Release Date: July 22nd, 2003

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: "The Fatality Inquiries Act"

AND IN THE MATTER OF: JOSHUA HARDER, Deceased

APPEARANCES:

Counsel to the Inquest: Mr. Kerry Pearlman (assisted by Ms Betty Owen - Inquest Co-ordinator)

For the City of Winnipeg: Mr. Douglas Buhr

For the Seine River Teachers Association: Mr. Garth Smorang, Q.C. assisted by Ms Shannon Carson

For the Seine River School Division: Mr. Daniel Ryall

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[1] Joshua Harder, a 5 year old kindergarten student, was celebrating the last day of school on June 27, 2002 when he went with the other Kindergarten to Grade Four students from St. Adolphe School on a school outing to a City of Winnipeg pool. He left on the school bus for the fifteen minute drive to the Margaret Grant Pool at about 10:25 a.m. Just thirty-five minutes later, he was seen floating face down in the corner of the shallow end near the pool observation room and was pulled from the pool unconscious. Resuscitation efforts were commenced immediately by the pool lifeguards, continued by ambulance and emergency personnel, and then by medical staff at the Victoria Hospital. He was pronounced dead at 12:02 p.m. by hospital staff, just fifteen days before his sixth birthday.

[2] The Chief Medical Examiner of the Province of Manitoba made a direction under S. 19(2) of **The Fatality Inquiries Act** of Manitoba that an inquest be held by a provincial judge to determine the circumstances under which this death occurred and to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[3] As the provincial judge conducting this inquest, I heard evidence from twenty-six witnesses over the course of ten hearing days between June 9th to 25th, 2003. **The Fatality Inquiries Act** C.C.S.M. F 52 requires that I provide a written report of this inquest to the Minister.

[4] The act indicates that I may recommend changes in the programs, policies or practices of the government and of the relevant public agencies or institutions or in the laws of the province that, in my opinion, would serve to reduce the likelihood of deaths occurring in similar circumstances. The legislation also stipulates that I may not express an opinion on, or make a determination with respect to culpability in such a manner that any person could be reasonably identified as a culpable party.

ACKNOWLEDGMENT:

[5] I have been fortunate enough to complete this report in a relatively short time due to certain assistance that I wish to acknowledge here.

[6] An inquest coordinator was initially hired by the province to assist with the 911 inquest. This inquest is the first time that I have been fortunate enough to have the assistance of Betty Owen, the inquest coordinator. The organizational work done by her in relation to the voluminous documents produced at this hearing was in itself invaluable. It was of great assistance to me in preparing this report. Her contribution throughout the hearing in accessing documents and witnesses also assisted all of those who participated in the hearing. It helped to make the hearing proceed smoothly and maximized Mr. Pearlman's usual efficiency and competence. This experience has persuaded me that the assistance of an inquest coordinator like Ms. Owen is invaluable and must be a necessary part of the inquest process in future.

[7] The cooperation of our new Chief Judge, Raymond Wyant, and of my colleagues, in ensuring that adequate time to write the report was made available to me as soon as the evidence was completed was also a welcome and necessary precedent for future inquests.

INTRODUCTION:

[8] Drowning is second only to motor vehicle accidents in Canada as a leading cause of unintentional death for children under five. Even older children are often passive drowners; in as little as ten to twenty seconds they may silently slip under the surface and be critically injured or drown without making any sound or attracting any attention. A child who is "actively" drowning may be flailing about in a manner that may be misperceived as play, since he or she is unable to speak or gesture for help due to a shortage of air.

[9] Swimming is the second most popular activity for Canadian children aged 5 to 12, after biking. This latter statistic will not be surprising to many of us in society who are familiar with most childrens' manifest delight at playing in and around the water, be it at the beach or at the pool.

[10] However information about the potential inherent dangers of aquatic activities is not as well understood by the public as it should be, according to national voluntary non-profit agencies like The National Lifesaving Society and The Red Cross, both of whom have expertise and a mandate to educate the public as to water safety.

[11] In her February 2002 inquest report into the drowning deaths of two young school age children at Bird's Hill Park in the summer of 2000, my colleague The Honourable Judge Mary Kate Harvie (as she then was) noted in her report:

> It is imperative that the public's attitude towards water safety changes, as it has with many other sports. Gone are the days when children ride their bicycles without helmets, play hockey or skate without the appropriate protective gear, or ride in a motor vehicle without seatbelts, car seats, or booster seats. A similar change in attitude towards water safety must be fostered.

[12] I agree with her conclusion. Public education on water safety is essential. Since swimming is such a popular pastime for our children, water safety must also become a part of the public school curriculum as essential "life skills" information for all citizens.

BEFORE THE INCIDENT:

THE SCHOOL:

[13] Early in 2002, Nancy Janzen, a parent member of the St. Adolphe School Parent Advisory Council made a suggestion to Roseanne Sylvestre, a teacher representative. Ms Janzen generously indicated that she would like to pay for a special event for the last day of class for her two daughters who attended the school. Her daughter in Grade 1 was in Ms. Sylvestre's combined Grade 1/2 French immersion class while her daughter in Grade 4 was in a combined Grade 3/4 immersion class. There were a total of fifty-three children in the Grade 1 to 4 French immersion classes.

[14] After some initial discussion, Ms Janzen decided that it would be more inclusive to also invite the English-only stream of students in these four grades as well, thereby adding another forty-one students to the proposed expedition, for a total of ninety-four students.

[15] Eventually a decision was made to include all fourteen of the kindergarten students too, bringing the total potential number of children from St. Adolphe School to go on the pool outing to one hundred and eight children, ranging in age from 5 to 10.

[16] Ms Janzen's two daughters took swimming lessons at the Margaret Grant pool, which is also presumably the nearest City of Winnipeg pool to St. Adolphe, a community just outside of Winnipeg. Therefore she undertook to speak to the pool officials and to bring the information back to Ms Sylvestre who would then discuss it with the other four primary teachers involved. After these staff meetings, the Parent Advisory Council would generally vet the plans as well. Ms Janzen would then attempt to obtain the answers to any questions raised by either of these groups by speaking to people at the pool again.

[17] In this way, through February and March, Ms Janzen reported back that the pool had a capacity of two hundred and could accommodate the student numbers contemplated. She also reported that she had been told that the kindergarten students were not too young to be included in the outing, provided that enough lifeguards were on duty. While technically two were

enough for minimum legal requirements, with this age group they would recommend three. Schools regularly booked the pool, typically for an hour, although a longer time period could be booked. Schools were generally given a good price. It was not necessary to split the group into two although staggering their arrival was probably a good idea. There was no written information available from the pool other than their information on birthday party rentals, information that would not apply to a school group. The pool would be responsible for providing lifeguard supervision and it was not a requirement that teachers or parents go into the water.

[18] Options for various time slots were discussed and ultimately, after direction from the school, Ms Janzen booked the pool in mid-March for Thursday, June 27, from 10:30 a.m. to noon. She paid $113.27 on her visa on June 6th for the exclusive use of the pool and the services of extra lifeguards. The only written documentation of the arrangements took the form of a March 18th letter of confirmation from the pool to the school stating the scheduling, the numbers, the cost and the pool's agreement to provide three lifeguards.

[19] The Seine River School Division’s field trip policy is contained in a document entitled “Beyond the Classroom: A Guide for Planning Educational Field Trips”. The Superintendent of the School Division, Roy Seidler, testified that the fifteen school principals in his division were expected to be familiar with the document but that individual teachers might not be, depending on what and who they taught. This policy provided that school trips of more than one day’s duration or beyond one hundred kilometres in distance had to be approved by the Superintendent’s office but that shorter trips need only be approved by the principal of the school.

[20] The principal of the St. Adolphe School, Laurel Kosman, did not ask for or receive a written proposal for this trip from Ms Sylvestre although she indicated that she was kept abreast of developments in the plan as they occurred by speaking to her teachers. A parental notification and consent letter was ultimately drafted by Ms Sylvestre and approved by Ms Kosman. Although the letter is undated, Ms Sylvestre believed that it would have gone to parents about ten days prior to June 27th.

[21] The one page letter was a fill-in-the-blanks form that was to be returned to the school no later than Monday, June 24th. It described a “fun swim and lunch activity” for Grades K to four, to depart the school at 10:15 a.m. for Margaret Grant Pool and to return to the school at 12:15 p.m. for a barbeque lunch at a total cost of $2 per student. Under “safety” rules the following is handwritten: “bus safety, water safety, group safety. Lifeguards are at the pool and will supervise the children”. Lower down in the form under “supervisors” the names of the five primary school teachers are listed: “ L. Michaud, L. Orbanski, R. Sylvestre, C. Roy, C. Gamble”.

[22] Perhaps because this fill-in-the-blanks form was used, no information was requested from the parents about their child's ability to swim nor any question posed about whether their child needed to use a personal flotation device, or PFD.

[23] Joshua’s parental consent form that was signed by his mother and returned to the school is dated June 22, 2002. This consent form is also a brief pre-printed form. It consists of an acknowledgment that the notification letter has been read by the parent together with a consent for the student to participate in the scheduled outdoor education activity.

[24] The Seine River School Division Policy document “Beyond the Classroom”, as revised in January 1999, is essentially only three pages long plus appendices. It is very generic and only delineates specific detailed requirements for canoe trips, wilderness excursions and ski trips. Even so, the pre-planning checklist that is to be used for all excursions does suggest a visit to the site of the outing beforehand, which was not done in this case. Some of the teachers, including Ms Sylvestre, had been at the pool previously for swim lessons with other classes or with their own children and perhaps presumed that they were sufficiently familiar with the facility.

[25] Supervisors of the “opposite” gender are also to be arranged in advance, according to this “Beyond the Classroom” document. In this instance that would have meant arranging for a male supervisor, since the five primary teachers were all female. Interestingly the fact that a male teacher was not participating led one parent to choose not to send their child on the outing due to concerns about the adequacy of the supervision in the change room. The Grade 1 teacher, Ms Orbanski, had called the pool about

the availability of a male lifeguard to supervise the male change room. The pool had told her that there would be a male lifeguard available.

[26] Another resource that was in effect and potentially available to schools prior to June 2002 was the “Safety Guidelines for Physical Activity in Manitoba Schools”. These guidelines are based on similar Ontario Guidelines as modified for Manitoba by a working group that was initiated by the Manitoba Physical Education Teachers Association. The group included representation from the Manitoba Association of School Trustees and Manitoba Education and Training, among others. Seine River School Division is acknowledged in the document as a contributor.

[27] These safety guidelines do not specifically address recreational aquatic outings for schools. They do however address instructional aquatic outings where students are receiving swimming instruction at a pool as part of their physical education curriculum. Instructor-student ratios are set out in these guidelines at one instructor for six students for “early years” and one instructor for eight students for “middle years”. In addition to the instructor, there is to be one teacher supervising for every twenty-five students. As Brian Hanson, the representative from the Department of Education, noted in his evidence structured swimming lessons are presumably more focused and orderly than a recreational swim. Nonetheless, this document might perhaps have been of use to the St. Adolphe staff in raising some pertinent questions, had it been consulted.

[28] No documents were ever consulted nor any telephone inquiries made by the principal or by any of the teachers prior to the outing. Aside from the call to the pool about male supervision in the locker room, there was no direct contact with the pool by anyone from the school or the school division prior to June 27th, the day of the outing. Total reliance was placed on verbal arrangements made through the parent volunteer who, as it ultimately transpired, was dealing with a clerk at the pool.

[29] Therefore the plan that was put in place with the booking of the facility in mid-March remained the same until the outing occurred. This plan was that these one hundred and eight children, ranging in age from 5 to 10 years old, whose swimming abilities were unknown to anyone at the school, would be supervised in the pool by the three lifeguards provided by the pool.

Any parents who inquired about volunteering, including Joshua's mother Kristin Harder, were told that they were not needed at the pool. It was suggested instead that the parents would be of more help at the barbeque at the school immediately following the swim.

THE POOL:

[30] Judy Ambrose-Walsh, a full-time clerk cashier who had worked at the Margaret Grant Pool for about a dozen years, proved to be the person at the pool from whom Ms Janzen had received her information. Ms Ambrose-Walsh had never been a lifeguard. She testified that the practice of renting the pool to various groups had only started about five years previously. Any training that she did receive in how to book the pool for group events was provided by the pool supervisor, Carol Hardy.

[31] Not surprisingly, Ms Ambrose-Walsh had virtually no recollection of any of her conversations with Ms Janzen. However she confirmed that she would have told anyone who inquired that she did not have any information to hand out to groups who wished to book the pool aside from information on birthday party rentals. She did know about the lifeguard ratios required by law under the **Public Health Act**, C.C.S.M. c. P210 and would likely have said that up to forty-nine people required one lifeguard, up to one hundred, two lifeguards and that over one hundred would require a third. She also said that anyone making inquiries about a group where "under sixes" were involved would usually have been told about the height requirement posted on the wall in the reception area of the building directly across from her desk: "ALL CHILDREN UNDER 48 INCHES (height shown) MUST BE ACCOMPANIED BY AN ADULT".

[32] Carol Hardy had been pool supervisor of both Margaret Grant and Bonivital Pools from about 1993 until her retirement a few months prior to this inquest. Ms Hardy said that she had worked as a lifeguard and an in-charge lifeguard prior to becoming pool supervisor.

[33] Sometime shortly after this incident, in the summer of 2002, a document entitled “school group guidelines” had been provided by the City

of Winnipeg to police and to the school division as constituting the guidelines applicable to Margaret Grant Pool. It was treated as such and put to various witnesses for comment throughout this inquest. However, when Carol Hardy ultimately testified as one of the last witnesses, she said the document had in fact been created for Bonivital pool by, and at the behest of, one of the permanent lifeguards there. Ms Hardy had never considered that the document applied to Margaret Grant Pool nor had she perceived there to be a need for such guidelines for Margaret Grant Pool. This was because Margaret Grant didn't have as many school group bookings as Bonivital. Coincidentally Bonivital has a shallow end that is not as deep as Margaret Grant's and a height requirement of only forty-two inches, though Ms Hardy did not see that as any explanation as to why it had more school bookings. Ms Hardy testified that she assumed that the birthday party guidelines for Margaret Grant Pool would apply to all group rentals, including school groups, although she does not seem to have communicated this expectation to the clerk doing the bookings.

