WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 2329/10

BEFORE:	S. Hodis:	Vice-Chair
	A. D. G. Purdy:	Member Representative of Employers
	F. Jackson:	Member Representative of Workers
HEARING:	November 25, 2010, June 20 and 21, 2011, and November 29, 2011 at Toronto Oral Post-hearing activity completed on January 23, 2012	
DATE OF DECISION:	June 11, 2012	
NEUTRAL CITATION:	2012 ONWSIAT 1287	
DECISION UNDER APPEAL:	WSIB Appeals Resolution Officer K. Hille decision dated March 11, 2010	

APPEARANCES:

For the worker:	G. Majesky, Union Representative
For the employer:	P. Wolfenden, Lawyer
Interpreter:	N/A

REASONS

(i) Introduction to the appeal proceedings

[1] The worker appeals a decision of the Appeals Resolution Officer (ARO), which concluded that the worker did not have entitlement for a right arm injury sustained on July 25, 2009 as the worker was not in the course of his employment at the time of the injury. The ARO rendered a decision based upon the written record without an oral hearing.

(ii) Background

[2] The worker was employed as a paramedic on July 25, 2009. While off duty, he attended a local festival with his wife where he witnessed a member of the public collapse. The worker came to the assistance of this person along with other members of the public. When the ambulance arrived he assisted the on duty paramedics in various aspects of the patient's care. In the process, he sustained an injury to his right arm. The worker reported the incident and sought immediate medical attention. The worker now claims initial entitlement. The issue in this appeal turns on whether the off-duty worker was in the course of his employment when he sustained a right arm injury on July 25, 2009.

[3] The ARO decision dated March 11, 2010 considered this issue and found as follows:

> Taking into consideration, time, place and activity, the evidence does not support that the worker was in the course of his employment at the time of the injury. While the worker may have been performing the same activities that he did as a paramedic, this does not necessitate that he was in the course of his employment. The worker was not being paid by the employer, the employer did not obligate the worker to assist and the worker was not under the supervision and control of his employer at the time of the incident.
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> In reviewing the information available to me, I find that the worker was not a worker at the time of injury as the evidence does not support that he had entered into or was employed under a contract of service, written or oral, express or implied. While the worker may have participated in a heroic life saving activity he was not in the course of his employment at the time of injury and as such there was no entitlement for the injury incurred on July 25, 2009.

(iii) Testimony

[4] The Panel heard the testimony of 4 witnesses including the worker. The summary of their evidence is as follows.

(a) Testimony of the worker

[5] The worker testified that he has been a paramedic for 28 years and has worked in several municipalities in Ontario. He started working with the accident employer full time in July 2001. He testified that he works 12 hour shifts with 4 days on and 3 days off. He testified that paramedics provide 24 hour/7 days a week coverage and as such is he is required to work shifts.

[6] The worker testified that when he is on duty he usually works with a particular partner, wears a uniform, and has a cell phone provided by the employer which is accessible to both paramedics during the shift.

[7] The worker testified that an Ambulance Call Report (ACR) is completed after contact with a patient by the attendant on call. The driver will review the ACR report when it is

completed and will sign it. The worker acknowledged that the ACR is a legal document and is very important. The worker testified that paramedics receive training on how to complete an ACR and acknowledged that when you sign an ACR you are agreeing to its contents. The worker confirmed that he did not complete an ACR report for the incident that occurred on July 25, 2009 because it is the ambulance crew who usually prepares the report. The worker testified that he would not put his initials on the ACR report as he did not complete the report. The worker confirmed that only the person who completes the report will put initials of the person who performed the specific tasks beside those tasks as listed on the ACR report. When asked why co-worker #2 did not put his initials on the report the worker testified that a vital signs absent (VSA) situation is very stressful and you are still excited when it is over. The worker testified that since he was not the author of the report he does not know why his initials were not put in the report. The worker testified that when you normally fill out the ACR report you would indicate who took the patient history, who put on monitor leads, who did suction, who applied straps, who carried backboard and stretcher, and who used trigger switch. The worker testified that he was never asked to review the ACR report after it was completed. The worker testified that he did not insist on reviewing the ACR report as he was on the way to the hospital himself for his injury. In addition, the worker testified that he cannot force the person completing the ACR to put anything in it. The worker speculated that co-worker #2 probably did not put his initials in the report because her mind was going fast and she was trying to recall what happened.

[8] The worker testified that in his 28 years of being a paramedic he has responded to off duty situations. He estimated that he has responded to 75 to 100 such calls. The worker testified that he has never completed an ACR report when he responded to a call when off duty. He testified that he has a badge which he shows to identify himself as a paramedic. He confirmed that he is not required to obtain permission from the employer before responding to one of these off duty calls. The worker recalled an incident while travelling on a highway when he approached an accident scene. The police saw his badge and asked him to assist. He was not wearing his uniform. The worker testified that he carries a first aid kit with gloves, bandages, etc. in his car. He confirmed that this is not required by the employer.

[9] The worker testified that the employer does not have a policy with respect to the expectations of a paramedic in emergency situations when off duty. He also testified that there is no training on what to do when one is off duty and an emergency situation arises. The worker testified that because he is a paramedic he must help. He testified that the employer recognizes paramedics for these incidents. He testified that he received a Chief's Commendation Award for the July 25, 2009 incident. The worker testified that he has never been directed by the accident employer to respond to an emergency situation when he is off duty. The worker also confirmed that he has never received training that informed him that he would be covered by liability insurance if he stopped at the side of the road and helped someone in an accident; however, the worker testified that as paramedics you are continually undergoing training and throughout the training procedures it is enforced that you are to respond to emergency situations.

[10] The worker testified that police, firefighters and paramedics are considered responders and each has a specific role to fulfill. Police are to do identification and crowd and traffic control. Fire is to provide support, assist with lifting, extricate and help with getting equipment. The paramedics are to treat, assess and transport patients. The worker testified that in a VSA situation the fire department usually responds. The worker testified that on July 25, 2009, the fire department did not respond to the call which was atypical. The worker testified that the fact

the fire department did not respond changed the dynamic of the situation for the ambulance crew. The worker testified that in VSA situations the more hands the better. In cross questioning, the worker acknowledged that most times a 2-person ambulance crew would respond to such a situation and they would not have the assistance of an off-duty paramedic and two doctors.

