

**PARAMEDIC ASSOCIATION OF NEW BRUNSWICK
("ASSOCIATION")**

**DISCIPLINE COMMITTEE
DECISION**

JULY 5, 2024

**IN THE MATTER OF A COMPLAINT BY JEFFREY LEVESQUE
CONCERNING**

**CALEB NODDIN (the "Member")
dated April 20, 2023 (the "Complaint")**

The Discipline Committee (the "Committee") met to consider the Complaint regarding Caleb Noddin on July 5, 2024.

Evidence

1. With the consent of the Member's counsel and the Complainant, the Committee received as evidence, and carefully reviewed and considered documents consisting of books of bound documents marked as Book 1, Book 2, Book 3 and Book 4, a list of which documents is attached to this Decision as Schedule "A";
2. The Committee received sworn testimony from the following witnesses:
 - Jeffrey Levesque, the Complainant,
 - Dale Shaw, on behalf of the Member,
 - Michelle Deveau, on behalf of the Member, and
 - Caleb Noddin, the Member.

Jeffrey Levesque

3. The Complainant testified that, on April 19, 2023, he and his partner were the second ambulance dispatched to a call regarding a single motor vehicle accident involving two patients. The Complainant stated that this was at the end of his shift but, recognizing he was the closest to the call, the Complainant put himself and his partner back in service to respond.
4. Upon arriving at the scene, the Complainant recognized that the patient in cardiac arrest ("Passenger") was the higher priority patient over the other patient ("Driver"), and immediately went over to help the Member's partner, Ms. Deveau, with the Passenger. Once there, the Complainant stated that he made the call for termination, as it was a traumatic arrest. The online doctor approved termination of resuscitation efforts and the Complainant informed Ms. Deveau of this.
5. During his testimony, the Complainant referred to his rebuttal of the Member's statement on page 46 of Book 1, wherein the Complainant stated that the Driver had no obvious injuries requiring attendance from multiple paramedics. The Complainant explained that

he “*sized up*” the Driver at a glance and within seconds was able to determine this and was why he immediately attended to the Passenger to assist Ms. Deveau.

6. The Complainant stated that he witnessed the Member walk the Driver to the Complainant’s ambulance (the “Lepreau ambulance”), which was against policy as the Member should have used a stretcher for the Driver. The Complainant testified that he then approached the Member to tell the Member to move the Driver to the Member’s ambulance, to which the Member responded, aggressively, “*no that’s your patient there.*” The Complainant thought the Member meant the Passenger, and so advised the Member that they were terminating treatment of the Passenger and the Complainant then left to inform Ms. Deveau that the online doctor had approved termination.
7. The Complainant testified that he then went back to the Lepreau ambulance and again asked the Member to put the Driver in the Member’s ambulance. The Complainant stated that the Member became aggressive and said that the Complainant had given up on his patient so this one, referring to the Driver, was now his. The Complainant stated that, because the Member became aggressive, he walked away, recognizing that this was not the place for that discussion.
8. The Complainant stated that the Member then met him in front of the ambulance and was directly in his face telling the Complainant that the Complainant cannot tell the Member what to do, and that the Driver was now the Complainant’s patient. The Complainant stated that he told the Member to back up from his face. The Complainant then walked away again, as it was not the time nor place to have that sort of conversation. The Complainant stated that the interaction between himself and the Member in front of the ambulance lasted for approximately a minute and a half.
9. In reference to the Member and Fire Chief Dale Shaw’s statements, found on page 21 and page 25 of Book 1, alleging that the Complainant pulled the Member’s ID tag, the Complainant stated that he did not pull the Member’s ID tag and stated that the statements were falsified. The Complainant stated that he would not need to check the Member’s ID tag to confirm the Member’s identity because the Complainant could check the rosters for that shift to obtain the Member’s name. The Complainant alleged that the Member and Mr. Shaw likely knew each other and, therefore, would support each other’s stories.
10. The Complainant testified that the Member abandoned the Driver by leaving the Lepreau ambulance to confront the Complainant, leaving the Driver alone in the Lepreau ambulance. The Complainant did not recall seeing anyone else in the Lepreau ambulance and, regardless, the Driver was not left with someone of the same level of care or higher as is required.
11. The Complainant stated that after the interaction with the Member, he attempted to call his supervisor and accidentally called dispatch. The Complainant spoke with Chris Goguen, who also agreed that the Member and his partner, being the night shift paramedics, should transport the Driver for further examination. The Complainant also explained that the laugh in the transcript of this call, found on page 48 of Book 1, was a nervous laugh, as he was uncomfortable from the confrontation with the Member.
12. The Complainant testified that the Driver was eventually moved to the Member’s ambulance following his conversation with the Member. Before putting the Driver into the Member’s ambulance, the Member said to the Complainant sarcastically, “*you’re an awesome medic.*”

