Release Date: August 1, 2006

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **KEYANNA MARIE SNOWDON, deceased**
(DOD: May 12, 2004)

Report on Inquest and Recommendations of
The Honourable Judge Heather Pullan
Issued this 27th day of July 2006

APPEARANCES:

Mr. A. Barg, Counsel for the Inquest
Mr. I. Frost, Counsel for Department of Family Services and Housing, Child and Family Services Directorate
Mr. M. Thomson, Counsel for Winnipeg, Rural & Northern Child & Family Services (Winnipeg Regional Office)
Mr. M. Paluk, Counsel for Janine Snowdon, the Birth Mother

Release Date: August 1, 2006

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST
RESPECTING THE DEATH OF: KEYANNA MARIE SNOWDON

Having held an inquest respecting the said death on June 20, 2005; June 21, 2005; June 22, 2005; June 23, 2005; June 24, 2005; January 16, 2006; January 17, 2006; January 18, 2006; January 19, 2006; January 20, 2006; January 23, 2006; January 24, 2006; January 26, 2006; and January 27, 2006, at the City of Winnipeg, in Manitoba, I report as follows :

The name of the deceased is: KEYANNA MARIE SNOWDON

In accordance with s.33(1)(a) of **The Fatality Inquiries Act**, the following is my report concerning when, where, and by what means the deceased person died, the cause of death, the name of the deceased person, if known, and the material circumstances of the death:

On May 12, 2004, shortly before 9 p.m., Keyanna Marie Snowdon drowned in the hot tub in her foster home. Keyanna Snowdon, 22 months of age, had been cared for in this foster home since birth. On the evening in question, three other children in the home had been using the hot tub. The door to the hot tub room was not closed. There was a lapse in the supervision of Keyanna Snowdon. Keyanna who was not yet walking, got into the hot tub room. She was later found by the foster mother in the tub, unconscious.

The cause of death was drowning.

I hereby make the following recommendations as set out in the attached schedule. Attached hereto and forming part of my report is a schedule of all exhibits required to be filed by me.

DATED at the City of Winnipeg, this 27th day of July 2006.

"ORIGINAL SIGNED BY"
Heather R. Pullan, Provincial Judge

Copies to: Chief Medical Examiner (2)
Chief Judge Raymond Wyant
The Honourable Gord Macintosh
Mr. Ronald Perozzo, Q.C.
Mr. Don Slough

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PART A: THE EVIDENCE

I. FACTUAL CIRCUMSTANCES LEADING TO KEYANNA SNOWDON'S DEATH

a) Evidence of Jeff Derraugh

[1] Mr. Derraugh has been a City of Winnipeg firefighter for 15 ½ years. He is trained both as a firefighter and a first responder. On May 12, 2004, he was dispatched shortly before 9 p.m. The brief report related to a two year old child, drowning and not breathing. Because the person to be dealt with was a child, he started preparing the child first responder gear. That equipment is not often used, and Mr. Derraugh wanted to ensure that he had everything in order. When he got off the truck, the first thing that struck him was the foster mother screaming. In this case, the foster mother's screams signaled to Mr. Derraugh that this was very serious. They could hear the screaming from outside the home.

[2] There were several children in the residence. The foster mother was distraught. Mr. Derraugh followed his colleague, Mr. Marco Cecchetto in. When Mr. Derraugh entered the room, the foster father had just handed the baby to Mr. Cecchetto. The child was wet. They assessed the child. The child was not breathing. Mr. Cecchetto started performing CPR. The captain, Mr. Johan Van Der Horst held the baby's head. Mr. Derraugh prepared the oxygen and the suction equipment.

[3] All of the liquid and stomach contents were coming up through the mouth. Those had to be gotten out of the way, because the airway was the first priority. The baby was lifeless and wet. She was wearing either a diaper or a pull-up. She had poor color. Mr. Derraugh observed no vital signs. Marco Cecchetto asked for a stethoscope because he couldn't get a pulse. Normally, Mr. Derraugh said he would have inserted an airway. He was unable to do that here because of the volume coming up from the stomach and lungs.

[4] A paramedic unit arrived. The paramedics hooked up the EKG monitor and the reading indicated no electrical activity coming from the heart.

[5] The paramedics decided it would be best to get the child out to the ambulance as quickly as possible. Once the airway was established, Mr. Derraugh used the bag valve mask with oxygen to breathe the child on the stretcher all the way out of the house into the ambulance. At that point, the medical supervisor, their level 3, showed up and got into the back of the ambulance.

[6] The firefighters were released. Mr. Cecchetto and Mr. Derraugh went back into the house together to gather their gear and see how the family was doing. In most situations the foster mother would travel with the ambulance. In this situation, the foster mother was not capable.

[7] This call was traumatic for the firefighters. As a result, they held a debriefing. Mr. Derraugh testified that he had been so focused on the child that he didn't see the hot tub. He didn't see the room the hot tub was in. Mr. Derraugh remembered the screaming when they went in. As soon as they started working on the child, he didn't hear anything other than the paramedics and the firefighters' conversations.

[8] Mr. Derraugh's unit took the call at about 8:50 p.m. It took approximately 3½ minutes to reach the residence. Mr. Derraugh's estimate was that they would have been at the patient by about 8:55 p.m. Four firefighters attended, and each had specific duties. The firefighters were there for about 2 to 3 minutes before the two teams of paramedics arrived.

[9] When firefighters returned to the house, they realized they had another patient in the foster mother. Firefighters were of the view that neither foster parent was in any condition to either go with the child in the ambulance, or to drive. Because of the foster mother's condition, high blood pressure and hyperventilation, her daughter was called. Her daughter was unable to calm her to the point where firefighters felt it safe for her to be driven to the hospital. Firefighters decided to call an ambulance for her, the second paramedic unit. Mr. Derraugh accompanied the foster mother to the hospital. The second paramedic unit arrived within 20 minutes of the first. It was then approximately 9:30 p.m. When they arrived at the hospital with the foster mother, the chaplain was waiting in the hallway.

[10] Mr. Derraugh testified that all the firefighters thought the child had a chance of survival even though there was no electronic heart movement. There are all sorts of circumstances, where people have been brought back from that, so firefighters thought there was still a chance.

[11] Mr. Derraugh asked the foster mother how long the baby had been out of her sight. She said she was working at the table on a scrap book. The child was at her feet. Mr. Derraugh's understanding was that the other three children had been in the hot tub. They had gotten out of the hot tub while the foster mother was working on the scrap book. Accidentally the child got away from her, unknown to her. When she realized that the child was gone, she did a quick search and found the child. Mr. Derraugh said that his understanding all flowed from what the foster

mother told him. She had a bad feeling, and one of the first places she checked was the hot tub. Mr. Derraugh said that the foster mother had told him that the child had been gone for 5 minutes. When counsel presented his written narrative indicating she had told him 10 minutes, he indicated that it probably had been 10 minutes the foster mother had said.

[12] Mr. Derraugh did not recall whether the foster mother's clothing was wet or dry. He did not deal with the foster father, so he could not testify as to the condition of the foster father's clothing.

b) Evidence of Marco Cecchetto

[13] On May 12, 2004, Mr. Cecchetto was the driver of the fire truck dispatched to Bachelor Avenue just short of 9 p.m. He remembered going to the door, and the foster mother screaming. When asked where the child was, she pointed and screamed. Down the hall, Mr. Cecchetto saw the foster father working on the infant. He did not talk to the foster mother. He was the first one in the front door. Mr. Cecchetto did not see a hot tub at all.

[14] The first thing he noticed was the distension in her stomach and the straining in her eyeballs. There was water coming out of her mouth and Alphagetti coming out of her nose. There was no breathing. There was no reaction to pain stimulus. There was no pulse. As the firefighters performed CPR, she aspirated through her mouth and nose. Mr. Cecchetto was so focused on the infant that he didn't hear anything going on around him. The captain said he was there at her head and helping, but Mr. Cecchetto didn't remember that at all.

[15] When the paramedics came, they took over. Once she was in the ambulance, the firefighters passed her off to a higher level of trained medical personnel. They then took to consoling the family. There were three other children that Mr. Cecchetto didn't even know were there. The foster mother was very bad. She was everywhere, screaming, yelling and crying. The firefighters were more worried about the foster father, because he was very quiet. He was checked, and seemed fine.

[16] Mr. Cecchetto spent most of his time with the children. Mr. Derraugh had spent most of his time with the foster mother. He asked the children to perform little tasks like get water, to get their minds off the situation. Mr. Cecchetto had no recollection of whether the foster father's clothes were wet. He did not recall whether the foster mother's clothes were wet.

c) Evidence of Johan Hendrik Cornelius Van Der Horst

[17] Mr. Van Der Horst has been a firefighter with the City of Winnipeg for 32 years. Prior to the incident May 12, 2004, he had some personal knowledge of Larry Payne. Larry Payne works at the lumber yard Mr. Van Der Horst deals with. He has known him for 20 to 25 years. He does not know him well.

[18] Mr. Van Der Horst was the captain, the person in charge. Mr. Van Der Horst followed Messrs. Cecchetto and Derraugh. There was very loud screaming and yelling. They were trying to find out where the baby was, and were shown around the back of the living room. Mr. Cecchetto and Mr. Derraugh started to work on the infant. Mr. Van Der Horst moved some furniture for them. The child was bringing up Alphagetti continually.

[19] Once everything was in order, Mr. Van Der Horst got out of the way, because he is a large person and this was a very small child. He describes his involvement in treatment as a third set of hands.

[20] There were three children, approximately 5, 3 and 6 or 7 years of age. Lee Payne was yelling and screaming loudly, and the foster father was distraught.

[21] Mr. Van Der Horst recalled the French doors into the hot tub room. The door on the right was closed completely, and the door on the left was ajar a couple of inches. The doors were not open. Mr. Van Der Horst confirmed that he was the individual who called the ambulance for the foster mother.

[22] Mr. Van Der Horst decided that it would be a good thing to have a debriefing in connection with this case. It was the death of a young child, affecting everyone.

[23] Mr. Van Der Horst did not remember if the foster mother and foster father's clothes were wet or dry.

d) Evidence of Randolph Colin Pearson

[24] Mr. Pearson has been a City of Winnipeg firefighter for 17 years. On May 12, 2004, he was dispatched to an address on Bachelor Street with three others. His role was to document the medical statistics the first responders would provide.

[25] Before entering the residence, he could hear a woman's voice. He was trailing the two responders, as he normally would. On the trip through the house, he noticed water on the floor. The water seemed to trail from the kitchen area or

nook through the living area around some kind of table in the middle of the living area, towards the hot tub. It was almost like a path of water on the hardwood floor.

[26] There was an infant on the floor being treated by Mr. Cecchetto and Mr. Derraugh providing CPR. Mr. Van Der Horst, the captain, was in the room.

[27] Mr. Pearson was getting no details, and it was very difficult to take notes. The woman couldn't answer any of his questions so he couldn't get a history on the infant. He tried to get information from the husband, but he, too, seemed to be in some state of shock.

[28] He eventually got some information with respect to the baby. The police arrived after the paramedics. French doors led into the family hot tub. It was Mr. Pearson's recollection that one of the French doors was shut and the other furthest from him was ajar.

e) Evidence of Grant Peter Hemmerling

[29] Mr. Hemmerling has been employed at the City of Winnipeg for 30 years. He has been working as a supervisor for three years.

[30] The medical supervisor is the senior paramedic, possessing a few more advanced skills than the paramedics working in the ambulance. The medical supervisor attends low volume, high risk calls. A minimum of two medical supervisors are on duty in a given day in the city, sometimes three. Medical supervisors work 12 hour shifts, 7 to 7. He has a level 3 training, equivalent to an advanced care paramedic. Mr. Hemmerling is qualified to provide advanced life support for adults and children. Dealing with children specifically, he is able to provide advanced airway management, drug therapy, and cardiac care.

[31] On May 12, 2004, he was dispatched to a residence on Bachelor Street. He had received information that a child had suffered cardiac arrest due to drowning. When he arrived, the patient had been moved into the ambulance and paramedics McKendry and MacKay were tending to the patient. Mr. Hemmerling observed the patient was in cardiac arrest, and being actively resuscitated. He confirmed the cardiac arrest, and proceeded to provide advance airway management. He was in the ambulance with the patient. He placed the advanced airway into the patient and proceeded to hospital, departing the scene at 9:09 p.m. The advanced airway was an endotracheal tube, a plastic tube placed into the trachea with the aid of a lit scope.

[32] According to Mr. Hemmerling, the endotracheal tube is the gold standard of airway management. It provides direct ventilation into the lungs, reducing stomach regurgitation. There was some suctioning done and some vomit removed, but Mr. Hemmerling had no difficulty placing the tube. It took about 20 seconds from arrival at the scene to place the tube.

[33] The procedure has the benefit of providing an airway, as well as a route for administering medication. When they arrived at Grace Hospital Emergency, the physician took over care. Mr. Hemmerling's treatment of this infant was for approximately five minutes.

[34] He experiences about two or three out of hospital pediatric cardiac arrests per year.

[35] There was another medical supervisor, Mr. Gord Ulrich, also in an acting capacity, at the scene. He arrived about 30 seconds before Mr. Hemmerling. His involvement was to assist with the administration of medication. He traveled in the ambulance with Mr. Hemmerling.

[36] There were three paramedics in the back of the ambulance, and one driving on route to the hospital. It took about five minutes to get to the hospital. They carried on with CPR and epinephrine. After the epinephrine was administered, there was no observable change in the child's condition.

[37] Mr. Hemmerling noted in his report that the short transportation time did not permit for intraosseous injection where a needle is placed in the bone of the lower leg. Through it medication is passed to the bone marrow. The purpose is to introduce epinephrine.

[38] Mr. Hemmerling testified that a typical time lag between the initial arrival of the first responder and the arrival of the supervisor would probably be about two to three minutes, a very short timeframe.

[39] The communication operators make the decision that a medical supervisor is called. In terms of training, Mr. Hemmerling practiced the endotracheal tube placement in the emergency room, under the guidance of an anesthetist at Children's Hospital. Intubation is part of that course. As to the actual skill, he had to complete a practicum in the operating room. The pediatric advanced life support was part of a much longer course that encompassed studying pediatric care. The whole course was two years but pediatrics is a component.

[40] In terms of potential enhancement of the number of individuals able to perform the procedure safely, and as a consequence possibly get to the scene faster, Mr. Hemmerling said that performing the procedure was one thing. Maintaining it a different matter. Fortunately, there are very few pediatric cardiac arrests so the experience level with a larger group doing the skill would be very limited.

f) Evidence of John Murray Mackay

[41] Mr. Mackay has been employed as a paramedic in Winnipeg for five years. Previously, he was a paramedic in Selkirk for 15 years.

[42] In Selkirk, he was, although not accredited, a level 3 paramedic which meant he provided full advance life support. This permitted advanced procedures, and the provision of advanced medications. After working in Selkirk for 15 years, he came to Winnipeg around 2000.