[11] The worker testified that on July 25, 2009 he was not on duty and he was not wearing his uniform nor had access to the employer cell phone. The worker confirmed that he was not dispatched to this call. He and his wife attended a local festival. While in attendance at this festival, a man in front of him collapsed and fell down. The worker identified himself as a paramedic to the man's wife and started obtaining a history from the wife. The worker testified that taking a history is part of the paramedic protocol. The worker examined the man and his face was blue and he had a hard time breathing. The worker knew that the man was in trouble. The worker testified that he and other members of the public (who he later found out were doctors) carried the man 4 or 5 steps out of public view so that they could start working on him. The worker testified that the other 2 members of the public never identified themselves as doctors. The 2 people who assisted him started doing CPR and artificial respiration. The worker testified that he allowed the two people to continue with CPR as they knew what they were doing. The worker testified that it is not uncommon for an ambulance crew to leave someone else to do CPR. A paramedic will usually observe to see if the person is doing it correctly. If so, then the paramedic will return to the ambulance to get equipment. The worker testified that he instructed the police officer in the vicinity to call for an ambulance as the police radio is directly connected to the dispatcher. The worker testified that he knew that time was of the essence.

[12] The worker testified that the ambulance arrived within 3 to 4 minutes. The worker testified that he was standing at the foot of the patient and talking to the patient's wife to get information. He testified that when the ambulance came he ran down the stairs and met the ambulance crew at the side of the road. He recognized the ambulance crew when they arrived. The ambulance crew consisted of co-worker #1 and co-worker #2. The worker testified that the ambulance crew did not know that the call involved a VSA as they told him this. He briefed the crew on the situation and the patient history which is important in these types of calls. The worker testified that he was never asked to leave the scene or to stand down by the ambulance crew. The worker testified that he and the ambulance crew continually communicated without one another and coordinated actions. The worker testified that he was never instructed not to assist. The worker testified that during the entire incident the ambulance crew and he worked as three person team. The worker testified that at the time the ambulance crew arrived the doctors stepped back and let him and the ambulance crew take over. He testified that the doctors left the hot zone. The worker testified that the hot zone is an area where the patient is and where the crew are working. Only police, fire, paramedics and family members are allowed in the hot zone. It is not a place where the public is permitted. The worker testified that he was never asked to leave the hot zone.

[13] The worker testified that co-worker #2 hooked up the pads for the defibrillator unit. The worker testified that when you are off duty you are not allowed to hook up the pads the for the defibrillator unit due to insurance reasons. The worker testified that co-worker #1 was working on the patient's airway. The worker testified that co-worker #1 handed him the suction unit and asked him to clear the patient's airway. The worker testified that due to the quick response the patient was revived after he was shocked with the defibrillator. The worker testified that after the person was revived you must monitor his heart beat. The worker testified that co-worker #2

handed him the monitoring pads and he applied the monitoring pads to the patient. At this point in time co-worker #2 was at the patient's feet and the worker was at the patient's chest area. The worker also testified that after he placed the monitor pads on the patient he went to the ambulance and obtained the backboard from the ambulance. He assisted the crew to place the patient on the backboard. The worker testified that it was the ambulance crew and himself that placed the patient on the backboard as there was no fire crew on scene. He then assisted putting the back board on the stretcher. The stretcher was located on the top of a landing which required it to be lifted down some stairs. The worker testified that after the patient was put on the stretcher, a 4 man lift was performed due to the weight of the stretcher and the patient which he estimated to be approximately 340 pounds. The worker was at the front left side of the stretcher at the trigger switch. The worker testified that when they were lifting the stretcher down the stairs the load shifted and the stretcher was tilting to the right. The worker testified that he tried to hold the stretcher up and as a result tore his bicep muscle. The worker testified that at the bottom of the stairs he activated the trigger switch. The worker testified that at the bottom of the stairs it was approximately 10 to 12 feet to the ambulance. The worker testified that he assisted in pulling the stretcher to the ambulance but was not able to assist with loading the patient into the ambulance because of the pain. The worker testified that he told co-worker #1 that he had injured himself when co-worker #1 was shutting the ambulance door. The worker testified that when the ambulance crew left the scene he proceeded to the hospital to seek medical attention for his bicep injury.

[14] The worker testified that a stretcher has a trigger switch which lowers the carriage of the stretcher to make it more accessible. The worker testified that one must be trained on how to use a trigger switch. The worker testified that a member of the public would not use a trigger switch. This task is reserved only for paramedics.

[15] The worker testified that if he had been on duty on July 25, 2009 he would have done exactly the same thing he did while off duty. The worker testified that the public would never be permitted to do suctioning or apply monitor pads to a patient. The worker testified that he did not get compensation for the time he was involved with this incident but he did receive the Chief's Commendation Award. The worker testified that another off-duty paramedic also received this award.

[16] The worker testified that prior to this incident he had never had any problems with his right arm or shoulder. The worker testified that he is in receipt of private disability benefits and has returned to work doing modified duties. The worker testified that he has not returned to full duties as a paramedic since the incident.

[17] The worker testified that, with respect to co-worker #1's email to the Director and Chief of the paramedic services dated August 31, 2009, this co-worker misconstrued some events. The worker testified that he did witness the patient arresting. The worker testified that since two bystanders were doing CPR he instructed OPP to call dispatch. The worker testified that co-worker #1 did not accurately record what was told to him by the worker. The worker testified that co-worker #1 only wrote down what he thought had happened prior to arriving at the scene.

(b) Testimony of co-worker #1 – JB

[18] Co-worker #1 testified that he has been a paramedic for over 29 years. He has worked with the accident employer for the last 10 years. He knows the worker for the last 8 to 9 years and has worked one shift with him 4 to 5 years ago.

[19] Co-worker #1 confirmed that an Ambulance Call Report (ACR) report must be completed whenever contact is made with a patient and that it is an important legal document which must be a as accurate as possible. He also confirmed that it is the responsibility of the paramedic who did not complete the form to review that form. Co-worker #1 confirmed that he reviewed the ACR report completed by co-worker #2 on the day of the incident and signed the report. Co-worker #1 confirmed that he has never changed an ACR report after reading it but he has on occasion added to the ACR report. He also confirmed that once the form is signed it can not be changed.

