Court of Queen's Bench of Alberta

Citation: Jegou v Canadian Natural Resources Limited, 2021 ABQB 401

Date: 20210520
Docket: 1501 05244
Registry: Calgary

Between:

Michael Jegou

Plaintiff

- and -

Canadian Natural Resources Ltd.

Defendant

Reasons for Judgment
of the
Honourable Mr. Justice G.H. Poelman

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I. Introduction

[1] Canadian Natural Resources Ltd. (“CNRL”) operated an oilsands facility known as the Horizon Oil Sands approximately one hundred kilometers north of Fort McMurray, for the mining and upgrading of bitumen to synthetic crude oil. It comprised in part a plant, airport, large pit mine, firehall, clinic known as the Horizon Health Clinic, and dorm-style residential camps. Usually there were between eight thousand and ten thousand employees and contractors on the Horizon Oil Sands site.

[2] Michael Jegou was a qualified paramedic, registered with the Alberta College of Paramedics. He obtained this designation in 2003. Prior to being a paramedic, he qualified for the lesser designations of emergency medical responder (“EMR”) and emergency medical technician (“EMT”). He worked at Horizon from August 10, 2009 until his dismissal on March 18, 2015.

[3] The primary issue is whether CNRL had just cause for summarily dismissing Mr. Jegou on the ground that he failed to act according to the standards of his profession and CNRL’s requirements for paramedical employees at Horizon. In addition, it must be determined what damages Mr. Jegou would be entitled to if his dismissal was unjust, including the notice period and elements of compensation to be included.

[4] The evidence comprises an agreed statement of facts, exhibits entered by agreement, additional exhibits tendered during the trial, the testimony of witnesses, and excerpts from discovery evidence read in at trial.

[5] I will begin with a summary of the evidence of the witnesses, with little comment on how I assess it. Thereafter, I will turn to my findings on the important facts, a review of the legal principles, and my conclusions on just cause and damages.

II. Summary of Plaintiff's Evidence

A. Michael Jegou

1. Background and Qualifications

[6] Mr. Jegou obtained the necessary educational qualifications to work as an emergency medical technologist-paramedic ("EMT-paramedic or EMT-P") in October 2003. At the relevant times he was registered as an EMT-P with the Alberta College of Paramedics. He first worked as a paramedic in Brooks. In 2009, he successfully applied for a position as firefighter/EMT-P at CNRL's Horizon site near Fort McMurray. He started as a paramedic in August 2009; one year later, he obtained a National Fire Protection Association firefighting designation.

[7] He testified that his understanding, based on verbal communications from Horizon's medical director, Dr. Johan Bouwer, was that if Dr. Bouwer was unable to answer a phone call the paramedic could deviate from CNRL's *Medical Controlled Guidelines* ("*Guidelines*") for the best interests of the patient. He reported directly to his platoon commander, Ian McLeod but was responsible to Dr. Bouwer on medical matters.

[8] During his time at CNRL, Mr. Jegou was designated a lieutenant and became the medical training officer for his shift (which did not affect his compensation). In 2014, he began to fill in from time to time as a shift captain when his captain or platoon commander were away. He received additional pay for those shifts.

[9] Prior to the fall of 2014, Mr. Jegou received very positive feedback on his annual performance reviews.

2. Fall Case: November 19, 2014

[10] On November 19, 2014, Mr. Jegou was on duty, working as captain. He received a call on emergency radio requesting medical assistance for a twenty-year-old male who had reportedly fallen about seven feet and broken a leg, arm and ankle. He went to the approximate location with a colleague, Dale Young. They had difficulty locating the patient through a busy, intricate area of the site involving a number of up and down flights of stairs and cage ladders. Radio communications were often interrupted.

[11] When they located the patient by an empty storage tank, he explained that he had fallen only about five feet. The entire distance was eight to ten feet, but the first part of the fall was broken by the "fall arrest" or harness he was wearing. Then the harness gave way and he fell approximately five feet. He landed on his wrist and chest. His wrist appeared swollen and slightly deformed. He was wearing a helmet, which was undamaged and he reported that he had not hit his head. He indicated that he had struck his left wrist and described minor injuries to his ribs.

[12] Mr. Jegou conducted physical examinations and ruled out a C-spine injury; noted that he had no spinal tenderness; and was able to turn his head from shoulder to shoulder without pain. He had no numbness but his left hand was sore.

[13] Various options were considered to remove the patient, one of which was calling for a rope rescue crew. The concerns were a risk of spinal injury and aggravating the obvious wrist injury. Calling a rope crew would have increased the amount of time the patient would be completely immobilized, as there would be considerable delay in getting a rope crew to the incident area. The exit with the assistance of the rope crew would also have been time consuming. The patient was asked whether with assistance (someone following him down the cage ladder) he would prefer to exit immediately; he preferred that suggestion, as he did not want to be stuck on a back board.

[14] Mr. Jegou testified that they really should have splinted his left wrist, to stabilize it better; however, he had come with a fire engine and did not have a splint with him. As the patient did not want to wait the time for Mr. Jegou to go down and get a splint (about ten minutes), Mr. Jegou took the "calculated risk" that they could get him out without doing further damage to the wrist.

[15] When the patient was taken out of the area, they were met by another paramedic, Tyler McLellan. He applied a splint to his wrist and transported the patient to a medical facility. Based on the patient care report prepared by Mr. McLellan, Mr. McLellan re-evaluated the patient's spine and ruled out a spinal injury. As with Mr. Jegou, he did not call for a back board.

[16] Concerns were raised about whether, because of the potential of a spinal injury, the patient should have been kept until a rope crew could arrive to extract him; and whether his wrist should have been splinted at the site. In his statement and at a meeting called to discuss the matter, Mr. Jegou explained the delay and difficulties involved in bringing a rope crew, and the patient's preference to exit, with assistance, by the cage ladder. It would have taken at least twenty minutes for a rope crew to arrive, and the extraction would have taken at least an hour.

[17] Further, he indicated that he did not have splint supplies with him, and elected not to return to his ambulance to procure them, because of the delay that would be involved. He agreed that he should have splinted the wrist; if the situation were to present itself again, he would definitely do so.

[18] According to Mr. Jegou, Dr. Bouwer said at the meeting that he agreed with Mr. Jegou's spinal assessment and with choosing not to immobilize the patient before removing him. Mr. McLeod supported Mr. Jegou's decision as well. John Penzo, a paramedic with special expertise, and Fire Chief Robert Slade both strongly disagreed, saying such cases always required immobilization. In Dr. Bouwer's opinion, however, the wrist should have been splinted although he recognized Mr. Jegou had not brought the equipment with him.

[19] As a result of these discussions, it was determined that the crew should go over spinal immobilization procedures and more rope technician courses should be arranged. Mr. Jegou, in accordance with these recommendations, went over spinal immobilization procedures and the need for one when appropriate with his crew.

[20] Mr. Jegou said he was never warned that discipline or termination would be possible as a result of this incident. He heard nothing more about it until after termination of his employment.

3. Stroke Case: February 17, 2015

[21] At 10:30 a.m. on February 17, 2015, Mr. Jegou and his colleague, Geoff Pyke, an EMT (thus having less medical training and qualifications than Mr. Jegou), received a call to respond to an inquiry about an employee who had not reported for work at 6:00 a.m. Mr. Jegou and his partner traveled to Calumet Camp, where the patient had a room, and were advised en route that he had been located. Mr. Jegou and Mr. Pyke saw the patient who was with a co-worker near his room. Mr. Jegou was informed in a call to the patient's supervisor that it was the patient's first rotation back from work; he had sustained a heart attack on site just before Christmas and was brought to the Northern Lights Regional Health Centre (the hospital in Fort McMurray).

[22] With the approval of the security attendant, Mr. Jegou went into the patient's room to look for medical records indicating that he was cleared for return to work and medications. He thought this information would be of assistance in assessing the case.

[23] On finding nothing, he questioned the patient and noted a facial droop, mild slurring of words and very mild decrease in strength to the left side. There was some confusion as to time; the patient appeared to believe the current month was March. Both Mr. Jegou and Mr. Pyke believed the patient had likely sustained a stroke. The last time he was seen well was sometime the prior evening; this was based on dispatch information that the patient's swipe card had last been used ten minutes before seven the previous evening.

[24] Mr. Jegou called a fire engine for extra assistance in lifting the patient on a stretcher from the third floor of the Calumet residence to the ambulance. He suggested to Mr. Pyke that they go to the Horizon Health Clinic for an "information grab." He was interested in seeing if there were any records of the patient's prior medical incidents, which might show a previous stroke, which in turn might indicate whether the current symptoms fell within the normal range for him. Mr. Pyke agreed with Mr. Jegou's suggestion.

[25] The driving distance from Calumet Camp to the clinic was about 1.1-1.2 kilometers, thus requiring only a few minutes. The driving time to Fort McMurray, in a different direction, was about one hour.

[26] In the ambulance and, indeed, throughout Mr. Jegou's time with the patient, his condition remained steady and his vitals were good.

[27] Before heading to the clinic, Mr. Jegou called and spoke with one of the clinic nurses, Keith Harrison, to advise they were coming to the clinic. Mr. Harrison strongly objected, stating that all stroke patients must be taken immediately to the hospital because no treatment would be available at the clinic. Mr. Jegou eventually hung up on Mr. Harrison because, he said, Mr. Harrison was cutting him off.

[28] Mr. Jegou did not call Dr. Bouwer while en route from Calumet Camp to the clinic. He explained that he knew he was on vacation in South Africa and thought he might not have his cellphone.

[29] On arrival at the clinic, Mr. Jegou and Mr. Pyke lowered the stretcher from the ambulance and wheeled it into the clinic's trauma bay, where the patient was left on the stretcher beside the room's regular bed. Mr. Harrison and another nurse, Louise Palin, strongly objected to Mr. Jegou having brought the patient in, insisting that stroke protocol required him to be transported immediately to the hospital. Mr. Jegou testified that when he explained he was not intending to leave the patient at the clinic, but merely look for information, they calmed down.

[30] Mr. Jegou went with Ms. Palin to a meeting room where they attempted to access the patient's information on "Medgate," the electronic records system used by the clinic. They could find no records. Then they went to the pharmacy (which had to be unlocked by a nurse) to use a landline telephone to see if Dr. Bouwer could be reached on his cellphone. Mr. Jegou was able to speak briefly with Dr. Bouwer even though he was on vacation in South Africa. In the meantime, Mr. Harrison put an intravenous ("IV") line into the patient's arm, although this was only a prepatory measure in the event that fluids needed to be given to the patient.

[31] During his testimony, Mr. Jegou was challenged on why he made the stop at the clinic rather than drive directly to the hospital in Fort McMurray; why he took the patient into the clinic, rather than one person go in for what information could be obtained; why the stop took thirty-two minutes; and why he did not attempt to call Dr. Bouwer on his cellphone before stopping at the clinic.

[32] Mr. Jegou gave way on most of these challenges, acknowledging that he made bad judgment calls. He testified that he knew the patient would have to be taken to the Fort McMurray hospital, and never intended to leave him in the care of the clinic staff, despite concerns to the contrary – and being challenged on this point in cross-examination. As he told the clinic staff, he also believed that the patient was well outside the 4.5 hours that was the accepted window within which medical procedures could be taken to reverse the effect of a stroke. He testified that with patients outside the window, they would still be taken to a hospital but the paramedics would not endanger other people by "blaring down the highway with lights and sirens"; he said you could take your time and make sure the patient is comfortable.

[33] He persisted in his concern about privacy in making a cellphone call about a patient's condition, rather than use a landline; but this suggestion was ridiculed by Dr. Bouwer in a later meeting, and Mr. Jegou acknowledged that there were landlines he could have used at the Calumet Camp. He admitted that, in hindsight, he should have simply telephoned the clinic to see if they had any medical information rather than make the stop. He was unable to explain why the stop at the clinic took thirty-two minutes.

[34] Ultimately, the patient was transported to the Fort McMurray hospital without further incident, with sirens and lights activated. Mr. Jegou notified the firehall that he and Mr. Pyke would be offsite for a couple of hours.

[35] An investigation involving a number of statements and meetings was commenced by Dr. Bouwer after his return from South Africa, apparently as a result of a complaint made by one of the clinic's nurses. Following a March 12, 2015 meeting involving Dr. Bouwer, Fire Chief Robert Slade and John Penzo, Mr. Jegou was advised that he was being sent home from Horizon while the matter was considered. On March 18, 2015, he was informed by telephone that his employment was terminated, and a letter of that date was subsequently received. The reason for his dismissal was stated in the letter as being his "failure to meet minimum standards of care required of a paramedic, and in which two patients were put at risk of serious and irreparable harm."

