Canadian Human Rights Tribunal | **Tribunal canadien des droits de la personne**

Citation: 2023 CHRT 1
Date: January 10, 2023
File No.: T2276/3118

Between:

Michael Eric Desson

Complainant

- and -

Canadian Human Rights Commission

Commission

- and -

Royal Canadian Mounted Police

Respondent

Decision

Member: Marie Langlois

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I. Decision

[1] The Tribunal dismisses the complaint of discrimination on the basis of disability of Constable Michael Eric Desson (the Complainant). The Tribunal finds that while the evidence establishes that the Complainant was treated adversely because of his disability, the RCMP justified its discriminatory actions by establishing that the standard applied to the Complainant was a *bona fide* occupational requirement.

[2] As for the Complainant's request for compensation in relation to the Respondent's alleged abusive or obstructive behaviour during the hearing, the Tribunal rejects it in the absence of a demonstration of abusive or obstructive behaviour on the part of the RCMP.

II. Overview

[3] Constable Desson was hired as a constable with the Royal Canadian Mounted Police (the Respondent) on January 28, 2008. He was posted to the Burnaby, British Columbia detachment as a constable where, after completing his training, he was able to work independently as of October 2008.

[4] On July 14, 2010, on the way to work, he suffered an epileptic seizure while driving his personal vehicle, resulting in a traffic accident.

[5] He was absent from work due to illness until his gradual return to work on November 6, 2010. At that time, he was relieved of his operational duties and assigned to administrative duties.

[6] Pursuant to a policy of the Respondent (referred to as the 5 Year Policy), he can only return to operational duties five years after the last epileptic seizure, with or without taking epilepsy-related medication. In fact, he returned to operational duties just before the end of the five-year period, in May 2015, while continuing to take medication.

[7] The period between November 2010 and May 2015 was punctuated by absences due to psychiatric illness which the Complainant assumed was related to his reaction to the 5 Year Policy preventing him from returning to operational duties prior to 2015. A subsequent

period of psychiatric leave between 2017 and 2021 is also allegedly related to the Complainant's reaction to the 5 Year Policy, he argues.

[8] The Complainant considers the 5 Year Policy to be prejudicial to him and discriminatory in that it applies to him without regard to his personal characteristics and his own specific risk of a recurrence of seizures.

[9] He argues that the policy applies to any person who has had seizure episodes regardless of whether the seizure was caused by illness or by the use of certain stimulants, as he claims was the case here. According to him, having stopped taking these stimulants after the July 2010 seizure, he would have been able to resume his operational functions within a timeframe of six months, as was recommended by his physician Dr. John Diggle, a neurologist. Since he is required to take medication to control his condition for the rest of his life, he considers the original policy on this matter to be even more unfavourable to him, even though the revised policy was actually applied to him. We will come back to this.

[10] The application of this policy also deprived him of training and career advancement opportunities, which allegedly had and is still having a significant financial impact.

[11] The RCMP argues that the Complainant has not discharged his burden of proving *prima facie* discrimination. It questions the credibility and probative value of the Complainant's testimony. It contends that the Complainant suffered no adverse effect as a result of the employer's policy. The Respondent adds that the Complainant's timeframe for returning to work is attributable to his inability to acknowledge and admit his pathological condition of epilepsy and his fear of being judged unfavourably by his peers and superiors. The Respondent also argues that the Complainant has demonstrated his perceived bias of discriminatory conduct.

[12] Alternatively, the Respondent argues that the employer's policy was applied to the Complainant in light of his particular circumstances and that it was justified by important safety considerations for the individual himself, his co-workers and the general public in light of the highly dangerous work of an RCMP officer who performs operational duties. In sum, in the RCMP's view, the 5 Year Policy is a *bona fide* occupational requirement under subsections 15(1) and 15(2) of the Act.

[13] In addition, in his written submissions, the Complainant seeks costs for abusive and obstructive behaviour on the part of the RCMP because the Respondent failed to disclose certain documents until the hearing was already underway.

III. Issues

[14] The issues are as follows:

A. Does the Complainant have one or more characteristics protected under the *Canadian Human Rights Act*, RSC 1985, c H-6 (the Act or CHRA)?

B. If so, did he experience an adverse impact with respect to his employment with the Respondent?

C. If so, were the protected characteristic or characteristics a factor in the Respondent's decision to with respect to removing the Complainant from operational duties?

D. If so, has the Respondent justified its decision under section 15 of the Act*?*

E. If not, what are the applicable remedies?

F. Has the RCMP engaged in abusive and obstructive conduct by only disclosing some documents during the course of the hearing?

G. If so, is the Complainant entitled to financial compensation?

IV. Legal Framework

[15] The Complainant alleges that he was discriminated against in employment on the basis of disability contrary to sections 7 and 10 of the Act.

[16] Disability is one of the prohibited grounds of discrimination enumerated in section 3 of the Act. It is defined in section 25 as follows:

> Disability means any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug.

[17] Paragraph 7(b) of the Act provides, among other things, that it is a discriminatory practice to differentiate adversely in the course of employment if the decision is based on a

prohibited ground or grounds of discrimination under section 3 of the Act. Section 10 makes it a discriminatory practice to deprive an individual of employment or advancement opportunities if the decision is based on a prohibited ground of discrimination under section 3 of the Act.

[18] Before addressing the issues in this case, it should be noted that the Complainant has the burden of showing that the practice to which he was subjected was, *on its face*, discriminatory (*prima facie* case). This proof is that which "covers the allegations made and which, if they are believed, is complete and sufficient to justify a verdict in the complainant's favour in the absence of an answer from the respondent-employer" (*Ont. Human Rights Commission v. Simpsons-Sears*, [1985] 2 SCR 536 at para 28 ("*Simpsons-Sears*").

[19] The case law recognizes the difficulty in proving allegations of discrimination by direct evidence given that discrimination is not a practice which one would expect to see displayed directly or overtly. The Tribunal's role, therefore, is to consider all the circumstances and to determine on a balance of probabilities whether there is discrimination or whether there is, as described in *Basi* (*Basi v. Canadian National Railway*, 1988 CanLII 108 (CHRT)), the "subtle scent of discrimination". In short, the Tribunal can draw an inference of *prima facie* discrimination when the evidence before it renders such an inference more probable than the other possible inferences or hypotheses (Beatrice Vizkelety, *Proving Discrimination in Canada* (Toronto: Carswell, 1987) at 142. See also *Khiamal v. Canada (Human Rights Commission),* 2009 FC 495 at para 60).

[20] Thus, to discharge his burden, the Complainant has to show, on a balance of probabilities (*Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Centre)*, 2015 SCC 39, at para 67 ("*Bombardier*"), that he has a characteristic protected under the Act*,* that he experienced an adverse impact with respect to his employment and that the protected characteristic (referred to as a "prohibited ground of discrimination" by the Act) was a factor in the adverse impact (*Moore v. British Columbia (Education)*, 2012 SCC 61 at para 33).

[21] In making his case, the Complainant is not required to prove that the Respondent intended to discriminate against him, given that, as the Supreme Court of Canada noted in

Bombardier, some discriminatory conduct involves multiple factors or is unconscious (*Bombardier* at paras 40, 41). Thus, the intent to discriminate should not be a governing factor. It is the result, namely the adverse effect, which is significant (*Simpsons-Sears* at paras 12, 14).

[22] In addition, it is not essential that the connection between the prohibited ground of discrimination and the impugned decision be an exclusive one, or a causal one, given that it will suffice if the prohibited ground played a role in the decisions or conduct complained of. In short, the evidence must establish that the prohibited ground of discrimination was a factor in the impugned decision (*Bombardier* at paras 45-52).

[23] Moreover, it is sufficient that the Complainant's disability was one factor in the Respondent's decision to remove him from operational duties for five years (*A.B. v. Eazy Express Inc*., 2014 CHRT 35 (CanLII) at para16).

[24] If that is the case, once this proof of *prima facie* discrimination is established, the employer could justify its decision by showing, also on a balance of probabilities, that it flows from a *bona fide* operational requirement under section 15 of the Act. The burden of proof then shifts to the employer (*Peel Law Association v Pieters*, 2013 ONCA 396 (CanLII) at para 67).

[25] Sections 15(1) and 15 (2) of the Act reads as follow:

> 15 (1) It is not discriminatory practice if
>
> (a) any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is established by an employer to be based on a *bona fide* occupational requirement.
> (b) (…)
> (c) (…)
> (d) (…)
> (e) (…)
> (f) (…)
> (g) (…)
>
> 15 (2) For any practice mentioned in paragraph (1)(a) to be considered to be based on a *bona fide* occupational requirement and for any practice mentioned in paragraph (1)(g) to be considered to have a *bona fide* justification, it must be established that accommodation of the needs of an

> individual or a class of individuals affected would impose undue hardship on the person who would have to accommodate those needs considering health, safety and cost.

[26] The Supreme Court of Canada developed a three step test to determine whether there is a *bona fide* occupational requirement in the sense of sections 15(1) and 15(2) of the Act. The test is set out in *Meiorin* [*British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, [1999] 3 S.C.R. 3, para. 54 as follows:

> 54 Having considered the various alternatives, I propose the following three-step test for determining whether a prima facie discriminatory standard is a BFOR. An employer may justify the impugned standard by establishing on the balance of probabilities:
>
> (1) that the employer adopted the standard for a purpose rationally connected to the performance of the job;
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> (2) that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
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> (3) that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.

[27] As stated in *Air Canada Pilots Association* v *Kelly*, 2011 FC 120, para 356 to 358 (*Kelly*) :

> 356 The first and second steps of the Meiorin test require an assessment of the legitimacy of the standard's general purpose, and the employer's intent in adopting it. This is to ensure that, when viewed both objectively and subjectively, the standard does not have a discriminatory foundation. The third element of the Meiorin test involves the determination of whether the standard is required to accomplish a legitimate purpose, and whether the employer can accommodate the complainant without suffering undue hardship: McGill University Health Centre v. Syndicate des employe-e-s de l'Hopital general de Montreal, 2000 (SCFP-FTQ) 2007 SCC 4, 1 S.C.R 161, at para.14.
>
> 357 As the Supreme Court of Canada observed in Hydro-Quebec v Syndicat des employe-e-s de techniques professionnelles et de bureau d'Hydro-Quebec, section locale 2000 (SCFP –FTQ), 2007 SCC 43, [2008] 2 S.C.R.

> 561, the use of the word “impossible” in connection with the third element of the Meiorin test had led to a certain amount of confusion. The Court clarified that what is required is “not proof that it is impossible to integrate an employee who does not meet a standard, but proof of undue hardship, which can take as many forms as there are circumstances”: at para.12.
>
> 358 As to the scope of the duty to accommodate, the Supreme Court stated that “The employer does not have a duty to change working conditions in a fundamental way, but does have a duty, if it can do so without undue hardship, to arrange the employee’s workplace or duties to enable the employee to do his or her work”: Hydro Quebec, at para. 16.”

[28] Further, commenting on subsection 15(2) of the *CHRA*, the Federal Court in *Kelly* stated that it should be interpreted as limiting the factors to be taken into account in an accommodation analysis to health, safety and cost.

V. Analysis

A. Does the Complainant have one or more characteristics protected under the *Canadian Human Rights Act*, RSC 1985, c H-6 (the Act or CHRA)?

[29] The Tribunal finds that there is no doubt that the Complainant has a disability within the meaning of section 3 of the Act.

[30] Indeed, the evidence on file and the testimony of the Complainant and his attending physician, Dr. Diggle, allow us to conclude that over the years, since 2005, the Complainant has suffered several episodes of epileptic seizures (grand mal seizures).

[31] In 2005, according to the notes from Dr. Diggle’s first consultation with him on July 27, 2010, his then wife noticed “a sudden onset, at night when the patient was sleeping, of stiffness of all 4 extremities, and then shaking, diffuse myalgia, petechial hemorrhage, and tongue biting”.

[32] At the hearing, Cst. Desson explained that in 2008**,** during a trip to Las Vegas for a friend’s bachelor party, he had consumed a lot of alcohol and had stayed in the sun most of the day. The friend he was sharing the hotel room with told him that he saw him having generalized convulsions, described by Dr. Singh, neurologist , in his report from February 8, 2011.

[33] Dr. Diggle indicates in his July 27, 2010 report that on May 8, 2010, another incident occurred when Cst. Desson was alone at his home. He felt “a sudden onset of anxiety, went to look out the window, and then felt “fixated” developed “tunnel vision”. His left arm started shaking, he developed ‘tunnel vision’, and he woke up, at least one hour of time has passed. He had a cut above his right eye. He did seek medical attention for stitches, but no medication were started for seizure prophylaxis.”

[34] Then came the epileptic seizure on July 14, 2010, which caused the car accident.

[35] The Tribunal’s file also contains medical certificates from Dr. Fasihy, the treating physician, after July 14, 2010 with the diagnosis of “seizures”.

[36] Paraclinical exams such as electroencephalography (EEG) were determined to be abnormal with demonstration of left anterior to mid-temporal spikes compatible with focal epilepsy. That is the diagnostic confirmed by Dr. Diggle. During the first consultation, on July 27, 2010 he wrote in his report:

> IMPRESSION
>
> Focal epilepsy, with pressured thoughts, anxiety as his aura. I suspect that the episodes of anxiety or focal seizures, and with secondary generalized tonic-clonic seizures admixed. I suspect that they are arising from the left temporal region, given the spikes on his EEG. The main differential would be a focal epilepsy from the right hemisphere, given the left arm numbness, and it is possible to have bitemporal foci, though uncommon.

[37] In light of this evidence, the Tribunal finds that the diagnosis of “focal epilepsy” constitutes a disability within the meaning of section 3 of the Act and a prohibited ground of discrimination within the meaning of sections 7 and 10 of the Act. The Complainant therefore has a protected characteristic under the Act.

[38] The answer to question A must therefore be in the affirmative. Cst. Desson has a disability under section 3 of the Act.

B. If so, did he experience an adverse impact with respect to his employment?

[39] The Tribunal is of the opinion that Cst. Desson suffered a detrimental effect in relation to his employment.

[40] Indeed, after the epileptic seizure and the car accident of July 14, 2010, as soon as the Complainant was able to return to work in November 2010, the Respondent changed his status to non-operational. He was assigned administrative duties.

[41] The Complainant testified that he could do very little or no overtime while doing administrative duties. Had he continued to perform his operational duties, his evidence is that he would have gained a substantial amount of overtime and experience that would have been very beneficial for his career advancement.

[42] The evidence also demonstrates that his base salary did not depend on whether he was on full duties in category O2, on sick leave in the category O6 or on administrative duty in the O4 category (the category system will be explained later). During the whole period of medical leave between July 2010 and May 2015 when he was back on category O2, full operational duties, he maintained the same basic pay plus progression through pay scale increments.

