WORKSAFEBC AND GOVERNMENT ACTION REVIEW: CROSSING THE RUBICON

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RECOMMENDATIONS

1. Begin investigations with a quasi-criminal approach when warranted, applying a flexible, situation specific criteria.

2. Restructure the Fatal and Serious Incident (FSI) Investigation Team from its current two team model to a one team model.

3. Amend s. 214(2) of the ***Workers Compensation Act*** to remove oversight and approval by the Workers Compensation Board for charges (delegated to CEO) under s. 214.

4. Separate the Investigation Unit from the Worker and Employer Services Group Due to Appearance or Apprehension of Bias.

5. Amend the ***Workers Compensation Act*** to include search and seizure powers.

6. Designate specific police contacts, both municipal and RCMP, for ***Criminal Code*** 217.1 and 219 offences and ensure that WorkSafe investigations know and have contacts for these previously designated Crown and police.

7. Create an Incident Command System for workplace accidents across agencies, including WorkSafe, Police (Municipal and RCMP), First Responders and others. This should include an information sharing agreement between police, WorkSafe Investigators and Crown Counsel, and a hierarchy of command.

8. Amend the ***Occupational Health and Safety Regulation***, section 3.12 to strengthen worker protections.

9. Create a confidential database that separates identifying information of a tipster or worker from the information so that the employer cannot find out who reported safety infractions.

10. Create a designated Worker Ombudsperson position at WorkSafe

11. Amend s. 217-219 of the ***Workers Compensation Act*** to allow for victim impact statements and publication

SUMMARY AND INTRODUCTION TO THIS REPORT

On March 28, 2019, I was retained by the Attorney General of British Columbia to undertake a review of the actions taken by the government of British Columbia and WorkSafe BC in response to the recommendations from the Dyble Report, the Macatee Report and the Coroner's verdicts after the horrific explosions and resulting fires at Babine Forest Products in Burns Lake and Lakeland Mills in Prince George.

My mandate is to provide advice for the purpose of informing potential further legislative amendments or other legal action taken by the government and WorkSafeBC.

I am an independent and impartial reviewer and have approached this Review with an open mind. Before beginning my review, I read the Dyble and Macatee Reports, the Coroner's verdicts, and the legislation that was in effect at the time of the explosions, after the explosions and today.

Through an information sharing agreement with WorkSafeBC, I have reviewed 3223 pp. of documents, 506 electronic files and nine Statutes or Acts of Parliament. In coming to my recommendations, I have interviewed 17 stakeholders and stakeholder group representatives, including:

1. WorkSafeBC Investigators, Management and Executives;
2. United Steelworkers, B.C. Branch;
3. B.C. Forest Safety;
4. Ministry of the Attorney General, Criminal Justice Branch;
5. Royal Canadian Mounted Police; and,
6. Lakeland Mills Workers.

I have invited submissions from other agencies, workers and governmental groups; at the time of writing this report, they had either explicitly or constructively declined this invitation. I do not find that the input would change with more time for this review, nor do I find that my review was hampered without input from these groups.

I have considered every submission, suggestion and piece of information given to me through this process and have taken seriously my duty to uphold my impartiality and independence. I am grateful for those who would vest their trust in me and this process.

I have been tasked with reviewing the actions taken by the provincial government and WorkSafeBC prior to the explosions, during the investigation, and after the investigations were concluded to answer two questions:

1. What steps have been taken in response to the recommendations?
2. How have the steps taken affected the processes engaged in by WorkSafeBC in performing its obligations pursuant to the Workers Compensation Act and any other issues the recommendations were intended to address?

There are limits to my review, including that I am not to review any decisions made by Ministry of the Attorney General – Crown Counsel (Criminal Justice Branch) in whether charges have been laid. I am also not reviewing any factual or legal circumstance of any civil or tortious claim against the province of British Columbia.

In making this Report, I have adhered to the rules of procedural fairness and justice. I've heard from a number of witnesses and read a number of provided statements, reviewed the legislation and all Reports, and reviewed all documents sent by WorkSafeBC. My goal was to hear all relevant points of view in order to provide the Attorney General with a comprehensive, fair, independent Report that abides by the Terms of Reference.

I have made eleven recommendations, all of which are with the former reports in mind and in consultations with stakeholders and document review.

In this report, I also examine those recommendations in light of the Macatee and Dyble Reports and the Coroner Jury Verdicts. I have also considered, and withheld, some recommendations, and I detail those and the reasons for doing so.

HISTORY BEHIND THIS REVIEW

WorkSafeBC is an independent agency created by provincial statute, the ***Worker's Compensation Act***. Governed by a board of directors appointed by the Province of British Columbia, WorkSafeBC's primary mandate is as a no-fault insurance service for the workplace. In addition to administering a no-fault benefits system for injured workers, the Board has a broad statutory mandate to protect the health and safety of workers in British Columbia through administration of the Act and the Regulation.

On January 20, 2012, an explosion ripped through Babine Forest Products, Ltd. Sawmill in Burns Lake, killing 2 people and injuring 19. Just over three months later, on April 23, 2012, a similar explosion and fire at the Lakeland Mills Ltd. Sawmill in Prince George killed 2 and injured 44.

Prior to both explosions, concerns had been raised by workers and WorkSafeBC employees about the conditions of the sawmills in general, and the presence of combustible dust in particular. Photographs from the Lakeland Mills site taken by an inspector prior to the explosion show dust "drifts" on the floor of the basement area.

A February 12, 2012 WorkSafeBC Report, after the first explosion but before the second, is in particular contention. In it, the manager wrote that WorkSafeBC needed to raise awareness among its officers about wood dust following the Babine explosion and other related fires. "Industry sensitivity to the issue given the recent event and limited clarity around what constitutes an explosion could lead to pushback if an enforcement strategy is pursued at this time," the document said.

CORONER'S JURY VERDICT

In July, 2015, The B.C. Coroners' Service held inquests into the explosions at Babine Forest Products Ltd. sawmill and Lakeland mill. In total, 41 recommendations were issued from the Babine Forest Products inquest and 33 recommendations were issued from the Lakeland mills inquest. After the Coroner's Inquests, WorkSafeBC took the 41 recommendations from the Babine Forest Products inquest and the 33 recommendations from Lakeland Mills, and turned them into directives or policy changes. As of December 2017, according to WorkSafeBC

documentation, all recommendations were fully implemented.

DYBLE REPORT

The Dyble Report was an analysis of the issues raised as a result of the investigation by WorkSafeBC into the Babine Mill Explosion in Burns Lake, B.C. on January 20, 2012. Dyble was asked on January 16, 2014 by the then Premier to develop a fact pattern of the events that led to the explosion and make recommendations.

Four recommendations were made:

1. Measures to improve interaction between investigating and prosecuting agencies;
2. Improvements of policies, procedures and communications within WorkSafe BC;
3. Enhanced training and improving the working relationship between the Criminal Justice Branch and WorkSafeBC; and
4. Moving forward- that Mr. Leonard Doust, Q.C., as independent advisor, verify the accuracy of legal issues and opinions expressed in the Report. Mr. Doust, Q.C. stated that the Report is accurate in the manner that it characterizes the roles of the Criminal Justice Branch and WorkSafeBC as well as in relation to the legal and constitutional context descried in the Report.

This report was rendered February 6, 2014.

The last Dyble recommendation is outside the scope of the Terms of Reference but the other three have been reviewed in this report.

MACATEE REPORT

In April 2014, the WorkSafeBC Board of Directors appointed Gordon Macatee as Special Administrator in response to the recommendations from the Coroner's Jury Verdicts and the Dyble Report. Following this appointment the Labour Minister, issued a letter to the WorkSafeBC Board Chair outlining a mandate for the Administrator and setting out five priorities for action. On July 1, 2014, the WorkSafeBC Review and Action Plan was submitted by Macatee to the Board and Minister Bond, containing 43 recommendations. Government and

the Board accepted the report and all of the recommendations on July 15, 2014.

Macatee was then re-engaged as a Special Advisor to the Board to monitor and report on the implementation of the recommendations. An interim report was submitted on February 25, 2015, at which time 23 of the recommendations had been fully implemented, and 11 were awaiting legislative amendments. As of March 1, 2016, all of the 43 recommendations had been implemented.

The Macatee Report had five goals:

1. Ensure future investigations are handled correctly
2. Ensure that BC's sawmills are safer workplaces.
3. Understand the merits of and determine best practices in organizational structures, specifically relating to the separation of enforcement vs. regulation
4. Develop a plan for implementing a world - class inspection and investigation regime
5. Conduct the search for and finalize the appointment of a new and permanent CEO

The final Macatee Report was rendered in April 2016. Macatee specifically recommended a two team investigative system, which was implemented. That system will be extensively addressed in this report.