[36] CNRL submitted a "termination report" to the Alberta College of Paramedics on March 31, 2016, referring to the February 17, 2015, incident as the reason for Mr. Jegou's termination of employment. As part of the proceedings by the college, Mr. Jegou with the assistance of counsel agreed to a joint submission regarding penalties. The joint submission including his acknowledgment that his conduct was a marked deviation from the required standards of practice

for his profession, that his "unskilled practice" was an isolated event and that this was his first finding of unskilled practice. The proceedings also included a lengthy recital of facts which were not in dispute, and summarized with the agreement of Mr. Jegou through his counsel.

4. Assessment

[37] For the most part, during his lengthy testimony, Mr. Jegou presented as a straightforward witness, attempting to answer the questions put to him, whether by his counsel or opposing counsel. He was not argumentative. Often, he was quick to acknowledge that he had made mistakes and should have handled the call to the stroke patient differently. Nevertheless, he frequently brought up the reasons he had used as his excuses in 2015.

[38] The difficulty with his testimony is that much of what he did on February 17, 2015 makes no sense in the context of responding to an emergency medical call, which is what it had become when Mr. Jegou arrived at Calumet Camp. It is hard to see how, even at the time, his justification for acting would have made sense to himself, as an experienced and well-trained paramedic. The unaccountable length of time for the stay at the clinic has still not been satisfactorily explained. The nature of much of his testimony on critical points is inherently problematic.

[39] Finally, in my view he was evasive and untruthful when challenged about why he had not called Dr. Bouwer before arriving at the clinic. Evidence from other witnesses, as will be seen, is overwhelming to the effect that Dr. Bouwer was always available at his cellphone.

B. Dr. Navraj Heran

[40] Dr. Heran was qualified as an expert in neurosurgery. In addition to his extensive qualifications as a neurosurgeon, for nearly thirteen years he has been a part of a group including paramedics and nurses as well as doctors dealing with stroke issues.

[41] He described a stroke, or "cerebral vascular accident," as blockage of a vessel in the brain affecting blood circulation. The extent of the damage depends on the blockage and its location. Brain tissue dies during a stroke. It is analogous to a heart attack, where the blockage in circulation occurs to a vessel in the heart. Sometimes the damage caused by a stroke is reversible.

[42] He assumed as accurate information provided for the basis of his opinion, such as timeline of events, distances and times of travel. He observed that there was no defined time for the onset of the stroke – at latest, it would have been the time the patient was due to report for work (6:00 a.m.). He was also given documentation from the hospital (with the patient's name redacted).

[43] He noted the reported symptoms were drooping left side of the face, slurring of speech, weak left-sided grip and mild confusion. Mr. Jegou had been informed that the patient had suffered a heart attack just before Christmas, and was on his first rotation back at work. The National Institutes of Health Stroke Scale score was reported to be in the range of five to nine – with most of the information indicating five or seven, both at the low end of severity. The lower the stroke score, the less likely intervention would be justified because of reduced benefit and the risk of bleeding and other complications caused by intervention. Typical interventions would include administering medications intravenously to dissolve clots.

[44] Dr. Heran agreed with the general proposition that upon recognition of a stroke, no time should be wasted in getting the patient to a hospital. Efficiency is very important; as time goes on

there is less possibility of reversing the damage. Generally, if someone called him advising of symptoms such as those exhibited by this patient, his advice would be to get the person to the closest hospital as soon as possible.

[45] However, in 2015, medical practice accepted that the intravenous stroke window was 4.5 hours (meaning that it would be unlikely that the Fort McMurray hospital could administer effective reversing treatment after that time), and the anterior circulation intraarterial stroke window was six hours (meaning that after that time, it would be unlikely that an Edmonton hospital could intervene with more advanced procedures).

[46] Based on his review of records, the patient was extensively managed at the Fort McMurray hospital and remained there for six days. The records show no deterioration in the patient's condition while in the care of the paramedics or the hospital.

[47] He was informed that Mr. Jegou had stopped at the Horizon Health Clinic because he thought it might have patient information in light of the patient's recent heart attack that could benefit hospital staff. However, the delay of about half an hour did not have an effect on the treatment that would have been available either at the Fort McMurray hospital or at an Edmonton hospital. It was suggested to him that it was not a paramedic's role to determine whether a patient was out of time for treatment, to which he responded that one would have to use their common sense.

[48] Dr. Heran gave his evidence in a clear, fair and balanced manner. He answered questions of both lawyers freely and confidently without becoming argumentative. There were no concerns arising from his demeanour.

C. Amanda Jegou

[49] Ms. Jegou is a registered nurse who worked for CNRL from 2008 through to and including the events at issue in this lawsuit. Her services were initially performed through a company contracting clinical workers to CNRL, but as of August 2012 she worked for CNRL directly. She has two speciality certifications, one in emergency nursing and the other in occupational nursing. It was in the latter capacity that she was working for CNRL during 2014 and 2015.

[50] She met Mr. Jegou while they were both working at the Horizon site. They have been married since 2013.

[51] She was working her normal shift at the clinic on February 17, 2015. From her office, she heard the backdoor open and went to say hello to those coming in. She saw her husband and Mr. Pyke with a patient on a stretcher in the trauma room. She got about eight to ten feet from the patient, whom she described as an older gentleman who seemed unkempt. She did not see any obvious signs of a stroke, but did not look at him carefully and did not do any form of assessment.

[52] Also in the trauma room were Ms. Palin and Mr. Harrison. She saw Mr. Jegou and Ms. Palin standing "toe to toe" and her husband using his "stern voice." She told him to be nice to her nurses and went back to her office. She did not see Ms. Boschee.

[53] She did not witness Mr. Jegou raise his arm or "get into" Ms. Palin's face, but they were close. She has never seen him get into someone's personal space or use threatening gestures.

[54] Over the course of the half hour that Mr. Jegou was at the clinic, she was following him around to some degree. She was hoping to ask him about the moment of tension she had observed, but never had the opportunity.

[55] During the half hour, she saw him with Ms. Palin looking at a computer for a patient file, in one of the examination rooms. Everything was calm between them again. She later saw him using the telephone in the pharmacy.

[56] At one point she went back to the trauma room, and saw Mr. Harrison starting to put an IV into the patient. She made some small talk with Mr. Pyke, but cannot remember what it was about. She was within six to eight feet of the patient but did not notice any of the stroke symptoms. When Mr. Jegou came back to the trauma room, she asked him what was going on and he indicated that he was going to town with the patient.

[57] She could not explain what took the thirty-two minutes spent at the clinic. She did not remember Mr. Jegou taking out any supplies. She suggested that perhaps the nurses had a role in delaying him.

[58] When asked whether nurses at CNRL had a protocol for dealing with strokes, she testified in her direct examination that she did not remember. As pointed out in her cross-examination, this contrasted with her full description in an August 26, 2016, interview she gave to an interviewer for the Alberta College of Paramedics: describing how a stroke patient would be treated in the triage process, taken back to the trauma centre, paramedics called, the doctor called and then stabilized for transfer.

[59] Dr. Bouwer was the person to whom she reported directly on medical matters. He had designated days and hours at the clinic, but otherwise was generally available by telephone. She called him daily, as all nurses did. In her direct examination, she testified that he was normally available by phone, although there were occasions where he was not and the nurses would then collaborate with each other and with the paramedics on what to do. Later in her testimony, she was confronted with the transcript of her Alberta College of Paramedics interview, where she indicated that the doctor was reachable "by phone 24/7, . . . regardless of anything. Regardless of holidays; regardless of vacations; regardless of anything." Further, she stated in her interview that anytime the nurses needed to do anything a little beyond their scope, they had to call the doctor and had to do it under his orders.

[60] Her earlier interview statement also conflicted to some degree with her trial testimony, where she said that the nurses sometimes deviated from their usual scope of practice; and that Dr. Bouwer told her he had no issues with how she would handle patients as long as it could be medically justified.

[61] Ms. Jegou was highly trained in the Medgate system. All patient information was stored on this system, which was commonly used by many oil and gas companies but not by Alberta Health Services. Anytime someone came into the clinic, a record was created for them on the Medgate. Patient information could usually be accessed on Medgate simply by typing in the last name. She observed that nurses at the clinic might have more patient information available than at the Fort McMurray hospital, but acknowledged that this was a guess.

[62] There was a very smooth, good working relationship between the nurses and paramedics. There was no hierarchy between them; rather, their positions were relatively lateral. At the end of the day, each was responsible to its own governing body for the patient in their care.

[63] In my view, Ms. Jegou was not always fair and balanced in her testimony. She was at pains to make a few points which, it appeared, were inconsistent with information she gave during the Alberta College of Paramedics investigation. This was particularly notable in her testimony on stroke policy (apparently trying to make the point that there was no strict policy for such matters) and her suggestion that Dr. Bouwer allowed a certain amount of latitude and other employees had to use their own judgment on occasions when he was not available. Finally, it is remarkable in light of her training and experience that she did not show an interest in the patient's condition. I find it likely she was seeking to minimize the evidence of a stroke in her testimony.

III. Summary of Defendant's Evidence

A. Keith Harrison

[64] Mr. Harrison is a registered nurse at the Horizon Health Clinic, and has worked in that capacity since August 2014. He graduated from nursing school in 2011 and has certificates for emergency nursing and acute care life support. He has worked in various nursing positions since his graduation.

[65] For the relevant period (2014-15), the main services at the clinic were drug and alcohol testing, occupational injury, and non-occupational illnesses and injuries.

[66] As of early 2015, Mr. Harrison reported directly to Dr. Bouwer on medical matters. The nurses worked 12-hour shifts. Three were on duty for the day shift and two for the night shift. The clinic was not part of the emergency services personnel working at the firehall but there was frequent contact between them.

[67] The patient records system used by the clinic was Medgate. The system had all of the patient's records, including the patient care reports prepared by paramedics. Mr. Harrison had access to Medgate by logging in, typing in a name or adding patient names.

[68] The procedure for transferring patients to the Fort McMurray hospital involved calling Dr. Bouwer (whose permission was required for any transfers off the CNRL site). He would give instructions as to whether the transfer would be by advanced life support ("ALS"), which meant a paramedic would have to take the patient, or basic life support ("BLS"), which meant an EMT could make the transfer.

[69] As a nurse, Mr. Harrison has been contacted by the Fort McMurray hospital from time to time. It would occur if they were looking for information, history on a patient. Such calls were, however, rare.

[70] The clinic had a large number of radios placed around the premises, which were tuned to the emergency channel. Staff could listen when there were incidents and have advance notice of things that might require their involvement at the clinic.

[71] Thus, the first Mr. Harrison heard of the February 17, 2015 stroke incident was the dispatch call for EMS to go to the Calumet Camp. He could hear the personnel responding and information about the incident as it was occurring.

[72] Eventually, he received a telephone call from Mr. Jegou, who said he had found a patient with stroke symptoms, wandering into the wrong room, slurring, having left-sided weakness, and uncharacteristically absent from work. Mr. Harrison responded to the effect of "it sounds like

you have to go to the hospital." Mr. Jegou said "nope, I'm taking him to you." Further discussion was ended when Mr. Jegou hung up on him.

[73] After the phone call, Mr. Harrison talked to Ms. Palin and Ms. Boschee to tell them the patient was coming into the clinic. He took them along to meet Mr. Jegou at the back emergency entrance because Mr. Jegou had said he was giving the patient to them. Mr. Harrison was expecting an issue and had only seven months' time at the clinic as of that date.

[74] The three nurses met Mr. Jegou, Mr. Pyke and the patient on a stretcher as they were going into the trauma room. Mr. Jegou got defensive. Ms. Palin asked the patient his name, and it was evident that he was really slurring his words. Ms. Palin checked the left-sided foot, and Mr. Harrison grabbed the left side hand. There was left-sided weakness. The patient had lots of facial drooping and sagging on his left side, and a great deal of drooling.

[75] Then, an argument started. Ms. Palin asked Mr. Jegou what he expected the clinic could do for the patient? He needed to go to the hospital for a CT scan. Mr. Jegou responded by saying words to the effect of "I don't know, just have him." Three to four times, Mr. Jegou said that the patient was outside of the timeframe. He had said this on the telephone call to Mr. Harrison as well. Mr. Harrison made the point that they did not know when the stroke had occurred. Ms. Palin expressed the concern that he could be bleeding and it was important for him to go to the hospital.

