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2026 CanLII 123815 (BC WCAT)

DECISION OF THE WORKERS' COMPENSATION APPEAL TRIBUNAL

WCAT Decision Number:	A2502223
WCAT Decision Date:	October 27, 2026
Panel:	Monica Cameron

Introduction

[1] The worker, a sergeant/deputy sheriff/peace officer, filed a claim for compensation with the Workers' Compensation Board, operating as WorkSafeBC (Board), for symptoms in his right elbow, sharp pain down his arm and neck pain which he attributed to his work.

[2] In a decision letter dated August 12, 2024, the Board denied the worker's claim for "right elbow, bilateral wrist, and neck conditions". The Board decided the worker's conditions were not compensable as personal injuries or as occupational diseases. Therefore, the Board denied the worker's claim under both sections 134 and 136 of the *Workers Compensation Act* (Act).

[3] The worker disagreed with the Board's decision and requested a review from the Review Division at the Board. In the Review Division decision of January 9, 2025 (*Review Reference #R0326175*), a review officer confirmed that the worker did not sustain a personal injury arising out of and in the course of his employment. However, the review officer referred the matter back to the Board for further investigation into the worker's diagnosed conditions and job duties, and for a new decision on whether the worker's conditions were compensable as occupational diseases.

[4] In a decision letter dated February 24, 2025, the Board determined that the worker's bilateral carpal tunnel syndrome, right lateral epicondylitis, and myofascial neck pain were not compensable as occupational diseases under section 136 of the Act, including that the conditions were not aggravated by the nature of the worker's employment.

[5] In a September 26, 2025 Review Division decision (*Review Reference #R0335522*) which underlies this appeal, the review officer confirmed the Board's February 24, 2025 decision to deny the claim for right lateral epicondylitis, bilateral carpal tunnel syndrome, and myofascial neck pain and found the conditions were not compensable as occupational diseases.

[6] The worker, who is self-represented, appealed the September 26, 2025 Review Division decision to the Workers' Compensation Appeal Tribunal (WCAT) and sought acceptance of the claim. The worker argued that the nature of his employment duties caused his carpal tunnel syndrome, epicondylitis, and the strain to his upper extremities and neck.

Workers' Compensation Appeal Tribunal

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[7] The self-represented employer is participating in the worker's appeal. The employer argues that the appeal should be denied and the Board's and the review officer's decisions should be upheld.

Preliminary Matters

[8] In the worker's notice of appeal to WCAT, the worker also sought:

> [… F]ull coverage of medical treatment expenses, including but not limited to physiotherapy, massage therapy, occupational therapy, diagnostic testing, and specialist consultations.
>
> Approv[al] and fund[ing for] surgical or other medical interventions if recommended by treating physicians[.]
>
> [A] permanent disability evaluation (permanent functional impairment award) if [his] condition is found to have lasting effects[.]
>
> [… O]ngoing entitlement to benefits for flare-ups, recurrences, or long-term effects of these conditions[.]
>
> Reimburs[ement] for any out-of-pocket medical expenses, treatments, or supports related to these injuries that [he has] paid for personally since [his] claim was filed[.][1]

[9] As the Board and Review Division denied the worker's claim, he would have had no entitlement to health care benefits or a referral for assessment of a permanent functional impairment award.

Issue(s)

[10] The issue in this appeal is whether the worker developed or aggravated right lateral epicondylitis, bilateral carpal tunnel syndrome, and/or myofascial neck pain as occupational diseases due to the nature of his employment.

Jurisdiction

[11] This appeal was filed with WCAT under section 288(1) of the Act, which provides for the appeal of a final decision by a review officer regarding compensation matters. Section 308 of the Act gives WCAT exclusive jurisdiction to inquire into, hear, and determine all those matters and questions of fact, law, and discretion arising or required to be determined in an appeal.

[12] This is an appeal by way of rehearing, in which WCAT considers the record and also has jurisdiction to consider new evidence and to substitute its own decision for the decision under appeal. WCAT has inquiry powers, including the discretion to seek further evidence, but it is not obliged to do so. WCAT may confirm, vary, or cancel the appealed decision or order.

[1] All quotations are reproduced as written, except as noted; block capitalization removed.

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[13] Subject to section 303(5) of the Act, the standard of proof is on a balance of probabilities. Section 303(5) of the Act provides that if WCAT is hearing an appeal regarding the compensation of a worker and the evidence supporting different findings on an issue is evenly weighted, in that case the appeal tribunal must resolve that issue in a manner that favours the worker. This means the standard of proof is at least as likely as not.

[14] I am bound to apply the published policies of the board of directors of the Board, subject to the provisions of section 304 of the Act. The applicable Board policies for this appeal are set out in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II).

[15] In his notice of appeal, the worker requested the appeal proceed by way of written submissions. The WCAT *Manual of Rules of Practice and Procedure* at item 7.5 (Appeal Method) provides that WCAT will normally conduct an appeal by written submissions where the issues are largely medical, legal, or policy based, and where neither a significant issue of credibility nor significant factual issues are in dispute.

[16] The Board and review officer considered the worker's description of his employment activities along with videos of him demonstrating his employment activities. My review of the evidence and submissions indicates that there is no significant issue of credibility and there is sufficient medical and video evidence of the worker's employment activities in the appeal record. I am satisfied that any dispute about the facts can be resolved without the need for an oral hearing and I determine that there are no other compelling reasons to convene an oral hearing. The appeal involves a consideration of the medical evidence along with the facts, law, and policy. I find that the appeal may proceed by way of written submissions, as requested by the worker.

Background, Evidence, Reasons, and Findings

[17] In making my decision, I have considered the worker's evidence and submissions to the Review Division and WCAT as well as the disclosed claim file material. I do not find it necessary to repeat the entirety of the claim's history. I have referred to the evidence and submissions in my decision to the extent necessary to explain my decision.

Law and Policy

[18] Section 1 of the Act defines occupational disease to include diseases listed in Schedule 1 of the Act and any disease the Board designates or recognizes by regulation of general application or by order dealing with a specific case.

[19] Section 136 of the Act addresses occupational diseases that are due to the nature of a worker's employment duties over time. Compensation is payable if an occupational disease disables a worker from earning full wages and is due to the nature of their employment.

[20] Subsection 138(2) of the Act states that the Board may designate or recognize a disease as an occupational disease by regulation.

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[21] Policy item C4-25.00 (Occupational Disease) of the RSCM II sets out the legislative requirements for compensation for an occupational disease.

[22] Policy item C4-25.10 (Has a Designated or Recognized Occupational Disease) outlines that, to assist in adjudicating the merits of occupational disease claims, some occupational diseases may be designated or recognized by inclusion in Schedule 1, or by regulation of general application.

[23] Policy item C4-25.10 (Has a Designated or Recognized Occupational Disease) subitem D designates both carpal tunnel syndrome and epicondylopathy (lateral and medial) as occupational diseases by regulation of general application as permitted by subsection 138(2) of the Act.

[24] Myofascial pain syndrome is not listed in Schedule 1 of the Act as a recognized occupational disease, or by regulation of general application. In this case, policy item C4-25.20 (Establishing Work Causation) states that the occupational disease is due to the nature of the worker's employment if the employment was of causative significance in producing the disease.

[25] Policy item C4-25.20 (Establishing Work Causation) specifies that the Board will conduct a detailed investigation of the worker's circumstances including information about the worker, the worker's diagnosed condition, and the worker's workplace activities. The Board is seeking to gather evidence to establish whether the worker's employment was of causative significance in producing the disease. The gathering and weighing of evidence generally is covered in items C12-97.00 through C12-97.50. The Board gathers the relevant evidence and determines whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence.

[26] Policy item C4-27.00 (Activity-Related Soft Tissue Disorders (ASTD) of the Limbs) provides guidance on the adjudication of ASTDs of the limbs. The policy specifies that the employment (the employment-related exposure to risk factors) need not be the sole or even the predominant cause; the employment only needs to have been of causative significance.

[27] Policy item C4-27.00(B) (Personal Injury or Occupational Disease) states that when a claim is made by a worker diagnosed with an ASTD of the limbs with no specific trauma or penetrating wound, it will be treated as an occupational disease and adjudicated in accordance with the Board's policies on occupational diseases.