[43] On May 12, 2004, he was classified in Winnipeg as a primary care paramedic, the second level of national standards now designated in Canada. Having crossed the perimeter highway to Winnipeg, working for a new doctor, the scope of his practice began again. When Mr. Mackay came to Winnipeg, he was recognized as a level 1 paramedic.

[44] As a second level primary care paramedic, he enjoys the same scope of practice as a primary care paramedic, but also symptom relief. He is permitted to give nitro for chest pain, Ventolin for asthma, epinephrine for someone having an allergic reaction, aspirin for someone having a heart attack but is not permitted to administer anything intravenously or advanced airway management.

[45] On May 12, 2004, partnered with Denise McKendry, he was dispatched to a residence on Bachelor Avenue arriving on the scene at one minute before 9 p.m. There was quite a crowd gathering on the street and a fire truck out front. One of the firefighters met him at the doorway. The responders confirmed there had been an arrest inside. They entered the home where people were hollering, and the firefighters were attempting to perform CPR on Keyanna.

[46] The floor was wet where Keyanna was, and quite slippery. Mr. Mackay asked the firefighters to continue with their efforts as paramedics hooked Keyanna up on the cardiac monitor. They hooked up three leads. All three leads read ‘asystole’ which, in laymen’s terms, means no electronic activity in the heart. They used a hand powered suction unit to try and suction contents out of the airway.

[47] He testified:

> "Based on the certification level that I have in Winnipeg, all that I was able to do was basic life support. As a PCP, and my partner, as a level two paramedic, are not permitted to treat anyone under 10 years old with IV or advanced airway management. Our job was to provide basic life support and to continue to clear that airway, continue CPR and get her to the hospital."

[48] They disconnected the cardiac leads for the walk out to the truck. Somewhere between the door to the house and the ambulance, the first supervisor, Gord Ulrich arrived.

[49] Even Mr. Ulrich, as a medical supervisor, was not yet accredited with the training to initiate an endotracheal tube. The endotracheal tube would have given direct air exchange with the lungs, preventing stomach contents from being aspirated resulting in a definitive airway.

[50] Mr. Mackay was at the house for ten minutes before they left for the hospital. Mr. Hemmerling pulled up just as they were going to pull away. They did not want to delay transport to await his arrival. He immediately got in the back of the truck and inserted the tube.

[51] In Selkirk, under Mr. Mackay's former medical director, Dr. Colin Nesbitt, Mr. Mackay testified that he was very fortunate to have a progressive medical director who did permit paramedics to do these procedures. The necessity does not happen often, but when it does, it can be beneficial.

[52] In Selkirk, as a level three, Mr. Mackay was certified for endotracheal intubation. He could perform intravenous therapy, including intraosseous infusion. In Selkirk, he was trained on both adults and children.

[53] In the eight minutes Mr. Mackay spent with Keyanna, there was no change in her condition. She remained in full cardio-respiratory arrest. Mr. Mackay remembered looking through the French doors to see the hot tub. The hot tub had a cover on it so he actually did not see the water.

[54] Mr. Mackay testified that if he had been able to insert an endotracheal tube, it would have made a difference for the paramedics to ventilate Keyanna more effectively. Whether the ventilation would have made a difference may be another issue. Young hearts, in his view, are very strong. One doesn't find someone without electrical activity, as here, unless they have been without air for some time. It is a bad sign this had progressed quite far.

[55] Whether an endotracheal tube would have made a difference and turned the situation around, Mr. Mackay could not say. He testified that in basic life support, within four to six minutes without breathing and pulse, brain death begins to occur. The heart will continue to beat a little beyond, while brain death is occurring. In this case, Keyanna's heart had already stopped.

[56] In Selkirk, there were only eight level three paramedics including Mr. Mackay. Dr. Nesbitt, if they had a call in the middle of the night, would meet them on the road with his uniform and come with them. Dr. Nesbitt was familiar with the individuals involved and the experience he had observed or become aware of.

g) Evidence of Denise McKendry

[57] Ms. McKendry has been employed by the Winnipeg Fire Paramedic service as a paramedic for over 17 years. Her present level of certification is ICP. That, she explained, is a level two. It is not advanced. On May 12, 2004, she was on duty in the evening.

[58] Ms. McKendry testified that they arrived on scene at 8:59 p.m. May 12, 2004 at a location on Bachelor Avenue. When they drove up, they could hear screaming coming out of the house. The first responders were doing CPR on a baby. They took over, assessed vital signs. The baby had none. They hooked her up to their monitor and she was flat lined. They proceeded to bring the patient to the ambulance.

[59] There were two adults. Ms. McKendry had no conversation with the adults. There were two or three other children there as well.

[60] For more advanced treatment, they had to wait for the supervisor. Ms. McKendry did notice a whirlpool on the right side in a small room. That is all she remembered. There was a patio door partially open.

[61] The information Ms. McKendry received from the first responders was the parents found the baby in the whirlpool, under the cover, and couldn't remember seeing the baby for about ten minutes before they found her.

h) Evidence of Gordan Ulrich

[62] Mr. Ulrich has been a City of Winnipeg Paramedic for 20 years, presently a medical supervisor. On May 12, 2004 he was a temporary supervisor but has now become permanent. On May 12, 2004 there were eight medical supervisors. There are presently 12.

[63] Mr. Ulrich's duties in treating this patient were to draw epinephrine in a syringe and prepare it for supervisor Hemmerling. After supervisor Hemmerling intubated the patient, Mr. Ulrich injected the epinephrine down the endotracheal tube. The epinephrine was administered at 21:10. After 21:14 when they arrived at Grace Hospital, Mr. Ulrich had no further contact with Keyanna.

[64] Mr. Ulrich is an advanced care paramedic and has been trained by Winnipeg Fire Paramedic Service to provide advanced life support for pediatrics. At the time of this event, Mr. Ulrich did not have the pediatric training. He was essentially there to assist supervisor Hemmerling.

i) Evidence of Scott Robert Meakin

[65] Constable Meakin has been a member of the Winnipeg Police Service since September 2001. On May 12, 2004, he was working out of District 6. Shortly after 9 o'clock, he received a dispatch to attend to a location on Bachelor Avenue at approximately 20:59 hours. They arrived on scene at 21:13 hours. By the time of police arrival the two year old involved had already been transported to the Grace Hospital. The police were concerned about Lee Payne's problems breathing, and called in an ambulance. Lee Payne was transported to Grace Hospital as well.

[66] There was a plastic bubble wrap floating on the top of the hot tub water. Patrol Sergeant Kloos attended and Constable Meakin remained at the house guarding the area until the Identification Unit could arrive.

[67] Constable Wagner of the Child Abuse Unit was notified at 22:20. At 23:20, Constable Léveillé from the Identification Unit attended. At 23:30 members of the Child Abuse Unit arrived.

[68] Constable Meakin believed that police entered the hot tub area through the French doors. The door to the hot tub room from the washroom was closed. Constable Meakin did not recall whether the foster mother or the foster father had wet or dry clothes. In the two and a half hours that he was with the foster father in the kitchen, Constable Meakin did not have any conversation with the foster father concerning what happened.

[69] It was Constable Meakin's understanding from the fire personnel that the three older children were permitted to use the hot tub. After they finished playing, they would normally close the bathroom door. In appeared that in this case, the door had been left open making access possible directly from the kitchen.

j) Evidence of Constable Dean Klein

[70] Constable Klein has been with the Winnipeg Police Service for 15 years. On May 12, 2004, he was working with Constable Meakin when they were dispatched to attend to an address on Bachelor. When they arrived, the patient had already left in an ambulance. His responsibility was to determine what had taken place and the type of police involvement needed.

[71] His supervisor was on scene, and they determined it was a child who had possibly drowned in a hot tub. Child Abuse Unit would be investigating. Constable Klein and his partner were to guard the scene until the Identification Unit and Child Abuse Unit attended. No one went into the room, and Constable Meakin believed that the French doors into the hot tub area were open.

[72] Constable Klein recalled the foster father saying that he'd been sleeping on a couch when the incident took place. He was awakened by his wife shouting at him or nudging him, Constable Klein didn't recall. Constable Klein specifically remembered some conversation that Mr. Payne fell asleep with the child napping, and the child must have gotten up and walked away. Constable Klein specifically remembered him stating that the child was sleeping on his chest at some point.

k) Evidence of Constable Léveillé

[73] Constable Léveillé is with the Identification Unit. On May 12, 2004 at 10:20 p.m., he was contacted by Constable Matthews and informed of an incident at 3614 Bachelor.

[74] Constable Léveillé arrived at approximately 11:05 p.m. Constables Meakin and Klein gave them a tour of the residence. Points of interest were a bathroom, a hot tub room, a livingroom area, and a set of doors leading into the same hot tub room.

[75] From the photographs, Constable Léveillé was unable to determine whether the French doors from the family room into the hot tub room were keyed or not. The locking mechanism on the bathroom door, between the bathroom and the hot tub room, operates such that in order to get into the hot tub from the bathroom one needs a key. On the hot tub side, there is a twist and lock mechanism. If one pushed the handle in and twisted, it would lock from the hot tub side.

l) Evidence of Constable Loverne Mathews

[76] Constable Mathews has been assigned to the Child Abuse Unit for about 10 years, and a Winnipeg Police Service officer for 22 years. Constable Mathews arrived at the Batchelor Avenue address at 10:02 p.m. May 12, 2004. Detective Sergeant Andrew Smith and Constable Michelle Wagner were already in attendance. Constable Mike Chiborak attended after. A briefing was conducted. Constable Mathews contacted the Identification Unit, and the Medical Examiner. Constable Mathews arrived at Batchelor Avenue at 11:28. After a walk-through of the residence, Constable Mathews met with Larry Payne and obtained a written statement. On May 13, 2004, Constable Mathews and his partner attended the autopsy at the Health Sciences Centre.

m) Evidence of Constable Mike Chiborak

[77] Constable Chiborak has been a member of the Winnipeg Police Service for 18 years. At the time of his evidence, he had been in the Child Abuse Unit for 13 months. Constable Léveillé and Constable Chiborak measured the hot tub. He noted the hot tub room itself to be cluttered. There were flippers and flutter boards. There were also numerous tools and other related items there. At the pool edge, there was minimal room between the edge of the pool and the wall. As he was walking along the surface was quite slippery. At one point he actually almost fell in the tub himself. He was wearing foot wear at the time. The floor itself was not quite level. The clutter created a situation where there was no access really to walk around where the clutter was, unless one walked over the items. The combination of the slippery surface and clutter made the situation fairly treacherous.

n) Evidence of Dr. David Charles Littman

[78] On May 13, 2004 Dr. Littman performed an autopsy on Keyanna Snowdon. She was pronounced dead on May 12, 2004 at 21:33 p.m. at the Grace Hospital.

[79] Dr. Littman observed evidence of medical intervention, consisting of an endotracheal tube, a nasogastric tube, and needle punctures to obtain vascular access for resuscitation. There was also an intraosseous needle in the left leg, another method of resuscitation.

[80] The external examination revealed very little trauma. There was a very faint purple bruise on the right side of the face near the mouth, which may have been due to resuscitation attempts. There were other small bruises not contributing to the death of the child.

[81] The cause of death was consistent with the scene investigation. There are no pathognomonic findings in the autopsy in a drowning victim. Scene investigation is very important to assist in coming to a conclusion as to cause of death. In this case, the only finding is that it is a negative autopsy. The lungs are slightly heavy, but there are many causes of lungs being heavy.

[82] The autopsy findings include petechial hemorrhages in the face which are non-specific. They are more commonly seen in asphyxial-type deaths of which drowning is one. There was an anatomical variation of the arch of the aorta and the description of the shape of the child's head includes brachycephalies.

[83] There was no pathognomonic finding that would enable Dr. Littman, for certain, to determine cause of death. Dr. Littman was unable to give any indication as to how long Keyanna Snowdon may have been under the water. What he could say, is that drowning in children can be quite rapid. The length of time in the water could be just a few minutes. He was unable to make any statement beyond that.

[84] Commenting on the endotracheal tube procedure, if performed incorrectly, Dr. Littman testified that the tube would go into the esophagus. Attempts to resuscitate result in air pumping into the stomach instead of the lungs. The stomach is filled with air, like a balloon, and with chest compressions there is significant danger of rupturing the stomach. The other aspect, of course, is that one is not getting air into the lungs which is the point of the procedure.

[85] Once an endotracheal tube is inserted, if correctly, there is control of the airway. The other big problem controlled is vomiting gastric contents and aspirating into the lungs.

[86] If the airway is blocked by vomit, one must suction out the vomit. If not, by pushing the tube in one in fact may be pushing the aspirated material into the lungs.

[87] The amount of time the brain can survive in a period of anoxia is minutes. The longer the period, the more nerve cells or neurons may be irreversibly damaged. Dr. Littman estimated the amount of time under water resulting in irreversible damage or death would be about five minutes. In cold water, children have survived much longer periods but that does not apply here.

o) <u>Evidence of Lee Payne</u>

[88] Lee Payne married Larry Payne in March of 1979. Prior to her marriage, she was personally involved in fostering children. She had two children of her

own, and saw an ad in the newspaper for foster parents. She called Child and Family Services, and the matter progressed from there.

[89] At the time, she needed four recommendations. A medical and a home study were done. These requirements were all those in 1970, at the time she first applied. At that time, Ms Payne was licensed for one infant. The infant stayed anywhere from 3-6 months to a year, depending on the circumstances.

[90] After her marriage to Mr. Payne in 1979, the family moved into the home on Bachelor Avenue in 1981 or 82. Ms Payne continued to foster. The two-storey home has five bedrooms. The hot tub was installed in 1983 or 84. The hot tub room is off the family room. French doors separate the hot tub room from the family room. There is an adjoining bathroom to the hot tub, that has two doors to get into the room. There are two ways of accessing the hot tub from the rest of the home, through the French doors, or through the bathroom. There are key locks on both doors.

[91] The bathroom door lock to the hot tub involves pushing a button on the hot tub side, and the key lock is on the bathroom side. You have to use the key to get into the hot tub. When one leaves the hot tub, to lock the door behind, one pushes the button and closes the door. That results in a locked door to the hot tub. To get back in, a key is required. The key was kept on the top of the shower stall in the bathroom. It could not be reached by a child, six feet above floor level.

[92] The French doors have a key lock. The key is the same as the other door. The two keys on one clip are both cut identically for accessing the doors.

[93] The French doors were just used for viewing purposes. Mr. and Ms Payne would sit in the family room and look into the hot tub room. If the older children were in there, they could still sit there and look through the doors and watch them play. The French doors were kept locked.

[94] The entire family used the hot tub. It was family recreation fun time. The hot tub is always kept full. Around the tub are ceramic floor tiles with a rough surface so they are not slippery. The tub itself is fiberglass. It is not slippery.

[95] As to supervision, Mr. and Ms Payne either sat in the hot tub with the children or on a bench in the room. Another alternative would be that Mr. Payne would sit in the family room and look through the window because you could see them play right there.

