from the WHO definition.

Criteria include:
- a. One or more of the following: confusion or disorientation, loss of consciousness for 30 minutes or less, post traumatic amnesia < 24 hours, and/or other transient neurological abnormalities e.g., focal signs, seizures, intracranial lesions not requiring surgery;
- b. GCS of 14–15/15 at 30 minutes post injury or later upon presentation for health care
- c. GCS of 13/15 at 30 minutes post injury or later upon presentation for health care and a normal CT scan. These manifestations of mTBI must not be due to drugs, alcohol, medications, or be caused by other injuries or treatment for other injuries (e.g., systemic injuries, facial injuries or intubation), other problems (e.g. psychological trauma, language barrier or coexisting medical conditions) or penetrating craniocerebral injury. (Ref #3)
Concussion (from WCB-IR-0089(1) cont’d))

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Additional Information</th>
<th>Start Date Offset</th>
<th>Akera Display</th>
</tr>
</thead>
</table>

CREDITS

These WorkSafeBC Recovery Guidelines are based on an extensive review of the current clinical literature along with relevant medical, psychiatric, psychological, compensation services and rehabilitation input. They are intended to provide non-clinical staff with an overview of the condition in terms of diagnosis, investigation, treatment/rehabilitation, prognosis and expected timelines and outcomes.

DIAGNOSIS (Day 1 – 42)
(History, examination results, tests to consider)

History: The individual may have a history of an injury to the head, followed by loss of consciousness (LOC). Transient loss of consciousness or brief loss of environmental awareness is the characteristic feature of a simple concussion. Severity of the symptoms and recovery time depend on the degree of brain dysfunction. Individuals with a concussion may be slightly dazed for a few minutes and complain of headaches. Mental confusion may be prolonged. Dizziness, difficulty concentrating and fatigue are commonly reported.

Physical exam: The physical is often unremarkable. Mental status testing may show subtle deficits such as memory problems, concentration difficulties, and impaired higher level cognitive functioning.

Tests: The Glasgow Coma Scale has been used as a semi-quantitative measure of the severity of brain injury and provides a guide to outcome. Head/brain imaging may have been performed to rule out more serious injuries. Normal brain imaging would be expected. Mild concussions (mTBI) may be associated with subtle, long term changes in neuropsychologic or cognitive tests (Ref #1)

INITIAL MEDICAL CARE
(Day 1 - 7)
- Initial care

An initial period of physical and cognitive rest in the acute symptomatic period following injury (24-48 h) may be of benefit. (Ref #4)

The vast majority of patients who have sustained a concussion/mTBI improve with no lasting clinical sequelae (Ref #5)

Patients sustaining a concussion/mTBI should return to normal (work/duty/ school/leisure) activity post-injury as soon as it is safely possible

• A gradual resumption of activity is recommended

• If physical, cognitive, or behavioral complaints/symptoms re-emerge after returning to previous normal activity levels, a monitored progressive return to normal activity as tolerated should be recommended. (Ref #5)
Concussion (from WCB-IR-0089(1) cont’d)

<table>
<thead>
<tr>
<th>RETURN TO WORK OPTIONS</th>
<th>Day 1c</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Day 1 – RTW)</td>
<td>Return to work and normal life activities is generally felt to be the best rehabilitative approach given consideration of the physical and cognitive components of the job duties. Aspects of the work environment or job duties may trigger a temporary increase in symptoms and is frequently best managed by a graduated resumption of normal activities.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REHABILITATION PLAN (Day 8 – 42)</th>
<th>Day 8a</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>For those patients who remain symptomatic after the first week or two, continued reassurance and progressive activation and return to normal activities are indicated for the majority of mTBI patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-level exercise for those who are slow to recover may be of benefit, although the optimal timing following injury for initiation of this treatment is currently unknown. (Ref #4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The majority of workers will recover spontaneously over several days. It is expected that most will return directly to pre-injury work although a minority may require a GRTW plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to see improvement or reported increasing symptoms at the three to four week mark should prompt consideration of a concussion clinic referral.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deterioration over time after mild TBI is uncommon. In those patients complaining of worsening symptoms, other issues such as psychological or social stressors should be considered. (Ref #5) Referral to a Medical Advisor may be indicated.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESTRICTIONS AND LIMITATIONS (Day 1 to RTW)</th>
<th>Day 8b</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom free patients require no restrictions. Some individuals may require temporary restrictions and limitations related to common symptoms (e.g. dizziness, balance, sensitivity to sound and light, fatigue, memory and concentration problems, headaches).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The case manager should liaise with the employer to find out if there are any safety sensitive aspects to the worker’s job and any specific standards that apply (e.g. aviation, diving, marine pilots, rail, transport, law enforcement officers and fire fighters).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Concussion (from WCB-IR-0089(1) cont’d))

<table>
<thead>
<tr>
<th><strong>PROGNOSIS</strong></th>
<th>The vast majority of patients will be symptom free and able to return to work and life activities, by three to six months (Ref #7)</th>
<th>Day 21a</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FACTORS FOR PROLONGED DISABILITY (Day 21 to RTW):</strong></td>
<td>In general, 80–90% of mTBI patients fully recover in less than 90 days. Another 10–20% of persons with mTBI do not recover within 90 days and may have post-concussive symptoms. This group may continue to report symptoms for several months or years. (Ref #6)</td>
<td>Day 21b</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| If identified, arrange Team Meeting unless RTW is imminent | **Generic Factors Prolonging Disability:**  
- Pre-existing psychiatric concerns (i.e. depression)  
- Co-existing psychiatric concerns  
- Sleep problems  
- Dysfunctional coping styles/personality traits  
- Lack of social network and support  
- Multiple previous musculoskeletal complaints; history of chronic pain  
- Multiple previous claims  
- Severity and extent of injury; severity of pain associated with the injury; treatment method; response to treatment; adherence to treatment;  
- Alcohol or drug use/misuse; use of opioids (prescription or street)  
- Psychosocial issues (catastrophizing; fear of pain/avoidance; pain behaviours; perceived injustice; disability beliefs)  
- Job requirements (occupational issues)  
- Non-occupational activities  
- Pre-injury fitness level/overall health; older age (>50 years)  
**Specific RTW Factors**  
- Previous traumatic brain injury  
mTBI does not appear to be a significant factor for long-term work disability. Predictors of delayed RTW or unemployment seem to include a lower level of education, nausea or vomiting on hospital admission, extracranial injuries, severe pain early after injury, and limited job independence and decision-making latitude. (Ref #7) | **ARRANGE TEAM** **MEETING** | If RTW is not expected in the next 7 days, reschedule team meeting within the next 14 days. | Day 21c | Yes |
| **PHYSIOLOGIC RECOVERY EXPECTED FOR ALL WORK** | Review and confirm RTW factors contributing to worker’s ongoing disability | Day 21d | Yes |
| **POTENTIAL COMPlications** | There is limited evidence that psychological disorders arise directly as a consequence of mTBI. A small percentage of mTBI patients may have symptoms that persist for one to two years. | Day 21e | No |
MD Guidelines (from WCB-IR-0089(5))

**MD Guidelines**

**Information Request 0089(5)**

**Note:** MD Guidelines (MDG), developed by ReedGroup, provides evidence-based practice guidelines, clinical content and disability duration estimates, organized by injury diagnosis/ICD9 code. At WorkSafeBC, clinical staff may refer to MDG, or ODG (Official Disability Guidelines) in their review of claim medical issues and recovery plans.

In 2012, WorkSafeBC embedded a link to MDG in the Case Management Recovery & Return to Work Planning site of CMS. This access to MDG for case managers and return-to-work specialists is intended to provide quick access to injury information, which is designed to be understood by non-clinicians. It allows claim owners to quickly learn the risk factors, symptoms, diagnostic tests, treatments, prognosis, complications, and disability duration (by job demand category) for injuries affecting the workers they serve.

MDG is a library of information only. It is not relied upon by WorkSafeBC to make entitlement decisions on a claim, nor does it replace medical evidence or opinion on individual cases. The disability duration guidelines in MDG are for information only and are not considered evidence in claim decision-making.

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**Sample Page: MD Guidelines: Concussion Injury**

**Overview**

A concussion describes a sudden change in mental status after a mild head injury, with no immediate or delayed evidence of structural brain damage. The change in mental status may or may not be accompanied by a loss of consciousness (LOC).

Consciousness may be lost for a few seconds in a mild concussion, or for several minutes after a more severe head injury. In a mild concussion, there is a temporary or transient LOC (less than 5 minutes) and possible impairment of the higher mental functions, such as loss of memory of events preceding or following the injury (retrograde or anterograde amnesia) and emotional instability (lability). A severe head trauma produces prolonged unconsciousness with impairment of brain stem function, such as transient loss of respiratory reflex, blood vessel (vasomotor) activity, and dilation of the pupils (mydriasis).

Mild concussions are very common and may occur without loss of consciousness. Mild concussions, like more serious concussions, are associated with confusion or memory loss. But with mild concussion, these complaints clear within 24 hours. The initial physical exam is normal or mildly abnormal with Glasgow Coma Scale ratings of 13 to 15 (see Tests below). Mild concussions may be associated with post-concussion syndrome and subtle changes on psychometric testing lasting for several months. Individuals who have sustained mild concussions are more sensitive to recurrent head trauma. Mild concussions may also be referred to as mild traumatic brain injury (MTBI).

Concussion differs from contusion in that in the former, the injury is functional (affecting the functions but not the structure), whereas in the latter it is organic (pertaining to an organ). If unconsciousness persists for more than 6 hours (coma), it is likely that permanent brain tissue injury has occurred.
MD Guidelines (from WCB-IR-0089(5) cont’d))

Length of Disability

- Medical treatment, mild concussion.

<table>
<thead>
<tr>
<th>Job Class</th>
<th>Minimum</th>
<th>Optimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Work</td>
<td>1</td>
<td>3</td>
<td>28</td>
</tr>
</tbody>
</table>

Factors Influencing Duration

Length of disability will be affected by the level of concentration required on the job; the severity of the concussion; and any complications such as brain damage, symptoms of post-concussion syndrome, and mental impairment. Mild complaints associated with MTBI and post-concussion syndromes may challenge return to work efforts.

Causation and Known Risk Factors

In every age category males are more likely than females to sustain a concussion. The major causes of TBI are falls (35.2%), motor vehicle accidents (17.3%), being struck by or colliding with a stationary or moving object (16.5%), and assaults, including assaults with firearms (10%). Activities such as sports and other recreational activities, and professions that involve the potential for injury or violence are often associated with TBI, especially mild TBI (Faul). American Indian and Alaska Native individuals have the highest death rate among ethnicities from a TBI; black Americans have the second highest death rate (Coronado).

Prevalence / Incidence

Most cases of concussion are not severe enough to require hospitalization, and thus the prevalence and incidence of this injury is underreported. There are no current databases that follow the incidence of mild concussion, but the Centers for Disease Control and Prevention (CDC) estimates that about 75% of traumatic brain injuries (TBIs) are concussions or other forms of mild TBI (Summers; CDC). Each year an estimated 1.7 million Americans sustain a TBI; about 1,365,000 are treated in emergency rooms, 275,000 are hospitalized, and about 52,000 of them die (CDC; Faul).

Diagnosis

History

The individual may have a history of a blow to the head, followed by LOC. Transient LOC or brief loss of contact with the environment is the characteristic feature of a simple concussion. Individuals with a concussion may be slightly dazed for a few minutes and complain of headaches for 12 hours or longer. Mental confusion may be prolonged. Headaches, retrograde or anterograde amnesia (inability to recall events before or after the injury), and dizziness may be present after concussion. Prolonged LOC may be contingent on swelling, hemorrhage, or diffuse nerve (axonal) injury (DAI), or contusion or laceration of the outer brain (cortex). Severity of the symptoms and recovery time depends on the degree of brain damage. If surgery was needed to repair other injuries occurring at the time of the concussion, postsurgical shock may also be present.

Physical Examination
MD Guidelines (from WCB-IR-0089(5) cont’d))

The physical exam may reveal dizziness, mental confusion, clumsy movements, impaired balance, and other injuries. The examiner must also test for abnormal eye movements (tonic deviations of the eyes), rhythmic movements of the eyes (nystagmus), and pupillary reflex abnormalities. One-sided paralysis (hemiplegia), impairment of language function (aphasia), cranial nerve paralysis (palsy), and coma are neurologic signs that suggest severe brain damage.

Tests

The Glasgow Coma Scale (GCS) has been used as a semiquantitative measure of the severity of brain injury, and provides a guide to outcome. Computed tomography (CT) evaluates the acute, serious head injury to identify any evidence of bleeding within the brain or signs of brain damage. Magnetic resonance imaging (MRI) and positron emission tomography (PET) studies may be important in the evaluation of late stages of recovery from head injury but are not important in acute care. Lumbar puncture may be done to examine the cerebrospinal fluid (CSF) if there is question of infection. Electroencephalogram (EEG) is not considered to be a useful test following acute brain injury, but can help identify and guide treatment of persistent symptoms (post-concussion syndrome). Mild concussions (MTBI) may be associated with subtle, long term changes in neuropsychologic or intelligence tests, but these tests generally are not appropriate for medical management and are rarely used.

Treatment

Treatment of individuals with concussion includes observation for several hours, physical and mental rest (both night and daytime rest), and temporary reduction of workloads. Headaches can be treated with acetaminophen; it best to avoid nonsteroidal anti-inflammatory drugs (NSAIDs) because of the possibility that these drugs increase the risk of bleeding. The return to work must be authorized by a physician after all signs and symptoms have disappeared, especially if the job involves the risk of re-injury.

About 1% of individuals with an initial diagnosis of mild concussion are later found to have severe brain injury and may require treatment in the intensive care unit (ICU) or even surgical treatment.

Prognosis

The outcome for the individual with a concussion is related to the site and severity of the injury. With mild concussions (MTBI) or minor degrees of cerebral swelling, individuals fully recover from LOC. However, minor complaints and subtle changes in thinking or emotions may persist for some time. The mortality rate is almost zero in individuals with simple concussion and less than 2% when there is a mild degree of cerebral swelling.

Differential Diagnosis

- Cerebral contusion

Rehabilitation

Individuals who sustain a concussion may present with a variety of physical and cognitive disabilities, depending on the severity of the injury. Individuals with mild concussions require no specific therapy
MD Guidelines (from WCB-IR-0089(5) cont’d)

and are able to return to their prior level of function after a brief period of rest; however, some individuals may go on to require therapy for post-concussion syndrome.

Comorbidities

- Seizure disorder (e.g., epilepsy)

Complications

A concussion doubles the risk of an individual of developing epilepsy within the first five years after the injury. There is evidence that multiple concussions over the course of an individual’s life may have cumulative effects, with lasting and progressive cognitive impairment. Second impact syndrome may occur in some individuals that suffer a second concussion before signs and symptoms of another concussion have resolved, with rapid and usually fatal brain swelling. Up to 80% of those with mild to moderate brain injury will experience some symptoms of post-concussion syndrome.

Ability to Work

Individuals with simple concussion are usually allowed to return to their usual activities after 24 hours of observation. Mild, general post-concussive complaints such as headaches, fatigue, decreased concentration, sleep disturbances, dizziness, or irritability can complicate return to work.

For more information, refer to "Work Ability and Return to Work."

Risk

Individuals with concussion are not at risk of harm when performing work activities for which they have appropriate intellect and motor skills. Following physician clearance for return to work, the brain does not become injured or get worse with activity. There is no basis for work restrictions, unless post-traumatic seizures are present.

Capacity

Capacity will be unaffected in individuals with simple concussion.

Tolerance

Tolerance is dependent on the individual’s complaints of headache and fatigue and whether post-concussive syndrome is present; this may be mitigated by temporary modification of work tasks.

Maximum Medical Improvement

180 days.

Failure to Recover

If an individual fails to recover within the expected maximum duration period, the reader may wish to consider the following questions to better understand the specifics of an individual’s medical case.

Regarding Diagnosis
MD Guidelines (from WCB-IR-0089(5) cont’d))

- Does individual have history of a concussion followed by loss of consciousness?
- How long was individual unconscious?
- Does individual complain of a headache or dizziness?
- On exam, did individual have dizziness, mental confusion, clumsy movements, and impaired balance? Were there other injuries?
- Was a complete neurological examination done to exclude severe brain damage? Did individual have tonic deviations of the eyes, nystagmus, or pupillary reflex abnormalities? Was hemiplegia, aphasia, or palsy present?
- What was individual’s initial Glasgow Coma Scale score?
- Has individual had a CT scan, MRI, or PET study? Was a lumbar puncture done? Did individual have an EEG later?
- Have conditions with similar symptoms been ruled out?

Regarding Treatment
- Did individual’s treatment consist of observation and discharge?
- Were headaches treated with acetaminophen?
- Did a physician authorize the return to work?

Regarding Prognosis
- Is individual’s employer able to accommodate any necessary temporary restrictions?
- Does individual have any conditions that may affect ability to recover?
- Has individual had more than one concussion?
- Does individual have any complications such as epilepsy, or lasting and progressive cognitive impairment due to cumulative effects of multiple concussions over the course of the individual’s life?
- Did individual develop second impact syndrome?
- Does individual have post-concussion syndrome?

Hospital Costs

The following hospitalization statistics are derived from the 2016 Nationwide Inpatient Sample (NIS), provided by the Healthcare Cost and Utilization Project (HCUP). The 2016 NIS provides all-payer data (including persons covered by Medicare, Medicaid, private insurance, and the uninsured) on approximately 7 million inpatient stays from about 4,500 hospitals; this approximates a 20-percent stratified sample of discharges from U.S. community hospitals.
WEBC-IR-0089(5) MD Guidelines (cont’d)

Hospitalization statistics are presented by ICD-10-CM and Diagnosis Related Groups (DRGs). DRGs were established by the Centers for Medicare and Medicaid Services as a patient classification scheme to account for the severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity.

Hospital Charges in USD represents the median amount hospitals charge for an entire hospital stay. This amount does not include professional (MD) fees. Charges do not necessarily represent actual reimbursement.

- **S06.0X0A** - Concussion without loss of consciousness, initial encounter

<table>
<thead>
<tr>
<th>DRG</th>
<th>Length of Stay</th>
<th>Medicare / Medicaid</th>
<th>Private Payer</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concussion with CC</td>
<td>2</td>
<td>$30,256</td>
<td>$32,507</td>
<td>$38,158</td>
</tr>
<tr>
<td>Concussion with MCC</td>
<td>3</td>
<td>$34,855</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Concussion without CC/MCC</td>
<td>1</td>
<td>$22,906</td>
<td>$19,201</td>
<td>$24,208</td>
</tr>
</tbody>
</table>

- **S06.0X1A** - Concussion with loss of consciousness of 30 minutes or less, initial encounter

<table>
<thead>
<tr>
<th>DRG</th>
<th>Length of Stay</th>
<th>Medicare / Medicaid</th>
<th>Private Payer</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concussion with CC</td>
<td>2</td>
<td>$35,057</td>
<td>$30,305</td>
<td>-</td>
</tr>
<tr>
<td>Concussion without CC/MCC</td>
<td>1</td>
<td>$24,155</td>
<td>$22,469</td>
<td>$30,536</td>
</tr>
</tbody>
</table>

- **S06.0X9A** - Concussion with loss of consciousness of unspecified duration, initial encounter

<table>
<thead>
<tr>
<th>DRG</th>
<th>Length of Stay</th>
<th>Medicare / Medicaid</th>
<th>Private Payer</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concussion with CC</td>
<td>2</td>
<td>$34,616</td>
<td>$37,092</td>
<td>$39,577</td>
</tr>
<tr>
<td>Concussion with MCC</td>
<td>3</td>
<td>$37,932</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Concussion without CC/MCC</td>
<td>1</td>
<td>$29,511</td>
<td>$29,271</td>
<td>$30,812</td>
</tr>
</tbody>
</table>

- **Inpatient statistics were only calculated if at least 100 records per group were present in the 2016 NIS**

This site displays data obtainable in 2018 (the year that HCUP released its 2016 NIS data base).

References

Cited
MD Guidelines (from WCB-IR-0089(5) cont’d))

Recovery and Return to Work (from WCB-IR-0089(6))

Recovery and RTW Plan

Information Request 0089(6)

Note: Below is sample content from an Recovery and Return to Work Plan (RRP) in the CMS training environment. (No actual worker/claim data is included).

New Recovery And RTW Plan...  Edit Recovery and RTW Plan...  Edit RTW Factors...

Claim Work Items |  Communications Log

Recovery and RTW Plan

WORKER’S CURRENT TREATMENT AND ANTICIPATED TREATMENT LEADING TO RECOVERY

MD Guidelines = ice, nonsteroidal anti-inflammatory drugs (NSAIDs) for a few days and then physiotherapy. Sasha has been only doing ice/ibuprofen and has not started physiotherapy – no discussion about this with physician.

WORKER’S CURRENT PHYSICAL CAPABILITIES VS WORKER’S PRE-INJURY JOB DEMANDS AND TRANSITIONAL DUTIES AVAILABLE

Much of Sasha’s pre-injury duties involve full ROM and strength in her right arm. She may be able to do lighter work such as price checks and inventory (with no merchandise handling or assisting customers with merchandise). Store Manager (Mark) is determining if transitional duties can be set up. He will provide an update by the end of the week.

MITIGATION STRATEGY FOR RTW FACTORS (if applicable)

Pain & lack of function: contact physician to discuss referral to physiotherapy. Discuss with MA if no referral for physio or progress within 1-2 weeks.