[20] Co-worker #1 confirmed that an ACR report is not completed when you are off duty. An occurrence report is completed when something above normal duties is done. As the patient that was the subject matter of the call on July 25, 2009 was without vital signs an occurrence report would be completed by the attendant and driver. Co-worker #1 is not aware of any paperwork that is required to be filled out when you are off duty.

[21] Co-worker #1 was working with co-worker #2 on July 25, 2009. Due to the crowd it took the ambulance 3-4 minutes to arrive on the scene. Co-worker #1 testified that upon arrival at the scene, the worker was at the roadside and provided him and co-worker #2 with good verbal information about the situation which allowed them to rule out a number of procedures.

[22] Co-worker #1 testified that when he was at the scene he saw two people performing CPR who were later discovered to be doctors. Co-worker #1 testified that they did not present any identification at the time. He also testified that he later found out from the worker that the worker had started working on the patient before they arrived. Co-worker #1 testified that he allowed the doctors to continue CPR as they were doing a good job. Co-worker #1 confirmed that the persons continued with CPR until they were relieved. Co-worker #1 testified that he did not pay attention as to whether the doctors were around or not as he was focused on the patient. Co-worker #1 did not recall the doctors remaining at the head of the patient until the patient was moved to the ambulance. Co-worker #1 testified that he saw the worker performing tasks in relation to the patient's airway management. He testified that he saw the worker perform suctioning tasks. He testified that they would not have allowed the doctors to bag the patient as they did not have the equipment and they would not have allowed them to use their equipment as they did not produce any identification that they were doctors. When asked why the worker's initials were not on the ACR report in relation to airway, co-worker #1 testified that co-worker #2 was estimating who did what. Co-worker #1 testified that co-worker #2 thought that one of the doctors or co-worker #1 was doing the airway management; however, co-worker #1 testified that he actually saw the worker dealing with the patient's airway management.

[23] Co-worker #1 testified that he was not completely sure if he saw the worker attaching the cardiac monitor leads to the patient but stated that he knew that the worker would not hesitate to do so. Co-worker #1 testified that he could not recall exactly what procedure everyone did as they were all working together to save the patient. Co-worker #1 testified that the worker was functioning as a member of the paramedic team. When the patient was resuscitated, the worker was on one side of the stretcher and co-worker #1 was on the other side at the back of the stretcher by the trigger switch. Co-worker #1 was unable to recall who got the backboard and who strapped the patient in.

[24] Co-worker #1 testified that they had two difficult lifts with this patient. The first one was moving the patient from the ground to the stretcher and the second one was moving the

stretcher to the ambulance. Co-worker #1 recalls having to navigate 1-3 steps with the stretcher. Co-worker #1 recalled that the worker, himself, co-worker #2 and a police officer lifted the stretcher to the ambulance and then another police officer took co-worker #2 spot and loaded the stretcher into the ambulance. He also recalled that the patient and board jerked back when it was lifted into the ambulance as the police officers lifted the stretcher quickly and he and the worker were not ready to lift the stretcher. Co-worker #1 testified that it is possible to get hurt when this occurs. Co-worker #1 recalled the worker telling him that he sustained an injury to his arm after they loaded the stretcher in the back of the ambulance and he closed the door.

[25] Co-worker #1 testified that the "hot zone" is a way to control a very crowded scene. Members of the public are sometimes allowed in the hot zone.

[26] Co-worker #1 testified that history taking, cardiac monitor, VVAC suction, fastening patient to backboard, carrying equipment, carrying stretcher, and operating trigger switch are all part of the duties of a paramedic. He also confirmed that not even firemen are trained to operate the trigger switch.

[27] Co-worker #1 testified that the worker saved the patient's life. If the worker did not get involved the patient would have died. Co-worker #1 testified that in this specific case, he and his partner would not have been able to deal with the call on their own without the help of the worker. If the worker was not present, procedures would not have been initiated so fast.

[28] Co-worker testified that it is natural for an off-duty paramedic to respond to a medical situation when off duty as they are trained to respond to these situations. He testified that he felt that there is a policy that requires an off-duty paramedic to help. He relied on the *Good Samaritan Act*. He acknowledged that the employer does not have a policy that requires an off-duty paramedic to assist when off duty. Co-worker #1 testified that a paramedic is supposed to respond to a situation to the training level they are at regardless of whether they are in uniform or not. He stated that it would neglectful if you were to walk away from a situation. He testified that every paramedic would fear legal repercussions if they did not respond and help while they are off duty.

(c) Testimony of co-worker #2 – KI

[29] Co-worker #2 testified that she is employed by the accident employer as a primary care paramedic full time and by another employer part time as an advanced care paramedic. She has been employed as a paramedic since 2002. At the time of the accident she was working for the accident employer as a primary care paramedic. She confirmed that she had never worked directly with the worker in the past although they both work for the accident employer.

[30] Co-worker #2 confirmed that the Ministry of Health has policies and procedures that regulate the expectations and conduct of paramedics which are contained in the Basic Life Support Manual (BLS Manual). This manual forms part of the training for paramedics and it is the Code of Conduct that the employer expects paramedics to follow. Co-worker #2 confirmed that the general standard of care applies when one is in uniform and/or identify oneself as a paramedic. She also confirmed that when one is off duty there is no specific reference in the BLS Manual with respect to the general standard of care however she interprets the general standard of care to also apply when one is off duty and has identified oneself as a paramedic. She also confirmed that there is no training on how to document incidents when one is off duty and performing tasks of a paramedic. Co-worker #2 confirmed that when one is at a scene and

functioning as a paramedic one is not able to abandon the patient and one is responsible for the patient until a higher level of care assumes responsibility. The transfer of care is usually done verbally and there is no paperwork involved in this process. Co-worker #2 confirmed that the consequence for abandoning a patient is the loss of certificate from the Ministry of Health.

[31] Co-worker #2 confirmed that at the end of a call an Ambulance Call Report (ACR) is completed as soon as possible after the call by the attendant on call. A manual exists that explains how the ACR is to be completed. Once the ACR is completed it cannot be changed. Co-worker #2 confirmed that she is familiar with the contents of the manual and has trained other paramedics on how to complete the reports.

