OPCC File No.: 15-11249

SUBMISSIONS OF CONSTABLE GEOFFREY YOUNG

Contents

1. INTRODUCTION

1. Cst. Young has been found to have committed the misconduct of discreditable conduct while off duty, by altering prescriptions for opioid pain killers, and by initially denying that he had tried to fill an altered prescription.

2. The differences in approach between the Commissioner and the member could not be more stark. The member asks that the penalty for the altered prescriptions – a written reprimand and an order that he comply with a drug rehabilitation program – be confirmed; and that a four-day suspension for lying to the RCMP be reduced to a written reprimand. The Commissioner, by contrast, asks for the harshest punishment available: dismissal.

3. Dismissal as a police officer is not merely the loss of a job, it is the loss of a career. Cst. Young would lose his livelihood and his access to extended health benefits, a serious matter for a person with his health history. Dismissal in these circumstances would also stigmatize Cst. Young as an incorrigible drug addict deserving of moral rebuke and harsh punishment.

4. The stark difference between the Commissioner and Cst. Young goes well beyond the punishment that the Commissioner seeks. They are diametrically opposed on the public health and law enforcement principles that should be applied when considering misconduct that is causally related to innocent addiction, on the legal tests under the *Police Act*, on the application of the British Columbia *Human Rights Code,* and on the record that the Adjudicator should consider as forming the factual basis of this case.

5. This case arises within the context of the North American opioid crisis. The opioid crisis has been described as the most serious drug crisis in North American history. A significant aspect of the opioid crisis is addiction caused by prescription opioids; that is, addictions created by medical intervention when physicians have prescribed dangerous levels of opioids to persons who were otherwise clean, sober, and fully functioning members of society. The great irony and tragedy is that in these cases physicians created illness as a result of their efforts to manage

extreme pain from an earlier illness. The prescription opioid crisis has been described as the greatest man-made prescription disaster in history.

6. The broadest and most fundamental disagreement between the Commissioner and Cst. Young is on the policy approach that should be taken when dealing with illicit drug-seeking behaviour resulting from innocent opioid addiction. This is the first time this question has been addressed by a retired judge under the *Police Act*, but it is not a new issue in society as a whole. Throughout Canada and the United States, governments, health-care professionals, the courts, prosecutors, police agencies, and the general public stand together in recognizing that addiction is an illness, drug-seeking behaviour is the essence of the illness, and illicit drug-seeking behaviour is a regrettably ordinary symptom of the illness. Law enforcement has united with public health practitioners in confronting addiction and illicit drug-seeking with compassionate treatment for the afflicted, not stigma or punishment.

7. In the face of this overwhelming consensus among enlightened and responsible professionals from all relevant disciplines, the Commissioner stands alone in insisting that illicit drug-seeking behaviour resulting from innocent addiction should be viewed as a moral failure on the part of the addicted persons, who should be treated as common criminals deserving of stern rebuke and harsh punishment.

8. This case will determine whether the administration of police discipline will stand with the overwhelming majority of responsible professionals, or whether it will stand in isolation with the Commissioner.

9. The Commissioner and Cst. Young are also starkly at odds in their interpretation of s. 126 of *Police Act,* which governs the imposition of disciplinary or corrective measures. The Commissioner asserts that the *Police Act* does not provide a statement of purpose or principle to guide Adjudicators similar to sentencing principles found in the *Criminal Code*. This is plainly incorrect. Section 126(3) of the *Police Act* states that when considering the application of disciplinary or corrective measures, education and correction must take precedence. There are only two exceptions when punishment may take precedence: when an approach that emphasizes correction and education is unworkable; or when such an approach would bring the administration of police discipline into disrepute.

10. In his submissions the Commissioner pays lip service to the existence of s. 126(3), but his argument does not address education or correction. Of course, dismissal has no corrective or educational aspect whatever. It is bluntly punitive. The Commissioner does not provide any argument on why the disciplinary or corrective measures proposed by the Discipline Authority would be unworkable, nor does he consider whether those disciplinary or corrective measures (or indeed, his own proposed punishment) would bring the administration of police discipline into disrepute.

11. By contrast, major portions of this submission address these three issues. The disciplinary or corrective measures proposed by the Discipline Authority constitute focused and effective correction and education, and the evidence presented by Dr. Farnan suggests it will continue to be effective going forward. The disciplinary or corrective measures proposed by the Discipline Authority are clearly not unworkable. Cst. Young has been welcomed back to work, and has been fully operational. It will be argued that the Discipline Authority's disciplinary or corrective measures would not bring the administration of police discipline into disrepute, but are instead consistent with the approach taken in publicly supported programs including, for example, drug courts and safe injection sites. To the contrary, the punishment proposed by the Commissioner would bring the administration of police discipline into disrepute by adopting unenlightened and retrograde policies that have been discarded as unreasonable, costly, dangerous, and lacking in compassion.

12. This case will decide whether the statement of purpose and principle contained in s. 126(3) of the *Police Act* are mandatory as Cst. Young submits, or whether it can be ignored altogether as the Commissioner does in his submissions.

13. The Commissioner and Cst. Young are starkly at odds in the application of the British Columbia *Human Rights Code.* Section 4 of the *Code* provides that it takes precedence over all other British Columbia enactments, which would include the *Police Act*. The Court of Appeal has found in more than one case that drug addiction is a disability. Summary dismissal of an employee for misconduct related to an addiction constitutes impermissible discrimination on the basis of a disability. The Court of Appeal has held that employers are obliged to accommodate the employees by allowing them to complete drug rehabilitation programs before they may

consider dismissal. If an employee is unwilling or unable to complete such a program, the employer may then be dismissed but not before giving the employee that opportunity. Policing is a "safety-critical operation", but the two leading cases also involved "safety critical occupations": nursing and heavy equipment operations in a mine.

14. In this case, the Discipline Authority proposed a continuation of the rehabilitation program that Cst. Young commenced on his own. To dismiss him summarily at this point would constitute discrimination on the basis of a disability, as prohibited by the *Human Rights Code.*

15. This case will decide whether the *Police Act* is subject to the *Human Rights Code*, as s. 4 of the *Code* states, or whether it can be ignored as the Commissioner does in his submissions.

16. Finally, the parties are starkly at odds in their approach to the evidence and the facts. That is the next topic in these submissions.

2. FACTS

17. The difference between the position of the Police Complaint Commissioner and the member on the facts is encapsulated in the first paragraph of Police Complaint Commissioner's submissions on the facts **(Commissioner's Submissions, para. 12)**:

> The record in this matter includes the Final Investigation Report (submitted 12 January 2017) ("FIR") and the Further Investigative Report (submitted 19 September 2017). In addition, it includes the decisions rendered by the discipline authority, West Vancouver Police Department Chief Constable Len Goerke. His findings with respect to misconduct are set out in his Form 3 Findings of Discipline Authority dated 9 April 2018 ("DA Misconduct Decision"). His conclusions with respect to sanctions are set out in his Form 4 Findings of Discipline Authority dated 27 April 2018 ("DA Sanctions Decision").

18. There is a glaring omission: the transcript of the Discipline Proceeding. There is not one citation to the evidence of Dr. Farnan or Cst. Young in the Commissioner's entire submission. The Commissioner refers on occasion to findings that the Discipline Authority made on the basis of evidence he heard, but not a single citation to the evidence itself.

19. The Commissioner places primary reliance on the FIR. At a Discipline Proceeding or Review on the Record, the FIR is similar to the Report to Crown Counsel in a criminal proceeding. It is a document prepared by the investigator, with no input from the member aside from inclusion of a transcript of the limited questions that the investigator chose to ask the member. The member has no ability to introduce evidence of his own, or comment on the analysis of the investigator. The FIR constitutes part of the evidence on a Review on the Record, but it is the most important part of the evidence.

20. The fact that the Commissioner has ignored the testimonial evidence is especially notable given that the Commissioner has elected to challenge the evidence. If the Commissioner disagreed with the testimonial evidence, or believed that it should be challenged or supplemented, he could have called a public hearing instead of a Review on the Record. Similarly, he could have supported the application to have Cst. Young testify on the Review on the Record. As it stands, the evidence of both Cst. Young and Dr. Farnan is unchallenged. An argument that ignores that evidence should be given very little weight.

2.1 EVIDENCE OF CST. YOUNG

2.1.1 Constable Young Admits The Conduct Alleged in the FIR

21. Cst. Young has admitted the facts set out in the FIR, including the alteration of prescriptions and lying to the RCMP officers.

2.1.2 Cst. Young's Background (Tr. Lines 1899ff)

22. Cst. Young comes from a policing family. Both his father and uncle were police officers.

23. Cst. Young has devoted almost his entire adult life to service to his country, province and community. He served in the army for three years beginning when he was seventeen, including a six-month tour in Bosnia.

24. He then served in the BC Corrections service at the Surrey Pre-trial centre. It was there that he had his first bout of ulcerative colitis.

25. After several months of battling ulcerative colitis, Cst. Young was able to return to flight school, graduating in 2003.

26. He flew as a commercial pilot from 2003 to 2007.

27. He then returned to public service as a Transit police officer.

28. In May 2009 he joined the Delta Police Department.

29. Throughout his career in the military, with Corrections, with the Transit Police, and with the Delta Police, Cst. Young has never been the subject of any complaint. No complaint of any kind was ever lodged, much less substantiated.

2.1.3 The Origins of Cst. Young's Diseases (Tr. Lines **1956ff)**

30. Cst. Young had his first bout of ulcerative colitis in 1999 when he was 22 years old. He had just returned from a trip to Mexico and thought he had caught a bug. He had stomach pain, sweating, bloating, and continual bloody diarrhea.

31. Eventually the pain and other symptoms got so bad that he could not stand up. Cst. Young was admitted to Royal Columbian hospital. The on-call specialist diagnosed him with ulcerative colitis and recommended immediate removal of his large intestine. He was only 22 years old. For a 22-year old to go through the rest of his life with a colostomy bag would be devastating. Fortunately, Cst. Young's mother was an intensive care nurse and she intervened.

32. This bout lasted about a month, after which Cst. Young was able to return to work at Corrections.

33. Cst. Young had a second flare-up when he was at flight school, in 2001. At first the symptoms were the same as during the first bout, but then they grew even worse. Cst. Young lost 50 pounds, dropping to 128 pounds. He is 6'3". He required constant blood transfusions as he was passing so much blood.

34. At one point Cst. Young lost so much blood that he had low blood pressure. One afternoon he found it hard to breathe. He didn't have even the breath to call out for help. He could not call his mother who was in the same house, just upstairs. This was before cell phones were common, so he called his girlfriend with the landline phone, and asked her to call his mother back on the land line.