BEGIN INVESTIGATIONS WITH A QUASI CRIMINAL APPROACH WHEN WARRANTED, APPLYING A FLEXIBLE, SITUATION SPECIFIC CRITERIA

RESTRUCTURE THE FATAL AND SERIOUS (FSI) INVESTIGATION TEAM FROM ITS CURRENT TWO TEAM MODEL TO A ONE TEAM MODEL

AMEND S. 214(2) OF THE WORKERS COMPENSATION ACT TO REMOVE OVERSIGHT AND APPROVAL BY THE WORKERS COMPENSATION BOARD FOR CHARGES

WorkSafeBC conducts investigations into workplace injuries and fatalities with two purposes: causation of incidents and prevention (leading to orders, citations or administrative penalties) and possible prosecution.

As framed by ***Macatee,*** page 5:

> When conducting a "cause" investigation, WorkSafeBC inspectors are permitted to use all the powers under the ***Workers' Compensation Act*** (Act), including gathering evidence without a warrant and to interview people without informing them of their right not to incriminate themselves.
>
> When conducting an investigation for purposes of prosecution, criminal law rules regarding evidence apply. For example, evidence must not be collected without a warrant and people being interviewed must be informed of their rights and their right to legal counsel.
>
> ...
>
> It is not always apparent at the beginning of an investigation that there might be grounds to consider a referral for prosecution. In those cases, it becomes necessary to shift from the cause mode to the prosecution mode, and to have the ability to proceed using criminal law rules for collecting evidence. The solution is a dual team model.

Since the implementation of the Macatee Recommendations, the current model of compliance and causation investigations until "crossing the rubicon" (as referred to in the Supreme Court of Canada cases of ***R v. Ling*** and ***R v. Jarvis,*** discussed below***)*** to a quasi-criminal

investigation has been shown to be cumbersome, slow and poor at preserving evidence, causing delays and issues with limitation dates. Further, the current two teams do not share information, meaning much of the work has to be duplicated, with delays inherent in that work.

R v. Ling and ***R v. Jarvis*** were companion cases of the Supreme Court of Canada that were interpreted by Macatee to set up the current dual team model. An examination of these cases is crucial to understanding the current set up, and why it should be changed.

In ***R v. Jarvis***[1], the Supreme Court of Canada set out the test for determining when ***Charter*** rights are engaged in the context of a regulatory investigation when conducted by regulatory officials. The Court found.that evidence may be validly compelled using statutory inquiry or inspection powers as long as the "predominant purpose" of the inquiry is not "penal liability". Once the predominant purpose of the inquiry or inspection is penal liability, an adversarial relationship between the state and the individual crystallizes and the "rubicon" or "point of no return" has been crossed.

When the rubicon has been crossed, an individual should receive from the investigator the "full panoply" of Charter rights. Once crossed, this line requires WorkSafeBC to cease using regulatory compulsion powers and to make use of criminal investigative tools, such as search warrants. Among the Charter rights most often at issue in the case of regulatory investigations are the investigation target's s. 7 right against self-incrimination (whether a statement to the investigator is voluntary and not coerced); and the target's s. 8 right against unreasonable search and seizure. Although the ***Jarvis*** decision arose in the context of an audit and subsequent criminal investigation under the ***Income Tax Act***, the decision has clear implications for WorkSafeBC, as its' investigators have broad inquiry powers to compel information and regulatory offences that attract penal consequences.

In 2015, WorkSafeBC implemented a new dual team model for its' fatal and serious injury (FSI) investigations in response to the Macatee recommendations. This model has two teams governed by protocols that limit, and sometimes restrict, the flow of information. When a team looking into the cause of an accident finds that there may be grounds to investigate for prosecution, the team suspends their investigation and the second team is introduced to start a

[1] A legal analysis and summary of ***R v. Jarvis*** has been attached as Appendix 1 to this Report.

new, separate information ("crossing the rubicon" as in ***Ling*** and ***Jarvis***). All information already gathered is vetted by the gatekeeper to remove any evidence that may possibly taint a prosecution; investigators are often re-doing work that has already been completed by the first team, although they may not know it. All further evidence must be gathered in accordance with Charter principles, including search warrants and Charter warnings prior to statements being obtained.

This idea of "crossing the rubicon" gave rise in the WorkSafeBC to two separate teams that don't information share (so information gathered in a regulatory context must be re-gathered by a quasi-criminal investigator), and a gatekeeper role within WCB to determine whether the line had been crossed. This has resulted in significant frustration with investigators, team leads, and within administration.

It has also been the subject of recent legal commentary. In ***Worker's Compensation Board*** v. ***Skylite Building Maintenance*** 2019 BCSC 231, released February 2019, the limitations placed on WorkSafeBC investigations were highlighted. The current investigation model puts WorkSafeBC in a straightjacket as evidenced by para 765 of the ***Skylite*** decision:

> [765] Given the timing of this administrative order and that Board staff had already determined that the stucco at the property was asbestos-containing, I find, based on the factors set out in ***R. v. Jarvis***, 2002 SCC 73 (CanLII) at para. 94, that the purpose of this order was to obtain evidence of suspected wrong-doing on Shawn Singh's part for the purpose of pursuing potential contempt charges, and not to ensure compliance with the Act or Regulation at the Brooks Property. Furthermore, I agree with the respondents that this order in these circumstances was essentially an attempted seizure, and should have been pursued by warrant and not by administrative order.

This recent case illustrates the problems inherent in the "regulatory first, quasi-criminal second" current model.

The interpretation of ***Ling*** and ***Jarvis*** used by WorkSafeBC is, to the Reviewer's mind, a too strict interpretation of these cases. The concept that all material must be withheld from the

second team is not one that is generally endorsed; see, for example, cases that fall under the jurisdiction of Canada Revenue Agency auditors using the ***Income Tax Act*** or Investigators with British Columbia's Mining Compliance and Enforcement Branch. A review of these other agencies would assist in forming policies about materials that can be shared between the teams.

As with a criminal context, time is always of the essence when conducting investigations that may result in quasi-criminal charges. Statements while memories are fresh and untainted and measurements of moveable objects are crucial and cannot properly be done weeks or months later.

I spoke at length with the investigation team at WorkSafeBC, all of whom were forthcoming. Practical problems with the application of ***Ling*** and ***Jarvis*** quickly emerged and were universal amongst this department:

- the determination of when they "crossed the rubicon" into a potential prosecution was a decision not made by the investigators but by the gatekeeper;
- the gatekeeper, identified as Ian Shaw, Sr. Vice President and General Counsel of the Legal Services Division, was generally good at turning around these files, but they also had to have the Board delegated authority of the CEO. Estimated times for turnaround on these opinions were, on average, 4 days, although there was a perception from the investigators and others that this was a lengthy turnaround – from "days" to "weeks" to "months and months".
- If an investigation was started after the rubicon was crossed and the gatekeeper and CEO agreed, this meant that the investigators had an issue with preservation of exhibits, evidence and were at a disadvantage with obtaining pure versions from witnesses facing memory loss and possible influence (usually subconsciously) by hearing or seeing other accounts of the incident being investigated.
- If an investigation was started after the rubicon was crossed, there was no information shared between the officer doing the compliance and the officer doing the investigation, meaning a duplication of work and a complete barrier of communication between the two officers. This was explained to me as there was a strict application of ***Ling*** and

Jarvis by WorkSafeBC management.

- If an investigation was started after the rubicon was crossed, the team switched legal counsel within the legal counsel department. This means that, again, there was a duplication of and barrier of communication. It also means that the counsel is starting to render an opinion when they may not be informed of all the facts or have facts withheld that could be pertinent to rendering a comprehensive opinion.

Almost universally, it was agreed that the two team model did not work. Currently, the two team model has 2 sets of Investigators, 2 sets of Supervisors and a manager for each team. The positives to this model are a strict separation of information crossover and a simple management structure. However, without communication between the two teams, it is unclear when the rubicon has been crossed. There is a lack of flexibility to respond to multiple incidents, and limited and inefficient communication between the quasi criminal team and the police.

The two team model means that one team starts an investigation with the idea that the investigation is for compliance and causation. Once there is any reason to believe that the investigation may be for quasi-criminal charges, the determination is turned over to the gatekeeper. The decision is made by the gatekeeper, and once the decision is made that the investigation is quasi criminal, only the materials that aren't tainted by the regulatory investigation are turned over. Practically, I was told that most material is not turned over and that investigations frequently start again from scratch.