[76] Mr. Jegou did two quick shuffle steps toward Ms. Palin, thrust out his arm and pointed his finger at her about one foot away. Mr. Harrison told Ms. Palin that they should just let Mr. Jegou finish his report, as he wanted to deescalate the situation. (A paramedic making an oral report is usually the preliminary to transferring care of the patient.)

[77] Because sending an ambulance offsite required Dr. Bouwer's approval, Mr. Harrison asked who was going to call him. Mr. Jegou responded with a sigh, and said that he would do it. Ms. Palin said that she would take him to a phone, and they left together. They were going to use the phone in the pharmacy, which required a nurses' passkey to access. As Mr. Jegou was leaving, over his shoulder he told Mr. Pyke "put an IV in, get him ready, I'll be back."

[78] Before Mr. Jegou left to make the phone call, those present in the trauma room were Mr. Jegou, the patient, Mr. Pyke, Mr. Harrison, Ms. Boschee and Ms. Palin.

[79] Mr. Harrison remained in the trauma room with the patient the entire time he was at the clinic, wanting to make sure he did not "crash and die." He assisted Mr. Pyke with the IV. Five or ten minutes after leaving the room, Mr. Jegou came back, carrying four or five boxes of gloves. He was asked if Dr. Bouwer had been called, and responded "yes, we're going." He put the boxes of gloves on the stretcher. He left again, and came back with two oxygen bottles (each about two and half feet tall, six inches in diameter). He put these on the stretcher as well.

[80] Mr. Harrison said that Ms. Jegou was never in the trauma room. He saw her pass by twice.

[81] The patient's symptoms remained the same throughout.

[82] Mr. Harrison said that in his opinion it was an emergency, and in such situations, one does not know the timeframe. The only thing to be done, at least initially, is a CT scan to see if there is a clot or bleeding. The CT scan can only be done at the hospital. Clinic nurses are not

permitted to even give the patient an aspirin until such a test is done. There was nothing he could do to treat the patient.

[83] Later that day, in the afternoon, Mr. Jegou was back at the clinic. He heard him speaking with Ms. Palin. Afterwards, Ms. Palin told Mr. Harrison that Mr. Jegou had apologized for his behaviour in the morning.

[84] Mr. Harrison said that he did not recall Mr. Jegou ever saying he had come for an "information grab." Nor does he recall Mr. Jegou and Ms. Palin looking up patient information on Medgate.

[85] Mr. Harrison was an impressive witness as to both his reliability and overall credibility. He answered all questions straight forwardly and without evasion or argument. No bias could be detected in his testimony.

B. Alessandra Grossi

[86] Ms. Grossi is a CNRL employee, who works in the human resources department at Horizon.

[87] Because Horizon is a remote site with anywhere from five to ten thousand people on site, many people lived in camp facilities. There are many amenities and necessaries provided, such as a firehall and a medical clinic. The emergency services team, working out of the firehall, was part of a group she looked after in her role as a human resources adviser in 2015.

[88] In her testimony, she confirmed that based on employment records, Mr. Jegou was hired as a "paramedic/firefighter." In her testimony, she was taken through a number of documents which formed part of the employment package he agreed to upon being hired. She also reviewed the details of many forms of compensation applicable to his position, which are set out in the agreed exhibits and the amended statement of agreed facts.

[89] Her involvement in the incident with the stroke patient was limited to her participation in a meeting and preparation of the termination paperwork.

[90] She was contacted on March 11, 2017 by Robert Slade, Chief of the firehall, who advised her of the incident involving the stroke patient and that a meeting was being set up to which she would be a witness. She was to be a "mutual third party" to assist both Mr. Jegou and CNRL, take notes and witness the discussions. She did not have much of a speaking role.

[91] Most of the discussions were between Dr. Bouwer and Mr. Jegou directly. Only after some argument did Mr. Jegou eventually say he was sorry and acknowledge that he had made the wrong decisions. Ms. Grossi felt that his apology and acknowledgement were not genuine, but something he believed was necessary as he had not prevailed in the argument.

[92] After Mr. Jegou left the meeting, Ms. Grossi stayed while Dr. Bouwer and Mr. Slade continued their discussion. Part of the discussion was whether they could pursue a course of performance management or whether termination would be required. Dr. Bouwer and Mr. Slade felt that the stroke patient incident, when combined with the November 2014 fall incident, justified termination.

[93] Ms. Grossi had no role in the decision, but agreed with it because of the significance of the issue and the prior incident. On instructions, she prepared the necessary termination documentation.

[94] Ms. Grossi's evidence was given in a clear, straight forward way, often helpfully explaining very complex compensation packages. There are no concerns about her credibility or reliability.

C. Colleen Boschee

[95] Ms. Boschee is a registered nurse, having graduated from the Foothills Hospital and University of Calgary. She has extensive specialized nursing experience with various institutions and private organizations. She began her employment at the Horizon Health Clinic in summer 2014, and before that worked for another oilsands medical clinic owned by CNRL.

[96] For part of the time at Horizon, she still worked part-time in the Foothills Hospital Emergency department. She has taught cardiology to nursing students, nurses, paramedics and doctors.

[97] As with Mr. Harrison, her first awareness of the patient with stroke symptoms was from the callouts and communications on the radios placed throughout the clinic. About fifteen or twenty minutes after the initial callout, she saw Mr. Harrison put down the phone after a call, saying "he hung up on me." He then said "they're bringing him to the clinic" and Ms. Boschee thought that must mean the person was deteriorating rapidly and needed help.

[98] The three nurses went to the back of the clinic and waited for the arrival. The EMS crew came in with the patient on the stretcher and pushed it into the trauma room, moving the clinic's stretcher out of the way to make room.

[99] Ms. Palin told Mr. Jegou that he had to get the patient to the hospital now. Ms. Boschee observed the patient had left side facial droop and drool coming out. All of the nurses joined in the request that he be taken to the hospital.

[100] Mr. Jegou responded that "they can't do anything for him now anyway." Ms. Boschee suggested that they go to call Dr. Bouwer on a private phone and took him in into the pharmacy. She did not hear any part of the call. That left her two coworkers, the EMT and the patient in the trauma room.

[101] The clinic was very busy. After Ms. Boschee left Mr. Jegou in the pharmacy, she went to the front to continue her triaging work. She admitted a few patients, and then saw a few. While she did not return to the trauma room again, she did go by at one point and saw people were still there.

[102] In her view, the patient's symptoms were obvious signs of stroke and in such a case the patient had to go to the hospital immediately. There was nothing clinical staff could do for someone in such condition, other than monitor vital signs and ensure open airways.

[103] She found Mr. Jegou's behaviour on arrival at the clinic odd. It was almost like he was grinning at them. However, she does not remember him being physically aggressive or finger pointing. She does not remember Mr. Jegou saying he wanted information on the patient. Nor does she remember Ms. Palin and Mr. Jegou going to get patient information, although she added she was only with the group a short time.

[104] Ms. Boschee was a fair and balanced witness. She obviously did not agree with Mr. Jegou's actions, but showed no bias against him in her testimony.

D. Dr. Johan Bouwer

1. General Matters

[105] Dr. Bouwer is a physician who initially qualified in South Africa in 1992, did his residency in the United Kingdom in 1993 and 1994 and, after some follow up training and experience in both counties, immigrated to Canada in 2003. Despite some of his post-qualification training, he considers himself a generalist – certainly no specialized training in neurology or neurosurgery.

[106] He started a clinic in Fort McMurray in 2003, which he continues to operate. He practices general medicine and provides some private contracting work through that clinic as well. As a result of an approach by CNRL, beginning in 2008 he has been director of medical services at the Horizon Health Clinic and medical director of emergency medical services operating out of the firehall.

[107] At the relevant times, he was at the clinic several days a week and always available by cellphone. Until testifying in court, he said, he had not turned his cellphone off for fifteen years.

[108] At the clinic, he oversaw the work of nurses. For emergency medical services, there were three levels of staff:

- EMR, with very basic training qualifications of a couple of weeks;
- EMT, with more advanced training of about six months, having a more advanced scope of work and able to provide a few medications; and
- Paramedic, involving more advanced care with authority to give more medications and manage a patient's airways.

[109] Paramedics reported to Dr. Bouwer on medical issues. When on emergency calls, they were under his supervision, in that they worked under his license and guidelines.

[110] The *Guidelines* with a revision date of April 2012 were the ones in effect as of 2014 and 2015. They were prepared by Dr. Bouwer and Mr. Penzo, taken with modifications from a variety of sources (including AHS's emergency protocols and guidelines for medical conditions such as strokes), to suit the circumstances at the Horizon site. Dr. Bouwer agreed that a better name would have been "protocol" rather than "guidelines" and the title of the document has since been changed.

[111] Dr. Bouwer wanted to know about each transfer of a patient offsite, for a variety of reasons. This was an oral protocol or direction, not included in the *Guidelines*. It was standard practice and had been followed for years.

[112] It was suggested to him that the part of the *Guidelines* on "Clinic Bypass/Site Physician Notification" actually expressly required notifications and covered only some circumstances. Dr. Bouwer said this was not relevant to the spinal and stroke conditions expressly dealt with elsewhere in the *Guidelines.*

[113] Any patient requiring urgent or emergency care was required to be transported to the hospital, not the clinic. If there was any difference of opinion between nurses and EMS personnel, and they could not talk to Dr. Bouwer the default mode of transportation was by ALS (with a paramedic), to the hospital. He advised staff of this in an email of April 2, 2014.

[114] There could be deviation from the *Guidelines* in rare cases, where a paramedic had advanced experience in the patient's problem. However, this would always require a call to Dr. Bouwer first. The *Guidelines* were intended to be followed, and were very specific for that reason.

[115] Patient confidentiality is an expectation of all medical personnel. It is engrained in them from initial training and throughout their careers. Communications by cellphone are well within the standard of practice for confidentiality and is a method of communication Dr. Bouwer uses all the time with his staff and other physicians. There has never been a privacy concern or complaint about this.

2. Fall Case: November 19, 2014

[116] Mr. Slade involved Dr. Bouwer in reviewing a patient call made by Mr. Jegou on November 19, 2014. It related to a patient who had fallen about ten feet with a partial break of the fall by a harness, injuring his wrist. It was in a very remote area, in a tank. Mr. Jegou was the first at the scene.

[117] There were two concerns involving Dr. Bouwer's responsibilities. The first was that the section of the *Guidelines* on "spinal injury" indicated that in high risk situations (which included falls from elevations greater than one meter) spinal immobilization with a back support was required. That had not occurred in this case. The second concern was that the wrist should have been immobilized, at least with a splint, because of uncertainty on the nature of the injury. While there was nothing specific in the *Guidelines*, treating injuries of this nature with a splint or similar device was "basic training."

[118] A meeting was called for November 24, 2014 to discuss the incident, at which Mr. Slade, Mr. Penzo, Eric St. Pierre (Deputy Fire Chief), Dr. Bouwer and Mr. Jegou attended. During the meeting, Dr. Bouwer expressed his view that the spine should have been immobilized, pursuant to the *Guidelines*; and similar treatment should have been given to the wrist. (The discussion about how the patient descended the ladder was within Mr. Slade's and Mr. Penzo's areas.)

[119] Dr. Bouwer asked Mr. Jegou if he could exclude the possibility of a spinal injury at the site. Mr. Jegou explained what he had done to take that possibility into account, and Dr. Bouwer commended him for what he did. When asked whether he was satisfied that the spinal issue had been adequately addressed at site, Dr. Bouwer testified that he was not satisfied that it was ideal, but accepted the difficulties of the location and that Mr. Jegou had addressed as well as he could the possibility of the spinal injury. He confirmed that he did not advise Mr. Jegou of any disciplinary concerns raised by the incident.

[120] Dr. Bouwer agreed that a paramedic should not force a patient onto a backboard or force him to accept a splint on his wrist.

3. Stroke Case: February 17, 2015

[121] Dr. Bouwer's initial involvement in the call to the stroke patient was a very short call he received from Mr. Jegou. He believed the call was made en route to the hospital because he believed he heard vehicle noise, but could not be certain. In almost all cases, he said he receives such calls while the vehicle is moving.

[122] All that was discussed on the call was that Mr. Jegou was already going to the hospital with a stroke patient which was obviously an ALS transfer.

[123] Dr. Bouwer was in South Africa on vacation at the time of the call. When he returned, Ms. Boschee spoke to him about the incident expressing concerns about how it had been handled. Dr. Bouwer therefore asked Mr. Jegou for a meeting to talk about the incident, and involved Mr. Slade in the communication – although the first meeting was between Mr. Bouwer and Mr. Jegou only.