[43] His testimony is corroborated by his Notices of Assessment from the CRA and the pay stubs from the periods prior to and after May 2015. It is obvious that as soon as he was allowed to perform operational duties, he started to add overtime to his normal work week, sometimes as much as 20 or 25 hours extra per week, which substantially increased his remuneration.

[44] That is sufficient to conclude that the Complainant suffered a financial prejudice. The Tribunal considers that it is not necessary to discuss the other prejudices that the complainant argued, for example the missed opportunities for promotion or the important psychological effect that the 5 Year Policy had on him.

[45] The answer for question B is therefore yes, Cst. Desson suffered a detrimental effect.

[46] The Tribunal also noticed that Cst. Desson testified of his perception of discrimination all through this period of 5 years. As examples, the cause of his motor vehicle accident on July 14, 2010, i.e. epilepsy seizure, was disclosed to his colleagues and that caused him anger and humiliation. He also mentioned that a colleague asked how his head was when he came back to work in November 2010. He perceived this as humiliating that people would know that he had had a seizure. For him, it was an embarrassing personal weakness.

[47] He explained that at the police station in Burnaby, the constables who were part of the detachment but not present at the station because they were off duty sick on long term, or other reasons, had their pictures on a wall. He considered it to be the "wall of shame" and did not want to be part of it. During his testimony, he added that Sgt. Cathy Shepherd, the Career Development and Resource Advisor, during a meeting belittled him when she told him that she had lost her husband and got back to her feet, implying he should do the same. He felt again humiliated and discriminated against. He also recounted that being considered one of Sgt. Shepherd's seizure people was extremely disturbing.

[48] These perceptions were certainly felt by Cst. Desson and he had the impression that they were discriminatory comments. But the Tribunal finds that these comments were more likely than not compassionate comments and a reasonable person would have perceived them as so. As for the "wall of shame", Cst. Desson's perception might be the result of his own distorted view of colleagues that were absent from work. It is not useful at this point of the analysis to distinguish between the personal perceptions of the different people and how it affected Cst. Desson. This analysis might be relevant in the remedial stage assessing damages for pain and suffering.

C. Were the protected characteristic or characteristics a factor in the Respondent's decision with respect to removing the Complainant from operational duties?

[49] The Tribunal is of the opinion that the fact that Cst. Desson suffered epileptic seizures and has been diagnosed with Focal Epilepsy is the cause of the application of the 5 Year Policy that restrained him from operational duties for 5 years after his last epilepsy episode.

[50] There can be no doubt, then, that the policy applied to the Complainant that removed him from his operational duties caused him significant financial harm, even though he maintained his base salary throughout the period in question. Indeed, he was not given the opportunity to work overtime and be compensated accordingly.

[51] The complainant's disability is the reason why the Respondent removed him from operational duties, which caused a significant financial detriment to him. As such, there is a link between the disability and the adverse impact on the Complainant's job.

[52] The answer to question C must therefore be in the affirmative, and the Complainant must be found to have made a *prima facie* case of discrimination on the balance of probabilities.

[53] The question remains as to whether, as the RCMP contends, the decision to keep the Complainant out of operations between July 2010 and May 2015 constitutes a *bona fide* occupational requirement. This will be discussed in the next section.

D. Did the Respondent justify its decision under section 15 of the Act by establishing that the standards applicable to Cst. Desson were a *bona fide* occupational requirement?

[54] Although Cst. Desson's inability to perform operational duties is *prima facie* discriminatory, as determined in the previous section, it is not a discriminatory practice if RCMP establishes, on a balance of probabilities, that the 5 Year Policy restricting him from operational duties is a *bona fide* requirement (BFOR) within the meaning of section 15(1) and 15(2) of the *CHRA.* In order to determine if the Respondent has met its burden of proof, the Tribunal has to answer the following questions:

> Question 1: Has the 5 Year Policy been adopted for a purpose rationally connected to the performance of the job and is the policy reasonably necessary?
>
> Question 2: Has the 5 Year Policy been adopted in honest and good faith belief that it was necessary to fulfill that legitimate purpose?
>
> Question 3: Has the Complainant been accommodated to the point of undue hardship under the 5 Year Policy?

[55] Before answering the first two questions, the Tribunal deems necessary to summarize the tasks of a General Duty Constable and the Medical Profile System with the grading of the Occupational limitations.

(a) The tasks of a General Duty Constable

[56] As a constable, Cst. Desson's tasks are described in the Integrated Task Bank for General Duty Constable outlined in a document called APP II-1-6 . They include the following:

a. Pursue fleeing suspect on foot or by appropriate vehicle (task 2.11);

b. Apprehend/restrain fleeing or resistant suspects, violent or deranged persons (chase, tackle or grapple with them, handcuff them, use deadly force and draw on physical ability, vision and hearing, training, knowledge of legal limitations in use of force as well as personal judgment to apprehend the suspect by using only as much force as necessary (task 2.12);

c. Carry out enforcement patrols in problem areas (task 3.3);

d. Respond to a call by radio, telephone or in person, requesting assistance for a sick, injured or drowning person (task 4.1);

e. Respond to radio calls or citizens requesting assistance to locate a lost child, lost hunter, skier, hiker, confused or elderly person who wandered away from residence, or runaway youth (task 4.2);

f. Respond to general requests for assistance made in person or received by radio, e.g. drive intoxicated persons home, rescue stranded motorists, drawing upon knowledge for community, personal discretion and positive concern in order to provide general assistance to the community (task 5.1);

g. Enhance highway Safety by stopping or giving pursuit in a police vehicle (task 7.2);

h. Act on one's initiative or on information from dispatch and undertake to stop a motor vehicle and the vehicle fails to stop (task 7.3) ;

i. Pursue vehicle at speeds up to 240 km/hour (task 7.4);

j. If dispatch informs officer of warrant, suspension, or outstanding fine, approach driver/occupant explaining the situation, arrest, towing if driver is suspended (task 7.7)

(b) The Medical Profile System

[57] The Medical Profile System of the employer is described in the documents as :

> The medical profile system describes the member's occupational fitness or limitations in relation to his/her ability to perform the tasks that define his/her duties, in a manner that does not compromise the safety of coworkers, the public or the member.

[58] Five aspects are evaluated : Visual capacity (V); Color Vision (CV); Hearing (H); Geographic availability of health care (G); and Occupational Restrictions (O).

[59] The Occupational factor (O) describes a member's occupational capacity based on the tasks analysis for a General Duty Constable.

[60] The grading for the Occupational Restrictions is described as follow:

- 01: The member is capable of performing all the tasks of a general duty Cst. [Constable] defined in APP II-1-6 [Task Analysis for General Duty Constable] and is also capable of performing specific tasks beyond his level. (…)

- 02: (Recruit Minimum): This is the entry level for a Cst. An applicant or member must perform all the tasks of the general duty CsT outlined in App. II-1-6 in a manner that does not jeopardize his/her safety, or that of coworkers and the public.

1. An RM [Regular Member] who is 02 must be able to participate fully in an operational call out and must not suffer from any condition that carries an increased risk of sudden incapacitation.

2. For a CM [Civil Member], O2 requires that the applicant or CM not suffer from any condition that might interfere with the ability to do the job for which he/she is hired without compromising his/her safety, that of coworkers or the public.

- 03: This applies to a member or applicant for RM status who suffers from a condition that may interfere with the performance of policing duties but does not jeopardize safety

    1 The individual's limitations and restrictions must be clearly stated.

    2 The individual must not suffer from a condition that carries an increased risk of sudden incapacitation.

    3 The individual will be subject to operational call out where the defined occupational limitations and restrictions will apply.

    4 For a CM, the 03 profile describes an individual with a condition that affects ability to do the job for which he/she is hired but does not prevent him/her from doing the job and does not compromise safety.

- 04: This applies to a member or applicant for RM status who suffers from a condition incompatible with the safe performance of police work as outlined in APP II-1-6

    1 The 04 factor will be assigned to an individual at increased risk of sudden incapacitation.

2 This factor applies to an individual who suffers from a condition which may result in an occurrence that threatens his/her safety or that of a coworker or the public. Limitations and restrictions must be clearly stated so that no such threat to safety occurs.

3 An 04 individual is not subject to operational call out.

4 This factor applies to a CM who suffers from a condition which prevents the safe performance of the tasks for which he/she was engaged

- O5: This applies to an individual capable of performing only sedentary duties
- O6: This applies to an individual not considered employable by the RCMP in any capacity because of physical or mental condition.

(c) The 5 Year Policy

[61] The policy in litigation in the present case is the RCMP profile assignment for general constable who has been diagnosed as having epilepsy or who has had two or more seizures. The original 5 Year Policy states that this person will be assigned profile O4 i.e. non-operational. If the person requires medication to control the seizures, he will remain O4 for the rest of his career. If a person is off medication and seizure free for five years, profile O2 i.e. unrestricted duties may be appropriate. Therefore, according to the original written policy, a person like Cst. Desson who would require medication indefinitely (as we will see later) would have to stay on profile O4, i.e. non-operational duties, for the rest of his career.

[62] According to the testimony of Dr. Ross, Dr. Johnson, Dr. Fieschi, and Dr. Beaulieu, that will be described in more details later, a change of that original policy was discussed in 2010 and finally applied to Cst. Desson. This change permitted him to return to operational duties within the 5 year period even if he was taking medication for his epilepsy condition indefinitely. The written policy has yet to be modified accordingly.

[63] The complainant's focus and some of his actions may have been motivated by the written 1995 policy, but what applied to him was the revised policy i.e. the return to operational duties after 5 years even if the person is still taking medication.

[64] As there was never a time when Cst. Desson was barred from operational duties under the original policy but would have been able to work under the revised policy, the Tribunal will therefore concentrate most of its analysis on the revised policy

Question 1: Has the 5 Year Policy been adopted for a purpose rationally connected to the performance of the job and is the 5 Year Policy reasonably necessary?

[65] The Tribunal is of the opinion that the original and the revised 5 Year Policy has been adopted for a purpose rationally connected to the performance of the job. Further, the 5 Year Policy is reasonably necessary.

[66] In order to analyse the question, the Tribunal took into consideration the general purpose of the 5 Year Policy, the legitimacy of the general purpose or, in other words, what is it designed to achieve? The Tribunal also considered whether there was any indication that these objectives could be accomplished some other means.

(a) The Facts

[67] The employer's 5 Year Policy is a specific Policy of maintaining a police officer on administrative duties for five years in the case of an individual with epilepsy. The applicable profile is the Profile App. II-1-5 that is specific to medical conditions of the Central nervous system. That is the profile that was applied to Cst. Desson. The rationale for the profile is explained in the document as follows:

> In assigning the appropriate profiles for a neurological condition, it is necessary to determine whether the condition presents a safety risk to the member, coworkers or the public. If the condition may cause sudden incapacitation, assigning the factor is not difficult. The effect of uncontrolled affective disorders on judgment is obvious, as is the effect of paralysis. The effect of extreme cognitive impairment is apparent, but for mild impairment, the line between medical disability and performance inadequacy may be difficult.

> Some guidance in this area can be obtained from the Canadian Medical Association guide for driver examination, since driving is such an integral part of police work. Driving a police vehicle requires a class 4 license. This is not the only issue where public safety is threatened by sudden incapacitation but serves as a useful guide. A history of febrile convulsions limited to early childhood can be ignored, as can seizures attributable to a toxic illness from which the person has completely recovered. A person who has spontaneous seizures should undergo neurological investigation. If no epileptiform focus is found, the person must be seizure free, and on no drug for one year before returning to unrestricted duties. In the interim, the person will be assigned profile G2 to G4, O4.
>
> A person who has been diagnosed as having epilepsy or who had two or more seizures will be assigned profile O4. A person who requires medication to control seizures will remain O4. If a person is off medication and seizure free for five years, profile 02 may be appropriate**.** A person who has seizures only during sleep or immediately on waking for at least five years and who has at least two normal waking EEGs may be assigned profile O2 or O3. A person who has undergone surgery to prevent seizures must be seizure free and on no medication for at least five years before duty restrictions are removed.
>
> Unexplained and recurrent syncopal episodes are treated in a manner analogous to seizure disorders.
>
> (emphasis added)

[68] The 5 Year Policy (profile App. II-1 5) specifies the relation to tasks for General-Diseases of the Central Nervous System as follow:

> Diseases of the central nervous system impact on police work in a number of ways: epilepsy carries a risk of sudden incapacitation; Alzheimer's …… The impact of the disease on police work will depend on the results of the condition.
>
> For the first Seizure Epileptiform Type:
>
> Epilepsy is impossible to detect if the epileptic event is not witnessed or the person denies the condition. Nevertheless, it is associated with sudden incapacitation. The occurrence of a seizure while pursuit driving or engaged in a task critical to the public safety could be disastrous and a person with an increased probability of such an occurrence must have duties restricted in a manner that will ensure public safety. Relevant tasks include: 2.11, 2,12, 3.3, 4.1, 4.2, 5.1, 7.2, 7.4 and 7.7 [A description is at paragraph 56 of this decision]. It is important to consider not only the potential ill effects of a seizure while

> performing a task, but also the consequences of the person's sudden absence.

[69] For the second Seizure-Epileptiform Type:

> Once a person has had two spontaneous seizures, the person can be considered epileptic and must not be employed where sudden incapacitation can adversely impact public safety. If the seizure is due to some other pathology, then the permanence of the duty restrictions are determined by the curability and sequelae of the other pathology.

[70] In summary, the reason expressed in the written policy is the safety risk to the member, coworkers and the public because of the risk of sudden incapacitation associated with the disorder. The 5 Year Policy is partly inspired from the Canadian Medical Association Guide for driver examination, since driving is such an integral part of police work.

[71] The evidence also includes a document from the Canadian Council of Motor Transport Administrator (CCMTA) that includes the medical standards for drivers with different health conditions, notably seizures and epilepsy (Chapter 17).

[72] The Complainant argues that the section of the CCMTA document on commercial driving, is not relevant as the RCMP does not require a commercial driver license (taxis, limousines, ambulances) (Class 4 in British Columbia) from their constables. It requires only a non-commercial driver license (Class 5 in British Columbia).

[73] The Tribunal is of the opinion that the section on commercial driving of the CCMTA is highly relevant. Even if the RCMP does not require a Class 4 driver's license, the risk associated with the kind of driving a police officer does on a Code 3 appears closer to the risk or even higher than a commercial driver and more comparable to an ambulance driver. Indeed, the evidence shows that a police officer on a Code 3 driving task may have to pursue a fleeing suspect in a vehicle while in contact with the dispatch and trying to read a license plate or check for a criminal record meanwhile not losing the fleeing suspect for example. The pursuit is done at speeds up to 240 km/hour. The cognitive demands of a pursuit while driving are very significant and certainly completely different from non-commercial driving. Therefore, the CCMTA guidelines for commercial drivers are relevant for the present case.