[96] If someone were observing through the French doors, and saw something happening inside the hot tub room, with a lot of strength, one could open the French doors. They are not easily opened because they are locked. The other way would be to travel from the family room through the bathroom. When the children were little, Ms Payne was always in the tub with them. The 5 and 6 year olds had been in the tub from when they were infants. They learned how to swim in it, and dive in it. It was not a scary place – it was fun.

[97] Ms Payne testified that she was always in the tub with the children aged three and under.

[98] The inspections from Child and Family Services included representatives going through the home to make sure the children had proper sleeping accommodations and that the home was not in disarray. They checked to ensure smoke detectors, a fire extinguisher, and then they would talk about any family matters concerning the children. Anita Krohn conducted the inspections. Anita has been the Payne's support worker for eight years. Prior, it was someone else.

[99] Both Mr. and Ms Payne would be in the home while the inspection was being done. They were never asked to make any changes. The hot tub was discussed, but there was never any discussion about safety issues surrounding the hot tub.

[100] During the annual inspections, Child and Family Service had no specific recommendations concerning safety issues with the hot tub. Ms Payne said they were aware there were locking doors. Watching the children, or being in the water with the children, was discussed. Nothing specific, however, was said concerning supervision. There was a discussion about what the children did when they were in the water, how they played, and that the hot tub was a fun place like a miniature swimming pool. No social worker ever outlined expectations of use of the hot tub. The blue plastic sheet reflected in the photographs is the only cover the Paynes have for the hot tub. The Paynes were unaware whether there was a locking cover available for the hot tub. For a time, they had Styrofoam on top of the hot tub but the children would bite it when they were playing or pieces would break off. The Paynes had talked about getting a different cover made for the hot tub, but they never got around to it.

[101] The water temperature was just above what a bath tub would be. Children were never permitted to go in the hot tub without getting permission from Mr. or Ms Payne.

[102] The hot tub room was also used for storing Mr. Payne's tools. When the home inspections were done by the social workers, the tools and other work implements were sometimes in the hot tub room. There were never any comments by anyone during the course of the inspection concerning that.

[103] The children in the home never had swimming lessons. There was no discussion in the course of the home inspections about how to child proof the environment. When shown a picture of the hot tub room taken by police after the drowning, Ms Payne identified toys the children played with, and other items. Also in the photograph, Ms Payne identified metal tool kits and a white bucket.

[104] Keyanna Snowdon first came into the Paynes' care when she was a week and a half old. Ms Payne picked her up from the hospital. Keyanna was developmentally delayed. At 22 ½ months in May 2004, she was not walking. She was also being treated with occupational therapy and physiotherapy. Keyanna scooted on her bottom. She did not crawl on all fours. She moved very quickly.

[105] When Keyanna was 22 months old, the three other children in the home were 8, 5, and 5. The children all got along well together.

[106] The 8 year old was in grade 2, the 5 year olds had just started half-day kindergarten, and Mr. Payne worked full-time during the day. Ms Payne is at home full-time with the children. In the morning, only Ms Payne and Keyanna would be home. The two girls would come home at lunch time.

[107] Keyanna had been in the hot tub many times. She loved the water. She would not go in the hot tub unless Ms Payne was in with her. The water was treated by chemicals. Mr. Payne looked after the chemicals. The chemicals were stored on a top shelf in the hot tub room. Mr. Payne looked after testing the water.

[108] In order to open the locked French doors, one would need a key to open the doors to the hot tub room. The key is in the bathroom up on the shelf. Ms Payne testified that the family never used the French doors to access the whirlpool room.

[109] On May 12, 2004, Ms Payne was in the kitchen working on a life book for one of the 5 year olds who was going to be adopted. Mr. Payne was in the family room. Keyanna was in the kitchen with Ms Payne. The three children had asked if they could go into the hot tub and Ms Payne had said yes. The children usually got ready for bed between 8:00-8:30.

[110] When Ms Payne found Keyanna in the hot tub, she jumped in and took her out. She hollered at Larry to phone 911. Keyanna had foaming from her mouth and nose. She thought Larry came into the room. He told her to bring Keyanna to him and she did. She does not remember a lot after that. When Ms Payne picked Keyanna out of the hot tub, she was limp.

[111] At the time, Ms Payne had no training in CPR. The other three children were upstairs in their bedrooms. The next thing she remembered was the house full of people, paramedics and firefighters. She did not remember what the people were doing to Keyanna. She knows Mr. Payne was on the phone with 911.

[112] Ms Payne remembered being taken to hospital in an ambulance. She went home from hospital the same night. Ms Payne remembered talking to the Pastor and his wife, but not anyone else. The support worker came to see how they were doing, but Ms Payne did not remember talking to anyone other than the support worker. The Agency made sure they were taken care of and that the children were looked after. Someone from the Crisis Centre came. Ms Payne remembered talking to a woman specifically to help deal with the children so that they did not blame themselves. At first they had said that they left the door open. Ms Payne testified she said to them it was okay, that no one was being blamed. It was an accident. The children asked lots of questions.

[113] The rules in place at the home relating to the doors at the time were they were told that both doors had to be closed, the bathroom door and the whirlpool room door. The bathroom door was always closed, even during the day, because Keyanna liked to play in the toilet. The three other children were told to make sure the door was closed when they went in and when they came out.

[114] After the incident occurred, the hot tub was drained. It has a plywood floor over it. The room is now utilized for Mr. Payne as a small workshop area. Ms Payne said she did not care if the pool ever got water in it again. After the incident, Ms Payne had no discussion with anyone from the Agency about what would be done with the hot tub. Mr. and Ms Payne had told the Agency it had been drained. Ms Payne did not go in that room for three months. She stayed at the lake with the children because she could not be at home.

[115] During all the home inspections over the years that the hot tub was in the home, there was never any suggestion by an Agency worker concerning getting CPR training. If Ms Payne had been asked to get CPR training, she would have done it. She just never thought about it.

[116] Referring to photos of the hot tub room, Ms Payne identified her husband's tools. She testified the room did not always look like that. She did not know what he had been working on, but he had his things piled there.

[117] They had life jackets for the little ones. Ms Payne would sit on the edge of the pool with her feet in the water. The children could stand on the flat seating all the way around in the pool with the water up to the chest on the older children.

[118] The eight year old knew how to swim, learning strokes in the hot tub. He learned how to dive in the hot tub. The girls would do the same thing. They learned how to put their heads in the water and come back up.

[119] Ms Payne is aware that the Red Cross offers swimming lessons for children as young as six months to come with a parent. Ms Payne had talked about getting the children enrolled in swimming lessons, but the time never seemed to be right.

[120] The eight year old and one five year old were still with the Paynes at the time of Ms Payne's testimony. The other five year old had been adopted. The eight year old is now nine, a foster child with the Paynes since birth. One five year old has been adopted by the Paynes, and the other by another family. The Paynes continue to foster children, but did not take any little ones until January 2005. Ms Payne called the worker indicating she was ready on Wednesday and had a baby in her home by Friday.

[121] To deal with the incident, the five year old that had been last out of the hot tub room was taken to play therapy.

[122] On the night of the incident, Ms Payne was sitting in the kitchen working on the life book. She was not able to see the three older children in the playroom. She told them that Daddy was in the family room. Keyanna was crawling back and forth between the kitchen and the family room. Keyanna liked to sit at the French doors that look into the whirlpool room, and watch the children through the doors. She got very excited when she saw children playing in the pool. To the best of Ms Payne's knowledge, the children went through the bathroom door into the whirlpool at about 7:00 p.m.

[123] The eight year old and one five year old got out of the whirlpool. Ms Payne said to them "did you close the door?" They had come into the kitchen with their towels. The eight year old said the other five year old was still drying off. Two of the children went upstairs to their bedrooms to get into their pajamas. The other five year old was coming behind. Ms Payne did not recall Keyanna

being at her feet at that moment. The remaining five year old came out of the bathroom a couple of minutes after. Ms Payne did not have a conversation with that child. She went straight upstairs to get her pajamas on. Ms Payne estimated the time between speaking to the five and eight year old, and the other five year old to be five minutes. Between five and ten minutes later, Ms Payne realized that Keyanna was not with her. She went directly to the bathroom. She noticed the door was open and went straight through into the whirlpool room. She discovered Keyanna in the water, face down, beside the cover. Keyanna was lying beside the cover which was scrunched. The children had not flattened it right out onto the water. They threw it on top of the water.

[124] Ms Payne jumped in and picked Keyanna up. She laid her right by the step on the floor.

[125] Ms Payne testified that her husband told her he fell asleep after the children got out of the hot tub. Ms Payne said that the routine was that she would check to make sure the bathroom door had been locked after the children were out of the hot tub, but on this occasion she did not.

[126] The hot tub was 30 inches or 76 cm deep, and has four jets. The jets are turned on from a switch on a bench. Most of the time, the switch was off when children were in the hot tub. On May 12th, the switch was off. The switch was off when Ms Payne entered the hot tub to find Keyanna in the water. The hot tub was in the home for 21 or 22 years. Mr. Payne used it every morning before he went to work. The children would use it every other day.

[127] Ms Payne felt that Anita Krohn, the foster home social worker, was an excellent worker. She had, according to Ms Payne, a good relationship with the Paynes. Ms Payne felt she could talk to her about everything.

p) Evidence of Larry Payne

[128] Mr. Payne became involved in fostering children, with Lee Payne, five years before they were married in March 1979. At that time, they dealt with the Children's Aid Society. With Children's Aid, they were an emergency placement and fostered hundreds of children short term. With Child and Family Services, they have had 49 children.

[129] Mr. Payne had the hot tub installed approximately 25 years ago. The locks on the doors leading into the hot tub room are keyed entry locks like you have on the front of a house. The keys for the doors were kept on the top of the shower stall, about six feet high. The same key opened both doors. Someone

leaving the hot tub room would have to push the knob in and close the door behind them to lock the door.

[130] The hot tub itself would be slippery because it is smooth. There are stairs going down that have texture to them. The tiles surrounding the pool are textured, so they do not get that slippery. Mr. Payne did not remember the reason for installing a hot tub in the first place.

[131] Since installation, the hot tub was used almost every day. The children played and soaked in it. Mr. Payne testified he used the hot tub almost every day before he went to work. Ms Payne did not.

[132] The foster children in the home all used the hot tub. The supervision necessary for each particular child was determined by Mr. and Ms Payne by the age of the child. It was nothing they actually thought about. If a child were under 10 or 12, Mr. or Ms Payne was there.

[133] If the child were under the age of 3 or 4, an adult would be in the water with them. A child over that age would be watched through the French doors. Most of the time the adult would make sure the French doors were unlocked, and sit there and watch. Mr. Payne has as much as the whole 9 year old hockey team, 8 children at a time, in the hot tub together.

[134] Mr. Payne testified that if he were watching someone through the French doors, and something occurred inside the room, the doors would usually be unlocked. An adult would open the door and go in. Even if the door were locked, if you pull on it hard enough, you could probably pop it open. Because the key is stored in the bathroom on top of the shower stall, it would not make sense to run around to the bathroom, retrieve the key, and come out, around, and back to the French doors. It would more sense just to go through the bathroom into the hot tub in that instance.

[135] As to inspections, Mr. Payne said that Children's Aid workers conducted an inspection once a year. Over the last few years, Anita Krohn conducted the inspections. Mr. Payne could not testify what was involved with the inspection, because he did not think he was there for any of them. He said Ms Payne was there. As a result of inspections, some changes had to be made to the home. Carbon monoxide detectors had to be installed, and smoke detectors by all the bedrooms. There were a few issues with cribs. The changes were made as they were required. Anita Krohn had meetings with the Paynes every two or three months. She would phone and ask if the Paynes wished to see her. She would come out and talk. Mr. Payne would come home from work at lunch, and the meetings

would be set for his lunch time. Mr. Payne did not have any contact with Ms Krohn outside those meetings.

[136] During all those years, and all of those meetings, no comment was made concerning the hot tub. No one from the Agency ever gave any advice to anyone in the family about water safety. Mr. Payne was unaware whether any advice was ever given by the Agency to the family about child proofing their home. When shown photos of the hot tub area taken by police, Mr. Payne identified items on the bench and floor of the hot tub room as being tool boxes. Mr. Payne explained that his daughter moved back, and his tools used to be down in the basement. His daughter's things were moved into the house, and his tools were kept under the bench in the hot tub room. The white bucket displayed in the photograph contained deck screws. Mr. Payne was not sure what was contained in the green coffee tin in the hot tub room. A bucket in the room contained wrenches.

[137] Concerning Keyanna Snowdon, Mr. Payne said that when she came into their care at 3 days of age, no one really knew the extent of her special needs. She was very slow developing, not walking when she was supposed to. She screamed a lot. Mr. Payne said he would never let his wife leave Keyanna with him because he did not know how to comfort her. She never talked or walked. Although Keyanna was taken for various appointments to hospitals and for therapy, Mr. Payne was not involved in that. She scooted with one leg under her, and got around really fast.

[138] Keyanna had played in the hot tub on 2 or 3 occasions. She loved the water. Mr. and Ms Payne tried putting a life jacket on her. They had a fear of drowning. In the whirlpool in the life jacket she could flip herself over face forward. Keyanna did not use the hot tub as often as the other children.

[139] Mr. Payne was responsible for maintaining the hot tub. He tested the water with a little test kit. He put drops in, and added chlorine. The chlorine was kept in the room with the hot tub on a high shelf. The water was kept at 98 degrees Fahrenheit.

[140] The hot tub was continually full, drained once a month because Mr. Payne found it easier than adding huge amounts of chemicals and trying to stabilize it. There was no actual rule in the home about what the children were to do when finished using the hot tub. They had to leave and close the door. There were rules like they were not allowed to splash water, were not allowed to jump off the sides.

[141] On May 12, 2004 the only people in the home were Mr. and Ms Payne and four children. The first thing Mr. Payne remembers about the evening is when

the children were getting out of the hot tub. He does not remember anything before. Keyanna had not been in with them. Mr. Payne was supervising the children by sitting at the French doors. Mr. Payne was looking through the doors. He was not certain where he was sitting.

[142] Mr. Payne recalled seeing the children get out and put the bubble cover on the tub. They walked out through the doors. Mr. Payne believes they shut the doors. Mr. Payne said he thought Nathan probably put the bubble cover on but he did not know. He believed Nathan went out first, followed by Trisha and Brittany. Nathan was then 8 years old. Mr. Payne thought they closed the door.

[143] Mr. Payne believed he was on the chesterfield watching TV. He was not sure. He thought Ms Payne was working on the life book in the kitchen. Mr. Payne did not realize Keyanna was up. When the three children left the hot tub room, they went to change in the bathroom. They then went to play in the front of the house. Mr. Payne was not sure where. Mr. Payne had fallen asleep on the chesterfield. He heard a scream and found Lee in the pool with Keyanna. He grabbed the door, opened it and jumped in too. He went back out through the French doors. He did not know who had Keyanna at that point. One of them called 911. Mr. Payne assumed it to be himself because he was talking to the operator. Ms Payne was screaming, hysterical. Mr. Payne did not know how he got through the French doors into the hot tub.