The two team model should be abolished and can be abolished if the only time the gatekeeper model is used is when an investigator investigating a regulatory matter **unexpectedly** finds information that could lead to criminal charges. In that case, I would not even suggest a gatekeeper model, but that the Director of Investigations, currently Steven Ramsden, could make the discretionary call that the investigation be turned into a quasi criminal investigation and a new investigator take over and ensure ***Charter*** compliance. As long as this decision is made in good faith, it is a discretionary call that the courts have not overturned lightly.

I recommend that an independent one team model be adopted. The one team model would see two sections within the FSI Investigation team: a larger regulatory team with a manager

and a smaller quasi criminal team with a manager. This section should operate independently of management (discussed below) and the current gatekeeper and/or CEO should not be a part of either its operating or Report to Crown Counsel decisions. One new position should be created as a director of this entire section; this person should have extensive criminal or quasi-criminal investigation experience and be available to assist the regulatory team with the "rubicon" decision and the quasi criminal team with both logistic and Report to Crown decisions. I would also strongly recommend that a lawyer be assigned solely to this section for consistent legal updates, legal opinions and to draft guidelines for Investigators' use and education in situations that may engage ***Charter*** protections.

The one team model has a number of positive aspects to it: it reduces resource waste, allows for efficient communications and handover of evidence, and allows for continuity of investigation. Flexibility should be allowed for in implementing this model, and the organization of the overall one team model should have discretion within it so that the new director can allocate investigators and compliance team members as she or he sees fit.

I spoke with investigators at other regulatory bodies, including Mines Health Safety and Enforcement Division. Many other investigation divisions of regulatory bodies have accrued a significant number of successful prosecutions. The universal attitude appeared to be that the gatekeeper function and the "regulatory first" model were hampering investigations. I am suggesting a re-structure that will allow for the goals of compliance and causation to adequately be addressed, while the WorkSafeBC core mandate of education, consultation and compliance can be respected.

The most significant challenge that will arise is the question: when does the event under investigation start as a quasi-criminal matter? Considering how many events are logged by WorkSafeBC, I would suggest that a flexible criteria be applied. That criteria should take into account, although not be bound by, the following factors:

1. The seriousness of the event's consequences, including serious bodily harm or death;
2. The seriousness of the possible outcome of the event, including any "near misses" or events where there was no injury but a potential injury was serious or severe;
3. A history of non-compliance or poor workplace practices within the industry or the specific business;
4. When tests, samples, or other objective evidence indicates that quasi criminal charges are a possible outcome (as per the judgment in ***Skylight***, above);
5. When a warrant should be applied for any purpose under the new warrant provisions, discussed below; or
6. Any other circumstance that the Director of the FSI Investigation Team or his/her delegate becomes aware of that would warrant quasi-criminal investigation.

AMEND S. 214(2) OF THE *WCA* TO REMOVE BOARD OVERSIGHT

S. 214(2) of the ***WCA*** reads:

> **214** (2) An information in respect of an offence may only be laid with the approval of the Board.

In the Current WorkSafeBC model, s. 214(2) has been interpreted to mean that before a Report to Crown Counsel is sent out, it must go through the gatekeeper, and ultimately to the CEO, who holds the delegated powers of the Board.

S. 214(2) introduces an unnecessarily repetitive step, as the function of Crown Counsel Charge Approval is to approve charges, send the file back for more investigation or not approve charges.

This section carries with it three major disadvantages: it slows down the submission of the Report to Crown, which hampers a possible prosecution; it may engage issues with the 2 year limitation date for charges engaged in s 214(1) of the ***WCA***; and it carries the appearance of bias.

The separation of the prosecution and investigative functions is a "well-established principle of the Canadian criminal justice system"[2]. Investigators in British Columbia do not lay their own charges but instead refer to Crown Counsel who make the decision whether to lay charges. Crown cannot comment or direct an investigation (or make determinations about when a regulatory investigation becomes a criminal investigation) but can make the decision as to whether charges should be laid and what those charges are. Standard practice is for an Investigator to write a Report to Crown Counsel, laying out the evidence gathered and the reasonable and probable grounds for the prosecution.

Delays in the submission of a Report to Crown Counsel carry inherent risks. The longer that a matter takes to come into the criminal justice forum, the more chance of lost evidence and fading memories. In the workplace context, the chance that possible witnesses will change jobs, become indirectly influenced by their employer or other witnesses or that the

[2] ***R. v. Regan***, 2002 SCC 12, para.70

management will change is a real one.

No decision that could be made by the gatekeeper or Board could influence whether sufficient evidence to meet the charge approval standard could be gathered. I observe that this provision allows for the introduction of assumed bias – that the CEO can somehow influence a decision not to prosecute a corporation or individual. For clarity: at no time did I find any indication or evidence that this had ever happened. However, it did present significant issues for some stakeholders witnessing this process. I agree that the independence of an investigation must be recognized for the outcome to be accepted as valid. The experience of the investigators and current Director of Investigations is such that discretionary decisions as to whether to submit a Report to Crown is well within the ambit of their experience.

I recommend that s. 214(2) be repealed and that the independence of the Investigations Team be affirmed.

SEPARATE THE INVESTIGATION UNIT FROM THE EMPLOYER INSURANCE GROUP DUE TO APPEARANCE OR APPREHENSION OF BIAS

As in the above, I understand that after ***Macatee*** and in reference to recommendation 12, different departments with perceived similar functions were grouped together for efficient resource allocation. Currently, the Investigation division is under the Worker and Employer Services - Investigation Services group. This group includes claim adjusters and entitlement officers for workers and provides employer insurance services.

I observe that this grouping specifically allows for the introduction of assumed bias – an assumption that there is some internal exchange of information that could benefit the employer in an ongoing investigation. At no time did I find any indication or evidence that this had ever happened. However, it did present significant issues for some stakeholders witnessing this process.

Because of the need for impartial and independent investigations, I suggest the Investigations division become its own department, set up as recommended by this report.

AMEND THE WORKERS COMPENSATION ACT TO INCLUDE SEARCH POWERS

In my review, it is clear that British Columbia has the most restrictive ***Workers Compensation Act*** provisions in Canada for search and seizure. Investigators currently only recourse to the ***Offence Act***. Across most provincial jurisdictions, search and seizure provisions are contained in the Investigator's authorizing statute. British Columbia has the fewest search and seizure provisions of any province.

Some provinces adopt by reference the powers of the Criminal Code, s. 487. I am recommending an amendment to the ***WCA*** that specifically enumerates the powers. Legislative amendments around search and seizure powers give clarity to the Investigators and enumerates the power in the originating statute.

Currently, there is no provision for WorkSafeBC Investigators ("Investigators") to apply for and receive judicially authorized warrants, except through the ***Offence Act***. The outdated and narrow ***Offence Act*** provisions in s. 21 apply to Investigators because the section specifically designates a justice "may issue and sign a warrant authorizing a person named in it or a peace officer to search" a specific place.

Not all Investigators are peace officers. Those that aren't, therefore, are excluded from the telewarrant provisions in s. 22 of the ***Offence Act***, leading to situations like one Investigator recounted where he had to draft a warrant in Port Hardy, drive to Burnaby to appear in person in front of the judicial justice of the peace and then return to Port Hardy to have the search warrant executed. Some investigators with WorkSafeBC have special provincial constable (SPC) status pursuant to section 9 of the ***Police Act***. Section 9(3) states that an SPC has the powers, duties and immunities of a provincial constable, subject to the limits of the Minister's appointment which are provided for in the appointment form. Section 10(1)(a) of the Police Act states that SPCs have "all of the powers, duties and immunities of a peace officer and constable at common law or under any Act". These Investigators could get a telewarrant, but there is no standardization for which Investigators may be available. In short, consistency would come from this power being included in the ***Workers Compensation Act***.

There is no provision for production orders for documents, taking samples or testing relevant substances or products, seizing computer hard drives or equipment that may afford evidence of a contravention or offence or seizing documents.

I recommend amending the ***Workers Compensation Act*** to include search and seizure powers. This should include six areas:

1. The ability to obtain a judicially authorized search warrant and to seize evidence in accordance with that warrant;
2. The power to test or take samples if they may, on reasonable grounds, afford evidence of a contravention or offence;
3. The power to obtain a telewarrant, allowing for the use of modern technology;
4. The ability to obtain a judicially authorized warrant to search computer hard drives if the information therein may afford evidence of a contravention or offence;
5. The power to seize documents that may afford evidence of a contravention or offence; and
6. Production Orders, to compel documents.