[74] The Tribunal also accepted this evidence because of the reliability of the document. Indeed, the CCMTA is an organization comprising representatives of provincial, territorial and federal governments of Canada, which, through the collective consultative process, makes decisions on administration and operational matters dealing with licensing, registration and control of motor vehicle transportation and highway safety.

[75] In Chapter 17, it explains seizure and epilepsy, its prevalence, the adverse driving outcomes, its effect on functional ability to drive, compensation and a guideline for assessment.

[76] It states that:

> The primary consideration for drivers with epilepsy is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving.
>
> (emphasis added)

[77] It adds that:

> The estimated risk of a recurrence after an initial unprovoked seizure ranges from 2.3% to 71% with an average risk recurrence for adults being 43%. If the cause of the seizure is unknown and the individual's EEG is normal, the risk of recurrence is reduced. Individuals who experience a partial seizure and have an abnormal EEG or other neurological abnormality, have an increased risk of seizure recurrence. A family history of epilepsy also increases the risk of recurrence.

[78] The CCMTA adds that the general approach of the guideline for drivers with epilepsy or who experience seizures is that "seizures must be controlled as a prerequisite for driving." Most of the guidelines include a requirement for a seizure-free period. The purpose of this requirement for an unprovoked seizure is "to allow time to assess the cause, and where epilepsy is diagnosed, to establish the likelihood that a therapeutic drug level has been achieved and maintained, the drug being used will prevent further seizures, and there are no side effects that may affect the driver's ability to drive safely." (emphasis added)

[79] For a commercial driver that has epilepsy, the CCMTA states that they are eligible for a licence if they have not had a seizure with or without medication for 5 years and the

conditions for maintaining a licence are met (i.e. routinely follow treatment regime and the physician's advice regarding prevention of seizures and if they cease driving and report to the authority and physician if a seizure occurs).

[80] For a non-commercial driver with epilepsy, eligibility for a licence is acquired 6 months after the seizure occurred with or without medication and if the conditions for maintaining a licence are met as for the commercial drivers.

[81] If the medication changed, the commercial driver is eligible for a licence if it had been 6 months since the prescribed change or withdrawal and they have not had a seizure during this time and if the conditions for maintaining a licence are met. For the non-commercial drivers, in the same conditions, the period is 3 months.

[82] Doctor Naomi Ross, occupied the function of Health Service Officer (HSO), occupational specialist, for the RCMP full-time at the pertinent time of the complaint. Her role was to assess member's fitness for duties, disability case management and regular health assessment for members of the British Columbia region. She testified at the hearing. She referred to an email sent on December 11, 2013 to Jeff Hurry the officer in charge of the Health Services of the RCMP and to Patti Parker, occupational health nurse, saying that the 5 Year Policy applicable to Cst. Desson was consistent with safety sensitive industry occupational guidelines for driving.

[83] She specified that the RCMP 5 Year Policy was adopted in 1995 and she learned in December 2010, after talking to Dr. Beaulieu, neurologist specialized in epilepsy and National Health Advisor for the RCMP, that the policy was in the process of being reviewed and the restriction of being off medication before returning to operational duties was to be removed and replaced by "being on or off medication". She added that the 5 Year Policy was aligned with the Canadian Medical Association Guidelines for Determining Fitness to Operate Vehicles (CMA), that were rather recent as they have been adopted in 2009. She added that the 5 Year Policy was also similar to the Canadian Railway Medical Rules Handbook and the American College of Occupational and Environmental Medicine Law Enforcement Officers Guide (ACOEM).

[84] She identified the risk of sudden incapacitation for a police officer and gave an example that the member can hurt himself, if he is alone in a confrontation with a violent offender, he can get hurt and his colleagues could be put in a situation where they would have to decide to look after their incapacitated colleague or attend the critical situation and protect the public. It could lead to catastrophic results.

[85] Dr. Ross added that commercial driving is a high risk activity, the risk being similar to a police officer Code 3 driving (driving at high speed with the siren on) therefore the comparison with the CMA guidelines for determining fitness to operate vehicles is accurate.

[86] Commenting on Doctor Diggle's report from July 27, 2010 on the seizure prophylaxis of a 98% chance to have a recurrence of seizure without medication considering that Cst. Desson had had 4 seizures in the past, she commented that RCMP tolerated a 1% risk of sudden incapacitation that comes after 5 years without any recurrence of seizures. The fact that Cst. Desson had an abnormal EEG confirming the diagnostic of epilepsy increased the risk of recurrence. She recommended that Cst. Desson was put on the O4 Profile (administrative duties).

[87] Dr. Ross added that if an individual were operational and had to change his medication, then he would be restricted from operational duties for a period of 6 months following the change in medication. She added that it was the same rule from the CMA guides, the Canadian Railway Workers medical rules and the American College of Occupational and Environmental Medicine Law Enforcement Officers medical guides(ACOEM).

[88] Doctor Krista Johnson, was also a Health Service Officer with the RCMP Health Service during the pertinent time of the complaint. She was in charge of Cst. Desson's case for a period of May 2011 to September 2012, after which, Dr. Ross again became the responsible HSO for his dossier. Her role amongst others would be to determine the fitness for work for police officers at the RCMP. At the hearing, she stated that the risk of seizure for a person suffering epilepsy was higher in the first 5 years after the seizure. She added that Cst. Desson had stopped taking his medication and the period of 5 years away from operational duties would restart thus the end of the 5 year period would now be on June 27,

2017. The discontinuance of the medication would have the effect that the period of 5 years would restart. She explained that the stop of medication worsened the risk of recurrence of seizures.

[89] Doctor Isabelle Fieschi was, as Dr. Ross and Dr. Johnson, an HSO at RCMP. She was involved in Mr. Desson's case in 2014 and 2015. She testified that when determining an occupational status, the risk of an inadequate response to an emergency situation is taken into account. A seizure can cause a loss of consciousness and can be potentially very dangerous. The postictal confusion following the seizure and the impairment could impact the safe performance of the police officer's duty. She adds that data shows that the risk of recurrence gradually declines with time. After 5 years, the risk is reduced to an acceptable level, as it would be for a person who never had epilepsy. According to her understanding, the change of medication would be followed by a period of 6 months without operational duties. Contrary to Dr. Johnson's testimony, she testified that it may prolong the clock, but does not restart it. Therefore, the period of 5 years would not restart after a change of medication. In fact, Cst. Desson's period of 5 years did not restart after he had stopped taking his medication for a period of time.

[90] Dr. Marc-André Beaulieu is a neurologist with a subspecialty of epilepsy. At the relevant time of the complaint, he was the National Health Advisor for the RCMP. He testified at the hearing that the rationale for restricting the police officer who had 2 or more seizures from operational duties for a period of 5 years is the risk of sudden incapacitation and postictal confusion provoked by the disease and the fact that the police officer has a safety-critical job. He explains the danger of having a seizure while driving, especially for a police officer. In a pursuit or on Code 3 driving, a seizure could have dramatic effects. He adds that a police officer who would become incapacitated during a physical altercation with a suspect in the midst of doing an arrest could also be catastrophic for the officer and the public. Also, there is a serious safety consideration of carrying a firearm and being incapacitated. He adds that not only the incapacitation stage is critical, but the postictal stage when the person is totally confused could have very dramatic effect. He adds also that police officers need to be pretty sharp in what they do because they have major decisions to make in a very short time. They can be flight or fight-type decisions, critical decisions.

[91] Dr. Beaulieu explained that the risk of sudden incapacitation diminishes with time if the individual does not suffer more seizures. After one year, for a person who had 2 or more seizures, the risk of having another one is 73%, after the third year, it drops to 8%, after the fourth it is 5% and the fifth year, it drops again to 3% and at the beginning of the sixth year, it is 2% or 1%. Therefore, after 5 years seizure free, for an individual who had not suffered another seizure, with or without medication, the risk of recurring seizures is reduced to an acceptable level of 2% to 1%. The original 5 Year Policy would permit an individual with epilepsy to go back to operational duties after 5 years without new seizures if he did not need medication. If medication was needed, the person would remain on administrative duties for the rest of their career. This aspect of the policy was changed in the course of 2010-2011 to allow a person who was taking medication to return to operational duties after 5 years.

[92] Dr. Beaulieu explained that the RCMP adopted the 5 Year Policy and revised it after reviewing other policies. He added that the RCMP, being a policing organization, does not have the resources to redo the work that the main regulators do, so RCMP looked at other policies as best practices. It took into consideration the policy of the Canadian Medical Association and other safety-sensitive industry regulators, such as CCMTA which requires commercial drivers diagnosed with epilepsy to be seizure free for 5 years with or without medication before returning to commercial driving. He added that they also looked at other groups like the Canadian National Railway driving guidelines. Dr. Beaulieu also noted that other policing agencies, such as the Ontario Provincial Police, had a similar 5 Year Policy. He added that in other jurisdiction like Australia, United Kingdom, United States and Europe, the benchmark for returning to commercial driving was 10 years, some allowing drivers to be on or off medication while others required drivers to be off medication.

[93] Dr. John Diggle is a neurologist with a subspecialty in epilepsy and the treating physician of Cst. Desson for the period of 2010 to 2016. He wrote in his July 27, 2010 report that Cst. Desson had 4 seizures in the past and he had a risk of recurrence seizure of 98%, therefore, he prescribed an anticonvulsive medication Tegretol.

[94] He testified through an affidavit and cross-examination at the hearing. He explained the 98% risk of further seizures as follows:

> This is based on well known aggregate data from medical literature which provides statistics on the rate of recurrent seizures in individuals with epilepsy diagnosis. Other neurologists aware of this medical data may conclude the risk as high as 100% or as low as 90%. The same medical data informed my conclusion that Mr. Desson had an 85% chance of achieving "seizure freedom" or no further seizure- by taking a single anticonvulsant medication indefinitely.

[95] He added "The medical data has established that approximately 15% of patients like Cst. Desson with epilepsy will have a further seizure even when following a single medication". In the course of his cross-examination, he explained that this would be called a breakthrough seizure, i.e. a seizure that would happen as the patient is under medication care. Certain patients will need 2 different medications while some others will need a third medication and "a small percentage of patients with epilepsy will not achieve seizure freedom in their lifetime, regardless of the medication regime they follow."

[96] Dr. Diggle indicated that "the risk of recurrence cannot be individualized and is generalized for all patients who receive a diagnosis of epilepsy. Only the passage of time without a recurrent seizure will reveal how and when a patient achieves seizure freedom and whether, ultimately, that patient will fall into the category of 85% of patients on a single medication without further seizure or the category of 15% of patients who will experience further seizures". His perspective was mostly on a clinical level i.e. deciding if one or two or three medications were necessary to help avoid a recurrent seizure episode.

[97] He explained:

> The risk of seizure recurrence in patients with epilepsy like Mr. Desson is front-loaded. As time passes without a further seizure, the patient's risk of recurrence diminishes. At the time, given Mr. Desson's circumstances, medical profile and my knowledge of statistics in the medical literature, I would have considered the risk of Mr. Desson having a breakthrough seizure after 3-5 years seizure-free on medication as very small.

[98] During his testimony, he explained the front-loaded risk of epilepsy, specifying that the risk of a recurrence is highest in the first six months. Then there is an exponential decline in somebody's lifetime risk that gets less and less and less over somebody's lifetime. So the longer that somebody is seizure free, the less likely they are to have a breakthrough seizure.

On medication people have a very small risk of recurrence at three years and five years if they've sustained seizure freedom over that time.

[99] Dr. Diggle also explained that it is common for individuals with epilepsy to suffer from postictal confusion and disorientation shortly after suffering a seizure and may also suffer temporary cognitive defects for a period of time (hours or even days) such as poor attention, poor concentration, poor short-term memory and retrograde amnesia in relation to a period of time (hours or rarely up to a day or more).

[100] Dr. Diggle did not comment on the 5 Year Policy, saying that he is not in a position to agree or support or negate or refute an internal guideline. He said that if it were an airplane pilot who has had a seizure, it would be for the Federal Aviation Administration (FAA) to know what the specific risk tolerance is. It is the same thing with the RCMP Policy.

[101] Cst. Desson admitted that as a police officer, a sudden incapacitation was a safety risk as amongst other things, there was a risk of being disarmed. He also explained that a Code 3 driving means to drive with the siren on, not obeying the rules of the road, driving over the speed limit, and at the same time, driving defensively and radioing the dispatch, reading the license plate, asking the dispatch for a criminal record, etc. At that time, the stress level of the police officer is quite high. It was his opinion that it is different and more risky than driving a commercial or private vehicle.

[102] He also testified that he did some research on his own to discover that the Edmonton Police policy for officers that had seizure would be a restriction from operational duties for a period of 10 years seizure free and 5 years without medication. The Toronto Police would be 5 years with or without medication.

(b) The Analysis

[103] Firstly, the Tribunal is satisfied that the evidence demonstrates that the police officer's job is a safety sensitive job. The role of a police officer as described in the Integrated Task Bank for General Duty Constable is essentially to protect the public. As seen before, an officer could pursue, apprehend and restrain fleeing or resistant suspects, violent or deranged persons; carry out enforcement patrols in problem areas; give assistance for a

sick, injured or drowning person; locate a lost, confused or runaway person; respond to general requests for assistance; enhance highway safety by stopping or giving pursuit and proceed to arrest a suspect.

[104] These specific tasks demonstrate the very safety sensitive nature of a police officer's job.

[105] Secondly, the Tribunal accepts, given the evidence, that the 5 Year policy is rationally connected to its goal of safety for the member, the co-workers and the public. Indeed, the risk of incapacitation and the postictal state after the seizure due to epilepsy is well demonstrated by the testimonies of two neurologists, specialized in epilepsy, Dr. Diggle and Dr. Beaulieu and by Dr. Ross, Dr. Johnson and Dr. Fieschi, HSO at RCMP. The CCMTA document, also explains the risk of sudden incapacitation due to epilepsy while driving, which is an important part of a police officer's job in the RCMP.

[106] Even Mr. Desson admitted that sudden incapacitation, during for example a fight with a suspect, could be extremely dangerous for the member, his coworkers and the public.

[107] The Tribunal considers probative the fact that, as established in the CCMTA document, seizures must be controlled as a prerequisite for restarting driving after a seizure. In order to achieve this goal, a seizure-free period is needed.

[108] The duration of 5 years during which a police officer is restricted to administrative duties is also related to the performance of the job, as the risk diminishes with time and the absence of new seizures and the compliance of the patient to his doctor's advice on medication. For an epileptic, after a seizure, the evidence shows that the risk of a recurrence diminishes to 15% if the patient is compliant with his medication and goes down to 3% or 2% after 3 to 5 years or even to 1% after 5 years.

[109] Doctors Ross, Johnson, Fieschi, Diggle and Beaulieu all share the same opinion on that subject, a 1% risk occurs after 5 years.

[110] The RCMP has chosen to accept a risk of 1%. This decision is compatible with other jurisdictions that have adopted similar policies for the same purpose, some being even more restrictive and prolongating the period to 10 years.