PLAN (include reason for extension of aRTW and inconsistencies with MD Guidelines, if applicable)

Call physician re: physio recommendation
Commence physio within 1-2 weeks
Commence transitional duties within 1-2 weeks (MD Guidelines = 14-20 days post injury)
s. 29 wage loss payable to aRTW date of July 08, 2017

ANTICIPATED OUTCOME

PERMANENT FUNCTIONAL IMPAIRMENT
VOCATIONAL REHABILITATION REFERRAL
x ABLE / UNABLE (provide details if unable)
Details: Click here to enter text.

RTW factors

Pain

Appendix 15:  Recovery Guidelines
APPENDIX 16: INTEREST HISTORY

Prior to January 24, 1979, the Board did not pay interest on retroactive awards. On January 24, 1979, the former Commissioners of the Board instituted a policy providing that interest would be paid on certain retroactive awards. Interest payable was compounded monthly at a period rate of 0.4166% (approximately 5% annual). Effective January 1, 1980, this rate was changed to 0.50%. On April 30, 1980, the Board decided that the rate of interest should be identical with the average rate of return on the Board’s total investment portfolio for the preceding year. Therefore, the period rate was changed to 0.66%, the average return on the Board’s investment portfolio in 1979.

The Board’s method of calculating interest had not changed since its adoption in 1980. The Gill Royal Commission and the Administration expressed concern that the method may no longer be suitable. An April 27, 2000 Discussion Paper was issued regarding Calculation of Interest. A second Discussion Paper on interest was issued April 2001. The 1980s and 1990s were a period of high interest rates. The attached Appendix 2 – Rate Comparison from page 15 of the April 2001 Discussion Paper shows that in 10 of 21 years the Chartered Bank Rate exceeded the Board’s Interest rate on Investment returns. In those years it was more advantageous to the Board and less advantageous to the worker to use the Board’s rate of return.

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193 See policy item #50.10 of the Rehabilitation Services and Claims Manual as of April 2000. Interest was paid on pension lump sum payments. Effective November 26, 1981, interest was extended to retroactive wage-loss payments.
194 This change was made at a time when interest rates were at record highs. For example, the prime rate was around 17% during the month the Board adopted the new formula.
The questions put to stakeholder in the Discussion Papers were:

- How should the Board determine the rate of interest?
- Should the Board continue to provide compound interest? If so to what degree?
- Should the Board provide different rates for employers and workers?
- Should the Board limit the amount of time interest may accrue? (including not paying interest unless there has been a blatant Board error)

Interest rates have been much lower since 2002 and the Board's investments have exceeded bank rates very regularly. Whichever method may be used to calculate interest rates have been significantly less than they were in the 1980’s and 1990’s. Interest on delayed benefits would be much smaller based on current rates than they were when the changes to interest policy took place resulting in the current situation.

There was stakeholder submission/input to the Calculation of Interest Discussion Papers. The Board passed resolution 2001/10/15-03 on October 15, 2001 that amended policy item #50.00 effective November 1, 2001 to provide simple interest at a rate equal to the prime lender of the banker to the government (i.e., the CIBC) where it is determined that a blatant Board error necessitated the payment. A blatant error must be an obvious and overriding error.

The result of the policy change was virtual elimination of interest on delayed benefits to workers. A decisional error to deny benefits was not a blatant Board error. A concern from the worker community was the policy consultation.

There were numerous cases before the Courts mostly by Mr. Johnson looking for redress for the denial of interest on his delayed benefits. There is relatively easy access to the saga of Mr. Johnson’s legal pursuit to the question of whether the Board’s Interest Policy is supportable under the Act in WCAT’s online Research Library accessible at: https://www.wcat.bc.ca/research/index.html.

In WCAT-2005-03622-RB, a precedent panel of WCAT denied interest on retroactive wage loss benefits that were owed from a disability allowed on appeal for a previously denied 1999 surgery. The decision that paid retroactive wage loss benefits occurred very shortly after the policy change allowing benefits only in a case of blatant Board error. Mr. Johnson challenged the policy to the Courts. This journey is summarized in point form below:

- **Johnson v. Workers' Compensation Board et al., 2007 BCSC 24 January 9, 2001** allows a class action to proceed for all workers whose claim for interest on retroactive wage loss and pension awards was decided on or after November 1, 2001, a subclass of which is those who were injured prior to November 1, 2001.
- **Johnson v. Workers' Compensation Board, 2007 BCSC 1410 September 26, 2007** The term compensation under section 5 of the Act requires interest where those benefits
are delayed and it is not supportable under the Act to base entitlement to interest on the type of error (blatant) made by the Board.

- **December 20, 2007 in WCAT-2007- 04002** a precedent panel referred the Board’s decision back to the Board and directed the Board to make a fresh decision concerning the worker's entitlement to interest in light of the BCSC decision that the new interest policy was unlawful, and in light of any further policy direction by the board of directors.

- **Johnson v. Workers’ Compensation Board, 2008 BCCA 232 May 27, 2008** the Court of appeal quashed BCSC 1410 finding the judicial review overturned a decision of the Appeal Tribunal that was not before the Tribunal.

- **Johnson v. WCB, BCSC (October 21, 2008)** Justice Gray denies an application by the WCB to remove her from hearing the application for Judicial review.

- **Johnson v. Workers' Compensation Board of British Columbia, 2008 BCCA 436 November 5, 2008** concludes the appeal ought to be adjourned as the related judicial review was referred back to the trial court in chambers for the consideration of the issues in the Petition that remain to be determined.

- **Johnson v. British Columbia (Workers’ Compensation Board), BCSC (July 2, 2009)** It would have been better if Mr. Johnson had raised section 5 arguments regarding eligibility for interest before WCAT. The class is now out of time to raise arguments on this, even though it was not the fault of the members of the class to fail to raise the Section 5 Argument.

- **Johnson v. British Columbia (Workers’ Compensation Board), BCCA (June 2, 2011)** the Court of Appeal set aside the September 9, 2009 decision of the BCSC and dismissed the judicial review petition. The Court found that the respondent had failed to exhaust the internal remedy available under section 251 of the Workers Compensation Act.

- **Johnson v. British Columbia (Workers’ Compensation Board), SCC (January 19, 2012)** application for leave to appeal from the Judgment of the Court of Appeal for British Columbia 2011 BCCA 255 dated June 2, 2011, was dismissed by the Supreme Court of Canada.

- Mr. Johnson had exhausted his challenge of the Board’s interest policy to a dead end for him in a labyrinthine process. His efforts drew comments in other cases before the courts in regard to Board policy. There are other examples of the nearly impossible routes to raise legitimate challenges to Board policy in areas of mental disorder claims and loss of earnings assessments.

- **WCAT issued an April 18, 2012 decision (WCAT-2012-01018)** that interest policy item #50.00 is so patently unreasonable that it is not capable of being

**APPENDIX 16: INTEREST HISTORY**

Section 251 of the *Workers Compensation Act* sets out a **labyrinthine appeal route** from decisions of the WCB where policies adopted by its board of directors are challenged. Ultimately, that route can culminate in the board of directors being asked by the WCAT to review its policy. In **Johnson v. British Columbia (Workers’ Compensation Board), 2011 BCCA 255**, this Court considered this internal review process and identified certain inadequacies in it.

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Jozipovic v. British Columbia (Workers’ Compensation Board), 2012 BCCA 174
supported by the Act. The issue that was being dealt with in this decision was whether it was patently unreasonable to base eligibility to interest on whether the decision to deny benefits was a blatant Board error. The WCAT finding was that requiring errors to be blatant in order to pay interest was unsupportable under the Act. The entitlement to interest on delayed benefits should not be dependent on the type of error made by the Board.

- In a July 17, 2012 letter\(^\text{198}\), the Board of Directors (BOD) reached the conclusion that the blatant Board error test is rational when considered in light of the objectives and purposes of the Act. There is no additional reasoning or explanation for this conclusion in 1¼-page letter from the BOD.

- In all the process on the issue of interest for delayed benefits, the questions avoided the central issue of whether interest should be paid on delayed benefits. There were massive resources expended on a peripheral question of whether a blatant error test was supportable under the Act. The BOD amended policy item #50.00 Interest in resolution 2013/11/20-01 by concluding that interest would be paid only in matters the Act provides express entitlement under sections 19(2)(c) and 258. This cut off entitlement to interest for delayed compensation benefits to workers even under blatant Board error. There was no policy consultation prior to resolution 2013/11/20-01. The policy was made in a vacuum relevant to the normal process of stakeholder consultation for significant or consequential policy changes.

- The frustrations and challenges of the debate of interest on delayed compensation and the eventual outcome of concluding that interest would not be paid except in circumstances where there are express provisions in the Act support a conclusion that there should be an express provision in the Act in order to resolve this issue. Before making a recommendation on a provision in the Act on interest for delayed compensation the matter of whether there should be interest for delayed compensation must be addressed on its merits.

Merits of the Issue of Whether Interest Should be Paid for Delayed Compensation

- In *Johnson v. Workers' Compensation Board, 2007 BCSC 1410* September 26, 2007, Justice Gray concluded that compensation under section 5(2) of the Act included interest for the time effect on the value of delayed payments. This decision was quashed on the technical issue that the procedures under s.251 had not been followed. We agree with the reason and conclusions of Justice Gray that there is a time value to benefits and that the time value should be addressed by the payment of interest on delayed benefits. There is no weight or precedent to Justice Gray’s conclusion. There is also no

impediment to consideration of the same reasoning. Irrespective of the quashed nature of this decision, I consider the arguments, facts and case law as set out reaching the same conclusion that compensation is payable under section 5(2) on the first day following the date of injury to be a correct conclusion. The value of payments (compensation) diminishes with time. This diminishment should be adjusted for by the payment of interest.

- Interest should be paid based on the delay in the payment and not on the nature of the error that resulted in the delay.
- Interest was paid on delayed compensation benefits from 1979 to January 1, 2014. The November 1, 2001 blatant error requirement dramatically reduced eligibility for interest but it did still exist until January 1, 2014. It would not be a new matter to return to paying interest on delayed benefits. Interest rates are considerably lower than they were when the policy changes started. There would be significantly less financial impact on the Board to paying interest due to lower interest rates.
- The rationale for paying interest as expressed in the April 27, 2000 Discussion paper are:

None of the published decisions of the former Commissioners, which created the interest policy, describes the rationale for paying interest. However, there are at least three general principles that may be applicable:

- Interest may be justified on the basis that delayed compensation payments are similar to overdue business accounts on which the Board, as a corporation, pays interest.
- Interest may be justified on the basis that it is compensation for the loss of advantage accruing from funds at the time they were originally payable.
- Interest may be justified on the basis that it is remedial - it places a person in the same position in which they would have been had the benefit been allowed in the first place. Interest remedies the expenses associated with borrowing money or expensing personal resources while awaiting the payment of benefits initially denied or over-looked.

Given the principles stated above, it appears reasonable to accept the Appeal Division’s conclusion that interest payments are intended to compensate the worker or employer for being denied the opportunity to have immediate access to money. If this premise holds true, the appropriate rate of interest should be that which provides adequate compensation for this loss or employer for being denied the opportunity to have immediate access to money.

- When workers are denied benefits for a significant period of time, they will deplete savings and, in many cases, add debt which may often be consumer (credit card) debt. The cost of the delayed payments is considerable to workers. It is not uncommon for workers who experience delayed benefits to lose assets, including homes, as a result. There is clear and ethical justification based on the loss experienced by the delay to compensate at least in part with interest. For the vast majority of workers that have
significantly delayed benefits, the loss will vastly exceed interest payments whichever method is used.

- There is a strong economic rationale for interest to be paid on delayed benefits. The Board accrues interest on retained benefits at the rate of interest on their investments. The Board has a financial gain when benefits are delayed. It does not matter whether there is any intention to delay benefits. Adam Smith’s “Invisible Hand” of economics creates a benefit to the Board in denying and delaying benefits when the Board gains interest and does not have to pay interest on delayed compensation benefits. Paying interest at the Board’s rate of return would remove the Invisible Hand economic effect making that impact neutral. Paying interest at some lower rate would retain some degree of economic influence and benefit to delay benefits. Applying the Board’s rate of return as the interest rate paid on delayed compensation results in a no loss/no gain scenario for the Board. It is for this reason it is recommended that the interest rate should be based on the Board’s rate of return on its investment portfolio.

- Interest should not be paid on short delays. The amount of interest paid on a short would not be significant even though the worker may have gained several thousands of dollars in consumer debt over the period of a few missed pay cheques. The period to start paying interest should not be as long as a year. That was provided for in previous policy. A delay of 180 days or greater is clearly excessive and would be result in significant loss for a person who has benefit payments delayed that long. Interest accumulates against a person on a compound basis and accrues to the accident fund on a compound basis. It is therefore suitable that compound interest should be paid.

- Other jurisdictions provide for the payment of interest on delayed compensation.\(^{199}\) Ontario pays interest under policy document 18-01-08\(^{200}\) for any delay under the rates in the Courts of Justice Act.

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\(^{199}\) Yukon WCA Interest, Section 31- If compensation is payable, the decision-maker, hearing officer or appeal tribunal shall order that interest be paid on that compensation in accordance with a board of directors’ policy and the board shall pay that interest. S.Y. 2008, c.12, s.31

### APPENDIX 2

**Rate Comparison**

<table>
<thead>
<tr>
<th>YEAR&lt;sup&gt;a&lt;/sup&gt;</th>
<th>BANK RATE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>CHARTERED BANK PRIME&lt;sup&gt;c&lt;/sup&gt;</th>
<th>BOARD’S INTEREST RATE BASED ON INVESTMENT RETURNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>15.67%</td>
<td>16.75%</td>
<td>8.65%</td>
</tr>
<tr>
<td>1981</td>
<td>17.40%</td>
<td>18.25%</td>
<td>9.62%</td>
</tr>
<tr>
<td>1982</td>
<td>15.32%</td>
<td>17.00%</td>
<td>10.93%</td>
</tr>
<tr>
<td>1983</td>
<td>9.46%</td>
<td>11.00%</td>
<td>11.83%</td>
</tr>
<tr>
<td>1984</td>
<td>10.82%</td>
<td>11.50%</td>
<td>10.30%</td>
</tr>
<tr>
<td>1985</td>
<td>9.75%</td>
<td>10.75%</td>
<td>10.05%</td>
</tr>
<tr>
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<td>11.25%</td>
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</tr>
<tr>
<td>1987</td>
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<td>12.00%</td>
</tr>
<tr>
<td>1988</td>
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<td>1989</td>
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<td>5.00%</td>
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</tr>
<tr>
<td>2000</td>
<td>5.50%</td>
<td>7.00%</td>
<td>12.60%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Shaded areas indicate those years when the Board’s rate was less than the prime lending rate.

<sup>b</sup> The month of April is used as a point of reference for comparison.

<sup>c</sup> Lending rates provided by the Bank of Canada.

<sup>d</sup> Lending rates provided by the Bank of Canada.
APPENDIX 17: GENDER-BASED ANALYSIS PROCESS


What is GBA+?

GBA+ is an analytical process used to assess how diverse groups of women, men and non-binary people may experience policies, programs and initiatives. The “plus” in GBA+ acknowledges that GBA goes beyond biological (sex) and socio-cultural (gender) differences. We all have multiple identity factors that intersect to make us who we are; GBA+ also considers many other identity factors, like race, ethnicity, religion, age, and mental or physical disability.

For more information about identity factors go to Government of Canada's Approach, or take the Introduction to GBA+ online course.
GBA+ and gender equality

In 1995, the Government of Canada committed to using GBA+ to advance gender equality in Canada, as part of the ratification of the United Nations' Beijing Platform for Action.

Gender equality is enshrined in the Charter of Rights and Freedoms, which is part of the Constitution of Canada. Gender equality means that diverse groups of women, men and non-binary people are able to participate fully in all spheres of Canadian life, contributing to an inclusive and democratic society.

The Government recently renewed its commitment to GBA+ and is working to strengthen its implementation across all federal departments.

To learn more about the Government's renewed commitment, including its response to the 2015 Report of the Auditor General of Canada "Implementing Gender-based Analysis", view the:

Action Plan on Gender-based Analysis (2016-2020)
View the Action Plan in HTML
View the Action Plan in PDF

Achieving gender equality depends on closing key gaps between diverse groups of women, men and non-binary people.

For more information about the history of GBA+ in Canada, see The history of GBA+ module of the Introduction to GBA+ online course.

Mythbusters

1. Myth: Women and men are already equal in Canada, so GBA+ is not needed.

While many advances have been made, significant equality gaps remain. Today, even women in Canada who work full-time earn on average only 87 cents to every dollar earned by men (Statistics Canada, 2017). Women are also more often the victims of domestic and sexual violence. They also continue to be under-represented in leadership and executive positions, occupying just 23% of board positions in Canada’s top 500 corporations (Canadian Board Diversity Council 2017 Report Card). The gap is even larger for women with particular intersecting identify factors, such as transwomen and women with a disability.

Gender equality benefits everyone in a society, and GBA+ can improve the situations of women, men and non-binary people. For example, in the same way that women were left out of heart disease research because it was seen as a “man's disease,” men have historically been overlooked in osteoporosis research. While osteoporosis is often considered a disease of post-menopausal women, men actually account for nearly a third of osteoporosis-related hip fractures.
2. Myth: GBA+ only applies to women’s issues – it is advocacy for women.

GBA+ is not advocacy. It is an analytical process designed to help us ask questions, challenge assumptions and identify potential impacts, taking into account the diversity of Canadians.

In addition to sex and gender, GBA+ considers all identity factors, such as race, ethnicity, religion, age and mental and physical disability. Once an issue has undergone the GBA+ process, gender may emerge as the most important factor, while in other cases it might be any or a combination of factors that influence a person’s experience of a government policy, program or initiative.

Your department’s mandate could also impact your entry point for GBA+. You might begin with ethnicity, or with (dis)ability. Regardless of entry point, however, every human cell has a sex and every person is gendered, and sex and gender must not be neglected in your analysis.

3. Myth: GBA+ only applies to the “social” sectors.

All government policies and programs affect people. While gender and diversity issues may be more obvious in some areas, such as education and health, and less obvious in others, such as natural resources and defence, this does not necessarily mean that gender is not relevant. GBA+ can and has been used in all federal sectors and domains. For example, using GBA+ to assess large-scale procurement projects can help to ensure that equipment and products meet diverse needs. It can also help to ensure that strong hiring strategies are implemented within the public service to ensure workplace diversity.

**Government of Canada’s Approach**

**GBA+**

**GENDER-BASED ANALYSIS PLUS**

- **Sex vs. Gender**
- **What about the “plus”?**
- **Our Commitment**
- **GBA+ is everyone’s responsibility**

**Sex vs. Gender**

Definitions of sex and gender are often – incorrectly – used interchangeably. Both need to be understood and carefully considered if we are to determine the impact and effectiveness of government initiatives. You might think (assumed) that only one or the other is a factor, but sometimes it can turn out to be the opposite of what you thought. And, often, there is a combination of physical and socio-cultural factors at play.

Not all individuals identify with a binary concept of sex or gender categories of male and female, masculine and feminine. Important dialogue on gender identity is ongoing in Canada and around the world. Our understanding of sex and gender and how and when to use these designations continues to grow and shift. Visit the [online course](https://www.ubc.ca/budget/gender) for a list of definitions.

**What about the “plus”?**

Gender-based Analysis Plus (GBA+) isn’t only about gender, and groups of people are not homogenous. Our experiences are affected by intersecting parts of our identity, the context we are in and our lived realities.

We all have multiple identity factors that intersect to make us who we are. This is called intersectionality. The “plus” highlights the fact that GBA has always gone beyond sex and gender. It examines how sex and gender intersect with other identities such as: race, ethnicity, religion, age and mental or physical disability.
Use GBA+ all the intersecting identity factors of diverse groups of women, men and non-binary people so that you can be more inclusive in your approach to developing, delivering and evaluating initiatives.

Without GBA+, we risk missing or misreading the experiences of a significant portion of the Canadian population and—as a consequence—risk developing policies and initiatives that can inadvertently increase inequalities. It is therefore critical that we apply GBA+ to optimize the impact and effectiveness of all federal initiatives.

To learn more about intersecting identity factors, watch this micro-learning video called Beyond sex and gender.
Our Commitment

Did you know that GBA+ is recognized as a key competency in support of the development of effective programs and policies for Canadians?

The Government of Canada has been committed to using GBA+ in the development of policies, programs and legislation since 1995. It provides federal officials with the means to continually improve their work and attain better results for Canadians by being more responsive to specific needs and circumstances.

The Government recently renewed its commitment to GBA+ and is working to strengthen its implementation across all federal departments.

To learn more about the Government’s renewed commitment, including its response to the 2015 Report of the Auditor General of Canada “Implementing Gender-based Analysis”, view the:

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GBA+ is everyone’s responsibility

Status of Women Canada plays a leadership role in the government-wide implementation of GBA+, however, the commitment to GBA+ is a shared responsibility across all departments and agencies.

All federal officials should incorporate GBA+ into their work by asking some basic questions and challenging personal assumptions about diverse groups of women, men and non-binary people. Through the systematic use of GBA+, federal officials are able to improve their work, ensuring it is inclusive of diverse perspectives.

Federal public servants are encouraged to visit Status of Women Canada’s GBA+ GCpedia page for helpful information on how to better integrate GBA+ in departments and agencies.