[124] Mr. Bouwer's initial concerns were based on his review of the patient care report prepared by Mr. Jegou. In his view, there was a long, unexplained delay in the transfer from the Horizon OilSands site to the hospital. It involved approximately half an hour at the clinic, but about forty-five minutes at the Horizon site overall. He wanted to give Mr. Jegou an opportunity to explain.

[125] Mr. Jegou, in the meeting on March 11, told Dr. Bouwer that he stopped for an "information grab." He mentioned that there had been a heated exchange with the nurses. He also expressed concerns about patient privacy as the reason he had not made a call to the clinic.

[126] Dr. Bouwer told Mr. Jegou that he believed it to be a serious deviation from standard practice and did not accept the concerns about privacy as being valid. He told him that he had done a good job in preparing the patient care report and a good diagnosis, but asked why he went to the clinic. He was not satisfied with the explanations.

[127] The follow-up meeting involved Mr. Slade, Mr. St. Pierre, Mr. Penzo, Ms. Grossi, Dr. Bouwer and Mr. Jegou. Some of the discussion from the previous meeting was repeated. Dr. Bouwer expressed his view that Mr. Jegou's reasons for stopping at the clinic were not strong arguments. He expressed the opinion that patient care was significantly affected in terms of the standard of care. He again commended Mr. Jegou on his preparation of the report and his diagnosis.

[128] Dr. Bouwer then asked Mr. Jegou whether he had done anything wrong, and the response was no. Dr. Bouwer then asked whether if he could go back and do it over, would he do anything different. Again, the answer was no.

[129] Mr. Jegou's response was a particular concern to Dr. Bouwer. Not only was there a serious departure from practice, but he showed lack of insight into the situation. Including the case of the patient who had fallen, there were now two occasions where Mr. Jegou had not followed standards. It was critical for Dr. Bouwer to have full confidence in his senior medical staff at all times.

[130] In his thirteen years at the Horizon Health Clinic, Dr. Bouwer is not aware of another case of an EMS staff member bringing a patient to the clinic with stroke symptoms.

[131] Dr. Bouwer acknowledged that most of the employees at Horizon fall into a younger demographic, and not many patients present with signs of stroke. However, the fact that Mr. Jegou may not have seen a stroke patient in five years did not mean he was not trained for it. In fact, he said, paramedics did training for this type of problem all the time.

4. Assessment

[132] Dr. Bouwer presented as a fair, competent, disinterested witness. He easily gave way on points that might not have been in CNRL's interest. On a few points, he became somewhat argumentative, but they were points having to do with what he considered misleading or uninformed suggestions, rather than points which favoured one party or another.

E. Geoffrey Pyke

[133] Mr. Pyke is an EMT, a qualification he obtained through a 4-month college course. He is not qualified as a paramedic: that would require an additional two year college program. (He has other, unrelated post-secondary education.) He worked as an EMT for the Fort McMurray Fire Department for three and a half years before joining the fire department staff at Horizon in October 2013.

[134] The *Guidelines* were in all the ambulances. EMTs and paramedics follow them on all medical calls. Mr. Pyke testified that if there were to be any deviations from the guidelines, they would have to call Dr. Bouwer to receive permission first.

[135] The attending paramedic or EMT would take notes on a call. These would constitute the patient care report, which was to be a picture of the entire emergency call from start to finish, detailing the patient's vitals, their pertinent information and a narrative or summary of everything that happened on the call.

[136] He is qualified to perform a rope rescue, and has the designation of a rope rescue technician. He was on duty on November 19, 2014, but not involved in the call for the person who fell. For a rope rescue, a minimum of five people would be required: at least two trained in rope rescues, and the other three having some basic knowledge of the procedure.

[137] On February 17, 2015, along with Mr. Jegou, he responded to a call about someone initially reported as missing, and then located at Calumet Camp. They found him on the third floor, where security had located him sitting on a bed in a room which was not his own.

[138] Mr. Pyke started checking his vitals, while Mr. Jegou asked him pertinent questions. Mr. Jegou was in and out of the room, making cellphone calls. Mr. Pyke did not know who Mr. Jegou was calling, but said it was common during responses to medical calls to telephone Dr. Bouwer.

[139] They observed that the patient was a poor historian, in that he was unable to tell the date or where he was – although he could tell them how he got there the night before. He also gave them a history about his heart attack. He was very disheveled in appearance: not clean-shaven, very frail, unhealthy looking. Their neurological assessment, based on facial droop, arm drift, and slurred speech, led them to conclude that he had suffered a stroke.

[140] They decided the patient needed medical attention. They were concerned that he was having a stroke, had cancer and a history of heart attack. These three factors combined to indicate he needed further attention by a doctor at the hospital. Mr. Jegou called another crew to get lift assistance in bringing him down to the ambulance. Before entering the ambulance, Mr. Jegou made the decision to have Mr. Pyke (who was driving) go to the clinic, which Mr. Pyke understood was to obtain more information on patient history. Mr. Pyke did not object to this decision or raise concerns. Mr. Jegou was his senior officer, known to be an experienced paramedic and Mr. Pyke trusted his judgment.

[141] Mr. Pyke recalled very little of what happened at the clinic. He could remember nothing out of the ordinary: for example, no intense arguments or Mr. Jegou acting in an intimidating manner. He could recall only one nurse involved, that being Mr. Harrison, who assisted with inserting an IV.

[142] He could remember nothing about whether patient information was available at the clinic, nor could he recall how long they stayed.

[143] At some point, Mr. Jegou told Mr. Pyke that they were taking the patient directly to the hospital. Mr. Pyke drove, activating lights and sirens. It was still considered an emergency call.

[144] There was a form of debriefing by Mr. St. Pierre and Mr. McLeod sometime following, at which Mr. Pyke was present, along with everyone else who was on his shift. By this time, Mr. Jegou was no longer working at the site. Mr. Pyke was not reprimanded or disciplined. During the debriefing, they were told if Dr. Bouwer could not be reached for any reason, they should call the nurses who would then seek to contact him. However, Mr. Pyke observed, he did not know if this was a change in procedure. Further, he said he had never been involved on a call where Dr. Bouwer could not be reached.

[145] Mr. Pyke was asked to explain his understanding of the "clinic bypass" flowchart in the *Guidelines*. As applying to a stroke patient, he said it indicated that the attending paramedic would be required to update Dr. Bouwer prior to leaving the site.

[146] Mr. Pyke presented as a straightforward, disinterested witness who answered all questions fairly and to the best of his ability. His memory, however, was weak with regard to the incident involving the stroke patient, and on many occasions, he indicated that he did not remember.

F. Louise Palin

[147] Ms. Palin is a registered nurse. She has been working at the Horizon clinic for a little more than seven years. Before that, she was an emergency room nurse for nine years at the Fort McMurray hospital.

[148] She was familiar with the stroke protocol followed at the Fort McMurray hospital (the same as the AHS protocol). As there was no neurologist, they were connected to University of Alberta hospital so that treatment would be recommended in conjunction with its staff, the emergency physician in Fort McMurray, and a radiologist.

[149] Their protocol required that within ten minutes of a patient's arrival, staff had to have completed an assessment, taken a history, performed an ECG to rule out cardiology problems. A CT scan would have to be done within twenty minutes and assessed within forty-five minutes. Staff always attempted to beat those timelines, based on the "time is brain" mantra.

[150] There were no diagnostic tools at the Horizon clinic. For strokes, the required diagnostic tool is a CT scan, available at the Fort McMurray hospital.

[151] She first became aware of the stroke patient by overhearing the radio reports. She was told by Mr. Harrison that, despite his protest, the EMS crew were bringing the patient to the clinic.

[152] When she first saw the patient in the trauma bay, Mr. Harrison and Ms. Boschee were already there, along with Mr. Pyke, Mr. Jegou and the patient. Ms. Palin stood at the bottom of the stretcher, and interrupted Mr. Jegou who was giving his verbal report. She told him that the patient needed to go to the hospital right away. Mr. Jegou became aggravated, held his hands up, and told her she needed to stop. She responded by insisting that he needed to go.

[153] Mr. Jegou said that the patient was out of time in any event. All three of the nursing staff insisted that he had to go to the hospital.

[154] When Mr. Jegou said that he brought the patient there to see if there was any information, she agreed to go and search. She quickly did so in a nearby examining room computer, and found nothing. She performed the search on her own, and then returned to the trauma room to report.

[155] It became clear that Dr. Bouwer had not been called. After discussion, it was agreed that Ms. Boschee would go with Mr. Jegou so he could make the call. Before they left, Ms. Palin went back to her duties.

[156] She only remembered seeing Ms. Jegou on one occasion. She was in the hallway when Ms. Palin was returning to report that she had found no records. She does not recall Ms. Jegou ever telling Mr. Jegou to go easy on her nurses.

[157] At some point, before the patient was taken out of the clinic, Mr. Jegou approached Ms. Palin in the examination room, and said something to the effect of "are we okay?" She responded to the effect of, "yes, just go."

[158] Ms. Palin confirmed that she checked the patient's leg strength and saw a bit of a left-sided facial droop.

[159] Ms. Palin gave her evidence in a clear, straight forward way, responding without hesitation to all questions asked of her. There are no concerns about her testimony.

G. John Penzo

1. General Matters

[160] Mr. Penzo graduated from paramedic school in 1997, after first being qualified as an EMT. He has had a variety of positions for various organizations as a paramedic and in related roles including dispatch supervisor for 911 calls. He has many fire and rescue certificates, and taught and developed the curriculum for paramedic training at the Southern Alberta Institute of Technology ("SAIT") for two years.

[161] During his time as an active first responder, from 1997 to 2011, he responded to over 6000 medical calls, 40-50 of which would have been strokes.

[162] He has created medical control guidelines for various institutions, including CNRL. The *Guidelines* at CNRL were prepared by him, with reference to and incorporating other standard protocols. After the times relevant to this action, the *Guidelines* were replaced by the AHS protocol.

[163] During the years 2014 and 2015, Mr. Penzo's title was "Emergency Services Specialist." As such, he was outside the chain of command governing firehall employees (paramedics, EMRs and EMTs). He reported directly to the firehall manager. Approximately two years ago, he took over the position of Fire Chief when Mr. Slade retired, and has responsibility for both the Horizon and Albion OilSands sites.

[164] Mr. Penzo has instructed all levels of emergency responders – EMRs, EMTs and paramedics. Instruction for all three involves stroke patients as a main component. The core piece is the same for all three levels, rapid recognition and rapid transportation to a hospital. Little can be done outside of hospital-based CT scans and follow-up treatment.

[165] On ALS calls, there is usually a paramedic and an EMT working together. The paramedic has the responsibility for what happens, as the highest medically-trained person on the call.

[166] CNRL provided regular continuing education programs – shorter sessions for night shifts on a weekly basis, more extensive two-day courses annually and on a rotating basis, sending personnel to Texas for in-depth refresher courses. Samples from some of the materials used during CNRL courses were explained by Mr. Penzo. A few examples:

(a) Cincinnati Prehospital Stroke Scale: identify stroke on the basis of three physical findings – facial droop, arm drift and abnormal speech, enabling the evaluation of a patient in less than one minute.

(b) Emphasizing rapid EMS-system transport and prearrival notification to the receiving hospital.

[167] Some of these materials note the significance of establishing the time when the patient was last known to be normal. Mr. Penzo said this could usually be determined from the patient or bystanders or family members. However, he said getting such information should not delay transportation. Information could be obtained by telephone during the trip to the hospital.

[168] Telephones were available at Calumet Camp, where CNRL's contractors stayed when onsite. Every room had a desk phone. There was adequate coverage for cellphones. There were public phones available on the main level of the camp, at various points.

[169] Calumet Camp had security personnel who also assisted EMS personnel as necessary. They could drive an ambulance and assist in carrying stretchers, for example – functions for which they were trained.

[170] The *Guidelines* were intended to be followed without deviation, except where required for the patient's wellbeing and in consultation with Dr. Bouwer – who has always been available everyday, every hour, by cellphone. Likewise, if for some reason a subject was not covered in the *Guidelines*, Dr. Bouwer was to be consulted.

2. Fall Case: November 19, 2014

[171] Mr. Penzo was involved in the fall case at the request of Mr. Slade, in his role as a subject matter specialist.

[172] His initial understanding was that a worker fell fifteen to eighteen feet (which he acknowledged on cross-examination was incorrect, as the height was seven to ten feet), landed on a hard metal surface, and fractured his wrist. Mr. Jegou ruled out a spinal injury so did not use back support in extracting the worker. Without splinting the wrist, he had him descend a cage ladder with the first responders supporting him below.