This mirrors the powers in Ontario's ***Occupational Health and Safety Act***, s.56 and 56.1, as reproduced below:

> 56 (1) On application without notice, a justice of the peace or a provincial judge may issue a warrant authorizing an inspector, subject to this section, to use any investigative technique or procedure or to do any thing described in the warrant if the justice of the peace or provincial judge, as the case may be, is satisfied by information under oath that there are reasonable grounds to believe that an offence against this Act or the regulations has been or is being committed and that information and other evidence concerning the offence will be obtained through the use of the technique or procedure or the doing of the thing. 2001, c. 26, s. 2.

(1.1) The warrant may authorize persons who have special, expert or professional knowledge to accompany and assist the inspector in the execution of the warrant. 2001, c. 26, s. 2.

(1.2) The warrant shall authorize the inspector to enter and search the place for which the warrant was issued and, without limiting the powers of the justice of the peace or the provincial judge under subsection (1), the warrant may, in respect of the alleged offence, authorize the inspector to,

(a) seize or examine and copy any drawings, specifications, licence, document, record or report;

(b) seize or examine any equipment, machine, device, article, thing, material or biological, chemical or physical agent;

(c) require a person to produce any item described in clause (a) or (b);

(d) conduct or take tests of any equipment, machine, device, article, thing, material or biological, chemical or physical agent, and take and carry away samples from the testing;

(e) take measurements of and record by any means the physical circumstances of the workplace; and

(f) make inquiries of any person either separate and apart from another person or in the presence of any other person. 2001, c. 26, s. 2.

(1.3) The warrant is valid for 30 days or for such shorter period as may be specified in it. 2001, c. 26, s. 2.

(1.4) The warrant may contain terms and conditions in addition to those provided for in subsections (1) to (1.3) as the justice of the peace or provincial judge, as the case may be, considers advisable in the circumstances. 2001, c. 26, s. 2.

(1.5) A justice of the peace or provincial judge may issue further warrants under subsection (1). 2001, c. 26, s. 2.

(1.6) Nothing in this section restricts any power or duty of an inspector under this Act or the regulations. 2001, c. 26, s. 2.

(2) The inspector may remove any thing seized under a warrant from the place from which it was seized or may detain it in that place. 2001, c. 26, s. 2.

(3) The inspector shall inform the person from whom the thing is seized as to the reason for the seizure and shall give the person a receipt for it. R.S.O. 1990, c. O.1, s. 56 (3).

(4) The inspector shall bring a thing seized under the authority of this section before a provincial judge or justice of the peace or, if that is not reasonably possible, shall report the seizure to a provincial judge or justice of the peace. R.S.O. 1990, c. O.1, s. 56 (4).

(5) Sections 159 and 160 of the Provincial Offences Act apply with necessary modifications in respect of a thing seized under the authority of this section. R.S.O. 1990, c. O.1, s. 56 (5).

56.1 (1) An inspector who executes a warrant issued under section 56 may seize or examine and copy any drawings, specifications, licence, document, record or report or seize or examine any equipment, machine, device, article, thing, material or biological, chemical or physical agent, in addition to those mentioned in the warrant, that he or she believes on reasonable grounds will afford evidence in respect of an offence under this Act or the regulations. 2001, c. 26, s. 3.

(2) Although a warrant issued under section 56 would otherwise be required, an inspector may exercise any of the powers described in subsection 56 (1) without a warrant if the conditions for obtaining the warrant exist but by reason of exigent circumstances it would be impracticable to obtain the warrant. 2001, c. 26, s. 3.

(3) Subsections 56 (3), (4) and (5) apply with necessary modifications to a thing seized under this section. 2001, c. 26, s. 3.

No such powers currently exist under the ***Workers Compensation Act***. The above referenced statute carries and confers the powers that should exist in the ***WCA***.

MACATEE RECOMMENDATIONS

Part of my responsibility in undertaking my duties as the reviewer was to look at how the Macatee Recommendations have been implemented and whether they are working effectively. In the context of the five recommendations above, the Macatee recommendations 1-4 become pertinent.

Those recommendations are:

1. A Memorandum of Understanding (MOU) with Police Services and the Memorandum of Understanding with the Criminal Justice Branch (CJB) should be signed.
2. WorkSafeBC should develop a policy to guide referrals to the CJB for prosecutions. The decision to refer a file for prosecution is made independently by WorkSafeBC; however, development of this policy should be informed by consultation with the CJB.
3. WorkSafeBC should proceed towards the adoption of a major case management (MCM) protocol and system in its investigations.
4. Implement a new investigation model that preserves the ability to conduct both cause investigations and prosecution investigations.

The policy to guide referrals to CJB for prosecutions has been developed and implemented, as has an MOU between the CJB and WorkSafe, signed on August 7, 2014. These are operational and work well.

The MCM model has been implemented and is working well, according to those who use it. In my review, it appears to be a strong model of its kind.

The decision to refer a file for prosecution is currently made by WorkSafeBC by referring to the Board, which has delegated its' power to the CEO. This burdens investigations and referrals,

making everything slower and impeding charge approval, and eventual prosecution. I was not sent written policies on this aspect of the exercise of the Board's discretion under s. 214(2). I am recommending the repeal of this section, and that the policies used by the Investigators when referring a file to Crown Counsel are the standard policies as used by the RCMP E-Division (British Columbia) and municipal police forces. Any discretionary call should be within the ambit of the Director of Investigations.

It should also be noted that this direct referral would meet a Macatee Recommendation found in Recommendation 38: increasing direct communication between WorkSafeBC and both the Criminal Justice Branch and the Ministry.

The new investigation model implemented on the ***Macatee Recommendation*** intended to preserve the ability to conduct both cause investigations and prosecution investigations does not work and is impeding the goals of the WorkSafe investigation team and management. The two-team approach to causal investigations and quasi criminal investigations does not work and should be abolished, for the reasons set out above.

CONCLUSIONS:

- The Investigation team should be independent from any other branch of WorkSafe, headed by a co-team lead investigator and legal counsel with criminal prosecution experience.

- The Investigation team should be able to directly refer a file to Crown Counsel

- The Investigation team should have the power to information share with the RCMP or regional police force with jurisdiction.

- The Gatekeeper position is unnecessary with a model that begins with a quasi-criminal investigation if determined by the Director applying a flexible criteria. If there is no quasi-

criminal aspect, the investigation is simply a compliance investigation until information emerges that causes a reassessment of the investigation.

- The current “two team” system should be abolished. WorkSafeBC investigators and health and safety staff should work together to assist each other. This can be accomplished with information sharing that will be facilitated by a top down model of quasi criminal investigation turning into a compliance investigation when there is cause to do so.

- Search powers should be enshrined in the ***Workers Compensation Act*** and allow for evidence to be collected pursuant to judicially authorized warrants and production orders.

DESIGNATE SPECIFIC POLICE CONTACTS FOR CRIMINAL CODE 217.1 and 219 OFFENCES AND ENSURE THAT WORKSAFE INVESTIGATORS HAVE CONTACT INFORMATION FOR PREVIOUSLY DESIGNATED CROWN AND POLICE

POLICE

There are two separate policing structures in British Columbia: regional police forces and the Royal Canadian Mounted Police. A recent working group between the police has been struck and is meeting regularly to deal with workplace matters; this is a positive change. This must continue as it will foster intra-agency and intra-jurisdictional cooperation.

While interviewing, I was able to speak with an RCMP officer who has been instrumental in assisting with peaceable conclusions to labour demonstrations. He has been a “point person” for this kind of action and, in his words, “created his own job” in this area by having an open door policy and the ability to be contacted. This model would work with a designated police officer on every shift to deal with workplace incidents and assist on the ground RCMP to coordinate with WorkSafe Investigators. Often, a first responder at a workplace incident is a general investigative service member (GIS) or patrol officer. That officer should know that their first call is to a designated phone number to be carried by an on-shift police officer trained in workplace incidents. That officer can then triage investigative resources, first responders (fire, ambulance) and WorkSafe.

This model would work in tandem with the recommendation for an incident command model, discussed in the next section.

Training manuals and police policies are not publicly available, and despite efforts with the RCMP and one municipal police force, I was not provided with any training or policy resources for police on workplace accidents. Through a different stakeholder, I was provided with the RCMP policy for Workplace Incidents from 2010, but I cannot confirm that is still their policy without amendment. If it is, it should be updated and ongoing training should be confirmed, specifically in the area of workplace criminal investigations and the applications of ***Criminal Code*** s. 217.1 and 219.

A contact list of designated people should be created and circulated throughout each agency, and these numbers should be readily available to any responder dealing with an emergency situation.

CROWN COUNSEL

I have specifically found an issue with communication throughout this report: namely, that some agencies have already dealt with issues that other agencies believe still exist. A key example of this is the perception that there are no Crown dedicated to assisting with workplace quasi-criminal prosecutions. There is a Crown team responsible for the charge approval on these matters and I understand that they are available to assist Crown in different referring regions.