Status of Women Canada:

- Shares GBA+ knowledge
- Provides technical assistance to departments and agencies
- Develops GBA+ tools and training

Central agencies:

- Exercise a challenge function
- Provide guidance on incorporating GBA+ where appropriate

Federal departments and agencies

- Conduct GBA+
- Integrate and sustain the practice of GBA+
- Monitor and report on GBA+ practice and outcomes

For more information on the roles and responsibilities for GBA+ in the federal government, see the GBA+ roles and responsibilities module of the Introduction to GBA+ online course.
APPENDIX 18: PRINCIPLES FOR LABOUR INSPECTORS

Principles for Labour Inspectors: With Regard to Diversity-Sensitive Risk Assessment, Particularly As Regards Age, Gender, And Other Demographic Characteristics. European Commission, 2018.
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N.B. All suggestions to labour inspectors in this document are only recommendations.
The respective member states’ national legislation applies.
1. Background to the publication

The Senior Labour Inspectors’ Committee (SLIC) decided in May 2017 to form a working group (WG) to consider new and emerging risks, called the WG Occupational Health and Safety Emerging Risks (WG EMEX). Its purpose was to address musculoskeletal disorders (MSDs), psychosocial risks, as well as the demographic challenges that all EU Member States face. A gender perspective was also expected. The original background to WG EMEX was the communication from the European Commission in January 2017 that identified new and emerging risks as growing concerns for European employers and thus for national labour inspectorates (NLIs).

Representatives of seven Member States, i.e., Cyprus, Denmark, Greece, Finland, Poland, Romania, and Sweden (chair) formed the WG EMEX in September 2017.

The purpose of this publication is to help NLIs develop inspection procedures and to increase the confidence of labour inspectors when addressing diversity-sensitive risk assessment. Also, it is intended to enhance the effectiveness of labour inspectors’ workplace interventions, particularly regarding age and gender issues.

The publication consists of four main chapters focusing on diversity-sensitive risk assessment. Chapter two explains why a holistic approach to occupational safety and health (OSH) is needed when dealing with new and emerging risks. Chapter three applies the same perspective to risk assessment. Chapter four clarifies why an age perspective on OSH and risk assessment is important when addressing the demographic challenge. Recommendations are given to labour inspectors on how they can prepare, carry out, and follow up inspections in order to promote this perspective. The last chapter presents a gender perspective on OSH and risk assessment, also making recommendations for labour inspectors.

A labour inspector will of course integrate questions from chapter two with age and gender aspects in her/his strategy when planning an inspection. He/she can also plan targeted inspections based on the suggested questions incorporating the age and gender perspectives, respectively. However, to clarify the importance of the different perspectives, it was decided to keep the information in separate chapters.

For further information, lists of references and suitable literature are provided at the end of the chapters.
2. A holistic perspective on occupational safety and health (OSH)

2.1 Introduction
To incorporate both a physical and psychosocial perspective, OSH issues at workplaces must be addressed using a holistic approach. According to the Framework Directive (89/391/EEC), which is implemented in every Member State's national legislation, an employer is, for example, obliged to:

- take the measures necessary for the safety and health protection of workers, including prevention of occupational risks and provision of information and training, as well as provision of the necessary organisation and means;
- be in possession of an assessment of the risks to safety and health at work, including those facing groups of workers exposed to particular risks;
- designate one or more workers to carry out activities related to the protection and prevention of occupational risks for the undertaking and/or establishment;
- take the necessary measures for first aid, fire-fighting, and evacuation of workers;
- keep a list of occupational accidents resulting in a worker being unfit for work for more than three working days; and
- consult workers and/or their representatives and allow them to take part in discussions on all questions relating to safety and health at work.

The term “OSH management system” is not used in the Framework Directive, but the very act of assessing a risk often leads in practice to the development of ideas for control measures, and thereby into the realm of risk management. This fact, together with a preventive approach, often means that an employer needs to create, maintain, and continuously develop procedures and activities as well as allocate tasks and resources in order to fulfill the requirements of the Framework Directive. Risk assessment is of course just one cornerstone of an effective OSH management system; the OSH policy of the employer (even if not mentioned in the Framework Directive), procedures for collaboration with the workers’ representative(s), and OSH training are other important factors. The extent of an OSH management system varies depending on, for example, the size of the workplace, but a holistic approach is always needed.

N.B. In this publication, the term “OSH management system” does not refer to a purchased system, but to the OSH organisation within a company, however it is achieved.

NLIs can promote the development of OSH management systems in various ways, for example, by setting up awareness-raising campaigns, uploading information and tools to their websites, training labour inspectors, and holding dialogue with stakeholders (e.g., employers, social partners, workers’ representatives, and OSH services).

2.2 What can a labour inspector do to promote a holistic approach to OSH?
Promoting a holistic approach to OSH management requires thorough examination of the workplace as a whole, taking account of and addressing all factors that could influence workplace safety and health. From this perspective, the labour inspector has a number of opportunities, as discussed below.
When planning an inspection the labour inspector can:

- Point out to the employer that he/she wants to discuss various aspects of OSH when inspecting, i.e., not focusing just on the risk assessment. This can be done by sending the employer a written agenda before the inspection. This initiative gives the employer a chance to both reflect and prepare her/himself. Also recommend that the employer initiate dialogue with safety representatives.
- If applicable, inform the employer about the NLI website, which contains information on various aspects of OSH.
- Remind the employer that the workers’ representative(s) is/are supposed to participate in the inspection. Ensure that he/she/they also receive the agenda.

During an inspection the labour inspector can:

Ask questions about the employer’s procedures for dealing with OSH issues at the workplace, including:
- collaboration with workers’ representatives;
- introduction of specific OSH training for new employees;
- when introducing new equipment or chemicals;
- when changing the organisational structure;
- reporting incidents and work-related accidents and injuries;
- when internal or external services are used;
- adaptation of workstations to specific, individual needs;
- when specific measures are needed to help an employee return to work after sickness absenteeism; and
- when procedures are followed up and revised (at least annually).

Ask the employer to present statistics about sickness absence as well as work-related accidents and diseases, including conclusions and proposed or taken measures.

Remember to ensure that the workers’ representative(s) participate in any discussions.

After an inspection the labour inspector can:

- Stipulate or give advice according to the applicable national legislation. He/she should also point out that a holistic perspective on OSH together with a preventive approach will create better and more effective results.
- Depending on the severity of the actual deficiencies as well as the internal NLI rules, decide whether a follow-up inspection is needed.

Further information:
3. Risk assessment with a holistic approach

3.1 Introduction
Currently, many risk assessments are based on workplace and work characteristics and on work factors. Less attention is paid to specific human characteristics, since risk assessments tend to be designed with the average human in mind.

A more holistic approach should take into consideration many factors, and be developed in line with corporate values and corporate safety culture. Risk assessment is a core element of the OSH management system concept. It has proved to be an effective way to raise the standard of protection against physical harm as well as to improve well-being in both the physiological and psychological senses.

To implement a roadmap to achieve this goal, one must start with policy and legislation. Based on specific provisions, a company carries out the risk assessment, bearing in mind work and workplace characteristics. The development and implementation of risk assessment requires employer commitment, a well-defined OSH management system, and a safety culture.

Considering and addressing new emerging risks takes risk assessment to a higher level and calls for appropriate OSH management processes and culture. However, in most cases such an approach is initially designed with the average human in mind. On second consideration, questions should be asked about whether all the processes, tasks, and measures mentioned in the risk assessment can be performed by everyone. In that sense, limitations posed by specific human characteristics, such as age, gender, and language, will be identified. Worker participation could be crucial at this stage, in which special attention is paid to human characteristics.

When considering the "human factor" in risk assessment, the three dimensions of matching the job to the person should be taken into account (see Figure 1).

![Figure 1. The dimensions of matching the job to the person.](image-url)
3.2 Individual factors – individual differences
Physical differences (e.g., build, gender, health, and ability) as well as mental differences (e.g., attitude, motivation, and experience) need to be considered carefully when establishing controls for work activities. Some differences may limit individuals in performing certain tasks, or even exclude them altogether from these tasks (see Figure 2).

![Diagram showing individual factors]

Figure 2. Individual factors.

3.3 Ergonomic/technological approach to designing tasks/jobs
Tasks should be designed in accordance with ergonomic principles in order to accommodate limitations in human performance and physical ability. The main areas of interest are: critical task analysis, design of person-machine interfaces (e.g., displays and control devices), and ergonomic design of tools, programs, and work equipment (see Figure 3).

![Diagram showing ergonomic/technological approach]

Ergonomics/technologies

- Machines and work equipment are adapted to humans and safe to use
- Use aids to promote good ergonomics
- Good visual and aural conditions
- Training is provided when launching new support systems
- ICT programs are intuitive, user friendly, and integrated
- Tools, programs and work equipment are adapted to the tasks

Ergonomics/technologies support humans
3.4 Organisational factors
The work culture should promote staff commitment to health and safety and emphasise that deviation from health and safety goals at any level is unacceptable. Organisational culture strongly influences human behaviour and can be critical in determining the well-being at work of sensitive groups of workers exposed to specific risks, such as psychosocial risks, bullying, and harassment (see Figure 4).

3.5 Benefits of a holistic approach to risk assessment
The result of a holistic approach should be an improved risk assessment. The whole risk assessment process should be regularly repeated and evaluated to address managerial issues and organisational limitations, motivated by the company’s safety culture and targeting the improvement of OSH management and OSH in general.

Employees should be seen as a diverse team comprising people with different and complementary characteristics. When working effectively, all team members collaborate on the same tasks, jointly accomplishing more than the sum of their individual efforts. Human factors should be seen as OSH areas that should be paid special attention; for example, older employees hold the keys to safety culture, business continuity, and internal processes, which are often held in the memory and not appropriately documented and described.

Companies usually learn only after incidents. However, they should proactively consider various good practices, look at what works, and develop their corporate risk management culture.
3.6 What can a labour inspector do to assess both the quality of the risk assessment and the measures taken/planned?

When planning an inspection, the labour inspector can:

- if possible according to national procedures, inform the employer that he/she wants to discuss their risk assessment practices (the content may vary depending on the sector, but should at least always address common sectoral risks, including MSDs and psychosocial risks); and
- if appropriate, inform the employer that the inspection will include a visit to a number of workstations.

During an inspection, the labour inspector can:

Ask questions, such as:

- Who conducted the risk assessment?
- Were the internal/external OSH services involved?
- How were the workers’ representative(s) involved?
- What tool(s) was/were used?
- Did the risk assessment cover well-known risk areas, including MSDs and psychosocial issues?
- Did the risk assessment take into account statistics on work-related incidents, accidents, and diseases?
- Did the risk assessment cover all workers who may be at greatest risk, i.e., vulnerable groups such as pregnant women, migrant workers, younger and older workers, and temporary-agency workers?
- Have the planned measures been taken?
- If not, does an action plan with defined responsibilities and deadlines exist?
- Will the measures planned or taken prevent work-related accidents and diseases, according to your own experience?
- Do the actual measures correspond to the provisions of the applicable national legislation?
- Has the employer followed the hierarchy of controls, i.e., prioritising collective measures over individual ones?
- Have the results of the risk assessment been disseminated to workers and their representatives, workplace managers, etc.?

The labour inspector can visit a number of workstations, talk to several employees belonging to different work groups, and assess whether the risk assessment covers them and whether suitable measures have been planned or taken.

After an inspection the labour inspector can:

Stipulate/give advice according to the applicable national legislation that the employer must:

- complete the risk assessment by addressing, for example, workstations, groups not covered, and risks not assessed;
- use internal/external OSH services;
- allow the workers’ representative(s) to participate in the work;
- consider who is responsible for future measures and applicable deadlines; and
- carry out concrete measures to eliminate non compliance with national OSH legislation.

References

1 Material to inspection campaign 2016-17, Healthy workplaces for all ages, Swedish Work Environment Authority, 2017
4. An age perspective on OSH and risk assessment

4.1 Why an age perspective?
This chapter presents the age perspective on OSH, to help labour inspectors address age in relation to risk assessment at the workplace. The purpose is to help labour inspectors identify shortcomings and to supply information regarding the risk assessment of working conditions for women and men of all ages.

According to the EU OSH Strategic Framework 2014–2020, the ageing workforce is one of three major challenges. Sound health and safety for workers are necessary for a sustainable working life and active and healthy ageing, especially in light of the ageing working population and the extension of the working life. This requires the creation of a safe and healthy environment throughout the working life of an increasingly diversified workforce, as health in later life is affected by working conditions in earlier life. Applying a life course approach to OSH should be the goal of every employer, and an age-management system could be a tool for doing so. The promotion of a culture of prevention is also essential to achieving this.

The European Healthy Workplaces Campaign 2016–2017 chose not to focus on older workers but to stress the importance of promoting sustainable work and healthy ageing from the start of the working life, and of preventing health problems throughout the working life.

“The young workers of today are the older workers of tomorrow.”

4.2 What is working life like for workers of different age groups in the EU?

4.2.1 The overall picture
- Current demographic developments in Europe in relation to workforce ageing represent a huge challenge, taking into account that 19% of the EU-28 population was older than 65 years in 2016. By 2080, Eurostat estimates that around 29% of the "EU-28" population will be over 65 years of age.¹
- Workforce ageing is a long-term trend reflected in an increasing number of older workers coupled with a declining number of working-age persons. From 2005 to 2015, the employment rate of older workers increased by more than 13% in EU-28, reaching 55% in 2016.² On the other hand, 23% of young men and 21% of young women in the EU were unemployed in 2014, while the average unemployment of the total population stood at 10%.³
- The average age at which workers leave the labour market in the EU is 61 years, significantly below the average official retirement age. Older workers are likely to face health problems, which could create difficulties for their full participation in the labour market. One reason why older people are more likely to experience poorer health is their longer exposure to risks in the work environment throughout their working life. At the same time, older workers’ experience and knowledge can compensate for decreasing physical capacity.⁴
- The proportion of younger people in the working population is decreasing significantly: in 1990, 56% of the working-age population was 15–54 years of age, whereas the estimated percentages for 2020 and 2040 are 51% and 46%, respectively.⁵
- Micro-enterprises tend to employ the highest proportion of employees aged 50 years or older, while large enterprises employ the highest proportion of young people.⁶
According to EU Statistics on Income and Living Conditions (EU-SILC) data, in the EU-28 in 2013, 33% of the employed population aged 55-64 years reported suffering from a long-standing illness or health problem, versus only 14% of those aged 16-44 years. They are more likely to be working part-time. Young workers do more shift work and weekend work and have more irregular working hours than do workers as a whole. There is no consistent evidence of an association between age and performance at work; rather, poor work performance is related to, for example, lack of recognition, work not being valued, conflict with supervisors, high job stress, and lack of support.

4.2.2 Young workers
OSHWiki considers those aged 15-24 years to be young workers. Included in this age group are: workers in their first jobs, full- and part-time workers, temporary workers, young workers still in full-time education working part-time to supplement their income either year round or in vacation time only, apprentices contracted to an employer (usually full time), and trainees in non-contractual work.

Information about the special regulations for young persons under the age of 18 according to Directive 94/33/EC is not presented in this chapter, as it’s assumed that all Member States already have legislation and procedures covering this matter.

Young workers are at risk of work-related accidents and injuries for a variety of reasons, such as:

- lack of experience, maturity, awareness of risks, skills, information, and training;
- unawareness of their OSH rights and of employers’ responsibilities;
- overrepresentation in temporary agencies;
- reluctance to speak out about problems and desire to please their employers; and
- employers unawareness of the additional protection (e.g., introduction and OSH training) that young workers need.

4.2.3 Older workers
There is no commonly recognised age at which someone is considered an older worker, but the threshold is usually considered to be 60 years of age. What should a labour inspector take into account in relation to older workers when inspecting a workplace? The following matters merit consideration:

- Older workers may be able to perform the same tasks as younger workers, but they may be working closer to their maximum performance level, especially from a physical perspective.
- The ageing process can affect the worker’s ability to undertake extended heavy physical activity and can reduce the body’s ability to adjust to hot and cold conditions (i.e., due to external temperature or physical work). When engaging in hard manual activity, older workers may become overheated more easily.
- Older workers tend to have fewer accidents than do younger ones, but when they do have accidents their injuries are often more severe and entail longer recovery times.
- During the ageing process, the human body loses range of motion and flexibility. Workers usually use a certain range of movements during their work tasks. Problems may arise for older workers when unpredictable situations require unusual movements.
Older workers are more vulnerable to the negative effects of shift and night work: decreased ability to adjust the body clock to night work and increased sleep disturbances may cause poorer tolerance of shift work in older workers.

- Vision and hearing change with age: older workers may not be able to see/read from a certain distance or to hear as well at higher frequencies.
- Some cognitive functions decline with age; for example, information processing slows down. Older workers can compensate for this with their experience. Enormous variability exists between individuals in this regard.
- Other conditions, such as changes in work organisation and demands for new skills, can also affect older workers more than younger ones. Moreover, fatigue, the need for a slower work pace, and the need for rest generally increase with biological ageing, as do chronic health problems.

4.3 Incorporating age issues in risk assessment

In view of the above considerations, which are not exhaustive, workers of all ages need adequate training and supervision as well as a safe and suitable work environment matched to their skills and mental and physical abilities. For these reasons, EU legislation (99/391/EEC) requires that employers take special account of vulnerable groups of workers during risk assessment and apply appropriate preventive and protective measures.

Workforce diversity must be taken into account when assessing and managing risks. A systematic risk assessment should improve workplace safety and health for all workers, independent of age. An overly general approach to risk assessment and prevention without an age perspective can result in risks to younger/older workers and in other age groups being paid insufficient attention or even ignored.

“What’s essential for one worker benefits all workers.”

Key issues for age-sensitive risk assessment:

- fostering commitment and taking age issues seriously;
- examining the real working conditions of all workers;
- involving all workers, from different age groups, at all stages;
- avoiding prior assumptions about what the hazards are and who is at risk;
- especially valuing younger and older workers as assets and not as problems;
- matching work to the individual, independent of age;
- providing adequate OSH information and training, and tailoring training materials to workers’ specific needs and characteristics; and
- receiving competent advice on addressing the risks faced by workers in different age groups from OSH services and authorities, occupational physicians, safety professionals, ergonomists, etc.

4.4 Examples of good practice

Keeping younger and older workers as well as all workers safe, healthy, skilled, and employed is a challenge in all European enterprises and relates to the system/institutional, organisational, and/or individual levels. Comprehensive and coherent active age-management approaches are often lacking in workplaces. To overcome these challenges, good practices should be applied in workplaces, such as:

- tailoring learning/training approaches to the needs of various actual age groups — these approaches should be proactive and life course oriented, with measures tailored to the characteristics and needs of the targeted workers;
- implementing age-management strategies in order to help managers make the best use of the strength and potential of all generations;
mixing work groups in enterprises so that they contain workers from different age groups, in order to increase efficiency and foster intergenerational learning (which includes mentoring, tutoring, and coaching) – by enabling interaction among people from different generations, all partners can learn;

focusing on MSD prevention, for example, by implementing ergonomic work processes for workers of all ages;

reducing the monotony of repetitive jobs by rotating work tasks between different age groups so that all have variation in their work;

designing workstations so that they are easily adjusted to suit everybody’s needs;

promoting learning among older people in order to keep them skilled and employed, since their average participation in lifelong learning tends to be significantly lower than that of younger generations;

developing and implementing appropriate ergonomic and preventive health programmes that promote physical, mental, and social health for workers of all ages;

visualising negative stereotypes, building on positive perceptions of age (e.g., experience, loyalty, and reliability), and raising older workers’ self-image as learners; and

organising seminars, round tables, and other OSH awareness-raising actions involving workers from different age groups.

Age-management strategies should not be limited to younger or older workers, but must be proactive and consider workers of all age groups in an integrated manner.

4.5 How to carry out an inspection applying an age-based approach

When planning an inspection:

The labour inspector’s role is important in raising OSH stakeholders’ awareness of the benefits of applying an age perspective in risk assessment. The main goal is a well-planned inspection for which the labour inspector is well prepared with regard to age-related issues. Before the inspection, the inspector should get acquainted with the specific risks in the sector in question, especially from an age perspective. A non-exhaustive approach to how labour inspectors should address age-related issues in risk assessment at the workplace is presented below.

During an inspection:

The labour inspector will identify shortcomings in working conditions for workers of all ages, using one or more guiding questions, such as:

- How are the workers distributed in terms of age?
- What do statistics indicate regarding work-related sick leave, accidents, and diseases in different age groups?
- How many young workers are working in their first job?
- What work tasks do young workers normally have and what introduction procedures are in place?
- Do young workers receive adequate training and information on OSH matters?
- Are there any identified specific risks for workers of certain age groups, for example, younger or older workers?
- Do young workers receive safety instructions when needed?
- Are workers from different age groups involved in the risk assessment process?
- Has some form of staff survey regarding psychosocial risks been conducted? If so, are statistics available regarding different age groups?
The answers to these questions can lead to ideas about how to address age-related issues. During the inspection, the labour inspector will probably visit a number of workstations. In that case, the inspector should ask workers from different age groups about what problems they face in performing their duties.