35. He had to be carried into the local hospital because he could to walk. Cst. Young was then transferred to UBC hospital where his specialist practiced. Cst. Young was there for six weeks. He was prescribed a variety of pain killers and immunosuppressants. His intestines were so damaged that he could not take ordinary food. He was fed through a tube into his carotid artery.

36. This bout occurred when Cst. Young was in flight school. The medical treatments ended in the middle of the school year, so he had to wait until the fall to go back. He lost a full year of school.

37. In 2002, Cst. Young developed pyoderma gangrenosum. Pyoderma gangrenosum is a flesh-eating disease that is related to ulcerative colitis, which in turn is related to irritable bowel symptom.[1] Pyoderma gangrenosum completely surrounded his left ankle. The disease itself was exceedingly painful, and the application and removal of dressings was even more excruciating.

38. Although Cst. Young was prescribed hydromorphone and Fentanyl over the many years he suffered from ulcerative colitis, pyoderma gangrenosum, irritable bowel disease and Crohn's disease, he never became addicted until his diseases of 2014.

2.1.4 Illness in 2014 (Tr. Lines **1888ff)**

39. [redacted]

40. The pain was the most painful thing Cst. Young had ever dealt with, even considering his earlier medical history. To manage the pain, Cst. Young was regular on doses of hydromorphone pills for chronic pain management. He was also given a self-administered hydromorphone pump for when the pain became especially unbearable.

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[1] Irritable bowel symptom is a collective term that includes ulcerative colitis and Crohn's disease, all of which are auto-immune diseases.

41. The abscess had not resolved when Cst. Young was released from hospital. Nurses came to his house every second day to change the dressings. He was on both extended release hydromorphone pills, and also fast acting pills to take before the nurses arrived.

42. Over the next fourteen months, from January 2014 to February 2015, Cst. Young had twelve more abscesses. Six of them required hospitalization.

43. Throughout this period, Cst. Young was being prescribed hydromorphone by physicians in the hospital and by his personal physician. Prior to April 2015, Cst. Young had no need to alter prescriptions because he was receiving very large (too large) quantities of pills by prescription.

44. Throughout the fourteen-month period between January 2014 and February 2015, Cst. Young would receive prescriptions from the hospital when he was admitted and discharged, and from his physicians after he had been discharged. The prescriptions were so large that he never ran out of prescribed hydromorphone pills.

2.1.5 Attempts to Wean off Hydromorphone (Tr. Lines **2285 ff)**

45. In the summer of 2014, Cst. Young became socially isolated. He was off work because of his illness. He was receiving home nursing to change his dressings and to to administer IV injections of immunosuppressants.

46. He had no work to go to, he had nothing productive to do with his days, and he was becoming depressed. Cst. Young began to count the hours and minutes until he could take another pill. He was lethargic. He was in his own words, “a waste of space.”

47. With hindsight it appears that Cst. Young had become addicted to hydromorphone. His wife would comment to Cst. Young about the number of pills he was taking, and he began to become resentful of her comments about the number of pills he was taking.

48. Although it now seems apparent that he was addicted to hydromorphone, at that time none of his doctors in or out of the hospital noted any problem, none of his physicians cut back on his pain medication, and no one prescribed a regimen that would have enabled Cst. Young to wean himself off the drugs.

49. Cst. Young was seeing his own physician, [redacted], every week. [redacted] would meet him for a minute or two, and then prescribe 70 or 80 pills a week.

50. In February 2015, Cst. Young was admitted to the hospital for another abscess. Someone on the medical staff of the hospital finally realized that Cst. Young was showing signs of addiction. A unilateral decision was made to abruptly curtail his pain medication. For the first time he began to feel the symptoms of withdrawal. Regrettably, even though Cst. Young was then in the hospital and his withdrawal could have been managed in the same way that it was later managed when he was in a residential treatment centre, no medical professional did anything to assist Cst. Young with weaning or withdrawing from the hydromorphone. Indeed, Cst. Young's own doctor, [redacted], did not tell him that he believed he was addicted, nor did [redacted] advise Cst. Young why he was reducing his pain medication. Instead, [redacted] called Cst. Young's wife and said simply "your husband is an addict." Cst. Young's wife asked the doctor what they should do about it. [redacted] had no answer.

51. While still in the hospital, Cst. Young was visited by a psychiatrist. [redacted] inquired whether Cst. Young had thoughts of suicide (he didn't), but otherwise did nothing whatever to alleviate Cst. Young's symptoms or help him with a plan to wean off hydromorphone. The psychiatrist called Cst. Young's wife and said that he should call the psychiatrist's office when he was discharged. After he was discharged his wife did so, but she was now told that he needed a referral.

52. Rather than addressing Cst. Young's addiction, the hospital released him with yet another prescription for hydromorphone.

53. When Cst. Young required additional prescriptions he continued going to [redacted], who continued to prescribe hydromorphone. [redacted] never told Cst. Young that he, Cst. Young, appeared to be addicted. Much less did [redacted] suggest any plan to deal with it.

54. Because the hospital medical staff, the hospital psychiatrist, and Cst. Young's own physician offered no plan to assist Cst. Young, he and his wife tried to come up with a plan on their own. They decided to talk to a pharmacist they knew in [redacted]. The pharmacist proposed a

progressive diminution of prescription. He did not address the symptoms of withdrawal. The pharmacist was not medical doctor, much less an addiction specialist.

55. Cst. Young and his wife took the plan to [redacted] had no comment on the plan. [redacted] did not mention any of the treatment elements that are actually necessary to treat addiction.

56. Cst. Young tried the weaning plan but because there was no treatment other than reducing his pill intake, it was not successful. When Cst. Young went back to [redacted] and said the weaning was not working, [redacted] just wrote more prescriptions.

57. In April 2015 [redacted] wrote Cst. Young a small prescription for hydromorphone. To his credit, perhaps [redacted] was finally beginning to realize that he had some role to play in helping Cst. Young. However, without any other treatment assistance, the drastic reduction in the prescription did not treat Cst. Young or his withdrawal symptoms. He just denied curtailed the quantity of the drug.

58. Cst. Young then altered the prescription, from six one-mg tablets to sixty-four-mg tablets. A pharmacist filled the prescription, but then notified [redacted] and the RCMP. [redacted] did not want to give a statement to the RCMP, so that RCMP file remained open.

59. [redacted] withdrew as Cst. Young's doctor. [redacted] cannot be faulted for that but it remains that [redacted] gave Cst. Young no parting advice, about how to seek or receive treatment for his addiction.

60. Cst. Young now had to find a new doctor. Over the next month, Cst. Young went to a walk in clinic and saw a variety of doctors there. The doctors there always prescribed Cst. Young with hydromorphone, albeit in conservative amounts. Cst. Young altered some of the prescriptions so that the pills would be larger than the ones prescribed.

61. In British Columbia, it is always hard to find a GP who is accepting new patients and this was so with Cst. Young. Eventually, he was taken on by [redacted], [redacted]. [redacted] prescribed very large numbers of pills. Cst. Young did not alter any of those prescriptions.

62. [redacted] did recognize the fact that Cst. Young was showing signs of addiction, and [redacted] prescribed clonidine to help with withdrawal symptoms. As will be seen, Dr. Farnan testified that clonidine is not a treatment for addiction; it merely addresses the symptoms of withdrawal in the short term. Cst. Young tried the clonidine. It lowered his blood pressure so seriously that on one occasion, Cst. Young passed out and broke his thumb. On another occasion Cst. Young passed out in his living room in front of guests. [redacted] limited assistance was not successful.

63. Cst. Young then went to see [redacted]. [redacted] but [redacted] seems not to have had very much relevant training or experience. [redacted] continued to prescribe Cst. Young very large quantities of pills. [redacted] would write prescriptions that were supposed to last two weeks, but when Cst. Young came back after nine days [redacted] would write another prescription.

64. The Discipline Authority found as follows:

> The evidence in this case does not flatter Cst. Young's physicians or our health care system. It seems clear that he was over-prescribed hydromorphone. His physicians did not adequately monitor his intake and were slow to notice he had become addicted. It also seems clear that once he was addicted, our health care system did not actively assist Cst. Young in treating his addiction even though he sought assistance from the system. **(Form 3, para. 95)**

2.1.6 Withdrawal Symptoms (Tr. Lines 2660ff)

65. Cst. Young described the symptoms when he began withdrawing from hydromorphone on the occasions when he ran out. He said he felt like he was burning alive. He was vomiting, itchy, sweaty, and could not sleep.

66. Worse that the physical symptoms was the mental confusion. He felt like, "I was absolutely insane. All I could think about to get rid of these symptoms was having pills, and that was all I would focus on."

67. As with any prescription, the patient is supposed to take the pills at prescribed intervals throughout the day. But when Cst. Young had become seriously addicted, "at the end of it I

wasn't …there wasn't really much time management. I wasn't counting hours down it was basically taking them as soon as I just felt sick. And that would come on very rapidly."

68. He became a slave to his pills:

> Well when I took a pill or pills, ah, you know it would everything would calm down it was, there was no more twitching, sweating, burning. There was no compulsion. If I had pills I felt safe. I didn't go out a lot the last you know nine months to a year or I missed so many family dinners with my wife I didn't, ah, I didn't socialize with anybody because, umm, I didn't want to be away from my pills. We would go out maybe grocery shopping for an hour, but I couldn't leave the house for longer than a couple of hours. And I would never take my pills with me they stayed at home and most of the time I stayed with them.
> November 8th, 2015

2.2 DR. FARNAN'S ASSESSMENT OF CST. YOUNG'S MEDICAL CONDITION

2.2.1 Dr. Farnan's Qualifications

69. Dr. Farnan has a unique set of qualifications. He is a Board Certified by the American Board of Addiction Medicine. This qualifies him too as a specialist in addiction medicine. Canada does not yet have a certification program in addiction medicine. **(Tr. Lines 260ff)** Dr. Farnan has given evidence in Canada and been recognized by the British Columbia Supreme Court as an expert in addiction medicine.

70. Addiction medicine involves a number of overlapping disciplines, including a biological understanding of disease and illness, significant psychological and psychiatric training, and an understanding of the social conditions that can give rise to and perpetuate addiction **(Tr. Lines 401 ff)**

71. Dr. Farnan also has training in the field occupational health medicine. **(Tr. Lines 230).** Occupational health medicine is concerned with evaluating medical conditions of workers and professionals in the context of the physical and mental requirements of their occupations or professions. **(Tr. Lines 378ff)**

72. Of particular interest is Dr. Farnan's expertise and experience in assessing the occupational health needs of professionals in safety critical occupations; that is, occupations where the employee has tasks and duties that impact on the safety of his coworkers or the public

generally. **(Tr. Lines 243 ff**) Obviously, being a police officer is a safety critical occupation but there are many others. **(Tr. Lines 310ff)**

73. He has taught at the Canadian Medical Association and given many presentations to conferences of medical professions in these fields **(Tr. Lines 300ff),** particularly addressing the challenges of dealing with opiate addiction in safety critical occupations.

