CANADA
Province of Alberta

Report to the Minister of Justice and Attorney General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court of Alberta

in the Town (City, Town or Village) of Didsbury (Name of City, Town, Village), in the Province of Alberta,

on the 27th to 29th day of February, 2008 (year), (and by adjournment

on the 23rd Day of September, 2008 (year)),

before Judge Bruce A. Millar, a Provincial Court Judge,

into the death of Jordan Neave (male) (Name in Full) 8 (Age)

of Carstairs, Alberta (Residence) and the following findings were made:

Date and Time of Death: May 5, 2006 at approximately 6:45 p.m.

Place: Olds Aquatic Centre

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquiries Act, Section 1(d)).

Drowning

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Accidental

Circumstances surrounding death:

1. On May 20, 2006 Jordan Neave ("Jordan"), together with his brother Daniel Neave ("Daniel"), accompanied by their grandpa, Orville Sailer ("Orville") attended the Olds Aquatic Centre ("OAC") during the family swim.

2. Jordan was eight years old and Daniel was nine years old. Neither boy could swim. They had their own lifejackets which they were to wear when attending the pool. Orville did not accompany the boys into the pool but remained in the public viewing area.

3. Both Daniel and Jordan had their lifejackets on when they entered the water. In addition, they had their "Boogie Boards", a small surfboard type flotation device, approximately three feet long by two feet wide.

4. Jordan went to the waterslide, located adjacent to the deep end of the pool. As a practice, bathers were required to remove their lifejackets before going down the slide. The rationale was that the jackets either scratched the slide or could get caught up on the slide and present a danger to the bather. There was no system or protocol to ensure bathers put their lifejackets back on after exiting the waterslide.

5. After taking off his lifejacket and using the slide, Jordan entered the deep end of the pool without his lifejacket. He was playing with another child and perhaps using his "Boogie Board" or a floating mat, supplied by the OAC.

6. Jordan's playmate notified an adult patron that Jordan was at the bottom of the deep end of the pool. The lifeguard was notified. She effected a rescue. CPR and emergency medical procedures were initiated. EMS and fire personnel attended.

7. Jordan was on the bottom of the pool for between 10 to 20 minutes prior to the lifeguard being notified. He could not be revived.

8. The child playing with Jordan witnessed his drowning, but did not fully comprehend what was happening and did not or could not effectively communicate the significance of the event as it happened, partially explaining the delay in notifying a lifeguard. He was eight years old.

9. The OAC had a written admission requirement that children under nine years of age must be accompanied by a responsible person 13 years or older, and always be within "arms' reach".

10. Children could wear their own lifejackets and brings toys, such as a Boogie Board into the pool.

11. Orville could not enter the pool with his grandsons because of a medical condition. Even though the boys were non-swimmers, needed lifejackets, could not be accompanied by a responsible person and Jordan was under nine years of age, they were allowed to enter the pool.

12. There was no protocol or requirement, written or otherwise, that the receptionist screen bathers for swimming ability and communicate same to the lifeguards on deck.

13. The OAC has the following amenities: a 25 metre pool with a shallow and deep end, a diving board in the deep end, a whirlpool, a wading pool and a waterslide. At all times relevant hereto, all areas of the pool were open to users. Attached as Appendix A is the floor plan of this facility.

14. On the day Jordan drowned there were two lifeguards and a receptionist working. Only one lifeguard would be on patrol at any given time and the other guard was engaged in cleaning duties throughout the facility.

15. The OAC operational procedures contained little or no attention to positioning of lifeguards or lifeguard scanning zones. A scanning zone is that area of the pool, both top and bottom, that can be viewed by a lifeguard from their position at a moment in time.

16. With the amenities that were operating in the OAC (*i.e.*25 metre pool with diving board, wading pool, whirlpool and waterslide) one lifeguard could not scan all areas of use, including the bottom of the pool, at a moment in time, from any position in the facility.

17. Much testimony was heard on the lifeguard to bather ratio. Prior to Jordan's death it was one guard to 50 bathers. After his death it was changed to one guard to 35 bathers. There is no provincial standard and the ratios vary from facility to facility within the Province. Estimates of the number of bathers during times relevant ranged from 30 to 50 bathers.