[28] Policy item C4-27.10 (Establishing Work Causation for ASTDs of the Limbs) of the RSCM II discusses risk factors for ASTDs generally. The policy states that when determining whether the worker's employment was of causative significance in causing the worker's ASTD, the Board considers a number of employment-related risk factors. While not an exhaustive list, the factors include duration, force, frequency, grip type, local contact stresses, posture, repetition, task variability, and unaccustomed activity. In relation to these factors, the policy directs the Board to consider the location of the affected part of the body; the muscles, tendons, and joints involved in the employment activities; and whether there is a biologically plausible connection between the employment activities and the development of the ASTD. The policy acknowledges that

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activities that are unaccustomed can be a risk factor. Additionally, ASTDs are often caused by exposure to a combination of risk factors, rather than just one risk factor.

[29] Policy item C4-27.30 (ASTDs Recognized by Regulation) of the RSCM II lists epicondylopathy as an occupational disease recognized by regulation of general application under subsection 138(2) of the Act. There is no presumption of work causation in this policy. Policy item C4-27.30(A) (Epicondylopathy) of the RSCM II explains that epicondylopathy can be divided into lateral epicondylopathy, which is known as tennis elbow, and medial epicondylopathy, which is known as golfer's elbow. The policy states that medical/scientific evidence on epicondylopathy does not as a whole confirm a strong association with employment activities and its mechanisms of development are obscure. The Board assesses work causation in the context of each individual case based on consideration of all relevant risk factors because medical/scientific evidence does not clearly relate epicondylopathy to any particular process or industry.

[30] The Board recognizes that where the worker was performing frequent, repetitive, forceful, and unaccustomed employment-related movements (including forceful grip) of the wrist that are reasonably capable of stressing the inflamed tissues of the arm affected by epicondylopathy, and in the absence of evidence suggesting a non-work-related cause for the worker's epicondylopathy condition, a strong likelihood of work causation will exist. These factors are not preconditions to the acceptance of a claim for epicondylopathy nor are they the only factors that may be relevant. The issue to be determined in any individual claim is whether the evidence leads to a conclusion that the epicondylopathy is due to the nature of the worker's employment.

[31] Policy item C4-27.30(B) (Carpal Tunnel Syndrome) of the RSCM II also explains that carpal tunnel syndrome is a condition caused by intermittent or continuous compression or entrapment of the median nerve as it passes through the carpal tunnel from the wrist to the hand. Increased pressure on the median nerve in the carpal tunnel can result in progressive sensory and motor disturbances in parts of the hand innervated by this nerve, leading to pain and loss of function. There are many causes of such a median nerve compression, both employment-related and non-employment. A comparison of medical/scientific evidence on carpal tunnel syndrome indicates that work activities utilizing the hand/wrist that involve high repetition associated with high force, prolonged flexed postures of the wrist, high repetition associated with cold temperatures, or the use of hand-held vibrating tools are more likely to be associated with increased risk for carpal tunnel syndrome. Non-employment-related risk factors include diseases or conditions that may contribute to reducing the size of the carpal canal including diabetes mellitus, rheumatoid arthritis, thyroid disorders, gout, ganglion formation, and other non-rheumatic inflammatory diseases.

[32] In addition to the above law and policy, I am guided by Practice Directive #C4-2 (Activity-Related Soft Tissue Disorder (ASTD) Claims). Although it is not binding on WCAT, Practice Directive #C4-2 states that when a worker was diagnosed with a condition that is recognized by regulation with no traumatic incident, the claim is adjudicated as an occupational disease under sections 136 to 138 of the Act. I find it is appropriate to be guided by this practice directive because it is consistent with the Act and Board policy.

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[33] Appendix 1 – Assessment Guidelines of Practice Directive #C4-2 lists risk factors by body part. The following are listed as wrist and elbow range of motion risk factors:

Body Part	Movement	Degrees of Movement
Wrist	Flexion	Greater than 25 from anatomical neutral
Wrist	Extension	Greater than 45 from anatomical neutral
Wrist	Ulnar Deviation	Greater than 10
Wrist	Radial Deviation	Greater than 10
Elbow	Flexion	Greater than 120

[34] The practice directive provides useful guidance but is not binding in the same way as the Board's policy; it sets out risk factors the Board considers for an ASTD and explains what is meant by the terms repetition, awkward postures, and forceful exertion for purposes of ASTD adjudication:

- Repetition means cyclical use of the same body tissues as a repeated motion/muscular effort without movement. Highly repetitive motions mean rapid steady motion/exertion with infrequent pauses and rapid steady motion or continuous exertion with difficulty keeping up. Repetition means two wrist and elbow movements per minute if working through full range of motion for greater than 2 hours, and 10 or more wrist and elbow movements per minute when working through less than a full range of motion for 2 hours or more.
- Awkward elbow postures mean flexion greater than 120 degrees, extension greater than 0 degrees, pronation greater than 80 degrees, and supination greater than 80 degrees.
- Wrist extension is in excess of 45 degrees from anatomical neutral; wrist flexion in excess of 25 degrees from anatomical neutral, wrist ulnar/radial deviation in excess of 10 degrees.
- Forceful exertion is lifting 55 pounds more than 10 times per day, 25 pounds more than 25 times per day from below knee to above shoulder or lifting at arm's length, and 10 pounds more than two times per minute for greater than 2 hours.
- Pushing/pulling 20 pounds for more than two hours for a distance of more than 60 metres, and if the load is unstable or on rough or inclined surfaces, the risk factors increase.
- Pinch gripping is two pounds or more unsupported over four hours or more. Power gripping is ten pounds or more unsupported for more than four hours a day.

[35] Policy item C4-25.20 (C ii.) (Aggravation of a Disease) of the RSCM II, provides that evidence that a pre-existing disease has been accelerated, activated, or advanced more quickly than would have occurred in the absence of the work activity may be confirmation that the aggravation resulted from the employment activity. This is distinguishable from work activities that simply produce symptoms.

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[36] The practice directive cited above also notes that when a worker feels increased symptoms from a pre-existing condition while working, but work has not significantly affected the course of the disease, an aggravation of the pre-existing condition is not accepted, and the symptoms are not compensable.

[37] On December 1, 2025, as a "housekeeping" measure, certain policies in the RSCM II were renumbered and consolidated without any change in the application of those policies. This housekeeping measure includes the policies in Chapter 12.

[38] I have also considered policy item C12-97.30 (Medical Evidence) at item B (Matter Requiring Medical Evidence) of the RSCM II, which provides that if the matter is one requiring medical expertise, the decision must be preceded by a consideration of medical evidence (this term includes medical opinion or advice).

[39] I have considered policy item C12-97.00 (Evidence-General) of the RSCM II and policy item C12-97.30 (Medical Evidence), at C (Statement of Worker about Own Condition), which provides that a statement of a worker about the worker's own condition is evidence insofar as it relates to matters that would be within the worker's knowledge, and it should not be rejected simply by reference to an assumption that it must be biased.

[40] I have also considered subitem E (Conflict of Medical Opinion), which provides that the Board must analyze the opinions and conflicts as best as possible on each issue and arrive at its own conclusions about where the weight of the evidence lies. If it is concluded that there is doubt on any issue, and that the evidence supporting different findings on an issue is evenly weighted, the Board must follow the mandate of section 339 of the Act and resolve that issue in a manner that favours the worker.

Background

[41] The worker indicated in his June 25, 2024 application for compensation that he was right-handed, 5 feet 6 inches tall, and weighed 240 pounds. He stated that he was employed with his employer as a deputy sheriff for approximately 24 years. In 2016 his position changed. He was promoted to sergeant and performed administrative and operations duties.

[42] The worker spoke with a Board adjudicator on June 27, 2024. They discussed the worker's condition and the worker explained his job duties. He also reported that beginning in May 2023 he missed six months of work due to emergency surgery. He returned to work at full duties in November 2023. The worker stated his symptoms began in June 2024 and his symptoms were aggravated when opening jail cell doors, turning door handles, and other physical movements.

[43] On the ASTD pre-site questionnaire, the Board officer documented that the worker's typical day and employment tasks consisted of the following:

- The worker began experiencing symptoms in mid-June 2024, caused by computer work and opening and closing jail cell doors.