Many stakeholders suggested one dedicated Crown Counsel for workplace matters. As an experienced criminal defence lawyer with significant charge approval experience both as defence and as ad-hoc Crown, I see some inherent flaws to this suggestion. A single dedicated Crown Counsel will be subject to ebbs and flows of work, succession planning issues should they leave their post, and the concern that should they follow a file and be in trial and another file arise, there will be an inability to manage the charge approval on the second file. I see a myriad of issues with only one Crown assigned to workplace matters. This is also not the general organization of the BC Prosecution Service who generally use a team approach to their charge approval and specialized prosecutions.

I have contacted the CJB and learned that there is a Crown team that has taken responsibility for workplace prosecutions. The correct description for the Crown team is “the Commercial, Police and Regulatory Section”.

In response to Macatee Recommendations 1 and 2, there are biannual meetings between the BC Prosecution Service and WorkSafeBC and I am satisfied that these are fruitful and assist WorkSafe in their education and information. All sides are working together to find solutions to quasi-criminal and regulatory prosecution issues.

FUNDING FOR TRAINING

Ss. 217.1 and 219 of the ***Criminal Code*** are key to workplace prosecutions. Detailed statistics are available for most sections of the Criminal Code, but not for these two sections, so it is impossible at the current time to do a cross-Canada comparison of how many of these prosecutions are carried out in British Columbia, as opposed to other jurisdictions.

I have received no information on specific training for RCMP or municipal police forces. I would suggest that information be solicited through the new municipal, RCMP and WorkSafeBC Working Group on what training and funding is necessary. As I have suggested that there be designated officers for investigation of workplace incidents, it will be crucial to train and continue their education in this regard. I would suggest a designated budget be submitted with the consultation of the Working Group and that budget be approved and implemented on a regular basis.

Information on Crown Counsel training that I received cited the three day Crown Conference among other delivery models for training on workplace injuries and fatalities, although no specific examples were provided as to when or in what form this training took place. Otherwise, I was provided with the information from the Deputy Attorney General that “Crown counsel prosecuting workplace injury and fatality related cases receive a variety of general and specialized training,” without further specificity. Of the 61 policies currently in the Crown Counsel Policy Manual, updated April 16, 2019, there is no policy that speaks to workplace or employer incidents or criminal negligence (there is, however, one for environmental prosecutions). The CJB should develop Crown Counsel policy around charge approval of criminal or quasi-criminal offences that arise out of WorkSafeBC or other workplace investigations. This will assist the WorkSafeBC investigations team in knowing what material or standard there is to meet for submissions of Reports to Crown Counsel and will assist in successful prosecutions.

CONCLUSION

A triage system should be set up with clear contacts in the municipal police, RCMP and Crown Counsel agencies. Crown should advise their charge approval Crown that workplace matters should immediately be referred to the Crown section assigned, no matter where in the province the incident occurs. Education on workplace investigations should be provided, and funding for such education should be provided as well.

CREATE AN INCIDENT COMMAND SYSTEM FOR WORKPLACE ACCIDENTS ACROSS AGENCIES WITH AN INFORMATION SHARING AGREEMENT IN PLACE

Creating an Incident Command System (ICS) for workplace accidents across agencies, including WorkSafe, Police (Municipal and RCMP), First Responders and others will assist in delineating a hierarchy of command, ensuring judicious use of resources and ensuring each agency does not hamper the other.

The ICS should include a specific information sharing agreement between police, WorkSafe Investigators and Crown Counsel, and a hierarchy of command.

Establishing authority and a clear command structure at the scene of a workplace accident is crucial to a successful investigation. Right now, there is no formal Incident Command System – that the investigation's interjurisdictional success is predicated on the investigators, police officers and regulatory officers on the ground informally working together, without clear outlines of jurisdiction. Ancedotes were relayed about both successful and failed co investigations where the police were either amenable to the WorkSafe investigator's assistance and investigation priorities – or not.

I am recommending that a clear incident command system be set up. An ICS is a standardized approach to the command, control, and coordination of emergency response providing a common hierarchy within which responders from multiple agencies can be effective.

An ICS ensures the safety of first responders, a clear hierarchy of investigative priorities, an efficient use of investigative resources across agencies and standardized procedures.

A successful ICS will have intra-jurisdictional cooperation. A Working Group of police forces and WorkSafe Investigators has been recently formed, and it is key that this continue. One of the priorities of this group should be suggested best practices for an ICS; I would also recommend other first responder agencies be brought in to assist in forming these standardized procedures. This will also require an ongoing, updated contact list to assist those at the scene – such as patrol members of the regional police forces and RCMP – so that they

know who to call in an emergency workplace situation, and a protocol for those responders to follow to ensure that there is a timely response.

STRENGTHEN THE OCCUPATIONAL HEALTH AND SAFETY REGULATION, s. 3.12 TO ENSURE PROTECTION FOR ALL WORKERS

The right to refuse unsafe work is one of the three basic health and safety rights accorded to workers along with the right to know about the hazards in your workplace, and the right to participate in workplace health and safety decisions.

OHSR 3.12 sets out the procedure for refusal of work that the employee deems unsafe:

(1) A person must not carry out or cause to be carried out any work process or operate or cause to be operated any tool, appliance or equipment if that person has reasonable cause to believe that to do so would create an undue hazard to the health and safety of any person.

(2) A worker who refuses to carry out a work process or operate a tool, appliance or equipment pursuant to subsection (1) must immediately report the circumstances of the unsafe condition to his or her supervisor or employer.

(3) A supervisor or employer receiving a report made under subsection (2) must immediately investigate the matter and

(a) ensure that any unsafe condition is remedied without delay, or

(b) if in his or her opinion the report is not valid, must so inform the person who made the report.

(4) If the procedure under subsection (3) does not resolve the matter and the worker continues to refuse to carry out the work process or operate the tool, appliance or equipment, the supervisor or employer must investigate the matter in the presence of the worker who made the report and in the presence of

(a) a worker member of the joint committee,

(b) a worker who is selected by a trade union representing the worker, or

(c) if there is no joint committee or the worker is not represented by a trade union, any other reasonably available worker selected by the worker.

(5) If the investigation under subsection (4) does not resolve the matter and the worker continues to refuse to carry out the work process or operate the tool, appliance or

> equipment, both the supervisor, or the employer, and the worker must immediately notify an officer, who must investigate the matter without undue delay and issue whatever orders are deemed necessary.

Under s. 3.12 of the OHSR, on reasonable cause, workers have the right to refuse to perform unsafe work. The worker must notify a supervisor or employer, who then carries responsibilities to determine if the work is unsafe and to fix the situation. The employer or supervisor can reassign a new task to the worker, at no loss in pay and ostensibly with no disciplinary action.

In my interviews, I found numerous examples, including with Lakeland workers, of attempts to bring the employer or supervisor's attention to unsafe working conditions, including where they or other workers had refused the unsafe work and been reassigned, only to see another employee doing the work they had deemed dangerous. Often, the pressure described was not from the employer, but a fear in a younger or less experienced employee that the refusal would lead to fewer on-call shifts or opportunities for promotion. A worker who refuses unsafe work and is reassigned can look on while another worker takes over without a designated recourse for the first worker.

The attempts by workers to draw attention at to the situation at Lakeland prior to the explosion highlight the need for a stronger approach when individual employees are not successful in having the unsafe situation remedied. The gap in application of this Regulation appears to be an employer reassigning an employee, not remedying the hazard and assigning another employee to continue working. On balance, while there always needs to be a reasonableness assessment, this cannot be an excuse for an employer to put another worker in harm's way. Possible remedies for this situation may be to draft the legislation such that the subsequent worker must be notified of a refusal by a previous worker and given the option to continue, a documentation process for the refusal (which is not required by this section) or any other available remedy which will protect workers from either employer or internal pressure.

CREATE A CONFIDENTIAL DATABASE THAT SEPARATES IDENTIFYING INFORMATION OF A WORKER REQUESTING CONFIDENTIALITY

Over the course of stakeholder interviews, I became aware of concerning assertions that in the days prior to the Lakeland explosion, a worker had reported the combustible dust conditions within the mill directly to WorkSafe by telephone and this telephone call had been recorded and played for the employer.

In reviewing the 'WorkSafe BC Combustible Dust Review" document, Section I: Action Requests, I note that in January 2018, a new Prevention Information Line was put in place by WorkSafe. This line operates Monday to Friday, 8:30 a.m. to 4:30 p.m. with an after hours protocol. The Line serves the entire province and prioritizes calls based on urgency, with top priority calls being triaged within 30 minutes. Top priority calls include situations that are referenced in s. 172 of the WCA. Important calls must be triaged within 60 minutes, and these include combustible dust calls.