A non-exhaustive assessment of the quality of the risk assessment conducted by the employer should consider the answers to the following questions:

- Have age-related matters been taken into account in the risk assessment?
- Have the risks facing different age groups been properly assessed? For instance:
  - Have long-term health risks (e.g., high noise levels and exposure to hazardous substances) as well as emerging and less obvious risks (e.g., stress, harassment, and violence) been taken into account?
  - Has the risk assessment taken into account information from statistics on sickness absence and work-related accidents and diseases?
  - Has the risk assessment taken into account the cumulative effects of the tasks of some workers (e.g., loaders and stackers)?
  - Is the work divided into shifts (e.g., in the case of three shifts, are three workers exposed at the workplace/workstation for eight hours each)?
- Has the employer decided on preventive and protective measures to be taken, based on the age-related risks detected in the risk assessment?
- Has the employer nominated those responsible for carrying out the age-related measures?
- Have the age-related measures been carried out in due time?
- Has the employer followed up the effectiveness of the measures? Have the age-related risks been reduced?
- Have the supervisors been trained in identifying age-related risks?
- Have the workers received information and training on how to prevent age-related risks?
- Has the employer used internal or external OSH services?

A non-exhaustive list of questions about diversity-sensitive risk assessment, useful during inspections, is presented in Appendix 1.

After an inspection:

At the end of an inspection, the labour inspector has various ways of taking action, according to the national legislation of the Member State, to ensure that the employer complies with his/her legal obligations regarding risk assessment, taking into account that the groups of workers particularly at risk, such as younger and older workers, should be covered. The labour inspector can draft an inspection report, issue improvement notices, and give instructions and/or guidance to the employer.

The labour inspector can also impose measures with deadlines if he/she finds noncompliance with the national legal obligations regarding the risk assessment, such as:

- noncompliance with OSH legal provisions (e.g., no evidence that workplaces were subject to risk assessment, vulnerable groups exposed to occupational risks, and not all workplaces assessed);
- discrepancies between risk assessment documents and the current exposure situation of younger/older workers (e.g., some risks have not been assessed and younger/older workers have not been covered); and
- younger/older workers exposed to risks for which no action has been taken, whether or not these risks have been assessed.
The labour inspector can then agree on an action plan from the employer, establishing preventive and protective measures targeting age-related issues and specifying precise deadlines and persons responsible.

Also, the labour inspector can stipulate/give advice to the employer on age-related issues, including:

- providing information about OSH legal provisions regarding risk assessment and its updating;
- providing information about relevant risk assessment tools;
- providing information about relevant training related to the risk assessment process;
- giving advice on risk assessment completion;
- recommending specialised support from internal/external OSH services or consultants;
- permitting the workers’ representative(s), including representatives of both younger and older workers, to participate in the process; and
- involving whoever is responsible for future measures and deadlines.

It is important to raise employer awareness of the need to include age issues in the risk assessments, given that addressing workforce ageing is an objective of the current EU Strategic Framework.

According to national procedures, the inspector will decide whether a follow-up inspection will be necessary in order to check the implemented measures targeting age-related issues and to verify that the action plan has been implemented in due time.

References

6 Young workers, Jennifer Webster, Health & Safety Laboratory, UK, OSHWiki, https://oshashiwiki.eu/wiki/Young_workers
Further information:

5. A gender perspective on OSH and risk assessment

5.1 Why a gender perspective?
In a communication from January 2017, the European Commission concluded: "There is evidence that work-related risks to women's safety and health have been underestimated and a gender-neutral approach has contributed to less attention and resources being directed towards prevention of work-related risks experienced by women". This chapter is intended to constitute a knowledge base on gender issues, providing support for labour inspectors. The aim is that labour inspectors should be able to detect shortcomings and provide guidance on the risk assessment of working conditions for both women and men.

Musculoskeletal disorders (MSDs) constitutes one of the main reasons for OSH problems at many workplaces. MSDs are a common cause of reported work-related injuries for both women and men. The exposure can differ between women and men. The organisation of work at a workplace has a great impact on the development of MSDs. Women and men often do different things at work, even if they have the same occupation, which is why their exposures differ. That is the most important reason why women experience more work-related pain and more MSDs. Biological differences, on the other hand, play only a small role. Men generally have greater variation in their work tasks, while women often have more repetitive tasks. Men tend to do quick heavy lifting, operate machines, and use tools. Even when women and men carry out exactly the same work tasks, the physical load can differ because equipment and workplaces are often designed for the average man.

The notion that women are born with better ability for caring than men has, for example, led to the health-care and social-care sectors being dominated by women. In workplaces dominated by men, their perspectives and ways of working have become norms. Women more often than men lack the opportunity to influence their work situation. In addition, the higher the position in an organisation, the fewer the women. An employer can reduce the risk of discrimination, harassment, and conflict, and increase creativity and profitability, by actively striving for a more gender-equal workplace.

There are other health risks related to gender. Men and women are vulnerable to different types of toxins that affect fertility. Men and women also face different types of psychological stress: women are more exposed to harassment and discrimination, while men are more exposed to stress and are more prone to cardiovascular diseases. Furthermore, women who work on construction sites with dirty or inappropriate bathroom facilities often avoid using bathrooms by not drinking water, which could increase the risk of bladder and kidney infections.

Preventing ill health and promoting well-being at work are important for the quality of work of both women and men. Often, however, the design and organisation of work and related equipment, including personal protective equipment (PPE), are based on the modelled "average" man, even though the principle of matching work to workers is enshrined in EU legislation. Lightening the load for women will lighten the load for men too.

"Women and men have the same right to a good working environment."
5.2 What is working life like for women and men in the EU?

The European-level literature, as presented below, notes both similarities and differences between women’s and men’s experience on the labour market.

- Women and men participate to varying degrees in the labour market (65% and 77%, respectively, in 2016).\(^\text{[8]}\)
- The labour market is gender segregated. Women work mainly in sectors and occupations with many other women, and men in sectors and occupations with other men. Gender-mixed occupations are the exception rather than the rule. The health and education sectors are female dominated, as are some occupations, such as clerks, service workers, and sales workers. Construction, transport, industry, and agriculture remain highly male-dominated sectors.\(^\text{[9]}\)
- On average, the employment rate of women is less than that of men, i.e., 61% versus 72%.\(^\text{[7]}\)
- Self-employment is male dominated, and women represent only 29% of entrepreneurs.\(^\text{[10]}\)
- Part-time work is more common among women than men (32% of women work part time versus 9% of men).\(^\text{[9]}\) In particular, mothers are more likely to work part time.\(^\text{[11]}\)
- Women also, compared with men, have a less secure connection to the labour market, being more likely to have irregular forms of employment, such as indefinite employment, fixed-term employment, and other "no-contract" arrangements.\(^\text{[8]}\)

5.3 Taking account of gender issues in risk assessment

Continuous efforts are needed to improve the working conditions of both women and men. However, taking a "gender-neutral" approach to risk assessment and prevention can result in risks to female workers being underestimated or even ignored altogether. Changing the situation by recognising and taking into account gender differences is a first step. When we think about hazards at work, we are more likely to think of men working in high-accident-risk areas, such as building sites or fishing vessels, than of women working in health and social care, on a filleting line in fish factories, or in facilities such as call centres. Careful examination of real work circumstances shows that both women and men can face significant risks at work. In addition, making jobs easier for women will make them easier for men too. It is important to include gender issues in workplace risk assessment and, moreover, "mainstreaming" gender issues in risk prevention is an objective of the European Community.\(^\text{[12]}\)

Key issues in gender-sensitive risk assessment:
- have a positive commitment and take gender issues seriously;
- look at the actual working situation;
- use evidence-based risk assessment tools to visualise risks that are difficult to see;
- involve all workers, both women and men, at all stages of the assessment;
- consider risks prevalent in both male- and female-dominated jobs;
- avoid making prior assumptions about what the risks are and who is at risk; and
- avoid making initial assumptions about what is considered "trivial".

5.4 Examples of good practices

Workplaces educated in dealing with differences and diversity perform several times better than do homogenous ones. Really innovative ideas are born in meetings and interactions characterised by differences. Creativity and efficacy increase with mixed work teams.
- Mix work groups so they include both men and women, as this can often increase productivity.
Reduce the monotony of repetitive jobs by rotating work tasks between individuals of both sexes, so that all have variation in their work.

- Design workstations so that they are ergonomic and easily adjusted to suit both women and men.
- Ask both women and men if they experience stress or harassment, including sexually oriented harassment, to the same extent.
- Supply tools and PPE suitable for both men and women.
- Involve workers of both sexes to the same extent in efforts to improve the work environment.

5.5 How to carry out an inspection applying a gender-based approach

The labour inspector’s role is important in raising the awareness of OSH stakeholders about the benefits of applying a gender perspective in risk assessment. Below are some examples of how a labour inspector could enter into dialogue with employers about the benefits of applying a gender perspective in risk assessment of the work environment. There are also several questions that the employer can be asked in order to help him/her notice and observe risks in the work environment related to gender and to detect possible shortcomings in the risk assessment.

When planning an inspection:
The main goal is a well-planned inspection for which the labour inspector is well prepared with regard to gender-related issues. Before the inspection, the inspector should get acquainted with the specific risks in the sector in question, especially from a gender perspective. A non-exhaustive approach to how labour inspectors should address gender-related issues in risk assessment at the workplace is presented below.

During an inspection:
Identify gender-related risks at the workplace; for example, look for both health and safety hazards as well as for “invisible risks” such as harassment, discrimination, excessive psychosocial workload, and threats and violence at work.

The following questions will help the labour inspector to identify and assess risks and shortcomings in the work environment, specifically as related to gender. The answers to these questions are expected to lead to ideas about how such risks and shortcomings can be addressed.

- How many women and men, respectively, work here?
- What work tasks do women and men have, respectively? Are they the same? Different?
- To what extent can the employees govern their working pace themselves? Are there differences between women and men in this regard?
- Are there any work tasks for which workers are bound to a certain place or workstation? If so, what are the proportions of women and men in these tasks? If they differ, what is the reason?
- How are safety equipment, protective clothing, protective equipment, work clothing, tools, and machinery individually adapted for women and men, respectively? How has the employer investigated this?
- What do work-related sick leave and accident statistics indicate when broken down by gender? What diagnoses dominate for women and men, respectively?
- Are there separate changing rooms for women and men? How are changing rooms/toilets distributed between women and men?
- Are workplaces individually and ergonomically adapted for women and men, respectively?
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- Has the employer conducted some form of staff survey about psychosocial risks? If so, are there accessible statistics broken down by gender? And if so, are there any differences in how women and men experience stress, threats, violence, harassment, bullying, victimisation, and support at work?
- N.B. Counter questions can also yield valuable information, for example: “What risk factors were evaluated as non-relevant or negligible at workplaces employing women/men?”

A non-exhaustive list of questions about diversity-sensitive risk assessment, useful during inspections, is presented in Appendix 1. A more detailed checklist about gender issues is presented in Appendix 2.

If the labour inspector visits a number of workstations, he/she should if possible apply a gender-based approach to assessing the work environment. In a structured way, both female and male workers should be asked about what problems they encounter in their work. Encourage women and men to report issues that they think may affect their safety and health at work, as well as health problems that may be related to work.

Based on the replies of the employer, the labour inspector should assess the quality of the risk assessment conducted by the employer:
- Have gender-related matters been taken into account in the risk assessment?
- Have the risks facing both women and men been properly assessed?
- Have the "invisible risks", including sexual harassment, been assessed?
- Has the employer decided on measures to be taken based on the gender-related risks detected in the risk assessment?
- Has the employer nominated responsible persons to carry out the gender-related measures?
- Have the measures been carried out?
- Has the employer followed up the effectiveness of the measures? Have the gender-related risks been reduced?
- Have the superiors been trained in noticing gender-related risks?
- Have the employees been instructed in how to prevent gender-related risks?

After an inspection:
At the end of an inspection, the labour inspector has various ways of taking action, according to the national legislation of the Member State.

The objective is to ensure that the employer complies with his/her legal obligations regarding the risk assessment, taking into account the groups of workers of both genders who are particularly at risk. The labour inspector has the ability to draw up an inspection report, issue improvement notices, and give instructions and/or guidance to the employer.

The labour inspector can impose measures with deadlines if he/she finds noncompliance with the national legal obligations regarding the risk assessment, such as:
- completing the risk assessment by addressing, for example, workstations and tasks;
- using internal/external OSH services;
- allowing the workers' representative(s), both women and men, to participate in the risk assessment work;
- considering who is responsible for future measures and applicable deadlines; and
- carrying out concrete measures.
According to national procedures, the inspector will decide whether a follow-up inspection will be necessary in order to check the implemented measures targeting age-related issues and to verify that the action plan has been implemented in due time.

References
3. Basic figures on the EU, Third quarter 2017, Eurostat
4. 6th European Working Conditions Survey, 2017 update, Eurofound
5. The life of women and men in Europe – A statistical portrait, 2017 edition, Eurofound
6. 6th European Working Conditions Survey, 2017 update, Eurofound

Further information:
- The European Agency for Health and Safety’s report, Gender issues in safety and health at work — A review, provides more information about risks to women workers and their prevention. This report is available at: http://agency.osha.eu.int/publications/reports/209/en/index.htm
- Factsheet 42 summarising the report and Factsheet 43 on how to include gender in risk prevention are available at: http://agency.osha.eu.int/publications/factsheets/
- The European Agency for Health And Safety’s website has a section providing links to further information related to women and occupational safety and health at: http://gender.osha.eu.int. Its contents are based on the publication How can the work environment be better for both women and men? from the Swedish Work Environment Authority.
- The Swedish Work Environment Authority has a lot of material (reports, short films etc. in English); https://www.av.se/en/work-environment-work-and-inspections/work-with-the-work-environment/gender-equality-in-the-work-environment/
Appendix 1 – A non-exhaustive list of questions about diversity-sensitive risk assessment

Purpose: These questions could be asked by labour inspectors at ordinary inspections. Initial questions about the workplace:

- How are the workers distributed in terms of age and gender?
- Do women and men do the same jobs? Do their exposures differ?
- Are tools and equipment, including PPE, adapted to workers of different sizes and heights?
- What do statistics indicate regarding work-related sick leave, accidents, and diseases in different age groups and between women and men?

Questions about the risk assessment:

- Does the risk assessment cover different age groups of workers?
  - Does it cover young workers and their need for introduction and OSH training?
  - Does it cover older workers and their need for individual adaption?
- Does the risk assessment cover "invisible" risks such as stress, harassment (including sexually oriented harassment), violence, and threats?
- Does the risk assessment cover vulnerable groups (e.g., migrant workers, temporary agency workers, and pregnant women)?
- Does the risk assessment cover long-term health risks, such as high noise levels, exposure to dangerous substances, and musculoskeletal disorders?
Appendix 2 – An extended list of questions addressing the gender perspective

Purpose: When a labour inspector wants to deepen and broaden the gender perspective in his/her inspection, the following questions, which have three perspectives – i.e., human, ergonomics/technology, and organisation – can be used.

This appendix is based on the publication “How can the work environment be better for both women and men?”, number ADI 690, from the Swedish Work Environment Authority; available at: https://www.av.se/en/work-environment-work-and-inspections/work-with-the-work-environment/gender-equality-in-the-work-environment

Human

- Does the OSH organisation incorporate a gender perspective?
- Is there a notion that certain tasks or areas are more suited to women and men, respectively?
- Do women and men have the same opportunities to influence and participate in questions concerning their work environment?
- Are there pictures, texts, or objects at the workplace that can be considered degrading? Is there use of language or jargon that can be experienced as degrading?
- Is the workplace inclusive or exclusive? Do staff members feel included, irrespective of gender?
- Is the workplace characterised by mutual respect and tolerance?
- Do women and men have the same opportunity for competence development?

Ergonomics/technologies

- Are tools at the workplace adapted for both small and large hands and bodies?
- Is there protective and work clothing that fits, irrespective of gender?
- Are there separate changing rooms for women and men?
- Are workplaces individually and ergonomically adapted? Are there differences between female- and male-dominated occupations when it comes to, for example, protective clothing, conditions, and tools?
- Are there machines or tasks that have been “gender stamped”, that is, that are used/perform only by women or men?
- Official statistics show that women are sick-listed more often than men are, and that more women than men are forced to end their working lives early because of ill health. Can this be linked to tools not being adapted for both women and men?

Organisation

- How many employees are there? How many are women? How many are men?
- What do the employed women and men do? Do women and men have the same positions?
- If women and men have the same positions, do they have the same work tasks?
- If women and men do different things, what risks do the women and men, respectively, face in their work tasks?
- Is there striving for more equal distribution of the numbers of employed women and men?
- What prerequisites do men and women have at the workplace to enable them to work on the same tasks? Do all employees have the opportunity to influence their own work situation? What employees are subjected to fast work pace, machine- or
client-determined work pace, lack of occupational development, or being physically bound to the workplace?

- How do different operational decisions affect women’s and men’s exposure to different risks and ill health?
- Do women’s and men’s opinions and views of problems and improvements in the work environment receive the same attention?
- If MSDs arise, can work rotation be a way to reduce and prevent injuries?
- Have any employees chosen to go down to part-time hours due to shortcomings in the physical or psychosocial work environment? Are there differences between men and women in this regard?
- What are the proportions of men and women in work groups, project groups, and development groups?
- Does multiple discrimination exist, for example, against women speaking a different language?
APPENDIX 19: WORLD HEALTH ORGANIZATION (WHO) CHECKLIST

4.2. The psychosocial work environment

The psychosocial work environment consists of such aspects as work organization, organizational culture and work-life balance. Here are some ways that employers can help reduce exposure to psychosocial hazards for women and men:

- Evaluate and address the potential differential impact of work organizational factors on the health and well-being of women and men workers.

- Encourage an explicit zero tolerance policy toward all forms of violence—including discrimination—, encouraging the reporting of violent incidents, providing support to victims of violence and other affected employees and instituting sanctions for perpetrators of violence.

- Without restricting women’s access to jobs, address women’s concerns about working alone or late and providing access to safe parking (e.g. Intercom and telephone availability, night guards, video cameras, special access floor/area for night parking by women).

- Educate workers on the issue of violence affecting women and men for instance through programmes, campaigns or information material to be distributed at the time of hiring or training that cover all forms of violence and that explain avenues for help or support. Perform periodic education and training of managers and supervisors on work-family balance, workplace violence and other health and safety issues from a gender perspective.

- When possible, institute formal flextime arrangements, self-scheduling, schedule exchanges, options for periodic unscheduled leave, telework/virtual work, compressed workweek, predictability of working hours, paid or unpaid leave for family emergencies, prolonged illness of a family member, and parental leave after the birth or adoption of a child.

- Institute workplace policies on workplace daycare (to put children during working time/after school) and providing a clean, private room for breastfeeding or breast milk pumping. This would ease women’s return to work following maternity leave and be of physical and psychological benefit to the baby and thus the community.

- Establish accessible, affordable communication pathways (including access to a telephone and ability to receive messages) and flexible and accommodating work places to enable workers to attend to family responsibilities during work hours, especially emergencies.

- Institute a work culture that is supportive of family relationships and responsibilities.
APPENDIX 20: Farmworker Health & Safety: Challenges for British Columbia

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EXECUTIVE SUMMARY

Every year, almost 10,000 mostly immigrant and migrant workers carry out a range of tasks in support of British Columbia’s horticultural industry. This workforce, which is so essential to this industry, to the families and communities that derive their livelihood from horticulture, and to the safety and quality of BC fruits and vegetables, comprises one of the lowest paid, least protected, and most vulnerable occupational categories in the province. Agriculture is also among the most dangerous jobs. This study, which examines the health and safety issues faced by BC’s farmworkers, was motivated by a significant change in the composition of the labour force. Since 2004, the province’s largely immigrant workforce has been complemented by migrant workers from Mexico under the federally administered Seasonal Agricultural Workers Program (SAWP). More than 3,000 workers participated in the SAWP in 2008. This is significant given that the largest contingent of Canadian workers—Punjabi-speaking immigrants supplied by licensed farm labour contractors (FLCs)—numbered some 6,000 that year. Given this changing workforce, our study explored workplace health and safety issues as related to citizenship and ethnicity. The research is based on qualitative and quantitative research with a range of stakeholders, including a survey of 200 immigrant and migrant farmworkers.

Our research found that ethnicity and citizenship play determining roles in workplace health and safety in complex and multiple ways. For example, the modes by which immigrant and migrants are incorporated into the labour market construct them as highly vulnerable workers. On the one hand, farmworkers from Mexico employed in Canada on temporary visas hold employer-specific work permits that restrict their mobility in the labour market and stifle their bargaining power. Also, other mechanisms of the SAWP, including employer rights to repatriate workers, exacerbate workers’ precarious relationship to their jobs. On the other hand, Canadian farmworkers, most of whom are Family Class immigrants, often live in suburban areas and depend on the farm labour contracting system to link them to the agricultural labour market. Their opportunity to earn money for their households, then, also depends on a single employer. This employment relationship creates distance between farm operators and farmworkers, minimizing the responsibility of farm operators for workplace health and safety. Language barriers, limited access to information, and lack of knowledge of their rights are other factors relevant to workplace health and safety that are intimately linked to people’s ethnicity and citizenship. Below we outline our key findings, followed by our principal recommendations.

KEY FINDINGS
A significant proportion of immigrant and migrant farmworkers do not receive adequate workplace health and safety training, an important step to mitigating and preventing occupational hazards. Seventy-four percent of our Mexican respondents and 70 percent of our Canadian respondents reported receiving no workplace health and safety information at all.

Workplace health and safety in agriculture is undermined by poorly maintained, inadequate farm equipment, deficient hygiene and sanitation at worksites, and lack of personal protective equipment (PPE). Of significant concern is contamination by bacterial, viral, parasitic and other food-borne pathogens, which has repercussions not only for the health of farmworkers but also for the safety of the food that they produce. Fourteen percent of our respondents claimed that they had no access to toilets in the field or at the worksite on the farm where they worked most in 2007.