[34] These birthday party documents in use by Margaret Grant Pool in the spring of 2002 were filed as an exhibit. I do not consider them to be guidelines. They consist of three documents or four sheets of paper in total. One sheet notes the times, dates, methods of payment, etc. that are presumably to be filled in by the renter or member of the pool staff making the booking. On that sheet there is a question, noted as important, about the approximate ages of children and numbers of people. The second document is a two page use agreement contract to be signed by both parties. It is primarily concerned with issues of cost, insurance and cancellation charges.

[35] A third document is entitled "Margaret Grant Birthday Parties" and says that it contains "everything you wanted to know about our birthday parties but were afraid to ask". The items dealt with on this page include, in order, the available times for rental, what the "2 hour birthday package" and the "1 hour package" respectively cover, the availability of fridges, stoves, microwaves, and the availability of slides and pool toys. Finally the very last sentence on the page, undifferentiated from the rest of the text in any way, states" If you are having children 5 years and younger in your group, we require 1 adult for every 3 to 4 children".

[36] Ms Ambrose-Walsh said that these were the only materials available to her for handout but that she believed that they were not relevant for a school group and accordingly did not give them to Ms Janzen. If she had done so however, at least the supervision requirements for the handful of five year olds in the group would have been stated in writing.

[37] Ms Hardy's testimony made clear that there was no central accessible repository of applicable information that could be consulted by staff at her pool or by the public to ascertain what the policies of the pool were. It would seem that even City officials in a supervisory position to Ms Hardy were unable to ascertain what the policies were at Margaret Grant Pool given her startling revelation almost a year later. This revelation was of course that in the opinion of the person in charge of the pool at the pertinent time the document that the City had produced as relevant to this inquiry did not in fact apply to the Margaret Grant Pool.

[38] Ms Hardy said that she kept any policies sent to her from the aquatics branch of the City in a file in her office. She also usually made a copy for each of the two permanent lifeguards at the pool and posted another copy on the staff bulletin board for some period of time. However there was clearly no mechanism in place to verify whether or not the many part-time lifeguards at the pool had seen the documents. Ms Hardy was asked how she could be sure that all of the lifeguard staff at the pool, particularly one who had come in only for a single shift to cover a birthday party for example, would be aware of the birthday party rental rules. She responded that she assumed that one of the other lifeguards with whom the casual lifeguard would be working would “fill them in” on relevant policies.

[39] Ms Hardy did not consider what we now know to be the Bonivital school group guidelines to apply at Margaret Grant Pool. Therefore it is perhaps not surprising that none of the lifeguards working there on June 27th had seen them. Nonetheless, they are of some guidance to me on the issue of appropriate supervision ratios.

[40] These Bonivital guidelines provide that for children of kindergarten age, four and five year olds, a four to one ratio of children to adult is appropriate, with adult supervision in the water within close proximity to the children. For children of that age to be less supervised, they must meet two

criteria: a height of 107 cm. (42") and basic swimming ability. For children in Grades one to three, a five to one child to adult ratio is appropriate for non-swimmers. Again the adult supervision should be in the water, within close proximity to the children. For children with swimming ability, a fifteen to one ratio of child to adult is appropriate. For children in Grade 4 and older, the guidelines indicate that the lifeguards would appreciate teacher supervision on deck, especially with larger groups of fifty or more.

[41] Gail Henderson-Ross, is a volunteer with the Red Cross Society, currently an instructor-trainer with their swimming programs and a former lifeguard herself. In addition to the pamphlets and website information on water safety available from her organization and others like the Lifesaving Society, and the Canadian Safety Council, she indicated that she can and does answer telephone inquiries on appropriate supervision ratios for children in a pool. She says that in doing so she is guided by the information she receives about the group including numbers, ages, and swimming abilities. She also takes into consideration the recommended instructor to student ratios for the Red Cross Aquaquest swimming lessons. These mandate ratios of one instructor to four children for preschoolers and one instructor to six or eight children for Aquaquest levels 4 to 6. For levels 7 to 12, one instructor is suggested for between eight and ten children. Ms Henderson-Ross said that she also takes into account the Provincial Day Care standards that she believes mandate a one adult to eight children ratio for the general (not aquatic) supervision of children ages 6 to 12.

[42] Taking into account the Bonivital ratios as well as those suggested by the Red Cross representative, I thought it useful to estimate the number of supervisors that these criteria would suggest ought to have been provided for on the school trip in addition to the lifeguards.

[43] In making this estimate, I have assumed that out of the total potential group of one hundred and eight children, based on their school Grade levels, eighty-four children were aged 7 to 10 and twenty-four children aged 5 and 6. I have also assumed that two-thirds of the older group (fifty-six children) could swim and meet the height requirement and that one-third of the younger group could do so (eight children). Using the one adult to fifteen swimmers ratio for the group of sixty-four (56 +8) children who could swim,

would mandate that there be at least four adult supervisors on the pool deck for those children. Using the one adult in the water to five non-swimmers ratio for the balance of forty-four children would require an additional nine adult supervisors in the water. Thus applying the Bonivital ratios would have necessitated that there be approximately thirteen adult parent and/or teacher supervisors in addition to the lifeguards.

[44] Alternatively, if one were to use the day care guidelines as Ms Henderson-Ross understood them to be, one adult for eight children aged 6 to 12, that ratio applied across the board for a group of one hundred and eight children would again involve approximately thirteen adult supervisors.

[45] In order to comply with reasonable water safety standards as articulated in either the Bonivital or Red Cross guidelines then, the five teachers and one parent who did attend the school trip would have needed an additional seven teachers or parent volunteers to accompany them. Most of those supervisors would have been in the water, with four or five on the pool deck and none standing behind the glass in the observation room.

THE INCIDENT:

[46] On June 27th Joshua was part of the second group to leave from his school for the pool. The teachers had decided that sending the Grade 3 and 4 students initially and then sending the remaining K to 2 students on the second trip would make things less chaotic at the pool on arrival. Since St. Adolphe School is only fifteen minutes or so from the Margaret Grant Pool, the plan meant that the older children would have about thirty minutes more in the pool than the younger children. Teachers testified that bus safety and group safety had been discussed with the students at the school prior to departure. However nothing was said to them about water safety other than the fact that the lifeguards would be telling them about the pool rules once they got to the pool.

[47] Sean Robert, 22 at the time, was one of the regular part-time lifeguards at the Margaret Grant Pool. He said that as of June 2002 he had

had about five years experience as a lifeguard and that he held the Royal Life Saving Society National Lifeguard Service Award.

[48] Mr. Robert had arrived at work that morning about 9:15 a.m. for a 9:30 a.m. shift. Susan Lee, one of the permanent lifeguards stationed at the pool, was in charge of the pool because Carol Hardy had taken the day off.

[49] Mr. Robert was initially assigned to guard a one hour school group on his own at 9:30 a.m. This was a class of about twenty children from Bonnycastle School who ranged in age from 7 to 9. Three adult supervisors were with this group of twenty children, two of whom were in the water, with the third on the pool deck. He did not have any discussion with the adults about what they would do but two of them entered the water.

[50] Mr. Robert said that this Bonnycastle group consisted of about half swimmers and half non-swimmers and was a fairly rowdy group. Since he was on his own, he had to give the initial pool rules speech to the group, to supervise the qualifying laps to enter the deep end, and to monitor the entire eighty-two foot pool including enforcing the rules, both in the water and on the deck. Mr. Robert said that he was not that comfortable being the sole lifeguard with the group and would have preferred to have some assistance despite the fact that he had the assistance of the three adults with the group. He indicated that he had on previous occasions been required to guard a group of thirty on his own and on at least one occasion had felt overwhelmed by the task.

[51] Mr. Robert believed that on any of the previous occasions that he had guarded school groups, either alone or with other lifeguards, he had never before been required to guard a group larger than fifty students. He also did not recall having ever before guarded a school group that included kindergarten students. He said that in his opinion the lifeguarding requirements for a school group needed to be more generous than the minimums set out in the **Public Health Act**, depending on the size of the group, the ages of the children, their swimming ability and their behaviour.

[52] As soon as the Bonnycastle group left the pool at 10:30 a.m., the first group of forty-seven Grade 3 and 4 students from St. Adolphe School entered the pool. Accordingly, Mr. Robert had no break between the groups.

He was immediately joined by two more lifeguards. Mr. Robert again gave the usual pool rules speech to this first St. Adolphe group, including the requirement that anyone who wanted to swim in the deep end of the pool would have to swim four widths of the pool. The lifeguards would then put a mark on these students' arms signifying that they had qualified.

[53] The two additional lifeguards who had come on duty at 10:30 a.m. were Christa Buccini, then aged 20, and Matthew Rice who was 21. Ms Buccini was a lifeguard with three years experience who, like Mr. Robert, was usually stationed at Margaret Grant Pool. She had the Royal Life Saving Society's Bronze Cross qualification. Since all of her service was with the City and she had just received her Bronze Cross Examiner's certificate (the card was issued July 2, 2002) she was the senior of the three lifeguards and thus eligible to be the in-charge lifeguard in the absence of the pool supervisor. The third lifeguard, Matthew Rice, held the Royal Life Saving Society National Lifeguard Service Award. Like Mr. Robert he had worked as a lifeguard since 1997 but had only been hired by the City of Winnipeg six months before, in December of 2001. His usual assignment was the Pan-Am pool. This was his first time lifeguarding at Margaret Grant Pool.

[54] The three lifeguards quickly sorted out responsibilities amongst themselves once the first wave of the St. Adolphe group started entering the pool. Mr. Robert would guard the deep end, Ms Buccini would guard mid-pool, supervising those who were swimming their qualifying laps, and Matthew Rice would take the shallow end.

[55] The bus lists of the St. Adolphe students who went on the outing were initially provided to the Winnipeg Police and then ultimately to this inquest. They appeared to be the class lists of the respective classes. Of the five teachers on the outing, only two completed and signed these bus sheets on which attendance was to be noted. One of the Grade 3/4 teachers testified that her entire class of twenty-nine students attended the outing. Although the other Grade 3/4 teacher did not complete the sheet, it would appear from what was noted on the sheet together with her testimony that virtually her entire class attended. Therefore the total number of kids from the first bus entering the pool at 10:30 a.m. would have been about forty-seven.

[56] This figure corresponds with the lifeguards' estimate that there were between forty and fifty students in the first wave. Very few of this group required life jackets as most had basic swimming skills. Since Ms Janzen had traveled in her own car to the pool behind the first bus, there were three adults at the pool with the first group. One of these adults, likely Ms Janzen, told the lifeguards that the other half of the group was en route. These three adults with the earlier group did not remain on deck but located themselves behind the glass observation room at the shallow end of the pool.

[57] The second group of St. Adolphe students arrived at the pool about fifteen or twenty minutes later, at 10:45 or 10:50 a.m. At that juncture, immediately prior to the second group entering the pool, Mr. Robert estimated that about half of the first group or twenty to twenty-five students were in the deep end, with another ten to fifteen either doing laps at Ms. Buccini's location or waiting to be tested. Therefore between thirty and forty students, the majority of the initial wave of forty-seven students, were in the deep end or at mid-pool when the younger group of children arrived.

[58] Teachers testified that only ninety-five of the potential group of one hundred and eight students ultimately went on the outing. It is impossible to discern from the bus lists which of the children were actually in attendance. However, for the reasons already indicated, if one assumes that almost all of the older group of forty-seven students were present, that would mean that approximately forty-eight of the potential group of sixty-one K to 2 group actually attended the outing. The second wave of students to enter the pool would thus have been approximately the same size or even larger than the first group.

[59] The kindergarten teacher, Ms Michaud, related that even though there had been no communication with parents about personal flotation devices or PFD's, about half of her group of twelve students had brought water wings or PFD's. While still at the school, she told those children that if their parents had sent these devices along with their children, the children would have to wear them in the pool. Ms Michaud recalled Joshua being very excited that morning at the prospect of the trip and trying to make some of his classmates laugh. She did not specifically recollect seeing Joshua after the group arrived at the pool.

[60] None of the lifeguards had been made aware of any request for a male lifeguard to supervise the male change room and it does not appear that any of the teachers asked them to do so. Ms Sylvestre supervised the male change room while standing in the doorway from the change room to the observation room. She related that most of the younger children were not exiting directly from the change room to the pool but were instead going through the observation room to where the lifeguard was organizing them to sit and hear the pool rules. Ms Sylvestre recalled that Joshua initially came out of the change room in his underwear and she sent him back in to take them off. She does not recall seeing him after that. This sighting appears to be the last time any of the teachers specifically recalled seeing Joshua before he was pulled from the pool.

[61] Matthew Rice, acting as the shallow end lifeguard, gave the pool rules speech to the second group of younger children. As part of that speech, he asked how many kids needed life jackets and provided them to the children who requested them. On questioning from inquest counsel, he said that he was content to rely on the children's own determination of whether they needed life jackets because he had found that children of that age tended to answer more honestly than older children who may not want to set themselves apart from their peers by doing so. Mr. Patterson, the lifeguarding expert disagreed with this view, stating that children under seven are not capable of recognizing risks to themselves nor of protecting themselves from those risks.

[62] It is clear that Joshua was not one of the children who volunteered to take a life jacket. Joshua was very comfortable in the water according to his mother, Kristin Harder, who indicated that her family had a cottage on a shallow beach. Joshua was capable of dog paddling and that spring he had just been learning to hold his breath. However he had never swum in a swimming pool before that day. Ms Harder said that if she had been asked if her son needed a life jacket, she would probably have said that he did not.