[111] This evidence supports that the 5 Year Policy is rationally connected to the safety sensitive nature of policing work.

[112] The Tribunal adds that no contradictory evidence to suggest that the probability of a recurring seizure decreased to 1% before the 5 years mark. Moreover, there was no evidence that a 1% risk of reoccurrence was an unreasonably low threshold for the RCMP to adopt.

[113] The Tribunal also considers that the 5 Year Policy is reasonably necessary for the performance of the job. The same evidence of safety risks demonstrates that the 5 Year Policy is rationally connected to the performance of the job also demonstrates that the 5 Year Policy is reasonably necessary to maintain appropriate safety standards for RCMP officers. The evidence demonstrates that an officer experiencing a seizure during their job would be a real risk to the officer, the public and their colleagues.

[114] The 5 Year Policy only restricts operational duty when this risk is above a certain threshold, which is about 1%. The Tribunal accepts that the RCMP is entitled to choose a reasonable level of risk that it is willing to accept and that this level is reasonable given the potential for very significant consequences if a seizure occurs in many operational settings. The 5 Year Policy is specifically tailored to this risk by tailoring the restrictions to individual circumstances, as medical knowledge allows. It does this by limiting the 5 year restriction to individuals whose seizures do not have a trigger that indicates that they are unlikely to reoccur. Further, the 5 year restriction cannot be further tailored to an individual officer's risk as there was no evidence presented that an individual officer can be accurately assessed to determine if they have a lower risk of a recurrence.

[115] Nonetheless, the evidence also demonstrates that the 5 Year Policy was applied flexibly to consider individual circumstances. Despite a lack of amendment to the original written policy, the medical experts applying the policy accepted that 5 years seizure free would be sufficient even if the officer was on medications to control seizures during that time. Further, as will be seen, Cst. Desson was ultimately individually assessed and allowed to return to full operational status slightly before 5 years had passed. As also seen in Dr. Fieschi's December 29, 2014 note commenting on the possibility of a return to full

operational status after three years and from the February 13, 2014 HSO Panel review, the policy allowed the RCMP to consider the officer's individual medical circumstances rather than rely exclusively on the policy.

[116] The 5 Year Policy is reasonably necessary because it is necessary to manage the severe safety risk of an officer becoming incapacitated from a seizure during operational work. It does this in a manner that accounts for an individual officer's circumstances and limits operational activities as little as possible given that it allows an individualized application of an officer's specific medical circumstances.

[117] Thus, the Tribunal answers yes to the first question and concludes that the Respondent adopted the 5 Year Policy for a purpose rationally connected to the performance of the job and that the 5 Year Policy is reasonably necessary.

Question 2: Has the 5 Year Policy been adopted in an honest and good faith belief that it was necessary to fulfill that legitimate purpose?

[118] The Tribunal is of the opinion that the 5 Year Policy has been adopted in an honest and good faith belief that it was necessary to fulfill its legitimate purpose.

[119] In order to answer this question, the Tribunal must consider whether the 5 year Policy was adopted by the RCMP for a discriminatory ulterior motive. This addresses the subjective element of the test.

[120] As the Supreme Court of Canada has enunciated in *Meiorin* [para 60-61], even if the general purpose is rationally connected to the performance of the job as we saw in the previous section, here we have to verify if the reasoning has some connection with targeting epileptic persons, or even Cst. Desson himself, or other people with similar characteristics.

[121] The original 5 Year Policy was adopted in 1995, a long time before Cst. Desson joined the RCMP and the revised policy was to Cst. Desson's advantage as it allowed him to come back to operative duties. Therefore, the Policy could not have been adopted to target Cst. Desson.

[122] The 5 Year Policy is similar to many policies in a safety sensitive industries. Indeed, the evidence demonstrates that there is a broad consensus across similar industries that the risk of subsequent seizures is sufficiently serious that it requires managing. No evidence was provided of any reasons for these policies not related to the job.

[123] The question is whether the RCMP adopted the standard in good faith. Here again, there can be no doubt that the RCMP satisfied the requirement. No one suggested that the RCMP had any motive for the standard it chose other than to maintain safety in the police force.

[124] The complainant argues that Dr. Ross did not approve of the 5 Year Policy as she was of the opinion that he could return to operational duties in January 2011 with the exception of operational driving. According to his view, she demonstrated bad faith when she informed him that he had to be off of all operational duties for a period of 5 years.

[125] The Tribunal is of the opinion that the reason for Dr. Ross's mistake was her lack of knowledge of the 5 Year Policy in 2010 and it does not constitute evidence of bad faith from the RCMP towards Cst. Desson. The Tribunal concludes that no evidence was provided to demonstrate that the original or the revised Policy was adopted in bad faith, in order to exclude people suffering from epilepsy, or Cst. Desson directly or arbitrarily from his operational job.

[126] On the contrary, the evidence shows good faith and necessary to fulfill the legitimate security purpose. Indeed, the reasons for adopting the 5 Year Policy relates to the real risk of sudden incapacitation and postictal confusion that come from epilepsy for the reasons security of the member, the coworkers and the public.

[127] The Tribunal concludes that the 5 Year Policy has been adopted in an honest and good faith belief that it was necessary to fulfill the legitimate purpose to protect the safety of the member, his coworkers and the public. The Tribunal answer yes to the question 2.

Question 3: Has the Complainant been accommodated to the point of undue hardship under the 5 Year Policy?

[128] The Tribunal finds that the RCMP accommodated Cst. Desson to the point of undue hardship.

[129] As mentioned before, the 5 Year Policy that applied to Cst. Desson was the revised 5 Year Policy allowing him to return to operational duties after 5 years without a seizure, even if he was taking medication indefinitely.

[130] Between July 14, 2010 and May 6, 2015, Cst. Desson was put in in category O6, complete medical leave, and in the O4 category, when he was able to perform administrative tasks, as follow:

- July 14, 2010 to November 2010: category O6, complete medical leave;
- November 2010 to January 2011: category O4, administrative duties;
- January 2011 to February 2013: category O6, complete medical leave;
- February 2013 to May 2015: category O4, administrative duties;
- From May 6, 2015: category O2, all tasks including operational duties.

[131] The complainant is of the opinion that when he was given administrative duties during the period of November 2010 and January 2011, he was not given any significant work that could help him in the **development** of his career. He believes that the respondent did not make sufficient efforts to support and accommodate him. He maintains that the Respondent applied the 5 Year Policy in a blanket fashion without taking into account his personal situation, the recommendation from Dr Fasihy and Dr Diggle, and the fact that his seizures were triggered by his use of ephedra, dieting, lack of sleep or overexercising.

[132] He is also pleading that between January 2011 and February 2013, he was on complete medical leave because of a psychiatric condition that he attributes to being informed of the 5 Year Policy. He added that during that period, the RCMP should have put him back on operational duties, which would have reduced his medical absence due to a mental health situation.

July 2010 to January 2011

(a) The Facts

[133] As seen earlier, on July 14, 2010, Cst. Desson had a seizure while driving his personal car to work. He was not wearing his uniform, but carried his service firearm, rounds of ammunition and handcuffs. He hit a cement rail and the car stopped without hitting anything else or hurting anybody. A bystander witnessed that accident and went to the vehicle to provide help. He noticed that Cst. Desson was shaking uncontrollably. An ambulance was called and Cst. Desson was brought to the hospital.

[134] The ambulance report stated that the RCMP was on the scene and took the weapon and handcuffs from the complainant. It reported that the complainant was driving on the highway and had a minor motor vehicle accident due to a seizure. "Pt [patient] stated before getting on the Hwy [highway] he had an anxiety attack, L [left] hand had gone numb. Pt stated I should have pulled over". The diagnostic is identified as Seizure-Postictal [altered state of consciousness after an epileptic seizure].

[135] Cst. Desson testified that on his way to the hospital he realized that he was going to be late for work and informed his college Justin Guiel by text message. When waiting at the emergency room at the hospital, Corporal Fluegal (Operations officer) and Corporal Stephane Hamel (District manager) showed up. He confided in Corporal Hamel, that he had had convulsions episodes in the past (a few months before when he was at home and also 5 years earlier and, at that time, his driving license was removed for 3 months).

[136] The emergency room treatment assessment specified that Cst. Desson had no recollection of the seizure and post seizure, and he had postictal confusion. The seizure lasted approximately 20 minutes. The emergency room doctor urgently referred Cst. Desson to a neurologist. He wrote "Thank you for seeing this 39 years old male police officer urgently who has had 2 seizures in 2 months, once while driving." The doctor added that the CT scan of the head was normal. In fact the CT scan showed no acute intracranial abnormality. Cst. Desson was released from the hospital.

[137] That night, he was informed that Sargent Rob Lemon disclosed to the night shift crew what had happened to him, i.e. the seizure and motor vehicle accident. Cst. Desson testified that he was super angry that this information was now known to his colleagues. He was embarrassed for having had a seizure that had caused an accident. He was afraid to be judged by his coworkers. He did not want anybody to know.

[138] On July 16, 2010, Cst. Desson was informed by Dr. Ross during a telephone call that he cannot do operational driving for 12 months and cannot do administrative driving for 3 months. She informed his managers (Jane Baptista and Walt Sutherland) that his medical profile was updated to O4 with duties solely in law-enforcement support or administration, not subjected to mobilization call out until July 12, 2011 and no administrative driving until a review on October 13, 2010.

[139] An electroencephalogram (EEG) was performed on July 27, 2010. It was considered abnormal with “spikes arising from the left temporal lobe suggesting a focal predisposition towards seizures arising from left temporal lobe”.

[140] On July 27, 2010, the complainant’s family doctor, Dr. Ellie Fasihy, declared him unfit for duty until July 30, 2011.

[141] After reviewing the EEG report, on July 27, 2010, Doctor John Diggle, neurologist, examined Mr. Desson. At the hearing, and via an affidavit he specified that he got the medical history information directly from Cst. Desson and did not have access to previous medical records. The neurologist noted in his July 27, 2010 report that Cst. Desson had recurrent seizures over his lifetime. The first one occurred in 2005 in Ontario. The doctor qualified the episode as a “grand mal seizure”. His then wife described “a sudden onset, at night when the patient was sleeping, of stiffness of all 4 extremities, and then shaking, diffuse myalgia, petechial hemorrhage, and tongue biting”. He may have had another one in 2007, but never sought medical attention. Another one occurred on May 8, 2010 but no medical attention was provided for the seizure. At that date, “He felt a sudden unset of anxiety, went to look out the window, and then felt “fixated” developed “tunnel vision”. His LEFT arm started shaking, he developed tunnel vision, and he woke up, at least one hour of time had

passed. He had a cut above his right eye. He did seek medical attention for stitches, but no medications were started for seizure prophylaxis."

[142] In his affidavit, Dr. Diggle specified that he made the diagnostic of focal epilepsy based on the results of the July 27, 2010 EEG (abnormal and indicative of epileptiform activity); the ambulance report and the emergency room report showing post seizure states; the history of four seizures in the previous 5 years; and the description of the symptoms he experienced or that were witnessed at the onset of his seizures. He added that Cst. Desson suffered from clear postictal confusion. He explained that it is common for individuals with epilepsy to suffer from confusion and disorientation shortly after suffering a seizure. This means a patient may be conscious and in control of their bodily functions but may not be appropriately oriented to their surroundings. Following a seizure, an individual may suffer temporary cognitive defects for a period of time (hours or even days) such as poor attention, poor concentration, poor short-term memory and retrograde amnesia in relation to the period of time (hours or rarely up to a day or more) prior to the seizure.

[143] Dr. Diggle described the July 14, 2010 seizure event when Cst. Desson was driving:

> Again, he felt a sudden rush of anxiety, developed a significant tunnel vision and weird, racing thoughts, like pressure of his thoughts. His left arm went numb and then he developed loss of consciousness. The next thing he knew, ambulance attendants, and RCMP were around him; he had bit his tongue in the right rear. He did not lose control of his bladder. He was diffusely myalgic, confused, and disoriented.

[144] After performing his medical exam, Dr. Diggle wrote his impression as:

> Focal epilepsy, with pressured thoughts, anxiety as his aura. I suspect that the episodes of anxiety or focal seizures, and with secondary generalized tonic-clonic seizures admixed. I suspect that they are arising from the left temporal region, given the spikes on his EEG. The main differential would be a focal epilepsy from the right hemisphere, given the left arm numbness, and it is possible to have bitemporal foci, though uncommon.

[145] Dr. Diggle's recommendations included:

> 1 MRI Scan of his brain, ? mesial temporal sclerosis

> 2 No driving for one year. If he is seizure-free and compliant with medicine, patient can resume driving safely at the 6 month mark, but we will make this ascertainment closer to that time.
>
> 3 He cannot carry a firearm or operate in a position of responsibility for public safety, over the next 6 months. This may place him on short-term disability, unless significant alternate duties (i.e. desk duties) can be found. If they cannot be found, I would consider him medically disabled. If they can be found, he could return to work, with modified duties.
>
> 4 Seizure prophylaxis, He has now had 4 seizures. Some 98% chance of recurrence. I have put him on Tegretol (…)
>
> 5 Disposition. I will see him in follow up in 3 months (…)

[146] At the hearing, Dr. Diggle added that while triggers may well have played a part in his history of seizures, it did not change his predisposition to seizures due to his temporal lobe epilepsy seen on the EEG. He told Cst. Desson that removing the identified triggers through lifestyle modification was important but would not offer adequate control against future seizures, therefore, he would have to take anticonvulsant medication indefinitely.

[147] On July 28, 2010, Dr. Ross completed a note in the Health Services Management System (HSMIS) that reads as follow:

> Telephone call with member
>
> He had the EEG yesterday. It did show some seizure activity in the left temporal lobe. The neurologist has restricted his driving license (including private) for 6 months. His family doctor has declared him totally unfit for duty for one year.
>
> He believes the family doctor made this prognosis because of stress … he is in the middle of a divorce proceedings, he hates living in BC and now the thought of standing at a bus stop is totally insulting and will likely result in a major depression episode. He has had minor depression episode in the past.
>
> He is resentful that his health situation was discussed openly at work (unsubstantiated by writer) and has some difficulties with some of his managers.
>
> He has seen Dr Schimpf in the past.

> P; Writer suggested contacting Dr Bowman to formulate a plan and develop coping strategies. Writer explained to member the difference between removal of a firearm for medical reasons and the removal of a firearm for administrative reasons.

[148] The complainant testified that he was very upset that he could not go back to his regular duties and could not drive a vehicle for a long period. He felt a large amount of stress. He could not picture himself stuck behind a desk on administrative duty and was embarrassed he would have to take the bus to go anywhere.

[149] On August 17, 2010, Dr. Fasihy, wrote in an Evaluation of Disability Questionnaire from the Respondent that there was a risk of collision if Cst. Desson has a recurring seizure while driving. In the section of Objective Findings, the doctor noted the seizure and the difficulty concentrating. In the section for restrictions and limitations, she noted “Patient states he is unable to concentrate and he is unable to do his regular job duties”. She added that he will be able to return to his regular duties if he is free of seizures for 6 months.