18. A minimum standard may be misleading and in this case does not address the issue. Bather safety depends upon the lifeguards being able to see all areas of their scanning zone from their scanning position, taking into account the use of the pool (*i.e.* family swim, adult lane swim only, lessons, etc.), and amenities being used (*i.e.* whirlpool, wading pool, shallow and deep-end, diving board, etc.).

19. In this instance the lifeguard on duty was in a fixed position beside the whirlpool and could not see the bottom of the pool in the deep end from her position.

20. <u>The lifeguard on deck at the time of the drowning was given an impossible task.</u> She could not have seen all scanning zones from all positions around the facility, given what amenities were in use and the nature of the use, *i.e.* family swim. Recall, Jordan was on the bottom at the deep end, from 10 to 20 minutes before being removed.

21. The ratio of bathers to lifeguards is important but must be put into context to the scanning zones and what is happening at the pool.

22. <u>Clearly, one lifeguard on duty at the time of Jordan's death was insufficient to adequately scan this facility with its multiplicity of uses and a family swim.</u>

23. There are a total of 964 regulated facilities in the Province, 513 of which are outside Calgary and Edmonton. These pools are regulated pursuant to the *Public Health Act, Alta. Reg. 293/2006 Swimming Pool, Wading Pool and Water Spray Park Regulation* and the *Pool Standards, 2006.*

24. As set out in the Regulations, the owner of a pool is the "responsible person" for that pool. The owner may designate another person to be the responsible person, as was done in this facility by the Town of Olds.

25. The responsible person must ensure the pool is equipped, operated and maintained in compliance with, among other things, the *Pool Standards, 2006* and must ensure the pool is operated by a person who meets the qualifications set out in the *Pool Standards, 2006.*

26. That responsible person must then develop and implement a safety and supervision plan.

27. In developing that plan the responsible person may consult with, among others, the Alberta Lifesaving Society and refer to the Society's publication on Safety Standards.

28. The Alberta Lifesaving Society is the Provincial branch of the national organization, The Lifesaving Society.

29. The Lifesaving Society is the Canadian authority in aquatic standards and safety and works with industry and government to provide expert consultation and safety audit processes.

30. At this inquiry we heard from two representatives of the Lifesaving Society, Mr. Michael Shane, Aquatic Safety Management Director for the national organization and Ms. Barbara Kusyanto, Chief Administrative Officer, Alberta and Northwest Territories Branch of the Lifesaving Society.

31. Mr. Shane's qualifications are extensive and speak for themselves. He was qualified to give expert opinion evidence with respect to lifeguarding and aquatic facility management. He remained in court and heard evidence from the witnesses at the inquiry prior to his testimony. He conducted a site visitation to the OAC on February 25, 2008. He then prepared a report, including recommendations which were entered as an Exhibit, a copy of which is attached as Appendix B, and gave oral testimony, a copy of that transcript is attached as Appendix C. These are attached for the benefit of the Honourable Minister of Justice to provide background for her officials and other responsible government departments to take such actions as the Honourable Minister deems necessary upon the recommendations set out at the conclusion hereof.

32. Ms. Debra Mooney, Project Manager with Surveillance and Environmental Health at Alberta Health and Wellness, and responsible for dealing with pool standards, attended and gave testimony. Her mandate is to review and develop the applicable regulation and pool standards. Ms. Mooney's training is as a Health Inspector as are the

majority of those responsible for the enforcement of the *Regulation* and *Pool Standards*.

33. Alberta Health and Wellness has as its primary concern the public safety of the physical pool environment, *i.e.* water quality and sanitation. A review of the *Regulation* and *Pool Standards* would confirm this focus as they predominantly address these issues.

34. The issue of bather safety is the responsibility of the pool owners or their designate. No one at the government regulatory level is checking on the qualifications of the responsible person, and the adequacy of their safety and supervision plan when it concerns bather safety. This amounts to a deficiency in regulatory oversight.

35. There may be many reasons but, certainly at this Inquiry, one is that those in government charged with the responsibility are, by and large, trained as public health inspectors and have as their focus public safety of the facility. In other words they don't have the training or mind set to oversee bather safety issues.