[173] Mr. Penzo attended a meeting to discuss this incident with Mr. Jegou and others. He expressed the view that Mr. Jegou had not followed the *Guidelines* for "spinal injury." These *Guidelines* indicated that where there was a fall from an elevation greater than one meter, the case qualified as uncertain or high risk and required spinal immobilization. Even if the assessment was low risk, the *Guidelines* required spinal immobilization if it was a "unreliable patient," meaning a patient whose experience of spinal injury symptoms would be masked by other injuries.

[174] Thus, a rope rescue was required which could be accomplished in one of two ways, both involving back supports while the patient was brought down the ladder. Even if trained rope rescuers were not on duty, they could be called from off duty or another site, and be at the firehall in twenty minutes and the site of injury in less than a further five minutes.

[175] He agreed that if a patient refused treatment (such as a rope rescue or splint) that might justify not providing that treatment – but such a basis for deviation would require documentation in the patient care report. He agreed that a paramedic would have some discretion in determining what was a distracting injury.

3. Stroke Case: February 17, 2015

[176] For the case involving the stroke patient, once again Mr. Penzo's involvement came at the request of Mr. Slade, because he was a subject matter expert.

[177] He attended the March 12, 2015 meeting, and expressed the opinion that the patient should have been taken by rapid transportation directly from Calumet Camp to the Fort McMurray hospital. There was no reason to go to the clinic. He did not recall Dr. Bouwer praising the quality of the patient care report nor raising the question of what "we did wrong." Further, he did not agree that Mr. Jegou took responsibility for making a mistake and going to the clinic.

[178] James Dunn, another paramedic and another subject matter expert, completed an audit of the PCR done by Mr. Jegou on the February 17, 2015 incident, entitled "CNRL PCR Review Toolbox." Horizon had implemented an audit of PCRs approximately two months before, with the first stage intended to monitor compliance with the formal aspects of completing PCRs: ensuring all of the boxes were ticked, and the appropriate information included. A second stage would start later, when the PCRs were also audited for the substantive quality of response to the call.

[179] The audit of Mr. Jegou's PCR for the stroke patient indicated that everything was completed, and included the commendation "all good!" One of the areas checked off was "skills," which was explained as correct techniques, timely, MCP deviations documented, equipment issues noted.

4. Termination of Mr. Jegou's Employment

[180] After the March 12, 2015 meeting, Mr. Penzo was asked to prepare a summary of the two situations in which Mr. Jegou's performance had been questioned: the fall and the stroke cases. His analysis included summaries of the relevant parts of the *Guidelines* and excerpts from other standard protocols, together with his conclusion about where Mr. Jegou had deviated from the standard level of care required of a paramedic.

[181] Mr. Penzo was not involved in the decision about whether to terminate Mr. Jegou. He became aware of it after the fact. Mr. Slade asked if he supported the decision, and he told him that he did, because of the two incidents in which Mr. Jegou had not followed required protocols.

5. Assessment

[182] Mr. Penzo is highly trained, skilled and knowledgeable as a paramedic and obviously well suited to his role as a subject matter specialist in 2014 and 2015. In my view, however, he was not a disinterested witness.

[183] Much of Mr. Penzo's background prior to dealing with Mr. Jegou involved developing and applying the *Guidelines* and other protocols, which he was personally responsible for preparing. When he was involved in Mr. Jegou's matters, it was as an expert in whether appropriate practices were followed. He was a "by-the-book" individual with little tolerance for anyone not meeting his exacting standards.

[184] Clearly, Mr. Jegou fell short of his standards. Mr. Penzo did not notice or remember the comments Dr. Bouwer made that were complimentary to or more accepting of Mr. Jegou's work. From the evidence, these include the quality of the patient care report on the stroke case and the decision not to use a rope rescue on the fall case. When testifying in direct examination, Mr. Penzo exaggerated the height of the fall, something that had to be pointed out during cross-examination.

[185] There is no concern that Mr. Penzo is untruthful or deliberately misleading. There is a concern, however, that his focus on written documents easily led him to prejudge Mr. Jegou's standard of care; and once he reached that conclusion, he became committed to it.

[186] Thus, while on the whole his evidence is informative and helpful, I treat some of it with caution.

H. Blair Lindsay

[187] Blair Lindsay was qualified as an expert on the standard of care for paramedics in Alberta for the purpose of giving an opinion on the role of Mr. Jegou, as paramedic during the February 17, 2015 call.

[188] Mr. Lindsay first graduated with his qualifications as a paramedic from SAIT in 1985, after having previously qualified as an EMT. Since 1985, he has maintained his registration. He also has a Bachelor of Health Sciences (2003) and a Master of Arts in Distributed Learning (2006), for which his thesis focused on simulation to assist in teaching paramedic students.

[189] He worked actively as a paramedic between 1985 and 2005, after which his career has focused on teaching. He is a full-time instructor at SAIT in the paramedics program and has a specialization in using and developing patient simulation practices to assist in teaching.

[190] Through his role as an instructor (which has included curriculum development), he is very familiar with the course content of the programs generally, including Advanced Cardiac Life Support courses.

[191] Mr. Lindsay stated that "strokes evolve quickly, are frequently life-threatening, and frequently life-altering, even when not fatal." Only hospitals are equipped to properly intervene with treatment.

[192] From the information received, Mr. Lindsay believed that the patient received good assessment and provisional diagnosis.

[193] However, in his view the decision to delay transport directly to the hospital and, instead, stop at the clinic "was inappropriate and unreasonable and contrary to establish standards of paramedic training, practice and protocols" including CNRL's protocol, which was consistent with common protocols. "There was no possible benefit to the patient," according to Mr. Lindsay, "and only the risk of further harm in an already life-threatening situation."

[194] Mr. Lindsay said all medical practitioners wish for an extensive patient history, but this is not always possible and seeking to obtain new information cannot justify a delay in rapid transport to the nearest hospital. It is very unlikely that the value of any information would offset the potential detriment of delaying transportation. Time is absolutely crucial, and every minute may be precious in saving brain cells.

[195] In his view, it is not within the scope of a paramedic's role to make decisions such as whether a patient was beyond the time window for treatment of a stroke. First, he said, sometimes the time the patient was last seen well may change as later information develops, so one can never be certain. Second, even when out of time for the theoretical window for reperfusion (procedures to restore blood flow after blockage) there may be therapies that can improve patient outcome. There may be complications of a stroke such as seizures, variation in body temperature and airway problems that are best addressed at hospital. Reperfusion, within the theoretical timelines, is not the sole therapy available.

[196] Mr. Lindsay emphasized that CNRL's protocol, AHS and standard practice do not leave room for alteration or delay on the basis that a paramedic believes nothing can be done for the patient anyway. A paramedic's course of action is always the same for a stroke patient: rapid transportation, no exceptions.

[197] He acknowledged that each step of a paramedic's response to a call requires some time, including collection of information at the scene and en route. However, the priority is always rapid transportation.

[198] Despite concerns about patient privacy, cellular phones are regularly used throughout the medical profession. One can avoid using a patient's name where possible, but should not hesitate to do so where it is important for the patient's welfare.

[199] Mr. Lindsay was not asked to give an opinion on whether Mr. Pyke, as EMT on the call, met the standard of care. He agreed that EMTs are accountable for their own actions. However, he was asked to address the conduct of Mr. Jegou, and together, the two of them did not meet the standard of care.

[200] Mr. Lindsay was a well-qualified, articulate expert in his field. Despite the fact that he has not actively worked as a field paramedic for some years, he has maintained his involvement by extensive teaching and research in the field and, until six years ago, was still doing ride-a-longs to maintain current awareness of conditions on the ground.

IV. Findings of Fact

A. General

[201] Having summarized the main parts of the testimony, I turn now to the facts that I find from the evidence. My findings are based on the oral testimony together with the documents, agreed facts and discovery evidence read in at trial.

[202] Mr. Jegou was an experienced paramedic by November 2014. He obtained his qualifications in October 2003 following a two-year program of studies, added to the earlier period required to qualify as an EMT. Then, he worked a number of years based in Brooks before starting at CNRL's Horizon site in August 2009.

[203] As a number of witnesses said, a paramedic (now known as an advanced care paramedic) is the highest of the three levels of paramedicine in Alberta. Usually, Mr. Jegou was the person with the highest medical training responding to a dispatch call.

[204] On matters governing treatment, care and transportation of patients, he was required to follow the *Guidelines* and obtain permission from Dr. Bouwer, the medical director, for any deviations. Dr. Bouwer was to be notified of any patient transfers off the Horizon site.

B. Fall Incident

[205] Mr. Jegou, temporarily acting as a shift captain, arrived at the scene of a reported fall with a fire truck, assisted by Dale Young (presumably an EMT, although the evidence is not clear). They were told to look for someone who had reportedly fallen approximately eight to ten feet by or into an empty tank.

[206] It was difficult to locate the patient through a maze of ladders and into an area by a thickening tank that was under construction. Cellphone reception was available intermittently. On locating the patient, it was determined that he had fallen about five feet, after his initial fall had been interrupted by a harness. He had a sore chest and what seemed to be a very swollen, broken wrist.

[207] Mr. Jegou conducted a physical examination to rule out a C-spine injury. Based on this he determined it was not necessary to have the patient brought out with support of a back board using a rope rescue team. He should have splinted the wrist but decided not to take the ten minutes needed to return to his vehicle to obtain a splint. The patient was extracted from the scene by being assisted down cage ladders with someone supporting him from below.

[208] Tyler McLellan, another paramedic, assumed charge of the patient when he was brought out of the area. He did his own spinal examination and agreed with Mr. Jegou's results. No back board was used. He splinted the wrist.

[209] In follow-up meetings, there were concerns about Mr. Jegou's decision not to immobilize the spine with a back board and having the patient brought out by a rope rescue crew. Those participating in the meetings – Dr. Bouwer, Fire Chief Slade and a paramedic who worked as a subject specialist, Mr. Penzo – all agreed that the *Guidelines* for "Spinal Injury" defined the incident as high risk because the fall was greater than one meter. Thus, spinal immobilization was required. Even if the incident fell within a low risk category, there was an "unreliable patient" in the sense that he had another distracting injury that might interfere with the ability to diagnose pain or restriction in the C-spine.

[210] However, Dr. Bouwer said Mr. Jegou had done a good examination of the spine and while he was not satisfied the method of moving the patient was ideal, he accepted the difficulties of the location and that Mr. Jegou had addressed as well as he could the possibility of the spinal injury. Mr. Jegou said his platoon chief, Ian McLeod also supported his decision not to wait for the rope rescue crew. It is noteworthy that Mr. McLellan did not use a back board either, although presumably this was because the patient was then on a stretcher. Fire Chief Slade and Mr. Penzo firmly remained of the view that the patient should have been put on a back board and brought down by rope rescue.

[211] Everyone, including ultimately Mr. Jegou, agreed that the wrist should have been splinted to avoid possible further injury, as that would have required only another ten minutes. As well, Mr. McLellan splinted the wrist when he took over care of the patient. The *Guidelines* do not

expressly require splinting, but the evidence establishes that it is part of the elementary practice requirements for qualified paramedics to follow. Mr. Jegou was well aware of it.

[212] Recommendations were made following the debriefing meetings to review with crew members, among other things, splint and immobilization techniques for ambulatory patients. Mr. Jegou did this with his crew.

[213] In the result, there were criticisms of Mr. Jegou's conduct. Regarding the concern about possible spinal injury, Dr. Bouwer was ultimately satisfied that Mr. Jegou followed a reasonable, if not ideal, course. I infer that, if Dr. Bouwer was contacted at the time, he would have approved Mr. Jegou's procedure. Everyone believed it was an error not to splint the wrist, although that was apparently given less attention in the meetings.

[214] There was no reprimand or other form of discipline following the fall incident. Rather, the meetings seem to have been held to discuss what happened with a view to ensuring proper protocol was followed in similar cases in the future. The results of the meetings also expressly recognize that "the patient's eagerness to exit the area may have contributed to the lack of proper splinting of the wrist and patient management." Further, it was "determined that lack of proper rope rescue training and rope rescue team members on duty may have contributed to the choices made to remove the patient."

[215] While there was no discipline, the nature of the investigation and review had the effect of emphasizing that those responsible for overseeing paramedicine operations required compliance with *Guidelines* and a paramedic's scope of practice.