[150] On September 17, 2010, Dr. Roland Bowman, regional psychologist with the RCMP wrote to Staff Sargent Regina Lyon to inform her that Dr. Schimpf, the treating psychologist, supported a return to work with restriction to administrative duties. He wrote that the complainant would feel more comfortable returning to his own section and was asking where she could best use his services.

[151] On September 27, 2010, Cst. Desson wrote to his direct supervisor, Corporal Babak Dabiri, that during his last medical appointment, it was decided that he would be returning to work on November 1st, 2010.

[152] At the hearing Cst. Desson testified that he felt very uncomfortable disclosing his medical information. He explained that when he first started in Burnaby, there were pictures on the wall of people who don’t come to the office because they are off work. He said that this is the “wall of shame” and he does not want his picture on that wall. The Tribunal considers that this was his own perception but no evidence was presented to support that there was a generally stigmatized view of constables’ medical restrictions.

[153] On September 29, 2010, Staff Sargent Labossière said in an email that Cst. Desson was supposed to come back to work on November 1, 2010 on administrative duties assisting Corporal Clark with the exhibit review.

[154] In October 2010, Dr. Fasihy wrote that “He has been unable to work the last few months due to increasing anxiety, recurrent seizures as a result of anxiety, insomnia, headaches and neck pain. His seizure recurrence has increased recently and he has been unable to drive to work.” Dr Fasihy noted that “He reports increase in his anxiety and stress since 2009 when his ex-wife, Heidi called him demanding money and making threats that she would call his workplace and report him to his employer that he has had seizures in the past and cause his termination from his work”.

[155] On October 22, 2010, Dr. Diggle wrote that Cst. Desson has had four tonic-clonic (Grand Mal) unprovoked seizures. He specified that there are probable triggers or precipitance that have been sleep deprivation, possible fasting, excessive exercise and ephedrine use. However, his EEG has shown spikes arising from left temporal lobe. He recommends continuing taking the medication Tegretol indefinitely and that he continues to address the triggers that he has identified as doing lifestyle modification. Dr. Diggle wrote:

> I tried to explain the difference between a predisposition towards seizures and triggers for the seizures. I think he is absolutely correct in identifying the triggers and he has gotten a number of different pieces of advice from a nutritionist, alternative health care providers and his own research. Again, I think the information that he has about triggers is absolutely correct; however, he does have an underlying/latent predisposition towards seizures and he should continue on the anticonvulsant even if he is controlling seizures adequately. (…) He is seizure free and he is compliant with his medication on stable dose of Tegretol. He can resume driving as of January 14, 2011, 6 months after his last seizure.

[156] Dr. Diggle wrote that Cst. Desson may resume driving as of January 14, 2011.

[157] On November 6, 2010, Cst. Desson started a gradual return to work on administrative duties at the Burnaby Department. Some of his colleague asked him how his head was doing or how he felt, if he was OK, and even if he had anymore seizures. Cst. Desson testified that it was then clear to him that his medical information had been disclosed and that its confidentiality had been breached. He also testified that the work

assigned to him at that time, i.e. preparing orientation packages for incoming members, was a mindless job that was humiliating to him and had no value for the advancement of his career.

[158] On November 18, 2010, Corporal Ferron sent an email to different people on the return-to-work arrangements for Cst. Desson. Being restricted from driving, carpooling was organized with a colleague, Constable Guiel. His work was set at the Burnaby department under the supervision of Corporal Clark for the review of exhibits and on spare time for orientation packages for incoming members. The work on the exhibits review assignment actually started on November 16, 2010.

[159] On November 25, 2010, Dr. Fasihy completed a medical certificate indicating that Cst. Desson had been seizure free since July 14, 2010. She added “able to resume full police duty Jan 14, 2011 -pathology resolved”.

[160] On December 7, 2010, Dr. Ross informed Cst. Desson she had received Dr. Fasihy’s recommendation and wrote in the HSMIS “we are going to clear you for all duties, except operational driving.” She added: “When there is a diagnosis of epilepsy, the guidelines are 5 years seizure-free with a proviso (recommendations for individual patients may differ on an exceptional basis)”..

[161] On December 10, 2010, Dr. Ross informed Cst. Desson that in order to benefit from the proviso she will need a written letter from Dr. Diggle to specify that he is cleared to do operational driving and why he does not need to wait the recommended 5 years.

[162] At that time, Cst. Desson informed Sargent Baptista that he will restart his full duties rapidly. Sgt. Baptista answered then that he has not been cleared for driving a police vehicle.

[163] On December 23, 2010, Dr. Ross informed Cst. Desson that she had a teleconference with someone from Ottawa (Dr. Marc-André Beaulieu) about the policy and would like to meet with him to discuss it. The meeting subsequently occurred on January 6, 2011.

[164] On January 4, 2011, Dr. Fasihy declared Cst. Desson unfit for duty until January 14, 2011. Then she declared Cst. Desson unfit for duty for the period of January 14 to February

29, 2011 because of “dizziness, can’t concentrate/stress/anxiety”. The absence was extended until 2013.

[165] Meanwhile, Dr. Diggle had a telephone conversation with Cst. Desson on January 6, 2011. His report of January 6, 2011, stipulated that according to what Cst. Desson had said to him, every seizure had been preceded by stimulant use (ephedra and ephedra based products). He wrote:

> While his EEG does suggest a lower seizure threshold than most other individuals, there are identifiable and proximate triggers to each of the seizures that he has had. While I would feel that the EEG suggest a predisposition, his MRI scan shows no structural abnormalities and his neurologic examination is normal.

[166] At the hearing, Dr. Diggle explained in his affidavit, that “Focal epilepsy is caused by a structural or inflammatory abnormality in the patient, although it is not uncommon – as is true in Mr. Desson’s case- for such abnormality to be too small for detection on medical imaging such as CT and MRI scans.” He added that “Mr. Desson carries a persistently elevated lifetime risk of seizures.”(emphasis added).

[167] The doctor recommended that Cst. Desson continues to take the anticonvulsant medication (Tegretol) indefinitely, avoiding triggers, so he can return to full functional duties and a full class 5 license.

[168] He added:

> I think the differentiating point between proximate triggers for this man’s seizures would be important. Clearly, the EEG does suggest a predisposition, but unlike in many patients with seizures, his did not rise unprovoked. They were each associated with a proximate trigger, being a differentiating point between spontaneous seizures and provoked seizures. As the EEG suggests the disposition, therefore the Tegretol.

[169] Dr. Diggle added that he was willing to discuss the case “given the unusual situation of having proximate triggers, which is a remediation factor in this particular case”.

[170] At the hearing, through his affidavit, Dr. Diggle added that not all individuals who suffer one or more seizures have epilepsy. For example, those individuals who suffer a

seizure for reasons such as alcohol withdrawal, drug intoxication or an infection such as meningitis which do not leave any lasting abnormality on the brain may not have epilepsy. He added that Cst. Desson had four unprovoked seizures and the presence of certain triggers or precipitating factors “does not change the conclusion that Mr. Desson’s seizures were unprovoked”.

[171] On the same day, January 6, 2011, at 15:12, Dr. Ross had a telephone conversation with Dr. Diggle. Her notes indicate that Dr. Diggle agrees with the revised 5 Year Policy, then in draft format.

[172] At the hearing, Dr. Diggle testified that he does not remember the details of that conversation, but it would be unlikely for him to agree or disagree on an internal guideline for return-to-work, as it is not his responsibility to comment on employers’ policies. His duty is a medical one, making sure that his patient receives the best care possible to avoid a recurrence of future seizures.

[173] Later on January 6, 2011, Dr. Ross sent a copy of the note to Cst. Desson and had a telephone conversation with him. She explained that contrary to what she had told him on December 7, 2010, the 5 Year Policy does not allow him to return to his full duties on January 14, 2011 as he was previously informed, but he would have to wait 5 years with administrative duties according to the policy.

[174] Cst. Desson was extremely disappointed with this news. He became suspicious and lost some trust in Dr. Ross.

[175] Cst. Desson testified that he also had a conversation with Dr Diggle on January 6, 2011 and reported that the doctor told him that he did not see any reason why he should not go back to work on full duties as of January 14, 2011, as previously decided.

[176] At the hearing, Dr. Diggle added that when he agreed to return Cst. Desson to his duties in January 2011, he did not decide what those duties were, if they were to be administrative duties or full police duties with Code 3 driving etc. This decision does not belong to him.

[177] Dr. Diggle explained that Cst. Desson had a 15% chance of having no further seizures if he was compliant with his medication:

> [I]n light of Mr. Desson's history of 4 prior seizures and abnormal EEG readings, without medication, he faced a 98% risk of further seizure. This is based on well-known aggregate data from medical literature which provides statistic on the rate of recurrent seizures in individuals with an epilepsy diagnosis. Other neurologists aware of this medical data may conclude the risk as hign as 100% or as low as 90%. Individuals such as Mr. Desson who have had multiple seizures are at higher risk of further seizure. The same medical data informed my conclusion that Mr. Desson had an 85% chance of achieving 'seizure freedom'- or no further seizures – by taking a single anticonvulsant medication indefinitely.
>
> The medical data has established that approximately 15% of patients like Mr. Desson with epilepsy will have a further seizure even when following a single medication.

[178] He added that the risk of recurrence cannot be individualized and is generalized for all patients who receive a diagnosis of epilepsy**.** Only the passage of time without a recurrent seizure will reveal how and when a patient achieves seizure freedom and whether, ultimately, that patient will fall into the category of 85% of patients on a single medication without further seizure or the category of 15% of patients who will experience further seizures:

> 17. (…) As time passes without a further seizure, the patient's risk of recurrence diminishes. At the time, given Mr. Desson's circumstances, medical profile and my knowledge of statistics in the medical literature, I would have considered the risk of Cst Desson having a breakthrough seizure after 3-5 years seizure-free and on medication as very small.
>
> 18. Based on Mr. Desson's self-reporting, I initially identified that there could be triggering factors or events that may have precipitated Mr. Desson's previous seizures. However, I ultimately concluded that these triggers did not cause Mr. Desson's seizures; rather, they may have further lowered Mr. Desson's seizure threshold. Epileptics such as Mr. Desson are already more vulnerable to seizures than the general population – thus, having a lower seizure threshold – and are at much higher risk of sudden incapacitation due to seizure. Certain triggers may exacerbate that higher risk of a seizure, such as stimulant use, exercise/hyperventilation and sleep deprivation. I concluded that avoidance of any suspected triggers – such as the use of stimulant, Ephedra, fasting or excessive exercise - alone would not offer reasonable

> control of Mr. Desson's medical condition given the number and nature of his prior seizures. Accordingly, I prescribed Cst Desson an anticonvulsant medication – Tegretol, otherwise known as Carbamazepine – and throughout Mr. Desson's treatment, maintained the recommendation that he remain on seizure-controlling medication indefinitely.

[179] On January 7, 2011, Cst. Desson met with Dr. Ross, Sargent Whitworth and Inspector Schwartz. Dr. Ross explained again that she had made a mistake in their previous conversation about returning to full police duties and that he would have to be on administrative duties for a 5 year period. Cst. Desson said he could not imagine doing administrative duties and thought that his career was ruined. Dr. Ross indicated in her notes that career options were discussed.

[180] On January 14, 2011, Cst. Desson ceased his administrative duties and went on sick leave for stress and anxiety for two years, until January 2013.

(b) The Analysis

[181] In light of this evidence, for the period of July 2010 to January 2011, the Tribunal concludes that Cst. Desson, contrary to his perception, was assessed individually and the 5 Year Policy was not applied as a blanket policy. The evidence also demonstrates that RCMP made numerous efforts to accommodate him in his return to work during that period.

[182] Indeed, Cst. Desson testified that he refused to admit that he suffers from epilepsy despite the opinion of the Dr. Diggle. His perception of his medical condition is that he had seizures, but they were entirely related to triggers that he had identified as Ephedra, overexercising, and sleep deprivation. He even said to Dr. Ross in a communication in July 2010, that the reason why his own doctor's prognostic of Dr. Fasihy. of being absent from work for one year was related to stress (divorce, hates living in BC plus taking the bus is insulting) and will likely result in a major depression episode. He did not acknowledge that he suffers from epilepsy. His opinion remained the same even after Dr. Diggle, a neurologist that specializes in epilepsy, confirmed without a doubt that Cst. Desson has epilepsy and will need anti-convulsant medication for the rest of his life even if he avoids those triggers. The source of the seizures is the predisposition for epilepsy that was shown on the EEG.

[183] In its application of the 5 Year Policy, the RCMP took into account the fact that Cst. Desson had a predisposition of epilepsy shown on the EEG and the diagnostic of Dr. Diggle. RCMP analyzed and made decisions based on Cst. Desson's specific case. The 5 Year Policy distinguishes between different seizures and the origin of those and when the origin is epilepsy, there is a specific application. That was done in Cst. Desson's case. The Tribunal also notes Dr. Diggle's explanation that the risk of recurrences of seizures cannot be individualized and only the passage of time can tell if a person will or will not have a recurrent epileptic seizure episode.

[184] Facing the reality that he would have to do administrative work and would not be allowed to drive a car for a period of time, Cst. Desson testified that not only was he disappointed, but he felt insulted and humiliated. That was also his reaction when he heard that some colleagues had been informed that he had had a motor vehicle accident and a seizure. His perception was that he would be put on the "wall of shame" and seen that way by his colleagues. As seen earlier, the Tribunal is of the opinion that there is no evidence supporting Cst. Desson's self-stigmatizing view.

[185] Despite Cst. Desson's refusal to accept his condition, and his attitude towards administrative duties, the RCMP tried to accommodate him in many different ways. Indeed, when Cst. Desson informed Dr. Ross that the situation of not being operational and not driving might bring him to a major depression, she suggested contacting Dr. Bowman, psychologist, to formulate a plan and develop coping strategies, which was done and psychologic care followed. In his communications with Staff Sgt. Lyon about the return to work, Dr. Bowman took into account that Cst. Desson would feel more comfortable returning to his own section, as his psychologist Dr. Schimpf recommended. This recommendation was followed as Cst. Desson started a gradual return-to-work on administrative duties at the Burnaby Detachment. Due to the fact that Cst. Desson could not drive, an arrangement was made by the RCMP for carpooling with a colleague. Schedules were organized accordingly.

[186] Cst. Desson testified that the administrative job that was provided at the Burnaby Detachment (review of exhibits and orientation packages for new members) was mindless, humiliating and did not add any value to the advancement of his career. Cst. Desson is of

the impression that his career was ruined by those decisions. The Tribunal is of the opinion that Cst. Desson's perception is not accurate.