Within the Officer Practice Directive: Managing Action Requests Contained in 'WorkSafe BC Combustible Dust Review" Section I: Action Requests, I have found that the new policy specifically states "officers must try to ensure that the employer is not made aware that the reason the inspection is being conducted is due to a complaint or provide any information to the employer that could be used to identify the caller" (p. 14). The policy also gives limits on ensuring confidentiality: "However in cases where the caller's evidence is needed to substantiate an order, it is unlikely that the caller's identity can remain concealed" and cite a situation where only the employee witnessed the violation. They concede in the policy that the orders where only an employee witnessed the violation are "much more likely to be cancelled should the employer request a review".

Should an employee caller request anonymity, I recommend that the call taker take their personal information and separate it from the action request in a separate, restricted database. That information can be stored, but it should be separated before it goes to an officer or inspector so that officer or inspector doesn't know who initiated the call. This would be

consistent with WorkSafe's own attempts to ensure that an employer does not know who initiated the call.

This recommendation does not, and should not, create an obligation on WorkSafe BC to create or hold Confidential Informant status with any worker who reports an event or hazard. However, there is a strong interest in ensuring workplaces with safety hazards are reported by those who are most likely to see them: the workers themselves. On balance, the need to ensure employees can report calls without fear of retribution from their employer outweighs the need for direct employee contact when that employee is unwilling to give their name, especially in light of the weaknesses inherent in orders being made where the employee is the only one to witness the violation and the employer was not made aware of it.

CREATE A DESIGNATED WORKER OMBUDSPERSON POSITION AT WORKSAFEBC

In interviews with affected workers from Lakeland Mill (Workers), I learned that part of their deep dissatisfaction with the process was they had never had the opportunity to express their feelings about the explosion and fire or the process. They recounted being "harshly" told by claims adjusters and other WorkSafeBC employees that the Coroner's Inquest process was for the deceased and that they could not express their point of view. To date, most feel as though they have never had the ability to either express their point of view or work with WorkSafeBC to ensure WorkSafeBC knows the full extent of the problems they saw within Lakeland Mill or within the industry as a whole.

In sitting with the Workers, I found them well informed, caring and articulate. All expressed a concern for younger workers or other industry professionals. All expressed frustration at a lack of response from WorkSafeBC or first responders.

The Workers have never been clearly informed of the results of any review or change in process at WorkSafeBC or any other agency. Most were given a copy of the Coroners' Reports and the Macatee Report; most were unaware of what those reports meant or what changes had been made. Because their physical and psychological health was directly affected from the accident, some have cognitive disorders or concentration problems that would make the dense reports difficult to read. All were left frustrated and concerned that no changes had been made to any process since Lakeland. That remains their view – because they have never been properly informed about some of the significant steps taken by WorkSafe in response to the Macatee, Dyble and Coroner's Reports. Many of the changes they suggested to me have already been implemented and are working well; a good example are workplace inspections that take place outside of office hours and over graveyard shifts.

I am recommending a Worker Ombudsperson position be created at WorkSafeBC. This person should be a liaison between WorkSafeBC and workers and be able to assist in plain language. An Ombudsperson should be a safe and confidential resource who can coordinate resources

for workers, explain processes, keep workers up to date on progress made as a result of reports and reviews, and assist with bridging the communication gap between workers and WorkSafeBC management. As well, an Ombudsperson can assist in resolving conflict between WorkSafeBC and workers, and employers and workers where safety is at risk.

I have not recommended a public inquiry process in this report. The only reason to hold a public inquiry now would be to allow the Workers and other stakeholders who were affected by this incident to have a forum to fully and properly express their feelings, the victim impact, and the changes they wish to see made. The reasons for not recommending this process are the length of time elapsed from the explosions and subsequent investigations to date, the great strides taken after Macatee and Dyble, and the processes that I see WorkSafeBC now has in place. I have also not recommended it because I believe that engagement would be low and many solutions that would come out of that process have already been implemented. Many stakeholders asked for a public inquiry process and based that request on solutions that are implemented but have never been communicated. WorkSafeBC has a communication problem in this regard. The Ombudsperson position – and responsive, timely communication through that person about changes to policy and input from workers directly – effectively obviates the need for the public inquiry process.

If an Ombudsperson is not implemented, I could see the need for a public inquiry as a way of assuring the wider community in an open, plain language process that significant changes have been made and continue to be made to ensure a tragedy like the explosions and fire at Babine Lake and Lakeland Mill are never repeated.

I recommend an Ombudsperson in concert with my next recommendation, updated sentencing provisions in s. 217-219 of the ***WCA***.

AMEND S. 217-219 of the WORKERS COMPENSATION ACT TO ALLOW FOR VICTIM IMPACT STATEMENTS AND PUBLICATION

The goals for regulatory sentencing are different than those of a pure criminal offence. Regulatory sentencing has, at its core, an emphasis on general deterrence, so that other employers and industry professionals understand that there are consequences to workplace safety being at risk. Workplace safety infractions should never come down to "the cost of doing business".

However, in review of the sentencing sections of the ***Workers Compensation Act***, I find there is room enough within the current sentencing sections to ensure that any benefit accrued to an employer from the infraction can be remedied, as per section 218. I also find that s. 219 allows for a prevention and corrective power that can be exercised by the judiciary.

Notably absent from this section, however, are two specific clauses: 1. Victim Impact Statements; and, 2. Orders for publication.

VICTIM IMPACT STATEMENTS

Had there been a quasi-criminal or regulatory prosecution over the Babine or Lakeland incidents, there would be no mechanism by which the living victims – or the families of the deceased – could speak to the trauma incurred in court. By failing to give workers an opportunity to speak about the effects that a breach in workplace safety have, they are deprived of input, leading to feelings of powerlessness and frustration.

In interviewing, it was common for those stakeholders who had been involved in workplace incidents – whether Lakeland, Babine, or other workplaces – to talk about their frustrations in not having their voices heard or their suggestions for improvement matter. In concert with the pre-sentencing assistance of an Ombudsperson, a post-sentencing option like the opportunity to address a court or tribunal on the way that the incident affected a worker would provide the ability for both improvement of the enforcement and investigation teams at WorkSafe and provide a forum for empathic listening, healing and correction of processes that have gone

awry.

A victim impact statement in this case would be a statement from a worker that describes the physical or emotional harm, property damage or economic loss they have suffered as the victim of an offence.

Victim Impact Statements are a common tool in criminal prosecutions. They are codified in s. 722:

> 722 (1) When determining the sentence to be imposed on an offender or determining whether the offender should be discharged under section 730 in respect of any offence, the court shall consider any statement of a victim prepared in accordance with this section and filed with the court describing the physical or emotional harm, property damage or economic loss suffered by the victim as the result of the commission of the offence and the impact of the offence on the victim.

Under s. 722(4), the Victim Impact Statement must be in writing. Under ss.(5), the victim can request to read the statement in court, with a support person nearby or behind a screen and may present it in any manner they wish. They can also present a photograph of themselves taken before the crime.

The ability for a victim to have their say on how the incident affected them is one that has deep meaning – for the victim and, in this case, for the employer and other employers who may be in a similar position. If the primary goals of regulatory sentencing are deterrence and prevention, a victim impact statement stands as a strong testament to the human cost of safety infractions and is a powerful tool for change.

PUBLICATION

There is currently no mechanism in the ***Workers Compensation Act*** for publication of the facts relating to the commission of an offence or contravention. Publication would serve as a strong deterrent effect, would affect a company or corporations standing in the public view and would also provide for an education tool for other companies in the same forum. I recommend that ss. 219 be amended to include publication as a sentencing option.

A precedent for this is found in the ***Wildlife Act***, s. 84.1 (h) directing the offender to publish, in any manner the court considers appropriate, the facts relating to the commission of the offence, and contains a penalty clause if publication is not made:

> (2) If a person fails to comply with an order referred to in subsection (1) (h) directing the person to publish the facts relating to the commission of an offence, the minister may publish those facts and recover the costs of publication from the person.

I recommend the WCA be amended to allow for publication as a result of a successful workplace prosecution.

MACATEE RECOMMENDATIONS: A CLOSER LOOK

I have looked at and researched all the Macatee Recommendations with the understanding that all recommendations were implemented by the Final Report rendered April, 2016. I have some additional comments on the Macatee Report Recommendations and will include them in this section.

I have specifically addressed recommendations 1-4 and 11-13 in the first section of this report, so will not duplicate that analysis here.