13. The Complainant explained that he did not have the opportunity to tell the Member why he believed the Member should take the Driver, including that the Complainant was the day crew and that he was not feeling well, as, from the start, the Complainant was met with aggression, negativity, and yelling from the Member. The Complainant testified that he has never had any similar disrespectful confrontations with any other paramedics before.

Dale Shaw

14. Dale Shaw is the Fire Chief in the Blacks Harbour district and was on scene for the call on April 19, 2023, involving the Complainant and Respondent.
15. Mr. Shaw testified that he recalled this incident and recalled that, when he arrived on scene, the two patients were in the ditch. Mr. Shaw stayed with the Driver, while another firefighter was doing chest compressions on the Passenger. Mr. Shaw recalled that, at some point, the mother of the Driver arrived and stayed with her daughter.
16. When the first ambulance arrived, Mr. Shaw testified that the Member came to assess the Driver and the Member's partner attended to the Passenger. Mr. Shaw stated that this was his first time working with the Member and they did not know each other previously.
17. Mr. Shaw recalled that, when the Lepreau ambulance arrived, both paramedics attended to the Passenger and did not assist the Member. Mr. Shaw recalled that the Lepreau ambulance parked behind the Member's ambulance.
18. Around this time, Mr. Shaw recalled suggesting to the Member that they should move the Driver from the ditch to get her out of the rain and so that she would no longer be able to see the Passenger. The Member agreed and the Member brought the Driver to the Lepreau ambulance and placed the Driver, along with her mother, into the ambulance.
19. Mr. Shaw recalled that, after the Driver was in the Lepreau ambulance, he saw the Complainant approach the Lepreau ambulance and heard the Complainant say to the Member, *"we're not taking her."* Mr. Shaw further recalled that he then saw the Complainant and the Member engage in a discussion at the front of the Lepreau ambulance. Mr. Shaw testified that the Complainant was getting more heated than the Member during the discussion and that he believed the Complainant acted unprofessionally. Mr. Shaw recalled hearing the Complainant state that he was *"calling my supervisor"* and to *"get her out of my ambulance."*
20. Mr. Shaw testified that the encounter in front of the Lepreau ambulance between the Member and the Complainant was not very long and estimated that it lasted two to three minutes. Mr. Shaw stated that, at one point, he thought he may need to step between the Member and the Complainant but that the conversation ended before he had to do so.
21. Mr. Shaw was asked about the notes taken of a conversation between himself and Ambulance New Brunswick ("ANB"), found on page 25 of Book 1. Mr. Shaw testified that he recalled that someone from ANB called him following the incident to discuss the call. Mr. Shaw clarified that the statement was the ANB manager's interpretation of what he said and he acknowledged that, contrary to the notes which indicated that *"the chief somewhat stepped between them,"* he did not have to intervene. When referred to this statement, Mr. Shaw recalled that the Complainant did pull on the Member's ID tag to look at the ID.

22. Mr. Shaw stated that the Member acted very professionally during the entire response to the incident and did not use any profanities during discussions with the Complainant. Mr. Shaw testified that the call was going well until the Complainant arrived.