C. Stroke Incident

[216] The call to Calumet Camp on November 17, 2015 was initially not classified as an emergency, when it was considered a search for a missing employee. It became an emergency call when the patient was discovered with stroke symptoms and remained an emergency call throughout Mr. Jegou's subsequent involvement.

[217] The *Guidelines*' algorithm for stroke patients is very simple: "identify signs and symptoms of possible stroke" then "immediate general assessment and stabilization" (involving a number of items, almost all of which can be performed in the ambulance), and finally "rapid transport to stroke centre." The ambulance traveling time to Fort McMurray's hospital from Calumet Camp was less than one hour – in this case, from the clinic (a little further from the camp, in the wrong direction) it took fifty-one minutes. But from the time Mr. Jegou and Mr. Pyke arrived at Calumet Camp (10:35 a.m.) to arrival at the hospital was two hours.

[218] Some of the testimony was critical of how much time the team took to load the patient into the ambulance and leave Calumet Camp. They spent twenty minutes at the patient's side in the camp before he was on the way to the clinic, and Mr. Jegou was unable to explain the reason for much of this lapse of time. Ultimately, however, the time at the camp was not the focus of later discussions.

[219] As indicated in my testimony summaries, Mr. Jegou and Mr. Pyke found the patient sitting on a bed in someone else's room. By talking to the security personnel and making a call to the employee's supervisor, they determined some basic history and diagnosed a stroke which had probably occurred overnight. Everyone agreed that the diagnosis was properly done. Mr. Jegou and Mr. Pyke then waited for help from another unit to remove the patient (rather than seeking the assistance, for example, of trained security personnel) and then drove to the clinic.

[220] The reason for the trip to the clinic is controversial. Mr. Jegou says he thought there might be some medical history there that would be of use to the hospital. He said he intended it to be no more than a five minute stop. In fact, it was thirty-two minutes. The other CNRL personnel involved in assessing the incident and Mr. Lindsay, who testified as an expert, said there could be no possible benefit gained from a stop at the clinic.

[221] Mr. Jegou initially defended his decision to stop at the clinic. First, he said, there might be medical information to assist the hospital. There was none. Second, he did not want to call on his cellphone from the ambulance for information, because of patient privacy concerns. No other witness gave this explanation any credence, but rather emphasized the standard practice of using cellphones in such circumstances. There certainly is no evidence that Mr. Jegou ever refrained from using cellphones on previous calls. Third, Mr. Jegou said it could do no harm to stop because they were already outside the window of time within which this patient could be helped at a hospital.

[222] The three clinic nurses were very concerned that Mr. Jegou was not going immediately to the hospital, as they could do nothing for the patient at the clinic. They further worried that the intention was to leave the patient in their care at the clinic. When Mr. Jegou first called the clinic to advise he was on the way, he did not advise Mr. Harrison that he was looking for information. He just said (on his evidence) that he was coming in with a patient who had stroke symptoms. Mr. Harrison testified that when Mr. Jegou called about the patient, he told him that he would have to go directly to the hospital and Mr. Jegou responded "nope, I'm taking him to you."

[223] The nurses' concerns were apparently born out when Mr. Jegou did not just come into the clinic, but both he and Mr. Pyke rolled the patient on the stretcher into the trauma bay by the clinic's bed. On a brief stop, it would have been usual practice to leave the patient in the ambulance with an attendant. Mr. Harrison and probably Ms. Palin believed that Mr. Jegou was attempting to leave the patient with them because, as he told them more than once, there was nothing to be done for him at the hospital and he seemed to be planning to transfer the patient to the clinic's bed. This led to a vigorous exchange of views between the nurses and Mr. Jegou, all in the trauma bay around the patient's stretcher. On the nurses' evidence, which I accept, there was no reference to a request for information until well into the discussion.

[224] Further, it did not take long for Ms. Palin to confirm that the clinic had no information on the patient. She testified that she made this quick check on a computer by herself, evidence I prefer to Mr. Jegou's assertion that he went with her. Likewise, I do not believe Ms. Jegou's evidence on this point, which seemed tailored to fit Mr. Jegou's.

[225] But after this search for information was unsuccessful, Mr. Jegou remained at the clinic. His call to Dr. Bouwer was very short, less than a minute according to Dr. Bouwer. I accept Mr. Harrison's evidence, who was in the trauma bay with the patient the entire time that Mr. Jegou brought two loads of supplies which he temporarily placed on the stretcher. Mr. Pyke with Mr. Harrison's assistance inserted an IV into the patient's arm, but that would usually have been done in the back of the ambulance while in transit.

[226] From the exchange of conversations reported by the various witnesses, I conclude that Mr. Jegou only called Dr. Bouwer about transporting a patient offsite because it had become obvious that he could not leave the patient at the clinic and a nurse prompted him to make the call. He did not tell Dr. Bouwer he was calling from the clinic. If he had intended to call Dr. Bouwer he would have done so well before he did.

[227] He made additional calls to dispatch and to his platoon commander while at the clinic to update them on his plans. They needed to know that Mr. Jegou and Mr. Pyke would be offsite for two hours, in case additional coverage was needed. Notably, he had not advised them before this that he was going to Fort McMurray and, of course, it was not necessary for the call to be made from the clinic.

[228] Taking all of this into consideration, there was no sensible reason for stopping at the clinic, and certainly not for taking the patient inside, if the stop was truly for a quick "information grab." It was an unprecedented departure from practice. Dr. Bouwer testified that in his thirteen years at the clinic, he is not aware of any other case of an EMS staff member bringing a patient to the clinic with stroke symptoms.

[229] I must address Mr. Pyke's evidence to the effect that Mr. Jegou suggested the information grab before they left Calumet Camp. That is some support for Mr. Jegou's evidence that this was always his intention.

[230] Generally, Mr. Pyke (who testified remotely) was a credible, reliable witness, although there were many details he did not remember (for example, the interaction with three nurses and what resulted from the attempt to get information at the clinic). For whatever reason, I conclude that his evidence about a discussion for an information grab was incorrect. It is inconsistent with the conduct of Mr. Jegou on the phone with Mr. Harrison and his initial confrontation with the nurses, who also testified he said nothing about getting information when he first arrived – and two of the three did not remember any request for information. It is also, in my view, inconsistent with moving the patient into the trauma bay of the clinic. Possibly Mr. Pyke's memory on this point was influenced by what he was told subsequently.

[231] The evidence leads me to the conclusion that Mr. Jegou intended to leave the patient at the clinic, at least for some period of time. Any other conclusion means that he went there for reasons he, as a very experienced and capable paramedic, acknowledges make no sense and the trip accomplished nothing other than getting some supplies. The strong objections and concerns raised by the three nurses are also very telling, as is the fact that Mr. Jegou denied the validity of their concerns at the time.

[232] Even if Mr. Jegou should be taken at his word to the effect that he was merely looking for information, any stop exceeding a few moments was grossly excessive. The fact that no one, not even Mr. Jegou, can remember what took him thirty-two minutes means it was wasted, unproductive time. He had one task, attested to by the *Guidelines* and accepted standards of his profession, as all witnesses confirmed: take a stroke patient directly to a stroke hospital. He willfully chose not to follow this course because, it appears, he did not see the reason for urgency in light of the fact that nothing could be done for this patient at the hospital.

[233] In passing, it is notable that the patient care report, prepared by Mr. Jegou while en route from the clinic to the hospital gave very little attention to the stop at the clinic. It contains no mention of the length of the stop, what was done there or the nurses' objection to him being there at all. It was misleading, and thus the positive audit of the report does not assist him.

[234] In the meetings that followed Mr. Jegou initially relied upon his stated reasons: getting information and not using a cellphone for privacy reasons. These excuses were summarily dismissed as without merit. Ultimately, I find, Mr. Jegou acknowledged he had acted with bad judgment and would handle the case differently another time. The other participants who

testified – Dr. Bouwer, Ms. Grossi and Mr. Penzo – did not believe Mr. Jegou seriously took responsibility but rather reluctantly acknowledged his mistakes when his arguments were not accepted.

[235] I come to the same conclusion – namely that Mr. Jegou never fully accepted that he had acted improperly. It was clear from his testimony and the entire direction of his case that Mr. Jegou continues to straddle the fence on whether it was reasonable for him to act as he did, or whether it was without plausible justification. In his pre-termination meetings and in his testimony, he continued to offer as explanations his efforts to seek out patient history, avoiding use of cellphones and, most troubling, returning to the theme that the patient was outside the time window when anything could be done for him. While he gives way to criticisms of these points, he considers them merely to have been an error in judgment from which he could learn.

[236] It was not an error of judgment. That implies at least arguable alternatives. This was a knowing breach of a clear, black-and-white protocol: stroke victims are to be immediately taken by rapid transport to the nearest hospital. A paramedic is not at liberty to exercise his own judgment on whether some other course may be followed because nothing can be done for the patient anyway.

[237] Some time was taken at the trial with questioning and argument to the effect that "CNRL's standard of care for paramedics consisted of a confusing combination of written and unwritten policies, courtesies and guidelines." I am satisfied from the *Guidelines* and testimony about it, including the testimony of Mr. Lindsay who found it consistent with all of the other governing protocols for paramedics in the province, that there was no uncertainty on the main points relevant to Mr. Jegou's conduct at CNRL.

[238] The fact that no harm may have been done to the patient does not assist Mr. Jegou's position. He chose to ignore a simple requirement on how to deal with a patient in an emergency, possibly life-threatening condition. According to some evidence, this could make a difference in some cases. Mr. Lindsay testified that even when outside the usual window of treatment for a stroke, there may be therapies that can improve patient outcome and deal with complications of a stroke that could occur at anytime. Furthermore, in addition to the unacceptable delay, this patient was subjected to the indignity of being parked in a trauma bay for half an hour while exposed to arguments of whether he should be taken to a hospital or whether it was too late for any treatment.

[239] The defence urges that I should accept as proved the factual findings and conclusions of the hearing tribunal of the Alberta College of Paramedics, which dealt with an investigation into Mr. Jegou's conduct regarding the stroke case.

[240] As the plaintiff points out, the hearing was brief and resulted from lengthy negotiations leading to undisputed facts and joint submission on penalty. While an investigator conducted telephone interviews of witnesses, there was no calling of evidence before the tribunal and thus no basis for a formal finding of facts.

[241] The materials, including the transcript of the hearing, do not indicate how the undisputed facts set out in the decision were determined. In his testimony at trial, Mr. Jegou specifically disagreed with the fact that "the Regulated Member attempted to transfer care of patient D.D. to the nursing staff at the onsite . . . medical clinic."

[242] Because of the nature in which the tribunal approached its task, particularly the absence of any evidence to deal with disputed facts (of which there was apparently only one), it would be improper for me to incorporate this finding of fact into my judgment. I must make my own findings based on the evidence before me.

D. Adverse Inference: Ian McLeod

[243] Before trial, the plaintiff served the defendant with a notice under rule 8.15 of the *Alberta Rules of Court* that it objected to the defendant's intention not to call Ian McLeod as a witness at trial. It took the position that as an employee of the defendant, Mr. McLeod was in the defendant's exclusive control and therefore an adverse inference should be drawn regarding the evidence he would give.

[244] *Howard v Sandau*, 2008 ABQB 34, *per* Wittmann A.C.J.Q.B. (later C.J.Q.B.), para 44, sets out a useful list of matters to consider on whether to draw an adverse inference. The factors, taken from Mewett and Sankoff, *Witnesses* (Toronto: Thomson Carswell, 2007), at 2-23 are as follows:

> (a) whether there is a legitimate explanation for not calling the witness;
>
> (b) whether the witness could provide material evidence;
>
> (c) whether the witness is the only or best person who could provide that evidence; and
>
> (d) whether the witness is within the exclusive control of the party and not equally available to both parties.

The same principles are referenced and applied in *John W. Page Welding Consulting Ltd. v Canonbie Contracting Ltd.*, 2014 ABQB 465, paras 85-90.

[245] First is the explanation offered for not calling a witness. The defendant explained that it called seven lay witnesses and one expert. Mr. McLeod was not involved in either incident, the meetings about them or the decision to terminate Mr. Jegou's employment.

[246] Second, on the material evidence Mr. McLeod could have offered, the plaintiff submits he could have testified about Mr. Jegou's general performance as an employee and positive performance reviews. CNRL points out that it does not take issue with the fact that Mr. Jegou's performance was positively reviewed and no reliance is placed upon any concerns before November 2014.

[247] The plaintiff also says Mr. McLeod might have spoken about his support for what Mr. Jegou did in the fall incident but, again, Mr. McLeod had no direct involvement in that matter and his generally supportive opinion has already been testified to.