[63] No one is sure of the exact time that the second bus arrived at the pool. One of the teachers recalled that the second group was still at St. Adolphe School at 10:25 a.m. so could not likely have arrived at the pool before 10:40 a.m. or 10:45 a.m. at the earliest. Then the children would still

have had to change their clothes and to sit down and listen to the lifeguard's recitation of the pool rules. Ms Janzen 's younger daughter had been on the second bus with Joshua. Ms Janzen asked her daughter how long she had been in the water before the lifeguard told them to get out. The child said that she had swum her laps to enable her to swim in the deep end, gone down the deep end slide once and swung on the deep end jungle rope twice, before they were told to get out of the pool. The 911 call was made at 11:06:10 a.m. according to ambulance records. It would appear then that the second group of children had been in the pool for fifteen minutes at most and possibly as little as eight or nine minutes when the incident occurred.

[64] When the second group of children entered the pool, the vast majority of them would likely have started out in the shallow end although some, like Ms Janzen's daughter, swam well enough to go to the deep end. The children waiting to do their laps were lined up in the pool, standing at the deeper part of the shallow end along the wall, until they were called in groups of four at a time to do their laps. Since ten or fifteen children from the first group were already in the shallow end when the second group arrived, there would have been more than sixty, or two-thirds of the entire group, in the shallow end of the pool initially.

[65] There were numerous toys in the pool as well in addition to the deep end slide and the jungle rope already noted. The buoy rope differentiating the shallow end from the deep end was placed at the 4' or 48" inch mark. There was a portable blue slide in the shallow end at the 3' mark nearest the observation room. A little further along that same side of the pool, closer to the deep end, there was a plastic basketball hoop. There were also at least two floating mats in the shallow end, one red and one blue, each with dimensions of 62" by 36" by 1". There were also a variety of other balls throughout the pool.

[66] Mr. Robert said that in hindsight he thought that the shallow end situation had been out of control. Although the children in the first group of swimmers had been excited and loud, and some had required discipline, he had felt that the situation was in hand before the arrival of the second group. While Mr. Robert had noted that the adults in the first group remained in their street clothes behind the glass he said that even had he thought of

speaking to them about coming on to the deck, he had not had the time to go and speak to them.

[67] However once the second group of younger children constituting a larger proportion of non-swimmers had entered the pool he thought that the situation in the shallow end was too crowded and hectic. Since it was not his primary area for supervision he chose not to raise the issue but waited for another lifeguard to bring it up. Ms Buccini also said that with the entry of the second group into the pool she became concerned about how busy the shallow end was. She would have gone to ask the teachers to come out on deck to supervise but was herself too busy to do so.

[68] Mr. Rice said that he knew that teachers would be accompanying the group and that before they arrived he assumed they would be coming in the water. When some teachers came out on deck dressed in street clothes and shoes to help the younger children with life jackets, he didn't specifically ask them to stay out on deck. Neither did he tell them to go into the observation room.

[69] All of the teachers said that they were under the impression from the initial discussions between Ms Janzen and the pool clerk, as conveyed to them by Roseanne Sylvestre, that if they went out on the pool deck or in the water, they might get in the lifeguards' way. However none of them thought to ask the lifeguards whether this was in fact the case or whether the lifeguards needed any help with supervision or even with putting on life jackets after their initial assistance with the younger group. The teachers also said that no one from their ranks had been designated as being in charge so that any decisions they made that day were based on what any or all of them perceived that needed to be done at any particular time. Since there was no one in charge, obviously no one had been identified to the lifeguards as the person to whom any queries or instructions should be directed.

[70] None of the adults present at the pool, neither teachers nor lifeguards saw what actually happened. Expert testimony from Larry Patterson of the National Lifesaving Society was to the effect that young children can slip under the water without a sound, or get themselves into critical condition in a matter of ten to twenty seconds. It is perhaps not surprising then that no one noticed a problem before Matthew Rice saw Joshua floating face down

in the water in the southeast corner of the pool, the only area of the pool which was not observable from the observation room according to Joshua's teacher, Ms Michaud.

[71] About six or seven children were interviewed by the police, some later that same day and some three months later. None of these children testified but since this is an inquest I will consider the evidence in the police notes of what they were told by these children.

[72] There are some common themes in the statements of all of these children. Virtually all of them said that Joshua had been using the slide at the shallow end of the pool, some of them recalling having been in line with him waiting to use it and another recalling that Joshua had asked a little girl in front of him if he could go down the slide before her and that she had let him do so.

[73] Most of the statements make reference to a red mat in the shallow end near the slide and are consistent in identifying by name some of the boys who were playing on it. The two children interviewed by police on the evening of the incident both related seeing Joshua under this red mat. Police were originally somewhat skeptical at the time about the little girl's account because she was referring as well to a blue slide in the shallow end that they hadn't yet seen or been told about. Nonetheless she seemed to them to be quite earnest about recounting what she had seen.

[74] These initial two childrens' statements are also consistent with that of another boy made the following day. He said that he had gone down the slide several times. He named four boys who were playing on a mat near the slide while he was going down it. When these boys moved the mat closer to the middle of the pool, he saw Joshua floating near where the mat had been. When he tapped Joshua on the head and asked him to play, he thought Joshua was just ignoring him so he just played on his own for a while until the children were told to leave the pool.

[75] This statement is also consistent with the statement of another young girl taken in September. Police described her as a quiet, intelligent child who did not appear to exaggerate or embellish the details. She said that she saw Joshua go down the slide and under the mat. She assumed that he had swum

out from under it until she went down the slide herself after him. When she came up to the surface, she saw him floating face down. Then the lifeguard told them to get out of the pool.

[76] Although there is no definitive evidence as to what caused Joshua to drown, it is clear that just prior to his death, he was using the slide positioned at about the 3' mark. Joshua was only 40" tall. He may well have found himself unable to stand up at the bottom of the slide due to the presence of a red mat overtop him with children playing on it. He could also just as easily have become disoriented underwater and consequently unable to get his bearings. He could have turned in the wrong direction at the bottom of the slide and found himself in water over his head. Whatever did happen, the number of children in the shallow end together with the number of toys and the dearth of supervision apparently prevented anyone from immediately noticing what had happened to him.

[77] Shortly before the incident happened, Matthew Rice, the shallow end lifeguard, had had to deal with a boy who had failed his qualifying laps and had been sent by Christa Buccini to get a life jacket. All of the pool life jackets were near the shallow end corner where Mr. Rice was positioned while the other two lifeguards were standing on the opposite side of the pool at mid pool and the deep end. Since there were no other adult supervisors on deck, by default, all of the children in any part of the pool who needed any help with life jackets would be looking to Mr. Rice for that assistance. The boy sent by Ms Buccini had run toward Mr. Rice and had been warned by him about running. Mr. Rice told him to grab a jacket and put it on and he would help him to zip it up. Once the boy had the jacket on he again started to run on his way back towards the other end of the pool, Mr. Rice told him that he had to walk a lap around the pool as punishment.

[78] Mr. Rice was then approached by two little girls from the shallow end who wanted to put on life jackets and needed help in doing so. He said that he glanced at them to assess their sizes and then quickly grabbed the appropriate size, based on the colour-coding of the jackets. Then he handed the jackets to the girls to put on. He visually scanned the pool before he began to assist the girls with zipping the life jackets up. While doing so, he

was standing facing the corner of the pool and the observation room at about a 45-degree angle to the pool.

[79] Meanwhile behind the glass, some of the observers were noticing the competing demands that assisting with life jackets was making on the lifeguard's attention. Ms Janzen had just noticed the kids playing on the mats. She said that Ms Sylvestre commented to her that those mats always scared her because she was always worried somebody would get caught underneath them. Ms Janzen mentioned that the lifeguard wasn't being very effective at zipping the jackets up because he wasn't really looking at the jackets while doing so. She and Ms Sylvestre decided that if any more kids needed help with the life jackets, they should go out to the deck and assist the lifeguard. Almost immediately Ms Janzen saw a look of horror on the lifeguard's face as he looked down into the corner of the pool. She heard Ms Sylvestre say, "What's he looking at?"

[80] Mr. Rice said that a boy floating face down in the water right near the ladder drew his attention. For some reason he looked different than most children who play possum, that is, lie face down on their stomach. Mr. Rice said something to a couple of children who were standing right near Joshua in the water. These children told him that Joshua was just holding his breath. Mr. Rice tapped the boy on the back. When he got no response he immediately slipped into the water and got the boy in a vise grip to turn him over, yelling something to his fellow guards about a non-breathing victim and to clear the pool and call an ambulance. When he turned Joshua over and saw that the boy's eyes were rolled back, he did a look, listen and feel check. That is, look to see if the chest is rising, feel for breath and then listen for it. None of these steps produced a response.

[81] The other two guards ensured that the ambulance was called and cleared the pool by using their whistles and instructing the children verbally. The children went into the change rooms where they waited with their teachers until Joshua had been removed by ambulance. Then the school buses were summonsed and the children were taken back to the school early for the barbeque lunch.

[82] Meanwhile because Mr. Rice had not seen what had happened and Joshua had been found close to the edge of the pool, the lifeguard proceeded

on the assumption that the boy should be treated as if he had sustained a spinal injury. This was a cautious but prudent assumption in the circumstances because a spinal victim can be injured even further if handled inappropriately by rescuers. Accordingly, once Joshua had been turned face up in the water with Mr. Rice maintaining the vice grip, the lifeguard did an ABC assessment, that is airway, breathing and circulation. If there is no airway, rescue procedure dictates that the first priority is to establish one and maintain it. Finding the airway clear, Mr. Rice started artificial respiration, giving two breaths. The boy then vomited so the airway had to be cleared and then the breaths started again. There was no carotid pulse apparent.

[83] The other two guards had brought the spine board into the water and put the head and chest straps on before lifting the boy out onto the pool deck where they continued the resuscitation efforts. On deck they were able to start CPR or cardio-pulmonary resuscitation with Ms Buccini taking over administering the breaths and Mr. Rice doing the compressions. Several bouts of vomiting occurred while the lifeguards were working on the boy, necessitating their having to clear his airway and start over each time.

[84] Mr. Robert had gone to get the trauma bag from the pool office once the boy had been placed on the pool deck. He then handed the easy-seal mask to Ms Buccini and started to set up the oxygen tank. This tank could be connected to the side of the tube through which Ms Buccini was breathing, in order to supplement the oxygen being administered by her. Mr. Robert could not find the valve used to attach the oxygen tank to the breathing tube and started to look through the bag for it.

[85] At this point the fire department arrived with their own set up ready for use as they walked in, so he attached the pool oxygen tank to the fire department equipment instead. This valve was later found at the bottom of the trauma bag. Even if there was a slight delay of seconds caused by this valve not being readily available, the lifeguarding expert from the Lifesaving Society, Larry Patterson, testified that research has not established whether supplementary oxygen in fact has any effect on outcomes.

[86] These first responders from the nearby fire station had appeared within two minutes of the ambulance call placed at 11:06 a.m. They took over the respirations while Mr. Rice continued doing the compressions until

the paramedics from the ambulance arrived at 11:12 a.m., four minutes after the first responders. The first responders had also suctioned the boy prior to the ambulance arrival.

[87] Cindy Hamelin, one of the paramedics, testified that the lifeguard doing the CPR compressions, Mr. Rice, was doing a very effective job and that she literally had to pull him off the boy to get information from him. Ms Hamelin said that she hooked up the cardiac monitor on her arrival and that there was a pulseless electrical activity (PEA) rate of about ten signifying that there was some electrical activity but that the heart was not pumping. CPR and suctioning were continued in the ambulance after the ambulance left at 11:17 a.m. en route to Victoria, the nearest hospital.

[88] Ms Hamelin said that as a level two paramedic, she was not permitted to administer drugs to children under 10. Normally epinephrine would be administered to someone in cardiac arrest but only a level three paramedic could do so in the case of a child. Since the only level three paramedic on duty at the time was on the other side of the City, it was faster for the ambulance crew to take the boy to Victoria Hospital rather than wait for the level three paramedic. If the boy had been stable, he would have been taken directly to the Children's Hospital.

[89] The ambulance arrived at Victoria Emergency at 11:22 a.m. and resuscitation efforts were continued for forty minutes until 12:02 p.m. when death was pronounced. It is likely impossible to know if it would have made a difference in the outcome but the fact remains that if a level three paramedic had been available at the pool initially, the epinephrine would have been administered to Joshua at least ten minutes earlier than it was.

[90] Joshua's teacher, Ms Michaud, was not permitted to travel in the ambulance to the hospital. However Nancy Janzen gave her a ride in her vehicle. Ms Michaud had called her principal prior to leaving the pool. The principal, Laurel Kosman, joined her at the hospital after notifying Joshua's father. Since Ms Harder had been doing errands in the city, she could not be reached until after Joshua's death had been pronounced.

THE AFTERMATH:

THE POOL:

[91] After the ambulance left for the hospital, the lifeguards apparently put the pool toys away and someone, presumably the pool maintenance staff cleaned up whatever might have remained of the vomit produced by Joshua during the resuscitation efforts. The lifeguards then each individually prepared a written report.

[92] Within the next few hours, various officials from the City Aquatics Branch came to the pool, as did a City public relations person. A City psychologist and social workers came to offer assistance to the lifeguards. Susan Lee, the Acting Pool Supervisor who had been at Bonivital Pool at the time of the incident, Lloyd Plueschow, the Lifeguard Trainer, and Phil Hay, the Senior Aquatics Coordinator were among the City staff who attended. It appears that at some relatively early point after the incident the media were also allowed in to the pool area to film and take pictures.