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- He works Monday through Friday, with two weeks of work from 7 a.m. to 3 p.m. and two weeks from 10:30 a.m. to 6:30 p.m. He is entitled to two 15-minute coffee breaks and a one-hour lunch break, but he does not always take his lunch break.
- He arrives at work, gets his uniform, body armour (weighs approximately 25 pounds), pistol (which he wears on his right side), and duty belt (weighs about 25 pounds). The body armour and duty belt with the pistol weigh 50 pounds combined. He rests his right hand on the holster of his pistol frequently.
- He logs onto the computer and completes computer/administrative work for approximately one hour.
- He goes in and out of the jail throughout his shift. He signs off a logbook, confirms medication for inmates, reads notes, uses the database to read inmates' histories, briefing notes, assesses safety risks and responds to calls or safety issues. He is constantly on call for all safety issues. He also processes individuals arriving at the facility. The risk assessment process could take hours of his day.
- He spends about five hours minimum per shift at his computer, but he is frequently interrupted, about 40% of the time, so his computer work is unlikely to be cumulative, but may be one to three hours, or a few minutes before he is interrupted. He estimates that he spends approximately 60% of his time mousing and 40% typing.
- He spends the rest of his shift (approximately two hours) at the jail, where he monitors his team and the building, handles telephone calls, assists with the information technology (IT) (cameras can have outages, deals with IT), and deals with the police department (putting together paperwork for remands).
- He has to deal physically with inmates daily. He must be present when inmates are brought in. There are physical incidents with inmates, about once a week, but this is variable.
- Staff perform cell checks, but he must do quarterly checks (four times daily) and ensure that the staff are performing these checks.
- To open a jail cell, an operator releases the cell, and then he pushes or pulls the door, depending on where the door is situated, and this opens the door. The doors are metal, heavy and electronic. He must physically move them in order to open them, because the doors have a weight-bearing mechanism for safety.

[44] On June 27, 2024, the Board officer prepared a 2024 ASTD job description and risk assessment report (ASTD report) summarizing the following:

- **Force:** Constant (67% to 100%) medium to heavy (25 to 50 pounds) forces when wearing the armour and duty belt. Shoulders are constantly exposed to medium forces; however, the worker's right elbow and wrists are not exposed to these forces. Occasional (11% to 33%) heavy (100 pounds) forces when dealing with a physical inmate. Administrative tasks expose the worker's right elbow and wrists to constant (67% to 100% of the workday) sedentary (under 5 pounds) forces when mousing, typing, and completing paperwork.

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- **Posture:** The worker mouses with his right hand, and when mousing he is exposed to dynamic movements with minimal radial/ulnar deviation within normal ranges. While typing, the worker's hands and wrists are not exposed to flexion, extension, or radial/ulnar deviation. The worker may be exposed to awkward hand, wrist, and elbow postures when dealing with a physical inmate, or when opening the cell door. There are no awkward neck postures.
- **Repetition/Duration:** The worker's work is variable depending on the day and the amount of calls received. He spends the majority of his day doing administrative work, but may need to assist with a physical inmate, if called. He is frequently interrupted while doing administrative work, and has natural breaks/rest periods when he changes tasks. In one shift, he may be pulling heavy metal doors 80 to 120 times.
- **Local Mechanical Stress:** Wrists may have light contact pressure on the desk.
- **Vibration:** No vibration forces present.
- **Other Factors:** The worker has been a sergeant since 2016. He is accustomed to his tasks. He wears gloves if and when needed when dealing with inmates.

[45] In the July 4, 2024 physician's first report, Dr. Soni, a family physician, had a telephone appointment with the worker. Dr. Soni documented that the worker was complaining of right elbow pain, weak grip strength, and neck pain. He reported experiencing tingling, and numbness in his right elbow. Dr. Soni noted that the worker had right elbow pain/tennis elbow and cervical radiculopathy. Dr. Soni indicated that the worker completed administrative tasks at work and frequently used a mouse. The worker also reported that he pulled heavy electronic jail doors and wore body armour. The worker reported these symptoms/pain started a few weeks ago and he was in constant pain. Dr. Soni referred the worker for an electromyography (EMG) study to rule out nerve pathology and arranged an in-person examination following the EMG result.

[46] Dr. Soni also completed a July 4, 2024 medical note which prescribed physiotherapy. Dr. Soni stated that the worker required 20 treatments of physiotherapy because of right elbow/forearm pain that was "due to [W]ork[S]afe related injury."

[47] The worker saw Dr. Soni, in person, on July 31, 2024. In another physician's first report, Dr. Soni stated that the worker experienced elbow pain, tingling/numbness, and had neck pain with movements. Dr. Soni documented that the worker reported difficulties with pulling heavy doors and objects. Dr. Soni reported the worker's Cozen's test (a test to check for lateral epicondylitis) was positive. Dr. Soni diagnosed the worker with right elbow lateral epicondyle tenderness and myofascial pain/tennis elbow. Dr. Soni requisitioned an x-ray, suggested that the worker continue wearing a brace, use Voltaren gel and consider a steroid injection for his elbow pain.

[48] On July 31, 2024, the worker's x-ray of the cervical spine revealed there was multilevel mild disc space narrowing, suspected multilevel mild to moderate facet hypertrophy and arthropathy. The findings were noted to "likely represent multilevel mild to moderate osteoarthritic change."

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[49] In an August 1, 2024 memorandum, the Board officer stated she had consulted with a Board medical advisor (BMA), Dr. Karrel, who had reviewed the medical information and determined that the working diagnosis for the worker's right elbow symptoms was lateral epicondylitis. The officer reported the BMA's opinion as follows:

> There are limited forces and no awkward postures in desk work. When opening doors, there is initial force, however opening of doors is intermittent and brief. The MA [Board medical advisor] pointed out that when initially moving the door, it takes medium force to overcome inertia, once the door is in motion, then momentum takes over the forces needed to further push or pull are much lower than initially.
>
> Overall, there are insufficient risk factors to cause a right elbow lateral epicondylitis.

[50] In a subsequent memorandum dated August 7, 2024, the Board officer documented that she consulted with the BMA again. The BMA stated that the medical reports showed the worker had a preexisting neck osteoarthritis condition. The BMA stated the worker had no awkward neck postures at work but there were medium forces on the worker's shoulders throughout his shift. The BMA opined that there were insufficient risk factors to support that the worker had an acceleration of a preexisting condition. The BMA also noted that the worker had been wearing his body armour for two decades or more and it was inconsistent for him to be asymptomatic and then symptomatic. The BMA noted this was not "consistent with an accelerated pace of degenerative changes." Instead, the BMA attributed the worker's neck symptoms to his elevated body mass index (BMI) and his preexisting neck osteoarthritis. The BMA opined that the work duties were not a cause of his preexisting neck osteoarthritis.

[51] In addition to the above, the BMA opined that the worker had insufficient risk factors for bilateral carpal tunnel syndrome. The BMA specified the following risk factors for right carpal tunnel syndrome:

- Repetitive and sustained awkward right wrist postures.
- Sustained forceful gripping.
- Vibration/Impact tool usage.
- Heavy forces.

[52] The BMA explained that Dr. Soni's July 4 and July 31, 2024 reports indicated the worker was experiencing numbness and tingling only in the right hand. The BMA noted that there was no mention of the left hand during the history or the physical examination. The BMA concluded that the medical evidence supported the diagnosis of right carpal tunnel syndrome but not left carpal tunnel syndrome.

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[53] In the August 7, 2024 report, the employer stated that the worker was right-hand dominant and was experiencing sharp pain down his right arm, tingling, numbness and elbow pain. The employer noted the worker reported he experienced loss of grip strength and was having constant pain in his neck and arm.

[54] On August 12, 2024, the Board issued a decision denying the worker's claim for right elbow, bilateral wrist and neck injuries as a personal injury and as an occupational disease.

[55] The worker submitted to the Review Division that he disagreed with the BMA's opinion. His job duties involved frequently "lifting heavy objects, sustained periods of forceful door pulls, and carrying significant body armor […]." The body armour weighed between 15 and 30 pounds and this was combined with his duty belt that held various tools and equipment. He stated he experienced significant strains to his shoulders, neck, and back when he wore this equipment for 8 to 12 hours a day. He argued the BMA opinion overlooked the "chronic, repetitive nature of wearing such equipment and its impact on [his] musculoskeletal system." In the worker's opinion, his job duties contributed to strains of his shoulder and neck. I note here that the worker's shoulder is not before me and was not addressed in the Board decision, or the Review Division decisions under appeal.