[32] Co-worker #2 testified that on July 25, 2009 she was the attendant on call and she completed the ACR report for the incident that is the subject matter of these proceedings after delivering the patient to the hospital. She verified that the time that elapsed between the call and the completion of the ACR report was approximately 30 minutes. Co-worker #2 did not recall receiving or responding to any other calls during this time period. Co-worker #2 testified that she did not put the worker's initials on the ACR report as there is only room for 4 initials. She explained that since there were doctors on the scene and they have a higher level of care, she put them on the ACR report. Co-worker #2 testified that worker could be put in the incident report. Co-worker #2 testified that she did not have any debriefing of the worker's involvement in the call until approximately 3 weeks later when she was asked to send an email explaining what had happened.

[33] Co-worker #2 testified that on July 25, 2009 she was on duty working with co-worker #1. She confirmed that co-worker #1 is not her normal partner but she had worked with him in the past on occasion. She testified that prior to receiving the call that is the subject of these proceedings, she was located 2 blocks away in the station. She heard an alarm signaling the call. She went to her vehicle, went online and waited to be dispatched with instructions. She testified that this process takes approximately 2 minutes. Co-worker #2 testified that she was dispatched to an unconscious diabetic. She confirmed that the patient she attended to was not the patient she was dispatched to. She confirmed that two calls were dispatched at around the same time that day.

[34] Co-worker #2 testified that when she approached the scene she was waiting for the police to clear a path through the crowd to allow the ambulance to approach the scene. As she approached the scene, the worker and another police officer were waving at them to indicate where the scene was. She rolled down her window and the worker approached the vehicle and reported to her the critical situation. The worker then went to the back of the ambulance to get equipment. Co-worker #2 and co-worker #1 also headed to the back of the ambulance to obtain equipment. Co-worker #2 testified that she and co-worker #1 pulled out the stretcher. She asked the worker to grab the "section unit" and gloves from the vehicle. Co-worker #2 confirmed that if the worker was not present they would have to do these tasks on their own. The stretcher was rolled to the base of the building where the patient was located. The stretcher remained there. Co-worker #2 and co-worker #1 carried the equipment up the stairs where the patient was located. The worker followed them up the stairs and debriefed them on the situation at hand. When questioned, co-worker #2 could not recall if she or her partner carried up the backboard or if they asked the worker or a police officer to get it for them. Co-worker #2 also confirmed that the worker was in the "hot zone" which is a zone that is approximately 5 feet around the patient. The purpose of the hot zone is to keep people out of the way and away from the patient. She

testified that the public is not allowed in the hot zone unless you require assistance from someone.

[35] Co-worker #2 testified that when she got to the top of the stairs she saw a man on his back lying on the cement. Two people were performing CPR who identified themselves as family doctors. One was located at the head of the patient doing mouth to mouth resuscitation and the other was doing chest compressions. The doctors continued to work on the patient in this position until the patient was placed on the stretcher and put in the ambulance. She confirmed that the amount of time from when they arrived at the call to the time the patient was put into the ambulance was 13 minutes. This is confirmed on the ACR report which indicated that the paramedics arrived at 10:23 am and departed at 10:36 am.

[36] Co-worker #2 confirmed that she was not involved in carrying the stretcher down the stairs to the ambulance as she was cleaning up the scene and picking up the equipment to return it to the ambulance. She went ahead of the patient so that she could prepare an IV for the patient and be ready for the patient when he arrives at the ambulance. She confirmed that co-worker #1, the worker and 2 police officers carried the stretcher with the patient on it to the ambulance. She also confirmed that the worker and co-worker #1 loaded the stretcher onto the ambulance although she could not recall their exact positions. Co-worker #2 confirmed that it takes training to be able to use a trigger switch on a stretcher and members of the public would never be allowed to operate a trigger switch. She also testified that fire fighters are allowed to use the trigger switch as they are trained in this regard but police officers are not allowed to use the trigger switch as they are not trained to load a patient into the ambulance. Co-worker #2 testified that at no time did she direct the worker to stand down or advise him that he was not needed as they had control of the situation.

[37] Co-worker #2 confirmed that neither the worker nor the family doctors went with the ambulance to the hospital.

[38] Co-worker #2 confirmed that she saw the worker later that afternoon at the ambulance station as the worker had parked there to attend the local festival. Co-worker #2 was unable to recall whether the worker mentioned anything about injuring his shoulder.

[39] Co-worker #2 also testified that after the incident she was made aware that the worker had identified himself as a paramedic at the scene.

[40] Co-worker #2 testified that she is unable to confirm if the worker did the initial assessment of the patient as she was not on the scene at that time. Co-worker #2 testified that she recorded on the ACR report that she attached the cardiac monitor leads but it is possible that the worker assisted her. Co-worker #2 testified that you must be trained on how to properly place monitor leads on a patient because if it is done incorrectly you can get incorrect rhythms. She does recall that the worker helped the doctor present at the head of the patient with suctioning as she asked the worker to assist the doctor. She testified that it was possible that the worker also provided air to the patient. Co-worker #2 confirmed that the scene was a very busy scene and as such she can not recall all that the worker did but she does recall asking the worker to assist the doctor. Co-worker #2 confirmed that she would not ask a member of the public to assist with suctioning or providing air to a patient.

[41] Co-worker #2 confirmed that she, as a result of her own experience, is aware of situations where off-duty paramedics assist at a scene. She also confirmed that this happens frequently.

She testified that she has assisted other paramedics or dealt with a situation herself when she was off duty approximately 5 to 10 times. She also confirmed that when she assisted at the scene she would engage in functions or activities that were similar to the ones she would perform as a paramedic on duty. She also confirmed that she would not fill out an ACR report in these circumstances or receive any credit for the work she did.

[42] Co-worker #2 agreed with co-worker #1 statement that the worker's involvement in this call was very important to the patient's survival.

(d) Testimony of Deputy Chief – PT

[43] The Deputy Chief testified that he has held this position since 2009. Prior to this time he was a paramedic since 1984.