[93] During the course of the afternoon other officials involved in an investigation of the incident came to the pool. Mr. Mike Leblanc, Regional Supervisor of the Provincial Environmental Health Services, a department of the Conservation branch charged with inspection of public pools, came to investigate on behalf of his department. Heidi Epp, an examiner from the Office of the Chief Medical Examiner also began to make inquiries. The primary responsibility for the investigation ultimately lay with the Winnipeg City Police and in particular Detectives Fogg and Lemire of the child abuse unit.

[94] The court was told that when 911 receives a call, a determination is made immediately as to whether to route it to fire and paramedic, or to police, or to both. In this instance the call was quite appropriately routed initially to the paramedics rather than the police. However as I noted earlier there are two factors that might have prompted early notification to the police. One is that this was an injury sustained on City property and Winnipeg City police investigate all such incidents. Therefore if the computer dispatch had been programmed to identify the address as a City

property, the police would have received the notification at the same time as the paramedics and would presumably have monitored developments.

[95] The primary rationale for notifying police is that the police child abuse unit investigates not only all physical and sexual assaults of children and vulnerable persons, but also all child deaths that are not homicides. Once the ambulance had reported back to dispatch about 11:20 a.m. en route to hospital that a child was being taken to Victoria hospital and was not expected to do well, dispatch should have notified police immediately so that they could begin an investigation. Testimony indicated that this is one of only a handful of instances each year when the notification to police is not done automatically along with the ambulance dispatch. In this instance the operator had to recognize the need to notify police and then do so manually. The consequence in this case is that police were not notified until about forty minutes later at 12:02 p.m., ironically just as Joshua's death was being pronounced.

[96] Police dispatch did not have a car available immediately even though the call was designated as a priority one call. The dispatch operator made additional inquiries of both the desk sergeant and the duty inspector of the relevant district in an attempt to increase the speed at which a car could be found. However no car was available until 12:33 p.m. By the time this first police car arrived at the pool, it was 12:46 p.m., one hour and forty minutes after the 911 call had been placed. After preliminary inquiries were made by the first unit, it took more time for the child abuse unit detectives to be assigned. Accordingly they did not arrive at the pool until 1:25 p.m., almost two and a half hours after the incident had occurred.

[97] The significance of these delays is of course their impact on the ability of police to carry out their investigation. It is crucial that any death or accident scene be preserved so that photos can be taken and measurements made in order to recreate the conditions as much as possible for any future civil or criminal inquiries. In some circumstances it might be essential to examine a sample of blood or vomit and to preserve a specimen so a forensic test could later be done. Here since the scene was not preserved, police did not even realize initially that it had been altered. This impacted on their ability to question witnesses in a meaningful way. One of the children the

detectives spoke to on the night of the incident impressed them except for her continued reference to a blue slide in the shallow end. The only slide they had noted at the pool was a yellow slide in the deep end so they were initially not as confident in the accuracy or veracity of this child's recollection.

[98] The second casualty of the delay was that it hampered police ability to locate witnesses. Ideally a timely attendance at the scene of an incident will mean that police are able to at least identify, if not speak to, potential witnesses at the earliest possible opportunity.

[99] As a result of this incident, the City took some immediate steps to rectify any problems that they had perceived could have impacted on these events. For example, all floating mats were removed from the pool pending completion of this inquiry. Clearer criteria for entrance to City pools were also created and communicated to the public.

[100] Copies of these documents reflect an attempt to deal with all potential circumstances and users identified by the aquatics branch, in particular public swim, school group rentals and birthday party rentals. For any of these categories, children under seven and children under the relevant height requirements for a given pool must be accompanied by an adult caregiver at a ratio of one adult for four children. Children who are non-swimmers and who do not meet the height and age requirement must remain in the shallow end of the pool. All groups using the pool will now be required to identify in advance different categories in their groups based on height, age and/or swimming ability.

[101] Under these new guidelines, a child such as Joshua Harder who did not meet the height or age requirement and could not swim would have to wear a PFD and would be required to remain in the shallow end of the pool. He would also have to be within arm's reach of the adult supervising him and his three classmates, based on the four children to one adult supervision ratio.

THE SCHOOL:

[102] Joshua's schoolmates and teachers had returned to St. Adolphe School for the barbeque lunch after leaving the pool. These teachers did not learn of Joshua's death until the end of the school day. This occurred at a meeting organized by the principal, Laurel Kosman, once she and Joshua's teacher Lynn Michaud had returned to the school from the hospital, shortly before school was dismissed that day. Because of the delay in locating Ms Harder, Ms Kosman and Ms Michaud had not been told of Joshua's death themselves until shortly before they left the hospital.

[103] As soon as the principal had been notified about the incident through Ms Michaud's telephone call from the pool, she arranged for the division's crisis response team to come to the school. They were present at the school for the balance of the day assisting the teachers both in responding to the children and in coping with the accident themselves. This was even before any of the teachers had received news of Joshua's death.

[104] The children were not told about Joshua's death that day. Ms Kosman did draft a letter that was sent home to the parents with their children, advising of the "serious incident" that the children had witnessed or been told about. It indicated as well that counselors were available should the children react in a way that might cause the parents any concern. A follow-up letter was then sent to parents about one week later on July 4th, identifying the counseling resources that would be available over the summer and asking parents to call Sergeant Kathy Hodgins if their children had any information that might be helpful to police.

[105] Detectives Fogg and Lemire interviewed all of the teachers who had been involved in the field trip shortly after the teachers meeting at the end of the day at which teachers had been told of the death. They also interviewed two children that evening and a few more children in the next few days and weeks with the last child interview taking place on September 30th.

[106] Like the City of Winnipeg, the Seine River School Division took remedial steps as a result of this incident. A committee was set up to review the incident and to create division policies for recreational aquatic outings. The committee included parent, teacher and principal representation as well

as representation from the Canadian Red Cross and the Faculty of Education. The risk manager from MAST, Keith Thomas, was also a participant and in that capacity has since recommended the resulting guidelines, the "Swim Safe" program, to other school divisions for implementation throughout the province.

[107] These new guidelines provide that in future all Seine River division schoolchildren on aquatic outings will have to wear a life jacket or PFD if they are in grades K to 2, regardless of their swimming ability. All non-swimmers, regardless of age, will be required to wear PFD's in deep water, or on watercraft, and they are recommended even for shallow water. Adult to children supervision for kindergarten will be one to four while the ratio will be one to six for children in grades 1 to 4. These supervisors are not required to be in the water but must be at or near the water line. All children on aquatic outings will be paired in a buddy system so that regular checks can be made every fifteen minutes. Swimming categories are to be established in advance by the school and swimming ability tested through an endurance test carried out by lifeguards on arrival at the venue. An in-charge teacher is to be designated and an emergency plan developed and communicated to all teachers and volunteers participating in the outing.

[108] These are some of the highlights of the plan adopted by the division in response to the incident. Had this policy been if effect for the June 27th incident, three supervisors would have been required for the twelve kindergarten students who went on the trip. An additional thirteen or fourteen adults would have been required for the balance of the eighty-three students, for a total of sixteen or seventeen supervisors in all.

THE RECOMMENDATIONS:

THE PROVINCIAL DEPARTMENT OF HEALTH:

[109] The Province of Manitoba has enacted regulations under the **Public Health Act** of Manitoba C.C.S.M. P210 governing public swimming pools. These are the "Swimming Pools and Other Water Recreational Facilities Regulations" registered in June of 1997 and amended in July of 2000.

Section 46 of these regulations provides that they are to be reviewed no later than five years after their enactment. This provision for a regular review would seem to recognize that changes in swimming pool designs, improvements in sanitation and safety equipment, and even in national standards for lifeguard certification might mandate ongoing changes being made to the regulations.

[110] Mr. Larry Patterson, the expert witness from the National Lifesaving Society is currently program manager for the society for Alberta and the Northwest Territories. He has thirty years experience with lifeguarding and with managing pools in Ontario, British Columbia and Alberta. He is also involved with program design and support for lifesaving and lifeguarding programs in Alberta and on the national level. Mr. Patterson is a branch trainer and as such trains the instructor trainers who ultimately teach the instructors of the NLS lifeguarding programs. Mr. Patterson also provides aquatic safety management services for the society. These involve consulting and support services around safety management and risk management in aquatic environments. He has also testified previously both at fatality inquiries and in civil proceedings.

[111] Mr. Patterson explained the distinction between lifesaving and lifeguarding. Lifesaving is primarily reactive and rescue oriented. That is, the individual is trained to extricate victims in need of assistance without sacrificing the personal safety of the rescuer. The lifeguard however will have received additional training in water safety and in both the prevention of situations that might require rescue and the ability to recognize them once they occur. In the opinion of Mr. Patterson and other national experts, the Lifesaving Society's National Lifeguard Service Award should be the minimum qualification for lifeguards in Canada. The Bronze Cross certification is essentially a lifesaving qualification rather than a lifeguarding one.

[112] Presumably that is why in 2002 Ontario enacted new regulations for public pools under its Health Protection and Promotion Act. Section 16 of its regulations stipulates that all lifeguards for public pools and wave pools must have the NLS lifeguard certificate. Those who hold only the Bronze Cross or the Award of Distinction (both of which are primarily lifesaving

credentials) may only be hired as assistant lifeguards. Interestingly, Phil Hay, the Recreation Aquatic Coordinator for the City of Winnipeg testified that of the last sixty-nine people hired as lifeguards for the City, fifty-three had the NLS award.

[113] While there is nothing in the evidence before me to suggest that the credentials of the lifeguards at Margaret Grant Pool had anything to do with what transpired in this instance, nonetheless the evidence in its entirety persuades me that Manitoba should strive to be a leader in the field of water safety. It only makes good sense for people acting as lifeguards at pools in Manitoba to have the necessary training to think and act proactively so as to prevent incidents occurring, rather than merely reacting to situations once rescue is required.

I therefore recommend:

1. That the swimming pool regulations under the ***Public Health Act*** *of Manitoba be amended with regard to minimum qualifications for lifeguards. At the very least they should be site-specific, and should provide that lifeguards for all swimming pools or wave pools open to the public must have their NLS Lifeguard Service Award as the minimum lifeguarding qualification, in addition to the appropriate first-aid certificate as articulated in the existing regulation. Those holding the Bronze Cross or Award of Distinction would qualify to be assistant lifeguards only at such facilities.*

[114] Larry Patterson's expert evidence and an examination of some other provincial regulations confirm that the ratio of swimmers to lifeguards set out in the Manitoba regulations is not atypical. Our regulations mandate one lifeguard for the first forty-nine bathers in a facility. Fifty bathers will require a second lifeguard and one hundred and one will require a third. From there the ratio increases in increments of one hundred bathers for the first seven hundred bathers such that a fourth lifeguard will not be necessary until there are two hundred and one bathers in a particular facility. Since Margaret Grant pool has a maximum capacity of two hundred bathers, technically that pool would never require more than three lifeguards to be in compliance with the regulations.

[115] The Manitoba ratios roughly correspond to the Ontario ratios after the first hundred bathers. However one example of a province that has a stricter lifeguard to bather ratio is Newfoundland. There the first thirty bathers in a pool require one lifeguard, with thirty to seventy-five bathers requiring two and the presence of between seventy-six and one hundred bathers requiring a third.

[116] The three lifeguards on duty at the time of the incident at Margaret Grant Pool in fact exceeded the minimum numbers required under the regulations for the ninety-five swimmers. I think that implementing ratios in Manitoba to increase the level of supervision for groups of fewer than one hundred bathers would assist in reducing the likelihood of a death in circumstances similar to those before me. Both Ontario and Newfoundland regulations require the presence of two lifeguards in a pool as soon as there are thirty-one swimmers in that pool. I note in this regard lifeguard Sean Robert's indication in his evidence that at times he has felt overwhelmed being the lone lifeguard for thirty children. Requiring a second lifeguard after thirty-one bathers is preferable in my view to Manitoba's existing ratios, which do not require a second lifeguard until there are fifty swimmers.

[117] Both the Newfoundland and Alberta regulations also require a third lifeguard once there are more than seventy-five swimmers in a pool whereas the third is not required in Manitoba and Ontario until there are more than one hundred bathers in the pool.

[118] These ratios become particularly telling when put in the context of supervising groups of children and one visualizes the scenario of a single lifeguard with forty-five students to supervise. Perhaps even more evocative is picturing only two lifeguards, (two currently being the legally required number for ninety-five bathers) struggling to deal with the ninety-five young children who actually did attend the St. Adolphe school outing last year.

I therefore recommend

2. That schedule C of the swimming pool regulations under the ***Public Health Act*** *be amended to provide that as soon as there are thirty-one swimmers in a pool two lifeguards are required and similarly that once*

there are seventy-six swimmers that three lifeguards are necessary. I also recommend that consideration be given to implementing in full the Newfoundland ratios of lifeguards to swimmers as set out in the schedule to their "Public Pools" regulations under their ***Public Health Act****.*

[119] The determination of what an appropriate lifeguard to swimmer ratio may be for a given pool in a given situation is obviously a complex calculation that is dependent on a number of variables, including the type of facility, its size, the number of tanks or pools it contains, the number of users at a given time, the age of these users, their swimming capabilities and their behaviour. Unfortunately the regulations as drafted do not explicitly recognize such variables but posit ratios based only on the total number of bathers. Common sense would dictate that fifty pre-school non-swimmers in a pool would have different lifeguarding requirements than fifty high school students practicing for a swim meet. While I recognize that it would be difficult to legislate the myriad of possible variables and how they might impact on ratio, I think that there needs to be an express reminder in the legislation that pool operators need to bear such factors in mind in making their staffing decisions.

I therefore recommend:

3. That the swimming pool regulations under the ***Public Health Act*** *be amended to include a statement that the legislated ratios set out represent the minimum staffing levels for optimum conditions and may need to be adjusted to reflect the particular needs of that facility, as well as the characteristics of a given group of users such as their ages and swimming abilities.*

[120] Section 23(2) of the existing Manitoba pool regulations stipulate that where there are less than fifty-one people in the pool area there must still be two persons on duty at the pool, including one lifeguard and one person over sixteen years of age. No qualifications are set out for this second person who could conceivably be a clerk-cashier taking money at the door during an early morning swim time when there is one lifeguard in the pool area.