[56] In the September 2, 2024 physician's progress report, Dr. Soni noted the worker had a telephone appointment and documented that the worker reported he was still experiencing neck pain, tingling, and numbness. Dr. Soni stated that the worker had cervical spine radiculopathy, myofascial pain, and tennis elbow. Dr. Soni suggested that the worker continue to use Voltaren gel and wear a brace, and that he may benefit from modified work.

[57] On September 10, 2024, Dr. Tanha, a neurologist, ordered that the worker complete an EMG study report due to suspected carpal tunnel syndrome. Dr. Tanha stated the EMG revealed that the worker's:

> Median distal palmar sensory latencies were prolonged bilaterally with reduced amplitude and velocity on both sides.
>
> Ulnar palmar sensory responses were normal bilaterally and comparable.

[58] The EMG report signified that the worker had bilateral distal median neuropathy. The study showed that "[t]he degree of abnormality [was] mild, approaching moderate range, on both sides" and the worker's left side was minimally more affected than his right side.

[59] Following the Board's decision, it received Dr. Tanha's September 10, 2024 consultation report. Dr. Tanha noted she had seen the worker four years ago, in 2020, for bilateral carpal tunnel syndrome when he had more symptoms on his right than the left. His symptoms improved until they began again in 2024. Currently, Dr. Tanha stated that the worker's symptoms supported a diagnosis of bilateral carpal tunnel syndrome. Dr. Tanha was unable to comment on the worker's report of tennis elbow because it was "beyond the area of [their] expertise." Dr. Tanha also noted that there was no obvious indication of myelopathy or cervical neuropathy, and that

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neuroimaging of the cervical spine was not warranted unless the worker's clinical circumstances changed.

[60] Further to the January 9, 2025 Review Division decision, the Board conducted a further investigation and in February 2025, the Board officer attended the worker's job site. The worker was present. As noted by the review officer, and as I observed from viewing the video, the Board officer's job site video showed video footage of the worker's workspace, equipment, and tools, as well as the worker demonstrating and explaining how he used his keyboard and mouse at his workstation, as well as pulling and pushing open the doors of jail cells, interview rooms, and other areas. In addition, the Board officer recorded video footage of the worker demonstrating how he ran up and down stairwells, manually unlocked doors with keys (about 200 times per shift from 2001 to 2016), and entered, sat in, and exited his work vehicle.

[61] During one portion of the video footage the worker, while holding physical keys to the jail door, demonstrated how he would open and lock the doors of the jail. He stated at the start of his career in 2001 to 2016, at different jails, they did not have electronic jail doors/keys. He referred to this as the "old school way." He estimated back in his career he would manually open/lock many doors, more than 200 times in one day.

[62] In a January 30, 2025 physician's progress report, Dr. Soni documented that the worker reported pain in the right elbow and neck. He reported experiencing numbness and tingling and had "neck pain/crunching sounds with movements." The worker reported to Dr. Soni that he had to wear heavy body armour at work, and pull/push more than other jobs. Dr. Soni recorded that the worker had cervical spine radiculopathy, myofascial pain, and tennis elbow. Dr. Soni suggested that the worker may benefit from modification at work because his work duties were causing his symptoms to worsen.

[63] In a February 4, 2025 memo and the ASTD report, the Board officer documented their observations/findings. In relation to the jail doors, the Board officer noted that there were lighter doors outside of the jail cell area. These doors required initial force to overcome inertia, but momentum then took over. However, for the doors located inside the jail area, force was needed to open the doors and this force was constant throughout the swing, because there was a degree of friction which prevented momentum from taking over. Depending on the type of door, light to medium forces were required. There were approximately 80 to 120 doors that the worker opened during a shift, with approximately 90% occurring in the jail cell area and roughly equally divided between push-pull and left- and right-handed actions.

[64] The Board officer in the memo and ASTD report identified the following risks:

- Force: Constant (67% to 100% of the workday) medium to heavy (25 to 50 pounds) forces when wearing armour and a duty belt. The worker's shoulders are constantly exposed to medium forces; however, his right elbow and wrists are not exposed to these forces. Occasional (11% to 33% of the workday) heavy (100 pounds) forces when dealing with a physical inmate. The worker's administrative tasks expose his right elbow and wrists to constant (67% to 100% of the workday) sedentary (less than 5 pounds) forces when mousing, typing, and completing paperwork.

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- Posture: The worker operates the mouse with his right hand and when mousing, he is exposed to dynamic wrist movements with minimal radial and ulnar deviation within anatomically neutral ranges. The worker may be exposed to infrequent awkward hand, wrist, and elbow postures when dealing with a physical inmate or when opening the cell door. The worker is not exposed to awkward neck postures. From 2001 to 2016, the worker's right elbow was exposed to frequent (34% to 66%) pronation and supination when unlocking/locking doors.
- Repetition and/or Duration: The worker works from 7 a.m. to 3 p.m. or from 10:30 a.m. to 3:30 p.m. He had two 15-minute coffee breaks and an hour lunch break; however, he may not always be able to take these breaks. His work is variable depending on the day and the amount of calls received. He spends most of his day doing administrative work, but may need to assist with a physical inmate, if called. He is interrupted frequently while doing administrative work and had natural breaks/rest periods when he changed tasks. In one shift, he may pull the heavy metal doors 80 to 120 times.
- Local Mechanical Stress: The worker's wrists may have light contact pressure when he rests them on the desk.
- Vibration: No vibration forces present.
- Other: The worker was well-accustomed to his work tasks because he has been a sheriff since 2000 and in his current position since 2016. When dealing with inmates, the worker wears gloves, when necessary.

[65] To aid in their decision-making, the Board officer obtained a February 20, 2025 opinion from BMA, Dr. Potiuk. After reviewing the medical evidence available at the time, the BMA stated the worker's diagnoses would be bilateral carpal tunnel syndrome, right lateral epicondylitis, and myofascial neck pain. The BMA provided a description of the three conditions. For carpal tunnel syndrome, the BMA stated the following:

> The physiopathology of CTS [carpal tunnel syndrome] is multifactorial, and the cause of CTS is not obvious in over 50% of cases; however, based on epidemiological studies, there is evidence that exposure to a combination of occupational factors including high repetition, high force, awkward wrist postures, and vibration increases the risk of CTS. The highest rates of CTS occur in occupations, with job tasks which involve high demands for intensive manual hand and wrist exertion - e.g. meatpackers, automobile assembly workers and poultry processors. And while carpal tunnel syndrome is also found in office workers, there are studies and peer review articles that have found no significant relationship between CTS and office-type or computer/keyboard work.
>
> In addition, carpal tunnel syndrome is more common in those who develop trigger digit, elbow tendinopathy, and ulnar nerve mononeuropathy at the elbow. And these associations raise the question of a congenital predisposition to musculoskeletal disorders and could suggest a non-work-related etiology, especially when occurring bilaterally. Other factors linked to carpal tunnel syndrome are age over 40, female gender, pregnancy and general medical

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> conditions like diabetes, gout, obesity, hypothyroidism, rheumatologic conditions, and collagen and blood diseases.

[66] The BMA noted that the worker's job duties that he described, and that were shown in the video, had a mixture of tasks. The BMA stated that the typing and mousing tasks used minimal force, were self-paced and had "non-awkward bilateral hand and wrist use, with the right side being used slightly more, due to mouse use with this hand. No awkward or forceful elbow, forearm, or neck use [was] required." The BMA opined that "the stress levels encountered would not be at a level that would increase the risk of developing or worsening carpal tunnel syndrome, lateral epicondylitis, myofascial pain syndrome, or a cervical radiculopathy."

[67] In terms of opening and closing the jail doors throughout his shift, the BMA stated that while there was brief stress on the worker's arms, there were opportunities to allow the "tendon/tissue rest and recovery between doors and while doing other tasks throughout the workday." The BMA opined that the worker's "arm and neck stresses encountered would not be at a level that would significantly increase the risk of developing or worsening carpal tunnel syndrome, lateral epicondylitis, myofascial pain syndrome, or a cervical radiculopathy."