74. The Government of British Columbia has consulted Dr. Farnan in its efforts to deal with the opioid crisis.

2.2.2 Cst. Young's Hydromorphone Prescriptions

75. Because there are many opiate and opioid drugs available, a scale of equivalence was developed. The effects of the various drugs are compared to morphine. A scale "morphine equivalents per day" or MEDs has been adopted. **(Tr. Lines 643ff)**

76. Dr. Farnan read Cst. Young's medical records and noted that in April or May of 2015, Cst. Young was being prescribed 107 mg of hydromorphone per day which is 535 MEDs; two and a half times the "watchful limit" recommended in 2010, and eleven times the maximum standard established by the British Columbia College of Physicians and Surgeons in 2016. **(Tr. Lines 923ff)** Cst. Young had been receiving prescriptions of hydromorphone at this level for over a year. This level of prescription for that length of time would create a "significantly elevated" risk of addiction. **(Tr. Lines 952ff)**

2.2.3 Addiction and its Effect on Behaviour

77. Addiction is a Bio-Psycho-Social condition; meaning its roots are in biological changes which have psychological and psychiatric effects, which in turn impacts on the social functioning of the addicted person. **(Tr. Lines 424ff)**

78. This evidence that follows is critical to this case. The position of the Police Complaint Commissioner appears to be based on the uninformed belief that addictive behaviour reflects a simple choice. The Police Complaint Commissioner submissions rely entirely on the evidence in the FIR, and entirely ignores the evidence at the Discipline Proceeding including the evidence of Dr. Farnan.

79. At the core of addiction are changes in the brain neurocircuitry that lead to changes in cognitive and psychological changes, which in turn lead to changes in behaviour. ***"At the pith of the disease there are neurological changes that result in changes of behavior."*** **(Tr. Lines 424-442 esp. 442)**

80. The "psycho" element of "Bio-Psycho-Social condition" refers to the fact that the biological changes manifests themselves in cognitive changes (changes in the way one sees and understands the world) and emotional changes.

81. The "social" element of "Bio-Psycho-Social condition" refers to the fact that addicted persons' relations with others will be affected by the addition.

82. Among the areas of the brain that are affected is the pre-frontal cortex which affects inhibition control, voluntary control of behaviour, and similar behaviour. The amygdala which affects emotions like fear and anger, is also affected. **(Tr. Lines 461ff)**

83. When the circuitry is broken, the addicted person experiences a loss of control. With addicted persons, the changes in the brain circuitry degrade or eliminate the ability to just say no to the drug they are addicted to **(Tr. Lines 494ff)**.

84. Those parts of the brain are necessary to prevent people from saying inappropriate things and doing inappropriate things. When they are damaged it impacts our judgment. A person's ability to prevent themselves from doing harmful or inappropriate things may be damaged. If the addiction remains untreated, the judgments become worse. **(Tr. Lines 1049ff)**

85. The brain effects are compounded by the effects of withdrawal. Opiates have a calming, soothing effect: less stimulation and less agitation. That is one of their benefits medically. When a person takes opiates, they lodge in opiates receptors which produces the beneficial effect in the brain. **1019ff)**

86. However, as a person continues to take opiates over a longer period, opiate molecules cover and deactivate opiate receptors which causes more and more opiate receptors to become activated. This leads to the addicted person needing more and more opiates to create the same soothing effect that was earlier achieved with lower doses. **(Tr. Lines 1019ff)**

87. When the process is reversed, the person will be more agitated and irritable with sore muscles. A side effect of using opiates is constipation, so reversing the process produces diarrhea.

88. Acute withdrawal from opiates is, "very, very unpleasant." **(Tr. Lines 1020 ff)**

89. At this stage of addiction, opiate users do not take the drug for recreation. Opiates do not have a euphoric effect. Opiates have a soothing effect, and addicted persons use them because without them they "become very unsoothed." The addicted person does not take the drug for fun, but to try to alleviate the discomfort of increasing tolerance; to bring themselves back to what they perceive to be a normal state. **(Tr. Lines 1303 ff)**

90. Because the damage to the brain diminishes inhibition, the affected person may do things to get more of the drug that he or she would not do if the brain had not been damaged. As the addiction develops and worsens the likelihood of making bad choices increases. This includes taking pills more frequently than was prescribed and doing things to get the drug that the addicted person would not do before the brain was damaged. This is not to say that the person no longer knows right from wrong or that they are acting like an automaton, but there is a clear connection between the poor behaviour and the addiction. **(Tr. Lines 1072ff)**

91. Thus a person who has become addicted but has run out of the drug, begins to experience the very, very unpleasant effects of withdrawal at precisely the time that the brain's disinhibiting functions have been damaged.

92. The combined effect of these two symptoms of addiction – diminished inhibition and the onset of very serious, unpleasant withdrawal symptoms – may lead people to engage in extreme drug seeking behaviour. It can also lead people to do illegal things to get the drug that they would not do, if they were not disinhibited as a result of the brain damage from the addiction. **(Tr. Lines 1111 ff)** When a person has committed a crime, we cannot look back and say they committed the crime because they were addicted to a drug, but one can say that addiction involves a medically recognized disinhibition effect and that disinhibition may lead them to do that. If they were well, they would not do it. Addiction can put people in situations where they will do things that they would not have done prior to the addiction developing. **(Tr. Lines**

1125ff) The addicted person's thinking and rationalizing becomes flawed, because there is a compulsivity about acquiring and taking the medication. **(Tr. Lines 1818ff)**

93. In assessing the role of addiction in misconduct, one thing a medical professional would look at is whether a person who committed a crime to get drugs had ever committed crimes in the past. Dr. Farnan has experience with medical professionals who developed an opioid addiction, and took drugs from their workplace. When properly treated, they may never repeat the illicit behaviour. **(Ibid.)**

94. One obvious example of drug seeking behavior, particularly relevant to this case is altering or fabricating prescriptions. It is a recognized form of aberrant behaviour that physicians are taught to keep an eye out for. Other similar behaviors include coming in early for prescriptions, "losing" prescriptions, taking drugs in unintended ways (snorting, for example). These types of behaviour are related both to the disinhibiting effect of the brain damage, and to the preoccupation with obtaining drugs to avoid withdrawal. **(Tr. Lines 1300 ff)**

2.2.4 The "Treatments" Offered to Cst. Young Were Inappropriate

95. As noted earlier, when one of Cst. Young's physicians realized he was addicted, [redacted] had no treatment option other than the suggestion that Cst. Young attend [redacted] methadone clinic.

96. Dr. Farnan testified that methadone would be entirely inappropriate for a police officer. To begin with, methadone treatment obviously involves taking methadone which would impair the abilities of a police officer, to the point where he could not carry out his duties safely. Second, the prospect of attending a methadone clinic on a daily basis would just not be workable for a police officer. **(Tr. Lines 1347ff)**

97. Another of Cst. Young's physicians suggested he take Clonidine. Dr. Farnan testified that Clonidine would not be classed as a treatment for opioid addiction. Its benefits are limited to reducing some of the withdrawal symptoms. **(Tr. Lines 1362ff)**

2.2.5 Dr. Farnan's Assessment of Cst. Young's Progress in Addressing His Addiction

98. Dr. Farnan met Cst. Young when he was asked to assess Cst. Young by Great West Life. Great West Life, not Cst. Young, was Dr. Farnan's client.

99. Dr. Farnan first met Cst. Young on December 9, 2015. This was shortly after he was arrested and the present proceedings were commenced. They met again in March 2016, and then again in October 2016.

100. Up to October 2016, Cst. Young's treatment and monitoring had been going well but in October 2016, Cst. Young had a glass of wine and that showed up on a urine test. Dr. Farnan concluded that Cst. Young needed additional resources before he would be fit to return to work.

101. In April 2017, Dr. Farnan concluded that he was fit to return to work. **(Tr. Lines 1388ff)** He assessed Cst. Young as being in stable abstinent remission. A person who has demonstrated one month of abstinence is assessed as being in "early" abstinent remission. A person who has gone twelve months or more without a relapse is assessed as being in stable abstinent remission. **(Tr. Lines 535ff)**

102. Dr. Farnan was asked to assess the long-term prognosis for Cst. Young. He could not give an individual long-term prognosis for any patient, including Cst. Young. He could, however, cite the statistics he had earlier cited that when a person receives high quality treatment, there is a 75-80% chance they will be working and not have had a relapse. **(Tr. Lines 1602ff)** He said that Cst. Young had very high-quality care. **(Tr. Lines 1565)** It involves very intense assessment, very intense treatment in the right place, and very intense monitoring and follow up.

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103. About a week prior to November 8, 2015, Cst. Young received a prescription from [redacted] as usual. He ran out of pills on a Sunday. [redacted] office did not open until Tuesday.

104. Cst. Young then went to Peace Arch hospital and an emergency room physician wrote him a prescription for six pills.

105. The FIR describes what happened at the Peace Arch Hospital as follows:

> On November 8th, 2015, Constable Geoffrey Young, a six and one-half year member of the Delta Police Department (DPD) attended Peace Arch Hospital

(PAH) in White Rock, BC and obtained a prescription for Hydromorphone. The original prescription was for six – four mg tablets.

Constable Young altered the prescription quantity from six (6) to sixty (60) tablets by writing a zero next to the number 6, and by writing the letters 'ty' next to the word six.

Constable Young then attempted to obtain the altered prescription from a Safeway Pharmacy. When the pharmacist suspected that the prescription was altered, they sent a copy of the prescription to PAH for confirmation. Constable Young left the pharmacy when advised of the confirmation. Later that same day, Constable Young re-attended PAH and attempted to obtain a new prescription by telling hospital staff that the original prescription was lost in the parking lot.

After confirming with the prescribing doctor that the prescription had been altered, a nurse at PAH contacted the Surrey RCMP. While attending the complaint, the RCMP were made aware that Constable Young was present at the hospital and spoke with him.

During a conversation with the RCMP, Constable Young was untruthful when he told the police he lost the original prescription, told the police he had not been to the Safeway Pharmacy, and told the police that he had not altered a prescription.

106. Cst. Young admitted that this is true.

107. Cst. Young was asked why he made the untruthful statements to the RCMP:

Well I hadn't been truthful really to anybody in the past few months leading up to that incident. And, you know opening up and talking about all my demons that I've had inside to Surrey RCMP before even telling my wife or anybody just really didn't seem like a an option at that time. I knew what was going to happen if I admitted they would have arrested me on the spot I would have been booked. There would have been no compassion even if I would have told them my whole story.