[144] Mr. Payne was speaking to the 911 operator who was telling him how to resuscitate. Mr. Payne had no training in CPR at the time. When the paramedics got there, they took over.

[145] When Mr. Payne was giving Keyanna CPR as the 911 operator instructed, he saw absolutely no signs of life. Keyanna was taken to hospital in an ambulance. Lee was hysterical and hyperventilating, and was taken to hospital in another ambulance. Mr. Payne stayed in the home. Later on, the police arrived and he spoke to them. When asked, looking back, whether there was anything Mr. Payne felt he could have done differently, he said

> "Yes. I should have got up and locked the door, made sure it was closed, the bathroom door."

[146] After the incident, no one from the Agency gave him any advice or instruction about the hot tub. Some crisis workers came out, especially for the children. The children were upset. Trish and Nathan started saying that Brittany was the last one out of the room. Mr. Payne testified that he immediately told them

that it did not matter. It was he that did something wrong, because he had not closed the door.

[147] None of the children in the home had taken swimming lessons. They had thought about enrolling the children for swimming lessons. If suggested by the Agency, he was not sure how he would have responded. Mr. Payne said they probably would have taken the children for lessons, but perhaps not. No one from the Agency has ever suggested, or instructed, that he take a CPR course. Mr. Payne testified that if the Agency had suggested or instructed that he take a CPR course, he probably would have. He did point out, that on the day of his evidence, a year after Keyanna's drowning, he had still not taken a CPR course. He did not know if he could now.

[148] Mr. Payne drained the hot tub two or three days later. He put a floor top over. They do not plan to use the hot tub again.

[149] Since that time Brittany has been adopted. In January 2005 the family received a new foster child. There are presently four children in the home, including the Payne's granddaughter who moved in two weeks ago.

[150] Mr. Payne was asked whether there was any reason why he did not drain the hot tub after it was used each time and then refill it. He responded that they could not afford that. He said that it required 500 gallons to fill the tub. Mr. Payne estimated to the top of the tub at 48 inches deep from the centre of the deepest spot. The children were not allowed to dive off the sides. Nathan did it a few times although he was not supposed to.

[151] Mr. Payne believed that his home had been inspected by Child and Family Service since May 12, 2004. He was not sure, and was not present for the inspection. To his knowledge, no one from the Agency, since the incident, commented on the tools and deck screws visible in the hot tub room in the photographs.

[152] Mr. Payne, at the time of his testimony at the Inquest over a year after the incident, was using the hot tub room as a storage room or work shop. It was his view that the Agency became aware of that use of the room when he had told Anita Krohn the day prior to his testimony. He did not think she knew prior to that.

[153] At the time of his testimony, over a year after the incident, he said that the Agency had never given him any instructions whatsoever on how he should use the hot tub with the children.

[154] Mr. and Ms Payne continue to be licensed by Child and Family Service as foster parents, and that licensing has never been interrupted since the early 70's.

[155] Mr. Payne was aware that there were hard covers commercially available for the hot tub, but they were expensive. That was why he made a Styrofoam cover which broke, and which was no longer in use.

[156] The primary purpose of the soft cover the Paynes did have was to keep the heat in and save some utility bills. Mr. Payne had never heard of a locking cover. No one from the Agency that licensed the foster home had ever suggested that he get a different kind of cover for the hot tub. No one from the Agency ever proposed that there be any kind of water safety program for the children using the tub. Similarly, no one had suggested CPR training for himself or his wife. No one from the Agency had ever set down any rules or discussed with him personally the ages of the children using this hot tub, or what kind of supervision should be required at different ages. The supervision regimen that Mr. and Ms Payne decided was something they developed themselves. Mr. Payne is of the view that anyone 12 and up familiar with using a hot tub could go in unsupervised. Under 12, some kind of supervision was necessary. Mr. Payne's usual procedure, when the children were in the hot tub, was to unlock the French doors. He would access the locking mechanism to the French doors by going in through the bathroom door and then going around back to the living room. On May 12, 2004, Mr. Payne did not recall whether he had actually unlocked the French doors.

[157] Mr. Payne did not recall seeing Keyanna while the three children were in the hot tub on May 12, 2004, and his wife was in the kitchen. Mr. Payne did not remember what the three children were doing in the hot tub. He had a mental blank spot from the time the children went into the hot tub until the time they got out.

[158] Mr. Payne did have a recollection of Nathan putting the cover on the hot tub, but testified he was not sure whether the recollection came from that day, or some other day. Mr. Payne did not remember the conversations he had with police on May 12, 2004. He remembered getting up from the couch. He did not think he fell asleep while the children were in the hot tub.

[159] Mr. Payne testified that although the pool depth was 40 inches, the water level would be about 30 inches in the middle.

[160] Mr. Payne did inform the Agency that the hot tub had been drained two or three days after May 12, 2004. It has been communicated that he has no current intention of refilling the hot tub, unless he could be 100% sure nothing would ever happen again. Mr. Payne testified that he constructed a floor from wall to wall in

the hot tub room. It would take days, he said, to take the floor out. The room is kept locked so the children will not interfere with the tools. The whole section of the house, including the family room, hot tub, hallway, computer room and bathroom was a new addition 25 years ago. The hot tub was installed at the same time the addition was put on. The French doors were added sometime after the construction.

II. EVIDENCE RELATED TO CHILD AND FAMILY SERVICES

a) Evidence of Anita Krohn

[161] Ms Krohn is employed by the Director of Child and Family Services, Winnipeg Region. Prior to the changeover in the Agency, she was employed by Winnipeg Child and Family Services Agency proper. She has been employed with the Agency for 17½ years. Presently, Ms Krohn is a foster care social worker. She was a protection worker for 12 years, and has been a foster care social worker for about 5½ years.

[162] Ms Krohn's responsibilities, as a foster care social worker, include supervision and support for foster parents. Part of her responsibilities entail ensuring that the home is in keeping with standards directed in the Program Standards Manual. In addition, her work is governed by the Foster Home Licensing Regulation. With a stable foster home, her contact would be three or four times per year, in person, and monthly telephone communication.

[163] Ms Krohn would typically be responsible for 40-43 homes. It was difficult to maintain appropriate contact with that number of homes, but possible. Once per year, Ms Krohn, in accordance with the Regulations, performed an inspection. She generally did a walkabout through the house with the foster parent, to ensure safety features such as railings on staircases, fire extinguishers, absence of clutter around the furnace and hot water tank, smoke detectors, general quality of cleanliness. In addition, she seizes the opportunity to go through the childrens' clothing to ensure the clothing was well maintained and adequate. The children in each foster home were not Ms Krohn's direct responsibility. They were the responsibility of the social worker assigned. Ms Krohn would have contact with the child's social worker, depending on the issues.

[164] In the course of the inspection, Ms Krohn would complete a three-page form addressing the safety issues. The form operates as a checklist. In situations where a problem is discovered, Ms Krohn consults with the foster parent. She consults with her supervisor. She tries to have remedial steps taken to correct the problem. Ultimately, if there are safety issues remaining unresolved, Ms Krohn has

closed foster homes, resulting in the suspension or termination of the license to foster.

[165] The process involved to become a foster parent starts with an Application to Foster. It is necessary for applicants to complete an orientation program. If the intake workers for foster care find foster parents require additional skills and knowledge, it is highly recommended that they attend training as well.

[166] Since 1977, the Paynes have been a licensed foster home without interruption. In that time, to Ms Krohn's understanding, there has never been an event giving rise to an investigation until the events here. Frequency of contact with the Paynes was direct contact five or six times per year, and either monthly or every three weeks by telephone. That contact was slightly more frequent than other homes because they foster children facing cognitive challenges, and Ms Krohn wanted to ensure adequate support.

[167] There were no issues of significance that arose during the Paynes annual reviews. Ms Krohn was aware of the presence of a hot tub. She had been told the hot tub had been in the home for 25 years. There have been no concerns with respect to the presence of the hot tub, from a safety perspective for any of the foster children.

[168] Ms Krohn's understanding of the safety procedures relative to the hot tub, when the annual reviews were performed, was that the doors were locked at all times when the hot tub was not in use. The keys were located on a ledge 8 feet off the ground in the bathroom. Ms Krohn was told that Keyanna was never in the hot tub on her own with the other children. If she were in the hot tub, Lee or Larry Payne would be in the hot tub with her. After addressing issues relative to the safety of the hot tub with the Paynes, Ms Krohn had no concerns. She described the Paynes as "exemplary" foster parents.

[169] Ms Krohn noted the tools in the hot tub room, the container of bolts, nuts, a caulking tube. She questioned their presence in the hot tub room, and was advised there was no safer place to store them. She ensured there was no electrical plug in the room that the hot tub was in. She was assured the children would pay no attention to those items.

[170] Ms Krohn discussed with neither Mr. or Ms Payne that they got CPR training. She was not aware whether any other foster care or social worker had requested they complete a CPR course.

[171] Ms Krohn's understanding was that if the branch were unable to find an adoptive home for Keyanna, they were prepared to care for Keyanna on a long-term basis.

[172] On May 12, 2004, when Ms Krohn was advised of Keyanna's death, she phoned her supervisor, Collette MacPherson at home and went to the hospital to be with the family. The social workers for Nathan and Brittany had been notified. It was Ms Krohn's assessment that the children were perfectly safe, and there would be no need to remove the remaining children from the home.

[173] It was Ms Krohn's understanding at that point that the three older children were in the hot tub. Larry Payne was in the living room watching through the French doors. Keyanna was scooting around outside the hot tub room between Lee and Larry. She received the information principally from the Paynes. She had no discussions with members of the Winnipeg Police Service. When in the home, after the hospital, Ms Krohn had no occasion to go into the hot tub area. At the time, Nathan was 9 and Brittany and Trisha were both 6. Had Ms Krohn had concerns about the safety of the three children, they would have been removed.

[174] In January 2005, an infant was placed with the Paynes. Currently there are three children there – a baby, Nathan and Trisha who is their adopted child. The Paynes are also currently caring, on a short-term basis, for their granddaughter. Ms Krohn continues to be responsible for the foster home. Subsequent to May 12, 2004 there have been no problems or issues that have arisen with respect to the Paynes' care of any children.

[175] Ms Krohn testified that Larry drained water out of the hot tub several days after the incident and a floor has been put over the top of the hot tub.

[176] An annual foster home review was conducted after the incident culminating in a report dated December 14, 2004. As a result of the review, there was no sanction in the licensing process.

[177] None of the other foster parents on Ms Krohn's caseload have a hot tub.

[178] When Ms Krohn performed her annual inspections, she checked on the washroom door to see whether it was locked into the hot tub area without anyone realizing she was doing it. She normally checks the medicine cabinet to ensure nothing harmful to a child is in the cabinet.

[179] Ms Krohn was sure, in her evidence, that she had conducted these checks. What she was not sure was whether she had made notes concerning it.

[180] It was Ms Krohn's opinion that there were guidelines concerning hot tubs, and that the facility needs to be locked and children need to be monitored in the specific area. She testified that Child and Family Services provided her with those written guidelines. The guidelines she was referring to had been left at her office and not brought to court. Although she could not recall specifically what age the guidelines directed children could play in a hot tub without an adult present, Ms Krohn's recollection was that the children in the Payne home, at ages 9 and 6, were old enough that they did not need an adult in the room with them. It was Ms Krohn's understanding that Mr. Payne was also watching through the window to ensure the children were behaving themselves in the hot tub.

[181] Ms Krohn was asked by counsel for Ms Snowdon about a copy of an e-mail in which Ms Krohn indicated it was her understanding that there was always an adult with the children when they were in the hot tub. She testified that she had been under the impression, in accordance with her e-mail, that there was always an adult in the hot tub room with the children.

[182] Ms Krohn went on to testify that there was a further document provided to foster parents relating to hot tub standards. After returning to her office in a recess, Ms Krohn had an opportunity to view all of the materials on her desk. There was nothing specifically addressing hot tubs.

[183] Ms Krohn confirmed her understanding that the older children had left the hot tub room, and for a period of 10 minutes Keyanna had not been seen by Ms Payne. At the moment when Ms Payne found Keyanna in the hot tub, Mr. Payne was sleeping in the living room.

[184] Ms Krohn had been interviewed by Lynda Schellenberg and Liisa Cheshire, Ms Schellenberg's supervisor, as part of an abuse investigation. As a result of that interview, Ms Krohn told the Paynes there may be safety requirements that would need to be met before the hot tub could be used again. Ms Krohn suggested to the foster parents that they not utilize the hot tub again until such time as it became evident that there would be new standards and regulations pertaining to hot tubs. Lee and Larry Payne informed Ms Krohn that they had no desire to ever utilize the hot tub again.

[185] Ms Krohn thought there should be stricter standards, but did not know what they should be. Suggestions made by the Payne family included a self-locking and self-closing door to the hot tub area.

[186] When Keyanna was placed with the Paynes, Ms Krohn was the worker who made the final determination that the placement was a good fit. If she were of the view that the fit were not appropriate, it would not have happened.

[187] Ms Krohn testified that the checklist for foster homes had changed since December 2002. The new form included a long list of issues relating to the home. Swimming pools or hot tubs are not among the items listed.

[188] The December 12, 2002 inspection of the Payne home was completed late. The inspection itself was completed after the date of the license expiry. Ms Krohn did not recall why that was in this case, but testified that that usually relates to having been involved in other matters that took precedence. Swimming lessons for the children was not something Ms Krohn would have suggested. She did believe, however, that the two older children were taking swimming lessons.

[189] On an inspection, had Ms Krohn found one of the doors permitting access to the hot tub unlocked, she said she would have had a chat with Mr. or Ms Payne and there would have been a letter following up stating that was unacceptable and inappropriate.

[190] Ms Krohn was aware that there were tools in the hot tub room. She was aware that some hardware was there. The hot tub room, however, was not in the condition depicted in the photographs taken by police just after the incident. Ms Krohn testified that had she seen the hot tub room in the condition it was shown in the photographs, she would have asked it be cleaned up.

[191] Although Ms Krohn has no guidelines from the Agency as to how to handle swimming pools in a foster home, as opposed to hot tubs, she does have some homes with swimming pools. On her own initiative, she sent City of Winnipeg guidelines out to two families who have above ground pools. She got the guidelines from the City of Winnipeg.

[192] Ms Krohn said that when she spoke to Lee Payne about rules governing the hot tub in the Payne residence, that Larry Payne was also present. She did not believe she had notes to that effect.

[193] Ms Krohn was not aware that the children might be supervised in the hot tub by somebody watching them through the glass of the French doors until after Keyanna’s death. Had she known that, she would have asked that one of them be in the room with the children. It was not contemplated, in her discussions, that the older children be the ones responsible for locking the door when they were finished in the hot tub. Ms Krohn received no formal direction from the Agency

concerning hot tubs. She did not recall any discussion between herself and the Paynes about what age a child needed to be before they could play in the hot tub by themselves. Even after the incident, there have been no specific recommendations about hot tubs in foster homes.