[68] In terms of the worker wearing the 25-pound duty belt and 7.5-pound body armour vest, the BMA accepted that they may not be comfortable to wear, but "they would not significantly increase the risk of developing or worsening carpal tunnel syndrome, lateral epicondylitis, myofascial pain syndrome, or a cervical radiculopathy." The BMA concluded that the worker's duties did not involve significantly forceful, awkward arm or neck use and were not significantly repetitive to increase the worker's risk or worsen carpal tunnel syndrome, lateral epicondylitis, myofascial pain syndrome, or a cervical radiculopathy. Instead, the BMA proposed that the work activities were revealing symptoms but did not cause the worker's conditions.

[69] For myofascial pain, the BMA outlined that there was no support for the conclusion that either occupational activities or trauma likely caused myofascial pain. The BMA stated that some psychosocial factors have been found to contribute to symptom awareness and distress from symptoms, but "not to a material aggravation or material damage to tissues." The BMA stated that the factors were sometimes called aggravating factors "but in reality, the use of the word aggravation here is simply one implying symptom awareness and not tissue damage. These factors include stress, fatigue, and trauma[…]."

[70] On February 21, 2025, Dr. Soni submitted another physician's progress report that specified that the worker was experiencing neck pain, elbow pain, tingling, and numbness, that his mental health had worsened, and that the worker reported the pain was worse with his posture at work. This was another telephone appointment and Dr. Soni stated that the "CT [scan] does not show evidence of pain correlating with his symptoms." Dr. Soni wrote that the worker should continue his physiotherapy exercises.

[71] In an April 9, 2025 consultation report, Dr. Tanha noted she met with the worker six months prior, and at that time thought the primary problem was carpal tunnel syndrome. Dr. Tanha noted that the worker had reported minimal improvement with the use of the carpal tunnel brace and he continued to experience persistent right elbow pain. Dr. Tanha stated that the worker's

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symptoms supported a diagnosis of bilateral carpal tunnel syndrome and recommended bilateral carpal tunnel decompression surgery. Dr. Tanha also detailed that the worker's right elbow pain appeared to be due to epicondylitis, but he did not have symptoms that referred to the right ulnar nerve.

[72] Dr. Tanha documented that while the worker had some neck pain, there was "no evidence to suggest cervical radiculopathy or myelopathy based on his symptoms. Objective neurological examination [was] nonrevealing." Dr. Tanha referenced the CT scan of the cervical spine and agreed that there were mild degenerative changes. However, Dr. Tanha stated that at no level was there "any significant central canal stenosis to cause cervical myelopathy" or "any significant foraminal stenosis that could cause numbness of the hands." Dr. Tanha opined that the cervical spine was not "causing any neurological symptoms." There were no further follow-ups requested with the worker by Dr. Tanha.

[73] In his submissions to the Review Division, the worker stated he disagreed with the Board's denial of his claim, and argued he performed repetitive motions during his shifts, such as typing, mousing, and opening and closing doors. He noted that his job duties were variable and unpredictable. He stated that the cumulative demands of his position which involved repetitive gripping, pushing/pulling of doors, and the constant use of a computer mouse and keyboard were the cause of the conditions. The worker felt that the Board failed to adequately consider the impact of his job duties. In particular, he argued wearing 32 pounds in the form of a duty belt and body armour continuously strained his neck, shoulders, and wrists, and that physical force and awkward postures encountered while restraining or controlling inmates have resulted in the development of right lateral epicondylitis. The worker also disagreed with the Board officer's job site visit observations. He argued they were too brief to capture the full range of stressors that he endured over his entire shift.

[74] On review, the employer provided a submission which stated the Board officer made a well-reasoned decision in accordance with law and policy. They asked that the Board decision be confirmed.

[75] In a January 27, 2026 submission to WCAT, the worker stated that he sought acceptance of his right lateral epicondylitis, bilateral carpal tunnel syndrome, and myofascial neck pain. He detailed his disagreement with the Review Division and Board decisions. The worker argued that the Review Division applied a causation standard closer to "primary cause", repeatedly discounted the accepted occupational risk factors on the basis that they were not independently sufficient to cause disease and failed to apply section 339(3) of the Act. He stated that the "elbows, forearms, shoulders, and neck—are repeatedly loaded across different tasks" and task variability was not a protective factor.

[76] The worker also argued that his symptoms arose during his employment and worsened with continued exposure. His family doctors and specialist records associate his symptoms with the occupational activities. He asserted that the medical evidence supported that he experienced a work-related aggravation and there were no non-occupational causes shown to have caused his condition. He argued that he was entitled to the statutory benefit of the doubt and that merit and justice required that the decision be made with proper application of Board policy. He argued

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that the cumulative and combined impact of his job duties should have been looked at and not the job duties in isolation.

[77] He referenced policy item C4-25.20 and argued that WCAT had "repeatedly held that occupational disease analysis must consider total exposure over time, particularly for long-service workers." The worker argued that there was too much weight placed on the BMA's February 20, 2025 opinion which he asserted relied on general literature and not his job demands. He argued that the BMA opinion dismissed an aggravation analysis and the BMA did not conduct an in-person assessment.

[78] In terms of his right lateral epicondylitis, the worker argued that his job duties involved "repetitive gripping, pushing, pulling, and resisted arm movements throughout each shift, amplified by load-bearing equipment." He stated that those activities were "biologically plausible contributors to lateral epicondylitis, particularly when performed cumulatively over long service."

[79] In relation to bilateral carpal tunnel syndrome, the worker stated his repetitive hand movement, sustained computer use and forceful tasks were all involved in his work. He argued that just because the symptoms presented bilaterally did not exclude them from being caused by his occupation.

[80] In terms of the myofascial neck pain, the worker stated that his static postures, stress vigilance and prolonged load bearing were recognized in contributing to chronic myofascial neck pain. He argued that denying his condition was contrary to section 138(3) of the Act. The worker also cited several WCAT decisions in support of his position which I will address further below.

[81] In response to the worker's appeal submissions, the employer argued that they were not disputing that the worker may have experienced symptoms relating to his condition while performing their work duties. However, the employer stated that this factor alone was not sufficient for claim acceptance. The employer argued that there was an absence of a connection between the worker's job activities and that the years the worker performed the activities. The employer argued the condition was not directly caused by the workplace activities and they asked that the Board and Review Division decisions be upheld.

[82] On February 17, 2026, the worker provided a rebuttal to the employer's submission. The worker argued the medical evidence supported that there was a causal connection between his right lateral epicondylitis, bilateral carpal tunnel syndrome, and myofascial neck pain and the nature of his job duties. He argued that the nature, intensity, and duration of his job duties and not only his symptoms were the basis of his appeal. He stated that the employment activities were a significant cause of the development of his conditions.

Reasons and Findings

[83] For the following reasons, I deny the worker's appeal. I find that the evidence does not establish that "it is at least as likely as not" that the worker's employment was of causative significance in causing or aggravating the worker's right lateral epicondylitis, bilateral carpal tunnel syndrome, or myofascial neck pain as occupational diseases.

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[84] Before turning to the analysis of the matter before me, I note that the worker referenced several previous WCAT decisions which he argued supported his position. A previous WCAT decision is not binding upon me. The worker did not explain how these decisions were helpful in advancing his position. Nonetheless, I reviewed the referenced decisions and provide a brief analysis below.

[85] In *WCAT-2011-01565*, dated June 23, 2011, the issue under appeal was whether the film industry worker suffered an aggravation of a pre-existing psychological condition due to their accepted soft tissue injuries sustained to their back, neck, and right shoulder. I do not find the decision assistive or supportive in this case. While the decision addressed the aggravation of a pre-existing condition, the issues are not similar and the conditions are not related.

[86] In *WCAT-2013-01916,* dated July 3, 2013, a panel concluded the worker suffered from occupational noise-induced hearing loss. I find that this decision is not related to the issues in the worker's appeal.

[87] In *WCAT-2015-02989,* dated September 29, 2015, a panel addressed a request by a worker to reconsider a prior decision dated October 8, 2013 (*WCAT-2013-02786* – the original decision) on the basis that there was a jurisdictional defect. The panel declined to reconsider the original decision. The original decision found that the worker had suffered a left shoulder injury in the motor vehicle accident which had aggravated a pre-existing underlying condition in the shoulder. The panel also found the worker had not suffered a hernia or a right hip labral tear, or other injuries as a result of the motor vehicle accident. I find that this decision is not related to the worker's current circumstances.