Michelle Deveau

23. Michelle Deveau was the Member's partner during the response to the call on April 19, 2023. Ms. Deveau testified that, upon arriving on scene, she attended to the Passenger, while the Member attended to the Driver. Ms. Deveau stated that she observed the Member trying to calm down his patient and checking the Driver over.
24. Ms. Deveau testified that once the Lepreau ambulance came, the Complainant and his partner came to assist her in responding to the Passenger and, to her knowledge, did not assist the Member.
25. Ms. Deveau stated that she did not witness any of the interactions between the Member and the Complainant. Ms. Deveau further stated that she did not witness any actions or conduct by the Member that would have caused a concern for patient safety or demonstrated a lack of professionalism.
26. After terminating treatment of the Passenger, Ms. Deveau testified that the Complainant told her that she and the Member were to transport the Driver. Ms. Deveau recalled that she was extremely confused by this statement, as she understood that their patient was the Passenger and that the second team should have attended to the Driver.
27. Ms. Deveau stated that she then found the Member in the Lepreau ambulance and that the Member also seemed confused. Ms. Deveau then helped the Member move the Driver from the Lepreau ambulance to their ambulance and transported the Driver to the hospital.
28. Ms. Deveau testified that she did not have a chance to do the coroner's report, as is required when resuscitation efforts are terminated on scene, because she had to leave to transport the Driver and did not want to delay transport any further.

Caleb Noddin

29. The Member testified that, on April 19, 2023, he attended to a call regarding a single motor vehicle accident involving two patients. This was the Member's third shift in Blacks Harbour and his first shift with Ms. Deveau. The Member stated that they were delayed in arriving at the call due to a navigation error and, therefore, when they arrived on scene, the fire department was already present.
30. The Member testified that, when he and his partner arrived on scene, he attended to the Driver while his partner attended to the Passenger. The Member immediately assessed the Driver and put the Driver in a C-Spine collar as a precaution due to the mechanism of injury. The Member stated that he recalled the Driver continuously saying "*I just killed my friend*" over and over and that the Driver was very distraught.
31. The Member stated that he understood that a second ambulance had been dispatched and that he believed that, when the second crew arrived, the second crew would attend to the Driver and the Member would then proceed to assist his partner with the Passenger.

32. The Member stated that, when the second ambulance arrived, both paramedics immediately went to the Passenger without asking how his patient was doing or if he required assistance.
33. As it had begun to rain, the Member decided to walk the Driver, along with her mother, to the Lepreau ambulance to get the Driver out of the rain, after ensuring the Driver was okay to walk. Although the Member agreed that he should have put the Driver on a stretcher, rather than allowing her to walk, the Member stated that he was confused at this point as to how the call was going and did not have help from the other paramedics to leave the Driver to get the stretcher. The Member further testified that he chose the Lepreau ambulance because of his belief that the second team would transport the Driver. The Member stated that the Lepreau ambulance was fully equipped, whereas his ambulance's equipment was being used on the Passenger, and the Lepreau ambulance was parked behind his ambulance, making for an easier exit.
34. The Member testified that while the Driver was in the Lepreau ambulance, he performed a series of tests, including two rapid trauma surveys, a psychomotor assessment, and a neurological assessment. The Member also checked the Driver's vitals.
35. At one point, while in the Lepreau ambulance with the Driver, the Member stated that the Complainant, who was on the phone, came and told the Member "*you need to take her and put her in your truck*" and walked away. The Member thought he had misheard the Complainant, as he did not think it wise to move the Driver once she was settled in the Lepreau ambulance. The Member remained in the Lepreau ambulance with the Driver and did not address the Complainant at this time as the Complainant had walked away.
36. The Member testified that the Complainant came back to the Lepreau ambulance a second time and told the Member "*you need to take her,*" in front of the Driver and her mother and, once again, walked away before the Member could ask him for further clarification.
37. At this point, the Member testified that he believed it was necessary to follow the Complainant to get a further explanation as to why there was a major delay in transport for the Driver and as to why he needed to put the Driver in his ambulance, as this made no sense to him. The Member told the Driver and her mother that he would be "*right back*" and that it would just take him "*one second*". The Member stated that he knew that it was "*a big no no*" to leave any patients alone, and so, asked a nearby police officer to watch the Driver while he went to talk with the Complainant.
38. The Member said he met the Complainant at the front of the Lepreau ambulance and attempted to ask for clarification. The Member stated that he was concerned about the delay in transport for the Driver and therefore felt it was necessary to address his concerns with the Complainant, in an effort to advocate for his patient.
39. The Member recalled approaching the Complainant and stating to the Complainant "*that's your patient right there, you should help her out*", referring to the Driver in the Lepreau ambulance. The Member stated that the Complainant kept walking away, so he raised his voice and said, "*dude, what are you doing?*", and the Complainant came back and was face to face with the Member. The Complainant responded that the Member "*was causing a scene*" and to get out of his face. The Complainant attempted to walk away again and the Member stated "*fine I'll write this up I guess,*" which prompted the Complainant to turn around, grab the Member's ID tag and state that he was going to call his supervisor.

