

ONTARIO PUBLIC SERVICE EMPLOYEES UNION  
RESPONSE TO THE DRAFT REPORT  
OF THE CHAIR OF THE  
OCCUPATIONAL DISEASE ADVISORY PANEL

Submitted to the Chair of the  
Workplace Safety and Insurance Board  
Occupational Disease Advisory Panel

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## **1. Introduction**

OPSEU is pleased to present this paper in response to the Draft Report of the Chair of the Occupational Disease Advisory Panel. As one of the province's largest unions, OPSEU represents over 100,000 members who work in a wide variety of jobs and sectors. For example, OPSEU represents lab technicians who work with many hazardous substances, including formaldehyde, a carcinogen, traditional office workers who are frequently exposed to airborne hazards such as moulds and elevated volatile organic compounds (VOC), correctional officers who are exposed to TB and blood borne pathogens, developmental care workers who are exposed to infectious disease, and outside workers who monitor highways and waterways and who potentially are exposed to West Nile Virus.

Additionally, OPSEU also represents the Operational Staff at the Office of the Worker Adviser, who for almost two decades have provided representation to occupational disease claimants from non-unionized workplaces and their survivors.

From discussions and experience with our members, we know that workers often are unaware that there may be a link between their illnesses and exposure to some substance in their work environment. Years and sometimes decades pass by before we may be notified that one of our members has an illness which may be due to chemicals they touched or the airborne particles they breathed, years earlier. Once a claim is made, workers have little access to the medical and scientific resources needed to investigate whether a link exists between their illness and their job.

## **2. Legal Principles**

The Report sets out the legal principles that govern the adjudication of occupational and disease claims. In general, OPSEU supports the Draft Report's statement of these principles. We will comment on areas which raise concern.

### **(a) Causation**

OPSEU concurs with the Draft Report's position that the significant contribution test is the standard which should be applied for causation in occupational disease claims. We also agree that no distinction should be made between the "significant contribution" tests developed by the WCAT/WSIAT (the appeals Tribunal) the "material contribution" test in the decision set out by the Supreme Court of Canada in *Athey v Leonati*.<sup>1</sup>

In accepting the significant contribution test, it should be recognized that work need not be the sole or even the predominant cause for entitlement to be accepted. Other than factors which may be outside the '*de minimis range*', there should be no numerical cut-off for significant contribution. We will comment later on areas where the report seems to require a reliance on facts that are neither material nor significant on establishing causation.

### **(b) Burden of Proof**

OPSEU accepts the position that there is no burden of proof in the workers' compensation system and that decision makers must not implement a different approach between occupational disease and chance event claims.

We support the Report's recommendation that the statement of legal principles emphasize that Ontario's workers' compensation system is inquisitorial rather than adversarial and that, consequently, neither our members or nor their employer bears the burden to prove its case. If more information needs to be gathered regarding a specific claim, the decision maker is obligated to obtain the necessary evidence and may not refuse to make a decision based on a lack of available or obtainable evidence. If the Board does not have the internal resources or level of expertise to gather or assess additional evidence, external consultation should be sought.

**(c) Standard of Proof**

OPSEU supports the position that the balance of probabilities is the correct standard of proof in the workers' compensation system. The criminal standard of 'beyond a reasonable doubt' has no place in the adjudication of occupational disease claims. The Draft report recommends that the question for decision makers is:

*"Is it more likely than not that this worker's employment was a significant contributing factor in the development of the occupational disease?"<sup>3</sup>*

However, in order for this standard to be effective, we support the worker representatives' comments that the statement of principles should address benefit of the

doubt with respect to the balance of probabilities. We recommend that the supplementary language suggested by the worker members of ODAP be adapted so that it is clarified that “more likely than not” is actually a likelihood of 50 percent or greater.

**(d) Benefit of the Doubt**

OPSEU strongly supports the Draft Report recommendation to include in the statement of legal principles the following two points concerning the 'benefit of doubt' provision under Section 119(2) of the *Act*:

*First, this provision applies to all issues that the decision maker must decide, not just the final decision itself. Therefore, each time that there is an issue for the decision, s. 119(2) may apply.*

*Second, this provision only applies when the evidence either way is approximately equal...It does not preclude the need to make a decision and it is not open to the decision-maker to resort to s. 119 (2) because it is too hard to make a decision.<sup>4</sup>*

Therefore, we cannot accept the employer members' recommendation that the provision should be applied only when making a final decision on the relative weight for and against from the aggregate evidence.