[194] When asked by Mr. Barg, whether it were possible that because of Ms Krohn's impression that the Paynes were exemplary foster parents, she gave them more leeway in terms of the hot tub than she may have with other foster parents, her response was as follows:

> "I'm in the human service industry. I work 8:30 to 4:30. I don't do bed checks. I don't check on people at nine o'clock at night. I form impressions, as does everyone, in the jobs that they do on a day-to-day basis. Some people present in ways that lead an individual to assess them positively, not only by what they say, but also how they – the whole home, how the, how the home presents, how the people within it present and interact and, yes, I think it would be fair to say that after some time you form an impression of an individual, and you no longer are, what can be termed as hyper-vigilant. There are individuals that you may need to be hyper-vigilant with and given the fact that they presented well, to me, and based on that, I, I think your statement would be a fair one."

[195] The inspections are done by appointment. The only time an inspection would be done without an appointment is if the Agency had specific concerns. Even since the drowning, the Payne foster home residence has not fallen into that category.

[196] The kind of incident that would make a foster home fall into the category to be subject to a surprise visit, would be if Ms Krohn had occasion to believe that there is something in the home that would cause risk to a child or that would not meet standards. The nails, buckets, and power tools in the whirlpool area would not raise that degree of concern.

[197] At the time of the incident, Ms Krohn was of the view that a child under the age of six using the whirlpool could do so without an adult in the room. Ms Krohn did say that on the day of her testimony, she would answer that question differently.

[198] As part of her work assessing the safety of environments for children and families, she received no specific training about water safety. Today, her opinion would be that a child could use a whirlpool unsupervised without an adult in the room at 12, the age for public facilities. What changed her mind between then and now is the fact of a fatality.

b) Evidence of Barbara Eileen Yuill

[199] Ms Yuill has been employed as a social worker by what is now the Director of Child and Family Services, Winnipeg Region since February 1992. She has been a child protection social worker for 14 years. Her typical caseload is 40 cases, each child in care, counted as a case, and the family would be a case.

[200] Ms Yuill's involvement with Keyanna Snowdon commenced when she was born on June 29, 2002. In April 2002 Ms Yuill became involved with Janine Snowdon when she was pregnant with Keyanna. A birth alert was issued, putting a message out to all Winnipeg hospitals that do deliveries that a child is about to be born and the Agency needs to be notified when the delivery occurs. Keyanna was apprehended July 11, 2002 and placed with the Paynes the following day. Ms Yuill provided information concerning Keyanna Snowdon to the Agency's placement desk. She was then told that the Paynes were the placement, and why.

[201] Ms Yuill saw Keyanna twice a week through to September 2003 when the permanent order was granted, because she was there visiting with her mother at Child and Family offices. Ms Yuill monitored the visits. Keyanna's development was very slow. At one point, there had been a guardianship application filed by the maternal grandfoster mother withdrawn mid-September 2003. On September 24, 2003, Mr. Justice Yard granted the permanent order of guardianship. By November 4, 2003 the file was transferred to the permanent ward social worker who was Debbie Baty.

[202] Ms Yuill never visited the foster home at all. Sometimes Ms Yuill visits the home a child is placed in and sometimes not. She does not have a rule about it. She was seeing Keyanna twice a week and communicating with the foster parents so that was reason enough not to go. If it is a requirement to visit the home before placing a child in it, Ms Yuill has not heard of it. She had heard that the Paynes were a very good foster home with a lot of experience, by word of mouth. She did not know there was a hot tub in the home. Until Keyanna's death, she did not know there was a hot tub there.

[203] In an ideal world, Ms Yuill thought she should go out every couple of weeks to the residence where children under her care were placed, but with the number of cases she carried it would not be possible so she relies on the foster parents' social worker to do that.

[204] Ms Yuill did not think that visiting the home would have prevented Keyanna's death because

> "I feel the death was accidental and no one who'd come out and inspected the home could have predicted at all how – you know, how this would happen, how this, this death would occur. I mean, if I'd gone out to the home several times and, and seen the hot tub, it wouldn't have occurred to me that that was a, a dangerous – something dangerous to have.
>
> Q. All right. I just want to make sure I understand what you're telling me. It would not have occurred to you that a hot tub was a dangerous thing to have in a child – in a home with small children?
>
> A. No, it wouldn't have occurred to me."

c) Evidence of Deborah Jean Baty

[205] Ms Baty was the adoption social worker for Keyanna Snowdon from early December 2003 until the date of her death. Ms Baty had been with the Agency since 1988, beginning as a family service worker and from 1991 as an adoption social worker. At the time of her testimony Ms Baty, in fact, was with the Child Guidance Clinic as a school social worker.

[206] Keyanna was registered on the Adoption Registry on May 6, 2004. Ms Baty understood Keyanna's special needs to arise, in part, from her premature birth.

[207] Dr. Longstaffe from the Child Development Clinic had assessed Keyanna and found her to be a puzzle. At the time of the social history, Keyanna was 23 months of age. She was just beginning to walk a few steps, mostly crawling or scooting. She expressed very few words, if any. She was still using finger food. She was globally delayed around a year.

[208] Ms Baty was at the Payne home on three to five occasions. The focus of the visits was to see Keyanna in her own environment and talk to the foster parents. Ms Baty also wanted to look at the home. Ms Baty did notice the hot tub in the residence. The hot tub area was one which Ms Baty would always ask about because she needed to know what the hot tub rules were. It was her view that the Paynes were very strict with the rules. The hot tub was always supervised, and both doors permitting access to the hot tub had locks on them. Once they were finished with the hot tub, everyone left and the door was locked.

[209] Ms Baty's recollection of a discussion with the Paynes concerning Keyanna's use of the hot tub was that she liked water and was not in the hot tub without supervision. Ms Baty's view was that it meant an adult was in the tub with Keyanna. Ms Baty had no concerns about the existence of the hot tub, or the rules.

[210] Ms Baty knew that the Paynes had experience with children with development delays arising out of the adoption of Trisha. Trisha, herself, was diagnosed with FAS, so there were some delays in her case.

[211] Ms Baty was on the periphery of the decision not to remove Nathan, Brittany or Patricia after Keyanna's death. Other workers for the other children in the home, Faye Simon and Nancy Bruyere did not have concerns about the children being left in the home.

[212] The police had investigated and their preliminary results were that it was an accident. The Chief Medical Examiner through Lonni Cruickshank, although the report had not been completed, was looking at it as an accident.

[213] When Ms Baty was in the home herself, she checked to see if the doors were locked permitting access to the hot tub. When asked about whether a hot tub in the residence is a hazard to the children there Ms Baty responded:

> "The hot tub, as in any home, you are always concerned about safety issues, but they're licensed by the foster care department and that would have been dealt with by their department. I was satisfied with the Paynes' explanation and in my own observations that the doors were locked.

[214] In the course of Ms Baty's training to work with Child and Family Services in her career, she never had any training, through her employment specific to water hazards in the home or water safety. The concern that she had, expressed in her evidence, about the existence of a hot tub or a pool in the residence, was something she gleaned from her own personal experience. Whenever she attended at the Paynes to see Keyanna, she always did so by appointment and never made a surprise visit. Had Ms Baty seen the power tools and the nails, they would have caused her concern because they are adult tools. Had Ms Baty seen the hot tub room in the condition displayed in the photographs filed here, she would have contacted Anita Krohn and expressed her concerns. She would have relied on Anita Krohn to remedy the situation. She would then look at the area again on her next visit. The next visit would have been by appointment.

d) Evidence of Lynda Schellenberg

[215] Ms Schellenberg is a social worker employed as a child abuse investigator with the Director of Child and Family Services, Winnipeg Region. She has been with that unit since June 2002 and the Agency since 1987. In the context of her position, she assesses risk to children, investigates allegations of physical or sexual abuse, and makes recommendations based on her investigation.
Ms Schellenberg's supervisor at the material time was Liisa Cheshire.

[216] The file concerning the death of Keyanna Snowdon was assigned to Ms Schellenberg on May 21, 2004. She first reviewed it on May 25th. On viewing the file, it was apparent to Ms Schellenberg that the police and the medical people involved were pretty clearly indicating the death was accidental.

[217] Ms Schellenberg's investigation was guided by her training and experience as a social worker, and by the provisions contained in the Program Standards Manual relating to investigating child abuse in foster care. In the course of carrying out her investigation, Ms Schellenberg consulted with her supervisor, Liisa Cheshire, on numerous occasions. Ms Schellenberg did go to the Payne residence and have a look at the hot tub room. She did not, however, go into the hot tub room itself. She saw it from the family room, through the French doors on June 23rd which would have been the first occasion she was in the residence.

[218] One of the recommendations in Ms Schellenberg's child abuse report was "that a more substantial hot tub cover be installed at the Payne home to ensure that adult attention is required to cover and uncover the hot tub".

[219] In making that recommendation, Ms Schellenberg did not consult anyone, did not read any materials, but simply applied her common sense. She concluded that her recommendation would result in the requirement that the actual hot tub would be covered, as opposed to the room secured, necessitating adult intervention to access the hot tub.

[220] On June 23rd, the Paynes told Ms Schellenberg that the hot tub was not in use. When she looked in the room, she saw no evidence of use at all. She does not recall whether or not she saw water in it, although Mr. Payne had told her the hot tub had been drained and would remain so. The recommendation concerning a cover was made, notwithstanding Mr. Payne's advice that the hot tub would not be used, because at some future point if it were used the recommendation would be helpful.

[221] Ms Schellenberg further recommended foster care standards be established regarding hot tub and indoor swimming pool safety, including access, covers, and other safety precautions. She had, in making that recommendation, no recourse to any written materials or resources. When making all of her recommendations, Ms Schellenberg spoke to Gary Johnson, one of the adoption supervisors, to discuss her understanding that there were no standards pertaining to hot tubs in foster homes.

[222] Ms Schellenberg's third recommendation was "that the Branch continues to provide support to this foster home and the children placed with

them". What Ms Schellenberg says she meant by that was that the family should be supported through this terrible time because they were a valuable resource for children in Agency care.

[223] When asked by counsel for the Department of Family Services and Housing whether there was any issue of neglect with respect to the incident, Ms Schellenberg's response was as follows:

> "I think it can be argued that for Ms Payne to have left this child, or Mr. Payne, for them both to have left this child unattended for a certain period of time where she got into the hot tub room, I think there could be an argument made for neglect."

[224] With respect to Ms Schellenberg's recommendation #1, that a more substantial hot tub cover be installed, Ms Schellenberg advised that she was not familiar with hot tubs. Her experience with them had been restricted to one in her friend's yard. She observed a heavy foam cover on her friend's hot tub, and that was the foundation for her recommendation of the appropriateness of such a cover. As to her second recommendation, that foster care standards be established regarding hot tub and indoor swimming pool safety, she did not know, at the time of her evidence, whether or not this had been done.

e) Evidence of Liisa Cheshire

[225] At the time of Lynda Schellenberg's investigation of Keyanna Snowdon's death, Ms Cheshire had been a supervisor of one of the abuse units for two and a half years. Her role as supervisor was to monitor the investigation ensuring all appropriate steps were taken, and the final risk assessment completed was accurate. She was consulted at each stage of the investigation by Ms Schellenberg. This report was submitted to the Child Abuse Committee and the conclusion was that no abuse had occurred.

[226] When asked whether there were concerns whether the Paynes had been neglectful of the child, Ms Cheshire said:

> "We gave due consideration to that. Given all of the wealth of information that we gathered throughout the course of the investigation, we concluded that it was not an incident of neglect, but rather an incident of an accident."

[227] When asked whether having lost track of the child for ten minutes would, in and of itself, constitute neglect it was Ms Cheshire's opinion that:

> "Losing track of a child for a number of minutes would not qualify as meeting community standards for neglect. It could happen, and does happen, sadly, for any kind of family."

[228] With respect to the recommendation concerning hot tub covers, Ms Cheshire testified that she had no knowledge of hot tubs or covers other than that gained from her personal life experience. In terms of foster care standards, she was not aware of that recommendation being pursued by anyone at the Agency, Director or any level.

[229] As to children remaining in the Payne foster home, it was Ms Schellenberg and Ms Cheshire's risk assessment that the children remaining in the home were at low risk of future harm with respect to the hot tub.

f) Evidence of Ellen Ann Peel

[230] Ms Peel is responsible for the resource programs for support staff working with families and children. Prior to Keyanna Snowdon's death May 12, 2004, Ms Peel had no personal involvement or knowledge with respect to Keyanna Snowdon or her placement with the Paynes. Ms Peel described the licensing process for foster homes presently as being more thorough than when Lee Payne was licensed in 1977. Until 1999, foster home licenses were issued for a two year period. Now there is a thorough written review annually.

[231] The kind of support and training offered to foster parents historically has varied over the years. More recently, larger agencies like Winnipeg Child and Family Services have developed specialized foster home programs within the organization. Specific training in areas of child development, fetal alcohol effects, mental illness and other specialized issues is much more available now than it would have been around 1977.

[232] Although foster parents initially go through training, there is other training, and updating made available to foster parents. The Agency offers periodic workshop-type training on a variety of topics either by invitation to all foster parents, or tailored to a particular population of children and parents meeting the needs of those children. The continual training is not mandatory.

[233] The annual foster home review is, however, mandatory. A six page document must be completed. One of the sections relates to health and safety factors. Some of the factors to be addressed in executing the review include the presence of smoke detectors, proper storage of guns, proper storage of alcohol, the presence of an approved fire extinguisher, safe storage of hazardous products and so on. There is also a heading for changes in the physical structure, if renovation has taken place.

[234] Ms Peel testified that there is presently no standard, regulation, protocol, or anything in writing from Winnipeg Child and Family Service or the Province specifically addressing hot tubs in foster placements. In the licensing process, nothing exists with respect to a specific recommendation or direction concerning hot tubs in foster homes. Ms Peel, however, would expect that incidental to preparation of a home study on a perspective foster parent, a hot tub would be referenced. The principal issue is to ensure that there are adequate safety precautions around the use of recreational facilities. The overriding concern is adequate supervision.

[235] In her evidence, Ms Peel confirmed that notwithstanding recommendations in the Schellenberg/Cheshire report, regarding the creation of standards for foster homes with hot tubs, no action has been taken by the Province or the Director. Although Ms Peel had no data collected on the number of foster homes with hot tubs, it was her impression that it would be a small number.

[236] There presently is no requirement that foster parents obtain training in CPR unless in an extraordinary situation such as a high medical need. Ms Peel thought children would be encouraged to take swimming lessons and confirmed that financial support is provided for swimming lessons.

[237] Ms Peel testified that the abuse investigation reports are ultimately sent to her because she has an overview of the foster care program as one of her responsibilities. When she receives a report of this nature, she generally discusses it with the supervisor, foster care supervisor, and foster care social worker. In this particular circumstance, at that time there was an assistant program manager directly responsible for foster care. Ms Peel discussed it with her. It was Ms Peel's belief that the individuals she would have then discussed the report with were Anita Krohn and Colette MacPherson according to protocol.