40. The Member testified that he does not recall stating “*you don’t tell me what to do*” or “*you gave up on your patient, and now this patient is yours,*” as alleged in the Complaint.
41. The Member testified that he did not leave the Driver for more than a minute and a half. The Member stated that he returned to the Driver and made sure she was alright and apologized to the Driver and her mother in case they heard the altercation.
42. The Member stated that his partner later came and advised him that they had to do a stretcher swap, as the Driver needed to go in their ambulance. When they were transporting the Driver to their ambulance, the Member tried to block the Driver’s line of vision so that she would not see her friend, the Passenger, that had passed away in the ditch.
43. Before the Lepreau ambulance left, the Member admitted that he sarcastically told the Complainant “*you’re a great medic*” and stated that the Complainant responded, “*you too.*”
44. When asked, the Member stated that he did not know Mr. Shaw prior to this incident. The Member recalled Mr. Shaw being close by during the Member’s conversation with the Complainant and recalled Mr. Shaw assisting him when he first arrived to assess the Driver.
45. The Member testified that if he had to do this call again, he would not have changed any of his actions as he felt he acted reasonably given the high stress of the call and given the confusion caused by the lack of assistance he received with respect to the Driver. The Member further stated that, although he may change that he raised his voice at the Complainant, the Member also felt he had no choice because the Complainant kept walking away from the conversation and the Member wanted to advocate for his patient.
46. The Member stated that this was a highly stressful call, given both the nature of the incident and the way the Complainant behaved. The Member testified that, following this call, he has engaged in counselling to assist him in processing this call and to assist him moving forward.

Submissions

47. Both the Complainant and the Member’s legal counsel made oral submissions to the Committee.
48. In his submission, the Complainant stated that the Member admitted to professional misconduct in that the Member admitted to leaving the Driver in the ambulance, raising his voice, and walking the Driver rather than using a stretcher. The Complainant stated that he wished for himself and the Member to be friends going forward and to put this situation behind them.
49. In his submission, the Member’s legal counsel stated that the Member had acted in the best interests of his patient during this incident. The Member’s legal counsel reminded the Committee that pursuant to The Paramedic Association of New Brunswick’s Code of Ethics, a paramedic’s duty is to prioritize the public’s interest and to advocate for their patients. The Member’s legal counsel stated that the Member, at all times, had his patient’s best interests at heart and acted reasonably, given the difficult circumstances. The Member’s legal counsel submitted that this was not a situation where the Member decided to abandon the Driver, but was instead concerned and advocating for her safety. Lastly, the Member’s legal counsel asked the Committee to dismiss the Complaint.