**3. Role of Evidence**

**(a) Assessing evidence using the legal test**

OPSEU agrees with the Draft report which requires that all evidence, including medical/scientific evidence, must be assessed using the legal test for causation. Although the adjudication of occupational disease claims has relied heavily on medical and scientific evidence, it must be clarified in the statement of principles, that the

adjudication of those claims is a legal exercise, not a scientific one. Where the scientific test demands a greater level of certainty in establishing a causal relationship between a disease and employment, the legal test asks, is it more likely than not that the employment was a contributing factor in the development of the disease. We must reject applying the principles of the scientific test in establishing causation.

**(b) Scientific Evidence**

**(i) Epidemiology**

While OPSEU recognizes that epidemiological studies are a useful method to analyze the link between illness and the workplace, we cannot accept the Report's conclusion that "well-conducted epidemiological studies offer the most persuasive evidence of the relationship between exposures and disease." It is OPSEU's position that evidence other than scientific evidence needs to receive the same level of consideration in the adjudication of occupational disease claims.

We reject the position that one type of evidence should automatically be considered the most persuasive evidence in every case. Factors such as dose response, latency period, low level chronic exposure and genetic makeup of an individual or the case group are often not addressed by epidemiological studies. If epidemiological evidence is always considered to be most persuasive, it will become only more difficult to prove entitlement for individuals where there are few or no epidemiological studies. If the Draft Report recommendation is adopted, we fear the decision-maker will prefer even

flawed epidemiological studies over more reliable evidence. Claims will be denied because no sound epidemiological evidence exists.

**(ii) Toxicology**

Toxicology studies use either live animals or cell culture to assess possible harmful effects of toxic substances on humans. While toxicology studies may be helpful, the Report notes that it is often impossible to apply the test results to humans. As the Draft Report states, the most useful toxicology studies are those where:

*“Evidence from a variety of animal species having similar responses, when the test agent is administered through a relevant route of exposure, have the highest validity for extrapolation to human exposures.”<sup>5</sup>*

There will be occasions where both toxicological and epidemiological data offer little information specific to new and emerging occupation-related diseases. We therefore submit that toxicology, as with epidemiology, not be given a greater regard than other types of evidence in establishing a link between a disease and workplace exposure.

**(iii) Evidence based Clinical Medicine**

In acknowledging the limitations inherent in an over-reliance on epidemiological and toxicological data, OPSEU supports the approach outlined by the worker members. Evidence such as work history, exposure to workplace agents, changes in the way the work was performed, and individual medical history must all be considered. The benefit of adopting this approach is explained on page 122 of the Draft Report. It is as follows:

*“The evidence-based approach to clinical medical practice is instructive for our purposes, as it emphasizes the necessity for framing the right question, developing tools*

*for finding as distinguishing strong and weak evidence, for critically appraising the best evidence and for individualizing that evidence to a particular problem.’<sup>6</sup>*

**(c) Other Types of Evidence**

Scientific evidence plays an important role in occupational disease. However it is not the only evidence available. We agree with the Draft Report recommendation which states:

*‘Where warranted, each worker’s personal employment history should be assessed from the earliest through to the most recent employment. Each workplace experience should be explored to characterize the working conditions to which that worker was exposed’.<sup>7</sup>*

Unless the disease is scheduled, it is always necessary to review the worker’s full employment and exposure history. Although the claim may initially link the disease to a particular workplace chemical or pathogen, there may be other agents and/or other workplaces that must be considered. Along with employment and exposure history, individual medical history should also be obtained.

**4. Establishing Causation**

We agree with the adjudicative approach recommended in the Draft Report to determine causation of claims. And we agree with the distinction between determining general causation and establishing an individual claim. It is critical that these distinctions are clear, especially when adjudicating individual claims.