Plus at that at that point in my life I mean my brain was so my brain was so hijacked and I mean my thought process – I went back to the hospital twice in one day. I mean I obviously wasn't thinking very clearly and you know just seeing, the RCMP come in it -- that's not the help that I needed right then and there.

And yes I know it was wrong. I mean perhaps I should not have said anything but I didn't know what to do. I mean my walls were crashing down on me I you know. I think the first thought was like -- oh my god what am I going to tell my wife you know well I'm going to have to tell her something now.

108. Cst. Young tried to describe what was going through his mind when he altered the prescription on this and earlier occasions:

> You know I, don't know ever really know what was going on in my head. All I knew at the time when I was doing that that when I was at a pharmacy filling it and it took them fifteen minutes to fill it.
>
> That fifteen minutes was way too long to wait to get my pills. I mean my wife said something to me that really, ah, really hurt later on when I was getting better. She said, 'you know if you would have spent at least half of the amount of time that you spent trying to fill prescriptions, go to doctors to get pills, if you would have spent half of that time with me, I would have been a happy wife." You know, I spent double that on my pills and it almost got to the point where my wife – just she couldn't even look at a pill bottle because it just reminded her of how… I'm sure she must have thought how insane this guy that she married was going, he just didn't care about anything.

109. Cst. Young acknowledged that the withdrawal did not rob him of the ability to tell right from wrong. It was just that with the pain and insanity of withdrawal, it was not relevant:

> Oh, I knew it was wrong, there's no doubt in my mind that I knew what I was doing was against the law. I didn't care. I don't think about it. At that time of my life I didn't really look forward to anything other than the present, like making sure I had enough pills to get through that day or a couple of days. I didn't think of consequences. I honestly didn't care if my wife came home as long as she would leave me alone and not question me about my pill intake. Yeah it was just very very bizarre.

110. As will be seen, when assessing whether conduct is related to addiction, the question is not whether the addiction "caused" the conduct in the sense that the addicted person has no control whatsoever over himself. Rather, the question is whether the conduct is "connected to" the addiction.

2.4 REPERCUSSIONS

111. On November 9th, the walls came crashing in.

> I hadn't told my wife what had happened. I was kind of processing what my life had become. How do I tell my wife that her husband who was a police officer broke the law to obtain the pain killers, the ones she absolutely hated the fact that I was on?

> My work phoned me – Inspector Craig New – and he said he wanted to come by and visit with me and have a chat. I said sure, yeah, come on over.
>
> He did. He asked me if I knew why he was there. I said I had a pretty good idea. And he just said, "Is there anything that you would like to tell me?"
>
> I think I just broke down. It's like Dr. Farnan was talking about. I don't believe that it's a rock bottom. I think everybody has a point in their life where the walls kind of come crashing down on them and that was mine.
>
> So initially I was upset, emotional and, thought, "you're just gonna … you're going to fire me." The Inspector ensured me that they wanted to help me, and so we had a talk.
>
> I kind of … I didn't really know where to go from there, and I said, well, I obviously need help, and what do we do? And he, said, well, we're going to figure that out so.

2.5 THE ROAD TO TREATMENT (TR. LINES **2730FF)**

112. The management at the Delta Police Department were very supportive of Cst. Young, and obviously wanted to give him whatever assistance he needed. However, they had not encountered a situation like his and they did not immediately have a plan.

113. Cst. Young then started to take control of his life again. He called a colleague from his days at BC Corrections who had a connection with a treatment centre. The colleagues laid out to Cst. Young the steps he, Cst. Young, needed to take to get into the treatment centre.

114. The first step was to get a referral to a treatment centre. Cst. Young had to make these arrangements through Great West Life. Great West Life tried to be helpful, but they operated on a bureaucratic time scale. Going through Great West's ordinary procedures would have taken two months or more to get an appointment with Dr. Farnan. Cst. Young's colleague knew Dr. Farnan and as a favour to the colleague, Dr. Farnan's office got Cst. Young an appointment within a couple of weeks.

115. Once Dr. Farnan had approved residential treatment on a medical basis, the financial approval had to work its way through Great West's bureaucracy. The decision could not be made locally and the decision was referred to head office.

116. Thankfully, Insp. New and Chief Constable Dubord stepped up. The Chief Constable decided that the department would commit to paying for the treatment, and they would work out the financial details with Great West later.

117. If Cst. Young had not known the colleague who in turn knew Dr. Farnan, and if Insp. New and Chief Constable Dubord had not been so supportive, it would have taken Cst. Young more than two months to get into the Cedars treatment centre. As a result of Cst. Young's initiative in contacting his colleague, the colleague's connections with Dr. Farnan, and the initiative taken by Insp. New and Chief Constable Dubord, Cst. Young was able to get into Cedars on December 14th.

118. In the interval between when Cst. Young was caught on November 8th and when he was admitted to the Cedars on December 14th, he had a very difficult time. He was in a great deal of pain and had a very hard time sleeping. He took over the counter pain medications for what little help they provided, and he had some sleeping pills from an earlier prescription. "It was a pretty rough month."

2.6 TREATMENT (TR. LINES 2771FF)

119. When Cst. Young arrived at Cedars, he was given some hydromorphone. That was the last time Cst. Young has taken hydromorphone.

120. The Cedars managed his withdrawal with a medication called Suboxone for five days. The medications eliminated his cravings and withdrawal symptoms. On the sixth day it was over. He had no serious symptoms. He felt a little flu-ish, a little achy, but he had no craving, and he wasn't throwing up.

121. It is a great pity that when the hospital staff realized Cst. Young was addicted in February 2014, they did not take these very same steps to help Cst. Young wean himself from his addiction – particularly as Cst. Young's medical records would no doubt have revealed exactly how and why he had become addicted.

2.7 Recovery and Monitoring

122. Cst. Young was discharged from the Cedars on February 5, 2016. Ever since he has been subject to third party monitoring, he is required to submit to random urine tests. Every morning, the first thing he must do is check his computer to see if he has been selected for a test that day.

123. Even when Cst. Young is out of town, he must be available to give a urine sample if it is required. When Cst. Young visited his father in Ottawa and when he went on vacation to Las Vegas, the monitoring agency gave him the address of labs he would have to visit there if he was required to give a sample.

124. The monitoring agency also checks Cst. Young's PharmaNet monthly to ensure that he is not taking any improper medications.

125. Cst. Young is also required to attend support groups which he does very willingly. When he checks the computer in the morning to see if he must give a urine sample, he also logs in his attendances at support group meetings.

126. When Cst. Young was first discharged from Cedars he went to support groups seven days a week. Today Cst. Young attends meetings three times each week. One of them is a professional accountability group led by a doctor from Royal Columbian Hospital. The other members are RCMP officers, municipal police officers, border guards, and so on.

2.8 The Opioid Crisis

2.8.1 Opiates, Opioids and Hydromorphone

127. In addition to his evidence about his assessment of Cst. Young, Dr. Farnan gave evidence about opiates and the opioid crisis generally. This evidence was very helpful but many aspects of it have become very well known to the general public, through widespread reporting on the crisis in all forms of medial

128. "Opiates" are drugs derived from the opium poppy. Opioids are synthetic opiates. Hydromorphone is an opioid. **(Tr. Lines 625ff)** One can use the term "opiates" to refer both to natural opiates and to synthetic opiates.

129. As noted earlier, because there are many opiate and opioid drugs available, a scale of equivalence was developed. The effects of the various drugs are compared to morphine. A scale "morphine equivalents per day" or MEDs has been adopted. **(Tr. Lines 643ff)**

130. Oxycodone (sold under the brand name Oxycontin) is 50% more powerful than morphine. 10 milligrams of Oxycodone is equivalent to 15 mg of morphine. By contrast, hydromorphone is 500% more powerful than morphine. One milligram of hydromorphone is equivalent to 5 mg of morphine **(Tr. Lines 643ff).**

2.8.2 Roots of the Opioid Crisis

131. When Oxycontin came onto the market, it was marketed in what Dr. Farnan described as an "unprecedented way." The manufacturer began "educating" senior physicians (the drug industry calls them "thought leaders") so they could in turn provide education to their less senior colleagues. The message was that the likelihood of getting addicted was "extraordinarily low." The drug companies coined the term "opiaphobic" to refer to physicians who were (in the drug companies' eyes) too cautious or careful about prescribing opioids. The message was that there is no upper limit for safe prescription, and the risk of opioid dependency was very, very low. **(Tr. Lines 682ff)**

132. Those claims turned out to be simply false. The "data" that the drug companies bandied about was based on a single, now-discredited letter that had been published in the New England Journal of Medicine. It is now recognized that a sizeable number of people who are started on prescription opioids, have serious side effects including addiction. **(Tr. Lines 727ff)** The prescription opioid crisis has been called the greatest man-made prescription disaster in history. **(Tr. Lines 884ff)**

133. The government of British Columbia has commenced an action against the manufacturers and distributors of opioids on the theory that they misled physicians and others, leading the physicians to over-prescribe: *AGBC v. Purdue Pharma Inc. et al.* (Van. Reg S-189395) The court

will determine whether the defendants in fact engaged in misleading practices, but there does not appear to be any dispute that physicians were in fact over prescribing.

134. Starting in 2007, occupational medicine physicians in the US began to sound alarm bells but those concerns did not circulate among ordinary GPs. It was not until 2010 that a Canadian "watchful dose" recommendation published of 200 MEDs was established; i.e. that no more than 200 MEDs of opioids or opiates should be prescribed. **(Tr. Lines 712 ff)** This was nothing more than a recommendation and a weak recommendation at that. Dr. Farnan had patients referred to him who had been receiving over 1000 MEDs. **(Tr. Lines 763)** In 2016, the British Columbia College standards (which are stricter and binding than recommendations or guidelines) of an upper limit of 50 MEDs. If a physician were to prescribe 90 MEDs or more, the college required, "substantial documented evidence" of need. As will be seen, Cst. Young was being prescribed 107 mg of hydromorphone per days, which is 535 MEDs.

135. Within the medical profession, there is now confusion about how doctors should treat opioid dependent patients. The risks and realities of opioid addiction have finally been recognized, but physicians do not know what to do with patients who have become addicted. **(Tr. Lines 754ff)** When the college instituted its more restrictive limits, it began monitoring physicians' prescription patterns through PharmaNet. Some physicians took the position that, "I would be willing to try to help a patient wean from, say 800 MEDs per day to 400, but this new limit is just too much; I can't do this, the patient will have to find someone else." This contributed to people trying to find opioids on the street, and people who thought they were buying Oxycontin actually were getting Fentanyl. **(Tr. Lines 776ff)**

136. In summary, there was a glimmer of recognition in around 2010 that there was a prescription opioid crisis. It was not until 2016 that hard standards were established, and the medical profession is still trying to work out what to do with "legacy patients" who had already become addicted to very high dosages of opioids. The expertise and skills that are necessary to help a person to wean from opiates is not yet part of the tool bag of the general practitioner **(Tr. Lines 795ff)**

137. Part of the problem is that busy family practitioners really cannot afford to spend more than, say 10 minutes with a patient. While the time it takes to explain an addiction to a patient

and to devise treatment program, takes much more time than that. Dr. Farnan said there is a saying: "It takes thirty seconds to say yes to a prescription, but it takes thirty minutes to say no and wean someone." **(Tr. Lines 816ff)**

138. In Cst. Young's case, the physicians were slow to realize that he had become addicted and when it was clear that he had become addicted, his several physicians had no plan for helping him deal with it other than cutting off or radically reducing his prescription.