[121] Both Ontario and Newfoundland have similar provisions in their regulations but require additional qualifications for the second person

present. The Ontario regulations stipulate that this additional person on duty must be trained in the emergency procedures for the pool while Newfoundland requires that person to be seventeen years old, trained in Emergency First Aid and CPR and aware of emergency and operational procedures for the pool. The rationale for requiring first aid competency for the second person at the pool should be apparent and might include scenarios where more than one pool user requires CPR or the lifeguard himself or herself is the person in distress.

I therefore recommend:

4. That the swimming pool regulations be amended to provide that where only one lifeguard is on duty in the pool area that the second person required to be in attendance when the pool is open for a smaller number of users be someone trained in emergency first aid and CPR and knowledgeable about pool emergency and operational procedures.

[122] Various witnesses who testified at the inquest referred to the Aquatic Emergency Response document prepared by the City of Winnipeg and used by the City to train its lifeguards. Undoubtedly most, if not all, public pools throughout the province have similar policies in place. However, this incident has demonstrated that there is sometimes a certain degree of complacency that sets in with regard to whether or not policies do exist for a particular institution, whether they are followed by its staff, and whether it is made clear to staff that they must be followed.

[123] Therefore I think that the Manitoba swimming pool regulations should be modified to specifically include a section on safety that would gather together all of the safety related provisions of the regulations in a manner in which they could readily be consulted and viewed. In addition to the provisions for lifeguard numbers, qualifications, and equipment, there should be a provision requiring pool operators to have written emergency and operational procedures and instructions in place, to locate them in a central accessible location and to train all lifeguards and assistant lifeguards in their implementation in the case of an emergency. Again I note that there are provisions to this effect in both the Newfoundland and Ontario legislation.

I therefore recommend:

5. That the swimming pool regulations be amended to explicitly specify the necessity for pool operators to have written emergency and operational procedures and instructions in place, and accessible to staff, and to train staff in their implementation.

[124] While I am confident that the City of Winnipeg and other pool operators believe that their staff should be aware of their entitlement on perceiving a safety hazard to either deny access to the pool or to take other appropriate action to rectify the safety concern, some staff, and in particular young staff, may not be fully cognizant of their right to do so. Given how events unfolded on June 27th it is difficult to discern whether the lifeguards' failure to urge the teachers to come out on the deck to assist in supervising the children was, as they suggested, due to their not having the time to do so, or to a reluctance to be perceived as "giving orders" to the teachers who were older than the lifeguards and potentially in a position of authority, at least to a recent high school graduate. The lifeguards clearly had all expected the teachers to come out on deck and indicated that they would have found it helpful had they done so. In any case, in my opinion it needs to be enshrined in regulation that when it comes to safety, the lifeguards on duty in the pool are to have the last word about anything that they perceive to be a potential threat to the safety of bathers and that they **must** act, rather than **may** act, in case of safety hazards.

I therefore recommend:

6. That the swimming pool regulations be amended to include a provision to the effect that when a public pool is in use and a lifeguard or an assistant lifeguard on duty determines that a safety hazard exists in the pool or on the deck, the lifeguard shall direct all persons to leave the pool or any part thereof and shall advise the operator of the existence of the safety hazard.

[125] As I noted at the outset of this report, drowning is both a serious and preventable cause of unintentional injury and death in our society. There are about six hundred drowning deaths each year in Canada. Drowning is the second leading cause of unintentional injury and death after motor vehicle

accidents for individuals under fifty-five, according to Larry Patterson of the National Lifesaving Society. Children under five are particularly vulnerable with lack of supervision being the primary factor in the deaths of children in that age group. However, since swimming is the second favourite pastime of children five to twelve, water safety is a crucial issue for that age group as well.

[126] When one includes exposure to ice on rivers or lakes in wintertime, the vast majority of all Canadian citizens will at some point or another in their lives, as children or as adults and/or parents, be in a situation of potential risk for drowning. Surprisingly, some seventy per cent of drowning victims did not even intend to be in the water in the first place but accidentally fell into a pool or other body of water or their boat capsized and they were not wearing PFD's. Although voluntary agencies such as the Lifesaving Society and the Red Cross attempt the task of public education their resources are finite and their message is not able to be as widespread as it should be.

I therefore recommend:

7. That the Provincial Department of Health, together with such other government departments and outside agencies it deems appropriate, develops and mounts a public education campaign on water safety.

THE PROVINCIAL DEPARTMENT OF EDUCATION AND YOUTH:

[127] A second area in which the provincial government has responsibility and authority regarding matters raised at this inquest is that of its role in the education of Manitoba students. There are presently two important provincial statutes in place regarding education: **The Public Schools Act** C.C.S.M. c. P250 and the **Education Administration Act** C.C.S.M. c. E10. One issue that arises is whether or not the province's role pursuant to this legislation is at present, or if not, should be, broad enough to encompass regulating the safety of school children on school outings.

[128] Mr. Brian Hanson has recently retired from his position after serving for the last ten years as Director of Education and Administrative Services with the provincial Department of Education and Youth. He testified that traditionally matters relating to the supervision of school students have primarily been left in the hands of local school boards rather than regulated centrally.

[129] The Administrative Handbook for Schools is a Departmental document described on its distribution by the Department as a practical compendium of information to assist superintendents and principals with their roles as administrators and education leaders. It does venture into the area of supervision on certain issues like parental notification and supervision of students on school buses and for extracurricular activities, field trips and at noon hour. Some of its contents are mandatory policies tantamount to ministerial directives while others are guidelines as to the suggested best manner of doing things. This document also amplifies the duties of principals and teachers that are set out in the **Education Administration Act** regulations.

[130] Mr. Hanson also said that his Department regularly holds in-services to assist in educating administrators about school administration issues, including supervision. Most administrators are appointed from the ranks of teachers and therefore may require additional training and assistance on management and administrative issues that may be new to them.

[131] While there are undoubtedly good reasons for a significant degree of local autonomy over curriculum and management of school facilities, I do not understand why something as fundamental as the standards for physical safety of Manitoba school children should not be consistent throughout the province rather than dependent on where a particular child may happen to reside.

[132] Much time, energy, and money has clearly been expended by a variety of different resources actively involved in developing good policies for schools, one example being the “Safety Guidelines for Physical Activity in Manitoba Schools” referred to earlier. However, despite the expertise and effort expended in developing such policies, their implementation is left to

the local school board which may or may not choose to utilize such guidelines for its own schools.

[133] Mr. Keith Thomas, Risk Manager for the Manitoba Association of School Trustees was also one of the witnesses at this inquest. MAST, the acronym by which it is known, is a voluntary organization of all of the Manitoba school boards in Manitoba, which currently number approximately thirty-nine. According to Mr. Thomas, one of the MAST functions is to self-insure school divisions to the greatest extent possible, to collectively manage members' property and liability insurance needs and to assist with loss prevention and risk management.

[134] Mr. Thomas has been instrumental through his work with MAST in developing or promoting many safety guidelines, like the Physical Activity guidelines referred to earlier, that would presumably impact on potential insurance liabilities for members of MAST. However Mr. Thomas related that MAST does not monitor their implementation and does not have any information other than anecdotal impression as to whether any or all or the school divisions to whom such information is regularly sent have implemented any or all of the suggested policies referred to them.

[135] Seine River School Division, with input from Mr. Thomas among others, has expended considerable effort this past year in designing guidelines for recreational aquatic events, its so-called "Swim Safe" program. Although Mr. Patterson of the Lifesaving Society had some suggestions for improvements to these guidelines insofar as they relate to outings to outdoor venues other than swimming pools, I am satisfied that these guidelines are so thorough in relation to outings to swimming pools as to make the likelihood of a similar occurrence very unlikely in the Seine River Division.

[136] However, from what I understand the evidence of Mr. Hanson and Mr. Thomas to be, there is presently no way to detect whether or not other divisions have chosen or will choose to act by implementing such guidelines for the students in their division. This is not a situation that should be allowed to continue. We do not want to wait for the death of another child from some other division in the province to demonstrate the need for every

division in the province to have such guidelines in place for their aquatic outings.

[137] Presumably it was similar considerations that prompted the recommendation in the Ontario coroner's report last year involving the deaths of two Grade 7 students. They were not wearing PFD's and drowned when the tour boat retrieving them from an overnight stay at a provincial marine park sank in a storm. The recommendation in the Ontario report was that the Ontario Ministry of Education set common safety standards for all school approved trips undertaken by students in all school boards in Ontario.

[138] This approach makes good sense to me, particularly in the absence of any existing mechanism to determine whether individual school boards have turned their mind to these issues and addressed them adequately.

I therefore recommend:

8. That the provincial Department of Education and Youth develop common safety standards for school field trips, and in particular, those involving aquatic and boating activities and other similar high-risk activities like skiing and wilderness trips.

9. That these standards either be enacted as regulations themselves or alternatively, that a regulation be passed prescribing the need for each school division to have such safety rules in place and setting up a mechanism for school divisions to provide the Department of Education annually with their respective rules such that the Department will be able to regularly monitor and evaluate the adequacy of each school division's safety rules.

[139] Mr. Hanson indicated that supervision is not an exact science but that the handbook does give guidance as to the standards of supervision expected by the department. He amplified on that in his evidence, indicating that specific precautions must be taken to provide the requisite level of reasonable care to students. He pointed out that one of the messages conveyed to principals at the in-services is that the principal of the school bears ultimate responsibility for supervision and safety of students. This is so even if students are out of the school on a field trip. A principal must have

that responsibility in mind in approving outings. He also stressed that for all school sponsored and endorsed activities responsibility for supervision remains throughout with the principal and teaching staff and in his words, "does not end at the door of a facility", even though facility staff may assist with the responsibility.

I therefore recommend:

10. That the Department of Education continue and enhance its efforts to assist in the training of school administrators and teachers about their duties and responsibilities in the area of risk management and effective supervision of students through provision of in-services and other appropriate mechanisms.

[140] As I have noted in my recommendations concerning the Department of Health, public education on water safety needs to be reinforced in every possible context. Mr. Hanson indicated that he was confident that there were resources available in the school system for provision of water safety education but that they could probably be enhanced and an attempt made to ensure that teachers and principals are aware of the resources that do exist.

[141] According to the website for the British Columbia Lifesaving Society branch, high school students in B.C. who obtain the National Lifesaving Society's certification for the Bronze Cross and the National Lifeguard Service certification can earn certain high school credits for doing so. If that is not already the case in Manitoba, perhaps consideration could be given to implementing a similar system here.

[142] The Red Cross representative, Ms Henderson Ross, indicated in her evidence that her organization has put together modules for teachers to use that are available through the Red Cross website and do not require any expertise on the part of the teacher to use the materials. She said that many pools were willing to have their staff speak to school classes about water safety.

[143] Mr. Patterson from the Lifesaving Society also related a new program from that organization called "Swim to Survive". Flowing from the drowning research that has been carried on jointly by the Red Cross and the

Lifesaving Society was a recognition that about half of those who drown each year are only three metres from safety when they do. Swimming skills are obviously the best protection but the Society concluded that three basic capacities could be distilled that would dramatically enhance an individual's ability to survive if they were at risk of drowning. These were an ability to orient themselves, that is find the water surface and get their head above water, an ability to support their head out of the water through a mechanism like treading water and lastly, an ability to move through the water, however that is done, be it through dog paddling or some less identifiable stroke. It may not be feasible for swimming lessons to become a mandatory component of the physical education curriculum in all schools but giving children basic "swim to survive" skills is something likely to take less time and might be more readily accommodated in existing physical education curricula. There is thus significant potential for the inclusion or expansion of water safety information at all levels of the curriculum.

I therefore recommend:

11. That the Department of Education and Youth cooperate with the Department of Health and other appropriate agencies in devising and promulgating public education on water safety and that the Department explores ways to enhance and expand water safety education and skills within provincial schools.

RECOMMENDATIONS FOR THE SEINE RIVER SCHOOL DIVISION:

[144] Although, as I have noted above, the new Seine River policy for recreational aquatic outings provides good criteria for supervision on pool outings, as well as for assessment and categorization of childrens' swimming abilities, there are still some improvements that could be made to division policies in my view.

[145] In the case of the St. Adolphe outing for example, no teacher was in charge or considered any other teacher to be. The only vehicle that was brought in addition to the school bus was Ms Janzen's private vehicle. This

was fortuitous since the ambulance did not permit any teacher to ride in the ambulance with Joshua. One can envisage a situation occurring where there is a less serious injury, like a serious sprain, which may not warrant calling an ambulance but should dictate that the child receive immediate medical attention. Thus it is imperative that there be always be a vehicle identified for emergency use on any outing, especially when a large group is traveling by a school bus that would not ordinarily be the most suitable option for emergency transport.

[146] Another related issue for managing outings is that of keeping accurate lists of who is present and who is not present on the outing. As I indicated earlier in this document, it is impossible to tell from the class list/bus lists presented in evidence at this inquest exactly which ninety-five children of the potential one hundred and eight actually did attend the Margaret Grant outing. This is probably because each individual teacher was well aware of which of her students were present and consequently viewed reducing the list to paper and leaving it at the school as unimportant.

[147] What if one of the teachers on the St. Adolphe outing had been the person injured however? If she was not conscious and the other teachers were trying to gather the children together to return to the school, they would presumably have been trying to reconstruct which children in her class they recalled having been on the trip, in order to ensure that the children were all present and accounted for on the return bus. This was especially so since no “buddy system” was in place on the outing.

[148] Another scenario that could have unfolded is if the bus had been involved in a serious accident with one or more teachers having been killed or injured, along with some of the students. In such a situation it would have been very stressful and inefficient for those attempting to notify the parents of the injured children. For instance, such officials could be spending precious time needlessly in a vain attempt to reach a parent whose child they thought might have been on the bus. Meanwhile unbeknownst to the school, that child and parent could be lazing on a sandy beach, having skipped the outing to start holidays early on that very day.