Macatee Recommendations 5-10: Ensure our sawmills are safer workplaces

All the recommendations in the report were implemented at the time of the final report. In my review, I note the following:

1. Occupational health and safety policies have been developed and implemented to address combustible dust hazards. These have been provided.
2. The sustained compliance plan for sawmills has been implemented and provided.
3. Inspection of other wood product manufacturers and pellet mills is ongoing and appears to have resulted in sustained compliance based on internal WorkSafe data.
4. The BC Forest Safety Counsel was expanded to address occupational health and safety issues. Although it has an industry Management Association Group (MAG) to advise, it does appear in my review to not be either guided or influenced by economic interests within that group and does not do any compliance or enforcement. WorkSafe is solely responsible for enforcement and compliance. This has not been outsourced to this group and the BC Forest Safety Council continues to assist both large and smaller mills and manufacturers in ensuring that safety resources are available. I should note that during my consultation process, the proactive way in which the BC FSA was looking toward safety and fatality prevention was impressive; their attitude of “how can we predict and prevent the next crisis” was appreciated. Workplace injuries and deaths in sawmills have continuously dropped across all sectors.

5. The Fire Inspection and Prevention Initiative has been extended, with continued funding from WorkSafeBC. and efforts made to find a permanent host at the municipal level. The transition and ongoing maintenance to permanent hosts has been made (The BC Forest Safety Council for combustible wood dust, Manufacturing Safety Alliance of BC for non-wood combustible dust and the Office of the Fire Commissioner for fire-safety plans). WorkSafeBC holds a Memorandum of Understanding with the appropriate agencies to ensure WorkSafeBC is notified when there is a fire at a workplace in BC.

Macatee Recommendation 14: Enforcement

The Workers Compensation Act was amended to enhance the occupational health and safety expertise of the Board of Directors by adding two new members, one who has legal and/or regulatory experience and one who is an occupational health and safety professional. This was done and appears to be of assistance. I have no comment here.

Macatee Recommendations 15, 16 and 17: Regulation Making Model

WorkSafe BC has retained the ability to develop and approve occupational health and safety regulations. Based on my review of all available material, including material from WorkSafe and from the BC Forest Safety Council, this has not been outsourced. The setting of regulatory priorities has been enhanced with the MAG working group, the efforts of Forest Safety BC and the seats at the table for labour and worker's interests.

Occupational Health and Safety Work Plans are updated and published annually and are available on the WorkSafe website.

Macatee Recommendation 18: Education

WorkSafeBC has continued to put a priority on education and proactive compliance and provide resource allocations accordingly. Everyone I interviewed said they felt that they receive more than adequate education in both investigation and proactive compliance and had an adequate budget for their needs. Investigators felt as though ongoing training was a necessity but that resources were being adequately provided.

Resources were provided to me by the BC Forest Safety Council that showed a significant investment in developing safety products that were “off the shelf” for companies to use. I am satisfied that WorkSafe’s investment in education is strong.

Macatee Recommendations 19-30: Enforcement

WorkSafeBC reviewed its risk-based model for the allocation of work and the setting of priorities with respect to inspection and enforcement activities. That model has been amended a number of times between 2016 and 2019 to assist in high level functioning.

A hierarchy of enforcement tools have been enacted and the Workers Compensation Act was amended to include s. 186.1 to introduce a compliance tool.

OHS citations, with escalating fine provisions, were introduced and have been used by compliance officers according to internal statistics. These citations are imposed on employers who violate certain OHS requirements.

Other enforcement recommendations have been followed and implemented, specifically in the areas of employer administrative penalties and regulatory violations.

Major case management has been put in place and is working well. WorkSafeBC continues to pursue prosecutions for regulatory violations.

Macatee Report Recommendation 31: Hazard Alert

The Memorandum of Understanding with Police Services has been expanded to provide guidance where a hazard alert may be necessary and to include an agreed upon procedure for making such a determination. The recent addition of the Working Group between municipal police, RCMP and WorkSafe will continuously improve this hazard alert system and I recommend the allocation of any funding needed to impose a standardized protocol, as recommended in my report, above.

Macatee Report Recommendation 32: Employer Incident Investigations

The Workers Compensation Act has been amended to specify timelines for employer incident investigations, with the timelines suggested by Macatee in place. Further, there are internal policies to deal with incident reports and a fast turnaround for action reports to be dealt with; in

the two highest incident categories, response times are 30 minutes and 60 minutes, respectively.

Macatee Report Recommendation 33: Enforcement Presence

WorkSafeBC routinely schedules Prevention officers to conduct inspections on weekends and evenings to create an ongoing and effective level of presence in the workplace.

This was a crucial area of complaint for the workers I spoke to, so I carefully reviewed internal documents. It does appear that prevention officers are regularly scheduled and conduct inspections on evenings and weekends. This must be maintained, including for graveyard shifts.

Macatee Report Recommendation 34 and 35: Review and Appeal

WorkSafe completed an assessment of the internal OHS review processes and oral hearings have been discontinued. The WCA has been amended to shorten timeframes of order reviews, penalty reviews, to reduce the time limit to apply from 90 days to 10 days, and an expedited review process for OHS citations. These amendments are now in force. I cannot comment on their efficacy as documents I reviewed did not compile statistics and I could find no report that detailed this process or the effectiveness of the changes.

Macatee Report Recommendation 36: Worksafe BC Performance Management

Performance measures to assess the “health and safety awareness” levels among workers; the “health and safety culture” of the business enterprise; the effective engagement of WorkSafeBC officers; and the effectiveness of compliance activities have been implemented.

The documents I reviewed showed a consistent effective compliance enforcement department.

Macatee Report Recommendation 37: Culture Change

I could not properly assess the culture at WorkSafe from my document review or assessment through interviews at WorkSafe. I decline to comment on this aspect of the Macatee Report, except to say that I was continually met with openness and collaboration through this process.

Macatee Report Recommendation 38: Internal and Stakeholder Communications

Internal and external communication is problematic at WorkSafe. Many of the stakeholders had little consistent communication with each other and with outside agencies. There is no direct line of communication for a worker to express their feelings or provide experience and advise to WorkSafe about worksites. This has to change. I have recommended a Worker Ombudsperson, above, and this Macatee recommendation is consistent with that.

Fundamental positive change has been made at WorkSafe in a few key areas including communication between investigators, police forces, the BC Prosecution Service and other agencies. This must continue.

Macatee Report Recommendations 39 and 40: Anticipation and Prediction of Emerging Trends

In the context of the investigations section, it is clear that WorkSafe has spent considerable time and resources ensuring that their section is up to date technologically. This clearly encompasses their Major Case Management system, but other tools such as drones and measurement instruments have been provided when requested.

The WorkSafe funded BC Forestry Safety Council has made it their mission to “get ahead of the next crisis” and to this end, funded by WorkSafe, has started a number of initiatives to predict where injuries may occur and proactively respond. This has been of benefit across the forest industry.

I do not have enough information to comment on this aspect for all of WorkSafe. Certainly, documents provided to me speak of an agency that is up to date and well provided for, but I cannot specifically comment on this but for the investigation and enforcement side.

Technology and process that would make data sharing between partners and jurisdictions is weak. An Incident Command System must be implemented.

Macatee Report Recommendation 41 and 42: Enhanced Training for Enforcement and Investigation Personnel

Worksafe BC has committed to enhanced training of officers and managers in the areas of penalty investigation techniques, interviewing skills, report writing, use of new IT systems and tools, and collaboration skills.

I am satisfied based on documents and interviews at WorkSafe that regular training for enforcement and investigation personnel is properly in place and well supervised by managers. I would only say that this training must be continued and pursued vigorously, especially as investigators dealing only with a handful of cases every year must accrue experience either in the field or via training and that experience must be maintained. I understand there is training on notetaking, interviewing and other aspects of quasi-criminal and regulatory investigation that is undertaken regularly.

Macatee Recommendation 43: Finalize the Search for a CEO

A CEO was found and in place at the time of this review.

THE DYBLE REPORT: A CLOSER LOOK

The Dyble Report Recommendations fell into four categories. I can comment on three of them:

1. Measures to improve interaction between investigating and prosecuting agencies;
2. Improvement of policies, procedures and communications within WorkSafe BC; and,
3. Enhanced training and improved working relationship

Measures to improve interaction between investigating and prosecuting agencies

The Dyble Report contained recommendations for the following:

1. WorkSafe and Police Services Memorandum of Understanding;
2. WorkSafe and CJB Memorandum of Understanding;
3. WorkSafe and CJB commitment to enhancing the cooperative and working relationship;
4. Major case management model and senior prosecutor availability;
5. Regular Informational Meetings

I am pleased to say that these priorities have been achieved and regular, ongoing communication and cooperation is in place. One of the recommendations, legal advice during investigations, has been only partially achieved, mostly because of the Ling/Jarvis separation and partially because Crown Counsel do not give ongoing prosecution advice. This will be strengthened by the recommendation for dedicated legal counsel that is assigned to work with an independent investigations unit at WorkSafe.

