CANADA
Province of Alberta

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Law Courts, 1A Sir Winston Churchill Square

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

on the 3rd and 4th day of October, 2011 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before Judge D. M. Groves, a Provincial Court Judge,

into the death of Jason Dean Neate (Name in Full) 19 (Age)

of 18623 70 Avenue NW Edmonton, AB T5T 3A6 (Residence) and the following findings were made:

Date and Time of Death: January 14, 2009 at 1906 hours

Place: Misericordia Hospital

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

Sequelae of drowning. Jason Dean Neate had previously been diagnosed with epilepsy which was a significant condition contributing to his death.

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

Accidental

Circumstances under which Death occurred:

See attached

Recommendations for the prevention of similar deaths:

See attached

DATED November 15, 2011 ,

at Edmonton , Alberta.

Judge D. M. Groves
A Judge of the Provincial Court of Alberta

History and Scope of Inquiry

This inquiry was held on October 3rd and 4th, 2011. The inquiry concerned the death of Jason Dean Neate (Jason). The Court heard from ten witnesses. Nine exhibits were filed during the course of the testimony. Exhibit #1 was voluminous. Along with numerous documents provided by the YMCA, it comprised of extensive medical, hospital and emergency personnel documents.

Five counsel participated in the inquiry. Mr. Whittaker and Ms. S. Bowes served as Inquiry Counsel.

Because Jason Neate was swimming at the Jamie Platz YMCA at the time of the incident, the YMCA was granted interested party status. The YMCA was represented by Mr. D. L. Picco and Ms. C.L. Bond.

Dr. Leung was Jason's family physician and Dr. Tai was Jason's specialist who had diagnosed Jason with epilepsy. At the start of the Inquiry, Ms. L. Inglis-Chubb who was counsel for Drs. Tai and Leung made an application on their behalf for interested party status. That application was granted.

Murray Neate, Jason Neate's father, chose to participate as is his right under s. 49(2)(a) of the *Fatality Inquiries Act*. Mr. Murray Neate was unrepresented by counsel.

The purpose and scope of this Inquiry is determined by legislation. The purpose of this Inquiry does not include any findings of legal responsibility or reach any conclusions of law. The scope of the inquiry is limited to an inquiry into the cause of Jason Neate's death, the manner of his death, and the circumstances under which Jason Neate's death occurred. If recommendations are appropriate, it is open to the Judge presiding over the Inquiry to make recommendations to prevent similar deaths in the future.

Jason Neate's Background Circumstances

Jason Neate was 19 years of age at the time of his death in January 2009.

In 2006 Jason was diagnosed by Dr. Tai with non-convulsive seizures. The precise type of seizure was recorded as petit-mal seizures or temporal lobe seizures. Dr. Tai prescribed medications to help control Jason's seizures. Dr. Tai last saw Jason on September 22, 2008. By September 2008, Jason's condition was stabilized by the prescribed medications, and Dr. Tai did not consider it necessary to follow him as frequently. Dr. Tai testified that he would expect Jason to make an appointment if any problems presented.

Circumstances under which the Death occurred

On the afternoon of January 13, 2009 Jason Neate was swimming at the Jamie Platz YMCA Swimming Pool in Edmonton, Alberta. Jonathan Smith (Smith) was the lone lifeguard on duty.

Smith began his shift at 12:30 p.m. Smith testified that he did not take a break from supervising on deck before this incident, which occurred at approximately 2:45 p.m.

Smith testified that he noticed Jason enter the shallow end of the pool and then begin swimming in the lane pool. Smith positioned himself closer to the deep end where Jason and one other swimmer were swimming. Smith observed Jason to swim part way and then dive to the bottom of the pool, come up, and then continue swimming to the end of the lane. Smith found this

swimming pattern somewhat odd and so kept a watch on Jason. The second time Jason went to the bottom of the pool, Smith noticed Jason's arms stopped moving. Smith estimated that Jason was at the bottom of the pool for 15 seconds before he dove in to rescue him. Smith brought Jason to the surface and began emergency procedures. He covered Jason with blankets and continued monitoring Jason's breathing and pulse while he waited for the ambulance to arrive.

Included under Tab E-3, Exhibit 1 was the YMCA Aquatics Procedure Manual. Page 10 of this manual stipulates the qualifications needed to lifeguard in any Edmonton YMCA Acquatic Facility. In addition to an age requirement, a lifeguard must have successfully completed and obtained a National Lifeguard Service Award, Acquatic Emergency Care certificate, and Basic Rescuer CPR Level C. Smith had all of those qualifications and his certifications were up-to-date. Smith was certified as a lifeguard for approximately 3 ½ years and was employed by the Jamie Platz YMCA for 1 to 1 ½ years.