[44] The Deputy Chief explained that the Chief's Commendation Award is a discretionary award given by the Chief to people who are actively employed at the time and who make a significant contribution or demonstrates care above standard or is involved in exceptional circumstances not involving patient care. This award is specifically given to employees of the paramedic service and is given on the recommendation of other paramedics. This award has been available for the last 2.5 years. The Deputy Chief also explained that another award that is given out is called a "shock pin." This award is given to staff who are involved in births or who have defibrillated someone and they survived. This award is different than the Chief's Commendation Award. The Deputy Chief confirmed that the worker received the Chief's Commendation Award for his assistance on the call of July 25, 2009.

[45] The Deputy Chief reviewed the ACR report and occurrence report and testified that based on these reports the only involvement of the worker was that he was present when the crew arrived. There is no indication on the ACR or occurrence report that the worker was involved in the treatment of the patient. The Deputy Chief confirmed that the ACR report must be completed whenever there is patient contact and must be completed as soon as possible after a call. The ACR report is to include a chronological sequence of events from time of patient contact to completion of call. It is also to contain the history gathered at the scene and any background medical history. Anyone involved in the treatment of the patient should be listed on the form and any paramedic assigned to the call should sign the document as well as anyone who did any procedures. The Deputy Chief testified that if more than 4 people assisted in the treatment of the patient then a second form should be created or they should be listed in the space provided at the bottom of the report. The Deputy Chief testified that if the worker was involved in the treatment of the patient he should have been listed on the reports. He confirmed that the only people listed on the ACR report that performed patient care was the 2 doctors and 2 on duty paramedics. He further confirmed that the occurrence report of co-worker #1 and co-worker #2 only shows that the worker was present. It does not show that the worker was involved in any other activity. The Deputy Chief explained that an investigation would not occur unless there is a concern with patient care or communication on the scene.

[46] The Deputy Chief testified that paramedics must comply with the BLS manual. He also confirmed that there is no written policy that requires paramedics to come back on duty. The Deputy Chief testified that according to the policies of the accident employer, the worker was not obligated to do anything with respect to the patient. The worker would not have been disciplined if he had done nothing. The collective agreement does not require the worker to perform any

duties when he is off duty. The Deputy Chief confirmed that the worker would, if he assisted the patient while off duty, would be held to the same standard as an on duty paramedic.

[47] The Deputy Chief testified that from the employer's point of view the only time the Code of Conduct applies is when a paramedic is on duty as this is the only time when the employer can manage the paramedic. The Deputy Chief acknowledged that the *Ambulance Act, 2000* contains regulations that govern conduct of paramedics outside of work.

[48] The Deputy Chief testified that a paramedics professional obligations end when their shift ends. When asked what the customs and practices are with respect to staff that are off duty, the Deputy Chief testified that this is a difficult question to answer. Paramedics may have a moral responsibility to act when off duty but that is not a responsibility imposed by the employer. The Deputy Chief testified that the worker could have walked away from the patient as the standard of care does not apply when he is off duty. The worker would only have personal reasons for deciding whether to respond or not.

[49] The Deputy Chief confirmed that paramedics are expected to engage in volunteer activities when they are on and off duty. The Deputy Chief confirmed that when volunteers are requested to attend a scheduled event they are registered for the event and have WSIB coverage. However, they do not have coverage if they just show up on their own accord and volunteer.

[50] The Deputy Chief testified that the safest way to transport a patient is with 4 people on a stretcher. He testified that usually police and fire are asked to assist with transport but only a paramedic would operate the trigger switch. The paramedic would also be responsible for managing the stretcher.

[51] The Deputy Chief testified that the mere fact that you have an off-duty paramedic assisting at a scene would not trigger an investigation. This situation would be no different than having fire, police, or ski patrol on the scene.

[52] The Deputy Chief confirmed in testimony that the typical paramedic crew is 2 people. He also confirmed that it is beneficial to have an extra set of hands available in a cardiac arrest situation.

[53] The Deputy Chief testified that paramedics, although they are responders are not regulated health care professionals. They are treated differently than police or fire personnel.

(iv) Medical evidence

[54] The medical evidence in the record is summarized in Board Memo No. 2 dated September 17, 2009 which indicated that the worker sought medical treatment at the hospital on July 25, 2009, the day of the incident, and then had surgical repair on July 30, 2009. A Form 8 completed by the family doctor on August 18, 2009 confirmed that the worker was diagnosed with a partial right bicep tear.

(v) Submissions

[55] The worker's representative and employer's representative provided written submissions. The worker's representative's submissions can be summarized as follows:

[56] Paramedics have a professional obligation to assist individuals in distress and that there are customs and practices in the workplace which place a real and positive obligation on

paramedics to respond to emergency situations even if off duty. The Ministry of Health BLS Binder (1999) supported that paramedics have a professional and moral obligations to assist members of the public once they declare themselves to be a paramedic and in fact re-enter the course of their employment when they declare themselves to be paramedics.

[57] Paramedics are not like police or fire fighters who are mandated under law to perform and come back on duty when an emergency arises.

[58] The employer does not have clear policies to deal with emergency situations when paramedics are off duty; however, the employer does recognize paramedics when they assist while off duty which confirms an unwritten expectation that paramedics will help while off duty. The worker received two special commendations for his actions on July 25, 2009.

[59] Although at the time of the incident the worker was in a place that was more in the personal sphere than the employment sphere, the worker's activities were incidental to his employment responsibilities and the tasks he performed on July 25, 2009 are the same tasks he would perform if he was an on-duty paramedic. The worker was asked to perform these tasks as the ambulance crew knew he was a paramedic.

[60] The worker was in his home jurisdiction based on where he normally works and as such there is an employment nexus to the place the incident occurred. If the worker was outside his home jurisdiction he would not have sustained a compensable injury as there would be no employment nexus to that situation.

[61] Emergency responders are a different type of employee and the special circumstances they encounter must be considered.

[62] The worker sustained a personal injury by accident arising out of and in the course of his employment. The worker did not have time, due to the nature of the situation, to call his employer to seek permission to come back on duty. The worker exercised his judgment to preserve life and perform paramedic activities for which he was trained and professionally obligated to perform.

[63] The worker was never asked to remove himself from the scene or to stop assisting when the paramedics who were on duty arrived.

[64] The worker had an obligation to act as a paramedic once he declared himself to be one which the worker did on July 25, 2009 and as such he could not abandon the patient. The worker was obligated to comply with the Standards of Care applicable to paramedics.