[187] The Tribunal is of the opinion that RCMP attempted to accommodate Cst. Desson's needs to the point of undue hardship. The RCMP made an honest effort to provide all opportunities they could short of undue hardship considering they could not provide operational duties in application of the 5 Year Policy. Instead, RCMP provided him administrative duties in his own detachment during this two month period of November and December 2010.

[188] On another note, the Tribunal notes that Dr. Ross had made an important error when she told Cst. Desson that his only restrictions would be operational driving for 5 years starting in January 2011. After verifying with Dr. Beaulieu, she then explained that she had made a mistake and that the 5 Year Policy said that he would be restricted for all operational duties, not only operational driving, for 5 years.

[189] The error made by Dr. Ross affected Cst. Desson. He became suspicious and lost some trust in Dr. Ross. Dr. Ross then suggested that another HSO could continue with Cst. Desson's file in order to restore the trust necessary between the employee and the HSO. Again the RCMP responded to the situation for the benefit and wellbeing of Cst. Desson.

[190] Moreover, it was the 5 Year Policy itself that had a very big impact on Cst. Desson's mental health condition. His ordeal became even more important, as he was on medical leave for almost 2 years after the announcement. The next section will discuss that period.

January 14, 2011 to January 2013

(a) The Facts

[191] During the period of January 14, 2011 to January 2013, Cst. Desson saw Dr. Fasihy and Dr. Schimpf on a regular basis, about once a month.

[192] On February 23, 2011, Dr. Bowman, regional psychologist with RCMP, noticed the fact that when Cst. Desson returned to work administrative duties at the Burnaby Detachment, he had found it very distressing to be in an operational department while being restricted to administrative duties. Dr. Bowman wrote an email to Sgt. Cathy Shepherd, Career Development and Resource Advisor, to inform her of that. He stated:

> Mike is not currently psychologically fit to work. However, he told me that he felt it could speed his recovery if a suitable work placement could be identified now so that he could focus himself on a goal. This makes good sense to me from a clinical perspective.

[193] On May 18, 2011, Dr. Myron Schimpf, treating psychologist, wrote in his Progress Report that Cst. Desson "will have considerable difficulty working in a police setting in which he is constantly reminded of that which he is no longer capable of, but at the same time, finding some type of suitable alternate duties will ultimately benefit the member". Therefore, Dr. Schimpf recommended that Cst. Desson not be posted to a detachment setting in which the presence of operational (in-uniform) police officers would likely remind him of his situation and worsen his status.

[194] On August 15, 2011, Dr. Bowman reported that he had a long conversation with Cst. Desson and suggested to talk to Staff Sargent Edna Dechant, who manages Burnaby staffing matters, to discuss a non-detachment placement.

[195] On October 6, 2011, Sgt. Shepherd asked Dr. Bowman and Dr. Johnson if Cst. Desson was ready to go back to a gradual return-to-work, saying that John Bruer was looking for a member at review services. The person would be looking at sensitive expenditures such as payments to intelligence sources.

[196] On October 7, 2011, Dr. Bowman noted that Cst. Desson does not think that he could go back to work anytime soon. He just could not accept the decision that he was unfit for operational duties. Dr. Bowman noted that Cst. Desson had unilaterally stopped taking his anticonvulsant medication and other medication. Dr. Bowman recommended that he sees a psychiatrist, Dr. Babbage.

[197] Dr. Bowman then informed Sgt. Shepherd that Cst. Desson was not ready to begin a gradual return-to-work.

[198] On November 1, 2011, Dr. Johnson informed Cst. Desson that there was a proposal to review the 5 Year Policy allowing a member to return to operational duties if the member is “on or off” the medication plus the other criteria. Cst. Desson then said that he will restart his medication with the guidance of a physician.

[199] On November 2, 2011, Dr. Johnson noted that Cst. Desson received a call from the psychiatrist to make an appointment, but declined the opportunity. He also informed her that he had conducted some research and decided not to take his medication.

[200] On November 3, 2011, Cst. Desson informed Dr. Johnson, Dr. Schimpf and Dr. Bowman during a conference call that it would be embarrassing and difficult to do a return-to-work at the Burnaby Detachment because people knew that he had a seizure disorder. He would be too ashamed to go back there.

[201] Dr. Bowman then wrote to Sgt. Shepherd to ask her to take into consideration that Cst. Desson could not go back to the Burnaby Detachment and should be place in a non-operational environment. He added “I would appreciate if you could give some priority to this member: he is understandably finding it very difficult to tolerate the uncertainty of his current situation”.

[202] On November 16, 2011, Dr. Johnson noted that Cst. Desson had a conversation with Sgt. Shepherd to discuss the positions he would be interested in.

[203] On December 29, 2011, Dr. Bowman noted that he had a conversation with Cst. Desson’s care provider who indicated that he was fit to work within his assigned occupational restrictions.

[204] On January 12, 2012, Cst. Desson informed Dr. Johnson that his care provider recommended that he remains off work until March 30, 2012. He also informed her that he does not want to take his medication because he states that he prefers the “natural” approach.

[205] At the beginning of 2012, Cst. Desson met with Sgt. Shepherd to discuss a gradual return-to-work. During the meeting, according to Cst. Desson's testimony, she addressed him as "one of my seizure people". Cst. Desson was very upset and did not want to be identified that way. Cst. Desson testified that Sgt Shephed even told him that her husband had passed away and she went back to work early, trying to give him hope and encouraging him to go back to work. Cst. Desson testified that she was undermining him and treated him with condescendence. Sgt. Shepherd testified that he was crying, frustrated and very emotional. She had the best intentions and was working to find duties that would be rewarding for him. She was trying to encourage him to get back to work and willing to put the effort towards that goal. Cst. Desson said he was not cleared to go back to work.

[206] On January 17, 2012, Sgt. Shepherd indicated that she received a request from the integrated proceeds of crime group that she thought would be suitable for Cst. Desson. She was asked when he would be returning to work. Dr. Bowman left a message with his care provider to verify the suitability of the proposed project.

[207] On February 22, 2012, Dr. Bowman made a new request for Cst. Desson to be seen by Dr. Babbage, psychiatrist.

[208] On February 28, 2022, Sgt. Shepherd wrote to Cst. Desson saying that she received several requests to staff a gradual return-to-work position. One of them was for the major crimes unit. She is asked if he was cleared to return to work.

[209] The next day, Cst. Desson wrote that he has not been medically cleared for a gradual return-to-work yet. He wrote "Please be advised that I will not be discussing any personal medical details with you, or answering questions about my personal medical history, as you know this is confidential".

[210] On March 6, 2012, Cst. Desson was assessed by Dr. Babbage, psychiatrist, for the first time. He indicated his impression: 1. Rule out major depression, mild superimposed on dysthymia; 2. Rule out depression due to epilepsy; 3. Rule out medication affecting mood; and 4. Rule out generalized anxiety disorder. Dr. Babbage continued to treat Cst. Desson regularly afterwards.

[211] On March 14, 2012, Dr. Bowman informed Sgt. Shepherd that Cst. Desson would not be able to return-to-work in any capacity for 3 to 6 months.

[212] In his May 8, 2012 report, Dr Schimpf identified the occupational restrictions as:

> There are no psychological restrictions with reference to full operational duties, but of course there is medical prohibition with reference to same (see above). The issue of light/alternate duties is complex, as the member has been medically cleared for same, but it is here that psychological limitations become relevant. More specifically, the member has long defined himself in terms of physical and athletic prowess (having been a competitive body builder and very active in in various sport-based activities), and being restricted from that which drew him to policing in the first place, is extremely difficult for him. As was pointed out in previous reports, he will have considerable difficulty working in a police setting in which he is constantly reminded of that which he is no longer capable of, but at the same time, finding suitable alternate duties will ultimately benefit the member. Therefore, careful planning and communication (which involves the member) maintains imperative. The writer would reiterate the recommendation that the member not be posted to a detachment setting in which the presence of operational (uniform) police officers would likely remind him of his situation and worsen his status.
>
> (emphasis added)

[213] On May 17, 2012, Dr. Bowman contacted the new staffing officer in charge of Cst. Desson's placement, Sgt. Dawn Parker (Return to work/Medical Discharge Facilitator, Workplace relations Services, E Division, Headquarters). He advised her that Cst. Desson's care provider cleared him for administrative duties in a non-uniform environment.

[214] On May 29, 2022, there was a meeting in Dr. Bowman's office involving Cst. Desson and Sgt. Parker. Dr. Bowman noted that "it is clear that Mike is still finding it very difficult to adapt to his non-operational status". He did not want a gradual return-to-work, but a full-time position because he felt a gradual return-to-work would single him out in a negative way. He wanted to work in a federal section but he agreed to try to keep an open mind to consider detachment placements. It was agreed, however, that at this point his care providers are recommending that he not work in a uniform environment and a non-detachment setting is preferable.

[215] On June 6, 2012, Sgt. Parker wrote to Cst. Desson informing him that if a position were presented to him within his limitations and restrictions and he did not accept it, he "will have to provide rationale as to why it is not suitable", as the process cannot go on indefinitely. She invited him to consider what was presented to him very carefully.

[216] On June 13, 2012, Supt. Aubry (OIC Client Services in Burnaby Detachment) wrote to Dave Nassichuck, that Cst. Desson is a young officer who has aspirations to contribute as a front-line officer in a position that would accommodate his disability and has expressed his interest for accommodation in an operational role. "I believe that he may be a good candidate for further consideration for Special O where he could be accommodated conducting surveillance".

[217] On July 3, 2012, Sgt. Parker asked Dr. Krista Johnson, the HSO in charge of Cst. Desson's file at that moment, about Cst. Desson's restrictions and limitations. She reported that in the medical profile, the only restriction identified was to administrative duties. In contrast, Dr. Bowman indicated that Cst. Desson's care provider suggested that it may be too difficult for him psychologically to work in a uniform environment and recommended a non-detachment setting. She asked if Dr. Johnson supported it as an actual restriction.

[218] On July 13, 2012, Dr. Johnson met with Dr. Bowman, Sgt. Parker and other individuals to discuss parameters for Cst. Desson's return-to-work.

[219] More discussions continued with Dr. Schimpf, Dr. Bowman and Sgt. Parker to find a satisfactory position for Cst. Desson and to try to accommodate his desire not to do a gradual return-to-work and not to be in an environment where uniformed personnel are present.

[220] On September 4, 2012, there was a meeting in Dr. Schimpf's office (Cst. Desson's treating psychologist) with Sgt. Parker, Dr. Bowman and Cst. Desson. Cst. Desson stipulated that he would consider jobs in federal positions, in Special O (Special Operations) or have a support position on an ERT (Emergency Response Team), or a position in community policing in Surrey. Sgt. Parker was to undertake to get back to Cst. Desson after doing more research on available jobs.

[221] In a written conversation with Dr. Johnson, Sgt. Parker asked for the actual medical profile considering that he indicated that neither his physician nor his psychiatrist have declared him fit to work however his profile in the system is still O4. She added “The way Dr Schimpf and Cst Desson put it [at the meeting in Dr Schimpf’s office] is that he would not be supported to return to work until he is presented with some work options which are agreeable to him”.

[222] In an email from Sgt. Parker to Dr. Bowman on October 1, 2012, she stated the following:

> Federal position: Due primarily to fiscal restraints, no vacant positions are being filled and as of last week, 80 positions are being cut from the federal units. He cannot be accommodated in a federal position.
>
> ERT: An inquiry was made of the respective CDRA. They cannot accommodate him as they require operational members and do not have work available for a Cst. on full administrative duties.
>
> Special O’: I spoke with Insp. ARNOLD. They are working with just over 60% operational members due to medical leave and members on restrictive duties. He is not able to accommodate another member on administrative duties only.
>
> Surrey Detachment : Insp. SCHWARTZ agreed to take Cst Desson while on a gradual return to work for a 3 month period however Cst. Desson is to return to Burnaby Detachment after his GRTW, whether he is up to full hours or not.
>
> As noted, I have not communicated this to Const. DESSON yet. If you have any questions, please let me know. I would like to speak to Cst DESSON soon and would appreciate any update from his caregivers that you may have

[223] Dr. Bowman informed Sgt. Parker on October 11, 2012, that he had spoken to Dr. Schimpf who reiterated the recommendation that Cst. Desson work in an environment where his contacts with uniformed members would be kept to a minimum, and that Cst. Desson should be reassured that he will not ever have to return to Burnaby. He suggested to verify the compatibility for the Surrey Detachment work settings. On November 5, he wrote to Sgt. Parker saying that he had a conversation with Cst. Desson’s psychologist Dr. Schimpf who believed that in the interest of his own health, Cst. Desson should return to work sooner than later. Dr. Schimpf encouraged Cst. Desson to fully explore and seriously consider the position in Surrey.

[224] The same day, Sgt. Parker informed Cst. Desson that members' positions were being cut and/or civilianized, fiscal restraint being applied to both federal and provincial business lines including eliminating RM positions. She stated:

> There is absolutely nothing available along those 2 lines and in fact those members whose positions have been cut or civilianized are also being placed in municipal detachments. You had asked specifically about ERT or Special O. The CDRA [Career Development Resource Advisor] responsible for ERT has advised that they cannot take another member with permanent limitations and restrictions. I also spoke with the OIC Covert Ops and the same applies there, over and above the fact that he has to eliminate positions.
>
> One of the municipal detachments discussed was Surrey. The Admin Officer has agreed to have you commence your graduated return to work schedule at that location. I spoke with her recently and the duties will be primarily associated to the front counter so general inquiries, assessing complaints, some investigative work, etc. Surrey will accommodate you for 3 months (or less if you are up to 40 hours within that time period) however you will have to return to Burnaby Detachment after that. This was discussed between Dr SCHIMPF and Dr BOWMAN and the message I have is that your care provider is encouraging you to accept this opportunity. It is very close to home for you, thereby eliminating a long commute as requested and at the very least, it will get you back to doing some real police work. I recognize that a return to Burnaby is not what you desire however there are really no options available right now. I do hope that you contacted Supt. AUBRY as suggested to you by Dr SCHIMPF to discuss potential opportunities for you at that location.
>
> I would strongly urge you to accept this GRTW placement as a starting point. As you know, the Force changes every day as do the priorities. Other opportunities may come through for you at any time but this is a good chance to get your foot back in the door and show them that you are capable and work towards some of the goals that you have in mind.

[225] On November 28, 2012 Dr. Ross wrote that Sgt Parker will follow up with the member regarding the Surrey position which has extremely limited exposure to uniform officers. She added that "Dr Bowman will review the situation as per Dr Schimpf's reports: if the sole factor preventing him from working is intolerance of uniforms, the profile will be updated to O4 as this is a staffing issue".

[226] On the same day, Sgt. Parker asked Cst. Desson if he had the opportunity to review the email sent on November 5 with regards to the gradual return-to-work at the Surrey Detachment.

[227] On November 29, 2012, Cst. Desson wrote to Sgt. Parker saying “Unfortunately I cannot except (accept) this position or return to the Burnaby Detachment. These positions are not suitable and conflict with my providers medical recommendations for me to work in a non-operational environment”. He continued, saying that his return to work required a non-operational environment position, preferably in a federal section, as recommended by his medical provider.