[88] In *WCAT Decision A1701268,* a joined appeal with *WCAT Decision A1701267*, dated November 10, 2017, involved a longshoreman whose claim had already been accepted by the Board for a right chest and right thigh contusion. The Board ended the worker's temporary wage-loss benefits because they had found the worker refused suitable light duties from his employer. I find that this decision is not related to the worker's current circumstances.

[89] *WCAT Decision A1802216* joined with *WCAT decision A1801247*, dated November 15, 2018, was about a worker's entitlement to additional temporary wage-loss benefits and his entitlement to a permanent partial disability benefit. After examining the decision, I find that it is not related to the worker's current circumstances or this appeal.

[90] Despite searches of the databases, I was unable to locate decisions *WCAT-2017-01234*, *WCAT-2019-03011*, *WCAT-2021-02177*, *WCAT Decision A1401854*, *WCAT Decision A1500302,* and *WCAT Decision A1501181*. It appears this may have been incorrectly provided by the worker or have possibly been an Artificial Intelligence (AI) hallucination.[2] As noted above, the worker also did not explain how any of the cited decisions were helpful in advancing his position.

[2] *1182573 B.C. Ltd. v Gerber*, 2026 BCCA 399 (CanLII), retrieved online from: 2026 BCCA 399 (CanLII) 1*182573 B.C. Ltd. v Gerber* | CanLII

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[91] *WCAT Decision A1600743,* dated June 13, 2016, involved a border services agent who was injured during a tactical training course. The Board accepted the worker's claim for various injuries, including a concussion, cervical and lumbar strains, and a right shoulder injury. In the two decisions the worker had appealed, the Board ended the worker's payment of temporary wage-loss benefits for his concussion and lumbar strain injury. I find that this decision is not related or helpful to the worker's current circumstances.

[92] In *WCAT Decision A1601029*, dated October 3, 2016, a worker's 2014 claim was denied by the Board for a lumbar strain. The worker also obtained a separate decision on their 2013 claim which denied a reopening of the claim due to a recurrence of a prior injury. The issues before the panel were whether the worker suffered a recurrence of her 2013 lumbar strain and was entitled to reopening of that claim and whether the worker's 2014 lumbar strain arose out of and in the course of her employment. The panel denied the worker's appeal. Part of the basis in the denial was the panel stated that there was "no medical opinion which state[d] the worker's chronic low back condition was caused by her low back strain accepted on the 2013 claim. Therefore, the flare of symptoms in October 2014 cannot be a recurrence of that condition." Again, I do not find that this decision is helpful or related to the worker's circumstances.

[93] In *WCAT Decision A1700892*, dated December 18, 2017, the worker, a correctional officer, had her claim accepted by the Board for right hip and knee strains. She received temporary wage-loss benefits and health care benefits and returned to work in January 2014. The worker began experiencing pain about a year later and contacted the Board. The Board denied a right hip or right knee condition under the claim. The Board also denied a viscosupplementation injection under the claim. The panel denied the worker's appeal and determined that the worker's 2012 claim should not be reopened for her right knee and right hip complaints, and those complaints were not compensable consequences of the right knee and hip injuries that were originally accepted under the 2012 claim. They also found that a viscosupplementation injection to the worker's right hip was not a reasonably necessary treatment for her compensable right hip injury as of October 2016. I do not find that this decision is helpful or related to the worker's circumstances.

[94] *WCAT Decision A1900427*, dated February 14, 2020, involved a bakery technician who had their claim previously accepted on appeal for a low back strain. In a later June 2018 decision, the Board determined that the worker's back strain resolved and that she aggravated a pre-existing lumbar spine degeneration and chronic low back pain which both became permanent as of January 14, 2018. In subsequent decisions, the Board granted the worker a disability award payable to age 65 and determined she was not entitled to wage-loss benefits beyond January 14, 2018. The panel allowed the worker's withdrawal request. The panel also allowed the worker's appeal and found the additional medical opinion helpful in determining that the worker's back condition changed and that wage-loss benefits were payable beyond July 1, 2018. I do not find that this decision is helpful or related to the worker's circumstances.

[95] In *WCAT Decision A2000631*, dated July 15, 2020, the appeal was by an employer who disputed the acceptance of the worker's claim and sought to be relieved of a portion of the claim costs for the worker's injury on the basis that the disability was prolonged as a result of a

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pre-existing disease, condition or disability. I find that this decision is not helpful or relevant to the worker's circumstances.

[96] In *WCAT Decision A2100308*, dated May 26, 2022, the worker's claim was previously accepted by the Board for a neck strain, bilateral traumatic knee bursitis, a permanent aggravation of right knee chondromalacia, and an L4-5 disc herniation. Since the worker had not missed time from work, the claim was accepted for health care benefits only. In an August 25, 2020 decision, the Board denied acceptance of an aggravation of the worker's pre-existing neck condition, or a chronic neck pain condition under the worker's claim. The Board determined that the worker's neck complaints were more than likely related to her non-compensable pre-existing degenerative neck condition and that her compensable neck strain had resolved. As such, the worker was not entitled to further benefits associated with her resolved neck strain.

[97] In the above decision, the panel allowed the worker's appeal. The panel found that the June 2018 workplace fall activated the worker's multilevel degenerative disc disease in her cervical spine earlier than would have otherwise occurred and was compensable under section 134 of the Act. The panel also found that the worker had compensable non-specific chronic pain and that as of May 2020 physiotherapy was reasonably necessary for the worker. While this decision dealt with a pre-existing condition, and other matters, the appeal related to an aggravation of a pre-existing condition as a personal injury and not an occupational disease. I find that this decision is not helpful or relevant to the worker's circumstances.

[98] *WCAT Decision A2101124*, dated October 25, 2021, involved a worker whose claim had been accepted by the Board. The issue before the panel was whether the worker's appeal should be allowed and whether the worker was entitled to a reimbursement for a $1,200 medical report. The panel allowed the worker to withdraw the appeal and ordered that the Board reimburse the worker for the medical-legal report. I find that this decision is not helpful or relevant to the worker's circumstances.

[99] *WCAT Decision A2200471*, dated June 26, 2023, was an employer appeal. The Board accepted the worker's claim for a right knee patellar enthesopathy under section 136 of the Act. The Board officer determined that the increased and unaccustomed stair climbing and walking the worker did from August 14, 2021 through August 18, 2021 contributed to this right knee injury. The claim was approved for temporary wage-loss and health care benefits.

[100] With regard to the above appeal, the Board obtained an opinion from the BMA, Dr. Potiuk, who has a special interest in sports medicine. The BMA was asked by the Board officer about a diagnosis and causation of the worker's right knee condition. Dr. Potiuk "explained that the work activities involved use of the right knee and were capable of stressing the tendons/tissues associated with the enthesopathy condition." Dr. Potiuk noted that, normally, the stair climbing and descending activities "would not be significantly stressful to result in pathology and he also noted that, in the worker's case, there was a significant amount of time between ascending and descending the stairs where there were minimal traction stresses occurring, which would allow time for tendon rest and recovery." Nevertheless, because the worker was unaccustomed to the activity that many times in his shift, this increased. Dr. Potiuk stated that the worker's risk of developing a repetitive strain injury would have been greater due to the worker's "significantly

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elevated BMI [body mass index]." Dr. Potiuk opined that the "unaccustomed amount and frequency of ascending and descending the 60-stair flight of stairs increased the risk of the worker developing or worsening his enthesopathy."

[101] *WCAT Decision A2200471* was an employer appeal of an accepted claim and the panel upheld that the BMA "based his opinion on an accurate understanding of the relevant facts and explained the basis for the conclusions he reached." Therefore, despite the worker referencing the decision, I find that *WCAT Decision A2200471* is not helpful or supportive for the worker's circumstances. It does not provide a helpful proposition that the worker's claim should be accepted based on his circumstances.

[102] I now turn back to the analysis of the matters under dispute in this appeal.

Right lateral epicondylitis

[103] I find that the evidence does not establish that "it is at least as likely as not" that the worker's employment was of causative significance in causing or aggravating the worker's right lateral epicondylitis as an occupational disease.

[104] I find that the worker's employment did not cause the worker's right lateral epicondylitis or aggravate a pre-existing condition. The medical records do not indicate that the worker had pre-existing epicondylitis. He told his doctor at his first appointment in July 2024 that his pain/symptoms began a few weeks prior and he filed his claim in June 2024. The worker also stated in his teleclaim application, and in his conversation with the Board (as indicated in the June 27, 2024 ASTD pre-site questionnaire), that he first noticed his symptoms in June 2024. It does not appear that any of the worker's medical treatment providers suggested that the worker had a pre-existing epicondylitis condition that had become disabling.