[65] The worker came back into the course of employment when he declared himself to be a paramedic to the patient's wife.

[66] The worker performed tasks that a member of the public or a Good Samaritan would not be allowed to perform. He performed tasks such as suctioning, using airway equipment, participating in the shocking procedure, applying cardiac leads, and operating the trigger switch which are tasks reserved solely for paramedics. He used paramedics' equipment to perform these tasks. The fact that the worker was not in uniform did not change the fact that he was performing the tasks a paramedic would perform.

[67] The worker was not a volunteer and as such Board OPM Document No. 12-04-02 does not apply to this situation.

[68] The employer's representative's submissions can be summarized as follows:

[69] The ARO decision was correct and the worker was not in the course of his employment at the time he sustained his injury. There is insufficient evidence that would have brought the worker into the course of his employment on July 25, 2009.

[70] The worker made a unilateral and voluntary decision to assist a bystander. Nothing that the worker did was required by the employer, the collective agreement, the Basic Life Support (BLS) Manual, the *Good Samaritan Act* or any other law.

[71] The BLS standards only apply when a paramedic is on duty.

[72] The worker was at no time, during the events of July 25, 2009, under the supervision or control of his employer and as such the worker does not meet the test set out in section 13 of the WSIA.

[73] Any actions or tasks performed by the worker on the day in question were so peripheral to what the doctors and on duty paramedics did that his participation was not even reflected in the ACR report. The worker was not involved in the treatment of the patient either before or after the ambulance arrived, while the on-duty paramedics were in attendance, or while the patient was transported to the hospital.

[74] The worker was not involved at any time of his reported injury in any specific tasks that would require the special training of a paramedic. Any member of the public could have assisted in this activity and either of the on duty paramedics could have handled the trigger switch.

[75] The ACR report is the best evidence as it is completed after the incident in question when the memories of the persons involved are fresh and it is a legally binding document. It should be preferred to the oral testimony of the witnesses at the hearing.

[76] The worker did not hook up the defibrillator because he was not allowed to do so because he was not on duty and was not covered by liability insurance while engaged in that activity.

[77] The worker has set hours and works regular shifts. Although when on duty he is mobile he knows exactly where he is to go as he is dispatched to a specific location.

[78] None of the activities performed by the worker on July 25, 2009 were of any benefit to the employer.

[79] The employer does not discourage off-duty paramedics or anyone from assisting in emergency situations; however, these situations are outside the ambit of worker's compensation legislation and outside the ability of the employer to manage or discipline those employees when they do not perform their duties and responsibilities correctly.

[80] There is no employment nexus despite the fact that the incident occurred in the worker's home jurisdiction.

[81] The worker's representative and the employer's representative drew the Panel's attention to the following Tribunal Decisions: *Decision No. 774/09R*, *Decision No. 1290/98*, *Decision No. 1173/00*, *Decision No. 747/91*. Both representatives agreed in their submissions that Board OPM Document No. 15-02-02, No. 11-01-03 and 11-01-13 apply to this case and that the time, place and activity test is the appropriate test in the circumstances. Both representatives submitted that the *Good Samaritan Act, 2001* does not apply to this case.

(vi) Law and policy

[82] Since the worker was injured in 2009, the *Workplace Safety and Insurance Act, 1997* (the "WSIA") is applicable to this appeal. All statutory references in this decision are to the WSIA, as amended, unless otherwise stated.

[83] Specifically, section 2(1) of the WSIA governs the worker's entitlement in this case.

[84] Pursuant to section 126 of the WSIA, the Board stated that the following policy packages, Revision #8, would apply to the subject matter of this appeal:

- Package #1 – Initial Entitlement
- Package #5 – In the Course of Employment – Special Circumstances
- Package #300 – Decision Making/Benefit of Doubt/Merits and Justice

[85] We have considered these policies as necessary in deciding the issues in this appeal.

(vii) Analysis

[86] At the end of the day, the Panel was unable to reach a consensus and what follows is the reasons of the majority of the Panel. The employer member's dissenting reasons will follow at a later date.

(a) Findings of fact

[87] The Majority finds all the witnesses credible and that they gave their evidence in a straightforward and honest manner to the best of their recollection. While there are some discrepancies between the evidence of the witnesses, these discrepancies are minor and do not affect the overall evidence which is generally consistent among the witnesses. For example, there is inconsistent evidence as to whether or not the worker was at the trigger switch; however, it is clear from all witnesses present at the scene that the worker was one of 4 people carrying the stretcher. The Majority, on a review of the whole evidence, does not find it material whether or not the worker was at the trigger switch. The material fact which has been consistently testified to is that the worker was one of 4 people carrying the stretcher to the ambulance. With respect to the evidence concerning the events that transpired on July 25, 2009 and the nature of the injury process, the Majority prefers the evidence of the worker, co-worker #1 and co-worker #2 to that of the Deputy Chief in relation to the actual events that happened on July 25, 2009 as these witnesses were actually present on the scene. We find that evidence to be more reliable on the events that transpired.

[88] The Majority has reviewed the evidence of the 4 witnesses that testified before the Panel. The Majority makes the following findings of fact on the basis that the following facts were not in dispute and were consistently testified to by the witnesses:

[89] The worker was not on duty on July 25, 2009 when the worker injured his right bicep.

[90] The worker was recognized by the employer for 2 Commendation Awards for his involvement in the events on July 25, 2009.

[91] The worker is a full-time paramedic with the employer.

[92] There is no written policy that requires paramedics to come back on duty or policy regarding situations when paramedics respond to emergency situations while off duty; however, it is typical for paramedics to respond to emergencies when off duty.

[93] Paramedics are held to the same standard when they are on duty or off duty if they assist a patient.

[94] The worker reported to the on duty ambulance crew when they arrived on scene and provided them with the history of the patient and the status of the situation.

[95] There were 2 doctors on scene performing CPR on the patient.

[96] The worker was never asked to leave the scene or stand down by the ambulance crew on duty.

[97] An ACR report must be completed after each call. It is a legally binding document and must be accurate. It is not completed when one is off duty.