2.8.3 Treatment of Persons in Safety Critical Occupations

139. Medical science does not yet know whether the physical changes to the brain are permanent, or whether the brain can fully recover. The traditional learning was that addiction is not curable, but it is treatable. More recently cases have been cited where a person who had been addicted to alcohol appeared able to use alcohol responsibility after main years of treatment, but it is unclear whether those persons were actually medically addicted in the first place. Therefore, the prudent course for any person who has been addicted to a substance is to avoid the substance for the rest of his or her life. **(Tr. Lines 551ff)**

140. However, while addictions may seldom if ever be completely cured they can, as noted earlier, be treated. Persons in safety critical occupations may return to those occupations after appropriate treatment, and a demonstrated history of stable abstinent remission. **(Tr. Lines 609ff)** As will be seen, Dr. Farnan assessed Cst. Young as being in stable abstinent remission.

141. As noted earlier, a focus of Dr. Farnan's work is occupational health assessments for workers in safety critical occupations who have suffered from drug or alcohol addiction. Generally, he provides independent assessments for employers or insurance providers. That is, he is not an advocate for the patient but has a more independent role. In this case, Dr. Farnan met and assessed Cst. Young not as Cst. Young's physician, but in the role as provider of an independent medical assessment.

142. Dr. Farnan has assessed physicians, neurosurgeons, cardiac nurses, commercial airline pilots, railroad engineers, sawmill workers, police officers, and others. Such persons have one advantage over others in that they have what is called "recovery capital", that is, both internal and external resources to help them on the journey to recovery **(Tr. Lines 847)**

143. When assessing addicted persons in safety critical occupations from an occupational health perspective, one of the principal concerns is to ensure that the treatment they have received, both immediate and in residential treatment, will ensure that the worker remains abstinent, both for the worker's own health and for the safety of others. **(Tr. Lines 325ff)**

144. The modern, proactive approach to addressing addiction in the workplace of safety critical occupations began with the medical profession in the 1960s and 70s. Other occupations and professions have slowly been catching up. Over time protocols were developed that focused on the early identification of doctors with addiction, ensuring appropriate residential treatment, and follow-up programs. With these programs, after five years there is a 75-80% success rate. **(Tr. Lines 344ff)**

145. As noted earlier, the pith of addiction is biological changes to the brain. The present state of medical imaging and the cost, does not permit a treating physician to examine the affected portions of the brain to see whether they have recovered physically and biologically after a treatment program. The practically available alternatives include ensuring that the individual attends peer counselling groups, random biological monitoring (urine tests). **(Tr. Lines 522ff)** As will be seen, Cst. Young has faithfully attended.

146. In the medical profession, the "old formal way" of dealing with medical professionals who had addictions was that the professional was told to stop working, and the focus was on an inquiry committee and discipline. Nowadays, Dr. Farnan does not observe as much of the old formal discipline, and the question is whether the addiction can be addressed without going the formal discipline route. The individual makes a voluntary undertaking to stop practicing until the person has been assessed, there has been treatment, and follow through monitoring. If the person follows through with their undertakings, they will be supported and returned to work. **(Tr. Lines 1167ff)**

147. This is not to say the potential discipline for discipline is ignored. The regulatory body is involved throughout. If the person does not follow through on the commitments or ignores the wellness approach altogether, they will be dealt with by the regulators. **(Tr. Lines 1187ff)** If the person does not do what is required of them in the wellness process, they may face disciplinary consequences. In the medical context that is rare. The more common result is that the regulator

oversees the wellness process but if the person does what is expected, the addictive behaviour is treated as an illness rather than as misconduct. **(Tr. Lines 1203ff)**

148. In fact, in Canada even if the medical professional has "diverted" drugs (i.e., taken drugs intended for patients) the police are seldom involved. **(Tr. Lines 1139ff)**

3. LAW AND ARGUMENT

3.1 THE COMMISSIONER IGNORES THE MANDATORY REQUIREMENT THAT CORRECTION AND EDUCATION TAKE PRECEDENCE

149. As noted earlier, the Commissioner and Cst. Young are in stark disagreement about the application of s. 126(3) of the *Police Act*. The difference between the member and the Commissioner on the purposes and principles of assessing the disciplinary or corrective measures is set out starkly in the Commissioner's submissions, para. 14:

> 14. The Act does not offer much guidance for decision-makers who must determine the appropriate disciplinary or corrective measure. It does not contain anything akin to the purpose and principles of sentencing in the *Criminal Code* or *Youth Criminal Justice Act*, for instance. The Act says, in s. 126(2), that the adjudicator is to determine what measures are "just and appropriate".

150. This is plainly incorrect. The *Police Act* does state the applicable purposes and principles, and it does so clearly and unambiguously. The purpose and principles for imposing disciplinary or corrective measure are stated in s. 126(3):

> (3) If the discipline authority considers that one or more disciplinary or corrective measures are necessary, **[1]** an approach that seeks to correct and educate the member concerned takes precedence, unless **[2]** it is unworkable or would bring the administration of police discipline into disrepute.
>
> [numbers in brackets added]

151. In his submissions, the Commissioner made a fleeting and formal reference to this subsection but consistent with his view that the *Police Act* contains no guiding principles, he then ignored it entirely. The submissions of the Commissioner do not consider either the first principle that correction and education must precedence over punishment; or the second principle that measures other than those directed to education and correction may be considered only

where correction and education are "unworkable", or giving precedence to correction and education would bring the administration of police discipline into disrepute.

152. The philosophy of correction and education set out in s. 126 is particular to British Columbia. There is no equivalent of s. 126(3) in the enactments of most other provinces. The first special aspect is the choice of the phrase, "disciplinary or corrective measures". In Alberta, for example, the equivalent provision to s. 126 is headed, "Punishment". *Police Service Regulation* AR 356/90, s. 17). The word punishment is not found in the British Columbia *Police Act*. The Alberta legislation does not include a policy statement like that found in s. 126(3), giving precedence to correction and education.

153. Because the legislature of British Columbia has deliberately chosen follow a path separate from those taken in other provinces, it is especially incumbent on decision-makers applying the *Police Act* to give full effect to the two principles found in s. 126(3).

3.2 Application of the Principle of Correction and Education

154. The principle that correction and education must take precedence recognizes that people make mistakes, but individual mistakes do not necessarily define the person.

155. Dismissal is the opposite of correction, education and rehabilitation. It is bluntly and harshly punitive. It is founded on an assumption that an individual is incorrigible; that no amount of correction or education enable the member to return to work as a functioning member of his department. Hence, there is no point in attempting education or correction: the employee will simply be terminated.

156. This is clearly a case where education and correction have been effective, and will likely continue to be effective going forward. Cst. Young has never had a complaint of misconduct or been the subject of an allegation that he is dishonest in the military, in BC Corrections, in the Transit Police, or the Delta Police. The assertion of the Police Complaint Commissioner that Cst. Young lacks a moral compass is patently unreasonable, with no basis in the evidence. The only difference between Cst. Young's blameless past and his present circumstances, is the intervening addition. Therefore in applying s. 126(3), the first question a Discipline Authority or Adjudicator

(or the Commissioner) should ask is whether a program or correction and education would adequately address the root cause of his misconduct, the addiction.

157. The evidence is uncontradicted that a carefully crafted recovery program is very likely to be successful. Dr. Farnan testified when professionals who suffer from addictions in safety-critical occupations follow a program beginning with residential treatment and continuing with ongoing monitoring, there is a 75-80% success rate that is, such individuals to not commit further addiction-related misconduct. Cst. Young successfully completed residential treatment. He is undergoing an intensive ongoing monitoring program. He has not used hydromorphone since he left the residential treatment program.

158. In short, this is a case where the root cause of the misconduct is readily identifiable, and tested rehabilitation programs exist to address the root cause.

3.3 Continued Employment With Monitoring Is Not Unworkable

159. Pursuant to s. 126(3), measures other than those that seek to educate and correct may be imposed only if correction and education would be unworkable, or such measures would bring the administration of police discipline into disrepute. It is submitted that a party who advocates dismissal, in the fact of s. 126(3), bears a heavy burden of establishing that one of these two exceptions apply.

160. It is plain and obvious that the corrective measures proposed by the Discipline Authority are not unworkable. It has already been shown they are workable, Cst. Young has complied with them, and he remains in stable remission, and he has been welcomed back to work.

161. It is evident that the Chief Constable of the Delta Police Department does not consider a return to work by Cst. Young to be unworkable. As noted, the Chief Constable and senior management have welcomed Cst. Young back to work, and they consider him to be fully operational. There is no evidence that his return to work has created any problems for effective policing.