Improvement of policies, procedures and communications within WorkSafe

There has been a significant improvement, based on interviews and document reviews, to internal communications at WorkSafe, including a process and hierarchy for internal communication at WorkSafe.

I am unaware if there was a report back to the board from the CEO on the measures taken and their effectiveness to assist with internal communication, so I will not comment on that.

In the wake of the improvements required by Dyble to WorkSafe investigative policies and procedures, communication has improved. Abolishing the two team system will provide a significant advantage of an ongoing flow of information.

Enhanced training and improved working relationships

All recommendations of the Dyble Report, including training materials, investigation protocol twice-yearly meetings and educational seminars and training have been provided and are sufficient and ongoing.

CORONER JURY RECOMMENDATIONS

I have reviewed, in full, the two separate coroner jury recommendations. All of the recommendations have been implemented across agencies and I have reviewed documents on each separate recommendation to be sure that they are in place.

OTHER CONCERNS

"Industry Pushback"

I have been provided, and reviewed, an internal memorandum from February 27, 2012 entitled "Wood Dust In Wood Product Manufacturing Facilities – Potent Fire and Explosion Hazards". This memorandum is gravely concerning. Written after the Babine Sawmill explosion and fire but before the Lakeland explosion and fire, it details that combustible wood dust, while not at that time determined to be the cause, was being considered as a potential factor. The writer expresses that there have been "several" wood dust related fires in sawmills and "at least 2" explosions.

The concerning paragraph is as follows:

> Industry sensitivity to the issue given the recent event and limited clarity around what constitutes an explosion has could (sic) lead to push back if an enforcement strategy is pursued at this time

I understand that no other review has directly addressed this issue. It was a significant cause of upset for a number of stakeholders in interviews.

The Board is reminded of their mandate:

> **111** (1) In accordance with the purposes of this Part, the Board has the mandate to be concerned with occupational health and safety generally, and with the maintenance of reasonable standards for the protection of the health and safety of workers in British Columbia and the occupational environment in which they work.

That mandate does not mention industry sensitivity and that is not a guiding principle of WorkSafeBC. In giving up the right to sue an employer for negligence or damage, the worker entrusts WorkSafeBC with the enforcement and compliance of safety standards on their behalf. All officers and managers must be informed that if a situation arises where safety is at risk, they must take immediate steps to remedy that situation, whether it be through more frequent checks, maintenance or clean up orders or any other remedy allowed to them. "Industry pushback" is not a valid reason for not pursuing an enforcement strategy.

Concern for industry sensitivity should never be factored into the safety of a worker in British Columbia.

Self Regulation

WorkSafeBC has not delegated their enforcement or safety duties to BC Forest Safety Council, either directly or indirectly. A concern was raised within this review that WorkSafeBC was delegating their enforcement and safety duties. I have conducted extensive interviews and in doing so was alive to this issue. I can conclude that the BC Forest Safety Council and the associated MAG working group are working together to find solutions to safety issues but that they are not given the power to self-regulate on safety issues.

WorkSafeBC must continue to fully regulate and enforce safety standards in British Columbia. I do not find, however, that this power has currently been delegated but it cannot, and should not, be delegated to the industry in future.

Clear Parliamentary Oversight

A stakeholder suggested I review whether there was clear parliamentary oversight of WorkSafeBC or if WorkSafeBC should be subject to the oversight of the Select Standing Committee on Crown Corporations.

Because WorkSafeBC operates primarily as an insurer, and because WorkSafeBC is accountable through the government, courts, reviews such as this one and many other mechanisms, I find that to change the current model of WorkSafeBC would not provide clear benefit. I find that the government's control and oversight on WorkSafeBC is ongoing, and that WorkSafeBC's independence from government should continue.

CONCLUSION

The recommendations in this report will achieve worthy goals in furtherance of workplace safety.

By restructuring the investigative team into one team with both compliance and quasi criminal investigators and empowering them with the ability to make independent decisions about charge approval submission, investigations will be faster, comprehensive and more likely to proceed to prosecution. Affirming the independence of the Investigation unit will ensure they are not subject to an appearance of bias and new search and seizure powers will ensure judicially obtained warrants will preserve the integrity of exhibits and investigations.

An ongoing, designated police contact and contact with the previously designated BC Prosecution Service Crown Counsel group will allow for information sharing, a hierarchy of command and a streamlining of shared resources.

Recommendations to preserve the integrity of worker's rights to a safe workplace have been made. A strengthening of ***OHSR*** 3.12 will allow for workers to work together to preserve their right to a safe workplace. A confidential database for reporting safety infractions will preserve relationships between workers and their employers.

When problems arise, a designated Worker Ombudsperson should be able to assist workers, explaining procedures and processes and able to provide a bridge to WorkSafeBC for worker's ongoing input into safety processes. When a prosecution results in a conviction, victim impact statements will give a voice to the affected worker, and publication will allow for all employers to learn about the hazards of ignoring workplace safety.

I wish to thank everyone who spent time to help me understand the necessary recommendations to make. This process has been an enlightening one and I am appreciative of the opportunity to render recommendations on such a significant issue.

APPENDIX 1: SUMMARY OF *R v JARVIS* [2002] 3 S.C.R. 757 (S.C.C.)

In ***Jarvis***, an auditor from the Canada Customs and Revenue Agency's (CCRA's) Business Audit Section began an audit to follow up on a "lead" that Jarvis had failed to report substantial income from the sale of his deceased wife's artwork for the 1990 and 1991 tax years. After contacting third party art-galleries and reviewing their books and records, the auditor found that the lead had some validity and arranged to meet with Jarvis. The auditor's stated purpose was to interview Jarvis and to review books and records relating to his tax returns.

At the interview, Jarvis was neither cautioned nor given the option to speak to counsel. Jarvis answered the auditor's questions and agreed to provide information about his banking arrangements, as well as receipt books tracking sales and expenses. Based on the information obtained after the interview and the review of Jarvis' books and records, the auditor discovered a significant discrepancy in reported income and transferred the file to an investigator in the Special Investigations Section of the CCRA.

After reviewing the auditor's file, the investigator felt there were reasonable grounds to believe that an offence under the Income Tax Act had been committed and obtained a search warrant based on information in the file. The evidence obtained pursuant to the warrant formed a substantial portion of the Crown's evidence at trial.

Jarvis alleged that the auditor began pursuing a criminal investigation after the auditor completed her review of the books and records of the third party art galleries. All of the evidence subsequently obtained, including his statements during the interview and the documents he provided in response to the auditor's requests, subject to a Charter challenge as collected in violation of Jarvis's ss. 7 and 8 Charter rights.

The Court held that when the "predominant purpose" of an investigation is one of penal liability, an adversarial relationship between the individual taxpayer and the state exists, which triggers the "full panoply" of Charter rights, such as ss. 7 and 8 rights.

The "predominant purpose" test is derived from the Supreme Court's decision in ***Branch v. British Columbia Securities Commission***, where the Court upheld the British Columbia Securities Commission's statutory power to compel witnesses to give testimony provided that

the "predominant purpose" of the compulsion was not to obtain evidence that would incriminate the witness.

The Court's challenge in ***Jarvis*** was to determine at what point the adversarial relationship crystallizes, and the predominant purpose of an investigation becomes one of penal liability. Recognizing that the inquiry is contextual and must take into account all relevant factors or the "totality of the circumstances," the Court listed the following factors for trial judges to consider:

1. Did the authorities have reasonable grounds to lay charges? Does it appear from the record that a decision to proceed with a criminal investigation could have been made?
2. Was the general conduct of the authorities such that it was consistent with the pursuit of a criminal investigation?
3. Had the auditor transferred his or her files and materials to the investigators?
4. Was the conduct of the auditor such that he or she was effectively acting as an agent for the investigators?
5. Does it appear that the investigators intended to use the auditor as their agent in the collection of evidence?
6. Is the evidence sought relevant to taxpayer liability generally? Or, as is the case with evidence as to the taxpayer's mens rea, is the evidence relevant only to the taxpayer's penal liability?
7. Are there any other circumstances or factors that can lead the trial judge to the conclusion that the compliance audit had in reality become a criminal investigation?

Applying these factors to the facts, the Court found that there was no investigation into penal liability before the auditor referred the file over to the Special Investigations Section. All evidence obtained prior to that date had been validly obtained and properly formed the basis for the search warrant.