[98] The worker did not complete an ACR on July 25, 2009 as he was off duty. The worker was not mentioned in the ACR report completed by the on duty ambulance attendant.

[99] An occurrence report is completed when a patient has no vital signs. An occurrence report was completed for the July 25, 2009 incident. The worker was mentioned in the occurrence report as assisting the patient and as being an off-duty paramedic.

[100] The trigger switch found on a stretcher is only used by paramedics as one needs to be trained to use a trigger switch.

[101] The worker could not hook up the defibrillator pads as he was off duty and is not covered for this action for insurance purposes.

[102] Based on the evidence from the people that were on the scene at the time of incident, namely the worker, co-worker #1 and co-worker #2, the worker was asked by the ambulance crew to assist with various tasks in relation to the patient. The worker assisted with airway management and suctioning, applying monitoring pads, lifting the patient onto the back board and onto the stretcher, and carrying the stretcher down to the ambulance.

[103] The Majority also finds that the worker reported his accident to co-worker #1 and sought immediate medical attention. The reporting of the accident was confirmed by co-worker #1. Both he and the worker testified that the worker told co-worker #1 when he was shutting the ambulance door that he hurt his right arm.

[104] The worker's evidence with respect his responsibilities when he identified himself as a paramedic was confirmed by co-worker #2. Her testimony confirmed the worker's testimony that the Code of Conduct contained in the BLS binder applies when one is off duty if you have identified yourself as a paramedic. Co-worker #2 also confirmed that once you begin functioning as paramedic, even if off duty, you can not abandon the patient as this could result in a loss of your certification as a paramedic.

[105] The evidence of co-worker #2 with respect to why the worker's initials did not appear on the ACR report clearly explains why the worker's initials did not appear on this document. Although all witnesses agree that an ACR report is a legally binding document and must be accurately completed, there does not appear to be a consistent practice in place when dealing with a situation where there are more than 4 people assisting a patient. The Deputy Chief gave

evidence that if there are more than 4 people assisting a patient a second ACR report should be completed. Co-worker #2 candidly explained that she did not put the worker's initials on the ACR report because there was only room for 4 initials and she put the doctor's initials on the report as they are a higher level of caregiver. Co-worker #2 never denied that the worker was present and in fact mentions him in the occurrence report which is also required to be completed in situations such as the incident on July 25, 2009. Co-worker #2 confirmed in her evidence that she asked the worker to assist in the care of the patient and to perform tasks that only a paramedic would do. This evidence is also confirmed by co-worker #1. The Majority finds that the fact that the worker was not mentioned on the ACR report does not mean that the worker did not perform tasks in the patient's care. Given co-worker's #2 explanation as to why the worker's initials were not put on the ACR report, the Majority is prepared to accept the evidence of the witnesses with respect to the actual events and activities that happened on July 25, 2009. For this reason the Majority does not accept the employer representative's submissions that the ACR report is the best evidence as to what occurred on the day in question and we prefer the oral sworn testimony over the ACR report.

(b) Application of the law to the facts

[106] The issue in this appeal is whether the injury the worker sustained while off duty was nevertheless a personal injury by accident occurring in the course of his employment. Board OPM Document No. 15-02-02 entitled "Accident in the Course of Employment" is instructive on how a Panel determines the answer to this issue. OPM Document No. 15-02-02 states:

> A personal injury by accident occurs in the course of employment if the surrounding circumstances relating to place, time and activity indicate that the accident was work-related.

[107] The importance of the three criteria of place, time and activity varies depending on the circumstances of each case. OPM Document No. 15-02-02, under the heading "Application of Criteria," states:

> The importance of the three criteria varies depending on the circumstances of each case. In most cases, the decision maker focuses primarily on the activity of the worker at the time the personal injury by accident occurred to determine whether it occurred in the course of employment.
>
> If the worker with fixed working hours and a fixed workplace suffered a personal injury by accident at the workplace during working hours, the personal injury by accident generally will have occurred in the course of employment unless, at the time of the accident, the worker was engaged in a personal activity that was not incidental to the worker's employment.
>
> The decision maker should examine the activity of the worker at the time of accident to determine whether the worker's activity was of such a personal nature that it should not be considered to be work related.
>
> In all other circumstances, the time and place of the accident are less important. In these cases, the decision-maker focuses on the activity of the worker and examines all the surrounding circumstances to decide if the worker was in the course of employment at the time that the personal injury by accident occurred.

[108] In this case, it is not disputed that the worker does not have a fixed workplace. As such, according to OPM Document No. 15-02-02, if a worker is normally expected to be away from a fixed workplace, a personal injury by accident generally will have occurred in the course of

employment if it occurred in a place where the worker might reasonably have been expected to be while engaged in work-related activities.

[109] With respect to the criteria of time, it is not disputed that the worker was off duty at the time of the accident and was not scheduled to work that day. OPM Document No. 15-02-02 stated that if the accident occurred outside the worker's fixed working hours, the criteria of place and activity are applied to determine whether the personal injury by accident occurred in the course of employment.

[110] OPM Document No. 15-02-02 states, in relation to the criteria of activity, that:

> If a personal injury by accident occurred while the worker was engaged in the performance of a work-related duty or in an activity reasonably incidental to (related to) the employment, the personal injury by accident generally will have occurred in the course of employment.
>
> If the worker was engaged in an activity to satisfy a personal need, the worker may have been engaged in an activity that was incidental to the employment. Similarly, engaging in a brief interlude of personal activity does not always mean that the worker was not in the course of employment. In determining whether a personal activity occurred in the course of employment, the decision-maker should consider factors such as:
>
> - the duration of the activity
> - the nature of the activity, and
> - the extent to which it deviated from the worker's regular employment activities.
>
> In determining whether an activity was incidental to the employment, the decision-maker should take into consideration
>
> - the nature of the work
> - the nature of the work environment, and
> - the customs and practices of the particular workplace

[111] The Majority has reviewed all the cases submitted by the parties. Upon reviewing the cases, it is evident that each case turns on its own facts. There cases submitted consistently apply the same test as set out in OPM Document No. 15-02-02; however, the result in each case turns on the particular facts of that case. The cases also consistently focus on the activity of the worker at the time of the accident to determine if the worker was in the course of employment when he was injured. They consider whether the worker was performing a work-related duty or activity reasonably incidental to employment.