162. More broadly, police leaders who have considered the challenges of addressing opioid addiction among police officers do not consider a return to work through a rehabilitation

program to be unworkable. The International Association of Chiefs of Police (IACP) has 30,000 members from 150 countries. It was founded in 1893. One of its principal functions is to establish model policies on a wide variety of topics that police departments throughout the world may adopt. The IACP does not consider bringing police officers back to work through monitored rehabilitation programs, to be unworkable:

> The culture of a police organization is evident in the ways the administration manages its employees, the officers perform their duties, and the department interacts with the community it serves. The authors believe that every police executive has the opportunity—and the responsibility—to develop, sustain, and improve an agency's culture. The stereotypical police culture of the past, where the personal challenges of individual officers were concealed by the offending officer and shrouded by the "blue wall" of their fellow officers, must evolve to address the issues of the present. Police in today's society are challenged with striking a balance between the warrior mentality and the guardian or caretaker mentality. The innovative police chief can use that balance to foster a guardian or caretaker culture within the organization, where coworkers look for signs of distress in fellow officers and where troubled cops can seek assistance without the fear of undue discipline or "career suicide." A chief who advocates for peer support initiatives, employee assistance programs, and professional mental health treatment options will be utilizing their leadership to help remove the stigma of police officers seeking help.
>
> …
>
> ***In cases of prescription drug abuse, it is common for people to seek prescriptions from multiple providers; however, sometimes people resort to obtaining prescription medications illegally.*** … Once it has been established that an officer has an opioid use disorder, the focus should be on ensuring that the officer receives the necessary treatment.
>
> …
>
> Progressive law enforcement executives should recognize that opioid use disorders have become the "new normal" in the United States. Moreover, although police officers are often recognized as stalwarts of society, police chiefs must realize that their officers are human beings who can succumb to the disorders plaguing other members of the very communities they serve. *It is important for law enforcement leaders to understand that their officers often don't choose to develop a disorder; rather, opioid use disorders typically emerge following an injury or from an effort to deal with job stress. Almost all police officers who develop an opioid use disorder are redeemable; thus, police chiefs should seek to rehabilitate those dedicated, highly trained, and highly skilled officers in whom the agency has made a significant investment of time, money, energy, and training. Making the decision to rehabilitate a formerly sound officer*

> *will send an unspoken message to the rank and file that the administration cares about the officers in the department.*
>
> That being said, it is important to note that the aforementioned recommendation to rehabilitate an officer is based on the assumption that the officer developed an opioid use disorder based on typical issues (e.g., physical injury) and not as a result of recreational use of prescription medications or the purchase or use of illicit substances. *Recreational use of licit drugs or any use of illicit drugs should be addressed through the disciplinary process, up to and including dismissal.* In addition, the decision to rehabilitate an officer is predicated on the assumption that the officer has not engaged in criminal conduct that would warrant termination.
>
> **L. Z. Schlosser, and G. P. McAleer, *Opioid Disorders Among Police and Public Safety Personnel: What Law Enforcement Leaders Need to Know* 2018 *The Police Chief* (the official journal of the IACP)[2] [italics added]**

163. In short, enlightened and informed leaders of the international policing community have recognized the fact that the opioid crisis hits police officers as it does other members of the community. They distinguish between those who have become addicted innocently as a result of injury or illness, and those who have become addicted through the recreational use of illegal drugs. They recognize that an ordinary part of addiction is that when sufferers engage in drug-seeking behaviour may also engage in illicit drug seeking behaviour. Finally while a more punitive approach may be used for police officers who have committed offences, that does not include illegal conduct in obtaining prescription drugs: that is in the nature of addiction.

164. The Commissioner has not offered any argument, much less an argument backed by evidence, that a return to work on a rehabilitation program would be unworkable. Indeed, consistent with his assertion that s. 126 of the *Police Act* does not state the purposes and principles that must be applied, the Commissioner has not even turned his mind to whether the disciplinary or corrective measures proposed by the Discipline Authority would be workable.

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[2] Retrieved 22 September 2018 http://www.policechiefmagazine.org/opioid-use-among-police-personnel/

165. Therefore, the Commissioner has not begun to meet the burden of establishing the first exception that would allow an Adjudicator to impose measures other than those directed to education and correction.

3.4 THE COMMISSIONER'S POLICY TOWARD ADDICTED POLICE OFFICERS WOULD BRING ADMINISTRATION OF POLICE DISCIPLINE INTO DISREPUTE

166. The second exception that would justify an Adjudicator in imposing measures other than those directed to education and correction is where such measures would bring the administration of police discipline into disrepute.

167. This branch of s. 126(3) was evidently borrowed from s. 24(2) of the *Charter*. The test under s. 24(2) asks whether a reasonable person informed of all the relevant circumstances, would consider that admission of the evidence would bring the administration of justice into disrepute.[3]

168. Therefore, one may ask how a reasonable, well-informed person would view the disciplinary or corrective measures proposed by the Discipline Authority on one hand, and the dismissal proposed by the Commissioner on the other.

169. Whether a person obtains his or her news through the print, broadcast or internet media, a reasonable, well-informed person would know about the opioid crisis generally and would know that a significant part of the opioid crisis arises from the over-prescription of opioids by honest physicians for honest patients. Such a person would have read countless accounts of ordinary law-abiding people who became addicted to prescription pain killers and when their prescription was abruptly terminated without assistance in weaning off the drug, they resorted to illegal means to obtain drugs. Reasonable, well-informed persons would have read about tragic overdoses on when previously honest and functioning members of society had resorted to street drugs.

170. The Commissioner may try to defend his position by arguing that he is not seeking to punish the addiction, he is just seeking to punish Cst. Young's conduct in altering prescriptions

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[3] See, eg. *R. v. Grant* [2009] 2 SCR 353.

and not telling the truth to the RCMP investigators. A reasonable, well-informed person would immediately see through and reject such an argument as being simplistic and entirely missing the point. A reasonable, well-informed member would know that drug-seeking behaviour including illicit drug seeking behaviour, is the very essence of addiction. A lay person may not know about the precise neurological mechanism by which physical changes in the brain drive a person to seek drugs at the same time that other changes to the brain reduce inhibition, but ordinary people know that the essence of addiction is an intense craving to obtain and consume drugs and that addicted persons suffer very unpleasant withdrawal symptoms if the drugs are not available. The addiction inherently involves drug-seeking behaviour, including illicit drug seeking behaviour.

171. The Commissioner argues that Cst. Young showed a lack of judgment which the Commissioner presents characterizes as a "moral failing", "a lack of moral compass", "morally blameworthy"; "a fundamental failing at a moral and professional level." A reasonable, well-informed person would be aware that healthcare professionals, law enforcement leaders, government officials, and the general public have set aside a moralistic approach to illicit drug-seeking behaviour as uninformed and dangerous. Such a person would be aware of the tremendous efforts that professional responders to the opioid crisis have made to educate the public that stigmatizing illicit drug-seeking behaviour as a moral issue, merely increases the risk to the addicted and the costs to society.

172. The Commissioner supports his moralistic approach to illicit drug-seeking behaviour by arguing that while Cst. Young's addiction influenced his behaviour, it did not pre-determine it.[4] A reasonable, well-informed person would recognize that the distinction between the addiction *impairing* his volition and judgment and the addiction *removing* volition and judgment, is sterile and pointless. As will be seen, termination of an employee who committed workplace misconduct in the context of addiction may amount to impermissible discrimination under the British Columbia *Human Rights Code*. The test for whether the misconduct was connected with the addiction is not whether the addiction *caused* the misconduct, but whether there is a

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[4] Commissioner's submissions, para. 10.

substantial connection between the addiction and the misconduct. In the present case, the evidence of Dr. Farnan makes it abundantly clear that while Cst. Young continued to know right from wrong, there was a very substantial connection between the addiction and the altered prescriptions. Indeed, the only point or purpose for Cst. Young to alter the prescriptions was to feed his addiction. This was not a case where, for example, someone steals money and one is then faced with the task of parsing out the benefit the person received by the stolen money generally, and the fact that he or she used some or all the money to buy drugs.

173. For many years, advocates for creative responses to opioid addiction have identified the obstacles that social stigma erects before addicted persons and those seeking to assist them:

> Stigma involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion as well as the internalization of community attitudes in the form of shame by the person/family being discredited.
>
> The social stigma attached to addiction constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the type and magnitude of cultural resources allocated to alcohol- and other drug-related problems.
>
> Social stigma attached to addiction is influenced by perceptions of the role of choice versus compulsion in addiction, the motivation for initial drug use (escape from pain versus a search for pleasure), and whether addiction is related to a socially defined "good" or "bad" drug.[5]

Today, with all that has been published in all forms of media, these facts would not be confined to learned journals, but would be well-known to a reasonably well-informed person. If one stigmatizes behaviours caused by addiction, one stigmatizes the addiction itself.

174. A reasonable, well-informed person would know that moral stigma does not only prevent individuals from accessing help they need, it can actually make the plight of addicted persons much worse. There are many commonalities between addiction and mental illness, and between

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[5]W.L. White, *Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia (With Particular Reference to Medication-Assisted Treatment/Recovery)* http://www.williamwhitepapers.com/pr/2009Stigma%26methadone.pdf (Retrieved 20 September 2018)

the stigma that remains attached to both. In the past few weeks, three police officers in the Ontario Provincial Police committed suicide. A well-informed person would have read in national media about the steps that the police unions, police managers, and public health officials in Ontario have taken to assure police officers that mental health problems will not be branded with negative stigma. Such person would be struck by the contrast between the approach of officials in Ontario, and the approach of the Commissioner in this proceeding.

175. Throughout his submission, the Commissioner argues that Cst. Young should receive the harshest punishment under the *Police Act* because, "the misconduct at issue amounts to criminal conduct." He referred to the altered prescriptions as "repeated and admitted criminal forgery." He claims that Cst. Young committed an "offence." It is not the Commissioner's function to punish criminal conduct. Mr. Lowe was once a prosecutor, but he is not one now. A reasonable, well-informed person would defer to those whom the law has appointed the task of deciding whether illicit-drug seeking behaviour should be punished as criminal conduct, or should be treated as the symptom of an illness. Such a person would be aware that in this case Crown counsel stayed the charges against Cst. Young, concluding that Cst. Young should not be punished as a criminal. A reasonable, well-informed person may be consider the Commissioner has strayed beyond his statutory powers, and is attempting to exercise powers that no longer belong to him. Such a person may conclude that usurping the power to punish supposedly criminal conduct would bring the administration of police discipline into disrepute.

176. A reasonable, well-informed person would be aware of the existence of The Drug Treatment Court of Vancouver. Offenders come before drug courts precisely because they have committed crimes to get drugs, or because an addictive lifestyle robs them of the ability to earn a living. Offenders who come to the Drug Treatment Court usually have committed crimes, and have criminal records that would justify jail sentences. However, if they acknowledge their misconduct and if they complete a rehabilitation program, they are not given the maximum penalty (as the Commissioner urges here). Rather they are congratulated for their efforts at rehabilitation in a graduation ceremony, and are given much reduced non-custodial sentences. The courts, Crown counsel, and the police support the approach that treats illicit drug-seeking behaviour as the symptom of an illness, not as ordinary crime. Evidently, the public supports the program as well.

177. A reasonable, well-informed person would be aware of the existence of safe injection sites. Nearly everyone who uses a safe-injection site is committing a criminal offence by possessing drugs illegally. These addicted persons are not treated or stigmatized as common criminals. Instead, the police create a safe area around the site and medical professionals monitor the users of the site. The Crown (federal and provincial) support the policy of not charging persons using the site. In Vancouver, the city government has supported and funded the safe injection site. This program has received wide-spread public support.

178. A reasonable, well-informed person would be aware that the Canadian Medical Association,[6] the City of Vancouver,[7] and the cities of Toronto and Montreal,[8] have all publicly called for the de-criminalization of drug possession of all kinds. Such a person would be aware that they have done so because of the evidence that establishes that when addiction and illicit drug-seeking behaviour are criminalized, addicted persons will be afraid to seek treatment, with increased risk to them and increased costs for society.