[248] Mr. McLeod, the plaintiff goes on to argue, could have spoken to the ability to "performance manage" Mr. Jegou rather than terminate his employment. Perhaps he would have had an opinion on that, but the witnesses and documents dealing with the two incidents show this was addressed by others as a possibility.

[249] Third is whether Mr. McLeod would be the only or other best person to speak to the material evidence. Those directly involved in the relevant events and decisions were called as witnesses, with the exception of Fire Chief Robert Slade who is retired and would have been available to either party.

[250] Fourth, on the question of exclusive control, the defendant points out that Mr. Jegou and Mr. McLeod were very close friends, spending time outside of work hours visiting and sharing recreational interests. In my view, however, that would not suffice to take Mr. McLeod outside of the defendant's exclusive control for adverse inference purposes given the length of time since Mr. Jegou saw him. In responding to an email from Mr. Jegou asking whether he would testify for him, Mr. McLeod made it clear that it would be awkward and difficult for him to get involved as Mr. Jegou's witness, given his continuing employment at CNRL.

[251] Having considered the four factors, I conclude this is not a proper case to draw an adverse inference. Mr. McLeod, while for some purposes a "direct report" for Mr. Jegou, clearly was not directly involved in dealing with Mr. Jegou's alleged breaches of protocol and the *Guidelines*. That role was filled by Dr. Bouwer and Mr. Slade with input from Mr. Penzo.

[252] It is not clear why Mr. McLeod was not involved, although the reporting lines and chains of authority were complicated and varied accordingly to the circumstances. Perhaps those with the power to make the ultimate decision, such as Mr. Slade, thought it best not to involve Mr. McLeod because of his close friendship with Mr. Jegou – but that is speculation. Apart from Mr. Jegou's bringing Mr. McLeod's name up in his testimony, his involvement on the matters at issue in this case appears to have been inconsequential. There is direct evidence on all the matters at issue so that I am not satisfied Mr. McLeod would have added anything material.

V. Summary Dismissal

A. General Principles

[253] Contracts of employment, whether written, oral or partly both, are usually for an indefinite term. Either party may end the contract and thus the employment relationship without cause if certain obligations are satisfied. For an employer, this means providing reasonable advance notice of termination, failing which it will be liable for damages in lieu of notice. In some cases, where the employee has engaged in serious misconduct, the employer may be justified in summarily terminating the employment contract without notice or compensation in lieu thereof.

[254] *McKinley v BC Tel*, 2001 SCC 38, established the modern framework for determining whether there is just cause for summary dismissal. It emphasized a contextual analysis leading to a test of whether the misconduct in question "gave rise to a breakdown in the employment relationship": para 48. Put another way, again in the context of dishonesty, it could be said "that just cause for dismissal exists where the dishonesty violates an essential condition of the employment contract, breaches the faith inherent to the work relationship, or is fundamentally or directly inconsistent with the employee's obligations to his or her employer": para 48.

[255] The *McKinley* test, interpreted and explained by *Dowling v Ontario (Workplace Safety & Insurance Board)*, 2004 CarswellOnt 4923 (C.A.), requires (1) determining the nature and extent of the misconduct; (2) considering the surrounding circumstances (such as the nature of the employee's work, the employer's business and the degree of responsibility of the employee); and (3) deciding whether dismissal was warranted, which includes observing the principle of proportionality: para 50; *McKinley*, paras 49-57.

B. Application

1. Nature and Extent of Misconduct

[256] Mr. Jegou's responsibilities when dealing with a patient who had suffered a stroke were urgent and clear. All the standards, including *Guidelines*, emphasized rapid transport to a stroke centre. Dr. Bouwer and Mr. Lindsay had never heard of stopping en route anywhere for information, let alone for half an hour. Mr. Jegou was fully aware of the rapid transportation requirement: Mr. Lindsay testified that for the three levels of paramedicine training, from base to more advanced, the importance of rapid transport of stroke patients is emphasized throughout.

[257] Mr. Lindsay testified that this is because strokes evolve quickly and are frequently life-threatening or even when not fatal, life-altering. Time is crucial in the treatment of strokes either to prevent death or to mitigate permanent effects.

[258] Dr. Heran, as a neurosurgeon, did not dispute the protocol for responding to strokes. As a physician, he stated that in a case such as this it was unlikely that the patient suffered harm to his health. He did not, however, propose to give an opinion on proper protocol for paramedics responding to a stroke call nor, as Mr. Jegou's counsel confirmed, was he put forward for that purpose. If someone called him advising of symptoms such as those exhibited by the patient in this case, he testified, his advice would be to get the person to the closest hospital as soon as possible.

[259] It is indisputable Mr. Jegou failed to follow the very clear requirements of his profession as a paramedic and the *Guidelines* of his employer. In the proceedings for the Alberta College of Paramedics, he agreed with the conclusion that his conduct "was a marked deviation from the required standards of practice for the profession of paramedicine in the province of Alberta."

[260] As indicated earlier, none of Mr. Jegou's explanations for this departure are convincing. Perhaps the worst is that he overrode his training, professional standards and CNRL's *Guidelines* by taking it upon himself to decide if it was too late for the hospital to do anything for the patient. He arrogated to himself the role of hospital staff with diagnostic tools and treatment options not available in the field and expertise far beyond his own. While according to Dr. Heran, perhaps no harm resulted, I accept Mr. Lindsay's opinion as an experienced paramedic that even if the patient was outside the "theoretical reperfusion window," there could be adjunctive therapies to improve patient outcome and complications could occur at any moment requiring rapid hospital response.

[261] Quite apart from the clear breach of protocol, the explanation of wanting more information has no merit. I accept the evidence of many witnesses that it was unlikely any information could have been obtained that would have impacted the hospital's diagnosis and treatment and any available information could have been obtained by a telephone call. The excuse of privacy concerns for not using a cellphone in these circumstances is patently absurd.

[262] Mr. Jegou's conduct was aggravated by the fact that all three nurses at the clinic vehemently expressed their views that the patient must go directly to the hospital. Mr. Jegou did not accede to this advice but reacted badly when his judgment was questioned. The situation then deteriorated with him making it obvious that he did not consider the case urgent.

[263] The trip to the clinic, moving the patient from the ambulance, disputing the urgency of the case with the nurses and being unable to account for the wasted time are consistent with an attempt to transfer care to the clinic or an irresponsible refusal to treat the patient's needs as

urgent. In light of the time it took to remove the patient from Calumet Camp (whatever the merit for that may have been), Mr. Jegou should have been trying to make up for lost time.

[264] Suffice it to say the nature and extent of the misconduct was extremely serious.

2. Surrounding Circumstances

[265] The surrounding circumstances aggravate the seriousness of Mr. Jegou's misconduct.

[266] He was usually the most highly-trained medical responder to emergency calls in a remote area. He was responsible for decisions and actions that could have life-changing impact on his patients. He was an experienced member of CNRL's paramedical staff with the role of medical training officer for his shift.

[267] These responsibilities were conferred upon him by an employer having responsibility for the wellbeing of eight to ten thousand employees and contractors in a remote area, with the nearest hospital nearly one hour away. It was vitally important for CNRL's moral, legal and reputational interests that its paramedical staff be completely trustworthy in how they discharged their responsibilities.

[268] Part of Mr. Jegou's case is that even though he departed from required practice, it should be taken into account that no harm resulted. He relies upon *Underhill v Shell Canada Limited*, 2020 ABQB 341, where an office-based employee was terminated over concerns about allegedly failing to identify a conflict of interest and protect third-party confidential information. As only one of many reasons relied upon for concluding that summary dismissal was not justified, Brooker J. noted near the end of his decision that "furthermore, I am not convinced that Shell suffered any significant deleterious consequences from Underhill's actions": para 106.

[269] That case, in my opinion, is not comparable to one where a medical professional has responsibilities directly affecting patients' lives and wellbeing. In cases of this nature, it is the possibility of serious harm that is important: *Rieckhoff v DC Diagnosticare Inc.*, 2001 BCSC 850, paras 47-48; *Harrop v Markham Stouffville Hospital*, 1995 CarswellOnt 1034, paras 57, 58 and 68; and (in the context of a school teacher's conduct), *Fernandes v Peel Education & Tutorial Services Ltd.*, 2016 ONCA 468, para 120 – leave to appeal to SCC ref'd, 2017 CarswellOnt 2698.

3. Whether Dismissal Warranted

[270] *McKinley* endorsed the principle of proportionality, where "an effective balance must be struck between the severity of an employee's misconduct and the sanction imposed": para 53. Even so, *McKinley* recognized that a single case of misconduct can be a sufficient ground for summary dismissal where it "is fundamentally or directly inconsistent with the employee's obligations to his or her employer": para 48.

[271] I agree with Hollins J.'s view, expressed in the context of a dismissal for sexual harassment, "that there can be no hard and fast rule about whether an employer must issue a warning to an employee . . . prior to terminating his or her employment. The greater the wrong, the less likely a warning will be required before a summary termination can be justified": *Watkins v Willow Park Gold Course Ltd.*, 2017 ABQB 541, para 98.

[272] The concerns that led CNRL to dismiss Mr. Jegou rather than implement a performance improvement program were that the incident was a very serious breach of professional and employer standards and that Mr. Jegou showed very little insight into his misconduct. Dr.

Bouwer, Mr. Penzo and Ms. Grossi all believed that he was brought to acknowledging what he had done wrong only very begrudgingly, if at all. Thus, I find there was every reason to be concerned of a risk that willful prioritizing of his own judgment over governing standards would be repeated.

[273] I find that CNRL was legally justified in its decision. The incident was a serious departure. It was made worse by the meritless excuses made by Mr. Jegou, none of which should have had credence with someone of his experience and training. Finally, there are no explanations, however unjustifiable, for the length of the stop at the clinic.

[274] This was not, as Mr. Jegou argues, one case of poor judgment. It was a dereliction of his duties – factually different but legally similar to *Franceschetti v Seven Oaks General Hospital*, 2017 MBQB 99, para 51. As in that case, the principle of proportionality is not offended by the summary dismissal of Mr. Jegou.

VI. Damages

A. General Principles

[275] Because of my finding that there was just cause for summary dismissal, my assessment of damages in lieu of reasonable notice is made provisionally.

[276] If an employer terminates an employment contract without just cause, failure to provide reasonable notice of termination is a breach of contract, which will justify an award of damages in lieu of notice: *Matthews v Ocean Nutrition Canada Ltd.*, 2020 SCC 26, para 43. This proposition is based upon an implied term that an employer will give reasonable notice of termination during which period the employee may work, and failing such a reasonable working notice, the employee is entitled to damages in lieu of notice subject to an obligation to mitigate the loss: *Noble v Principal Consultants Ltd. (Trustee of)*, 2000 ABCA 133, para 8; *Bardal v Globe & Mail Ltd.* (1960), 24 D.L.R. (2d) 140 (Ont. HC), at 143-44.

[277] The amount of damages must compensate an employee for the amount they would have earned had they worked during the notice period: *Matthews*, para 59; *Noble*, paras 7 and 8; and *Sylvester v British Columbia*, [1997] 2 S.C.R. 315, at 320, quoted in *Noble*, para 19. Damages must include the loss sustained as a result of not receiving all elements of the compensation package, including wages, salary, bonuses, stock options, incentives, and other benefits: *Matthews*, para 53; *O'Reilly v IMAX Corporation*, 2019 ONCA 991, para 32.

B. Notice Period

[278] The commonly-accepted *Bardal* factors used to determine the length of reasonable notice are the character of the employment, the length of service, the age of the employee and the availability of similar employment, having regard to the experience, training and qualifications of the employee: *Bardal*, at 145. *Bardal* also emphasized that there is "no catalogue" of reasonable notice, it is something that must be decided with reference to each particular case.

[279] The first *Bardal* factor, character of employment, takes into account that Mr. Jegou was working as a firefighter paramedic, a highly-qualified role that initially had required over two years of education. He worked in a remote location for a company involved in oil sands operations. He did not have managerial or supervisory roles, although was usually the lead on a two-person crew responding to calls because the second person was an EMT, with less medical

training. He filled in as a crew captain, with extra pay, for shifts when someone holding that position was not available.

[280] Mr. Jegou's role could be described as a technical, professional one, but was probably distinct from many other paramedics in Alberta because of the remote area where he did his work, which added an additional level of responsibility and seriousness.

[281] The second *Bardal* factor is length of service, which is usually a major factor in determining a reasonable notice period. Longer periods of service tend to generate longer periods of reasonable notice. Mr. Jegou was dismissed from employment after 5.5 years of service at CNRL. In comparison to other cases, this falls within the "moderate" length of service.