[112] In *Decision 1173/00*, the worker who was a police officer was off duty when he was motioned to stop by another worker. He was punched by an unknown man when he approached the vehicle. The worker identified himself as a police officer and attempted to defuse the situation. The worker was further assaulted. The Panel found that the worker entered the course of employment when he identified himself as a police officer and attempted to defuse the situation. This case is distinguishable from the case before this Panel as the parties agree that police officers have a legal obligation to come back on duty and fulfill their role as a police officer when they witness a crime being committed. This factor is peculiar to their employment as a police officer and does not exist with paramedics. Although the Majority does not disagree with the findings and result in this case, the Majority does not find the facts of this case analogous given the unique legal duty police officers have while off duty.

[113] *Decision No. 1290/98* deals with the issue of whether or not the worker who was a police officer was in the course of employment while proceeding to and from work. This is not the same issue that is before this Panel. The Majority does not find this case to be of assistance.

[114] *Decision No. 774/09R* involved a resident manager of an apartment building who accompanied a plumber to inspect work that the plumber had performed the day before and to ensure that the catch basins were working properly. The worker injured himself during this inspection. At the time of the inspection, the worker was not on duty and was leaving for vacation. The worker was not requested by the employer to undertake this task; however, the evidence before the Panel was that the worker would respond to situations on a 24/7 basis if needed without being specifically called by the employer to do so. The evidence also showed that the worker would respond to situations that required his assistance at any time. The Panel found the worker to be in the course of his employment when the accident occurred. The worker in *Decision No. 774/09R* , despite having a regular 40-hour work week, had a custom and practice of being on call 24/7 to deal with issues that would arise at the apartment building he managed. The Panel found that the worker's actions of accompanying the plumber to ensure that a previous night's emergency had been resolved benefited the employer and only delayed the worker's personal interest of proceeding on a vacation. Unlike the case before this Panel, the worker was not asked to assist in an employment related task that resulted in injury. While the request to perform employment related tasks is one factor for a Panel to consider in circumstances where a worker is injured while "off duty" it is not the only factor. As the Panel found in *Decision No. 774/09R*, the worker's duties were sufficiently fluid and the worker would respond to specific situations on a 24/7 basis if need be without a specific request being made.

[115] Of the cases submitted by the parties, the facts of this case are most similar to the facts in *Decision No. 747/91*. In *Decision No. 747/91*, the off-duty firefighter was brought back into the course of his employment during the time period that he performed activities that were part of his job. The Panel found that the worker was recognized as a fellow firefighter. The Panel stated that it was not clear that the worker was directly asked to assist and perform activities that were part of his job. However, the Panel found that it did not matter in the particular circumstances of the case if the off-duty firefighter was "asked" to assist by the Captain or if he volunteered. The Panel found that the worker in *Decision No. 747/91* pulled a hose because he was recognized as a firefighter; the Captain assumed the worker knew what to do and was glad for his assistance; and the worker was doing something which he had knowledge about specifically because of his employment and he was known as a fellow firefighter to the on-duty firefighters. The firefighter was not granted entitlement for injuries sustained prior to on-duty fire crew arriving; however, was granted entitlement to injuries sustained after. Thus, the Panel found that the worker was more in his capacity as an employee doing something referable to his employment than in a personal capacity.

[116] In the present case, the worker was asked by the on duty paramedics to assist in the patient's care. The worker provided assistance to the point in time when the patient was loaded into the ambulance and was taken by the on duty paramedics to the hospital. It is during this time period that that the worker injured his right bicep. The Majority finds that the worker, as the worker in *Decision No. 747/91*, was performing tasks because he was recognized as a paramedic by the on duty paramedics who knew that the worker knew what to do and were grateful for his assistance. During the time the worker was assisting the on duty paramedics at their request he was acting more in his capacity as an employee doing something that is referable

to his employment than in his personal capacity. If the worker had assisted a member of the public on his own without any request by his employer or fellow co-workers to assist, the worker would not have re-entered the course of his employment.

[117] The evidence from those at the scene consistently stated that the worker was asked by the on duty paramedics to assist with the patient's care and to perform tasks that a paramedic and not a member of the public would do. Co-worker #1 testified that he and co-worker #2 could not have handled the call on their own without the assistance of the worker. The Majority finds that the worker was asked to assist with paramedic tasks because he was a trained full time paramedic with the employer. The activity the worker was performing at the time of the accident was incidental to his employment as the nature of the work he was performing and the work environment were consistent with the worker's normal duties as a paramedic. The activities he performed were not a deviation from his regular employment activities. The Majority finds that although the worker did not enter into the course of his employment when he assisted the patient, on his own accord when the patient initially collapsed, he did re-enter his course of employment when the on-duty paramedics asked the worker to assist in activities that he would normally do as a paramedic. The on duty paramedics recognized the worker in this case as a fellow paramedic. The employer, through the on duty paramedics, exercised control over the situation and the worker when they asked him to assist. It was in the course of rendering assistance that the worker injured his right bicep. Further we note that the worker did not hook up the defibrillator pads as he was not covered for insurance purposes. The Majority also finds that the employer exercised a degree of control over the tasks that the worker was able to do in this situation and all paramedics on the scene were acting in compliance with the employer's policy.

[118] The Majority wishes to stress that the worker's entitlement to benefits is not based on the fact that he saved a life. A great deal of emphasis was placed on the fact that the patient survived. This fact is irrelevant to the determination of whether the worker was injured in the course of his employment. The worker's entitlement is based on the fact that he was asked by the on duty paramedic crew to assist because he was a paramedic.

[119] For the reasons stated above, the majority of the Panel finds that the worker suffered a personal injury by accident which occurred while the worker was engaged in the performance of a work-related duty or an activity reasonably incidental to his employment as the worker was asked by the on-duty paramedics to assist in tasks that only a paramedic would perform.

DISPOSITION

[120] The majority of the Panel allows the appeal as follows:

1. The worker is granted initial entitlement for a right arm injury sustained on July 25, 2009.

[121] The nature and duration of benefits flowing from this decision will be returned to the WSIB for further adjudication, subject to the usual rights of appeal.

DATED: June 11, 2012

SIGNED: S. Hodis, F. Jackson