179. A reasonable, well-informed person would be aware that police officers in British Columbia are now routinely issued Noxalone to administer to persons in overdose. Police officers' principal role in addressing the opioid crisis is now as caregivers, not as enforcers of the law.

180. A reasonable, well-informed person would be struck by the inconsistency of a policy that recruits police officers in the battle against opioid addiction where they are trained to approach illicit drug-seeking behaviour not as crime, but as the symptom of illness in their role as enforcers of the law; but when they find themselves in the same dire straits as the citizens they serve, they should be punished as common criminals. Such a person would consider that so hypocritical a policy would bring the administration of police discipline into disrepute.

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[6] https://www.cbc.ca/news/politics/cma-president-decriminalizing-opioid-1.4832141

[7] (https://www.cbc.ca/news/canada/british-columbia/city-of-vancouver-drug-possession-1.4570720)

[8] https://www.cbc.ca/news/canada/montreal/montreal-public-health-drug-decriminalization- 1.4764319

3.4.1 Approach to Addiction-Related Misconduct in Other Regimes

181. Dr. Farnan spoke about how the medical regulators have come to deal with addiction and misconduct in the medical profession. One example Dr. Farnan discussed is when an addicted medical professional "diverts" drugs (i.e., steals drugs). In former times, the misconduct would immediately become the subject of formal discipline proceedings. Now the more common approach is for the regulator to be informed of the incident from the outset, but to take a watching brief. The focus of the response is on assessment, immediate treatment, and long-term monitoring. If the medical professional acknowledges the illness and complies with treatment, the regulator often takes no further action. If on the other hand the medical professional is defiant or does not make proper efforts to comply with the treatment program, formal discipline proceedings may be pursued. Even though in this example the professional committed theft by stealing drugs, law enforcement is generally not brought in.

182. The regulators of the medical profession have a duty to protect the public interest in a safe medical system in much the same way that a discipline authority has a duty to protect the public interest in policing. The theft of drugs by a nurse or doctor strikes closely to the heart of public confidence in the medical system, because it is a violation of the prescription system that the medical community is entrusted to administer. Yet, the regulators of the medical professions do not see treating diversion of drugs as an illness rather than as misconduct as something that would bring discredit upon their profession.

183. In summary:

(a) Section 12(3) does provide a statement of purpose and principle that must be applied when considering disciplinary or corrective measures.

(b) The statement of purpose and principle gives precedence to education and correction, except where doing so would be unworkable or would bring the administration of justice into disrepute.

(c) The rehabilitation program proposed by the Discipline Authority is focused on the obvious and demonstrable cause of Cst. Young's misconduct. It has been effective until now, and is very likely to continue to be effective going forward.

(d) That rehabilitation program is obviously not unworkable. The Commissioner has not argued that it is unworkable, much less made such an argument backed by evidence.

(e) A reasonable, well-informed person would not consider that the disciplinary or corrective measures proposed by the Discipline Authority would bring the administration of police discipline into disrepute.

184. Therefore, the measures proposed by the Discipline Authority for misconduct that consists of altering prescriptions should be upheld.

3.5 THE CRITERIA IN S. 126(2) OF THE *POLICE ACT*

185. The *Police Act* requires the Adjudicator to take into account an open list of criteria in assessing the disciplinary or corrective measures.

(a) *Seriousness of the Misconduct*

186. Both the altered prescriptions and the misstatements to the RCMP are aspects of illicit drug-seeking behaviour. The alteration of the prescriptions has been discussed above.

187. The Commissioner and the Discipline Authority treated the misstatements to the RCMP as categorically different from the altered prescriptions. It is submitted that this misses the essential point that the misstatements to the RCMP were solely to cover up the illicit drug-seeking behaviour. Further, the misstatements were not part of a planned campaign of deceit as in the cases cited by the Commissioner. Rather, it was a spontaneous, panicked response to being suddenly caught when Cst. Young was in the throes of withdrawal symptoms. It is therefore submitted that the misconduct was morally blameworthy in the way that planned and deliberate deception may be.

(b) *The Member's Record of Employment*

188. Cst. Young has no record of misconduct, in the military, British Columbia Corrections, the Transit Police, or the Delta Police. This is an important mitigating factor.

189. The Commissioner argues, however, that this good record is not relevant. He offers no explanation for why it is not relevant. He also argues that if separate proceedings had been commenced for each altered prescription by the time the latter proceedings concluded, he would have had a significant negative record. This is truly grasping at straws. The illogic of this argument is manifest.

(c) *Impact of the Proposed Sanction on Cst. Young and His Family*

190. This process has already had a serious impact on Cst. Young. He has had to pay his own legal bills at the Discipline Proceeding, and now at this Review on the Record.

191. Cst. Young has made great progress with his addiction and before the Commissioner called this review, he had been accepted back on the job and back on the road. Not surprisingly, this proceeding and the prospect of losing his job, his salary, and his extended medical benefits, has been exceedingly stressful for Cst. Young and his wife. The stress of this Review on the Record has been enormous particularly after Cst. Young received the submissions of the Commissioner in which he asked for his dismissal, arguing that Cst. Young lacks a moral compass and should be treated as a common criminal.

192. Dismissal from the Delta Police would amount to dismissal from policing in general. The financial impact including present salary, retirement pension, and extended health benefits for a person with Cst. Young's health care needs would be catastrophic. The Commissioner appears to recognize these facts but then says that Cst. Young and his family deserve this punishment, because of Cst. Young's moral failure. The moral failure argument has already been addressed.

(d) *Likelihood of Future Misconduct*

193. Addiction is unpredictable and there always remains the possibility that recovery will be interrupted. However, Dr. Farnan noted that 75-80% of professional in safety-critical positions are able to remain clean and sober.

194. The Commissioner claims that the evidence "establishes" that it is likely that Cst. Young will commit misconduct again. Notably, the Commissioner did not actually cite any of the evidence in that submission. The Commissioner's argument on this point is highly freighted

with his moralistic attitude towards Cst. Young's illicit drug-seeking behaviour. Again, this the Commissioner's moralistic attitude has been addressed above.

(e) *Whether the Member takes responsibility and takes steps to prevent recurrence*

195. The Commissioner concedes as he must based on the evidence, that Cst. Young took full responsibility from the outset for his conduct and has taken every available measure to become, and remain clean and sober. However, the Commissioner is unwilling to give Cst. Young due credit for this. Once again, the Commissioner argues that the member should receive no credit on this criterion because he "lacks the moral compass" to decide right from wrong. As this last assertion has no basis in Cst. Young's actual record of employment, it is simply one further instance of the Commissioner's moralistic approach to addiction and drug-seeking behaviour.

(f) *Did the Department's Policies Contribute to the Misconduct*

196. This is not applicable.

(g) *The Range of Sanctions in Other Cases*

197. The Commissioner has included an appendix which includes penalty decisions in a number of deceit cases. The Commissioner overlooks the fact that Cst. Young was not accused of deceit, and he was not found to have committed deceit. Deceit under the *Police Act* does not mean simply telling an untruth. It is confined to two situations: (1) making false statements *in the officer's capacity as a police officer*; and (2) destroying, altering, concealing *official records.*[9] Obviously, deceit by a police officer in the course of his professional duties or altering official records, is a very specific and serious form of misconduct. In the present case, Cst. Young did not make any misstatement in his capacity as a police officer, and the prescription could not be considered an *official record.* Therefore, the precedents the Commissioner relies on are of no relevance whatever.

198. A more relevant decision is found in [redacted] *of the Victoria Police Department* per the Honourable Ian H. Pitfield. In that case, the member failed a roadside screening device and

[9] "Official record" is not defined in the *Police Act*.

when asked by the operator when his last drink was, he gave a false answer. The allegation against the officers was discreditable conduct while off duty, as here. In both cases the member committed a regulatory infraction. In both cases the member initially tried to cover it up with a misstatement. [redacted] received a four day suspension for the failure of the roadside screening device, and a four day suspension for not telling the truth to the operator.

199. The [redacted]. case was more serious than the present case in several respects. First, the regulatory infraction was more serious. Failing a roadside screening device indicates that the driver had a blood alcohol level substantially above the criminal standard. This, in turn, means that he was engaging in a dangerous criminal activity; drunk driving. The misstatement to the operator was also more serious. There is no indication that the driver was addicted to alcohol, or that the misstatement was causally related to addictive drug-seeking behaviour, or an attempt to cover it up.

200. It is therefore submitted that the decision in [redacted] should be seen as the upper limit for cases of discreditable conduct where a person commits a regulatory infraction, and then briefly covers it up with a misstatement. The four day suspension for the drunk driving should not be considered a precedent that would require a similar suspension for Cst. Young's very different conduct, under very different circumstances. Further, it is submitted that the mitigating circumstances surrounding Cst. Young's innocent addiction and its connection with the misstatements to the RCMP investigators mandates a lesser penalty than a four day suspension. It is submitted that a written reprimand for this misconduct is also appropriate.

201. The Commissioner relies on the decision in *Cst. Thandi.* There are three fundamental reasons why this decision does not assist the argument of the Discipline Representative, and in fact is of no relevance to this case.

202. First, there was no clear evidence that the subject officer in fact suffered from any condition that might affect his mental functioning. Evidence was tendered to the effect that he *might have* been in a state where his judgment was impaired. On the Review on the Record, the retired judge found that the possibility that the subject member might have been in a state of hypomania at the time of the incident was merely "retrospective speculation;" that is, there was insufficient evidence that at the time of the alleged misconduct the subject member suffered from

any form of psychiatric illness. This is a reasonable finding. In that case, the evidence went no further than that the subject member had had "infrequent" periods of hypomania several years earlier. (*Thandi,* paragraph 4-5). In this case by contrast, there is no doubt whatever that Cst. Young was in the throes of as serious opiate addiction at the time that he committed the misconduct.

203. Second, in *Thandi* there was no evidence of a medical connection between the asserted mental illness and the misconduct. By contrast, in this case there was unchallenged medical evidence addiction involving physical changes to the brain that diminish the patient's centres of inhibition. At the same time, the withdrawal symptoms induce power drug-seeking behaviour which is also the result of physical changes to the brain. There was no similar evidence in *Thandi.* Indeed, in *Thandi* the evidence was that the subject member engaged in misconduct both when his illness was under control by medication and when it was not (*Thandi*, para. 17). In this case, Cst. Young did not engage in any misconduct before or after he became addicted to hydromorphone.

204. Third, in *Thandi* there was no legal discussion whatever of the elements of the misconduct of discreditable conduct. Much less was there any discussion of the elements of discreditable conduct in the context of mental illness generally, or addiction in particular. The retired judge never asked the question whether a reasonable, well informed member of the community would consider that the conduct of the subject member in that case brought discredit upon the municipal police department. That was understandable in the *Thandi* case because there was no evidence of a psychiatric condition for a reasonable, well informed member of the public to take into account.