[105] With regard to whether the worker has a compensable occupational disease under section 136 of the Act, I find the Board's February 4, 2025 memorandum and ASTD report, which documented the Board officer's observations/findings, were thorough and correctly referred to law and policy.

[106] As described above, policy item C4-27.10, section B (Analyzing Risk Factors), indicates that the Board will consider the risk factors including force, duration, frequency, grip type, repetition, awkward postures, task variability, unaccustomed activity (tissues not used to the activities performed), work cycle, and work recovery. The policy notes that these risk factors do not form an exhaustive list, and the Board may consider relevant factors not listed in its policy.

[107] As indicated above for epicondylopathy, where a worker is performing frequent, repetitive, forceful, and unaccustomed employment-related movements (including forceful grip) of the wrist that are reasonably capable of stressing the inflamed tissues of the arm affected by epicondylopathy, and in the absence of evidence suggesting a non-work-related cause for the worker's epicondylopathy condition, the Board recognizes a strong likelihood of work causation.

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[108] The worker stated he was in his position for roughly 24 years. In 2016, he was promoted to his current position. He stated that the cumulative demands of his position which involved repetitive gripping, pushing/pulling of doors, and the constant use of a computer mouse and keyboard were the cause of his conditions.

[109] I accept that the worker regularly uses his arms, elbows, and hands when he completes his job duties. While some of the tasks were repetitive, they were not repetitious to the point that he had to complete them without interruption. The worker did not report any unaccustomed work tasks. Although the worker stated that from May 2023 to November 2023 he missed six months of work due to emergency surgery, I find that the worker was accustomed to employment-related movements and job duties.

[110] The worker argued that the Board officer's job site visit observations were too brief to capture the full range of stressors that he endured over his entire shift.

[111] I place significant weight on the ASTD risk evaluation reports. I find that the Board officer's report provides objective information and clearly sets out the Board officer's observations. The Board officer considered the worker's employment activities described as opening/closing jail doors, administrative tasks, wearing the armour and a duty belt. I rely upon it and find that the report accurately captured the worker's job duties. I do not find that they were too brief and I accept the video footage of the worker demonstrating/explaining his work activities to be an accurate reflection of his work duties.

[112] In relation to the risk factor of force, the Board officer documented that the worker had constant to medium to heavy (25 to 50 pounds) forces when wearing armour and a duty belt. The worker's shoulders were constantly exposed to medium forces; however, his right elbow and wrists are not exposed to these forces. The worker had occasional exposure to heavy forces when he had to deal with an inmate physically. The worker had constant exposure to his right elbow and sedentary wrists forces when mousing, typing, and completing paperwork.

[113] In regard to the risk factor of posture, the Board officer considered that he had exposure to dynamic wrist movement with minimal radial and ulnar deviation when he operated his mouse with his right hand. He also had exposure to infrequent awkward hand, wrist, and elbow postures when opening the cell door or dealing with a physical inmate. The Board officer reported that the worker was not exposed to awkward neck postures. However, it was noted that from 2001 to 2016, his right elbow was exposed to frequent pronation and supination when unlocking/locking doors.

[114] Regarding the risk factors of repetition and duration, the worker's workday was from 7 a.m. to 3 p.m. or from 10:30 a.m. to 3:30 p.m. He had two 15-minute coffee breaks and an hour lunch break. Although he reported he was not always able to take the breaks and his work was variable. The Board officer noted that the worker spent most of his day completing administrative work, but may have to assist with an inmate, if needed. The Board officer also noted that the worker had natural breaks/rest periods when he changed tasks and that he was frequently interrupted while doing administrative work. Additionally, in one shift, he may pull the heavy metal doors 80 to 120 times.

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[115] The Board officer also noted in relation to local mechanical stress, when the worker rested his wrists on his desk, he may have light contact pressure.

[116] While the worker repeated some activities, I find the worker's elbow (and wrist) movements were not involved in highly repetitious tasks per minute for greater than two hours, or 10 or more movements per minute when he had to work through the full range of motion for two or more hours. The Board officer noted the worker had natural breaks, 15-minute coffee breaks and changed tasks frequently. Although he opened 80 to 120 jail doors, this was not done for the entirety of his workday without any opportunity for breaks.

[117] In terms of unaccustomed job duties, I considered whether there were changes in the worker's employment. While he may have advised the Board that beginning in May 2023, he missed six months of work due to emergency surgery, I note he returned to work at full duties in November 2023. The worker did not attribute his condition to an early period of time and stated his symptoms began in June 2024. The medical evidence on file also supports that the worker did not report symptoms until June 2024. I find that the worker was accustomed to his job duties and note that the Board officer also documented that the worker was accustomed to his work duties/tasks. The Board officer's report did not identify any other risk factors for his right lateral epicondylitis and this evidence weighs against a finding that the worker developed the condition due to the nature of his employment.

[118] The medical evidence also supports my conclusion, and I place weight on the February 20, 2025 BMA opinion. While the worker argued against the BMA opinion, I find that the BMA opinion was thorough and included a review of the worker's medical and claim information in relation to the risk factors. The BMA noted that the worker's job duties as described and shown in the video, had a mixture of tasks such as computer work, performing risk assessments, processing convicts, supervising, and monitoring. The BMA stated that the typing and mousing tasks required minimal force, and did not involve awkward forceful elbow, forearm, or neck use and would not be at a level that would increase the risk of developing or worsening lateral epicondylitis.

[119] The worker stated he spent a majority of time typing (about five hours), mousing, and completing administrative tasks. He stated that his job was unpredictable. He also argued in his submission on appeal that task variability did not "negate cumulative exposure where the same anatomical structures—wrists, elbows, forearms, shoulders, and neck—are repeatedly loaded across different tasks." However, I find that these self-paced activities were not over a continuous five hours of time throughout each shift, as he described. The worker noted that he was frequently interrupted during his workday. He had breaks and would complete other tasks.

[120] I find that this is a matter that does require medical expertise. The worker's report that he was frequently interrupted throughout his shift, and that his day was variable, aligns with the BMA opinion about the mixture of tasks the worker completed in a day. I do not find that it weakens the BMA opinion. The worker's position that the unpredictability of his job tasks, without more persuasive evidence or argument, is speculative in showing that his condition was caused by work.

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[121] The worker also attributed his condition to opening/closing of the jail doors. I accept the BMA's opinion that some force was required to open and close the 80 to 120 doors throughout his shift. The BMA stated that while there was brief stress on the worker's arms, there were opportunities for the worker's tendon/tissue to rest and recover between doors and throughout the workday. According to the BMA, the worker's arm and neck stress did not significantly increase his risk of developing or worsening his lateral epicondylitis condition. The BMA also did not attribute the worker wearing the 25-pound duty belt and 7.5-pound body armour vest to him developing or worsening a lateral epicondylitis condition.

[122] I find it significant that the worker stated on the job visit footage that earlier in his career he manually opened the jail doors hundreds of times. In the jail he was currently working, they used an electronic key card system. Yet, he did not attribute his symptoms to an early period of time at work. Instead, he stated his symptoms developed in his current position in mid-June 2024. I find that the use of the electronic key cards would decrease his use of his wrists and elbows when opening the jail doors.

[123] The worker argued that his medical evidence on file supported that his lateral epicondylitis condition was caused by his work duties. I reviewed the medical information on file, and I was unable to locate medical evidence which supported that his employment caused or aggravated his right lateral epicondylitis condition (or his bilateral carpal tunnel syndrome, or myofascial pain). Instead, I find the worker's family physician, Dr. Soni, and the neurologist, Dr. Tanha, recorded the worker's reported observations. I find the medical evidence of his treating professionals do not provide opinions outlining that the worker's condition was caused or aggravated by his work duties.

[124] I highlight that Dr. Soni's February 20, 2025 physician's progress report also stated that the CT scan did "not show evidence of pain correlating with his symptoms." While Dr. Tanha's consultation reports, including the April 9, 2025 consultation report, noted treatment recommendations, Dr. Tanha did not provide an opinion on the cause of the worker's symptoms and conditions or attribute them to the nature of the worker's employment. From the claim file, the worker's medical professionals were aware that the worker attributed his symptoms to repetitive gripping, pushing/pulling of doors, and the constant use of a computer mouse and keyboard, yet neither Dr. Soni nor Dr. Tanha provided opinions/reports stating that the worker's employment duties caused his right lateral epicondylitis.