**(a) General causation**

The Draft Report recommends the using the Bradford Hill criteria to draw general inference for causation. OPSEU does not support the use of the Bradford Hill criteria alone as test for general causation. We agree with the worker members that the preferred test for general causation should be based on ‘potential significance.’ In reviewing Sir Austin Bradford-Hill’s paper, published almost 40 years ago, it is apparent that his intention was not to set out hard and fast rules on causation, but to suggest areas that must be considered when attempting to determine causation. Sir Bradford Hill cautioned his readers on the use of his nine viewpoints

*“What I do not believe – and this has been suggested – is that we can usefully lay down some hard and fast rules of evidence that must be obeyed before we can accept cause and effect...what my (viewpoints) can do...is there any other way of explaining the set of facts before us, is there any other answer equally, or more likely than cause and effect. None of my nine viewpoints can bring indisputable evidence for or against the cause and effect hypothesis and none can be required as a sine qua non.”<sup>8</sup>*

And

*“In asking for very strong evidence I would, however, repeat emphatically that this does not imply crossing every ‘t’ and swords with every critic, before we act. All scientific work is incomplete –whether it be observational or experimental. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have, or to postpone the action that appears to be demanded at a given time.”<sup>9</sup>*

OPSEU strongly suggests that future reference on the ‘Bradford-Hill criteria’ is tempered by those words from the author himself.

It must be remembered also, the Bradford-Hill criteria were intended to provide a framework to determine if a link exists, based on a scientific analysis as opposed to the

legal analysis of the evidence. As argued above, legal principles, not scientific principles, are to be applied in claim adjudications. Therefore OPSEU recommends that a rigorous application of the Bradford-Hill criteria be avoided.

**(b) Specific Causation**

OPSEU agrees with the Draft Report statements that using grouped data to draw conclusions about an individual may be problematic. We recommend that specific adjudicative directives be written to ensure that statistical models derived from large groups are not used to override specific evidence and to adjudicate individual claims.

We agree with the Draft Report position that decision makers can look to individual subgroups within studies if there is no clear evidence of a relationship of between the outcome and the work exposure. However, care must be taken to ensure that the subgroup is similar to the claimant and that the study methodology and statistical interpretations are sound.

Studies may offer conflicting evidence as to the cause of the disease in some situations. The existence of conflicting evidence alone is not reason enough to deny a claim. Instead, the decision maker must examine the evidence and render a decision. We disagree with the recommendation that where the evidence is equally weighted that:

*'The decision-maker must seek out other information to determine if the individual's exposure pattern is consistent with the individual disease.'<sup>10</sup>*

This approach undermines the Draft Report recommendation of legal principals with respect to the burden of proof and the standard of proof recommendation found respectively on pages 11 and 12 of the report. Once all the evidence is gathered and reviewed and there is no other evidence to be obtained, the benefit of the doubt provision must be applied.

## **5. Adjudicative Channels**

### **(a) Schedules**

The purpose of the Schedules is to establish presumption of work-relatedness for some diseases and work processes and to remove the need for case-by-case adjudication. Schedule 3 allows for rebuttal of the presumption. Schedule 4 does not. The legislation does not set out any standards for scheduling. It is OPSEU's position that the standards for scheduling should be determined according to the purpose and function of each Schedule.

It is OPSEU's position that it is a mistake to employ too rigid a standard or test to determine whether a disease is to be scheduled. If the principle of meeting a legal standard and not a scientific standard on causation is maintained, absolute certainty is not required to establish a connection between a disease and the workplace.

We support the position of the worker members that the appropriate threshold standard for scheduling is the general causation test of potential significance. It is as follows:

*“Can this workplace, process, occupation, chemicals, etc. be a significant or material contributing factor in causing a {particular} disease?... If the answer is yes – then the disease or process should be added to the schedule.”<sup>11</sup>*

**(i) Schedule 4**

OPSEU does not support the Draft Report's position which is as follows:

*“Strong and consistent epidemiological evidence that in virtually every case the disease occurrence is linked to a single cause and that the cause is associated with an occupation, workplace or work process.”<sup>12</sup>*

This position undermines the Draft Report's adoption of the legal principles of accepting both the significant and material contribution tests.

By adopting a restrictive and rigid bar as proposed here, a disease or process will be added to the schedule only if it is found to be 'beyond a reasonable doubt'. If this standard is adopted, rarely will any disease or process be entered in Schedule 4. The decision by the Supreme Court of Canada in *Snell v Farrell* commented on the differences between a legal and a scientific/medical standard in determining causation.