[149] As Mr. Hanson from the Department of Education and Mr. Thomas, risk manager for MAST, both indicated, good risk management policies

require this kind of “what if” thinking to be employed. Since people are likely to be under significant stress when a tragic incident does occur, in most cases that is not likely to be the time that they will be doing their best thinking. That is the reason why delineated procedures well thought out in advance will be of great assistance to someone in the throes of a tragic event.

[150] Mr. Hanson also noted that the standard of “the reasonable and prudent parent” has been articulated by the Supreme Court of Canada and other Canadian courts as the standard of care that schools owe to children. In his view this translates into considerable cautiousness in dealing with other people’s children, perhaps even more caution than one would exercise with one’s own children.

[151] The reasons for taking this view should be apparent. If one is planning an outing with one’s own children, one may not need to do formal contingency planning as to the proper course of action in the event of an injury for example. Such planning is essential however for schools and teachers that step into the shoes of the parent while the children are in their care.

[152] The Seine River swim trip pre-planning checklist set out in the “Swim Safe” document for outings does address many of the needs to be addressed in contingency planning. For example, the notion that one teacher must act as the “in-charge” person for the outing and that an emergency action plan must be developed as an integral part of any activity are addressed in the document.

[153] Reference is also made to the Emergency Action Plan contained in the “Safety Guidelines for Physical Activity in Manitoba Schools”. This latter document also refers to the need to establish emergency communication procedures for off-site activities as part of any emergency planning. It details the need for those involved in the incident to complete an accident report and file it with the appropriate board official and school administrator. The only serious gap in the emergency action plan criteria is the failure to address the potential of having to deal with possible police involvement or the involvement of any other accident investigators.

[154] In the Joshua Harder case, the investigation was impaired by the fact that all of the teachers left the pool immediately after the incident with all of the students. None of the teachers prepared any written report because the principal said that the pre-printed accident report form was not appropriate and so rather than adapting it, they didn't do any report at all.

[155] The negative impact on the investigation of the delay in police speaking to witnesses has been alluded to earlier in this report. The police were not able to interview any of the adults who had been on the trip until the end of the school day, some 4 ½ hours after the incident. At that time the principal provided the names of two of the remaining ninety-four children who had been on the trip. She also cautioned the police in doing so that rumors were rampant throughout the student population during the course of the afternoon and may have influenced the children. It is again difficult to know in hindsight what impact a timely interview with potential witnesses may have had on the outcome of the investigation. It may well have created more certainty about what happened to Joshua and why. It certainly couldn't have made the outcome worse.

[156] Obviously and understandably, the teachers on the outing were concerned for the welfare of their students when they made the decision to take them back to the school after the incident with Joshua. No one would suggest that it would be reasonable to keep a group of five to ten year olds at the pool indefinitely so that the police could speak to them. However the same consideration did not apply regarding the adults present. Possibly as part of contingency planning, there could be advance designation of a teacher to do follow-up to any incident that might occur in order to ascertain whether or not an investigation would be taking place and if so, what would be required of the school in order to cooperate. Assuming, as was unfortunately not the case here, that there was a timely indication of police involvement, one teacher remaining to speak to the police and the pool authorities would likely have been very useful in relation to this incident.

[157] The fact that some of the children were upset immediately after the incident together with the fact that rumours were purportedly rife amongst the students that afternoon demonstrates that the children were well aware that something serious had happened. Yet none of the teachers indicated that

they had spoken to the children about the incident after it occurred. Certainly it might have been inappropriate for police themselves to directly question potential student witnesses that afternoon without their parents being present. That would not have precluded the classroom teachers from asking the children more generic questions about who was playing with Joshua in the pool or who was going down the slide with him or who was near the lifeguard when he jumped into the pool. Merely identifying children who placed themselves in these categories would have significantly assisted the police. It likely would have identified immediately which children might actually have witnessed something. Contacting their parents might have taken the police only weeks rather than months as it ultimately did.

[158] The detectives who conducted the investigation were, as I have noted above, members of the child abuse unit and skilled in questioning young children. In fact the principal, Ms Kosman, made a point of saying that the police had treated her, her staff, and the children compassionately and sensitively in pursuing their inquiries.

[159] These deficiencies that I have identified above in the school's dealing with the aftermath of the incident could be reduced or eliminated with proper contingency planning in place.

I therefore recommend:

12. That detailed pre-event planning and contingency planning be required in writing by the school division for all school outings and presented to the assistant superintendent or the principal for approval.

13. That such plans include but not be limited to:

- *a) the designation of an in-charge teacher;*
- *b) a requirement for a planning visit to the venue and a discussion with appropriate venue personnel;*
- *c) a requirement for a written agreement with the venue as to mutual expectations and commitments regarding inter alia, supervision;*
- *d) a requirement that immediately prior to departure a list of those*

students actually attending the outing be prepared by the teacher of each class and left at the school, with another copy provided to the in-charge teacher for the outing;

e) *particularly for outings involving students in Grades K to 6, that consideration be given to utilization of a "buddy system" where each child is assigned a buddy and on a specified signal is to find their buddy and stay with them until a head count is done. Through such a system checks can readily be done on entering and leaving a facility for example and at other appropriate points;*

f) *a particular vehicle be identified to all adults in attendance as being available for use in case of a medical emergency;*

g) *a plan for parent notification in the event of an emergency be in place (e.g. the school secretary to do notifications based on the pre-departure attendance lists);*

h) *a follow-up person being designated and prepared for any serious incident that might occur-- for such tasks as dealing with investigators, identifying witnesses, preserving the scene of any accident until investigators arrive, etc.;*

i) *if a serious incident does occur, a requirement for written reports to be prepared by all teachers in attendance at the outing and given to designated school and school board personnel;*

j) *other potential provisions such as procedures for dealing with injuries as outlined in the "Safety Guidelines for Physical Activities in Manitoba Schools".*

[160] Larry Patterson of the Lifesaving Society was asked to comment on the"Swim Safe" program. He indicated that with respect to aquatic outings to lakes and other unsupervised outdoor environments the document does not fully address some elements of the lifeguarding system suggested in it and omits some emergency and safety supervision elements.

I therefore recommend:

14. That the school division review its Swim Safe document insofar as it relates to outings other than pools with a view to ensuring that it complies with best lifeguard safety practices.

[161] Another issue raised in this inquest involves the adequacy of information provided to parents about school outings and of the parental consent form that they are asked to sign. Many parents will likely give these only perfunctory scrutiny, trusting that the school will have made adequate preparations for the outing, a trust that on occasion may be misplaced. It is essential that parents have adequate information for them to make informed decisions about whether or not they wish their children to be involved in particular activities.

[162] The new sample letter to parents contained in the Seine River Swim Safe program is a good example of an appropriate parental consent letter. It includes a reminder to parents of the inherent risks in the activity, and a requirement that parents turn their minds to the issue of whether their child who is in Grade 3 or older is a swimmer who will likely be able to pass the pool endurance test (akin to an Aquatest 6 swim badge) or a non-swimmer who should remain in shallow water. If their child is a non-swimmer, the parent is also asked to address the issue of whether or not the child should be wearing a PFD.

[163] This kind of detailed information and consent form should be a prerequisite for any kind of high-risk physical activity to be undertaken on school outings. While the Seine River "Beyond the Classroom" policy contemplates parental information trips for wilderness and canoe outings, it does not include a sample parental consent form for these kinds of outings containing the same level of detail outlined in the general swimming and aquatic programs. It would probably be a good practice to include such information for any parents who may not be able to attend an information session offered in advance of a wilderness or overnight program. It would probably also be advisable to provide on the consent and information form an emergency contact number for parents to call in relation to such trips should an emergency occur, as well as to seek from parents any additional emergency numbers for contacting them, as is done on the medical information form required for camp attendance for example.

[164] The school division may also wish to consider including on the consent form for any given outing a question as to which parents may wish to volunteer for the outing, the conditions for their doing so, and any qualifications that may be of particular assistance to the outing. That is, are they a swimming instructor themselves, do they have current first aid and CPR qualifications, are they nurses or doctors? Conditions may be such that they will have to provide their own transportation to the outing and may have to pay their own admission fee to the venue. Parents could be canvassed about these issues as well as the issue of whether they would be willing to give other parents a ride who may not have transportation.

[165] Ultimately the school, its parent council and the school division must make decisions about the extent of parental involvement in each instance or one could potentially have a situation of more parent than student participants. Nonetheless it should be the practice in most situations to canvas for potential parent volunteers.

I therefore recommend:

15. That the school division include in its parental consent forms for each school outing sufficient detailed information for parents to make an informed decision about their child's involvement in a particular activity.

16. That the school division also consider including information outlining the conditions for parent volunteers to participate, a request for information as to any special qualifications parents might have and an indication of their availability should volunteers be required.

[166] The evidence at the inquest persuasively demonstrated that swimming is one of the most popular pastimes for children. A strong argument could be made that swimming lessons, or at least the "swim to survive" skills identified by the Lifesaving Society should be part of the education of every Canadian child. Some of the schools in the Seine River division, St. Norbert for one, have already chosen to include swimming lessons as part of their physical education curriculum for primary grades. Particularly with the opening of the new Steinbach aquatic centre, Superintendent Seidler suggested that there would be more opportunities for access to local facilities at which to schedule lessons. With the June 27th incident of last year fresh in

their minds, it might be salutary for the school board to seriously examine making swimming lessons a priority physical education curriculum item for all division schools, regardless of what may be done by the Department of Education.

[167] Even if swimming lessons are not viewed by the school division as a feasible priority at this time, certainly the issue of water safety is one that can and should be accommodated in existing physical education programs, at least for the early grades.

[168] Ms Henderson-Ross, the volunteer from the Red Cross, produced for the court some of the water safety materials available from her organization. Some of these are clearly geared to very young schoolchildren with pictures of Buckles the Life Jacket, Crafty the Canoe and Ringo the Buoy Ring for colouring and other games and quizzes on water safety. If these messages are reinforced to children in early years then hopefully they will have some consciousness of the need for water safety and what is entailed. Certainly if any school is planning an aquatic outing, this would seem to be the perfect time to invite a lifeguard to speak to the children about water safety and to distribute such materials as these.

I therefore recommend:

17. That the Seine River school division give serious consideration to including swimming lessons as an essential component of physical education for primary grades but in any event that it mandate water safety as an essential component of at least the primary grades physical education and health curriculum.

RECOMMENDATIONS FOR THE CITY OF WINNIPEG:

[169] The delay in beginning the investigation into Joshua's death was in part due to the fact that ordinarily the computer dispatch system will automatically notify police of any matter likely to merit a police investigation at the same time that the ambulance is dispatched. Here the need for police involvement was not immediately apparent at the time of the

call so that the situation necessitated a subsequent manual notification to police. This was done as soon as the operator recalled the need for police involvement in an incident where a child was seriously injured or had died.

[170] However in this case, as I have noted in the narrative above, there was a second rationale that would also have triggered police involvement if that rationale had been recognized immediately. Winnipeg Police Service are required to carry out an investigation into any accident that occurs on City property. Had dispatch recognized the address in question as being a City property, the incident would have come to police attention much earlier and the investigation may also have commenced earlier. This information about whether a particular address is a City owned property could easily be programmed into the 911 computer dispatch. Both Sherry Hobson, Supervisor of the 911 Communication Centre, and Joseph Kowal, manager of the Fire and /Ambulance Communication Centre, said that it would be a welcome addition to the dispatch data. This would likely increase the speed at which any investigation is commenced in future regarding an incident on any City property, including an incident at any of the City pools.

I therefore recommend:

18. That the computer system used by 911 dispatch be programmed so that whenever the address of any property owned by the City of Winnipeg comes onto the dispatch screen it will be identified as such to the dispatch operators without them having to make further inquiries.

[171] Only one paramedic capable of administering drugs to children under ten years of age was on duty at the time of this incident and he was at the other end of the city. There are only ten paramedics with these skills throughout the entire City paramedic service. For a city the size of Winnipeg, it would seem sensible to have more paramedics capable of assisting young children in this way.

I therefore recommend:

19. That the City increase the number of paramedics who have the necessary skills and training to administer drugs to children under ten years of age. Ideally, most if not all City paramedics should have this training.

[172] Some understanding of the structure within which the Margaret Grant Pool operates is essential to understanding how and why events transpired as they did and how any changes might be implemented.

[173] Mr. Phil Hay is the Recreation Aquatic Coordinator for the City who testified as to the structure and functioning of the City Aquatics Branch. He indicated that there are twenty-four pools operated by the City, twelve of which are year round indoor pools. Six pool supervisors are employed by the City and report to Mr. Hay and/or his colleague with whom he shares responsibility. Except for the supervisor of the Pan-Am pool, each pool supervisor has responsibility for more than one indoor pool plus additional outdoor pools in the summer. The groupings for which an individual pool supervisor is responsible are in part geographic and in part historical.

[174] The Margaret Grant indoor pool is grouped with the Bonivital indoor pool and five outdoor pools and the same supervisor is responsible for this grouping.

[175] There are other permanent staff employed at City pools. These are instructor guard three (IG3) positions. An IG3 is responsible for both teaching and lifeguarding tasks and assumes the role of pool supervisor in the absence of the pool supervisor. The balance of pool lifeguarding staff employed by the City are temporary or casual employees in either the entry level IG1 position or the IG2 position that is attained with some degree of seniority with the City. These casual staff will work primarily within their own group of pools but may take shifts at other pools outside their group.

[176] The tasks of scheduling, planning and budgeting are performed at the pool supervisor level, with input from the aquatics coordinator. The hiring, training and orientation of the lifeguard staff are tasks done centrally by the Chief Swimming Instructor Randy Trager and the Lifeguard Trainer Lloyd Plueschow who are also responsible for putting together and implementing the Aquatic Emergency Response Manual that is now used to train all new lifeguarding staff. There is also a safety officer for the department to whom injuries of both staff and public are to be reported.