Unsafe vehicles and careless driving continue to put farmworkers, particularly Canadian workers employed by FLCs, at risk as they are transported to and from work and between worksites. Workers reporting an insufficient number of seatbelts are more likely to be travelling in vans or buses driven by a FLC and to work on larger farms.

A considerable number of Mexican migrant farmworkers are living in accommodations that are unsafe, lacking in services, and/or poorly furnished. The state of some housing puts migrant farmworkers at risk of illness (e.g., due to poor sanitation, overcrowding, dilapidation) and injury (e.g., due to dilapidation or fire risk). The existence of such housing conditions indicates issues not only with employer compliance regarding their contractual obligations as set forth in the SAWP’s housing provisions, but also with regulatory deficiencies in the current system of housing approvals.

Immigrant Canadian and migrant Mexican farmworkers face language barriers in the workplace. This leads to misunderstandings regarding instructions and to problems reading health and safety information, which is rarely available in their language. Workers whose self-assessed English proficiency is poor or very poor are more likely to have sustained a work-related injury.

BC farmworkers work extremely long hours, a factor that increases their risk of workplace injury or accident. Migrant Mexican workers were found to work even longer hours than their Canadian counterparts, averaging 12 hours a day on weekdays and 8 hours a day on Saturday and Sunday at the height of the season. Although workers often agree to these hours out of economic need and, in the case of Canadian workers, to qualify for employment insurance (EI), farmworkers also fear that that refusing to accept long shifts will jeopardize their jobs.

Farmworkers seldom refuse work or transportation that they perceive as dangerous because they fear that they may jeopardize their current and future employment opportunities.
Similarly, they work when ill or injured and/or avoid reporting illnesses and injuries. The larger the size of the farm, the less likely workers are to feel that they can communicate a health-related problem to bosses or supervisors without suffering reprisals.

When farmworkers do report health concerns to their employers, these requests are at times met with indifference or delays, or completely ignored. For some farmworkers, the most significant barrier to accessing health care and medical treatment is an unsupportive employer.

Migrant workers face unique barriers, including rural or remote locations, to accessing medical attention. Transportation in rural areas is often limited and expensive.

The cost of medical treatment is a significant barrier that impedes migrant farmworkers’ access to medical care. The majority of migrant farmworkers in British Columbia do not have access to the province’s Medical Services Plan (MSP) and are forced to rely on private insurance, which requires that workers pay for health services before receiving treatment and file an insurance claim later. As a result, workers are more likely to receive medical care from lower-cost providers and to depend on their employers to pay for their treatment. For those with MSP, the required monthly premiums are prohibitive for low-income farmworkers.

Migrant farmworkers who access BC’s healthcare system do not always receive quality care. In some cases, quality of care is related to language barriers and cultural differences between workers and care providers. In other cases, care is simply not adequate or comparable to what other groups might receive.

Farmworkers may not be receiving the health services they are entitled to because of the barriers they face in accessing WorkSafeBC benefits. This leads to underreporting and failed compensation claims.

KEY RECOMMENDATIONS

THE PROVINCIAL GOVERNMENT SHOULD:

Reform BC medical insurance for SAWP workers so that they receive health coverage immediately upon arrival as well as eliminating high upfront costs and waiving premiums in recognition of these workers’ low-income status.

Provide workers with information resources concerning the details of their healthcare and insurance coverage in their languages, including region-specific information on local healthcare providers.
Ensure, through the Ministry of Labour and Citizens’ Services, that WorkSafeBC is fulfilling its mandate to promote healthy and safe workplaces through the administration of the Workers’ Compensation Act and the Occupational Health and Safety (OHS) Regulation for all workers, including farmworkers.

Ensure that greater attention is placed on the safe transportation of farmworkers by implementing the recommendations in the 2009 coroner’s inquest into the March 2007 van crash that killed three women farmworkers and injured 14 others. Central among them is increasing random inspections of commercial vehicles.

Fund community organizations and agencies active in working with immigrant and migrant farm workers that are well-connected to these populations and have developed appropriate cultural, linguistic, and other resources.

WORKSAFEBC SHOULD:

Maintain budget increases to agriculture that were put into effect following the 2007 van crash and recognize it as a high-risk industry.

Continue collaboration with the Employment Standards Branch, the Ministry of Transport, and the Royal Canadian Mounted Police (RCMP) aimed at improving farmworker transportation in such areas as random inspections of vehicles used by farm labour contractors (FLCs).

Encourage and support the formation and activity of health and safety committees at larger farms that can respond to issues related to workplace health and safety and do regular inspections for health and safety hazards.

Increase the budget of the Farm and Ranching Safety and Health Association (FARSHA) to enhance its ability to fulfill its mandate in the context of a multilingual, multiethnic agricultural community.

Provide training courses for medical professionals who practice in areas of high farmworker concentrations to ensure that they have a proper understanding of immigrant and migrant worker issues and of agricultural health hazards.

Provide interpreters in hospitals and walk-in clinics to help farmworkers communicate their medical needs to healthcare practitioners with the aim of reducing workers’ dependency on their employers and improving the reporting of workplace injuries to WorkSafeBC.
THE FARM AND RANCH SAFETY AND HEALTH ASSOCIATION (FARSHA) SHOULD:

- Provide more multilingual health and safety training and resources for employers and workers.
- Educate farmworkers about their rights and responsibilities through accessible, language-appropriate materials.
- Adapt current practices to adequately address the needs of a migrant workforce (for example, by offering training schedules that take into account the varying arrival dates of SAWP workers).

MUNICIPAL GOVERNMENTS SHOULD:

- Adopt comprehensive regulations for migrant worker housing and improve enforcement of these regulations, including mid-season assessments.

THE FEDERAL GOVERNMENT SHOULD:

- Create a path to permanent residency for all temporary foreign workers, including farm workers, modeled on the opportunity currently available to live-in caregivers.
- Amend the Immigration and Refugee Protection Regulations so that accompanying immediate family members of farmworkers with a temporary work permit are automatically eligible for an open work permit.
- Amend the Immigration and Refugee Protection Regulations to reduce the dependency of Family Class immigrants on their sponsors.
- Restructure the SAWP, including replacing employer-specific work permits with open or industry-specific work permits.
- Abolish repatriation as an employer right. In cases of illness or injury, workers should receive coverage in Canada or in Mexico for the full length of their recovery and should also receive support in accessing their right to compensation and employment insurance. A process for appealing dismissal, administered by an independent body, should also be established.

THE MEXICAN GOVERNMENT SHOULD:

- Improve and increase health and safety information provided to workers through pre-departure orientation and resources.
Carry out medical assessments of workers upon their return to Mexico at the end of each work term.

Increase the mediating role of the consulate and promote more proactive protection of the rights of Mexican workers.

EMPLOYERS SHOULD:

Help migrant workers obtain their Medical Services Plan (MSP) CareCard shortly after they arrive in Canada.

Comply with existing regulations under the Workers Compensation Act and the Occupational Health and Safety (OHS) Regulation, including proper maintenance of worksites and the availability of toilet and handwashing facilities, drinking water, first-aid materials, and personal protective equipment.

Provide workers, free of charge, with all safety and personal protective equipment, including raingear and work boots not covered under existing regulations.

EMPLOYER ORGANIZATIONS SHOULD:

Improve the dissemination and promotion of health and safety information to employers by including these materials in regular newsletters and any seasonal information packets distributed to their members.
INTRODUCTION

Every year, almost 10,000 immigrant and migrant workers perform a wide variety of labour-intensive tasks in support of British Columbia’s horticultural production. Yet this workforce, which is so essential not just to this industry and to the families and communities that derive their livelihood from it but also to the safety and quality of BC fruits and vegetables, comprises one of the lowest paid, least protected, and most vulnerable occupational categories in the province. In Canada, farm work is one of the country’s most dangerous jobs. Farmworkers face a variety of occupational hazards, including exposure to a range of carcinogens, the risk of acute and long-term disabilities due to repetitive motion and intense physical labour, a higher-than-average risk of infectious diseases, and poor sanitation and inadequate facilities at worksites and often in their housing arrangements.

Immigrant and migrant workers have contributed to the growth of an industry that has performed well in the increasingly competitive and globalized market for horticultural products. Horticulture is among the most important contributors to provincial agricultural production. Some 40 percent of the total number of farms in British Columbia are in the horticultural industry, and horticultural exports accounted for 44 percent of the province’s total agricultural exports in 2008 (Statistics Canada 2008; 2009). Clearly, such a significant presence in exports indicates that the horticulture industry’s production goes well beyond an interest in providing the province with a self-sufficient supply of healthy food. Given the productivity of BC horticulture, the question arises as to whether there is any justification for the persistence of the substandard health and safety conditions in this industry documented in this report. Our starting point for this assessment is that all workers in British Columbia are entitled to a safe work experience—regardless of their immigration status or country of birth.

Most farmworkers in British Columbia are immigrants from South Asia or, increasingly since 2004, temporary migrants from Mexico. Due to successive waves of Family Class immigration to the province, South Asian immigrants, particularly from the Punjabi-speaking region of India, have comprised the majority of the agricultural workforce since the 1960s. In 2004, however, the extension of the federal Seasonal Agricultural Worker Program (SAWP) to British Columbia introduced dramatic changes to the social composition of the labour force by allowing agricultural employers to hire Mexican nationals, and later Caribbean workers, on temporary visas. Five years later, the number of Mexican migrant farmworkers in the province had increased 64 times, reaching just under 3,000 in 2008. Since the number of domestic farmworkers remained more or less stable between that period, at 6,000 workers, this means
that in five years, temporary visa workers from Mexico came to represent half of the seasonal farmworker population in British Columbia.¹

This study took a comparative approach to examining how the ethnicity and citizenship of these two dominant groups within BC's horticultural workforce—Canadian immigrants who are mostly Punjabi Sikhs and migrant workers from Mexico—affects workplace health and safety within the industry. As we discuss in this report, a number of social relations of inequality—age, class, race, ethnicity, and gender—shape farmworkers' experiences. Here we conceptualise ethnicity as shared cultural heritage based on common ancestry, language, or religion. In sociological terms, ethnicity is also seen as a relation of power and therefore takes on specific meanings and experiences in relation to other groups, namely the dominant group. Moreover, in Canada, both immigrant and migrant farmworkers are members of racialized groups or non-Aboriginal people of colour.² Current research suggests that racialized groups are more vulnerable to labour market segmentation and declining socio-economic status (Galabuzi 2006).

Citizenship is often understood in terms of national citizenship (i.e., membership in a nation-state collectivity). In this report, we recognize the contemporary reality of how state citizenship is experienced. First, the growth in international labour migration has resulted in diverse workforces in terms of immigration status. These workforces can include citizens, permanent residents or landed immigrants, temporary visa holders, and undocumented migrants. Second, within a global framework in which inequalities between countries have widened, immigrants as well as migrants from lower-income countries who enter affluent countries often experience citizenship and the immigration status they are granted as mechanisms that reproduce inequality. For immigrants and migrants, then, a number of markers of social difference, including poverty, race, ethnicity, and gender, may serve to position them negatively in the labour markets and societies of receiving countries.

In this report, we detail the key findings of our research and provide policy recommendations with the goal of reducing or eliminating occupational health and safety hazards for all agricultural workers in British Columbia. The two key research questions that guided our study were:

¹ The figure of 6,094 refers to the number of Canadian workers bonded to licensed farm labour contractors (FLCs) servicing horticultural farms (Government of Canada, 2009). Although this measure excludes farmworkers who are employed directly by horticultural firms, it is considered the most accurate measure of the seasonal labour force.

² The term "racialized groups" to refer to non-Aboriginal people of colour is becoming preferred among scholars studying race relations in Canada because it is considered to more effectively convey the social (rather than biological) construction of the category of race and the experience of oppression that is often masked by the more neutral "visible minorities" (Galabuzi 2006:xvi).
What perceptions and awareness of occupational health and safety issues in farm operations are held by the various stakeholders—employers, farmworkers, regulators, and advocates—in BC’s horticultural industry?

What differences, if any, in attitudes and awareness towards, as well as implementation of, occupational health and safety standards appear between Canadian workers and Mexican migrants in the horticultural labour force?

Within the context of a diverse workforce in terms of ethnicity and citizenship, we focused on exploring possible differences that may result from working as a temporary visa worker or a Canadian citizen/landed immigrant and belonging to a particular ethnic or racialized group. Our overall aim was to generate a descriptive analysis of health and safety issues that affect the province’s horticultural industry workforce and to arrive at recommendations that may reduce or eliminate health and safety hazards for these workers. To that end, we offer a series of policy recommendations to stakeholders in the horticultural industry.

It should be clear from the outset that, although we also offer policy recommendations to the Mexican Consulate, it is Canada’s provincial governments that have the prime responsibility for the health and safety conditions of all workers, migrant or immigrant, and it is the federal government’s responsibility to ensure the human rights of all people within Canada. The Mexican Consulate is primarily the representative of a foreign government that has a presence in a foreign jurisdiction but has limited influence on these issues. For example, the consulate has the authority to move workers in precarious conditions in one place of employment to another or to send them back to Mexico, but, beyond such extreme situations, the day-to-day health and safety conditions of Mexican migrant workers are determined by agricultural employers and regulated and enforced by Canadian provincial authorities.

METHODOLOGY

This report is based on both qualitative and quantitative research carried out between 2007 and 2009 with a variety of different stakeholders, as well as on detailed reviews of government documents, reports, and academic studies on the occupational health and safety of immigrants and migrants in the agricultural labour force. In-depth interviews were conducted with key informants from a range of stakeholder groups, including employers (growers and farm supervisors); agricultural industry representatives; civil servants and consultants involved in occupational health and safety at the provincial and federal levels; representatives of the Mexican government; and immigrant and farmworker rights groups.
A second set of exploratory interviews, aimed at identifying key issues and concerns related to occupational health and safety risks, was conducted with Canadian\(^1\) and Mexican farmworkers. Table 1 lists the abbreviations used in this report to refer to each group of interviewees. Each interview was transcribed and these transcripts were subjected to a detailed and rigorous qualitative analysis using N-Vivo software. The objective of this analysis was to capture the range of perceptions held by stakeholders and their experiences as they related to the topic of the study.

**TABLE 1. In-Depth Interviews**

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Respondents Interviewed</th>
<th>Abbreviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian farmworkers</td>
<td>8</td>
<td>CFW</td>
</tr>
<tr>
<td>Mexican farmworkers</td>
<td>14</td>
<td>MFW</td>
</tr>
<tr>
<td>Employers (excluding farm labour contractors)</td>
<td>12</td>
<td>EMP</td>
</tr>
<tr>
<td>Health and safety consultants and officials</td>
<td>6</td>
<td>GOV</td>
</tr>
<tr>
<td>Industry representatives</td>
<td>6</td>
<td>REP</td>
</tr>
<tr>
<td>Immigrant and farmworker rights advocates</td>
<td>7</td>
<td>ADV</td>
</tr>
</tbody>
</table>

In addition, the findings from the preliminary qualitative research were used to formulate a face-to-face questionnaire in which a purposive sample\(^2\) of 200 farmworkers—100 Canadian citizens or permanent residents of South Asian descent and 100 Mexican migrants—participated. These groups were chosen intentionally to meet the criteria for inclusion in the study. Random sampling is difficult with this population because there is no list of the total farmworker population. Moreover, farmworkers are a group that is difficult to access. Given these limitations, a sample of 200 as a share of all farmworkers can be considered large. We conducted the survey in each of the three main horticultural valleys in British Columbia—the Lower Mainland, the Fraser Valley, and the Thompson-Okanagan Valley—and, within those three areas, aimed to interview workers with experience in a range of crops, on the assumption that some health and safety risks vary with different types of crops. Crops themselves vary across the different valleys, so we hoped to address the issue of variations in risk by sampling in the three regions. Together, these three regions account for nearly three-quarters of horticultural farms in the province, and they can therefore be seen as representative of the industry as a whole (see CHARTS 1 and 2, page 17).

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\(^1\) For ease of referencing, in this report we refer to of all our domestic respondents as Canadians despite the fact that a third of our sample was composed landed immigrants (permanent residents). Permanent residents have the same labour rights as Canadian citizens and become eligible to apply for citizenship after living in Canada for three years. See Table 4 below for specific data on years spent in Canada by the workers in our sample.

\(^2\) Purposive sampling, unlike random sampling, is a non-probabilistic sampling procedure that does not aim for formal representativeness.
Farmworkers were recruited mostly through service-providing agencies. Mexican migrants were contacted primarily at the Agriculture Workers Alliance (AWA) centres (Abbotsford and Kelowna) due to their extensive contact with migrant workers. To illustrate, in 2007, the Abbotsford centre had case files for about half of the 2,000 Mexican workers in the province that season. Mexican participants were also recruited at a local church in Chilliwack. Canadian farmworkers were recruited through a service provider, Abbotsford Community Services, and through snowball sampling, a strategy whereby participants are asked to identify someone who meets the criteria for inclusion in the study. The distribution of questionnaires across the three sites was similar for both groups. Approximately half of our surveys were conducted in the Fraser Valley and a quarter each in Kelowna and the Lower Mainland.

Surveys were administered face-to-face by bilingual interviewers in Spanish, Punjabi, or English, depending on the preference of the interviewee. Because of the language differences in the surveys, we were selective and cautious in the comparisons we made between Mexican and Canadian responses. In addition to our descriptive analysis of responses on a number of health and safety issues, our findings are also, where possible and relevant, based on cross-tabulations using bivariate analysis of some variables that have explanatory value. Bivariate analysis is a statistical technique used to examine the strength of a relationship between two variables. It investigates whether two variables are associated and change in a correlated way, either directly or inversely, or whether they are entirely independent of each other. The main purpose of trying to detect a relationship between two variables is to help in the task of explanation. For example, it is one thing to show, using univariate analysis, that people vary in their perceptions of health risks. But it is another thing to explain why some people have higher or lower perceptions of health risks than others. Given the study limitations mentioned above, we have employed nonprobabilistic techniques to facilitate a relatively reserved, noninferential analysis that investigates the strength, direction, and nature of certain associations between variables within our sample.

This study was reviewed and approved by the research ethics boards at Simon Fraser University and by the University of Guelph. The researchers informed potential participants of the study’s nature, goals, and funding source before seeking their voluntary participation. Owing to high rates of illiteracy within both populations, verbal informed consent procedures were used for farmworker participants with both the in-depth interviews and surveys. Other stakeholders read and signed a consent form before participating in interviews. Survey respondents were anonymous, and the data collected from both the surveys and the in-depth interviews was treated as confidential. The researchers took measures to safeguard all of the data gathered, including assigning password protection to interview transcripts.
APPENDIX 21: Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work


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**Best Approaches**

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**Recognizing Time to Heal – Assessing Timely and Safe Return to Work**

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**Principles**

- An injured worker’s ability to return to work beginning the day following the accident is to be determined based on an assessment of all relevant information. This includes information from the worker, the employer and the treating health practitioner(s). It is recognized that there are cases where “real” is an appropriate form of treatment and required in order to speed recovery and facilitate a successful return to work. This should be determined based on an assessment of the nature and degree of the injury in each case.
- The decision-maker must be convinced on a balance of probabilities that:
  (a) the job or duties offered by the employer is/are suitable in that they are within the worker’s physical and/or psychological and vocational capacity to perform and will not pose a safety risk to worker or others or impede the worker’s recovery, and,
  (b) the job and the job duties have been clearly communicated to the injured worker prior to the worker beginning the job or job duties.
- In assessing the appropriateness of the return to work situation, the decision-maker must have regard for any collateral issues that may pose an obstacle to the worker. This includes such issues as the impact of the injury on the worker’s ability to travel to and from the workplace or the impact of medication on the worker’s capacity to perform work in a safe manner.

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Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

Background

Any claims in which the worker is able to return to work the day following the accident is considered “no lost time.” This return may be to regular duties or accommodated or modified work, at no wage loss. No Lost Time claims have minimal impact on an employer’s experience rating, and are, therefore, desirable from an employer’s point of view. Many mid to large sized employers have information posted in highly visible areas recording the number of days with no lost time claims.

From a worker’s perspective, no lost time from work is also desirable. Research has demonstrated that the best recovery occurs in the workplace. Other positive benefits are no interruption in salary or employment benefits and minimal life disruption.

A number of factors over the last two decades have led to a philosophy in support of “no lost time” claims. These include:

a) medical rehabilitation strategy of the early 1990’s
b) service delivery model of the late 1990’s, increased emphasis on employer education, particularly with the creation of the position of the account manager
c) employer incentive programs
d) the development of strong return to work programs in medium to large workplaces

e) passage of the Workplace Safety and Insurance Act with its emphasis on self-reliance and early and safe return to work and the development of the functional abilities form
f) a shift away from rest as an acceptable form of treatment for soft tissue injuries

The result has largely been positive. Rather than spending extended periods of time at home and becoming de-conditioned, many workers have had the opportunity to gradually reintegrate into the workplace, even though starting with very limited functional abilities and/or limited hours upon their initial return to work.

On the other hand, it is possible to lose sight of the fact that not everyone can return to work the day following the injury, even if the employer has a return to work program.

This can be true even for soft tissue injuries and those injuries considered somewhat minor in nature.

The Impact of an Injury on RTW

Pain

The International Association for the Study of Pain defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Acute pain is a protective process against further damage, usually with a known local cause. Acute pain responds to analgesic, narcotic and/or anti-inflammatory medications (although these may not be indicated in all cases).

We cannot ignore the impact of pain on an individual and on their functional abilities, especially in the early stages of recovery.