Brandon Kerfoot (Kerfoot) an off-duty lifeguard was the second responder to assist. Kerfoot entered the pool deck from the staff locker room and noticed Smith pulling Jason from the pool. Kerfoot pushed the emergency button to alert the front desk staff that assistance was needed. Kerfoot did not administer any first aid, but assisted Smith in moving Jason into a recovery position. Kerfoot did not notice any shepherd's hook on the pool deck.

Elizabeth-Anne Major (Major) was on deck at the time of the incident and was involved with instructing a swim lesson in the teach pool. Major testified that she heard a 'clang' and then a splash. She could not remember if she saw Smith enter the pool, but she did see Smith bring Jason out of the water. Major testified that she noticed the shepherd's hook on the pool deck near Smith. Major testified that normally the shepherd's hook was stored on the wall. Major did not see Smith use the shepherd's hook. Major used the deck phone to call 911 while Smith and Kerfoot were attending to Jason.

Included with a number of the documents entered as exhibits was an incident report prepared by an unknown staff member from the YMCA. The report indicated that the author of this report spoke with a Rudy Sherman (Sherman) on January 15th. The incident report indicated that Sherman was a patron at the pool at the time of this incident. Sherman was invited to complete a report but preferred that he be allowed to discuss matters over the phone. The report revealed that Sherman's version of events was somewhat different than that of Smith's. It was alleged, through the author of this incident report, that Sherman, who was also swimming in the lane pool, noticed Jason at the bottom of the pool. After waiting approximately 20 seconds, Sherman swam down and touched Jason. Sherman then surfaced and called for help. It is further alleged in this report that the lifeguard on duty, who was Smith, first used a pole to touch Jason before jumping into the water. Sherman was subpoenaed to attend the Inquiry but due to unexpected family circumstances he was unable to attend.

Evidence from Catherine Forner, Manager of On-Line Learning for the Canadian Red Cross Society, suggested that unless the Court accepted the hearsay evidence of an unidentified reporter regarding the allegations of Sherman, the emergency procedures performed by Smith were proper and complied with his training.

From everyone's account of the events, EMS arrived quickly. It was estimated that the ambulance arrived in less than 10 minutes after they were notified.

A review of the City of Edmonton Emergency Response Services Detailed Event sheet disclosed that the call was received at 14:58:46, and the EMS personnel were dispatched one minute later at 14:59:50. EMS arrived on scene at 15:04:01 and at 15:05:26 they were with Jason. They immediately began their assessment and at 15:07:56 started treatment. They left the Jamie Platz YMCA with Jason at 15:33:11 arriving at the Misericordia Hospital at 15:39:24.

Jason was placed under the care of the medical personnel at the Misericordia Hospital. There were no concerns raised surrounding Jason's treatment at the Misericordia Hospital. The following day January 14, 2009, Jason was pronounced dead.

The Certificate of Medical Examiner listed the immediate cause of death as sequelae of drowning, with other significant conditions contributing to the death but not causally related to the immediate cause as epilepsy. That assessment was also confirmed in the evidence of Dr. Tai, who testified that in his opinion, Jason likely suffered a seizure while swimming.

Events Prior to January 2009

Prior to January 2009 the Jamie Platz YMCA facility had never had an external audit performed on their site.

While all lifeguards were required to ensure their certifications were up-to-date, a stringent means of monitoring their compliance had not been implemented.

While attendance at in-service training sessions was mandatory for YMCA staff, accurate and detailed documentation of the topics covered during these sessions was not kept.

Staff were given manuals when they began their employment. Measures were implemented to ensure staff were aware of any changes in policy and procedure and employees were required to sign off that they read the manuals and any amendments thereto.

The Jamie Platz YMCA had a sign posted on the wall located to the left of the general locker rooms that included a warning that patrons suffering from any medical condition were to advise the lifeguard.

Steps Initiated Subsequent to this Event

Following this event, the YMCA implemented a number of action plans.

1) In January 2009 a new lifeguard certification tracking process was implemented, and in May 2009 a new audit process for certification was implemented.

2) A new Manager of Acquatics position was created in May 2009. This new position was responsible for four YMCA locations in Edmonton: Lutsky, Wheaton, Jamie Platz, and Castledowns. The primary responsibility of this new position was strategic vision for all four centers. The person responsible looked at risk management, education, communication to members, and supervised program delivery.

3) In April of 2009 the facilities began archiving their aquatic in-service records.

4) In January 2010 a new aquatics performance evaluation was undertaken.