Findings

50. Based on the evidence received, the Committee finds that:

- a. On April 19, 2023, the Member and his partner attended to a single motor vehicle accident involving two patients, one of whom was in cardiac arrest. When they arrived on scene, the Member attended to the Driver, while his partner attended to the Passenger and began running the arrest.
- b. The Member ran two rapid trauma checks tests on the Driver, a psychomotor assessment, a neurological test, and general tests, such as her vitals. Although there were no signs of serious injury, the Member put a C-Spine on the Driver as a precaution due to the mechanism of injury.
- c. When the Lepreau ambulance arrived on scene, both the Complainant and his partner tended to the Passenger and did not offer any assistance to the Member.
- d. The Member decided to move the Driver to the Lepreau ambulance to get her out of the rain, by walking the Driver to the Lepreau ambulance. Although the Member did not follow C-Spine protocol when walking the Driver to the Lepreau ambulance, the Member acted reasonably in the circumstances given that: he had no assistance from another paramedic; he could not leave the Driver to get the stretcher; he confirmed the Driver was okay to walk and monitored her; and that the best interests of the Driver were protected by removing her from the rain and from being able to see the Passenger. The Member's decision to put the Driver in the Lepreau ambulance was also reasonable, as the Lepreau ambulance had easier access to the road, was fully equipped, and was the second ambulance to arrive on scene.
- e. The Complainant approached the Member while the Member was attending to the Driver in the Lepreau ambulance and said to the Member something to the effect of "*you need to take her and put her in your truck.*" The Complainant walked away before the Member could ask the Complainant for an explanation. The Member stayed with the Driver in the Lepreau ambulance. Although the Member could not recall exactly when the mother of the Driver arrived on scene, the Committee accepts that the mother of the Driver was in the Lepreau ambulance at this time.
- f. The Complainant once again approached the Member in the Lepreau ambulance and repeated something to the effect of "*you need to take her*" to the Member and walked away before the Member could ask the Complainant for an explanation. This prompted the Member to follow the Complainant to the front of the ambulance, leaving the Driver with her mother in the Lepreau ambulance and asked a nearby police officer to watch the Driver.
- g. The Member raised his voice towards the Complainant and said, "*dude, what are you doing?*" to the Complainant as the Complainant was walking away. The Member had to raise his voice to get the Complainant's attention as the Complainant was walking away. The Member was attempting to advocate for his patient's best interest by seeking clarification about the transport of the Driver.

- h. During the conversation with the Complainant, the Member made a comment to the effect of “*that’s your patient*” to the Complainant, referring to the Driver. The Member was standing very close to the Complainant during this interaction, prompting the Complainant to say “*get out of my face*” to the Member. As the Complainant was walking away, the Member made a comment to the effect that he would be “*writing this up.*” The Complainant then turned around, pulled on the Member’s ID tag, made a comment to the effect that he would be calling his supervisor, and waked away. This interaction lasted approximately 1-2 minutes.
 - i. It is more likely than not that the Member did not make a comment to the Complainant to the effect that “*you gave up on your patient*” or that the Driver must stay in the Lepreau ambulance.
 - j. The Member’s partner later came to the Lepreau ambulance and assisted the Member in transferring the Driver to their ambulance. When the Member was getting into the back of his ambulance, he stated to the Complainant, sarcastically, “*you’re an awesome medic.*”
 - k. When the Member left the Lepreau ambulance to discuss the transport of the Driver with the Complainant, the Member did not abandon his patient but was, rather, taking reasonable steps to advocate for the best interests of his patient.
 - l. The Member’s actions, including the discussion with the Complainant, were reasonable given the high level of stress of the call and were the Member’s reasonable and good faith efforts to advocate for the best interests of his patient.
51. The Committee generally found the witnesses to be credible but, where their accounts differed, the Committee preferred the evidence of the Member and Mr. Shaw over the Complainant’s evidence.
52. In particular, the Committee preferred the evidence of the Member and Mr. Shaw and finds that it is more likely than not that the Complainant pulled on the Member’s ID tag at the end of their conversation. The Member and Mr. Shaw’s testimony was consistent with each other and with their statements made shortly after the incident. The Committee does not accept the Complainant’s allegation that the statements were falsified because the Member and Mr. Shaw knew each other. Rather, the Committee accepts that the Member and Mr. Shaw did not know each other prior to the incident.
53. The Committee further accepts the evidence of the Member and Mr. Shaw and finds it more likely than not that that the mother of the Driver was in the Lepreau ambulance with the Driver when the Member approached the Complainant outside of the Lepreau ambulance.

Order

Based on the evidence and the findings, the Committee finds that the Member is not guilty of professional misconduct or incompetence and dismisses the Complaint and orders that no further action be taken.

DATED this 5th day of July, 2024.