[282] The third *Bardal* factor is the age of an employee at date of his dismissal. Age may be a factor in determining reasonable notice, but usually only when the person is over fifty. Mr. Jegou was thirty-nine years old when he was dismissed from employment, making his age a neutral factor.

[283] Availability of similar employment is the fourth *Bardal* factor, which takes into account experience, training, qualifications and availability of similar employment. It overlaps with the other factors because they all relate to the availability of similar employment. Special circumstances sometimes considered under this category are qualifications, experience, specialization, managerial position, remuneration and economic conditions.

[284] As I mentioned in relation to Mr. Jegou's character of employment, his role as a paramedic for a corporation in a remote area could be considered a form of specialization. Also relevant is that his total annual compensation in 2014, as reported for income tax purposes, was $215,290.07 – an amount, according to the evidence, well above what many paramedics in Alberta can earn. It is reasonable to conclude that the type of work Mr. Jegou had with CNRL, including the level of compensation, would have made it more difficult to find comparable employment at comparable compensation.

[285] Mr. Jegou also points to adverse economic conditions in the oil and gas industry. It is notorious that the oil and gas industry, including the oil sands sector of that industry, have been adversely affected by many conditions over the past several years. However, I have no evidence about the circumstances in 2015, when Mr. Jegou was dismissed, and am not prepared to assume that adverse economic conditions were a factor to be taken into account for notice periods at that time.

[286] Mr. Jegou's counsel submitted that the reasonable notice period should be at least nine months, thus ending on December 18, 2015.

[287] While acknowledging that there are few decisions giving guidance to these unique facts, the following cases were submitted in support of the nine-month notice period:

a. ***Tsakiris v Deloitte & Touche LLP*, 2013 ONSC 4207**: The plaintiff was a 33-year-old manager employed with the defendant for seven years, nine months. His work was highly specialized and he worked at the highest level below partner, that of senior manager. He had significant client responsibilities. His "highly specialized experience, training and qualifications and the significant remuneration he was being paid in 2008 (in the $200,000 range) suggest that the number of comparable positions

might be relatively restricted": para 80. He received ten months reasonable notice.

b. ***Kelly v Monenco Consultants Co*, 1987 Carswell Ont 5289 (HCJ)**: The plaintiff was a mechanical engineer with slightly less than four years of service, 44 years old when his employment was terminated. It was noted that he supervised mechanical engineers and worked "within his fairly limited field of engineering related to energy," (para 5) and was laid off during a downturn in the energy field. He was awarded ten months' pay in lieu of notice.

c. ***Bent v Atlantic Shopping Centres Ltd*, 2007 NSSC 231**: The plaintiff was employed as a mall manager for nine years, a role characterized by the court as lower management. She was 35 years of age when her employment was terminated, an age that "should not have affected her ability to obtain comparable employment" (para 100). The ten months' compensation paid by her employer was considered reasonable by the court, and thus no damages were awarded.

d. ***Ratzlaff v Medstar Ventures Inc*, 2006 SKQB 167**: The plaintiff was an emergency medical technician with 4.5 years' service, 23-years-old when her employment was terminated. Her notice period was set at five months, with the court noting that "she has specialized training and lives in a rural area where opportunities in her field are limited" (para 43).

[288] CNRL submits that the notice period should be between four and five months. It submits the following cases in support of its position:

a. ***Serbanescu v Span Manufacturing Ltd*, 2010 ONSC 6087**: The 38-year-old plaintiff held a degree in electrical engineering from Romania, but had no Canadian professional qualifications. His service was 3 years, 1.5 months working in a technical position. The notice period was set at 5 months.

b. ***West v Jim Pattison Charters Ltd*, [1994] B.C.J. No. 1103 (S.J.)**: The 35-year-old plaintiff worked as chief airline pilot for 4 years and 7 months. The notice period was set at 6 months.

c. ***Unrau v Calm Air International Ltd*, 1995 Carswell Man 163 (QB)**: The 36-year-old plaintiff worked for 3 years, 7 months as a pilot. The notice period was set at 5 months.

d. ***Bhavsar v Canadian Natural Resources Ltd*, 2016 ABQB 471 (M.)**: The master heard summary judgment applications to determine damages for three plaintiffs. The one relied upon by CNRL as applicable in this case was a 38-year-old electrical engineer, who had been employed for 2.5 years. His notice period was set at 4 months.

e. ***Allen v MacMillan Bloedel Ltd*, 1984 CarswellBC 1619 (SC)**: The 42-year-old plaintiff was employed as a process engineer, and had served 5 years as of termination of his employment. His notice period was set at 6 months.

f. ***Dragos v Hunterwood Technologies Ltd*, 2018 ABPC 40**: The plaintiff was 53-years-old at the time of termination, and had been employed as a control systems specialist for 2.1 years. His notice period was set at 3 months.

[289] These cases show a wide variety of circumstances, types of work and qualifications, and notice periods. They are of assistance in understanding the possible ranges, but none are directly applicable.

[290] Taking all of the factors into account, I conclude that the reasonable notice period for Mr. Jegou is seven months, which would thus come to an end on October 18, 2015.

C. Elements of Compensation Package

[291] There were many elements to Mr. Jegou's compensation package, partly due to special provision being made for working in a remote location and working twelve hour shifts, seven days a week, thus regularly incurring overtime entitlement and statutory pay entitlement. In addition, CNRL's compensation package included a variety of additional perquisites.

[292] First, I will address those elements of the compensation package both parties agree should be included in damages over a reasonable notice period. In using 2014 (Mr. Jegou's last full year of employment) as a base, each party calculated these benefits in a similar fashion, adding an increment to reflect the adjustment to Mr. Jegou's base salary for 2015. In oral argument, the parties agreed that their approaches were similar but not identical, thus leaving minor differences in results. I have tested these assurances by reducing their total damages calculations to monthly amounts and found that the values are sometimes identical, and where there is a difference, it is immaterial. Thus, I will use the plaintiff's calculations for monthly amounts.

[293] In brief, the undisputed elements of the compensation package to be included over the notice period are as follows:

a. Base salary: $114,046.00 annually or $9,504 monthly;

b. Overtime: $712.79 monthly;

c. Double overtime: $1,092.14 monthly;

d. Compensation for working night shift: $222.92 monthly;

e. Statutory days off: $272.93 monthly;

f. Working statutory holidays: $656.52;

g. Temporary supervisory shifts: $153.66 monthly;

h. Employer compensation to group benefits: $309.58 monthly.

The total of these monthly amounts is $12,924.54.

[294] Three other elements of compensation are agreed (subject to the length of the notice period) as follows:

a. Two payments from CNRL's cash election plan totalling $1259.75 would have vested and been paid to Mr. Jegou on November 1, 2015;

b. Stock options would have vested at various stages during 2015, but had no value because actual share price had fallen before the exercise price; and

c. Bonus shares would have vested on various dates, with the following values based on actual share price at vesting dates:

   i. May 1, 2015: $639.97;

   ii. July 1, 2015: $568.29; and

   iii. October 1, 2015: $329.47;

   which total $1,537.73.

[295] Additional elements of the compensation package claimed over the notice period by Mr. Jegou but disputed by CNRL are as follows:

a. ***Compensation paid for flying in and out of camp***: Mr. Jegou and Ms. Grossi each testified that approximately ten percent of base salary was paid to employees to compensate them for traveling to and working in a remote location. In 2015, the monthly amount was $950.38. This amount was paid irrespective of actual expenses. For example, the cost of the flights was paid for by CNRL.

   While the payment was not directly tied to expenses, programs of this nature are designed to compensate employees for the inconvenience and additional costs of living far away from home and frequently traveling. That inconvenience and additional cost ended with Mr. Jegou's employment, and thus I find he is not entitled to damages for loss of this amount.

   (I have been referred by CNRL to *Bhavsar v Canadian Natural Resources Ltd.*, 2016 ABQB 471, paras 34 and 35, as already deciding this point in CNRL's favour. In my view, even if the case relates to the same "fly in/fly out allowance" it does not apply on the evidence before me. Hanebury M. referred to the allowance as compensating employees for the cost of travelling from their homes to the site for work, which is not the evidence before me.)

b. ***Stock savings plan***: Mr. Jegou could (and did) contribute up to ten percent of his annual salary and CNRL would contribute 1.5 times his contribution, with a total funds used to acquire common shares, averaging $1,813.92 monthly. CNRL argues that these vest only in January of the following year, which would be outside any arguable notice period. Mr. Jegou submits that the January vesting repayment date was not invariable, because he received vested shares valued at $23,896.90 in March 2015 for the 2014 calendar year.

   The agreed exhibits contain a copy of a CNRL "Employee Stock Savings Plan," which is undated and unsigned. It contains terms regarding vesting and what happens upon termination of employment, but there is no evidence Mr. Jegou was ever presented with a copy of this document, let alone that he agreed to its terms. It was not one of the documents enclosed

with his offer of employment, and he testified that he did not remember ever seeing it before exchange of documents in this action. In my view, the limiting terms of the plan cannot be imposed on an employee in the absence of confirmation that he accepted them as part of the terms of his employment.

Further, the testamentary and documentary evidence before me indicates that on at least one occasion, a stock savings plan payment was made on a date other than referred to in the plan.

In my view, the benefits of the stock savings plan were a regular part of Mr. Jegou's compensation and his entitlement for damages in lieu of this benefit over the notice period is based on time of earning rather than payment. I accept the plaintiff's calculation of the employer's contribution at $1,814 per month.

c. ***Performance bonus***: CNRL announced cash performance bonuses in December of each year for that calendar year, paid in January of the following year – Mr. Jegou receiving $3,450 in January 2015 for the year 2014. Mr. Jegou claims that he should be paid the share of a bonus which would relate to the notice period during 2015, even though it would be payable later. CNRL argues that entitlement is outside the notice period and, in any event, because of the fall and stroke incidents, Mr. Jegou would not have received this discretionary bonus.

   Entitlement to bonuses over the notice period, in my view, is determined by when they would be earned, not paid. They form part of an employee's compensation package for all of the time worked: *Noble*, para 41; *Rosscup v Westfair Foods Ltd.*, 1999 ABQB 629, para 55.

   Ms. Grossi testified that every year, there are some employees that do not receive a bonus because of unsatisfactory performance. In Mr. Jegou's case, because of his very good performance record before November 2014, he received a bonus for every year of his employment. I am not satisfied, on a balance of probabilities, that he would not have received a performance bonus for time worked during 2015. For reasons given earlier, there was no indication that the 2014 fall incident would result in any form of disciplinary action, nor was he significantly criticized for his work. Thus, if the stroke incident was not just cause, it would be the only blot on an otherwise very good record, and it is plausible that another seven months of good performance would have resulted in Mr. Jegou still receiving his bonus. I agree with the plaintiff's calculation which works out to a monthly amount of $228.

d. ***Bonus stock options and share bonuses***: these appeared to have also been discretionary awards that CNRL says would not have been awarded to Mr. Jegou but, in any event, it seems that Mr. Jegou has not claimed them, perhaps because of declining share values. Thus, there is nothing on which to decide for this item.

D. Total Damages

[296] In summary, I find that the damages to which Mr. Jegou would be entitled in lieu of reasonable notice, if he was not dismissed for just cause are as follows:

a. Undisputed elements of compensation package totalling $12,924.54, multiplied by seven months, for a total of $90,471.78;

b. Elements of compensation agreed, subject to the length of the notice period, which are all of the vested bonus shares for a total of $1,537.73 (the payments from the cash election plan falling outside of the notice period, therefore not compensable);

c. Compensation for the stock savings plan at a monthly amount of $1,813.92, which for seven months is $12,697.44; and

d. Compensation for the monthly value of a performance bonus of $228, for a seven month total of $1,596.

The total amount of Mr. Jegou's provisional damages therefore is $106,302.97, from which must be deducted $1,493.99 for income earned in 2015 in mitigation of his damages, for a revised total of $104,808.96, with any further deductions or withholdings required by statute.

[297] The parties may schedule a further appearance if there are clarifications arising from these reasons or if they are unable to agree on costs.

Heard on the 22nd, 23rd, 24th, 25th, 29th and 30th day of March, 2021 and the 1st day of April, 2021.
Dated at the City of Calgary, Alberta this 20th day of May, 2021.

G.H. Poelman
J.C.Q.B.A.

Appearances:

J. Irwin and L. Onia
for the Plaintiff

G. Ross and Y. Guo
for the Defendant