*“It is not therefore essential that the medical experts provide a firm opinion in supporting the plaintiff's theory on causation. Medical experts ordinarily determine causation in terms of certainties whereas a lesser standard is determined by the law. As pointed out in *Louisell*, *Medical Malpractice* vol 3. The phrase “in your opinion with a reasonable degree of medical certainty,” which is the standard form of question to a medical expert is often misunderstood. The author explains, at page 25-57, that:*

*Many doctors do not understand the phrase...as they usually deal in “certainties” that are 100% sure, whereas “reasonable” certainties which the law requires need only be more probably so. i.e. ' 51%....In *Harvey, Medical Malpractice* (1973), the learned author states at p. 169:*

*Some courts have assumed an unrealistic posture in requiring that the medical expert state conclusively that a certain act caused a given result. Medical testimony does not lend itself to precise conclusions because medicine is not an exact science.”<sup>13</sup>*

We recommend adopting the standard proposed by the worker members; that “a disease ought to be included in Schedule 4 when the best available general evidence dictates that each case in the defined class would be allowed if properly adjudicated on a case by case basis. In other words, there is certainty of adjudicative outcome.”

**(ii) Schedule 3**

The Draft Report recommends the following standard be adopted for inclusion in Schedule 3:

*“Strong and consistent epidemiological evidence supporting a single or multi-causal association with the disease, one cause being occupation.”<sup>14</sup>*

For example, tuberculosis is currently placed in Schedule 3 because, although it may be contracted as a result of a non-occupational exposure, it is seen most commonly in certain workplaces that house TB-infected persons -- hospitals and correctional facilities. It is accepted that health care and correctional workers are at a greater risk in developing the disease because of their work environment. Certain work processes or workplaces are known to significantly or materially contribute to a condition and even though it may be possible the cause was non-occupational – the condition along with the process and/or workplace should be entered into Schedule 3. When considering the significance of non-occupational factors that may contribute to an illness, it is critical to consider significance of the workplace exposure at the same time.

One suggestion may be to review the ‘de minimis’ range mentioned in *Athey v Leonati*. No numeral value or percentage is given in establishing a value of what falls within or outside the range. In *Athey v Leonati* the Supreme Court agreed with the lower court's ruling on what would be outside the range.

*“...on the balance of probabilities, that the injuries suffered in two earlier accidents contributed to some degree of subsequent disc herniation. She assessed this contribution at 25%. This falls outside the de minimis range and is therefore a material contribution.”<sup>15</sup>*

We would caution against establishing a numeral cut-off value between what is deemed a significant or material contribution. However, one can infer in order for the Board to deny entry of an occupational disease or work process in Schedule 3, there must be evidence non-occupational factors contributing to the disease are higher than the ‘de minimis’ range.

It is OPSEU's position that in cases where there is evidence that the workplace exposure may be a significant contributing factor to a disease that, the disease should be entered into Schedule 3. For example, hepatitis B and hepatitis C should be entered into Schedule 3 for all workplaces where workers have a high risk of exposure to blood borne pathogens. The following example illustrates the importance of this issue:

A 50-year-old worker is employed in a work process where she sorts and sterilizes medical instruments. Much of the equipment is contaminated by blood and other body fluids. During the cleaning process before instruments were put in the sterilizer, it is not uncommon for the worker to sustain superficial lacerations to her hands

and arms. After many years on the job, the worker tested positive for hepatitis C. In her early 20s, the worker had experimented with intravenous drug use on a few occasions. No specific information is available to indicate when or how the worker was exposed to the hepatitis virus that she has contracted.

The Board may deny the claim because the worker has never reported any workplace needlestick or laceration incidents and because of her prior intravenous drug use. Although there was a remote possibility that the disease was contracted outside the workplace, it is more likely than not that she contracted it because of a workplace exposure cleaning contaminated instruments. If hepatitis B and C were included in Schedule 3, it would then be presumed that the cause was in the workplace unless there was other strong evidence to rebut that presumption.

**(iii) Rebutting the Presumption**

In its discussion of the issues around scheduling certain illnesses, the Draft Report recommends that the term ‘rebuttal matrix’ be abandoned. OPSEU agrees with that recommendation and that some form of guidelines need to be established to determine what evidence is necessary to rebut the presumption.

An adjudicative advice binder on rebutting the presumption must emphasize the absence of available evidence is not enough to rebut the presumption. However, the advice must clearly note that even if the rebuttal evidence is significant, but it has also

been established that the workplace evidence is also significant, the presumption is not rebutted as the ‘benefit of the doubt’ provision still allows entitlement.