Donald A. Taylor

Donald Taylor, Chairperson

Kevin Drake

Kevin Drake, Committee Member

Annette Lebouthillier

Annette Lebouthillier, Public Member

SCHEDULE "A"

PARAMEDIC ASSOCIATION OF NEW BRUNSWICK

IN THE MATTER OF THE COMPLAINT RESPECTING CALEB NODDIN

DOCUMENTS CONSIDERED BY THE DISCIPLINE COMMITTEE

I N D E X

<u>Tab</u>	<u>Date</u>	<u>Description</u>
Book 1		
1.	April 20, 2023	Complaint by Jeffrey Levesque
2.	September 13, 2023	Notice of Complaint to Member, Caleb Noddin
3.	September 13, 2023	Letter to Complainant, Jeffrey Levesque, acknowledging receipt of Complaint
4.	September 15, 2023	Email to S. Mecking from Complainant, Jeffrey Levesque, attaching: A) Operations Internal/External Incident Report – April 19, 2023
5.	September 22, 2023	Email to S. Mecking from Member, Caleb Noddin, attaching: A) Statement of PCP Michelle Deveau – Undated
6.	September 27, 2023	Email to S. Mecking from Complainant, Jeffrey Levesque, attaching: A) Rebuttal Response to Michelle Deveau's Statement from Complainant, Jeffrey Levesque – September 25, 2023 B) Submission by Complainant, Jeffrey Levesque – September 27, 2023 C) Transcript of Recording with Dispatch – April 19, 2023 D) Transcript of Recording with the MCMC OM – April 19, 2023
7.	October 3, 2023 11:39 PM	Response to Complaint from Caleb Noddin
8.	October 3, 2023 6:45 PM	Email to S. Mecking from Member, Caleb Noddin attaching: A) ANB Operations Manager Christopher Oakley – April 20, 2023
9.	October 3, 2023 6:50 PM	Email to S. Mecking from Member, Caleb Noddin, attaching: A) Patient Care Record #480243 & Supplemental Form – April 19, 2023, B) Patient Care Record #480242 & Supplemental Form – April 19, 2023
10.	October 3, 2023 6:56 PM	Email to S. Mecking from Member, Caleb Noddin, attaching: A) ANB Incident Report by Michelle Deveau – April 20, 2023
11.	October 5, 2023	Letter to Member, Caleb Noddin, acknowledging receipt of further documents
12.	October 5, 2023	Letter to Complainant, Jeffrey Levesque, enclosing further documents
13.	October 10, 2023 7:21 PM	Email from Complainant, Jeffrey Levesque containing information from Privacy & Information Access Officer
14.	October 10, 2023	Email from from Complainant, Jeffrey Levesque, attaching: A) Dispatch Record – Incident #420658 – April 19, 2023 B) Response from Jeffrey Levesque to Caleb Noddin's Statement – October 10, 2023 C) Rebuttal to Fire Chief Statement, from Jeffrey Levesque – October 10, 2023 D) Summary of Events from Jeffrey Levesque – Undated
15.	October 16, 2023	Letter to Member, Caleb Noddin, enclosing further documents
16.	October 16, 2023	Letter to Complainant, Jeffrey Levesque, acknowledging receipt of further documents

<u>Tab</u>	<u>Date</u>	<u>Description</u>
17.	October 17, 2023	Character reference letter from Phil Comeau regarding Jeff Levesque
18.	October 19, 2023	Email message from Member, Caleb Noddin, to Complaints Committee
19.	November 20, 2023	Complaints Committee Decision respecting Caleb Noddin
20.	December 5, 2023	Letter to Member, Caleb Noddin, enclosing Complaints Committee Decision
21.	December 5, 2023	Letter to Complainant, Jeffrey Levesque, enclosing Complaints Committee Decision
Book 2		
22.	February 7, 2024	Character Reference from Shailer Shepherd
23.	February 7, 2024	Character Reference from Makenna Burgess
Book 3		
24.	February 9, 2024	Character Reference from Jordan Pollard
Book 4		
25.	February 16, 2024	Character Reference from Bryson foster
26.	February 16, 2024	Character Reference from Reggie Sceeles
27.	February 20, 2024	Character Reference from Darcy Crowther