A significant and growing proportion of injuries in Ontario are soft tissue injuries. The following is a summary of the soft tissue healing process.

Soft Tissue Injuries – The Healing Process and Recommended Treatment

Following this type of injury, inflammation develops during the first 48 hours and treatment may consist of rest, ice, compression, elevation and medication.

After the first 48 hours, the patient should usually start to mobilize the injury, to prevent unnecessary stiffening and loss of function. This means gently trying to regain the normal range of movement and strength of the affected part, which should be expected to cause some mild pain.

The patient should use common sense and listen to what his/her body is saying to tell him. The patient should not ignore the warning signs of overdoing it, or allow a mild increase in discomfort to put him/her off work. In general, exercises that encourage a good range of movement but avoid large or sudden forces are most suitable.

The patient may be advised to see a medical practitioner for specific advice to facilitate timely

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Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

recovery, either because of the severity of the initial injury, or if the recovery appears to be slower than expected.

As outlined earlier, there are cases where “rest” is an appropriate form of treatment, and required in order to speed recovery and facilitate a successful return to work.

Neither the WSIB nor the employer should insist on a return to work too early in these situations. Too early a return to work could cause damage, result in further injury for the worker, and more time away from work.

Medication

There are a number of drugs that may be prescribed to treat injuries. For example, the initial musculoskeletal drugs (under drug formulary 25WS), includes possible medications, all of which are automatically allowable and paid for as long as they relate to the work injury within the first 12 weeks. Some of these require prescriptions, and some are available over the counter.

Many of these medications have side effects that may impact the physical well-being and the behaviour of workers. The impact differs from person to person, based on factors such as individual sensitivity, body weight, and other drugs being taken. The Compendium of Pharmaceutical Specialties (CPS) may be helpful and the nurse case managers or medical consultants are available to assist the decision maker.

Return to work while taking certain medication may be in contravention of the Occupational Health & Safety Act, or local Health & Safety rules. This may not be evident to the employer or the decision-maker at the WSIB and careful questioning around medication is needed prior to developing a return to work plan.

Psychological Issues

Depending on how the injury happened, there may be psychological barriers to return to work. Sometimes an individual may feel concern over returning to work. For example, a worker may feel that his/her employer did not take every precaution possible to prevent injuries in the workplace. The worker may feel that the employer encouraged the use of “shortcuts” or did not pay attention to proper ongoing maintenance and repair of equipment, resulting in his/her accident. In these situations, the worker may be reluctant to return to work prior to a full recovery, particularly if it is perceived in some way as supporting the employer. This barrier may not be immediately evident to the decision-maker without careful questioning.

The injury may have resulted from an accident that was traumatic for the worker. For example, if a worker suffers a severe laceration, he/she may have a fear of returning to the workplace. This type of situation is not uncommon, and was one of the barriers to return to work identified in the in-house WSIB Return to Work education workshops. There is no easy solution and a sensitive approach is needed. Open discussion between the decision-maker and the worker is beneficial. Case conferencing with the nurse case manager and the return to work mediator can assist in the return to work process.

Travel to and from the Worksite

In those cases where a set of precautions have been identified by the health practitioner, the decision-maker must keep in mind issues such as the impact of the worker’s injury on the ability to travel to and from the worksite.

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Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

Travel to and from the Worksite

**Example A**

A worker has a work-related accident in which he fractures his lower right leg. His lower leg is casted past his knee. He cannot drive with the cast.

The employer has a job that would be suitable and within the worker's functional abilities, if the worker could safely get to work. The employer is not prepared to arrange taxi service or provide any other alternate transportation.

Although the employer does have work within the worker's functional abilities, it is not suitable since he is unable to get to work. Loss of earnings benefits would be payale in this case.

**Example B**

Another example might be an individual who habitually drives an hour or more to work each day, and has a preassumption against prolonged sitting. Is the driving going to prolong his recovery? The decision-maker has to review the practicality of measures such as stopping by the road for a stretch break. What road is the person travelling on, and is it safe to do? What time of year is it? If using public transportation, is there the opportunity to sit down if needed, and are there other alternatives?

**Example C**

The job duties may be suitable but safe access to the worksite is not feasible. Example – The worker has to walk 300-400 yards across rough ground to get to the site of the modified work being offered. Noting the worker cannot reasonably get to the job, the work is not suitable.

Another example might be a situation where the parking lot is so far away from the actual worksite that the worker has a significant risk of re-injury because of the amount of walking involved.

Factors to Consider When Determining Ability to Work

There are three primary sources of information that must be considered when assessing a worker’s ability to return to work beginning the day following the accident:

a) health and functional abilities information from treating health practitioner(s).

b) information from the worker about the workplace and any job offered, and,

b) information from the employer about the workplace and any job offered.

**Treating Health Practitioner(s)**

The health practitioner is required under the WSIA to promptly provide the WSIB with information as may be required. This may be done on the Form 8 – Health Professional’s Report, Section E – Treatment Plan and Return to Work Information. Section 5 states the following: “Please indicate the patient’s status and task limitations in relation to the diagnosis.” This provides the option of no limitations, specified limitations, and no return to work.

**Return to Work – No Limitations.** If there are no task limitations, usually no further information is required from the health practitioner. If the worker, or less commonly the employer, is in disagreement, then further discussion may be needed. Resources such as the medical consultant or the nurse case manager may be called on for assistance as well. The Best Approaches Document, “Weighting of Medical Evidence”, available on CONNEX is also a good resource.

**Return to Work – Specific Limitations.** If there are specified limitations, then information is needed from the worker and employer regarding return to work. It may be that both parties have arrived at an agreement about the work to be performed and the decision-maker does not need to intervene.

In other cases, the situation is not so clear. The document “Adjudicative Advice – Retrospective Return to Work (RTW) Situations” provides some guidance. If there are any outstanding questions about the functional abilities/precautions the employer should contact the WSIB to help clarify the situation.

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Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont'd)

If the health practitioner (HP) suggests that the worker is to be off work, and provides no rationale/limited information it maybe helpful for the decision-maker to consult with/invite the WSIB nurse case manager or medical consultant. Contact with the HP could assist in clarifying the reasons. The decision-maker should consider the duration of time off work.

Is it a situation where rest is a reasonable part of the treatment process? Has the worker been prescribed medication? What is the side effect/s? What is the method of transportation to work? Will he/she be a safety hazard to himself/herself or others?

Information from the Work
There are a number of questions that can be asked of the worker, including:
1) What was their understanding of the direction given by his doctor?
2) What is the job being offered by the employer?
3) How was the job communicated, for example, verbally or in writing, and by whom?
4) Was he/she involved in the process of designing the job? (not necessary but very helpful)
5) What is his/her perception of the job being offered by the employer in terms of physical demands?

6) Prior to the injury, did he/she receive training on his/her responsibilities and rights following an accident?
7) When does the worker think he/she will be able to return to work?

The decision maker should also consider whether there are any language barriers that could impact the worker's understanding of the job offer.

Information from the Employer
Questions that can be asked of the employer include:
1) If there was any question about the medical precautions was the WSIB contacted to request clarification?
2) Was the worker advised of the particular job available? A blanket statement that any and all precautions or limitations will be accommodated is not sufficient
3) Were details of the job, in terms of the physical demands, conveyed to the worker?
4) Was the offer made in writing? (not necessary, but very helpful)
5) Prior to the injury, did the worker receive training on rights and responsibilities following an accident?

Conclusion
Ultimately, the decision to pay lost time benefits rests with the decision-maker who will provide a detailed and clear rationale. There are a number of resources available, including the return to work mentor, ergonomist, nurse case manager and medical consultant. Useful resource documents are “Adjudicative Advice - Retrospective RTW Situations” and “Best Approaches - Weighing of Medical Evidence”.

In addition to assessing the suitability of the job offered and the communication between the worker and employer around that offer, the decision-maker must review the medical information. The decision-maker should take into account the accident itself and any trauma around it, the period of acute pain, any medication the worker is taking, as well as the treatment recommended by the health practitioner. All of these elements must be considered prior to limiting loss of earnings benefits because of work offered by the employer.

Entitlement to loss of earnings benefits should only be limited when the decision-maker is satisfied, on balance of probabilities, that:
(a) the job or duties offered by the employer are suitable in that they are within the worker’s physical and vocational capacity to perform and will not pose a safety risk or impede the worker’s recovery.
(b) the job and the job duties have been communicated to the injured worker prior to the worker beginning the job or job duties.

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APPENDIX 21: Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work
Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

**Before Making a Return to Work Decision – Checklist**

Before making a RTW decision, consider payment of LCE by comparing your set of facts to this checklist.

<table>
<thead>
<tr>
<th>Information from Health Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the diagnosis and proposed treatment? Is a period of rest reasonable in these circumstances?</td>
</tr>
<tr>
<td>Were the functional abilities clearly outlined?</td>
</tr>
<tr>
<td>Were there any differences in opinion among the health practitioners?</td>
</tr>
<tr>
<td>If there were differences, was the evidence weighed appropriately?</td>
</tr>
<tr>
<td>What medication, if any, was the worker taking? Were the side effects and expected duration considered?</td>
</tr>
<tr>
<td>Did the side effects impact the worker’s ability to work safely and/or impact the safety of others?</td>
</tr>
<tr>
<td>Did the injury or side effects of medication impact the worker’s ability to travel?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information from Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a functional abilities form provided?</td>
</tr>
<tr>
<td>What was the job offered? Was it clear what was being offered?</td>
</tr>
<tr>
<td>What was his/her understanding of functional abilities?</td>
</tr>
<tr>
<td>Are there any transportation issues?</td>
</tr>
<tr>
<td>Is he/she taking any medication that will impact his/her ability to work safely?</td>
</tr>
<tr>
<td>Are there any psychological barriers to return to work? This might include such things as fear of re-injury, actual fear of re-entering the workplace.</td>
</tr>
</tbody>
</table>

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**Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)**

<table>
<thead>
<tr>
<th>Information from Employer</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a functional abilities form provided?</td>
<td></td>
</tr>
<tr>
<td>Was contact made with the WSIB if clarification was needed about the workers medical precautions?</td>
<td></td>
</tr>
<tr>
<td>Was a clear job offer made (e.g. with details about the work being offered)? Was it made verbally, or in writing?</td>
<td></td>
</tr>
<tr>
<td>Was worker invited to come into work to view the job and provide input into what they would be doing?</td>
<td></td>
</tr>
<tr>
<td>Are there any transportation issues or barriers to the actual worksite that you are aware of?</td>
<td></td>
</tr>
</tbody>
</table>
Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

Putting It All Together

Scenario A - Sample Decision Memo to Worker - C. Reid

Issue: Payment of LOE for July 8, 2005

History:

On Thursday, July 7, 2005, this 42-year-old warehouse worker felt an immediate onset of low back pain while lifting a washing machine with a co-worker. He reported the pain immediately and left to go to the medical centre. He was given a Functional Abilities Form for Timely Return to Work (FAF) for completion. His employer advised him that they could accommodate any medical precautions. He returned to modified duties on Monday, July 11, 2005.

Medical:

The initial diagnosis was acute lumbo-sacral strain. He was advised to take Naproxen, rest as needed, and apply ice to the area. The doctor completed the FAF, recommending return to work with precautions on Monday, July 11th. The precautions were outlined on the FAF. A further medical appointment was set for July 16th.

Other Pertinent Facts:

Mr. Reid dropped off his FAF after his doctor’s appointment. He declined an offer of modified duties, citing his doctor’s recommendation that he stay off until Monday, along with the fact that he was in so much pain that he could hardly stand or walk. The employer feels that he should have returned to work right away and certainly on Friday.

Decision:

Mr. Reid experienced an acute onset of back pain that caused him to leave work immediately and go to the doctor. He was given an FAF, and had it completed, as requested. He returned to his place of employment with the FAF, and returned to modified duties on Monday as indicated by the doctor. Mr. Reid, by his own account, was in a great deal of pain.

From the evidence available, it appears that Mr. Reid was unable to work on Friday, July 8. He was in acute pain, and required a period of rest and icing prior to being able to return to light duties. LOE is payable for July 8th.
Dear Mr. Curtis:

As we discussed today on the telephone, you have concerns about the payment of loss of earnings benefits (LOE) to Mr. Reid for July 8, 2005 because of the availability of modified work on that day. Mr. Reid did not return to work until Monday, July 11th.

A worker who has a loss of earnings as a result of a work-related injury or disease is entitled to loss of earnings (LOE) benefits.

Mr. Reid felt an immediate onset of pain when he was lifting a washing machine on July 7th, and left work right away to go to the medical centre. You gave him a Functional Abilities Form (FAF) that he had completed and brought back to you after his appointment. His doctor suggested a return to work with precautions on Monday, and rest and ice in the meantime. He did not recommend a return to work until then.

Mr. Reid’s immediate supervisor, John Birch, asked him to remain at work on Thursday, and if not, then to return to work on Friday. Mr. Reid declined to do this, because of his doctor’s recommendation along with the fact that he was in a great deal of pain.

I have considered your concerns regarding the payment of LOE for July 8.

Mr. Curtis, I feel that Mr. Reid’s decision to decline modified work for the balance of July 7th and for July 8th was reasonable. His doctor had advised him to return to work on Monday, which he did. Mr. Reid was in a great deal of pain, and had difficulty standing or walking.

There is no evidence to suggest that Mr. Curtis was capable of light duties on July 8. Therefore, I have decided to pay LOE for that day.
Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

If you have any further information that you would like me to consider, please call me so we can talk about it.

If you do not understand the reasons for the decision, or if you do not agree with the conclusions reached, please call me. I would be pleased to discuss your concerns.

I also wish to inform you that the Workplace Safety and Insurance Act imposes time limits on appeals. If you plan to appeal the decision, the Act requires that you notify me in writing by (insert six month deadline).

Yours sincerely,

Adjudicator’s Name
Adjudicator
Service Delivery Division

Phone Number

Copy: Worker
Representative, if applicable
Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

Scenario B

The following is a second possible scenario, resulting in an adverse decision to the worker. A sample letter follows.

On July 7, 2005 (Thursday) this 42-year-old warehouse worker, Mr. Reid, felt an immediate onset of low back pain while lifting a washing machine with a co-worker. He reported the pain immediately and left to go to the medical centre. He was given a Functional Abilities Form for Timely Return to Work (FAF) for completion and he dropped it off to his employer after his doctor’s appointment.

New information:
• The initial diagnosis was acute lumbo-sacral strain. Mr. Reid was advised to rest as needed, and apply ice to the area for the remainder of the day. No medication was prescribed. The doctor completed the FAF, recommending return to work with precautions. The precautions were outlined on the FAF. A further medical appointment was set for July 10th.
• Mr. Reid’s employer prepared a written job description following the return of the FAF on July 7th and offered to go over it with Mr. Reid on Friday morning (July 8th) prior to him starting the job. The employer indicated a willingness to show the worker the job and amend the job activities if necessary.
• The work was at no wage loss
• Mr. Reid indicated his doctor had told him to take it easy for a few days. As a result he felt he was entitled to have a longer rest period with a return to work on Monday morning.
• The physician was contacted. There was no information in the medical record pertaining to a direction around rest.
Best Approaches: Recognizing Time to Heal: Assessing Timely and Safe Return to Work (cont’d)

Decision Letter to Mr. Worker – Based on Scenario B

Dear Mr. Reid:

This letter is to confirm our telephone conversation about payment of loss of earnings (LOE) benefits for July 8, 2005, related to your accident of July 7, 2005.

Section 43 of the Workplace Safety and Insurance Act (the Act) states that a worker who has a loss of earnings as a result of an injury is entitled to payments beginning when the loss of earnings begins. The payments continue until the earliest of:

1. the day on which the worker’s loss of earnings ceases,
2. there is no longer an impairment, or,
3. an age requirement (usually age 65) is met

If your employer is able to provide you with suitable work at your regular pay, then any wage loss is unrelated to your injury, and I cannot pay you LOE benefits.

You were seen at the medical centre on July 7, 2005 and advised to ice the affected area and rest for the balance of that day. The doctor indicated you would be able to work within the precautions outlined on the Functional Abilities Form (FAF). On July 7, when you brought the FAF to your employer, he advised he would prepare a written job description for you to discuss on July 8. He indicated a willingness to show you the job and amend it if you had any concerns.

Mr. Reid, I asked you why you did not return to work on July 8 to meet with your employer. You told me you did not want to meet with your employer that day because your doctor had indicated to take it easy for a few days. You felt you required the extra time to rest.

I explained to you that the medical report from your physician indicates that you would be able to return to work as long as you did not exceed the precautions provided. I could not verify that there was medical direction to not work at all for a few days.
Best Approaches: Recognizing Time to Heal - Assessing Timely and Safe Return to Work (cont’d)

REID, First Name
Claim 12345678
Date
Page 2

We discussed the work offered by your employer. You did agree that your employer has a modified work program, and that when you did return to work on Monday, July 11, the work duties were within your functional abilities.

It is my decision that you should have returned to work on Friday, July 8 to attempt the work. The job would have been the same work that you were able to perform on Monday, July 11. There has been no medical evidence provided to indicate you were not physically able to do the work on Friday. For these reasons I am unable to pay LOE benefits for July 8.

If you have further information that you would like me to consider, please call me.

If you do not understand the reasons for the decision, or if you do not agree with the conclusions reached, I would be pleased to discuss your concerns.

I also wish to inform you that the Workplace Safety and Insurance Act (the Act) imposes time limits on appeals. If you plan to appeal the decision, the Act requires that you notify me in writing by (insert six month deadline).

Yours sincerely,

Adjudicator’s Name
Adjudicator
Service Delivery Division

Phone Number

Copy: Employer
Representative, if applicable

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APPENDIX 22: Governance History

Governance is fundamental to the ongoing operation and oversight of the workers' compensation system. It is through governance direction and oversight of the Board that this takes place. Modernizing governance is necessary to modernizing the compensation system. Governance is an issue identified by key representatives as an issue that needs to be addressed in order to improve confidence in the system.

We will provide a very brief historical overview of BC's WCB governance to place this issue in context. A more detailed history is in an April 7, 1997 Briefing Paper prepared by the Board for the Gill Royal Commission. This Appendix will include additional details past 1997.

The Board was governed by Commissioners that were appointed by the Provincial government from 1916 to 1991. Commissioners had broad control over the Board not only in governance and oversight but also in direct management of the organization. The Royal Commissions of 1942, 1952 and 1966 addressed governance issues but the fundamental structure remained the same until a 1988 report from Donald R. Munroe, QC recommended a new governance structure. The Munroe Report conducted extensive consultations with stakeholders and included a broad range of high-level representatives of worker and employer community stakeholders.

The recommendations of the Munroe Advisory Committee were adopted by government. The new Board consisted of 13 voting members: a chair, two public interest representatives, five worker representatives, and five employer representatives. The Munroe report also recommended creating a president and chief executive officer (CEO) to be responsible for day-to-day administration and a chief appeal commissioner (CAC) who would be independently responsible for deciding appeals. The Appeal Division also had the responsibility of addressing the legality of policy. This structure was in place from 1991 to 1995.

The Workers’ Compensation Board of Canada Board Governance Review Report and Recommendations, Judi Korbin & Patrick O’Callaghan (1995)\(^{206}\) identified numerous issues including the enormity of the task assigned to the Board, politicization of key roles, lack of continuity and leadership, and lack of cohesiveness. There was a crisis in the leadership and personality conflicts in 1995. The government took the extraordinary measure of replacing the Board of Governors (BOG) with a Panel of Administrators (POA). Membership of the POA varied between 3 and 5. There has been a single representative of the worker community and a single representative of the employer community since 1995.

The Gill Royal Commission\(^ {207}\) in 1999 recommended that the existing POA be replaced by a ten-person board that would include equal representation from workers, employers and the public, plus a neutral chair, all of whom would be required to act in the best interests of the workers’ compensation system. This recommendation was not adopted. It was superseded by the Winter Report\(^ {208}\) in 2002 that recommended that employers and workers be represented on the Board but that these groups should not constitute a majority of membership of the Board. Representation of workers and employers on what is now termed the Board of Directors (BOD) under a more corporate model of governance has remained at one representative apiece since then.

To sum up this governance history, there have been three broadly consultative reviews of governance between 1988 and 1999 that recommended that the primary stakeholders of worker and employer representatives make up a majority of the Board. Despite those well-reasoned and consultative reports, there have remained single members of those communities to provide oversight on behalf of those communities while there has been an expanding public interest and special interest representation on the BOD that has not been supported by any open and transparent process for governance.

While this governance situation has persisted in BC for over 2 decades, the predominant governance models in other Canadian jurisdictions provide for multiple worker and employer representatives in equal numbers.\(^ {209}\) The overriding principle is that the core stakeholders, employers and workers, should have sufficient and equal representation to proficiently and responsibily carry out the governance on behalf of their communities. A single representative, who participates on a part-time basis, can easily be overwhelmed in governance responsibilities faced against a larger number of directors that does not share or understand the stakeholder communities’ interests. This system of multiple key stakeholder directors has worked in other Canadian jurisdictions.