[238] Winnipeg Child and Family Service has in the neighbourhood of 700-800 foster homes. Ms Peel was of the view that there was an appreciation by staff within the Branch that hot tubs are a potential hazard to children. Ms Peel did not see any difficulty with the suggestion, in the abuse report, of mandating a hard cover in foster homes with hot tubs. She also thought that a general information session for foster parents who have hot tubs or a swimming pool, to ensure their awareness of the dangers was certainly feasible. She was concerned that a recommendation that foster parents and children take swimming lessons if there is a hot tub in the home, was problematic. Swimming lessons may not be appropriate for them, in Ms Peel's view, because of their age or physical condition. Ms Peel

saw no difficulty with the requirement that foster parents who have a hot tub or pool in their home take a CPR course.

[239] In the December 9, 2003 foster home review on the Payne residence, there was no reference to a hot tub in the Payne home. Ms Peel noted that any hazardous device in the home should be mentioned, but they are not always. Ms Peel would include a hot tub in the category of potentially hazardous devices.

[240] Ms Peel estimated that of 800 foster homes, perhaps 20 would have hot tubs. The number of children potentially available for placement in those homes, because there are not that many homes, would not be great.

g) Evidence of Colette MacPherson

[241] From August 4, 2003 to May 14, 2005 Ms MacPherson was the supervisor of foster home social workers including Anita Krohn.

[242] Ms MacPherson was not aware that there was a hot tub in the Payne residence at the time of Keyanna's death. She would have expected her staff would discuss this in the physical inspection process. Although there were no policies or guidelines for social workers to address safety issues in respect of hot tubs or indoor pools in foster homes, Ms MacPherson testified that was caught by social work best practices relating to anything in a foster home that poses any kind of potential risk. After the incident, within her unit, Ms MacPherson was aware of a count taken of hot tubs and pools in foster homes. Twelve foster homes dealt with by Ms MacPherson's team had a pool or a hot tub out of 320. Some homes may have had both a pool and a hot tub.

h) Evidence of Linda Burnside

[243] Ms Burnside, Director of Authority Relations for the Child Protection Branch, is involved in the restructuring process as a result of the Aboriginal Justice Inquiry Child Welfare Initiative. She and her team are responsible for ensuring that the Child and Family Service Authorities and their agencies are complying with provincial standards. Ms Burnside testified that there are approximately 30 agencies. They vary in size.

[244] If there were an interest in developing new standards, they would also be implemented and the responsibility of the Child Protection Branch. Ms Burnside's role, in working with the Authorities through the Standing Committee, is to work with members of the Authorities around the development of standards, the compliance with standards, and ensuring that the service delivery system is

adequately functioning. She expressed the hope that any recommendations flowing from this inquest would take some of the issues relating to balancing enhanced safety with creating undue expectations that are difficult or impossible for agencies to meet.

III. WITNESSES CONNECTED TO REGULATORY ENTITIES

a) Evidence of Basil Charles Van Haute

[245] Mr. Van Haute, Director of Child and Family Resources, Department of Family Services and Housing, testified that the Child and Family Services Act defines the responsibility for licensing of foster homes as a Child and Family Service Agency responsibility. The foster home licensing regulation, pursuant to the Child and Family Services Act identifies the requirements for licensing of a foster home. A manual has been developed by the Branch providing information to agencies regarding the licensing process.

[246] One of the documents in the manual is the Public Health Act Regulation regarding outdoor pools and hot tubs. There is nothing in the manual that deals with indoor hot tubs.

[247] Following the incident here, Mr. Van Haute did a more in-depth review to determine legislation in existence. He concluded that there is a dearth of regulatory schemes surrounding hot tubs in homes.

[248] The Provincial Foster Home Manual serves as a reference for Child and Family Service Agencies in the licensing of foster homes. Mr. Van Haute testified that it was developed in collaboration with the Agencies and his Branch. The reason that the Licensing Manual, according to Mr. Van Haute, does not address indoor hot tubs is that the manual strives not to duplicate what is already dealt with in other legislation. The Branch relies on authorities with jurisdiction in those areas to provide direction in terms of the best course to take.

[249] There is only one reference to open water bodies and child safety entitled “Drowning”. It deals with bathtubs, buckets, above ground pools, and backyard pools. It also speaks generally about water safety. There is no reference to hot tubs, indoor or outdoor.

[250] The Branch is in the process of completing a major review of its standards. Work on the area of foster care is just beginning. This is one of the issues that will be given consideration relating to the need for a standard in relation to an indoor hot tub. Three documents would need to be considered – the Standards

Manual, the Foster Home Licensing Manual, and regulations that deal specifically with foster home licensing.

b) Evidence of Richard John Sokolowski

[251] Mr. Sokolowski is a senior consultant with the Department of Conservation, Province of Manitoba. He is the senior person in the area of public health programs administered throughout the province. He provides advice to public health inspectors in the Department of Conservation.

[252] The Department administers the Public Health Act, the Environment Act, the Dangerous Goods Handling and Transportation Act, the Contaminated Sites Remediation and Consequential Amendments Act. In the course of his professional responsibilities, Mr. Sokolowski sits on a committee that reviews swimming pool regulations.

[253] The 350-400 semi-public and public pools and hot tubs are inspected by Mr. Sokolowski's department. The City of Winnipeg still has jurisdiction over the old City of Winnipeg boundaries. The provincial health inspectors have jurisdiction in the suburbs around Winnipeg, and the rest of the province.

[254] When a public health inspector inspects a hot tub, they have an inspection sheet used as a guideline. Among the factors inspected, would be signage, water quality, sanitation, first aid kit. The inspector would check that the automatic shut-off switch works, the water temperature, and any other safety issue around the pool and deck.

[255] In a hot tub, there are four mandatory requirements. Long hair must be restrained to minimize the risk of getting caught in the equipment. Individuals must keep head above water at all times. No person shall remain in the whirlpool longer than ten minutes, and children under the age of 12 must be accompanied by an adult.

[256] Mr. Sokolowski did not know the origin of the age of 12 as the minimum for independent attendance in a hot tub. After initial opening, a routine inspection would take ten minutes. It could take longer if there were a problem, or if one were dealing with the operator.

[257] Commenting upon photographs of the Payne hot tub taken by police in connection with Keyanna Snowdon's drowning, Mr. Sokolowski said that the number of items on the deck would not be permitted. Deck size is covered by regulation and if the pool is less than 7 square meters, one must have a 1.3 meter

deck on two sides. The idea for minimum space surrounding the hot tub is to permit access in the event of an emergency. Otherwise, theoretically someone could put it in a room with a door opening and no deck at all.

[258] If the Payne pool were public, warning signs and depth markings would be required. A rail would be required, depending on the depth for walking down the stairs. Inspectors try to ensure a non-slip surface. The shut-off switch must be easily accessible. Hot tub load is required by regulation to be no more than one person per square meter unless the manufacturer has different recommendations. There is a requirement for a first aid kit.

[259] Mr. Sokolowski would recommend covers to make hot tub environments safer for children. Saying that, he acknowledged that covers were not a requirement for semi-public hot tubs. The other recommendation would be a locked room. Recognizing that practicalities may involve hot tubs in major areas his primary recommendation was a hard cover.

[260] Mr. Sokolowski testified that City of Winnipeg inspectors, not having a by-law, use a provincial regulation for swimming pools and whirlpools. Supervision, from Mr. Sokolowski's perspective, means the adult is nearby the child, not necessarily in the tub.

[261] Mr. Sokolowski testified that the strategy for the inspection of public whirlpools and swimming pools is by surprise visit. If it were by appointment, there would be an opportunity for someone to correct things that would not be that way under normal operating conditions.

[262] The regulations were amended to include individuals not putting their head under the surface of the water, meaning no swimming in the whirlpool, for safety. The concerns related to hair entanglement, medical concern over putting one's face under the hot water for an extended period, and sanitation.

c) Evidence of Peter Parys

[263] Mr. Parys is the administrative coordinator of Community and Environmental Health Services for the City of Winnipeg. He is responsible for the Insect Control Branch and Environmental Health Services. The health inspectors employed by the City of Winnipeg fall under his responsibility. The City presently has 24 positions at the field level, and 3 supervisors. These 27 individuals report to Mr. Parys. Inspection of pools and whirlpools falls under his jurisdiction in public and semi-public environments. In the City of Winnipeg, at last count, that comprised 133 facilities. Pools and hot tubs are inspected, on average, 3 to 4 times

a year. From that, subsequent re-inspections may arise from findings on an inspection. Inspections are usually unannounced. Outdoor pools may be inspected less frequently, because they are seasonal. The 133 number referred to, also includes wading pools. The laws inspectors enforce are the regulations under the Public Health Act. There are no additional City by-laws regulating swimming pools.

d) Evidence of Gregory Charles Marsh

[264] Mr. Marsh has been a public health inspector for the City of Winnipeg, Environmental Health Services for 15 years. He recently participated in a committee reviewing regulations and recommending changes in the Public Health Act. He also was one of three co-authors of the Pool Safe Manual for Pool Operators currently used by several schools that teach the environmental health program.

[265] Mr. Marsh did not know where the age of 12 as a minimum requirement to use a hot tub unaccompanied by an adult, came from originally. In a hotel, for example, a typical inspection would probably take an hour assuming no problems. Mr. Marsh's estimated time of an hour, different from the 10 and 20 minute estimates from other witnesses, includes producing a printout of violations produced on the computer and reviewing it with the operator to ensure corrections are made and to reduce potential difficulties in the future.

[266] Commenting on photographs of the Payne hot tub taken by police, Mr. Marsh testified that he would recommend cleaning up the pool deck. The articles and items of clutter would prevent clear access in case of an emergency.

[267] In the case of a public or semi-public whirlpool, regulations require an emergency shut-off valve. The largest concern arising from the photographs, for Mr. Marsh, is the decking. The tools and other objects by the pool ought not to be there. Were this a semi-public situation, the decking itself is insufficient around the whirlpool. The stair treads should be contrasting in colour to show where the step is and where it ends.

[268] Semi-public whirlpools are usually drained and refilled about once a week, due to the large amount of usage. Replacing the water reduces the growth of organisms that can cause various health problems.

[269] Although the Department's regular hours of work are 8:30 to 4:30 Monday to Friday, if a complaint is received or the usual hours of operation of the facility are outside those hours, they inspect after hours.

e) Evidence of John Barnes

[270] Mr. Barnes is the Chief Housing Inspector with the City of Winnipeg, Planning, Property and Development Branch. He testified with respect to the renovations at 3614 Batchelor Avenue, the Payne residence.

[271] When the hot tub was installed, there was an electrical inspection as well as a building inspection required. The electrical inspection would be more comprehensive, involving more of the components of the tub itself. The building inspection would be related specifically to the structural component supporting the weight of the tub.

[272] The building permit was issued May 2, 1984 and the electrical permit September 1985. The electrical permit application indicated 200 amp service being installed so the electrical permit and the building permit are related. This was a homeowner's addition project that took several years. A permit is required for the installation of a hot tub today. If the hot tub is being installed inside a house, the safety requirements are considerably less than those that apply if a hot tub is being installed outside where it could be accessible to the public. There are no safety requirements beyond the electrical required for an installation inside a dwelling. Unfortunately, in many cases, this work is done without the appropriate permits. Sometimes the Department is notified by way of complaint. Often the Department is not notified at all. Mr. Barnes speculated that probably more people do not take out permits than do.

[273] The fees for the permits involved are assessed based on the value of the work declared by the applicant. In this case, the value of the work declared by the applicant was $30,000.00. Here there were no water lines directly connected to the tub, and no drain directly connected to the tub. The tub would have to be filled and drained by some other method.

[274] The number of permits issued for a hot tub installation in the City of Winnipeg in 2005 were 45, in 2004 there were 36, in 2003, there were 37 hot tub permits issued, in 2002 there were 35 hot tubs and in 2001 there were 44 hot tub related permits issued.

[275] If there were enhanced safety standards, the inspection would not see significant impact because inspectors are attending sites anyway to inspect electrical and building permits.

IV. WITNESSES CONCERNING SPECIFIC ISSUES

a) Evidence of Dr. Robert Andrew Grierson

[276] On May 12, 2004, Dr. Grierson was, and currently is, the Medical Director of the Winnipeg Fire Paramedic Service, in addition to being an emergency physician at the Health Sciences Centre in Winnipeg. As Medical Director of the Winnipeg Fire Paramedic Service, the medical skills that both firefighters and paramedics practice in the field are conducted under his medical licence. The majority of the skills performed are considered delegated medical skills, requiring a physician to oversee them. Administratively, Dr. Grierson also liaises with the WRHA for other types of protocols.

[277] Included in his supervisory responsibility is paramedic training, and maintenance of training. Approximately 200 paramedics and 800 firefighters practice under his supervision. He testified concerning the training and experience generally required for the official classifications of primary care paramedic, and advanced care paramedics. These are nationally recognized classifications. The additional nationally recognized level, critical care paramedic, generally is dedicated to those who transport critical patients in airplanes and helicopters for long distances. Usually, the practice of para-medicine in Winnipeg does not include that skill set. Advanced care paramedics have more experience, and skills than primary care paramedics. They have, for example, the ability to intubate, start an intravenous, and administer a number of different medications. They have advanced trauma management skills and perform needle decompression of the chest. They can perform advanced airway management above intubation for trauma patients. There is an extensive list of their skill set in addition to what can be performed by a primary care paramedic. In Winnipeg, of the 200 paramedics, 60 are advanced care paramedics.

[278] The 14 supervisors have advanced training in pediatric advanced care management. Specifically, regarding pediatric intubation, they have an additional two days of course work and classroom. They have spent time in the Childrens' operating room learning to intubate children, and start intravenouses. They have spent a day in the pediatric recovery room managing children coming out of anaesthesia in addition to an enhanced skill set relating to obstetric patients, dialysis patients, and others.

[279] The reason 14 individuals are trained in this position, is that the goal is to have two on the street at all times.

[280] Dr. Grierson testified that in addition to being regulated by the College of Physicians and Surgeons of Manitoba, he is advised by the Medical Advisory Committee of the Winnipeg Fire Paramedic Service. This advisory committee, comprised of 10 physicians and 10 other individuals within the health care system, assist Dr. Grierson in making decisions concerning medical practices and protocols of the Winnipeg Fire Paramedic Service.

[281] John McKay, paramedic, testified that when he was previously employed in Selkirk as a paramedic, under the supervision of Dr. Colin Nesbitt as Medical Director, he was permitted to perform endotracheal intubation of children. It was his view that had he been able to insert an endotracheal tube at the scene in Keyanna Snowdon, the insertion could have performed earlier than when it was performed by supervisor Grant Hemerling who arrived on the scene after Mr. McKay.