5) In February 2010, the YMCA engaged in a relationship with the Lifesaving Society to undertake a comprehensive safety audit of the YMCA aquatic facilities. This safety audit was conducted on the Jamie Platz facility in September 2010.

6) In 2010 a lifeguard fitness skills program was implemented.

7) In 2010 the Lifesaving Society conducted a "Lifeguard Position Training" at each of the YMCA facilities. Jamie Platz had their training session in April 2010.

8) In September 2010 the YMCA "Aquatic Emergency Policies and Procedure Manuals" were reviewed, updated and consolidated.

9) And finally, in February 2011, the YMCA once again engaged the services of the Lifesaving Society to perform a specific issue (topical) audit of the Jamie Platz facility. This time to look specifically at lifeguard positioning analysis in order to identify what steps should be taken to minimize the risk of drowning or serious water-related injuries within the area of Lifeguard Safety and Supervision Systems.

Independent Audit

At the request of this Court an independent audit was conducted by the Canadian Red Cross Society who prepared a report dated September 22, 2011. The report provided recommendations to improve the overall aquatic operation at the Jamie Platz facility, and to enhance the safety of all persons participating in the aquatic recreation activities.

The recommendations were divided into three categories: 1) staff; 2) policies, procedures, and operations; and 3) the physical aquatic facility.

1. Staff

a) *In-service Training*

Since the Canadian Red Cross Society did not have access to all the YMCA documentation concerning in-service training, some of their recommendations were generic in nature.

While in-service training was always and continues to be mandatory for the YMCA staff, from the evidence presented at the Inquiry detailed documentation of these sessions was not previously maintained. Evidence was tendered during the Inquiry and entered as Exhibit #5, that as of April 26, 2009 accurate and detailed documentation of these in-service training sessions were now being kept.

b) *Primary Lifeguard Duties*

The Canadian Red Cross Society had concerns regarding the requirement that lifeguards were responsible for clean-up and pool maintenance while performing their surveillance duties. It was recommended that any reference in the "Aquatics Procedure Manual" to the performance of additional duties while on deck performing patron surveillance should be removed from the manual.

2. Policies, Procedures, and Operations

Recommendations were made that would require all emergency procedures to be performed by aquatic staff, to be found in one location. In fact, this change has been implemented in the new "YMCA of Edmonton Aquatics Emergency Procedures Manual" that came into effect in September 2010.

The Red Cross Society also recommended that there be a consolidated aquatic staff policy and procedure manual which would contain all the information necessary for aquatic staff to perform their job.

The Canadian Red Cross Society further recommended that the documentation used to report incidents be revised, and that in-service training sessions be provided to educate staff on how to properly complete this documentation.

3. Facilities and Equipment

Recommendations were made that legislation should be amended requiring signage to be posted that informs patrons that they should consult their physician prior to engaging in aquatic recreational activities.

The Red Cross supported the Jamie Platz YMCA's initiative to post a sign advising that patrons are to advise lifeguards of any medical condition, despite that this is not required by legislation. The Canadian Red Cross Society also recommended that the warning include examples of serious medical conditions that should be brought to the attention of a lifeguard.

Recommendations

Given the significant initiatives that the YMCA has undertaken since January 2009, the recommendations that this Inquiry may suggest to prevent similar deaths in the future are limited.

One recommendation for change involves a consolidation of manuals. It became apparent from a review of all the YMCA manuals entered as exhibits, that aside from the general confusion that can result from duplicity, some inconsistencies existed between them. I would strongly urge, and as was suggested by the Canadian Red Cross Society, that one consolidated manual for the aquatics staff be compiled. That manual would include everything that the aquatics staff would need to perform their job. An outline of suggested headings was included in the Canadian Red Cross Report dated September 22, 2011.

Also, as suggested in the September 22, 2011 Canadian Red Cross Report as well as being noted in the Lifesaving Society Public Aquatic Facility Safety Standard manual, and also as referenced in the Lifesaving Society Lifeguard Positioning Analysis, it is strongly recommended that since lifeguarding is a vigilance task, a lifeguard should be assigned no other duties while supervising the pool deck. In addition, in order to keep a lifeguard alert and focused, a lifeguard should be required to take a minimum 15 minute break from supervising every 2 hours.

Since aquatics operations are complex and require continuous evaluation, it is recommended that an external audit be conducted on each facility no less than once every 2 to 3 years.

It is recommended that additional signs be posted to remind patrons of the need to inform the lifeguards of any medical conditions. Such signs could be posted at the front entry near the Customer Service Desk with additional signs around the pool deck and inside the locker rooms.