[125] Thus, while I acknowledge that the worker reports he experienced pain symptoms in his right elbow, wrist, and neck, I find that the worker's job duties do not meet all or some of the applicable risk factor(s) listed above. I find that the evidence does not support that the worker's employment activities involved the worker performing frequent, repetitive, forceful and unaccustomed employment-related movements that were capable of causing epicondylopathy as described in the Board's policy.

Bilateral carpal tunnel syndrome

[126] I deny the worker's appeal. I find that the evidence does not establish that "it is at least as likely as not" that the worker's employment was of causative significance (causation or aggravation)

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of the worker's bilateral carpal tunnel syndrome as an occupational disease. I find the nature of the worker's job duties did not expose him to sufficient risk factors to cause or aggravate his carpal tunnel syndrome.

[127] Policy item C4-25.20 (Establishing Work Causation) of the RSCM II, states that for an occupational disease to be compensable under section 136 of the Act, there is a requirement that the occupational disease the worker has is "due to the nature of any employment" in which the worker was employed. The occupational disease must "disable the worker from earning full wages at the work" at which the worker was employed.

[128] Policy item C4-27.30, B (Carpal Tunnel Syndrome) of the RSCM II also explains that medical/scientific evidence on carpal tunnel syndrome indicates that work activities utilizing the hand/wrist that involve high repetition associated with high force, prolonged flexed postures of the wrist, high repetition associated with cold temperatures, or the use of hand-held vibrating tools are more likely to be associated with increased risk for carpal tunnel syndrome.

[129] The worker argued that while carpal tunnel syndrome may be multifactorial, his work required sustained computer use, forceful manual tasks and repetitive hand movements. He argued that the bilateral nature of his condition did not mean that his occupation did not cause the condition.

[130] I find that the worker's employment duties did not involve exposure to vibration, cold or extreme temperatures or handheld vibration tools. The worker was also accustomed to the work and indicated he had been in his position for approximately 24 years. The medical evidence showed that the worker previously had symptoms of carpal tunnel syndrome. Dr. Tanha's September 10, 2024 consultation report noted she met with the worker four years prior, in 2020, for symptoms of bilateral carpal tunnel syndrome. However, Dr. Tanha noted the worker reported his symptoms improved until they began again in 2024. Dr. Tanha did not attribute the worker's bilateral carpal tunnel syndrome condition to his job duties as described or opine that the worker had an aggravation, or recurrence, of his previous carpal tunnel syndrome due to his employment activities. Despite knowing the worker's prior history of carpal tunnel syndrome, Dr. Tanha did not identify what specific work activities the worker was engaged in nor outline occupational risk factors that could have led to the condition.

[131] My finding is also based on the author of the February 2025 ASTD report finding that the forces involved with the worker's administrative tasks expose his right elbow and wrists to constant (67% to 100% of the workday) sedentary (less than 5 pounds) forces when mousing, typing, and completing paperwork. He also had exposure to infrequent awkward hand, wrist, and elbow postures when opening the cell door or dealing with a physical inmate. I also find that the worker had sufficient breaks and that any repetition from the administrative task was not a risk factor in the development of the bilateral carpal tunnel syndrome.

[132] The ASTD report, and the worker's description of his workdays/job duties, support that he was interrupted frequently while doing administrative work and had natural breaks/rest periods when he changed tasks. The worker's wrists were noted to possibly have light contact pressure when he rested them on the desk. I note there were no vibration forces present with his work tasks.

Workers' Compensation Appeal Tribunal

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[133] Additionally, I rely on the February 20, 2025 BMA opinion. The BMA stated that the computer duties which involved typing and mousing tasks did not involve awkward, forceful, or significantly repetitive forceful and/or awkward arm or neck use. I accept the BMA opinion that the worker's administrative tasks were self-paced and involved minimal force and non-awkward bilateral wrist and hand use. The BMA opined that the risk of developing or worsening carpal tunnel syndrome would be unlikely based on the stress levels the worker encountered.

[134] Similar to the above, while the worker argued the medical evidence on the claim file supported that his medical professionals attributed his carpal tunnel syndrome to his job duties, I find I am unable to find sufficient persuasive medical evidence to support his position. Therefore, I rely on the BMA opinion. I find the BMA's medical opinion has considered the worker's employment tasks in consideration of the risk factors for carpal tunnel syndrome. There is no persuasive medical opinion to the contrary.

[135] After considering the evidence, I find that the nature of the worker's job did not expose him to sufficient risk factors to cause or aggravate his carpal tunnel syndrome. Therefore, I find that the worker is not entitled to have bilateral carpal tunnel syndrome accepted on his claim as either a new condition or an aggravation of a pre-existing condition.

Myofascial neck pain

[136] I find that the evidence does not establish that "it is at least as likely as not" that the nature of the worker's employment duties was of causative significance in causing or aggravating the worker's myofascial neck pain.

[137] As mentioned above, myofascial pain syndrome is not a recognized occupational disease listed in Schedule 1, or by regulation of general application.

[138] Policy item C4-25.20 (Establishing Work Causation) states that the occupational disease is due to the nature of the worker's employment if the employment was of causative significance in producing the disease. The decision on whether the disease is due to the nature of any employment in which the worker was employed is determined on the merits and justice of the claim without the benefit of any presumption. Causative significance means more than a trivial or insignificant aspect.

[139] The Board officer reported in the ASTD report that in relation to forces, the worker had constant medium to heavy (25 to 50 pounds) forces when wearing armour and a duty belt. The report showed that the worker's shoulders were constantly exposed to medium forces. The Board officer did not document that the worker's neck had any other risk factors and documented that the worker was not exposed to awkward neck postures. I accept that the worker's neck and shoulders were involved in performing his employment duties.

[140] I again rely on the BMA opinion. The BMA detailed in the February 20, 2025 opinion that myofascial pain was not always based on a diagnosis with underlying pathology, and that the syndrome was a constellation of signs and symptoms such as tenderness, stiffness, spasm, and pain. He noted that the cause of the condition was not known and the medical literature

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evidence did not support that trauma or occupational activities were the cause. The BMA stated a "material aggravation of the pathological lesion of myofascial pain is not logical." The BMA stated that the use of the word aggravation usually implies that there was some symptom awareness and was not reflective of tissue damage. The BMA stated that sometimes psychosocial factors including stress, fatigue, and trauma, contributed to the symptom awareness. After a detailed and thorough review, the BMA opined that the work activities did not cause the worker's myofascial neck pain or aggravate the condition.

[141] The worker argued that prolonged load bearing, stress, static postures, and vigilance are contributors to myofascial pain.

[142] I highlight that Dr. Soni's February 20, 2025 physician's progress report also stated that the CT scan did "not show evidence of pain correlating with his symptoms." The worker was accustomed to the job duties, had task variability throughout his day, and had natural and scheduled breaks (although he was not always able to take his breaks). I find there were insufficient risk factors in relation to myofascial pain. I have considered the reports, the worker's description of his job duties, the worker's arguments and the medical evidence. I conclude that the evidence does not support that the worker's job or his job duties involving gripping, pushing/pulling of doors, and the administrative tasks, use of a computer mouse and keyboard exposed him to sufficient risk factors to cause or aggravate myofascial neck pain. Therefore, I find that the worker is not entitled to have myofascial neck pain accepted on his claim as either a new condition or an aggravated pre-existing condition.

Conclusion

[143] I deny the worker's appeal and confirm the September 26, 2025 Review Division decision (*Review Reference #R0335522*). I find that the evidence does not establish that "it is at least as likely as not" that the nature of the worker's employment duties were of causative significance in causing or aggravating the worker's right lateral epicondylitis, bilateral carpal tunnel syndrome, or myofascial neck pain as occupational diseases. Therefore, I find the worker is not entitled to have his claim accepted for right lateral epicondylitis, bilateral carpal tunnel syndrome, or myofascial neck pain, including an aggravation of any of these conditions.

Appeal Expenses

[144] No appeal expenses were requested, and none are apparent to me. Thus, I make no orders for appeal expenses.

Monica Cameron
Vice Chair

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