\(^{207}\) [http://www.qp.gov.bc.ca/rcwc/report.htm]


\(^{209}\) See Appendix 24 Governance Table
APPENDIX 23: **Purpose Statements / Code of Conduct (from WCB-IR-0003(4))**

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</table>

- ACM: Alberta Claims Management
- BC: British Columbia Workers' Compensation Board
- SK: Saskatchewan Workers' Compensation Board
- MB: Manitoba Workers' Compensation Board
- ON: Ontario Workers' Compensation Board
- PQ: Quebec Workers' Compensation Board
- NS: Nova Scotia Workers' Compensation Board
- NL: Newfoundland and Labrador Workers' Compensation Board
- PEI: Prince Edward Island Workers' Compensation Board
- NF: New Brunswick Workers' Compensation Board
- YT: Yukon Workers' Compensation Board

Note: The table provides a comparison of whether each organization has a purpose statement and a code of conduct.
### Governance

**Patterson Review | 2019-04-18**

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<th>Organization</th>
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<td>(s.3(3) of the Act)</td>
<td>(s.50.2(1) of the Act)</td>
<td>(s.143(1) of the Act)</td>
<td>(s.149(1) of the Act)</td>
<td>(s.149(2) of the Act)</td>
<td>(s.149(1) of the Act)</td>
<td>(s.149(2) of the Act)</td>
<td>(s.149(2) of the Act)</td>
<td>(s.149(2) of the Act)</td>
<td>(s.149(2) of the Act)</td>
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<tr>
<td>Maximum term length for Chair?</td>
<td>5 years</td>
<td>3 years</td>
<td>5 years</td>
<td>4 years</td>
<td>Not in Act, typically 3 years</td>
<td>5 years</td>
<td>5 years</td>
<td>5 years</td>
<td>5 years</td>
<td>3 years</td>
<td>3 years</td>
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<td>(s.1(1) of the Act)</td>
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<td>(s.1(1) of the Act)</td>
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1. Jurisdictions marked with a * are responsible for occupational health and safety regulations (information from AV/CBC).
2. Maximum or minimum amount of BOD numbers not specified in legislation, current BOD has nine members.
3. BOD Vice-Chair also has 5 year term limit.
### NEW DIRECTIONS:

**WCB Review 2019**

<table>
<thead>
<tr>
<th>BC</th>
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<tbody>
<tr>
<td><strong>Chair able to be re-appointed?</strong></td>
<td>Yes, may not serve more than 10 years in a row (s. 8.1(2) of the Act)</td>
<td>Yes, up to two terms, may not serve more than 10 years (s. 8.1(2) of the Act)</td>
<td>Yes, after consultation with stakeholders (s. 8.1(2) of the Act)</td>
<td>Yes</td>
<td>Not in Act</td>
<td>Yes* (s. 1.24) of the Act</td>
<td>Yes</td>
<td>Not in Act</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Max term length for non-Chair BOD members?</strong></td>
<td>3 years (s. 8.1(2) of the Act)</td>
<td>3 years (s. 8.1(2) of the Act)</td>
<td>4 years (s. 8.1(2) of the Act)</td>
<td>4 years (s. 8.1(2) of the Act)</td>
<td>Not in Act, typically 3 years</td>
<td>3 years (s. 1.44) of the Act</td>
<td>4 years (s. 1.2(2) of the Act)</td>
<td>5 years (s. 8.1(2) of the Act)</td>
<td>Set by Cabinet (s. 8.4(4) of the Act)</td>
<td>2 years (s. 8.1(2) of the Act)</td>
<td>3 years (s. 8.1(2) of the Act)</td>
</tr>
<tr>
<td><strong>Non-Chair BOD members able to be reappointed?</strong></td>
<td>Yes, may not serve more than 6 years in a row (s. 8.1(4) of the Act)</td>
<td>Yes, up to two terms, may not serve more than 10 years (s. 8.1(2) of the Act)</td>
<td>Yes, after consultation with stakeholders (s. 8.1(2) of the Act)</td>
<td>Yes</td>
<td>Not in Act, yes, up to three terms</td>
<td>Yes (s. 1.2(2) of the Act)</td>
<td>Yes, may serve two terms 3 year terms (s. 8.1(2) of the Act)</td>
<td>Not in Act</td>
<td>Not in Act</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>Number of worker and employer reps?</strong></td>
<td>1 each (s. 8.1(2) of the Act)</td>
<td>Up to 2 each (s. 8.1(2) of the Act)</td>
<td>2 each (s. 8.1(2) of the Act)</td>
<td>2 each (s. 8.1(2) of the Act)</td>
<td>Not specified</td>
<td>7 each (s. 1.41) of the Act</td>
<td>Up to 4 each (s. 1.13)(3) of the Act</td>
<td>Min. 4 each (s. 8.1(2) of the Act)</td>
<td>Number not specified</td>
<td>2 each (s. 8.1(2) of the Act)</td>
<td>2 each (s. 8.1(2) of the Act)</td>
</tr>
<tr>
<td><strong>Required to appoint worker/employer reps from list or to consult?</strong></td>
<td>List (s. 8.1(2) of the Act)</td>
<td>List (s. 8.1(2) of the Act)</td>
<td>List (s. 8.1(2) of the Act)</td>
<td>Consult (s. 1.24) of the Act</td>
<td>Not in Act</td>
<td>List (s. 1.44) of the Act</td>
<td>Not in Act</td>
<td>Not in Act</td>
<td>Minimum two from list (s. 8.1(2) of the Act)</td>
<td>Consult (s. 1.24) of the Act</td>
<td>List (s. 8.1(2) of the Act)</td>
</tr>
</tbody>
</table>

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1. Terms of Office are renewable.
2. The number of worker and employer reps must be equal.
3. The number of worker and employee reps must be specified but need not be equal.
4. The number of worker and employee reps must be equal.
5. Cabinet must consider submissions respecting membership made by workers and employers.
6. Minister will consider any recommendations for appointment of employer representatives from employers.
<table>
<thead>
<tr>
<th>BC</th>
<th>AB</th>
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<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</table>

**APPENDIX 24:** Governance Table (from WCB-IR-0003(3a))
APPENDIX 25: ACTIVITY-RELATED SOFT TISSUE DISORDER (ASTD) Claims

Board Policy defines activity-related soft tissue disorders (ASTDs)\textsuperscript{210} as:

\textbf{Definition of ASTD}

The terms “cumulative trauma disorder”, “repetitive strain injury”, “repetitive motion disorder”, “occupational overuse syndrome”, “occupational cerviobrachial disorder”, “hand/arm vibration syndrome”, “work-related musculoskeletal disorder”, and others, are broad collective terms used to describe a diverse group of soft tissue disorders which may or may not be caused or aggravated by employment activities. Each of these collective terms can be misleading. They may imply the presence of “repetition” or “trauma” or “motion” or “work-relatedness” where in fact the cause of the disorder may be due in whole or in part to other factors that are not work-related.

The common elements of the disorders included in these collective terms are:
- they are related to physical activity; and
- they affect muscles, tendons, and other soft tissues.

The Board uses the term ASTDs to describe this group of disorders which may or may not be caused or aggravated by employment activities.

The reasoning as to how ASTDs came to be under section 6 of the Act as an occupational disease is unclear. In the 1966, Tysoe Royal Commission Report what is now Schedule B of the Act\textsuperscript{211}, which lists occupational diseases to a presumption applies under then section 8(2) does not list any ASTD type condition. The current Schedule B contains the following ASTD related items:

Item 12 Bursitis
  (a) Knee bursitis
  (b) Shoulder bursitis

Item 13 Tendinopathy:
  (a) Hand-wrist tendinopathy
  (b) Shoulder tendinopathy

Item 16 Hand-arm vibration syndrome

Hand-arm vibration (HAV) syndrome is somewhat different from ASTDs in that it results from exposure to the physical force of vibration rather than an activity of the muscles and tendons.

\textsuperscript{210} Policy item #27.00 ACTIVITY-RELATED SOFT TISSUE DISORDERS (“ASTDS”) OF THE LIMBS
\textsuperscript{211} See Tysoe Royal Commission WCA section 8(2) and Schedule section 8(2)
We will concentrate more on activities in this section and leave HAV as a separate matter for now.

British Columbia appears to be unique among all Canadian jurisdictions in classifying ASTDs as Occupational Diseases. It is also unique in requiring a determination of whether a condition identified as an occupational disease is compensable based on whether the condition is due to the nature of the employment rather than occurring out of and in the course of employment which is the test for physical injury. In WCB-IR-0066, a jurisdictional scan summary, it is noted that no other Canadian jurisdiction deals with ASTDs in the same manner as BC. Some other jurisdictions will have a very limited listing of occupational diseases with presumptions the same as BC’s Schedule B. These jurisdictions include: Alberta; Saskatchewan; Manitoba, Ontario; Quebec; and Nova Scotia. The citations are in almost also circumstances for bursitis and tenosynovitis. The citations appear to be archaic. Tenosynovitis is a subset of a much broader range of conditions now referred to as tendinopathies. Prior to the adoption of the term tendinopathy there used to be regularly used diagnoses of tenosynovitis and tendonitis. Tenosynovitis is inflammation of the tendon sheath and tendonitis is inflammation or irritation of the tendon. Decades ago, there was medical consensus that tenosynovitis was likely the result of activities in certain occupation. There was similar consensus about certain bursitis conditions such as carpet layers knee from using tools that involved knee impacts to stretch carpet.

The entries of bursitis and tenosynovitis in Canadian jurisdictions indicate these entries were made long ago and the processes for such entries have never been updated. There is one slight exception for BC in that the term tenosynovitis was updated to tendinopathy in Schedule B. There are conditions such and carpal tunnel syndrome or epicondylitis that have no mention in any occupational disease schedules. Where tenosynovitis and bursitis have been entered schedules of occupational disease presumption it appears to be a flavour of a particular time that has not continued. The treatment of RSI or ASTDs as occupational diseases is limited only to bursitis and tenosynovitis where the conditions correspond with industry requirements in column B. The column B requirements are generally very restrictive. It is probable that very few RSI/ASTD injuries would be addressed as occupational diseases on other jurisdictions.

Our review of repetitive strain injuries (RSIs)/ASTDs in other jurisdictions indicates that no other jurisdiction except Nova Scotia adopts the term of ASTD. All other jurisdictions apply the same adjudication criteria for personal injury of whether the injury (condition) arose out of and in the course of employment. We did not discern that any other jurisdiction applies a “due to the nature of the employment” causation requirement to RSIs/ASTDs. Nova Scotia has recently adopted some elements of BC policy in an October 1, 2015 Practice Guideline Over Period of Time Injuries. This Guideline sets out the requirements under out of and in the course of employment. No mention is made in the Guideline of occupational disease. The Nova Scotia Guideline makes reference to the Board’s ASTD Reference Guide. The BC ASTD Reference Guide was retired several years ago because it is outdated and the information on which it was based is not scientifically reliable.
It is notable that an employer submission in a physically demanding service industry with repetitive work, that is active across Canada and so would be in a good position to comment on the adjudication of ASTDs, finds that adjudication of these conditions under section 6 is problematic. The scientific literature also indicates that the Board’s approach to ASTDs is outdated. The Guidelines used by the Board are derived from the 1997 NIOSH study Musculoskeletal Disorders and Workplace Factors A Critical Review of Epidemiologic Evidence for Work-Related Musculoskeletal Disorders of the Neck, Upper Extremity, and Low Back. Not only is this study very much dated now, many of the guideline numbers and conclusions the Board derived and attributed to this study are questionable.

In sum, BC is out of step with all other Canadian Jurisdictions in adjudicating RSI/ASTDs as occupational diseases. Claims that are adjudicated under section 6 should be required to meet the same causative significance test as claims under section 5. The test is whether it is as likely as not that the injury (condition) was significantly caused by the work. The term “as likely as not” for the purposes of compensation means that the possibilities are at least evenly balanced. If the possibilities are evenly balanced as noted in section 99(3), the matter must be resolved in a manner that favours the worker. The term “significantly caused” has been means that the cause must be more than trivial or insignificant.

There is a mistaken impression that the numbers in the guidelines must be met in order to conclude that it is likely the condition is due to the nature of the employment. This is a mistaken conclusion. The guidelines provide numbers under which scientific evidence through studies indicate musculoskeletal injuries are likely to occur in healthy individuals. It is not valid to conclude that if the guidelines are not met or exceeded it is unlikely that the work caused the condition. Nevertheless, many adjudicators improperly apply guidelines in this method. This misuse of guidelines provides an additional, but certainly not the only or even most significant, reason to take the adjudication out of section 6 of the Act and place it back into section 5.

Moving RSI/ASTDs out of section 6 presents a possible problem for the Schedule B recognition of bursitis, tendinopathy and HAV syndrome. Some other personal injuries that are not occupational diseases have presumptions such as traumatic mental disorders for certain prescribed occupations. It is not an insurmountable problem to address the Schedule B presumptions. Rather than the route of amending the Act to provide a presumption as has been done for certain mental disorders it would be more appropriate to address causation recognition in policy including the causation provisions currently addressed in Schedule B. There is a policy review in progress for ASTD claims. Advances could be made on that policy development work to create new policy for ASTDs under section 5 and Chapter 3 Personal Injury of the RSCM II.
## Mental Disorder Coverage

Patterson Review | 2019-04-18

### Canadian WCBs

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<tr>
<th>Organization</th>
<th>BC</th>
<th>AB</th>
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<td>Workers’ Compensation Board of Alberta</td>
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### Post-Traumatic Stress Disorder (PTSD) Presumption

- **All Workers**: No, No, No, No, No, No, No, No, No, No, No, No
- **First Responders**: No, Yes, No, No, Yes, No, Yes, No, Yes, No, Yes, No

### Mental Disorder Presumption

- **All Workers**: No, Yes, Yes, No, No, No, No, No, No, Yes, No, No
- **First Responders**: Yes, No, Yes, No, No, No, No, No, Yes, No, Yes, Yes

### Mental Disorder (Non-Presumptive) Coverage

- Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes

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1. Newfoundland’s PTSD presumption comes into force on July 1, 2019.
2. The PTSD presumption applies to all employers, defined as corrections officers, emergency response workers, firefighters, paramedics, peace officers (sheriffs), police officers and other occupations prescribed by the regulation.
3. The PTSD presumption applies to first responders and other workers defined as firefighters and fire investigators, police officers, members of an emergency response team, paramedics, emergency medical attendants, maintenance service managers, workers in correctional institutions, workers in secure custody/temporary detention facilities, workers involved in dispatch, members of the college of Nurses of Ontario, and provincial health authority.
4. The PTSD presumption applies to emergency responders, defined as firefighters, paramedics, and police officers.
5. The PTSD presumption applies to emergency response workers, defined as firefighters, paramedics, and police officers.
6. The PTSD presumption applies to emergency responders, defined as firefighters, paramedics, and police officers.
7. The mental disorder presumption applies to all employers, defined as corrections officers, emergency medical attendants, firefighters, police officers, sheriffs, emergency response workers, and others.
8. On April 11, 2019, the British Columbia Government introduced Bill 11, which proposes amendments to the Workers Compensation Act. If passed, Bill 11 will extend presumptive cancer and mental disorder coverage to all federal firefighters, fire investigators and firefighters working for First Nations and other Indigenous organizations.
## CPP Deductions as of 2019-09-16 with CPP Deduction Year Between 2014-01-01 and 2019-09-16

<table>
<thead>
<tr>
<th>CPP Deduction Year</th>
<th>Claim Count</th>
<th>Total Monthly CPP Deduction</th>
<th>Total CPP Deduction for the Year</th>
<th>Avg Monthly CPP Deduction</th>
<th>Avg Total CPP Deduction for the Year</th>
<th>Estimated Claim Count</th>
<th>Estimated Monthly CPP Deduction</th>
<th>Estimated Total CPP Deduction for the Year</th>
<th>Total Yearly CPP Amount (Declared + Undeclared Total)</th>
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<td>413</td>
<td>$196,991.13</td>
<td>$2,082,648.49</td>
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<tr>
<td>2016</td>
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<td>$2,648,811.38</td>
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<td>$5,113.54</td>
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<tr>
<td>2017</td>
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<td>$268,907.46</td>
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<td>$64,170.75</td>
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<td>$4,271,133.68</td>
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</tbody>
</table>

### Notes:
1. **Claims with Declared CPP**: claims with CPP deduction in CMS
2. **Estimated Claims with Undeclared CPP**: claims without CPP deductions in CMS, but are expected to apply for CPP benefits after the Board has approved a monthly pension
3. **Estimated Claim Count**: estimated count of additional claims where the worker will apply for CPP disability benefits after the Board has issued the pension
4. **Estimated Monthly CPP Deduction**: estimated additional CPP amount
   - Formula: Estimated Monthly CPP Deduction = Estimated Claim Count (column G) * Avg Monthly CPP Deduction (column F)
5. **Estimated Total CPP Deduction for the Year**: Estimated Monthly CPP Deduction (column H) * 12 months
6. The value for Estimated Claim Count (G16) in 2019 is pro-rated to 8.5 months to reflect the estimated value as of the data refresh of 2019-09-16
APPENDIX 28: INDIGENOUS CONSULTATIONS (BACKGROUND and INITIATIVES)

A. Initiatives Related to the Truth and Reconciliation Commission’s (TRC) Call to Action:
   
   • The B.C. Government committed to adopting and implement the TRC’s calls to action and have coordinated initiatives at the level of the provincial government through the Ministry of Indigenous Relations and Reconciliation (MIRR). In 2016-2017, this included an Off-Reserve Aboriginal Action Plan (ORAPP) and a Provincial Coordination Team (PCT). The PCT has been acknowledged as a best practices approach for collaboration and partnership between urban Indigenous communities and governments.

   • The B.C. Government developed Indigenous Relations Behavioral Competencies to help the BC Public Service work effectively with the Indigenous people of B.C. which can be used as a model by other organizations.

   • The First Nations Health Authority (FNHA) created a program “Cultural Safety and Humility in Health Services Delivery for First Nations Aboriginal Peoples in British Columbia.”\(^{212}\) In addition to providing health services to culturally safe ways, the FNHA has a mandate to gather knowledge (including but not limited to research) and make it meaningful to their communities.

   • The Law Society of British Columbia established a Truth and Reconciliation Advisory Committee\(^{213}\), as did the Workers Compensation Appeal Tribunal\(^{214}\). Both resulted in changes in policy and practices.

   • In October 2, 2018, the Board’s Joint Diversity Committee (JDC) at the Board reviewed some of these initiatives and made recommendations about how the Board might go about exploring its roles and responsibilities under the TRC. Some of the JDC’s recommendations mirrored those that had been provided in the Board’s 2008 study Working Safe in Aboriginal Communities.\(^{215}\) To date these recommendations have not been implemented.

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\(^{212}\) Thanks to Board Medical Advisors, Dr. Dunn and Dr. Martin, who provided this information.


\(^{214}\) WCAT published Responding to the Truth and Reconciliation Commission Calls to Action in Fall 2018.


B. Board Initiatives re Indigenous Outreach

   The Board has made some initiatives about Indigenous Outreach.

   - From 2013-2016, the Young and New Worker team (Industry & Labour Services) coordinated tours of communities, delivering presentations at on and off-reserve schools and sharing resources with schools with Indigenous youth populations.

   - For the last 9 years, the Board participated in the 2-day career and education fair that gather thousands of Indigenous youth and chaperones, the “Gathering Our Voices”.

   - In 2019, the ILS Young and New Worker team participated in the Kwantlen First Nation Education Fair.

   - In May 2018, Board staff participated in a workshop Working Effectively with Indigenous Peoples.

   - In April 2019, Dr. Henry Harder, an Aboriginal Health researcher at UNBC, made a presentation on Indigenous Perspectives within Vocational Rehabilitation to Board staff.

   - In May 2019, at the Workers’ Compensation Inter-organizational training day for RD, WCAT, WAO, EAO, FPO, and WES, Dr. Janet Hare presented on Indigenous Cultural Competencies and what Reconciliation means following the TRC’s calls to action.

   - The Chief Review Officer attended a meeting of the BC Government Statutory Decision Maker (SDM) Working Group to obtain information to assist the development of a corporate plan for the implementation of the U.N. Declaration on the Rights of the Indigenous People (UNDRIP) and the TRC call to action.

   - The Board is in the process of retaining a consultant to assist in the development of an Indigenous Relations Strategy for WorkSafeBC.
C. Research

- In December 2008, WorkSafe funded and then published research by the United Native Nations Society under the title *Working Safe in Aboriginal Communities*. The principle application was David Johnson, of the United Native Nations, with co-applicants being author Charles Horn (University of Victoria) and Danielle Levine (Royal Roads University).

- The Board published *Safeguarding our Indigenous Communities* (2012)

- There have been important attempts to identify worker compensation injuries among aboriginal populations in B.C., from a quantitative linking of data bases.²¹⁶ The study considered both work-related injuries (WCB) and other injuries. In a summary of the study, two of the authors noted that injuries were reduced with reduction in poverty and increased urbanization but that Indigenous people had higher rates of injury and that whatever factors were involved, they hurt Indigenous women more than men.

- Atira Women’s Resource Society *Your Rights on Reserve: A Legal Tool Kit for Aboriginal Women in BC* – good intro to band jurisdiction and employment on reserve issues.

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APPENDIX 29: COMMENTS AND RECOMMENDATIONS RECEIVED THROUGH CONSULTATION WITH INDIGENOUS WORKERS AND SERVICE PROVIDERS

- The following is a compilation of recommendations received through consultation with Indigenous workers and service providers who participated in the public hearings and further interviews concerning on-reserve employment.

1. WSBC must recognize the special relationship that First Nations Individuals have to their community, culture and land (physical location) in designing rehabilitation programs.