36. The current Aquatic Co-ordinator for the OAC, and also the responsible person, designated by the Town of Olds, gave testimony. His qualifications are extensive and he had an opportunity to review the Expert Report of Mr. Shane prior to his testimony. He was not the responsible person at the time of Jordan's death. Mr. Shane was of the opinion, which I have adopted in this report, that one lifeguard on duty at the time of Jordan's death was insufficient. Yet the person responsible disagreed and stated that one guard was sufficient to scan the entire facility. It is patently obvious that this cannot be the case.

37. Bather safety is left up to the pool operator. They are mandated by Regulation to formulate a plan and inform the public. However, those in charge of enforcing the Regulations (Alberta Health and Wellness), may not have the qualifications to review and assess the adequacy of the plan and it is likely that these plans are not even reviewed by regulators.

Recommendations for the prevention of similar deaths:

1. Initiate a comprehensive review of Regulations and their enforcement

The Lifesaving Society has the expertise and provides a service to audit a pool, *i.e.* where is the problem, and recommend a plan. At this point in time, regulation provides that pool operators may consult the Society. There is no minimum standard for using or implementing this expertise and regulators are not equipped for checking to ensure that any standards are being met. Each pool is left to its own devices. Why not use this expertise? This question needs to be answered by government and I recommend a comprehensive review of Regulations and their enforcement, with an emphasis on the safety of the bathers, in consultation with the Lifesaving Society and other stakeholders.

2. Establish a provincial admission standard

In order to ensure the supervision of young children, public swimming pools should adopt a provincial admission standard based on swimming ability and age. An example of such a provincial admission standard is to be found in the recommendations of Mr. Shane, Appendix B.

3. Ensure that lifeguard position, scanning zones, and rotation charts are defined and posted in the pool office.

Supervisory staff should ensure that for each of the various aquatic activities (e.g., recreation swim periods), lifeguard placement and supervision zones need to be defined. Issues affecting the placement of lifeguarding personnel should be identified (e.g. surface water glare) and resolved. Lifeguard rotation schedules should then be created.

Once defined, all of these items need to be documented and incorporated into the staff handbook and operational procedures manual. Diagrams or charts illustrating these placements and procedures should be posted in the pool office and staff given appropriate and regular training.

4. Ensure all "*responsible persons*" are certified with the Lifesaving Society Aquatic Management Training certification or equivalent training.

In all aquatic facilities there are management personnel responsible for the direction of aquatic staff. In order to ensure they are familiar with aquatic standards, all management personnel must receive training. The Lifesaving Society has a certification program that would ensure personnel have the necessary information to safely manage aquatic facilities.

5. Enhance lifeguard scanning training.

A training session should be conducted for all lifeguards highlighting scanning techniques and scanning standards. The Lifesaving Society has created a PowerPoint presentation which pool supervisory personnel can access. Lifeguard scanning practices should be monitored on a random and ongoing basis. The Lifesaving Society's SEE (**S**upervision **E**valuation and **E**nhancement) evaluation system can assist pool supervisory personnel with swimming pool scanning evaluation.

6. Establish operational and supervision standards for the safe use of swimming pool mats, inflatable toys and life jackets.

The Government, in consultation with The Lifesaving Society, should research and develop operational and safety standards for the use of this equipment. Consideration should be given but not limited to the type of equipment used, type of program in the pool, bather load, amount of pool surface obscured, etc. Operational and safety standards should be part of the *Pool Standards, 2006*.

7. Promote the completion of the Lifesaving Society Comprehensive Aquatic Safety Audit.

The purpose of the aquatic audit is to maximize the safety of participants utilizing public pools. An aquatic safety audit indentifies what steps might be taken to minimize the risk of drowning or serious water-related injuries in aquatic facilities. To enhance safety, owner/operators should be encouraged to undergo a Lifesaving Society comprehensive safety audit. Such an audit would have identified that one lifeguard during a family swim at the OAC was insufficient.

All of which is respectfully recommended.

DATED March , 2009 ,

at Calgary , Alberta.

Bruce A. Millar,
A Judge of the Provincial Court of Alberta