[228] On December 3, 2012, Sgt. Parker had a conversation with Cpl. Ferron from the Burnaby Detachment. In her notes, she wrote that Cpl. Ferron contacted all of his off-duty sick members to discuss how he can assist in alleviating anxiety about returning to work, offering to have them attend the CPO’s to access email, stay in touch with other detachment personnel, etc. and emphasized that the longer a member is away, the harder it is to come back. Cpl. Ferron attempted to determine what a member’s wishes were upon their return to work so they can be accommodated in the best fashion possible.

[229] On December 6, 2012, Sgt. Parker has a meeting with Sgt. Nassichuk, Sgt. Shepherd, Cpl. Ferron, Supt. Aubry and Dr. Bowman regarding the preferred non-uniform environment. All agreed that this would be a huge issue and possibly career ending for Cst. Desson if it cannot be overcome to some degree. All also were aware that returning to work after such a long absence would likely be quite difficult but all would do what they could, respectively, to support Cst. Desson. A job opportunity at Operational Support Branch would be offered to Cst. Desson at a meeting the following week.

[230] On December 10, 2012, Sgt. Parker wrote to Dr. Bowman, about a reviewer analysis job description. She wrote it was recognized that Cst. Desson is relatively junior in service and did not yet possess all of the knowledge, skills and abilities that would normally be expected of someone fulfilling this position, however he would be provided all of the support and mentorship required to be successful. She said that she knew quite a bit about the unit and thought that the work was very interesting and operationally focused.

[231] She sent the job description to Dr. Bowman who sent it to Dr. Schimpf. She wrote that NCO's wear their uniforms but not every day. "It is a mixed bag". Cst. Desson would be expected to wear winter dress with long sleeved dress shirt and tie and dress pants. Even if it was not the ideal situation, she thought that the work and the general environment could be very positive experience for him if he could work through the issue to some degree.

[232] On December 13, 2012, Cst. Desson attended a meeting with Dr. Bowman, Sgt. Parker, Sgt. Nassichuk, Cpl. Ferron, Supt. Aubry and a representative of the police association (MPPA) Mr. Lee Keane. The objective was to facilitate the return-to-work for Cst. Desson. All were empathetic and encouraged and invited Cst. Desson to talk to any person present should he have questions or need support. There was talk of him commencing a gradual return-to-work at Ops Strategy Branch that was a new entity that would be physically at the Headquarters.

(b) The Analysis

[233] In light of this evidence, the Tribunal notes that when Dr. Bowman realized that Cst. Desson had stopped taking his anti-convulsant medication, prescribed by Dr. Diggle for life, he recommended that he see a psychiatrist. An appointment was made, but Cst. Desson declined it. A few months later, Dr Bowman made another request for Cst. Desson to be seen by a psychiatrist. The Tribunal considers that the RCMP made the efforts to support Cst. Desson's mental health condition by providing him with an opportunity to be treated by a specialist.

[234] The Tribunal also finds that Dr. Bowman, in his assessment of Cst. Desson's case, took into consideration his reactions to his previous placement on administrative duties at the Burnaby Detachment. He also took into account the opinion of Cst. Desson about what a suitable work placement would be. He tried to accommodate Cst. Desson's needs (non-uniform surroundings, not operational environment, not Burnaby Detachment) when communicating his instructions to the staffing personnel. In those instructions, Dr. Bowman also considered Dr. Schimpf's opinion which reiterated that there were no psychological restriction with reference to full operational duties but some psychological limitations applied

during the period that Cst. Desson was on administrative duties. Dr. Schimpf noted that it would be difficult for Cst. Desson to work in a police environment with colleagues in uniform performing operational duties because this would remind him of what he was not allowed to do. At the same time, Dr. Schimpf indicated that finding suitable alternate duties will ultimately benefit him. The Tribunal concludes that the RCMP through Dr. Bowman tried to accommodate Cst. Desson's needs as much as possible in its instructions to staffing personnel.

[235] Meanwhile, Sgt. Shepherd, acting as the staffing officer, had different conversations and a meeting with Cst. Desson. She tried to find openings that would suit the needs communicated by Dr. Bowman. She proposed certain positions that she thought would be acceptable considering Cst. Desson's limitations and preferences reported by Dr. Bowman, i.e. Review Services with John Bruer, Integrated Proceeds of Crime, and the Major Crime Unit. The efforts to find a suitable position were not successful as Cst. Desson was not ready medically to return to work. Sgt. Shepherd testified that the meeting of January 2012 did not go well. Cst. Desson considered that she was undermining him and treating him with condescendence and she testified that she was trying to encourage him to get back to work. Dr. Johnson and Dr. Ross testified that the longer a person is off work, the more difficult it is for the person to get back to active duties. Again, the Tribunal finds that RCMP is trying to accommodate Cst. Desson's needs in different ways, that are sometimes perceived in a negative way by Cst. Desson.

[236] In September 2012, Cst. Desson indicated that he would like to work in a federal position or in Special O or ERT. Sgt. Parker, who became the new staffing officer, looked into those possibilities but positions in those fields were not possible because of fiscal restraints and job cuts, the positions require operational status, or there were enough people in the unit on restricted duties. She proposed a position in the Surrey Detachment for a period of 3 months but with a return to the Burnaby Detachment thereafter. Even if the Surrey Detachment proposal did not respect Cst. Desson's wish and Dr. Schimpf recommendation, the Tribunal notes that multiple efforts were made by the RCMP to support a return to work.

[237] In light of Dr. Schimpf's opinion that, for Cst. Desson's own interest, he should return to work sooner rather than later, Dr. Bowman had another meeting with Cst. Desson, Sgt. Parker, Supt. Aubry and other individuals in December 2012. Another position was offered in a new entity at Ops Strategy Branch at Headquarters. This seems to have been accepted by Cst. Desson and by Dr. Schimpf. The next section will discuss this new opportunity.

[238] In light of the evidence, during the period of January 2011 to January 2013, while Cst. Desson was off duty sick, the RCMP continued its efforts to try to find him a suitable position. They took into consideration the recommendations of his treating psychologist Dr. Schimpf and his limitations and restrictions. In February 2013, at the same time as Dr. Schimpf declared him not psychologically fit to work, the psychologist added that Cst. Desson had told him that he felt it could speed his recovery if a suitable work placement could be identified. So the work of placement continued. Dr. Schimpf added that it would be preferable that Cst. Desson would not be posted in a police setting where his colleagues would be in uniform and performing operational duties as it would remind Cst. Desson of what he could not do, and it would worsen his medical status.

[239] RCMP's efforts to find a position acceptable took into consideration the recommendation of Dr. Schimpf even if it significantly limited the likelihood of a job placement.

[240] In fact, in August 2011, Dr. Bowman directed Cst. Desson to an officer at the Burnaby Detachment to discuss a non-detachment placement.

[241] In October 2011, Sgt. Shepherd had a position to offer at Review Services but she was informed that Cst. Desson was not ready to begin a gradual return-to-work. In February 2012, she wrote to Cst. Desson informing him that different positions were open as gradual return-to-work in Major Crimes Unit. He was not yet cleared to start working. The evidence showed that he just could not accept the decision that he was unfit for operational duties. This was a recurrent block to the numerous efforts made by the RCMP to find a placement.

[242] Cst. Desson also required that he not to go back to his previous Burnaby Detachment because it would be embarrassing and difficult for him because people knew that he had had a seizure and he would be ashamed to go back there. RCMP took into consideration

Cst. Desson's feelings of embarrassment and shame when trying to find him a new placement, as suggested by Dr. Schimpf. Indeed, Dr. Schimpf mentioned at different occasions that there was no psychological restrictions for full operational duties but, for a gradual return-to-work, Cst. Desson would have difficulty working in a police setting as he would be reminded of that which he was restrained from doing. But at the same time, Dr. Schimpf indicated that finding alternate suitable duties would ultimately benefit him. The RCMP took this information into consideration. In light of the fact that most of the jobs are in police settings, the RCMP made efforts to find something that would also accommodate those needs that were not disputed by Dr. Bowman or others. The Tribunal is of the opinion that this shows a high level of accommodation that the RCMP was demonstrating into finding a suitable placement.

[243] Through Dr. Bowman, the RCMP made many efforts to accommodate Cst. Desson's preferences and needs. Dr. Bowman pressed Sgt. Shepherd to give priority to Cst. Desson's placement, because "he is understandably finding very difficult to tolerate the uncertainty of his current situation". Sgt. Shepherd had conversations and a meeting with Cst. Desson to discuss not only positions that were available, but positions that he would be interested in. She was trying to find a position that would be rewarding to him. She was trying to encourage him to get back to work and was willing to put effort towards it. The Tribunal finds that RCMP demonstrated a real concern not only to the professional aspect of job finding, but the personal interests of Cst. Desson.

[244] Cst. Desson perceived that at a meeting at the beginning of 2012, Sgt. Shepherd was undermining him and he felt she was treating him with condescension. At the hearing, Sgt. Shepherd refuted these remarks and indicated that she was trying to help him. The Tribunal is of the opinion that in order to decide on the level of accommodation that RCMP demonstrated towards Cst. Desson it does not need to discuss whose perception was justified during the January 2012 meeting. What matters is the fact that the meeting occurred and this was another example of the efforts made by the RCMP to find a suitable job for Cst. Desson even if it was perceived negatively by Cst. Desson. The Tribunal noted that through his testimony, Cst. Desson showed self-stigmatization of his epileptic condition.

[245] Sgt. Shepherd and Sgt. Parker, who took over responsibility to find a gradual return to work placement for Cst. Desson, tried their best to accommodate Cst. Desson's needs and his desires. Many opportunities were considered. Cst. Desson would have liked to work in the federal sector, but as expressed by Sgt Parker on October 1st, 2012, fiscal restraint and job cuts would not permit a gradual return-to-work in that sector. Other opportunities were also not available (ERT, Special O) because of the context at the time. There was an opportunity at the Surrey Detachment but again this was not feasible because, after a 3 month period, Cst. Desson would have to go back to Burnaby Detachment where he had said he would be embarrassed to return. The RCMP took this into consideration and continued active efforts to find something suitable.

[246] The Tribunal finds that in trying to find an administrative position for his gradual return to work during the period of January 2011 to January 2013, when Cst. Desson was off duty sick, the RCMP accommodated Cst. Desson's needs and preferences as much as possible. The Tribunal considers that RCMP's obligation was not to create a job. Assigning him to a federal position or ERT or Special O, would have been undue hardship considering the explanations given by Sgt. Parker in her email of October 1, 2012.

[247] It is also notable that Dr. Bowman insisted that Cst. Desson be seen by a psychiatrist considering his mental state and he organized the appointment. The Tribunal finds here also the intention from RCMP to honestly help Cst. Desson.

February 2013 to May 2015

(a) The Facts

[248] On February 6, 2013, Dr. Bowman wrote that he had spoken to Cst. Desson's care provider who supported an immediate gradual return-to-work.

[249] On February 6, 2013, Dr. Ross mentioned that since anxiety is a major factor, the member would be better off working half-days every day, rather than having days off between shifts.

[250] Finally, on February 8, 2013, Cst. Desson started a gradual return-to-work at Division E of Headquarters in the Operational Response Unit in an administrative role.

[251] On March 11, 2013, Dr. Schimpf noted in his report that there had been a degree of improvement "which is attributed to the fact that he is participating in a graduated work-return process (with duties entailing provision of security services within a new E Division Headquarters building), with reference to which he feels optimism". The occupational restrictions were as follow:

> There are no psychological restrictions with reference to full operational duties, but there is medical prohibition with reference to same (see above). The issue of alternate duties is complex, as the member has been medically cleared for same, but it is here that psychological limitations become relevant. More specifically, the member defines himself in terms of physical and athletic prowess, and being restricted from that which drew him to policing in the first place, is extremely difficult for him. He will therefore have considerable difficulty working in a police setting in which he is constantly reminded of that which he is no longer capable of, but at the same time, finding suitable alternate duties will ultimately benefit the member. The writer has therefore recommended that the member not be posted to a detachment setting in which the presence of operational (uniform) police officers would remind him of his situation and worsen his status. However, the current work-return plan (the provision of security services at the new E Division headquarters) is being relatively well received by the member, and is seen as a good option.
>
> (emphasis added)

[252] On April 22, 2013, Cpl. Eric Sheppard informed Dr. Ross that there was a potential staffing for his unit (Operational Response Unit-Duty NCO's). He wrote "From what I/we can tell, there may be some middle ground that might satisfy the aspirations of this member as well as address concerns you may have with regard to his operability. The ORU is unique and may be a good fit for Mike over the next couple of years".

[253] On April 23, 2013, Dr. Ross wrote back to Cpl. Sheppard informing him that the medical profile for the job suggested is O2 (full operational) and Cst. Desson was still O4 (administrative duties only) until July 2015. She added that as an O4, a member cannot be in uniform in public and cannot carry firearms in the context of police work (i.e. while on duty). She then suggested some options like changing the job duty code and confirming that

no uniform or firearm carrying were required or, as a second option, if there are parts of the job which require uniformed work and carrying a firearm, the managers could bundle the job in a way that the member can carry out the duties which do not require operational work. This opportunity did not pan out in the end.

[254] On January 7, 2014, Cpl. Sheppard, who is Cst. Desson's supervisor at his current gradual return-to-work position wrote to Sgt. Parker and other individuals:

> Within his role, he has contributed significantly to the efficiency of operations and has been very receptive and motivated in his personal development as a member (on the admin/ORU management side of the house). Since his arrival, I have been able to develop Cst. Desson's abilities in several of our Organizational and Functional Competencies, within the ORU and by proxy, the CROPS Secretariat. I am of the opinion that Mike is on a solid path of development in the best environment possible considering his restrictions. ORU/CROPS also provides him with currency in the current state of operations within the Force (close proximity to CROPS) while being attached to a uniformed unit (ORU). I firmly believe his current role with my unit is providing opportunity to set him up for a strong return to operations and his future as a supervisor down the road.
>
> I fully support retaining Cst. Desson on the EHQ ORU for the entire duration of his O4 period at which time we can re-assess in July of 2015 when his TO4 status is reviewed.

[255] On February 13, 2014, the HSO panel reviewed the file and concluded that based on the medical information available, the restriction from operational duties were to be maintained including the use of a firearm. It added "At this point in time, we have no medical information that would allow us to support special consideration/accommodation, based on best medical practices already in place. To do so would also be unfair to other members in comparable situations who have not been given special consideration. Should this allowance be given, there is clear risk to the members as well as notable organizational liability".

[256] On August 20, 2014, Cst. Desson requested a meeting with Dr. Ross to discuss "current RCMP Policy and Medical profiles from the RCMP Medical Profile Factors Admin Manual as it relates to a member's operational status. The purpose of the meeting will be an opportunity for an early resolution to my current grievances". Cst. Desson attached a

document to the email in which he explains his view on the issue of the restrictions applied to him and on the 5 Year Policy.