[282] Dr. Grierson testified that when a decision is made, the Committee requires evidence. Concerning the skill of pediatric intubation, Dr. Grierson said that the evidence clearly supports keeping that skill in a small group of individuals, resulting in the ability to maintain a high level of skill and training which may not be possible if a larger group were involved.

[283] In 2004, in Winnipeg, there were 60,000 patient care instances. Of those 60,000 calls, there were 18 where a child was intubated. Clearly, there are a very small number of instances where the skill is utilized. Children, in this context, are considered those 9 years of age and under.

[284] Dr. Grierson referred to an important article from the Journal of the American Medical Association in the year 2000 studying this issue. The study, filed as an exhibit in these proceedings, compared pediatric intubation versus bag valve mask ventilation where an oxygen mask is placed over the individual’s mouth and nose. The issues ultimately considered were survival to hospital discharge of children, and neurological outcomes.

[285] The study reflected no difference between the two procedures in terms of survival to hospital discharge and neurological outcome. The children managed with bag valve ventilation did equally well to the children intubated. Importantly to Dr. Grierson, was that in the group where intubation was attempted there was a longer on scene time of the call and only a 50% success rate in intubation. Dr. Grierson compared that to the Winnipeg Fire Paramedic Service success rate when last studied of 94%.

[286] Of significance to Dr. Grierson, two groups of pediatric cardiac arrests were in the study where the intubated children did worse than the children treated by bag valve mask ventilation – children who had respiratory arrest prior to cardiac arrest and children that were the victims of child abuse.

[287] It was believed that the intubated children did worse because of the longer scene time. Another point of interest was that the intubated group sustained a fatal complication of the intubation procedure itself, 8% of the time.

[288] Dr. Grierson testified that this particular study lead to a big change in practice across North America, with respect to how pediatric intubation is viewed.

[289] Dr. Grierson confirmed that an endotracheal tube is the gold standard for airway management, but clearly is not so if it is not going to be performed properly and in a timely fashion. In addition, Dr. Grierson noted that the instructor manual for the pediatric advanced life support course internationally recognized and mandated through the Heart and Stroke Foundation of Canada references the exact article. It noted that if individuals are going to perform pediatric intubation, one must ensure that those individuals do the skill frequently enough to maintain the skill is critical.

[290] Dr. Grierson further testified that the decision to confine pediatric intubation to a small cadre of paramedics was supported by the College of Physicians and Surgeons, and the Medical Advisory Committee of the Winnipeg Fire Paramedic Service.

[291] Specifically, Dr. Tenenbein, pediatric expert on the Medical Advisory Committee and the Director of Childrens' Emergency at the Health Sciences Centre, further supported the decision on the basis that it would be impossible to train a large number of people to perform and maintain this skill because the operating room is not capable of accommodating them.

b) Evidence of Rochelle Kopp

[292] Ms Kopp presently occupies two roles with the Red Cross. She is the program representative for first aid and water safety for the Province of Manitoba. She is also specifically involved in managing the drowning data collection project for 2004 for the Province of Manitoba for the Canadian Red Cross. She holds a Bachelor's Degree in Recreational Studies, is presently pursuing a Bachelor's Degree in Nursing and holds an Emergency Medical Responder's Certificate from Red River Community College.

[293] Ms Kopp testified that drowning is one of the leading causes of death in children ages 1 through 4. Toddlers are the second most at risk group, second to adult males, for drowning. For any age, regardless of swimming ability, the Red Cross recommends continual supervision. In half the drownings that occur in toddlers, half are not supervised. In short, the Red Cross recommends that individuals never swim alone. The nature of supervision referred to with children, is within arm's reach. Even with bathtub safety, a parent should never leave a child alone in the water. Children can drown in as little as one inch of water.

[294] Ms Kopp testified that in a situation where three children were playing in a hot tub, ages 8, 5 and 5, supervision through French doors would not be appropriate in accordance with Red Cross views. The Red Cross advocates no diving of any sort in above ground, or in-ground home pools. They are too shallow, have various obstacles, and inclines. Specifically, in hot tubs, often one is unable to see the bottom so one has no idea of depth. People who dive into them have high rates of neck, and back injuries. The Red Cross has swimming education programming available starting with very young children designed for parent and child. The focus is parent education concerning water safety. The parent and child programming starts as young as six months.

[295] Ms Kopp testified that the standard for pool and hot tub use in public facilities requiring supervision for children under the age of 12 accords with the Red Cross position. There should always be some form of supervision, whether a lifeguard or a parent.

[296] Commenting on photographs of the Payne hot tub taken by police in connection with Keyanna Snowdon's drowning, Ms Kopp commented that the clutter in the hot tub area was problematic. The clutter, she testified, would be intriguing to a child, and hazardous in terms of tripping and falling into the hot tub. She recommended a self-latching cover for the top of the hot tub for when it is not in use. The Red Cross does further recommend that hot tubs or pools not in use be drained so they are not attractive for children.

[297] Hot tub jets cause a risk for entrapment for hair or articles of clothing to be caught. Ms Kopp testified that hot tubs should not be for children under 5, and not recommended for children under 12.

[298] Commenting on the yellow life jacket with Disney characters visible in the hot tub photograph Ms Payne had testified Keyanna wore in the hot tub, Ms Kopp remarked that the item is a personal flotation device. It does provide some safety for a child in the water. It could however flip a child onto their front

and leave them face down. A life jacket by contrast, will flip a person over onto their back. A personal flotation device will not. Ms Kopp emphasized that PFDs and life jackets are not a form of supervision. A child, even when wearing such a device, still needs to be within arm's reach of the supervisor.

[299] One of the key roles the Canadian Red Cross plays is injury prevention. The Red Cross is willing to provide anyone with information or information sessions free of charge.

[300] Ms Kopp, when asked her views on potential legislation in connection with hot tubs, said that legislation should be provincial, and mandatory. In her view, recommended standards would be insufficient. The statistics Ms Kopp referred to saw 39 hot tub drownings in Canada in a 10 year period, reflecting approximately 4 per year. The greatest improvements in drowning rates in Canada between 1991 and the year 2000 were among infants less than one year.

[301] From the Red Cross perspective, the most important endeavour to prevent future deaths, would be to ensure appropriate training if individuals are going to have hot tubs in and around their homes. The Red Cross would urge a self-latching gate surrounding the aquatic environment, fencing, and lids on the hot tub. In addition, a telephone almost within arm's reach of the pool area for emergencies would prevent the dilemma of having to leave the area of the emergency to summon assistance.

c) Evidence of Kenneth Tomihiro

[302] The Pool and Hot Tub Council of Canada is a voluntary membership trade association, representing manufacturers, retailers, builders, and service companies for swimming pools and hot tub equipment, and the pools and tubs themselves. Mr. Tomihiro is the Executive Director of the organization. At last count, the Pool and Hot Tub Council of Canada had 450 members. Mr. Tomihiro has held this position since 2000. He has been in the swimming pool industry since 1974.

[303] Mr. Tomihiro lives in Ontario. In that province, there are no regulations for pools and hot tubs at the municipal level except for barrier codes. The same goes for hot tubs. There is not a uniform standard across the province for residential units.

[304] In the public sector, swimming pools are governed by the Ontario Building Code. The operation is governed and regulated under the Health Act. Public hot tubs were only subject to regulation since July of 2005. Enforcement

commenced January 1, 2006. The change came as a result of a drowning in 2000 in a public hot tub in Ontario. Mr. Tomihiro was unaware of any jurisdiction in North America where residential hot tubs were regulated.

[305] A basic hot tub costs anywhere from $4,000-$20,000.00. In the case of custom installations, the cost can be higher. These costs do not include the cost of installation. In terms of operating costs, the higher the usage the greater the cost. With high usage, the jets are going to be used more often, and the chemical consumption higher. Mr. Tomihiro guessed the operating costs to be in the range of $1.00-$2.00 a day.

[306] With a modern hot tub, safety features include guards over the intake to prevent suction entrapment. From the electrical perspective, the systems are equipped with ground fault circuit interrupters. Most manufacturers supply a hard cover, which is like a vinyl covered foam slab. It is generally in two parts, which would insulate and protect. The cover would carry the weight of a child and most of the covers come equipped with mechanisms to lock them in place. These covers are available after market. They wear out over time, and need to be replaced. Even if the hot tub were so old that covers were not commercially available, it is possible to have a cover custom made to fit a hot tub. The cost would be from $300-$500.00.

[307] Soft covers are like an insulating blanket. They are similar to a solar blanket on a pool. They reduce evaporative losses and hopefully maintain some of the heat. They do not provide any form of safety. One of the difficulties with soft covers is that someone unaware may think the cover would carry their weight. They might step onto it, and in some cases end up in the water underneath the cover and not visible from outside the pool. Children, particularly, may be unaware and try to step on it.

[308] One of the functions of the Council is education and training. Members are encouraged to provide customers with not only technical information, but safety information. The Association publishes a series of safety pamphlets including one relating to sensible ways to enjoy your hot tub. It is a 20 page booklet, with a number of safety elements in it. With respect to specific safety advice for home hot tubs, Mr. Tomihiro said that he would need to know who was going to be using the hot tub. With a home including young children and newborns, he highlighted that the number one issue in almost every case of youth drowning is supervision. Mr. Tomihiro referred to the Life Saving Society's program called "Within Arms Reach". He said that the philosophy is that if children are outside of arms reach near a body of water, they are too far. The

Association works with the Life Saving Society to distribute that very same safety message. The Association members distribute Life Saving Society pamphlets as well.

[309] Mr. Tomihiro believed that the age of 12, below which hot tub use without supervision is not permitted by regulation, is a uniform age across the country. He did not know where the age of 12 came from.

[310] In terms of draining and refilling hot tubs, while there were formulas, the general recommendation is 3 or 4 months. Water that is there to stay requires filtration equipment and consistent sanitization.

[311] Commenting on a photograph taken by police of the Payne hot tub, Mr. Tomihiro observed the absence of a hard cover. He noted that access is then controlled only by the doors. He noted the items in the immediate area of the tub, and expressed concern about a tripping hazard. As to the toys surrounding the hot tub area, Mr. Tomihiro said that play toys are discouraged. A hot tub is not a miniature pool. It is not a place where you go to learn to swim. A false sense of security can be given in a pool with flotation devices. The room itself looked to Mr. Tomihiro more like a playroom than a place where the family goes to relax and enjoy, on an occasional basis.

[312] The difficulty with a playroom approach is that children go in when adults are not around. It is a soaking tub, not a playroom. If children are playing in the hot tub area, and a toy falls in the water they are going to try to retrieve it.

[313] Mr. Tomihiro would not encourage people to get in a hot tub with a floatation device. When the hot tub is in operation and the jets are on, the bubbling decreases visibility so you cannot see what is going on under the water.

[314] To the best of Mr. Tomihiro's recollection, there are no standards requiring a certain coefficient of friction for surfaces around a hot tub. They do require some anti-slip substances on the steps.

[315] From the Association's perspective, they would like to see a protocol to ensure that whatever regulations are already in place, are followed. One of those, he highlighted, is the Canadian Electrical Code. There is also a point at which a permit is going to have to be taken out for work on the pool or hot tub.

[316] If that electrical work is subject to a permit, at some point there must be an inspection by an electrical inspector. When a permit is taken out, the municipality could be proactive in the distribution of safety information. Member

retailers and dealers are encouraged to do the same thing, but there is no requirement. In Ontario, an apprenticeship has been created for pool and spa service technicians, and pool and spa builders. These are now recognized trades in the province. The Association feels that there needs to be more regulation of who operates pools and hot tubs because of the public danger, incidents of drowning, of transmission of infectious disease. Presently it is an industry that is totally unregulated.

[317] Mr. Tomihiro testified that there are regulations for construction and some of the daily maintenance, but what happens after one of the units gets built is up to a health inspector who may not have the expertise to address the mechanical components.

[318] He testified that some provinces have a requirement that the owner or operator of a public pool or hot tub get an annual operating permit. The Association is asking the Ontario government to bring in such a regulation. With it, comes an inspection component with the necessity for trained evaluators.

[319] In Ontario, the Ministry of Training, Colleges and Universities has approved the apprenticeship program with specific schools and a government approved format. The Association is working with the government to develop standards of competency for pool and hot tub operators and technicians in the public sector. On the issue of self-locking doors on the room containing the hot tub, Mr. Tomihiro acknowledged the benefit of that feature. He however noted that there were potential difficulties if a child is in trouble and the doors have locked and somebody is trying to get in to help. There has to be some override mechanism for an adult to be able to open the door to get into the area.

[320] Mr. Tomihiro observed that cost, particularly in the context of a private residence, is always an issue. The more endeavours implemented from a mechanical point of view, the higher the cost. He talked about potential for installation of sensory devices for movement, as in alarm systems otherwise in homes, cameras, and other forms of security that would enhance the cost of operation. From the industry's point of view, liability has become an increasingly significant issue. Mr. Tomihiro said that insurance companies are viewing the industry in a different light. From that perspective, the Association, in discussions with membership, highlights the necessity for the provision of safety information. Mr. Tomihiro described such an endeavour as a self-preservation mechanism.

[321] Mr. Tomihiro testified that it would not be a burden to retailers to impose a requirement to sell a cover with the hot tub. He said most of them are

doing that now. Most manufacturers, he testified, provide hot tubs with a locking cover already fitted to each model. The difficulty, he highlighted, is that every time you use the hot tub you take the lid off. It is incumbent on the user to put it back. Locking hard covers were not available until 15 years ago, and generally not offered in a package until about 10 years ago. There are homes with hot tubs installed 15 or 20 years ago that do not have locking covers. As an industry, Mr. Tomihiro was of the view that a requirement of selling a hard cover would be welcomed.

[322] In most cases today the hot tubs are self-contained units approved by CSA. The installation really consists of placing it in the room or the yard where the customer wants it. The requirement of certification of self-latching doors in the room could become a component of the building permit process.

PART B: DISCUSSION

[323] Pursuant to s.33(1) of **The Fatality Inquiries Act**, the duties of a provincial judge at an inquest are:

> 33(1) After completion of an inquest, the presiding provincial judge shall
>
> (a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
>
> (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and
>
> (c) send a copy of the report to the medical examiner who examined the body of the deceased person;
>
> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[324] In addition, pursuant to s.33(2)(b) of **The Fatality Inquiries Act**, in the report, the provincial judge:

> (b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

[325] In accordance with s.19(1) and s.19(2) of **The Fatality Inquiries Act**, Dr. A. Thambirajah Balachandra, Chief Medical Examiner, directed this inquest be held:

1. to determine the circumstances under which Keyanna's death occurred;

2. to examine codes, regulations and standards currently in effect across Manitoba, in urban centres as well as in rural municipalities, with respect to residential hot tubs, their installation, maintenance and user safety issues;

3. to examine the regulations and standards currently in effect across Manitoba with respect to the inspection and licencing of private residences as foster homes; and,

4. to determine what can be done to prevent deaths, similar to Keyanna's from occurring in the future.

