REVIEW DECISION

Re: **Review Reference #: R0331974**
Board Decision under Review: October 31, 2024

Date: **April 14, 2025**

Review Officer: **Sarah Frost**

Introduction and Background

The employer operates a medical facility. In August 2024, the employer's electrical generator system failed during a planned power outage. On October 28, 2024, an officer of the Workers' Compensation Board ("Board"), which operates as WorkSafeBC, conducted an inspection in relation to this incident.

In an October 31, 2024 inspection report, the Board issued an order to the employer for a violation of section 21(2)(e) of the *Workers Compensation Act* ("*Act*") in relation to the above noted incident.

The employer has requested a review of the Board's order. It seeks to have the order cancelled. Two of the employer's unions are participating in this review, and one provided submissions in support of the Board's decision. In addition, the employer's submissions were sent to the Board officer who issued the order for comment. The Board officer's comments were provided to the employer with an opportunity for rebuttal, but no further submissions were received.

Section 20(3) of the *Act* gives me the authority to conduct this review. Section 339(2) of the *Act* requires me to make a decision on the merits and justice of the case, applying the policies of the Board's board of directors applicable in the case. The policies are found in the *Prevention Manual.* The standard of proof that applies to this review is the balance of probabilities.

Issue

The issue on this review is the Board's order to the employer under section 21(2)(e) of the *Act*.

Reasons and Decision

Section 84 of the *Act* gives the Board the authority to make orders for carrying out matters and things regulated, controlled or required by the *Act*. Section 84(2)(b) gives the Board the authority to make orders requiring persons to take measures to ensure compliance with the *Act* and the *Regulation.* Policy item P2-84-1, *OHS Compliance Orders,* states that when identifying violations at a workplace, the Board will ordinarily write orders.

Section 21(2)(e) of the *Act* requires employers to provide the information, instruction, training, and supervision necessary to ensure the health and safety of its workers and other workers at the worksite.

Section 21(2)(e) is a general duty section of the *Act*. Therefore, due diligence is the standard the employer must meet. Due diligence means that the employer must take all reasonable care to fulfill its obligations under section 21(2)(e). Assessing whether the employer had done so involves consideration of what a reasonable person would have done in the circumstances.

In the inspection notes in the order under review, the Board officer explained that an incident investigation had identified several issues that contributed to the failure of the electrical generator system during the scheduled power outage. He stated that:

- There were many redundant safety systems in place to prevent the generator control system from failing when the emergency system was activated. However, the power supply from the intrinsic generator batteries was either not present or insufficient.

- Control power was lost at the switchgear as a worker was replacing the batteries in the 24vdc power supply cabinets #1 and #2 during a 5-year preventive maintenance schedule.

- The Programmable Logic Controller lost power and had a fatal error.

The Board officer explained that written procedures provided a standard method for reducing errors when replacing batteries and there was variance in how different technicians performed tasks, and prevented equipment damage such as connecting wires with incorrect polarity, short circuits, or an arch flash. However, he found that there were no written procedures available to workers for replacing the batteries in 24vdc power supply cabinets #1 and #2.

Considering the above, the Board officer found that the employer did not provide workers with adequate information, instruction, and supervision when replacing the storage batteries in 24vdc power supply cabinets #1 and #2 and as a result, the emergency power generators failed. He directed the employer to immediately write procedures detailing how to replace the 24vdc batteries in power supply cabinets #1 and #2. The employer provided a new procedure to the Board on November 8, 2024.

On review, the employer seeks to have the order rescinded. It submits that it has a comprehensive Electrical Safety Program (“ESP”) providing detailed guidance for performing electrical tasks safely, and that the ESP explicitly addresses risks associated with battery replacement in the 24vdc power supply cabinets and adequately covers battery replacement tasks. The employer says that the

generator failure was the result of human error, not due to deficiencies in the ESP, and that human error is not evidence of non-compliance.

In addition, the employer submits that the worker involved in the battery replacement was a certified electrician who had undergone extensive ESP training. It says that electrical staff have continuous access to the ESP and related materials via training binders and its intranet website. The employer submits that the head electrician is appropriately licensed and completed the appropriate tasks and training. The employer further submits that an emergency power generator failure is not a violation of the *Act* and should not be considered evidence of non-compliance.

In the comments provided on review, the Board officer states that the electrical department's lack of understanding of how the backup generator's low voltage cabinets interacted with the switchgear control system directly contributed to the complete power system failure during a critical moment. He says that during his inspection, neither the director nor the supervisor responsible for the system could provide any evidence they understood the risks associated with improper battery replacement, as the electrical worker was required to change batteries in more than one cabinet. The Board officer further notes that these workers failed to recognize that even a routine procedure could, if done incorrectly, cause a catastrophic emergency power failure. In his view, this lack of awareness demonstrated a failure to ensure that personnel responsible for safety-critical systems had the necessary technical knowledge and procedural guidance from the electrical generator supplier to perform their tasks safely.

The Board officer wrote that while the employer's ESP included general written procedures for battery replacement, these generic procedures did not account for the specialized nature of the emergency power system. He said the emergency power system was integral to maintaining the health and safety for all the facility's workers and patients, making it essential that those responsible for its operation had specific, system-focused training rather than relying on generic electrical safety guidelines.

The employer's union that provided submissions also says that the order should be confirmed.

I have considered the employer's submissions. I acknowledge that a certified, trained electrician completed the work. However, it is significant to me that, as documented in the Board officer's contemporaneous notes from the inspection, the employer's electrical department director agreed that a proper, system-specific procedure would have prevented the outage and the resulting unsafe work conditions. The employer then prepared a specific, new procedure that was provided to the Board on November 8, 2024. In my view, the fact that this information was not available prior to the incident in question supports a finding that the employer did not provide the information, instruction, training, and

supervision necessary to ensure the health and safety of its workers and other workers at the worksite.

I have also considered the employer's submission that an emergency power generator failure is not a violation of the *Act* and does not establish non-compliance. While this may be the case, as outlined by the Board officer in his comments, the failure of the emergency power generator failure resulted in unsafe conditions for workers onsite, as well as patients, and that matter is relevant to this review. The unsafe conditions included no site communication, a lack of lighting, potential elevator entrapment, no CCTV, and a lack of controlled access to the premises. I find that these unsafe conditions resulted from the employer's failure to provide the information, instruction, training, and supervision necessary to ensure the health and safety of its workers and other workers at the worksite.

I further find that the employer was not duly diligent in taking all reasonable steps to prevent the violation. Specifically, given the important nature of the emergency power generator, in my view a duly diligent employer would have ensured that specific procedures and training were available to workers managing its critical infrastructure to prevent failures such as the one at issue.

After considering the requirements of the *Regulation*, the evidence, and the employer's submissions, I find that the employer was in violation of section 21(2)(e) of the *Act* and the order under review as appropriately issued by the Board. As a result, I deny the employer's request.

Conclusion

As a result of this review, I confirm the Board's October 31, 2024 decision.

Sarah Frost
Review Officer
Review Division