[257] He also commented on the HSO panel's response. He stated that the HSO Panel reference to the unfairness to the other members if there were a proviso applied to him showed that he has not been assessed individually. He wrote:

> Each member is to be assessed individually, which should have no bearing on the fairness to any other member. No member, including myself, should be compared to any other member, like I have been here. In January 2011, one week before I was to be back to full operational status, Dr. ROSS called and requested that I attend to her office at E-Div HQ to meet with her. During the meeting, Dr. ROSS told me that I was no longer returning to full operational duties for 5 years. Dr. ROSS apologized, stating that she was confused and did not fully understand the RCMP Medical Policy relating to seizures. Dr. ROSS then stated that there was a female member who had also suffered seizures, but her providers would not clear her fit for duty. Dr. ROSS stated that this confused her, after my providers cleared me fit for duty, and the female members providers would not clear her.

[258] Dr. Ross answered the same day that she was not able to address this topic again. She wrote "I have used all my verbal and written abilities to relay RCMP Policy around your condition. I do not have any new skills. If I haven't been able to clarify the situation up until now. I will still not be able to". She sent him a copy of the answer given by the HSO panel on February 13, 2014.

[259] Cst. Desson replied that he will continue on with his grievances, complaints to the College of Physicians & Surgeons and or any civil litigation process. He expressed his disagreement with the HSO Panel's answer and argued that he had not been assessed individually.

[260] On August 22, 2014, Dr. Ross informed the HSO Panel that she thought that Cst. Desson would be happier to have another HSO managing his case.

[261] In September 2014, Dr. Isabelle Fieschi took over Cst. Desson's file in replacement of Dr. Ross. She sent an email asking him to have some documents filled before his return to operational duties in July 2015. She mentioned that the documents have to be filled during the 6 months before the return to full duties.

[262] Meanwhile, in September 2014, the Career Development & Resourcing advisor, for the E Division, Cpl. Mike Liu verified the operational status of Cst. Desson because there was a position with the Canadian Air Carrier Protection Program available if Cst. Desson were back with the O2 Profile full operational status.

[263] On December 29, 2014, Dr. Fieschi wrote the following:

> I discussed this member's situation with Dr Marc-André Beaulieu, the acting medical director of OHSB in Ottawa, who also happens to be a neurologist, specializing in epilepsy, on 2014-12-18. Unfortunately, Dr. Beaulieu is moving to a new position with the Public Health Agency of Canada in a few days. He did however, provide useful feedback.
>
> Without mentioning the member's name, I gave him a synopsis of this member's history of seizures, read out the MRI and EEG results available, the opinions of his neurologists including the fact that they feel there are specific triggers to members seizures. I explained that Dr Ross had initially mistakenly restricted him only from operational driving but soon had to restrict him from operational duties entirely due to national discussion re members with seizures in accordance with the guidelines written by Dr Beaulieu himself.
>
> Dr Beaulieu commented on the fact that it was reassuring that member has not had any seizures for about 4,5 years, since being on medications and stated that the therapy was apparently suppressing them successfully, irrespective of whether other triggers may have been present. He was also reassured by the fact that member has been compliant with treatment for this time. Feels member clearly at risk for more seizures if off meds since there is focal discharge on EEG.
>
> He felt that, given that we are close to the 5 year mark with no seizures he would consider putting member back in an operational role a few months ahead of time after a final reevaluation by the neurologist which should include a new EEG, confirmation that medication levels are therapeutic and clear recent opinion from neurologist that member not at increased risk of incapacitation. I asked about another MRI and he stated that this could be at the neurologist's discretion as he may want to make sure there is nothing "growing there" since the initial one which was normal, and that it should be gadolinium-enhanced if performed.
>
> I also asked whether he would have returned this member to operational duties at or around the 3 year mark if he had been asked then: he stated he would definitely have wanted an MRI at that point but would likely not have returned him to full duties then due to the presence of focal epileptic discharge on EEG. At this point, the additional time elapsed without seizures is

> reassuring that things are stable, hence him being OK with returning the member to the road a few months in advance of the 5 years mark.

[264] On January 19, 2015, she informed Cst. Desson of the result of her conversation with Dr .Beaulieu telling him that he could be back on full operational duties before July 2015. She requested the necessary medical documents in order to change his operational status. She also informed him that if in the future there is a change in the medication, or if the medication is withdrawn, he would be put back on administrative duties (O4) for a period of a minimum of 6 months during which he will have to be seizure free. Then medical information will be needed in order to put him back on operational duties.

[265] On May 26, 2015, Cst. Desson started back on his full operational duties.

(b) The Analysis

[266] In light of this evidence, for the period of February 2013 to May 2015, the Tribunal finds that RCMP accommodated Cst. Desson up to undue hardship.

[267] Indeed, RCMP took notice of Cst. Desson's anxiety when the gradual return to work occurred in February 2013, as Dr. Ross suggested work half-days every day rather than having days off between shifts, for the benefit of Cst. Desson's health.

[268] In 2013, Dr. Ross and Cpl. Eric Sheppard also tried to find an arrangement for a job at the ORU, one of the departments that Cst. Desson had identified as being of interest to him. That job required a full operational status, but even if Cst. Desson was still on administrative duties, discussions occurred between Dr. Ross and Cpl. Shephard on the subject. The Tribunal notes another sign of goodwill to accommodate Cst. Desson's aspirations.

[269] Cst. Desson pleaded that the RCMP did not assess him individually but applied a blanket policy without considering his specific condition. As seen earlier, the Tribunal cannot accept this view. The RCMP tried in many ways to satisfy the aspirations and desires of Cst. Desson. In 2014, when a job in the ORU was considered, the HSO panel reviewed Cst. Desson's file. It concluded that no medical information supported lifting the restriction to operational status a year in advance of the 5 years. The fact that the HSO Panel, in its

reasons to refuse to modify the O4 profile in 2014, referred to unfairness to other members and liability to the RCMP does not change the fact that all through the years 2010 to 2015 Cst. Desson was assessed and treated individually.

[270] Finally the arrangements were not possible, but the Tribunal notes that the RCMP was still trying to find a job that would satisfy Cst. Desson's aspirations.

[271] In conclusion, the Tribunal decides that RCMP has proven that it accommodated Cst. Desson until undue hardship during the whole period between July 2010, when he had a motor vehicle accident due to epilepsy, and May 2015 when he went back on full operational duties.

[272] Therefore, the answer to Question D is yes, the RCMP has proven that the 5 Year Policy constitutes a *bona fide* occupational requirement within the meaning of paragraphs 15(1) and 15(2) of the *CHRA*.

E. If not, what are the applicable remedies

[273] Considering that the RCMP has proven that the 5 Year Policy constitutes a *bona fide* occupational requirement, it is not necessary to discuss remedies. Therefore, all the evidence presented to justify remedies, including the effects of the application of the 5 Year Policy on the long term, i.e. after May 2015, will not be analyzed.

F. Has the RCMP engaged in abusive and obstructive conduct by only disclosing some documents during the course of the hearing?

[274] The Complainant seeks compensation related to costs due to the conduct of the Respondent during the disclosure stage of the procedure. Some key documents were only disclosed during the hearing that lasted for 30 days. The hearing started on February 23, 2021 and the last hearing date was December 8, 2021. Then the parties provided their written arguments and the Tribunal took the case under deliberations after April of 2022.

[275] On July 11, 2021, the *Canadian Human Rights Tribunal Rules of procedure* (2021-06-03 Canada Gazette Part II, Vol 155, No. 13 (*New Rules*) came into force for all new

proceedings. The new Rules did not apply to matters referred to the Tribunal before July 11, 2011 unless if all parties consent to their application.

[276] Considering that the hearing of this case had started on February 23, 2021, the former Rules Canadian Human Rights Tribunal Rules of Procedures (03-05-04) apply to the present case.

[277] Rules 6(1)(d) and 6(1)(e) specify that each party shall amongst other obligations, serve and file a list of all documents in the party's possession, that relate to a fact, issue or form of relief sought in the case, including those facts, issues and forms of relief identified by other parties under this rule.

[278] A copy of the documents referred to in the list must also be provided to the other parties with the exception of the privilege documents, according to Rule 6(4).

[279] The jurisprudence states that if the document at issue is arguably relevant, it has to be disclosed. The standard to determine what is arguably relevant is not a particularly high threshold for the moving party to meet: "If there is a rational connection between a document and the facts, issues, or forms of relief identified in the matter, the information should be disclosed..." (*Brickner* v. *Royal Canadian Mounted Police*, 2017 CHRT 28, para 6 (*Brickner*)). However, the demand cannot be speculative or amount to a fishing expedition (*Guay* v *Canada (Royal Canadian Mounted Police*, 2004 CHRT 34, par. 43)). The documents should be identified with reasonable particularity (*Brickner* at para 7) and they have to be in the party's possession, access and/or control (*Clegg v. Air Canada*, 2019 CHRT 3 at para 84 to 88). Therefore, the Tribunal cannot order a party to generate or create new documents for disclosure (*Gaucher* v *Canadian Armed Forces*, 2005 CHRT 42, at para. 17).

[280] As a general principle, the *Rules of procedure* are to be interpreted and applied so as to secure the informal and expeditious proceedings, according to Rule 1(1). They are in place to help parties resolve human rights complaints quickly, efficiently, and fairly.

[281] Pursuant to subsection 50(1) of the Act, the Tribunal must give the parties a full and ample opportunity to present their case.

[282] It is therefore obvious that the documents have to be disclosed before the hearing starts.

[283] In the present litigation, it was not the case for certain documents and the Complainant is asking for compensation for obstruction of the adjudication process.

[284] During the course of the hearing, at day 11 of the hearing, on May 4th 2021, while the cross-examination of Cst. Desson that had started on the 4th day of hearing, was still being performed, the Respondent's counsel informed the Complainant and the Tribunal that during the preparation of one of his witnesses (Dr. Beaulieu) a few days before the May 4, 2021 hearing day, he came across a new document relevant to the case that had not yet been disclosed.

[285] It was a 187 pages document retrieved from the Health Services Management Information System (HSMIS) Case Management. This case management document concerns the Complainant and consists of notes and conversation related to in part to the management of the medical file and the application of the 5 Year Policy to the complainant. This information was added in the system by the HSO and was confidential except to the HSO team.

[286] The 187 pages documents refers to 83 attachments (PDF files) that were also produced by the Respondent at the 17th day of hearing in on June 29, 2021 when the Complainant finished his evidence.

[287] The Complainant submits that the Respondent obstructed the adjudication process. He refers to a decision of the Tribunal in *First Nations Child and Family Caring Society of Canada et al.* v *Attorney General of Canada*, 2019 CHRT 1 (*FNCFCS*) and to a decision of the Federal Court of Appeal in *Tipple* v *Canada*, 2012 FCA 158 (*Tipple*).

[288] In *FNCFCS*, the Canadian Human Rights Tribunal recognized that it remains bound by the Supreme Court of Canada's decision in *(Canadian Human Rights Commission) v Canada (Attorney General)*, 2011 SCC 53, (*Mowat*) which found that the Canadian Human Rights Tribunal does not have the jurisdiction to award successful complainants recovery of

their legal costs under the head of “expenses resulting from the discriminatory practice pursuant to section 53(2)(c) of the CHRA”. This is the general principle.

[289] In *FNCFCS*, the Tribunal stated that the costs that are requested for abusive and obstructive conduct do not emanate from the Tribunal’s authority to award expenses pursuant to section 53(3)(c) of the *CHRA* but rather, from the what the Federal Court of Appeal in *Tipple* describes as an “Inherent authority for a Tribunal to control its process”.

[290] These two decisions describe very unusual facts.

[291] Indeed, in *FNCFCS* case, the parties had brought a joint motion in writing to the Canadian Human Rights Tribunal for an order, on consent, that Canada would pay the complainants and the interested party compensation as a result of Canada’s obstruction of the Tribunal’s process in 2013, as agreed to between the parties.

[292] There was therefore an admission between the parties of the obstruction that Canada had knowingly failed to disclose 90,000 documents, a number of which were prejudicial to Canada’s case and highly relevant, and found that Canada failed to advise the Tribunal and the parties of this fact at the earliest opportunity. The complainants and the interested party incurred costs thrown away as a result of the late disclosure of those 90,000 documents by Canada and the related three-month delay in the hearing on the merits.

[293] In *Tipple*, PWGSC, the Respondent, had engaged in obstructive conduct by repeatedly failing to comply with orders from the Tribunal for the disclosure of information, causing Mr. Tipple to incur unnecessary legal expenses to enforce the adjudicator’s orders. PWGSC displayed a pattern of late and insufficient compliance, which was remedied only after constant pressure from Mr. Tipple’s counsel.

[294] The facts on which the decision *FNCFCS* and the decision *Tipple* are based are quite different from the present case.

[295] In the present case, not only there is no consent by the parties to acknowledge abusive behaviour of RCMP as in *FNCFCS,* but there is no evidence of abusive and obstructive behaviour from the RCMP as in *Tipple*. In fact, the RCMP counsel informed the Tribunal and the Complainant during the course of the hearing as soon as he realized that

the HSMIS document existed. This happened when he was preparing one of his witnesses during the course of the hearing. The Tribunal would have expected that this important information would have been found and disclosed before the hearing started, but the Tribunal considers that it was probably due to a lack of preparation and a late discovery of the document or an honest mistake, that the RCMP did not engage in intentionally obstructive or abusive behaviour as in *FNCFCS* and *Tipple*.

[296] Furthermore, a good part of the HSMIS document was already disclosed in the two volumes of the joint book of documents.

[297] The Tribunal considers that the two cases in *FNCFCS* and *Tipple* are very unusual cases with very unusual circumstances that can be encountered only exceptionally. It certainly is not the case in the present case.

[298] Therefore, the Tribunal concludes that no costs are to be awarded.

G. If so, is the Complainant entitled to financial compensation?

[299] Considering the previous conclusion there is no financial compensation awarded to the Complainant.

Signed by

Marie Langlois
Tribunal Member

Ottawa, Ontario
January 10, 2023

Canadian Human Rights Tribunal

Parties of Record

Tribunal File: T2276/3118

Style of Cause: Michael Eric Desson v. Royal Canadian Mounted Police

Decision of the Tribunal Dated: January 10, 2023

Date and Place of Hearing: February 23 & 24, 2021
March 30 & April 1, 2021
April 26-29, 2021
May 3-6, 2021
May 26-28, 2021
June 29, 2021
July 6-8, 2021
July 20-21, 2021
July 26-27, 2021
September 28-29, 2021
November 3-5, 2021
December 7-8, 2021
April 4, 2022

By videoconference

Appearances:

Jeff Sanders, for the Complainant

Graham Stark, for the Respondent