[326] The evidence was clear that a residential hot tub presents a significant hazard to children in the home. It is impossible to over emphasize the importance of the recognition of the danger a hot tub presents, and the critical nature of maintaining vigilance to address it.

[327] As helpful as regulatory schemes are in providing a framework for minimum standards, the real key to enhanced water safety lies through education. The use of a home hot tub has the potential to enhance quality of life for family members. With that, goes the responsibility of fully understanding the risk presented by it, and taking adequate safety measures within the home. It is vital that those with hot tubs in the home never become complacent about the ever present hazard of a home hot tub.

[328] The evidence concerning the practices and protocols related to foster home licensing, foster care social worker and other Child and Family Services social worker training, related to Winnipeg Child and Family Services agency, as it then was. Recognizing that foster home licensing is an agency responsibility, subject to provincial regulation and standards, it is anticipated that all agencies will measure present practices against those recommended here concerning water and hot tub safety, with a view to ensuring a safe home environment for all foster children.

[329] This Court had a remarkable opportunity to develop a unique appreciation of Keyanna, through the evidence of many witnesses who loved and cared for her, and through seeing her in the video prepared of her in contemplation of being considered for adoption just prior to her tragic death. It is hoped that, through these recommendations, another death of a child in circumstances such as these will be prevented.

[330] I am tremendously indebted to counsel for the professional, sensitive, intelligent, and extremely helpful manner in which they dealt with some of the difficult evidence and issues connected with this inquest.

[331] Finally, Legal Aid Manitoba should be commended for appointing counsel for Janine Snowdon, Keyanna Marie Snowdon's birth mother. That she was able to be represented, greatly enhanced her ability to effectively participate in the proceedings.

PART C: RECOMMENDATIONS

1. **THAT foster care social workers receive training concerning water safety in general, and the specific dangers presented by bodies of water in the home specifically.**

[332] In this case, the foster care social worker was responsible for the annual inspections of the foster home as directed by the Foster Home Licensing Regulation. It was clear from the evidence that social workers for the children relied on the expertise of the foster care social worker for the safety of the home environment. The evidence was that there were no specific written guidelines with respect to hot tubs. Even though the foster care social workers work directly related to assessing safe environments for children and their families, she had received no specific training to water safety.

2. THAT all social workers in the area of child protection and children in care receive water safety training.

[333] The evidence of the social workers here was that they had not received such training. One social worker did not appreciate that a hot tub was a potential danger in a home with small children. Another would rely on the expertise of the foster care social worker concerning the safety of a child's home environment. All of the social workers who gave evidence at the inquest were very well experienced. Training in this area would address the need for all social workers to adequately assess the safety of the home environment with respect to water hazard.

3. THAT all foster parents receive mandatory training in connection with water safety.

4. THAT annual foster home reviews be conducted on time.

[334] Pursuant to s.3(5) of the Foster Home Licensing Regulation 18/99 Registered February 19, 1999, a foster home licence is issued for a one year period. Section 13(1) of the Regulation mandates a review prior to the expiry of the

licence to determine if the licence should be renewed. In this case, foster home reviews were conducted late because of work load. The regulation is clear on timelines for renewal reviews. The safety and appropriateness of the foster home environment is a critical responsibility of the foster care worker, and adherence to mandated timelines is essential.

5. THAT foster homes be subject to unscheduled inspections as a regular, rather than extraordinary, occurrence.

[335] Photographs of the hot tub area taken by police as a consequence of Keyanna Snowdon's drowning, reflect a hot tub room cluttered by towels, toys, power tools, buckets of nails and other debris. Constable Mike Chiborak noted all of this, and commented that he almost fell into the tub. Various social workers, when presented with photos taken by police, testified that if they found the tub in this condition, they would have asked that it be cleaned up or notified the foster care social worker of the condition. Mr. Sokolowski testified that the number of items on the deck surrounding the Payne hot tub would not be permitted in the inspection of the public hot tub by the Province. Mr. Marsh, public health inspector for the City of Winnipeg, noted that the tools and other objects by the pool ought not to have been there. Rochelle Kopp, for the Red Cross, noted the clutter unacceptable. Mr. Tomihiro, for the Pool and Hot Tub Council of Canada, expressed concern about tripping hazard presented by the debris.

[336] The evidence was clear that the Paynes were experienced and highly regarded foster parents. They had been fostering for over 25 years, subject to inspection. Ms Payne, in her evidence, was unaware of the extent of the debris in the hot tub room. Even after the events here, the Payne residence has still not been the subject of an unscheduled inspection.

[337] It is recognized that it is very important to be respectful of foster parents, and minimize privacy intrusions. On the other hand, the importance of maintaining a safe environment in the foster home cannot be over emphasized. Regardless of the experience of the foster home, an unplanned inspection could identify hazards in the home not revealed in the course of an anticipated inspection.

6. THAT foster care social workers' work hours be subject to sufficient flexibility to accommodate after hours unplanned inspections and accommodate foster parents' work hours.

[338] In this case, the foster father worked full time outside the home. As a consequence, he does not think he had been home for any of the annual

inspections. He was not present for any inspection conducted subsequent to May 12, 2004. It was apparent from the foster care social worker's evidence that her work hours were restricted to 8:30 a.m. to 4:30 p.m. It was clear that she did not contact foster parents on a regular basis in the evening. Greater flexibility in the foster care social worker's regular hours of employment would greater accommodate annual inspections involving foster parents who work outside the home, and better facilitate unannounced inspections.

7. THAT all foster parents in the home should be present for annual inspections, and sign the foster home report.

[339] All foster parents in the foster home are engaged in the care of the children and the maintenance and appropriateness of the home environment. As a consequence, it is important that each foster parent in the home participate in the dialogue necessitated by the review process, and sign the report acknowledging all the issues reflected in it.

8. THAT the foster home review check sheet include, in the section relating to "safety/health factors", the existence of a hot tub and a confirmation that safety of the environment has been checked.

[340] The form presently reflects a number of hazards including guns, alcohol storage, hazardous product storage, etc. The form is used as a check list for review in the course of the annual inspection. The addition of the existence of a hot tub to the form would serve to highlight the existence of a hot tub as a risk factor in the home, and mandate the confirmation of the continued safety of that environment.

9. THAT the Child and Family Services Program Standards manual, in its discussion of the physical structure of the home, include the existence of a hot tub. The importance of the hot tub environment being in a locked room and inaccessible to children without adult supervision should be highlighted. The standards should also include that the hot tub environment is devoid of apparent hazard.

10. THAT every hot tub in a foster home be secured by a locking hard cover when the hot tub is not in use and that the hard cover be removed from the hot tub for use and replaced only by an adult.

11. THAT the Province enact regulations with respect to safety standards for residential hot tubs, addressing issues of installation, maintenance, and user safety.

[341] It is impossible to determine whether the physical configuration of the Payne hot tub contributed to Keyanna Snowdon's drowning, as no one saw her fall in the hot tub. The evidence does disclose, however, the physical structure inconsistent with public health standards, and concerns expressed by several of the witnesses about it from a safety perspective. That guidance from the regulatory scheme applicable to public hot tubs is of some assistance in the residential environment, is illustrated in part by the fact that Mr. Van Haute included those regulations in the Foster Home Licensing reference manual as a guideline even though they did not apply to residential hot tubs.

[342] Mr. Tomihiro, of the Pool and Hot Tub Council of Canada, was unaware of any jurisdiction in North America where residential hot tubs were regulated. Based on the evidence presented at this inquest, and considering the significant risk that hot tubs present in the home, particularly to children, Manitoba has a real opportunity to be a leader in this initiative.

12. THAT a consultative committee comprised of interested community partners be struck to assist the province in the design and implementation of the recommended regulatory scheme.

[343] This inquest heard evidence from private industry including The Pool and Hot Tub Council of Canada, the community water safety sector through the Canadian Red Cross, and representatives of the Municipal and Provincial agencies concerned with public and semi-public safety. All indicated a willingness to collaborate and consult relative to residential hot tub safety in the province.

I respectfully submit my recommendations and conclude this Report this 27th day of July, 2006 at the City of Winnipeg, in Manitoba.

"ORIGINAL SIGNED BY"

HEATHER PULLAN, P.J.

WITNESS LIST

Jeff Derraugh, Firefighter

Marco Cecchetto, Firefighter

John Hendrik Cornelius Van Der Horst, Firefighter

Randolph Colin Pearson, Firefighter

Grant Peter Hemmerling, Medical Supervisor, City of Winnipeg, Fire Paramedic Service

John Murray Mackay, Paramedic, Winnipeg Fire Paramedic Service

Denise McKendry, Paramedic, Winnipeg Fire Paramedic Service

Scott Robert Meakin, Constable, Winnipeg Police Service

Gordan Ulrich, Medical Supervisor, Winnipeg Fire Paramedic Service

Dean Klein, Constable, Winnipeg Police Service

David Charles Littman, Forensic Pathologist

Constable Léveillé, Identification Unit, Winnipeg Police Service

Lee Payne, Keyanna Snowdon's Foster Parent

Larry Payne, Keyanna Snowdon's Foster Parent

Constable Loverne Mathews, Child Abuse Unit, Winnipeg Police Service

Constable Mike Chiborak, Child Abuse Unit, Winnipeg Police Service

Anita Krohn, Foster Care Social Worker, Director of Child and Family Services, Winnipeg Region

Barbara Eileen Yuill, Social Worker, Director of Child and Family Services, Winnipeg Region

Deborah Jean Baty, Adoption Social Worker, Director of Child and Family Services

Lynda Schellenberg, Child Abuse Investigator, Director of Child and Family Services

Liisa Cheshire, Former Supervisor – Abuse Department, Director of Child and Family Services

Ellen Ann Peel, Resource Manager, Director of Child and Family Services, Winnipeg Region

Colette MacPherson, Former Foster Home Supervisor, Director of Child and Family Services

Basil Charles Van Haute, Director of Child & Family Resources, Government of Manitoba, Department of Family Services & Housing

Linda Burnside, Director of Authority Relations, Child Protection Branch

Dr. Robert Andrew Grierson, Medical Director, Winnipeg Fire Paramedics Service and Emergency Physician, Health Science Centre of Winnipeg

Rochelle Kopp, Program Representative for First Aid & Water Safety, Province of Manitoba; Project Manager 2004 Drowning Data Collection, Province of Manitoba for the Canadian Red Cross

Richard John Sokolowski, Senior Consultant, Department of Conservation, Province of Manitoba

Peter Parys, Administrative Coordinator of Community Environmental Health Services, City of Winnipeg

Gregory Charles Marsh, Public Health Inspector, Environmental Health Services, City of Winnipeg

Kenneth Tomihiro, Executive Director of the Pool and Hot Tub Council of Canada

John Barnes, Chief Housing Inspector, City of Winnipeg, Planning, Property & Development Branch

EXHIBIT LIST

Exhibit No.	Description
1.	30 Photographs of Scene
2.	Videotape of Keyanna Snowdon
3.	CD of 911 Call from Winnipeg Police Service
4.	Tape Cassette from Winnipeg Paramedic Service
5.	Emergency Medical Responder Patient Care Report re: Keyanna Snowdon
6.	Emergency Medical Responder Patient Care Report re: Lee Payne
7.	Pumper Company Report
8.	Narrative of Jeff Derraugh
9.	Diagram
10.	Program Standards Manual
11.	Booklet of photographs
12.	Letter of approval requirement checklist dated December 16, 1997
13.	Hand drawn diagram of residence
14.	Second hand drawn diagram of residence
15.	Police statement of Larry Payne
16.	Five-page curriculum vitae of Dr. Littman
17.	Autopsy report
18.	Excerpt of Section 460 to 468 from Program Standards Manual
19.	Copy of Foster Home Licensing Regulation

Exhibit No.	Description
20.	Six Page Foster Home Review Form
21.	Foster Home Review, December 15, 2004
22.	Copy of Email from Ms. Krohn to Cheryl Bergantim
23.	Ms. Krohn's File Notes re Payne Family
24.	Foster Home Licensing Regulations
25.	Copy of Section 20 from Foster Family Manual
26.	Foster Home Review, December 9, 2003
27.	Adoption social history on Keyanna Snowdon, dated May 5, 2004
28.	One page document entitled "At A Glance" and one page document entitled "Child's Profile"
29.	Typewritten notes of Deborah Baty, detailing chronology of events from May 12, 2004 to Fall 2004
30.	Excerpt from Child and Family Services program standards manual regarding death or injury of a child in care
31.	Nine page document titled: Section 182.1, Death of a child in care, dated May 13, 2004
32.	Two page document titled: Section 182.2, Death of a child in care, dated May 14, 2004
33.	Winnipeg Child and Family Services CRU intake and AHU forms prepared by Sandi Baranoski, dated May 12, 2004
34.	Photocopied contents of file produced by Anita Krohn
35.	Excerpt from Child and Family Services program standards manual, Section 336: Investigating child abuse in foster care
36.	Abuse investigation and closing summary, prepared by Lynda Schellenberg, dated September 2, 2004

Exhibit No.	Description
37.	Foster Family Manual
38.	Foster Home Review
39.	Three-page document titled Children's Foster Home Requirements Check List Dated November 25, 2004 re: Lee and Larry Payne
40.	Five-page document - typewritten file notes re: Payne foster home of Colette Macpherson
41.	Position description documents
42.	Curriculum vitae of Basil Van Haute
43.	Foster home licensing reference manual
44.	Section 10 report
45.	Curriculum vitae of Linda Burnside
46.	Document entitled Authority relations Director
47.	Booklet entitled Promise of Hope
48.	Chart entitled Child Death Review Process
49.	Small black binder containing Child and Family Services standards manual
50.	Seven page curriculum vitae of Robert Grierson
51.	Nine page American Medical Association report entitled, Effect of Out of Hospital Paediatric Endotracheal Intubation on Survival and Neurological Outcome
52.	Two page excerpt from instructor's manual -- P.A.L.S. Part 1, Chapter 5 -- The Science Behind the Paediatric Resuscitation Guidelines 2000
53.	Three documents including a three page letter dated September 12, 2003 to College of Physicians and Surgeons from Dr. R. Grierson; a one page letter of response from

Exhibit No.	Description
	Dr. J. B. Carson to Dr. R. Grierson dated October 21, 2003; and minutes of a meeting of the Medical Advisory Committee of the Winnipeg Fire Paramedic Service dated October 28, 2003
54.	One page excerpt from the Journal of Emergency Medicine entitled, Effect of Paramedic Experience on Pro Tracheal Intubation Success Rates
55.	Two page curriculum vitae of Rachelle Kopp
56.	31 pages of documents of the Red Cross Re Water Safety
57.	Copy of Regulations
58.	Letter from Kenneth Tomihiro to Andrew Barg dated May 18, 2005 and curriculum Vitae of Kenneth Tomihiro
59.	Package of documents including permits and related documents regarding the renovations of 3614 Batchelor Avenue
60.	Copy of City of Winnipeg bylaw number 3199/82
61.	Copy of City of Winnipeg bylaw number 4555/87