**(b) Adjudicative Policy**

The Draft Report endorses the use of policy instead scheduling diseases:

*“When schedule 3 criteria are met but the process can not be defined as follows.”<sup>16</sup>*

The Report goes on to advise that although there may be a high risk of disease associated with certain processes, there are cases where there are subgroups of worker with certain minimum latency or exposure duration that cannot easily be described in terms of a work ‘process.’ In these cases, the Report recommends the use of policy rather than schedules. We strongly disagree. Board policies currently in use, place the burden of proof beyond what should be required to establish causation. In many cases, the policy leads to guidelines setting out minimum exposure levels or latency periods. Such policies tend to discourage the decision maker from looking at other evidence in cases where minimum exposure and/or latency periods guidelines are not met.

**(c) Adjudicative Advice**

We agree with the worker member alternative text (p.126) which recommends the use of Adjudicative Advice Binders rather than Adjudicative Policies, an approach similar to that currently used by Board staff to adjudicate chronic obstructive pulmonary disease claims. OPSEU is concerned that the Draft Report of the Chair makes no mention

of adjudicative advice and its effective uses. The use of Advice binders rather than Board Policies allows Board staff a broader degree of flexibility to investigate a claim based on current information from the scientific, medical and the workplace parties.

Adjudicative advice is a useful tool to employ when considering emerging conditions where there is not yet enough information available to place an illness in a Schedule and where Adjudicative Policies may become too rigid. For example, it would be useful to provide Adjudicative Advice to decision-makers required to determine if West Nile virus illnesses are compensable. While the cause of West Nile virus is known, it is not well understood why some people develop such severe symptoms, the number of bites required to transmit infection, if some people are more susceptible, or why outbreaks are worse in certain geographical areas and at certain times. At some point, it may be enough information to place West Nile virus in one of the schedules with corresponding work processes.

It may also be useful to develop Adjudicative Advice for environmental sensitivity illnesses. More information is now available about the hazards of sealed buildings that have inadequate air handling systems and may have elevated levels of moulds, dust mites, Volatile Organic Compounds, environmental tobacco smoke and other chemical contaminants. Additionally, more is known about the illnesses that arise among people exposed over long periods to these contaminants within sealed buildings. While it may never be possible to schedule environmental sensitivity illnesses due to the complexity of exposure information necessary and the complexity of symptoms, it would

be useful to develop Adjudicative advice to assist decision-makers faced with these claims.

Another area where Adjudicative Advice would prove useful would be to deal with claims arising from exposure to low levels of complex chemical mixes. OPSEU has a large number of members who work as X-ray Technologists. Part of their work is to develop x-ray films. While there is a gradual transition from standard wet developing to digital imaging, in Ontario, for the most part, x-rays are still developed using traditional wet developing processes. In the last 20 years, there has been an increasing number of complaints of illnesses known as darkroom disease, among x-ray technologists. There is a wide range of symptoms associated with the syndrome and those most severely affected often are forced out of the workforce altogether. While much research has been done into the syndrome and the exposures, it is still not clear which chemical or combination of chemicals is the cause. In most cases, the measured exposure levels to the airborne chemicals is within legal limits, but workers continue to get sick. Eventually, it may be possible to schedule 'darkroom disease' but for now, an inclusion in the Adjudicative Advice binder would be helpful.

**(d) Case by case Adjudication**

It is OPSEU's position that case-by-case adjudication should take place where there may be insufficient general evidence to schedule a disease or to create adjudicative advice binders. We agree with the Draft Report that recognizes a causal relationship

cannot be dismissed just because the general evidence may be inconclusive or simply non-existent. The decision maker should return to the ‘balance of probabilities’ principle to consider whether the workplace was significant contributing factor in the development of the disease.

## **6. Future Consultation**

OPSEU is aware that the ODAP mandate was limited by its Terms of Reference. However, we believe the panel should advise the Board that additional consultation is needed to address other areas of occupational disease, such as the need for an independent occupational disease panel. Once the ODAP public consultation process is completed, the Panel should forward specific areas of concern that various stakeholders have raised through this process, to the Board.