205. Therefore, the *Thandi* decision did raise either the factual or legal issues that are raised in this case.

3.6 THE *HUMAN RIGHTS CODE* RSBC [1996] C 210

206. The Court of Appeal has accepted that the *Police Act* is "highly specialized labour relations legislation dealing with the employment of police officers, and the protection of the public by means of the disciplinary tools provided by the statute."[10]

207. Relations between employers and employees on matters of disability and the duty to accommodate are governed by the British Columbia *Human Rights Code.*[11] Section 4 of the Code provides:

> If there is a conflict between this Code and any other enactment, this Code prevails.

Therefore, the *Police Act* is subject to the Code.

208. Section 13 of the *Code* provides:

> **13** (1) A person must not
>
> (a) refuse to employ or refuse to continue to employ a person, or
>
> (b) discriminate against a person regarding employment or any term or condition of employment
>
> because of a… physical or mental disability ….

2. In *Health Employers Assn. of British Columbia v. B.C.N.U.* 2006 BCCA 57 the Court of Appeal considered the case of a nurse who had become addicted to drugs (the nature was not stated). The nurse was found to have stolen drugs. The nurse had committed misconduct on several prior occasions, and was unable or unwilling to comply and complete rehabilitation programs. On earlier occasions, he had entered into "last chance agreements" under which he undertook to adhere to a recovery program. He did not remain abstinent, but instead stole drugs and falsified records. This gave rise to two questions: (1) was drug addiction a disability that required employers to accommodate the employee; and (2) did the employer in this case accommodate to the point undue hardship.

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[10] *Florkow v. Police Complaint Commissioner* 2013 BCCA 92 at para. 2.

[11] [RSBC 1996] c. 210

On (1), the court concluded that addiction is a disability that requires accommodation:

> 38 Discrimination is defined in s. 1 of the *Human Rights Code* to include conduct that offends s. 13(1)(a). A finding that there was a "refusal to continue to employ a person" on the basis of a prohibited ground is discrimination. Therefore, under s. 13(1)(a), to establish a *prima facie* case of discrimination, an employee must establish that he or she had (or was perceived to have) a disability, that he or she received adverse treatment, and that his or her disability was a factor in the adverse treatment: *Martin v. Carter Chevrolet Oldsmobile*, [2001] B.C.H.R.T.D. No. 39, 2001 BCHRT 37 (B.C. Human Rights Trib.) at para. 22, [*Martin*].
>
> ***39 In the present case, there is no dispute that Mr. Bergen has a disability and that he was adversely treated in that his employment was terminated. The contentious issue is whether his addiction was a factor in the termination or whether there was an explanation for his termination unrelated to his disability.***
>
> 40 The employer argues there was no medical evidence that Mr. Bergen's addiction disability was a causal factor in his misconduct, and that the arbitrator erred in assuming that the duty to accommodate arose simply because Mr. Bergen had an addiction.
>
> 41 It is important not to assume that addiction is always a causal factor in an addicted employee's misconduct: see *Martin*, *supra* at para. 28. To find *prima facie* discrimination, there must be evidence that the employee's misconduct was "caused by symptoms related to" the disability: see *Handfield v. School District No. 26*, [1995] B.C.C.H.R.D. No. 4 (B.C. Human Rights Council) at para. 156, [*Handfield*].
>
> ***42 The arbitrator held that there was an "overwhelming connection between the grievor's addiction and his workplace misconduct", and that his misconduct was "partly culpable and partly non-culpable with the predominant factor being his addiction".*** The misconduct relied upon by the employer to justify the termination was Mr. Bergen's failure to abstain from drug use *as required by the second last chance agreement*, theft and dishonesty (see para. 31 above). Although the employer could not rely on the last chance agreement, it could properly rely on Mr. Bergen's failure to abstain from drug use as required by the employer's policy in that regard.
>
> 43 It would be reasonable to infer, as the arbitrator appears to have inferred, that Mr. Bergen's theft and dishonesty, as well as his failure to abstain, were caused substantially by his disability, namely his addiction.
>
> 44 So although the arbitrator did not expressly find that there was *prima facie* discrimination, the facts she did find would clearly satisfy the definition of discrimination as set out in s. 13(1)(a) of the *Human Rights Code* (para. 26 above). There is therefore no useful purpose to be served by remitting the case to the arbitrator on this issue. *Prima facie* discrimination has been established as

> defined in the *Human Rights Code*, and it is therefore necessary to address the employer's duty to accommodate.

3. The test applied by the Court of Appeal was not whether the addiction *caused* the misconduct, but whether there was a *connection* between the misconduct and the addiction. The finding that the "misconduct was "partly culpable and partly non-culpable with the predominant factor being his addiction" was sufficient to establish a connection between the addiction and the misconduct, without the need to find that the misconduct had *caused* the addiction.

4. Therefore, there was a duty on the employer to accommodate the employee. On the facts of that case, the employee had twice before been given "last chance agreements". The British Columbia Court of Appeal considered this to be sufficient accommodation:

> 52 The arbitrator's error, having correctly put the last chance agreement aside, was in failing to consider adequately or at all that Mr. Bergen had received two prior employment opportunities to cope with his addiction, and had failed to do so. The employer's duty to accommodate Mr. Bergen was matched by his duty to facilitate the accommodation process: see *Renaud v. Central Okanagan School District No. 23*, [1992] 2 S.C.R. 970 (S.C.C.) at paras. 43-44. Addiction, as a treatable illness, requires an employee to take some responsibility for his rehabilitation program: see *Handfield*, *supra*. Mr. Bergen failed to discharge that duty, and the duty to accommodate was exhausted.

5. It appears, therefore, that if the nurse had not violated several earlier "last chance" agreements, the employer would have had to accommodate the disability – addiction – by providing an opportunity for the nurse to complete a rehabilitation program. In the present case, Cst. Young has taken responsibility for his illness. He has attended and successfully completed residential treatment, continues to attend mutual support groups, and continues to be subjected to intrusive biological monitoring.

6. It may be noted that the misconduct that had earlier been accommodated was criminal in nature and unlike in the present case, was directly related to the nurse's professional duties. In the present case, Cst. Young was off duty in long term disability when he altered the prescriptions, so his misconduct was unrelated to his disability.

7. The case of *Kemess Mines Ltd. V. IUOE Local 115* 2006 BCCA 58 was heard by the Court of Appeal with the *Health Employers' Assoc.* case. In *Kemess Mines,* a heavy equipment

operator in an open pit mine smoked marijuana at work. As with policing and nursing his job was also in a safety-critical occupation. Smoking marijuana was illegal and contrary to the employer's zero tolerance policy on drugs. The conduct of the employee here was much more serious than that of Cst. Young, because Cst. Young did not take any opioids while on duty (he was on long term disability), and the drugs he took were legal for him to take.

8. A preliminary issue arose as to whether principles of the *Human Rights Code* or the *Labour Relations Code* prevailed. The Court held that, "the duty to accommodate is a matter of general law that is not limited by any principles of labour relations, either expressed in the *Labour Relations Code* or another statue." This is consistent with s. 4 of the *Code,* cited above.

9. In *Kemess*, unlike in *Health Employers Assoc.*, the employee had not previously been given a "last chance" agreement or other return to work rehabilitation program. The arbitrator ruled that to dismiss the employee in those circumstances amounted to discrimination on the basis of a disability (addiction to marijuana), and that the employer had not accommodated to the point of undue hardship, as required by the *Code.* The Court of Appeal upheld the arbitrator's order.

209. In the present case, Cst. Young's employer is more than willing to accommodate his addiction. Indeed, the employer has been very active in assisting Cst. Young to obtain treatment and once he was cleared by his psychiatrist for a return to work, the employer has welcomed Cst. Young back with open arms. It is only the Commissioner who says that Cst. Young's disability should not be accommodated.

210. It is therefore submitted that the principles enunciated in s. 13 of the *Human Rights Code* apply to discipline under the *Police Act*. It is therefore unlawful to order that a police officer be dismissed because of conduct that is substantially related to an addiction, unless the employer has made proper efforts to accommodate the addiction and the police officer has failed to facilitate the accommodation.

4. CONCLUSION

211. When Cst. Young altered the prescriptions and covered it up briefly in misstatement to the RCMP, he was in the throes of a serious addiction.

212. The altered prescriptions and misstatements were wrong, but they harmed no one but Cst. Young himself. He was not on duty so no member of the public was affected.

213. Cst. Young contracted the addiction completely innocently: through hydromorphone that had been prescribed for over a year to manage the pain from an exceptionally painful condition. That is, one illness (Crohn's disease) led to another (addiction).

214. The altered prescriptions and lies were errors of judgment. All humans make errors of judgement. But Cst. Young's errors were not ordinary errors of judgment by a person who is healthy, and whose brain has the ordinary inhibiting function to put the brakes on bad decisions. In Cst. Young's case, he was in the throes of the compulsive drug seeking behaviour that is the very essence of addiction. This compulsive behaviour has its roots in physiological changes to the brain. At the same time, another part of the brain that would ordinarily inhibit improper behaviour was also damaged. He was a passenger in a car with the gas pedal jammed down, and no brakes.

215. Section 126(3) mandates and approach that gives precedence to disciplinary or corrective measures that educate and correct. The disciplinary or corrective measures proposed by the Discipline Authority for the altered prescriptions is sufficient to educate and correct Cst. Young with respect to that misconduct, and with respect to the brief denial that Cst. Young had tried to fill the altered prescription earlier in the day. The altered prescription, the attempt to fill it, and Cst. Young's statement to the RCMP when they prevented Cst. Young from filling it, all have the same source: the innocent addiction to hydromorphone.

216. A return to work subject to the rehabilitation program is manifestly not unworkable. To the contrary, it is working and there the evidence suggests it is likely to be successful going forward.

217. A reasonable, well-informed member of the public would see Cst. Young's conduct as the outward manifestations of illness, not misconduct deserving of punishment. Such a person would understand drug-seeking behaviour including illicit drug-seeking behaviour, as being the essence of addiction to opioids. A reasonable, well-informed member of the public would see the

punishment of Cst. Young as the exercise of an unenlightened policy that encourages addicted police officers to remain in the shadows, thereby increasing the risk to public safety.

218. The *Human Rights Code* applies to decisions under Part 11 of the *Police Act*. Summary dismissal for conduct substantially connected to an addiction, amounts to impermissible discrimination on the basis of disability contrary to s. 13 of the *Code.*

219. Therefore, it is submitted that the Adjudicator should uphold the decision of the Discipline Authority on the disciplinary or corrective measures for the misconduct of altering the prescriptions, and should substitute the same measures for the misconduct of his statement to the RCMP officer.

23 September 2018

M. Kevin Woodall

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