[177] It would appear from Mr. Hay’s evidence that new staff are given an orientation and a new employee orientation manual when they are hired and

that the pool supervisor is to give them a site specific orientation once they are assigned to a pool. Annually thereafter they are given a pool test to ensure that their competence with rescue skills is maintained. There does not seem to be any comparable testing or refreshing of their knowledge of the guidelines and rules that they are expected to enforce.

[178] Mr. Hay testified that he expected that function would be carried out at the annual in-services held for pool staff. However neither the June 18, 2002 summer in-service general session, nor the site specific Margaret Grant in-service held later that same day, contain any reference in their respective agendas to group admission requirements, although there is some brief reference in the outline to “diving rules” and “site and rope rules”. Ms Hardy testified that she expected the other guards on duty to tell any new guard hired during the year about the requirements for birthday party supervision for example. The in-service agendas covered topics like wearing your uniform, cleaning up the pool and calling in sick.

[179] These lines of authority and responsibility are somewhat bewildering to an outsider such as myself, a factor that may contribute to some of the confusion over who was supposed to do what task.

[180] The evidence at this inquest demonstrated that there were different guidelines for school group use at Bonivital pool and Margaret Grant pool even though the same person supervised both of these pools. According to Mr. Hay there were some rules applicable city-wide, some applicable within the grouping supervised by a particular pool supervisor and some particular to an individual pool. When he canvassed other pool supervisors after this incident about their group supervision requirements, he said that all had similar ratios that they indicated would be explained on the phone to prospective renters. Some did have written materials to send out. Mr. Hay said that he believed that ratios used were comparable to the instructor-student ratios for the City learn to swim program that would range from one adult to four, six, or ten children depending on ages and swimming proficiencies.

[181] Mr. Hay said that last summer he had asked one of the lifeguards at Bonivital pool to fax him their pool rules and he was given the twenty-three pages that were filed as an exhibit and styled by the pool, “pool rules for the

good, the bad and the ugly". An examination of the individual topics covered in the twenty-three pages shows that they include topics such as the clean-up of fecal and vomitus matter, school group guidelines, pool entry requirements, deep end requirements, using the deep end slide, change facilities, parents on deck, no shoes on deck, whirlpool and sauna use, basic lifeguard image, the guarding program, equipment use, the jungle rope, slides, PFD's, weight room rules and exceptions to rules.

[182] It would seem that very few, if any, of these topics would relate only to Bonivital and/or Margaret Grant pool. In my opinion there is no plausible rationale for having different rules for group admissions or different safety rules for each City of Winnipeg pool. Such a practice makes it more difficult for individual and group pool users to know the rules and even for the lifeguard staff who may work casual shifts from time to time at any of the pools around the city. Familiarity with use guidelines and safety rules would increase over time with consistent policies and in that way standardization would assist with both public and staff education. For similar reasons, I would suggest that the points to be covered by each lifeguard in making a safety speech at the outset of a group swim should be consistent across the system to the greatest extent possible.

[183] If there are guidelines that are so specific as to be applicable only to a particular pool, they should be identified as such on the top of the document and dated. They should also be posted at the entrance of the pool building, in the staff room, in the change rooms, and in the pool office adjacent to the pool deck.

I therefore recommend:

20. That both the guidelines for individual admission and for group admission to City pools as well as the rules for safe operation of City pools be reviewed and standardized for all City pools throughout Winnipeg.

21. That since the annual pool in-services seem to be the logical place to do so, that all such guidelines for group admission and supervision and safety rules for pool operation be reviewed annually with the lifeguard staff at the in-services both to reinforce their existence and to consider whether any changes are warranted.

22. That any guidelines applicable to an individual pool be identified as such on the document, dated and posted in several locations throughout their respective pool buildings, locations that are standard from pool to pool such as the entrance to the pool building, the change rooms, the staff room and the pool office used by the lifeguards.

[184] Even though Mr. Hay was the supervisor of Carol Hardy he was apparently unsuccessful in locating and providing to the inquest copies of the rules in force at Margaret Grant pool in June of 2002 and he could not say if such rules could have been produced to a member of the public who may have inquired. Obviously it is essential that all safety rules for City pools and guidelines for pool admission must also be easily accessible to all pool staff as well as to the public, rather than buried in a manual in an inaccessible location such as the pool supervisor's office.

I therefore recommend:

23. That the system-wide pool safety rules and guidelines for admission be displayed on the recreation branch website and in a prominent place near the admission desk of each pool. A paper version should be available to the public on request and signs listing the rules should be in a standard format and posted in standard locations in each pool.

24. That these system- wide pool safety rules and guidelines for admission also be printed on a card or in a small booklet to be provided to all members of the lifeguard staff individually and replaced, with the date noted, whenever a new pool rule or admission guideline comes into effect.

25. That the points to be covered by lifeguards giving a safety speech at the beginning of a group swim also be noted in point form on a card provided to each lifeguard for easy reference.

[185] The terms "group admission guidelines" and "safety rules" were chosen advisedly by me. While I am not wedded to these terms in this context, I believe that it is essential that there be consistent use of terms such as "policies", "guidelines", "criteria" and "rules" throughout the aquatics branch. This is also a factor that can only enhance public compliance and

enforceability of the rules by staff in clarifying the degree of flexibility, if any, expected in their enforcement.

[186] There are undoubtedly matters on which it makes sense to give staff some flexibility. One that comes immediately to mind is the use of pool toys. Even if their use is permitted, it makes good sense for the lifeguard staff to be able to remove them from individual users or even from the pool, if they are being abused or if they are creating a dangerous situation.

[187] On the other hand, the requirements that there be no diving in the shallow end of a pool and that admission to the deep end is dependent on the individual's ability to swim four widths of the pool unassisted are presumably not requirements that the City wishes its staff to use discretion in enforcing. Again the prohibition against bathers running on the deck would seem to be a safety rule that must be enforced although there may be some discretion left with the staff as to penalty, such that the first infraction does not require expulsion from the pool but recurring infractions may.

[188] This lack of clarity in existing documents is exemplified in a page in the Aquatic Emergency Response Manual styled "Rule Enforcement" which lists three types of rules or policies to enforce: safety rules to protect patrons, policies to ensure enjoyment and fair treatment, and rules designed to protect the physical facility. The message to staff regarding their enforcement however sets out "degrees of rule enforcement" and exhorts staff to remember that patrons who do not enjoy themselves as a result of strict rule enforcement may not return and that may affect revenues and jobs. While there is some room for flexibility regarding certain infractions and penalties as I have noted above, this is a confusing message to give staff in my view and does not recognize a hierarchy of standards in which safety considerations must come first.

I therefore recommend:

26. That the City of Winnipeg provide the aquatics branch with whatever expertise is necessary to review any and all staff manuals and directives to the staff in the aquatics branch as well as all communications to the public. The purpose of the review is to systematize a coherent hierarchy and terminology of terms relating to the regulation and use of the pool

throughout the branch - be they guidelines, policies, rules, regulations, etc.- and to their enforcement.

[189] What was not clear to me from Mr. Hay's recital of the organization of the various roles and responsibilities of individuals in the aquatics branch was where overall responsibility for safety compliance and for safety audits lay and whether or not there was anyone in the system who was engaged in risk management for the aquatic facilities. Mr. Hay's three page job description does delineate one of his numerous responsibilities to be "develops and enforces all by-laws and regulations regarding the safety and health standards of all facilities and programs as related to aquatics area" This seems on its face to be limited merely to legislative responsibilities in regard to safety. Mr. Hay's evidence did not suggest that development or even identification of the pool rules was something that he had perceived to be part of his job in the past. He is the only City employee whose job description has been provided so perhaps these tasks are assigned to someone who has not been identified to me as having that area of responsibility.

[190] Joshua Harder's death was only the third death at a City pool in the past thirty years according to Mr. Hay. Drowning deaths at supervised aquatic facilities are relatively rare. According to Larry Patterson of the Lifesaving Society less than one per cent of the drowning deaths across Canada each year occur at supervised facilities.

[191] The occurrence of a death at such a facility seems then to me to be an appropriate impetus for the City to have a safety audit done of the aquatics branch by an outside individual or agency with specific expertise in the area of aquatic management safety. Issues that may not have been raised or addressed at this inquest would hopefully be brought to light through such an audit. In looking at the website of the Alberta Lifesaving Society that Mr. Patterson represents, I note for example that they might have the expertise either to do such an audit themselves or to assist the City in locating an appropriate resource to do so.

I therefore recommend:

27. That the City consider engaging an outside expert with expertise in

the safe management of public aquatic facilities to perform a safety audit to assist the City in their implementation and enforcement of system-wide safety standards.

[192] Mr. Patterson was asked to comment on the Aquatic Emergency Response manual that was prepared recently to train City staff. He noted one area of concern in particular regarding possible spinal injuries and the appropriate method of dealing with an unconscious victim who is breathing as compared to one who is not. He suggested that a decision tree type of representation of the options available to the rescuer might clear up some of the ambiguity he perceived and might make the stages of the differing treatment options clearer.

I therefore recommend:

28. That the Aquatic Emergency Response Manual, and in particular those sections dealing with treatment of possible spinal injury victims be reviewed with a view to clarifying the treatment options and making them more readily understandable.

[193] The City has implemented new public and group admission guidelines that have been promulgated throughout the pool system. This is a welcome and necessary step that the City has already taken. However, while the content of these guidelines is excellent, their accessibility is not. The language and presentation is somewhat intimidating and does not seem likely to be readily understood, especially for people with limited literacy. The manner in which a document like the public admission entry requirement guidelines is presently organized means that a number of the requirements are repeated for each category, making the document longer than necessary.

[194] For example, there is a statement in these guidelines that minimum height requirements are site specific. A photo was tendered in evidence showing the signage at Margaret Grant at the time of the incident which stated that children under 48" must be accompanied by an adult. Mr. Hay testified that the height requirements then and now related to the necessity for the water level at the deepest part of the shallow end to come no higher than the chest or shoulder level of the individual in question. He said that

different facilities had previously used the chest measurement while others had used shoulder height. Now the expectation across the City pools was that the measurement was intended to consistently refer to the level at which the water would reach the chest of the person being measured.

[195] If this is correct, then the true height requirement for Margaret Grant pool is such that it is unlikely to be met except by adults and some adolescents. A more accurate wording of the requirement then and now would seem to be: “To comply with the height requirement of this pool the person’s chest level must be at approximately 48 inches from the floor so that their shoulders and head will be out of the water.” That is not the same meaning conveyed by a statement that "children under 48 inches" must be accompanied by an adult.

[196] The requirement in the new guidelines that the adult supervisor for certain children be in the water and within arms’ reach of the child is relatively straightforward and ties in with the Lifesaving Society's message to parents: "If you are not within arm's reach, you've gone too far".

[197] However what of the requirement that children seven and older who can swim but don’t meet the height requirement be "accompanied by" an adult? Does an adult “accompanying” a child have to remain on the pool deck at all times while the child is swimming or can they go for coffee? While I do not profess to have any special expertise in plain language drafting, I am confident that someone with such skills could simplify and improve the understandability of the information directed to the public by the City.

I therefore recommend:

29. That the City of Winnipeg review its public admissibility guidelines with the assistance of whatever expertise is necessary to make them easier for the general public to understand.

[198] Whatever the standards are called, the issue of dealing with group rentals of City pools is one that should be given further consideration by the City. Clearly there are some City facilities that may be more appropriate for certain users. Mr. Hay mentioned that Pan-Am pool has a kiddy pool for

example and Bonivital also has a separate shallower tank. Due to its depth profile and the rapidity of the angle at which it slopes toward the deep end, the Margaret Grant pool was not the ideal facility for the St. Adolphe group which likely would have been better served by a pool with a walk-in beach-like entry if one were available. However the fact that Winnipeg does not have a facility with the newest designs for pools does not mean that Winnipeg children cannot make use even of a pool like Margaret Grant so long as proper safeguards are put in place to adequately manage risks for the group using it. Prospective renters should be given adequate information on the City website, and through other materials available to the public such as the Leisure guide, so that they can make appropriate choices. Competition amongst various City facilities, if any exists, needs to be set aside to ensure that groups have all of the information that they need to make the best choices for their members.

[199] The City has made a policy decision regarding height requirements for public swims. Although the desire to standardize the conditions for public swims is understandable, there does not seem to have been any contemplation of adjustments and modifications that might be made in a particular situation to make a pool safer for a given rental group. At Margaret Grant pool, the buoy rope is apparently always placed at the four foot mark even though there is the capacity to place the rope at any depth marker, be it three feet, four feet, five feet, etc. Simply placing the rope at the three-foot mark would have dramatically increased the safety of that pool for the St. Adolphe Group as no part of the shallow end would have been over the head of a child forty inches tall like Joshua Harder. In the words of Mr. Patterson, the placing of the buoy rope creates a visual and physical boundary that can enhance safety in an appropriate situation. In addition to the choice of facility then, a group might also wish to be made aware of their options for differentiating the shallow end from the deep end of the pool. Another factor that may be relevant to prospective renters is the design of the pool relative to observers who will not be in the water. For groups where at least some of the supervision may be done from the deck, a facility that has open stands for observers along the length of the pool may provide an opportunity for additional observers to supplement the required numbers. In that respect, it may be preferable to a facility like Margaret Grant pool where

the glassed in observation room is half the width of the pool and at the shallow end.

[200] One of the factors that was noted by both Mr. Patterson and Mr. Hay is the impact that familiarity with a pool may have for groups using it. People who swim regularly at a facility will be more likely to be familiar with its rules and admission requirements. Mr. Hay for example said that generally groups that rented the pools brought supervisors with them. Ironically the result of the fact that most pool user groups knew the "rules" seemed to be the development of a certain amount of complacency with regard to the need for the facility to articulate its requirements to new users. It might be advisable then to include in the inquiries made of prospective users whether or not they have had previous experience with renting a pool or that pool in particular. The need to reinforce the rules to such renters will then be evident.