### **(a) Creation of a permanent independent Occupational Disease Panel**

The Chair expresses concerns with the creation of an independent panel similar to the previous Occupational Disease Panel. The Chair has concerns over the proposed cost and size of the model and that it would at least in part, parallel the responsibilities of the Board’s Medical and Occupational Disease Policy Branch. Instead, the report recommends the creation of an ad hoc advisory committee to the WSIB Board of Directors with no staff or specific responsibilities. No comment is made on what tools or assistance the current Medical and Occupational Disease Policy staff received when they assumed the responsibilities of the previous Occupational Disease Panel when it was

dissolved almost a decade ago. The employer representatives' suggest more consultation through existing and possibly new consultative panels.

While both the Board's medical and policy branch is able to provide support to staff in adjudicating claims at the micro level, an independent body is needed. In the appeals system, both workers and employers are afforded the opportunity to continue their claim or appeal before an independent body. Why would we then not give consideration to the establishment of an independent body to deal with occupational disease issues?

Section 4(1) of the *WSIA* lists the functions of the Board. These legislated functions include the following:

1. *To promote public awareness of occupational health and safety.*
3. *To foster a commitment to occupational health and safety among employers, workers and others*
9. *To provide funding for occupational health and safety research.*<sup>17</sup>

The worker members recommend a new body similar to the ODP, but with a broader mandate to include research and education that would help the Board to meet its legislative requirements under s. 4 (1). OPSEU supports the worker members' recommendation.

**(b) Current costs to stakeholders**

The report, except when the costs of a new ODP were raised, did not examine the issue of economic impact analysis. It is expected the measures recommended in the Draft Report would not have a negative economic impact on employer premiums. However, it

must be recognized that the costs of occupational illnesses are already far too high, for workers, their families and employers. Aside from the human cost of suffering, sick workers are not at work, and if they are at work, they are very probably less productive.

Most of our members have some type of short or long term income protection plan that they can turn to when they become ill. In many cases, as we have argued above, workers and their doctors do not make the connection between the workplace and the illness. Even when workers do believe that something in the workplace has made them ill, their compensation claims are frequently denied, unless they have an illness that has previously been scheduled. In these cases, ill workers will turn to other forms of income protection.

Under short-term income protection plans, the employer absorbs the full cost of lost time wages. Long term income protection plans are administered by an insurance carrier. Similar to the trends seen in automobile and home insurance coverage, the premium costs of these plans have increased. The premiums may be paid solely by our member or the employer or shared between each party. One of the reasons for increased premiums is the increase in lost time days.

Employers are demanding concessions in the area of non-salary benefits as they cannot afford the costs of insurance plans. At the bargaining table, tough choices are made between obtaining wages and giving up income protection language.

If long term protection benefits are denied or no longer continue, workers will be forced to draw on government-sponsored plans such as employment insurance, provincial or municipal social assistance or the Canada Pension Plan. The payments from such plans, more often than not, fall below the poverty line.

OPSEU believes it is imperative that the adjudication of occupational disease claims be improved – it must be transparent, fair, and consistent, and the principles that the Chair of the Panel reiterated must be maintained. If a worker has developed an illness because of their work, they should receive compensation from WSIB, not be forced to rely on other benefits.

Additionally, workers, the Board and the public must have access to better and more, well-researched information examining the relationship between work and health. This can best be achieved by the establishment of an independent occupational disease research panel. Such a panel would not only result in better claims adjudication, but it would contribute to the body of research necessary to put proper prevention programs in place in the workplace to reduce the incidence of occupational illness.

## Endnotes

1. (1996), 140 Dominion Law Reports (4<sup>th</sup>) p. 235
2. Ibid p. 246
3. WSIB, Draft Report of the Chair of the Occupational Disease Panel by Brock Smith (Toronto: WSIB, 2004) p. 12
4. Ibid p. 13
5. Ibid p. 18
6. Ibid p. 122
7. Ibid p. 19
8. Section of Occupation Medicine, The Environment and Disease: Association or Causation? Sir Austin Bradford-Hill (London: Meeting on January 14 1965) p. 299
9. Ibid p. 300
10. Draft Report p. 24
11. Draft Report p. 125
12. Draft Report p. 28
13. (1990) , 72 Dominion Law Reports (4<sup>th</sup>) ps. 301 and 302
14. Draft Report p. 29
15. 140 Dominion Law Reports (4<sup>th</sup>) p. 246
16. Draft Report p. 29
17. Workplace Safety and Insurance Act ( Ontario: 1997) p. 25