2. WSBC needs to pay special attention to the institutional barriers facing First Nations individuals including:
   a) Institutional and structural setups that are focused on serving mainstream (non-First Nations) populations;
   b) Lack of familiarity with historical trauma and the local history of each specific community and each specific individual;
   c) Long-term barriers to education
   d) Unfamiliarity with procedures, forms, application deadlines

3. WSBC needs to make better efforts to liaise and build partnerships with First Nations Organizations that are already involved in improving the health and vocational capacity of their own people. Intrinsic in this factor is a sense of “local control” for individuals working with WSBC. Examples of these organizations include:
   a) Friendship Centres;
   b) First Nations Chief and Council (especially those personnel who work on providing vocational opportunities for their people);
   c) First Nations based Healing Centres;
   d) First Nations competent Physicians and Health Care Workers
   e) North Vancouver Island Aboriginal Training Society

4. WSBC urgently needs to consider the use of funded First Nations Systems Navigators to remedy many of the above factors. Systems Navigators are already widely in place in Courts, Health Care and Child Protection. There are some general principals which help in the creation of successful navigators:
   a) Answer to the individual and Community and NOT to WSBC
   b) Be embedded in the individuals’ communities and have extensive knowledge of support services and vocational opportunities;
   c) Support and accompany workers as they navigate the WSBC system and also navigate re-entry into job retraining and vocational opportunities.
d) WSBC should consider sub-contracting local navigational services already in place in many communities (eg. Speak to Sassaman’s Society and train one of their already competent systems navigators to become WSBC navigator.

5. Vocational Rehabilitation Consultants are often remotely located and not familiar with the “situation on the ground”. As such, there is no one size fits all” vocational solutions. Consider a more holistic definition of vocational rehabilitation and consider all factors: mental, emotional, spiritual, cultural and vocational. This would also mean that the vocational rehabilitation consultants should also engage an “all services as needed” to effect a successful personal rehabilitation.

6. A vocational rehabilitation return to work mandate must also take into consideration:
   a) Physical and psychological suitability
   b) Availability of work
   c) Location of work
   d) Earnings (LTW wage rate)
   e) Worker vocational rehabilitation profile (skills, education, work experience, personal circumstances such as relational, legal, status, social, motivational, socio-economic and self-concept.

7. Provide more supports for people living in remote locations:
   a) Consider training to access positions in the local area, even if the wage rate is lower
   b) Relaxation of criteria for self-employment.

8. Relocation is a difficult challenge of VRC’s and workers in general and must consider:
   a) Familial connections, supports and home life
   b) Whether the individual is living on or off reserve
   c) Employment opportunities
   d) Inter-racial marriage and Band membership status
   e) Long history of attachment to land
   f) Supports in the local area
   g) Familial and community supports

9. Cultural sensitivity training for all WSBC staff.

10. Respectfully request an invite to foster a better working relationship in order to break down the distrust of “Government Agencies” and establish a relationship built on respect, compassion, wisdom, responsibility, caring, sharing, harmony and balance.
11. Provide access to locations such as the Tsow-Tun Le Lum (Helping House) trauma program or Kwunatsustul Trauma Program to address pre re-employment issues.

12. Provide information kit (a roadmap through the compensation system. (For workers and employers).

13. Consider partnering with a branding company, to assist in provide multiple services such as communications planning and support, workshops, staff training.

14. Approach the Federal government to get provisions added to Federal contracts for support and information for injured workers.
APPENDIX 30: JURISDICTION, INDIGENOUS BANDS AND EMPLOYMENT

There are often complex jurisdictional, employment and status issues involved in the working lives and workplaces of Indigenous employers and workers in B.C., including issues related to tax status and labour relations (federal and provincial). The Board’s jurisdiction to regulate Occupational Health and Safety in Indigenous workplaces is also complex. The Board’s OH&S jurisdiction is set out in Part 3 of the Act and it applies only to those enterprises “ordinarily within the jurisdiction of the Provincial Government”, an issue which neither simple nor without dispute. The absence of Board safety culture in Aboriginal communities was noted some time ago and since then, there have been some programs for the Indigenous community around safety and prevention.

Currently, there is one difference between band enterprises which are federal enterprises and those which are provincial enterprises – the right to a duty to accommodate. Federal enterprises are part of the federally regulated private sector and are bound by the Canada Labour Code (“Code”). This Code requires employers to obtain provincial compensation coverage but also states that they have a duty to accommodate injured workers who can return

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218 The Prevention Manual Policy Item D1-108-1 concerns the application of the Act where the Canadian Constitution or other federal and provincial legislation puts limits on the Board’s authority. The policy notes that “These limits are largely matters of general law over which the Board has not control. They are also too complex to state in this Item.” In the Part 3 Guideline G-D1-108-1 WorkSafeBC jurisdiction over operations involving Aboriginal people, the guidelines notes that section 108 of the Workers Compensation Act provides that Part 3 of the Act applies to “every employer and worker whose occupational health and safety are ordinarily within the jurisdiction of the Provincial Government.”

219 As noted in the Board’s 2008 study, “Working Safe in Aboriginal Communities”, there is an absence of WorkSafe’s presence in promoting safety in Aboriginal communities in general, irrespective of these jurisdiction issues. The study offers a path for WorkSafe to build a relationship with the Indigenous community, around safety, and in a way that recognizes the particular role of community. The recommendations of this study are a valuable starting point for any consultation on safety or compensation with the with the Indigenous community.

220 One program came to the attention of the Review was the ongoing presence over 9 years of the Young and New Worker Team at the Gathering Our Voices Conference, an annual Indigenous youth leadership event in Port Alberni, B.C. The Team noted that this conference is particularly important as many of the attending students live on reserve and may not get the career planning instruction through WorkSafeBC’s Student WorkSafe modules that off-reserve teachers incorporate into lessons. There also have been recent training sessions for WorkSafe staff on Working Effectively with Indigenous People.

221 As noted in the articles above, the determination of federal vs. provincial jurisdiction over on reserve employment rights is highly fact sensitive and has been the subject of much litigation as it highlights a “constitutional divide” between federal and provincial powers.
to work. Provincial enterprises are exclusively governed by the *Workers Compensation Act* which, at this time, does not include a duty to accommodate provision.

These complexities are less present in compensation matters. Part 1 of the *Workers Compensation Act* provides WorkSafe with the authority to admit individuals working in B.C. and designate their status as workers, employers and independent operators. While these classifications are not always simple, they cross over other jurisdictional boundaries. In practice, this means that even when a band is engaged in an enterprise which is not within provincial jurisdiction and has no connection to WorkSafe Prevention policies or practices, the band employer must still register and pay assessments to WorkSafe and its workers are entitled to compensation, if injured.

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222 provision under section 34 of the *CLC Regulation.*

223 Part 1 of the Act (compensation) is not limited to those within provincial jurisdiction.

224 As noted in the Board’s 2008 study, *Working Safe in Aboriginal Communities,* there is an absence of WorkSafe’s presence in promoting safety in Aboriginal communities in general, irrespective of these jurisdiction issues. The study offers a path for WorkSafe to build a relationship with the Indigenous community, around safety, and in a way that recognizes the particular role of community. The recommendations of this study are a valuable starting point for any consultation on safety or compensation with the Indigenous community.
APPENDIX 31: CLAIMS ACCEPTANCE RATE FOR INDIGENOUS CLAIMS

In WCB-IR-0084, the Board provided the Review with information regarding First Nations Operations. Included in the IR response was Table 2-3: Work Injuries Reported and Claims First Paid by Year, and Employer Size reproduced below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Work Injuries Reported</th>
<th>Number of Claims First Paid</th>
<th>Percentage Reported Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>425</td>
<td>158</td>
<td>37.17%</td>
</tr>
<tr>
<td>2010</td>
<td>432</td>
<td>153</td>
<td>35.42%</td>
</tr>
<tr>
<td>2011</td>
<td>480</td>
<td>176</td>
<td>36.67%</td>
</tr>
<tr>
<td>2012</td>
<td>515</td>
<td>195</td>
<td>37.86%</td>
</tr>
<tr>
<td>2013</td>
<td>546</td>
<td>232</td>
<td>42.49%</td>
</tr>
<tr>
<td>2014</td>
<td>517</td>
<td>158</td>
<td>30.56%</td>
</tr>
<tr>
<td>2015</td>
<td>512</td>
<td>174</td>
<td>33.98%</td>
</tr>
<tr>
<td>2016</td>
<td>502</td>
<td>155</td>
<td>30.88%</td>
</tr>
<tr>
<td>2017</td>
<td>549</td>
<td>177</td>
<td>32.24%</td>
</tr>
<tr>
<td>2018</td>
<td>639</td>
<td>224</td>
<td>35.05%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>5117</td>
<td><strong>1802</strong></td>
<td><strong>35.22%</strong></td>
</tr>
</tbody>
</table>

A quick glance at the numbers indicates the number of claims paid as a ratio to those reported looks small. Calculation of the rate of injuries reported to those first paid yields a rate of 35.22% over the ten-year period 2009-2018. This rate is fairly consistent whether the ratio is calculated for each year individually, which ranges between 31 and 44 percent and averaged yielding 35% of all of the claims first paid (1,802) and dividing by all of the claims reported (5,117) in the ten-year period which yields a percentage of 35.22% of claims being reported being paid in the same year.
The Board publishes a ten-year summary of consolidated financial statements\(^{225}\). This financial statement includes the same statistics of claims first reported and claims first paid but for all claims made to the Board. The following table presents this data:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Work Injuries Reported</th>
<th>Number of Claims First Paid</th>
<th>Percentage Reported Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>141495</td>
<td>94815</td>
<td>67.01%</td>
</tr>
<tr>
<td>2010</td>
<td>136584</td>
<td>95663</td>
<td>70.04%</td>
</tr>
<tr>
<td>2011</td>
<td>141339</td>
<td>103940</td>
<td>73.54%</td>
</tr>
<tr>
<td>2012</td>
<td>144758</td>
<td>104710</td>
<td>72.33%</td>
</tr>
<tr>
<td>2013</td>
<td>144781</td>
<td>103672</td>
<td>71.61%</td>
</tr>
<tr>
<td>2014</td>
<td>146515</td>
<td>102791</td>
<td>70.16%</td>
</tr>
<tr>
<td>2015</td>
<td>145511</td>
<td>102823</td>
<td>70.66%</td>
</tr>
<tr>
<td>2016</td>
<td>149132</td>
<td>103687</td>
<td>69.53%</td>
</tr>
<tr>
<td>2017</td>
<td>152567</td>
<td>106808</td>
<td>70.01%</td>
</tr>
<tr>
<td>2018</td>
<td>155753</td>
<td>109960</td>
<td>70.60%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1458435</td>
<td>1028869</td>
<td>70.55%</td>
</tr>
</tbody>
</table>

The ten-year claim percentage first paid of all claims reported is 70.55%. The percentage of claims paid per claims reported to Indigenous employers is half of that for all claims. This is a shocking figure. A person reporting a claim to a First Nations employer is half as likely to be paid for the claim. These are not subtle statistics. A 100% (2 times) difference in the probability of being paid wage loss benefits on a reported claim is a stunning and stark contrast. This is not a minor difference.

This raises a question of a presence of a systemic discrimination against acceptance and payment of claims reported to a First Nations employer. This matter demands a much closer examination into why this difference exists.

ACRONYMS AND ABBREVIATIONS:

“app” Application [such as computer application]
AB At Board
ACN Approved Community Navigator
Act Workers Compensation Act
ASTD Activity-Related Soft Tissue Disorder
ACN Approved Community Navigator
ATA Administrative Tribunals Act
BC Fed British Columbia Federation of Labour
BCCA British Columbia Court of Appeal
BCGEO British Columbia Government Employees’ Union
BCNU British Columbia Nurses’ Union
BCSC British Columbia Supreme Court
BMA Board Medical Advisor
Board Workers’ Compensation Board
BOD Board of Directors
CA Collective Agreement
CN Community Navigators
CCA Customer Care Agent
CCP-D Canada Pension Plan – Disability Benefits
CEO Chief Executive Officer
CEU Compensation Employees Union
CLAC Christian Labour Association of Canada
CM Case Manager
CMHO Chief Mental Health Officer
CMO Chief Medical Officer
CMS Case Management System
CN Community Navigators
COHE Centers of Occupations Health and Education
Commission Fair Practices Commission
CQP Compensation Quality and Practices
CRO Chief Review Officer
CRWDP Centre for Research on Work Disability Policy
CSA Group Formerly the Canadian Standards Association
CSPDM Canadian Society of Professions in Disability Management
DA Disability Awards
DM Disability Management
DRC Disability Management Consultant
DMSA Disability Management Self Assessment
DSM Diagnostic and Statistical Manual of Mental Disorders
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>DTA</td>
<td>Duty to Accommodate</td>
</tr>
<tr>
<td>DWC</td>
<td>Disability and Work in Canada</td>
</tr>
<tr>
<td>EAO</td>
<td>Employers’ Advisers Office</td>
</tr>
<tr>
<td>EDMP</td>
<td>Enhanced Disability Management Program</td>
</tr>
<tr>
<td>EDMWG</td>
<td>Enhanced Disability Management Working Group</td>
</tr>
<tr>
<td>EO</td>
<td>Entitlement Officer</td>
</tr>
<tr>
<td>EOT</td>
<td>Extension of Time</td>
</tr>
<tr>
<td>F6</td>
<td>Workers’ Application for Compensation Form</td>
</tr>
<tr>
<td>F7</td>
<td>Employers’ Report of Injury</td>
</tr>
<tr>
<td>FAF</td>
<td>Functional Abilities Forms</td>
</tr>
<tr>
<td>FNHA</td>
<td>First Nations Health Authority</td>
</tr>
<tr>
<td>FOIPPA</td>
<td>Freedom of Information and Protection of Privacy Act</td>
</tr>
<tr>
<td>FPC</td>
<td>Fair Practices Commissioner</td>
</tr>
<tr>
<td>FPO</td>
<td>Fair Practices Office</td>
</tr>
<tr>
<td>FRPS</td>
<td>Federally Regulated Private Sector</td>
</tr>
<tr>
<td>GBA+</td>
<td>Gender-based analysis plus</td>
</tr>
<tr>
<td>GVREDU</td>
<td>Greater Vancouver Regional District Employees’ Union</td>
</tr>
<tr>
<td>HAV</td>
<td>Hard-arm Vibration</td>
</tr>
<tr>
<td>HCO</td>
<td>Health Care Only</td>
</tr>
<tr>
<td>HEU</td>
<td>Hospital Employees’ Union</td>
</tr>
<tr>
<td>HRPA</td>
<td>Human Resources Professional Association</td>
</tr>
<tr>
<td>HRT</td>
<td>Human Rights Tribunal</td>
</tr>
<tr>
<td>IAIABC</td>
<td>International Association of Industrial Accident Boards and Commissions</td>
</tr>
<tr>
<td>IASP</td>
<td>International Association for the Study of Pain</td>
</tr>
<tr>
<td>IASP</td>
<td>International Association for the Study of Pain</td>
</tr>
<tr>
<td>ICD9</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>ICF</td>
<td>International Classification of Functioning, Disability and Health</td>
</tr>
<tr>
<td>IDMOSC</td>
<td>International Disability Management Standards Council</td>
</tr>
<tr>
<td>IHP</td>
<td>Independent Health Professional</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Office</td>
</tr>
<tr>
<td>ILS</td>
<td>Industry and Labour Services</td>
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<tr>
<td>IME</td>
<td>Independent Medical Examination(s)</td>
</tr>
<tr>
<td>ISSA</td>
<td>International Social Security Organization</td>
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<tr>
<td>JDA</td>
<td>Job Demands Analyses</td>
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<tr>
<td>JDC</td>
<td>Joint Diversity Committee</td>
</tr>
<tr>
<td>JSV</td>
<td>Job Site Visits</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>LMIA</td>
<td>Labour Market Impact Assessment</td>
</tr>
<tr>
<td>LOE</td>
<td>Loss of Earnings</td>
</tr>
<tr>
<td>LOF</td>
<td>Loss of Function</td>
</tr>
<tr>
<td>LRB</td>
<td>Labour Relations Board</td>
</tr>
<tr>
<td>Acronym</td>
<td>Abbreviation</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>LTD</td>
<td>Long Term Disability</td>
</tr>
<tr>
<td>LTWR</td>
<td>Long Term Wage Rate</td>
</tr>
<tr>
<td>MAHSI</td>
<td>Manitoba Aboriginal Health and Safety Initiative</td>
</tr>
<tr>
<td>MBI</td>
<td>Mild Brain Injury</td>
</tr>
<tr>
<td>MIRR</td>
<td>Ministry of Indigenous Relations and Reconciliation</td>
</tr>
<tr>
<td>MLA</td>
<td>Members of Legislative Assembly</td>
</tr>
<tr>
<td>MMR</td>
<td>Maximum medical recovery</td>
</tr>
<tr>
<td>MPO</td>
<td>Medical Panels Office</td>
</tr>
<tr>
<td>MSC</td>
<td>Medical Services Commissioner</td>
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<tr>
<td>MSD</td>
<td>Musculoskeletal Disorder</td>
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<td>Musculoskeletal Disorders</td>
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<tr>
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<td>MTBI</td>
<td>Mild Traumatic Brain Injury</td>
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<td>NIDMAR</td>
<td>National Institute for Disability Management and Rehabilitation</td>
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<tr>
<td>OD</td>
<td>Occupational Disease</td>
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<td>ODS</td>
<td>Occupational Disease Services</td>
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<td>OH&amp;S</td>
<td>Occupational Health &amp; Safety</td>
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<td>OHÇOW</td>
<td>Occupational Health Clinics for Ontario Workers</td>
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<tr>
<td>OIS</td>
<td>Occupational Injury Service</td>
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<td>ONIWG</td>
<td>Ontario Network of Injured Workers Groups</td>
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<tr>
<td>OR1 / OR2</td>
<td>Occupational Rehabilitation 1 and 2 Programs</td>
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<td>ORAPP</td>
<td>Off-Reserve Aboriginal Action Plan</td>
</tr>
<tr>
<td>P2P</td>
<td>Peer-to-peer</td>
</tr>
<tr>
<td>PCT</td>
<td>Provincial Coordination Team</td>
</tr>
<tr>
<td>PCU</td>
<td>Pacific Coast University</td>
</tr>
<tr>
<td>PD</td>
<td>Professional Development</td>
</tr>
<tr>
<td>PDA</td>
<td>Physical Demands Analysis</td>
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<td>PDAC</td>
<td>Psychological Disability Advisory Committee</td>
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<td>PDES</td>
<td>Permanent Disability Evaluation Schedule</td>
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<td>PFI</td>
<td>Permanent Functional Impairment</td>
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<td>PICS</td>
<td>Progressive Intercultural Community Services</td>
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<td>PO</td>
<td>Provincial Ombudsperson</td>
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<td>PPCC</td>
<td>Policy Practices Consultative Committee</td>
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<td>PPD</td>
<td>Permanent Partial Disability</td>
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<td>PPWC</td>
<td>Public and Private Workers of Canada</td>
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<td>PRRD</td>
<td>Policy Regulation &amp; Research Division</td>
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<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
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<td>PWHS</td>
<td>Partnership for Work, Health and Safety</td>
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<tr>
<td>RO</td>
<td>Review Officer</td>
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<tr>
<td>RSCM II</td>
<td>Rehabilitation Services and Claims Manual, Volume II</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>RSI</td>
<td>Repetitive Strain Injury</td>
</tr>
<tr>
<td>RTW</td>
<td>Return to Work</td>
</tr>
<tr>
<td>RTWS</td>
<td>Return to Work Specialist</td>
</tr>
<tr>
<td>SAWP</td>
<td>Seasonal Agricultural Worker Program</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
</tr>
<tr>
<td>TFW</td>
<td>Temporary Foreign Workers</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>TRC</td>
<td>Truth and Reconciliation Commission</td>
</tr>
<tr>
<td>TWA</td>
<td>Temporary Work Assignment</td>
</tr>
<tr>
<td>TWL</td>
<td>Temporary Wage Loss</td>
</tr>
<tr>
<td>UBC</td>
<td>University of British Columbia</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>USW</td>
<td>United Steelworkers</td>
</tr>
<tr>
<td>VR</td>
<td>Vocational Rehabilitation</td>
</tr>
<tr>
<td>VRC</td>
<td>Vocational Rehabilitation Consultant</td>
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<td>WAO</td>
<td>Workers’ Advisers Office</td>
</tr>
<tr>
<td>WCAT</td>
<td>Workers’ Compensation Appeal Tribunal</td>
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<td>Workers Compensation Board</td>
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<td>WCB-AB</td>
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<td>WCB-MB</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WL</td>
<td>Wage Loss</td>
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<td>WSIB</td>
<td>Workplace Safety and Insurance Board (Ontario)</td>
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<tr>
<td>WSSC</td>
<td>Workers’ Safety &amp; Compensation Commission</td>
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</table>
BIBLIOGRAPHY


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https://www.leg.bc.ca/content/Hansard/38th4th/H0311pm-06.pdf

https://www.leg.bc.ca/content/Hansard/38th4th/H0312pm-07.pdf


Commission for Complaints for Telecom-Television Services (CCTS). CCTS Home page on website. Information and instructions on how to submit a complaint to the CCTS. https://www.ccts-cprst.ca/


First Nations Health Authority. FNHA Case Study – Island Health – Aboriginal Employment Program


First Nations Health Authority. FNHA Case Study – Island Health: For the Next Seven Generations – For the Children


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<td>WCB-IR-0105</td>
<td>Selective/Light Employment Practice Directive C5-5</td>
</tr>
<tr>
<td>2019-10-18</td>
<td>WCB-IR-0106</td>
<td>Non-Return to Work Event: Deemed Able to Return to Job</td>
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