[201] Another issue that I suggest be raised with groups is the use of pool toys. While as I have noted above, there is no definitive evidence that the floating mats used in the pools were a contributory factor in Joshua Harder's death, there is no question that they make supervision of a pool area more challenging. Mats of the size used at Margaret Grant pool can and do attract groups of children to play on them. The 62" length of the mats means that they are virtually one and a half times the length of a child of Joshua's age. Particularly when used in combination with other pool toys like slides, they may impede visibility. Common sense dictates that they are likely to necessitate increased supervision.

[202] However the evidence is clear that such mats are used in pools across the country and according to Mr. Patterson, in some circumstances are beneficial in increasing cooperative play. He related that mats came in all shapes and sizes. I am reluctant to recommend an absolute prohibition on the use of mats. That being the case, the aquatics branch will need to give careful thought to developing guidelines for which mats, if any, should be used in the pool. Would smaller mats make it easier to manage safety issues for example? Criteria for when and how they might be used should be developed and enforced by the lifeguard staff, perhaps with the assistance of some appropriate outside expertise. Considerations for use might include

whether there are times that there are too many people in the pool for them to be used safely at all, whether there should be an absolute limit on how many mats can be used in a pool at one time, whether the behaviour of certain children in playing with them may be too boisterous to allow for their continuing to be used, and whether their use should be permitted in conjunction with the other toys that are being used at the time, like jungle ropes, slides, etc.

I therefore recommend:

30. That the City determine and make known to the public through its website, the Leisure Guide, and any other appropriate vehicle such information about its pools as may be necessary to assist renters in determining which may be the most appropriate venues for certain rental groups such as those that include young children.

31. That for all group rentals involving children under twelve, the various options for placement of the buoy rope dividing the shallow end from the deep end should be discussed with prospective renters.

32. That part of any discussion with group renters, either at the time of the rental or the time of the event, or both, should include a discussion of which pool equipment and toys will be used and how that may impact on supervision and lifeguarding requirements. It must also be made clear that the lifeguard staff may at any point remove any pool equipment that they perceive to be presenting a hazard.

33. That one of the City wide safety rules should provide that the use of any mats, pool toys and equipment in the pool is at all times at the absolute discretion of the lifeguard staff, any of whom may remove any equipment that they perceive to be presenting a hazard at a given time.

34. That the aquatics branch, in consultation with the lifeguard staff and any appropriate outside expertise develop system-wide guidelines on the use of pool toys and equipment, covering such issues as under what circumstances, if any, mats can be used safely, what size mats may be used, what, if any, additional equipment may be used while mats are in use and under what conditions, such as crowding, or misbehaviour, they should be

removed from a pool

[203] As noted above, the lifeguard-bather ratio is a variable figure that in Manitoba has been set at one lifeguard to fifty bathers. I have recommended that the province change the regulations. However I do not recommend that the City wait to see if such regulations are passed before taking action on its own. I believe that the City must make some changes in its own policies for rentals to user groups composed primarily of children. This does not apply only to the school groups that are primarily seasonal pool renters, the seasons being the last week of school before any school break such as Christmas, spring break and most significantly summer break. The evidence showed that birthday parties are the major group rentals for City pools and occur year round. The tragedy with Joshua Harder involved a school group this time but the next incident could just as easily involve a birthday party rental if proper safeguards are not in place.

[204] One of the acronyms used in lifeguarding is RID, which refers to factors that have contributed to drownings in settings supervised by lifeguards. The first letter refers to recognition and means a lifeguard's failure to properly interpret signs of distress in a drowning victim while the second relates to intrusion of non-life guard activities on a lifeguard's primary task of preventative lifeguarding. The final letter represents distraction of a lifeguard from surveillance duties. Some degree of intrusion and distraction are inevitable in enforcing pool rules about running on the pool deck for example. However, the kind of intrusion that occurred in this case with the lifeguard being distracted by the unskilled task of putting on life jackets is another factor that the City must keep in mind in assessing appropriate lifeguard ratios in a variety of settings. The more ancillary duties expected of the lifeguard, the less likely it will be that the fifty bather to one lifeguard ratio will be appropriate. Many prospective adult supervisors may also be unskilled at the task and may need to be directed by the lifeguards as to where they should station themselves in the pool or on the pool deck and how they can be of most assistance by performing such tasks as putting on lifejackets.

I therefore recommend:

35. That the City develop and implement, at least for school group

rentals, birthday party rentals, and rentals to any other groups of children, variable lifeguard-bather ratios dependent on the profile of the group involved including ages, swimming abilities, etc but in any event no less than one lifeguard for every twenty-five children exclusive of any adult supervisors that may be in attendance.

36. That all rental agreements for aquatic facilities be in writing and contain pertinent information about the composition of the group including the total numbers and in the case of all children, the ages of those who will be using the facility, the swimming ability as measured by an objective criteria such as the appropriate Red Cross Aquatest level and the likely number of PFD's required as well as the number of adult supervisors that will be provided by the group and their swimming ability.

37. That information to rental groups contain a stipulation that prior to any member of the group entering the water, the lifeguard staff will have a brief discussion with the person or persons in-charge of the group, reviewing pool expectations regarding supervision requirements and the tasks to be carried out by supervisors, together with relevant safety rules, and guidelines for equipment use. The City should also convey this expectation for such a discussion to take place to its lifeguards as part of their training.

[205] I have indicated earlier in this report the importance of public education about water safety. Clearly an institution like the City has an interest in educating the public and in particular that segment of the public that uses its facilities. Displaying safety posters in its facilities and materials on its website from organizations like the Red Cross and the Lifesaving Society is one way in which the City can play a role in educating the public. They may also wish to consider distributing the pamphlets put out by these organizations at City pools or at least providing information about how the public can obtain them. If the City is not already providing speakers from their pool staff as a resource to work with schools on water safety campaigns, they should consider doing so.

I therefore recommend:

38. That the City review and consider the role it can play in public education on water safety in conjunction with other agencies engaged in the

same task.

39. That as part of its initiative the City consider developing a pamphlet, perhaps in conjunction with the Province, educating the public on the role of City lifeguards and the fact that they are a merely a trained and skilled supplement to, rather than a substitution for, adult supervision of children in water.

[206] I will not repeat the reasons I have already set out for my recommendation to the Province that lifeguard qualifications under the pool regulations be enhanced. However it is clear that the sophistication and complexity of the lifeguarding tasks carried out by City staff means that such staff must have the lifeguarding skills of prevention and teamwork in place as soon as they enter the position and that possessing only lifesaving or rescue skills is no longer adequate for the City system.

[207] The additional training by the City in the form of the Aquatic Emergency Response program is commendable but should not replace the requirement for lifeguard certification at the entry level.

I therefore recommend:

40. That in future the City of Winnipeg require that all lifeguards hired by them for City pools have the National Lifesaving Society National Lifeguard Service Award as a minimum qualification.

[208] The evidence indicated that even though there was a checklist for pool safety equipment completed at Margaret Grant pool each day, these documents were not retained and consequently were not available to be produced for the inquest. There is little point in completing a written checklist if such documentation is not retained for at least a year.

I therefore recommend:

41. That written checklists confirming the presence of all necessary pool safety equipment be completed daily by the lifeguard who opens each City pool.

42. That all documentation relating to pool safety compliance such as the daily checklists for pool safety equipment, any documents relating to the purchase or inventory of safety equipment for a particular pool and the lifeguard staffing of pools be retained by the City for at least one year.

[209] There is reference in the Aquatics Emergency Response Manual to the reporting and documentation requirements for staff in the event of a serious injury and in fact the three lifeguards involved in this incident all prepared written reports as required, shortly after the incident occurred. The events that transpired on June 27th, 2002 demonstrated a need for some additions to this policy.

I therefore recommend:

43. That the response and documentation requirements set out in the Aquatic Emergency Response Manual be amended to include a reminder that the Winnipeg City Police are to be notified in the event of any serious injury that occurs on City property.

44. That the documentation and notification requirements in the Aquatic Emergency Response manual be amended to include a provision that the scene of any serious accident or death is to be preserved as it was at the time the incident occurred until released by police. No members of the public or the media should be admitted to the pool area, no equipment should be put away and no clean up of the pool or the pool deck should be carried out by maintenance until such time as police have examined the scene.

[210] Sean Robert was the lifeguard on duty on June 27th, 2002 before the arrival of the St. Adolphe group. He said that Susan Lee, the IG3, was there when he arrived and was acting as the in-charge person or pool supervisor in the absence of Carol Hardy. She left some time before the Bonnycastle group finished but Mr. Robert did not know exactly when that was.

[211] Then Christa Buccini and Matthew Rice started their shifts. Mr. Robert presumably knew that he was not in charge of the pool, and Ms Buccini knew that she was, because of the kind of shift that she had chosen. Mr. Hay said that a lifeguard choosing a particular shift would know that it is an in-charge shift for which he or she will be receiving a pay premium. However Matthew Rice did not know which of the other two lifeguards was the in-charge person at the time of the incident; he told police that he thought it was Mr. Robert. This demonstrates that the other staff at the pool building will not necessarily be aware of who is acting as the person in charge of the pool unless they are so advised. Even though it did not likely impact on events here, it makes good sense for staff to know who they are to deal with.

[212] Mr. Patterson also testified that an important part of risk management was making clear to persons in charge of a pool, even on an acting basis, what their

duties were and ensuring that he or she had the necessary training or experience to carry out the tasks involved. The evidence indicated that the only requirement for a member of the lifeguard staff to be able to take an in-charge shift was that he or she have their examiner's credentials for Bronze Cross, a qualification which bears no relevance to the task.

I therefore recommend:

45. That whenever the pool supervisor or person acting in that capacity leaves the facility they identify the person to whom they are transferring responsibility for the pool, indicate that they are doing so and inform other pool staff present of who the in-charge person will be. A similar procedure should be followed each time the in-charge status is transferred.

46. That the responsibilities entailed in assuming an in-charge shift be delineated in writing and any appropriate training be provided to those eligible to opt for an in-charge shift.

[213] The City's new admission guidelines contain a statement about the ability of a pool supervisor to limit access to the pool or any part of it should a safety concern arise. That responsibility is in itself is one reason why it is essential for pool staff to know who the pool supervisor or acting pool supervisor is at any given time.

[214] I have recommended that the Province amend the pool regulations under the **Public Health Act** to expressly delineate the responsibility of a lifeguard to act in a situation of a perceived safety threat. Even if the Province does not amend the legislation in the manner I have recommended, I urge the City to make such a statement as part of its City wide safety rules.

I therefore recommend:

47. That the City of Winnipeg put in place a safety rule to the effect that if any member of the lifeguard staff determines that a safety hazard exists in the pool or on the deck, that lifeguard shall immediately advise the pool supervisor or the acting pool supervisor of the existence of the safety hazard and if that supervisor is not immediately available to do so, shall direct all persons to leave the pool or any part thereof until such time as the hazard has been addressed.

CONCLUSION:

[215] The death of Joshua Harder was an incomprehensible tragedy to his parents and family. Their loss is immeasurable.

[216] It should also be acknowledged that many of the witnesses at this inquest were personally touched by either direct involvement in the events that occurred on June 27, 2002 or the subsequent investigation. It was clear that the death of this five year old boy affected them profoundly. The death of one child exacts a high price indeed. It is a cost that requires that consideration be given to any changes that might reduce the likelihood of another such death.

DATED at the City of Winnipeg in the Province of Manitoba this 17th day of July, 2003.

"Original signed by
Judge Susan Devine"

SCHEDULE "A"

Exhibit List

Exhibit #1	Binder containing the following documents: Section A: Medical Examiner Records of Joshua Harder CME File 1476/02; Section B: WPS documents concerning Joshua Harder Incident Incident # 200124899; Section C: Documents from Education Administrative Services, Education & Youth, Department of Education; Section D: Documents from the City of Winnipeg re Margaret Grant Pool; Section E: Documents from the Seine River School Division; Section F: Documents from four other school divisions.
Exhibit #2	Curriculum Vitae of Dr. Charles Littman, Pathologist at the Health Sciences Center.
Exhibit #3	Booklet of photographs of Margaret Grant Pool taken by Constable V. Laveille, Identification Unit, WPS.
Exhibit #4	A copy of the Seine River School Division's policy entitled *JFG Interrogations & Searches*.
Exhibit #5	Three photographs of a blue floating mat taken from the Margaret Grant Pool.
Exhibit #6	A copy of the Personal Injury Accident Report: The City of Winnipeg, signed by Philip Hay, June 29, 2002.
Exhibit #7	Curriculum Vitae of Mr. Philip M. Hay, Recreation Aquatic Coordinator for the City of Winnipeg.
Exhibit #8	Curriculum Vitae of Lawrence Thomas Patterson, Program Manager, Lifesaving Society, Alberta and Northwest Territories.
Exhibit # 9	A copy of the video *The Reasons People Drown: Safety Meeting Leader's Guide* produced by L.S.A. Productions Inc.-features Frank Pia.

Exhibit #10	Copy of a pamphlet entitled *Within Arms' Reach: Basic Supervision for Parents and Childcare Providers in Aquatic Settings* produced by the Lifesaving Society.
Exhibit #11	Package of documents pertaining to Birthday Parties held at Margaret Grant pool.
Exhibit #12	Copy of *Swim at School* module distributed by Canadian Red Cross Society.
Exhibit #13	*Family Water Safety Activities Worksheet* produced by the Canadian Red Cross Society, Water Safety services.
Exhibit #14	Water Watch Safety Tips produced by the Canadian Red Cross Society.
Exhibit #15	*Risk Management at a Glance for Manitoba Schools,* a publication of the Manitoba Association of School Trustees (MAST).