Drowning Incident Analysis

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Introduction

In the summer of 1987, a four year old female drowned during a supervised recreational swim period at a municipal outdoor swimming pool operated by the City of Etobicoke (now City of Toronto, Ontario, Canada). This article describes the event, the City's response, how it prepared for the Coroner's investigative Inquest and the lessons learned.

Note:

- *The names of the victim and the swimming pool have been changed.*
- *This paper was first published in the Lifesaving Society's"Lifeliner" member newsletter in 1991 under the title "When a Drowning Strikes". Aquatic practices and procedures described in the article are accurate as of the original publish date but are not intended to represent current City of Toronto practices and procedures.*

The author is the former Supervisor of Aquatics including the pool where the drowning occurred and was personally involved in all aspects of post-accident events, the Inquest and the implementation of the Coroner's Jury recommendations. He is the Past President of the Ontario Branch of the Lifesaving Society.

The Accident

On July 22, 1987 four year old Loretta Marques drowned near the end of a public swim at Etobicoke's Shady Brook outdoor pool She had come to the pool during the afternoon accompanied by her 7 year old brother and 13 year old cousin.

Shady Brook is a typical 25 metre outdoor pool located in the northern section of Etobicoke. The pool is a walk-to design meaning that dressing room space is limited. It has a relatively deep shallow end compared with other City pools: 107 cm (forty-two inches) at its deepest point, sloping to a depth of 168 cm. (sixty-six inches) in the deep end.

Staff reports and testimony at the Coroner's inquest revealed that the accident began to unfold at approximately 4:25 pm. The Public Swim had begun at 2:00 pm and was coming to a close. It was standard practice for the lifeguards to clear the pool five minutes early to allow swimmers to leave the area so the swim team could prepare for its 4:30 pm practice.

This day was in no way unusual. Approximately forty swimmers were in the pool at closing time, the weather was bright and sunny, the water was clear and the temperature was a warm 28 degrees Celsius.

At 4:25 pm there were three staff on deck---one lifeguard was seated in the tower on the northwest side of the pool at the deep end. A second lifeguard was standing at the southeast corner of the pool deck at the shallow end. The pool Supervisor also happened to be on deck near the shallow-end lifeguard. (Having just participated in a change-over, she had chosen to remain on deck for the pool-clearing). The third lifeguard was in the pool office preparing for the swim team practice.

At 4:25 pm the three lifeguards sounded one long blast of the whistle, the standard signal for swimmers to leave the pool. The lifeguard in the deep-end tower jumped to the deck and began to walk clockwise around the deep end of the pool urging swimmers to leave the water and go toward the change rooms. Most of the bathers were in the shallow end however two teenage boys floating on inner tubes ignored her call and lingered in the deep end. She continued down the east side of the pool to the centre buoy line where she began to pull the rope out of the water and coil it against the fence.

The second guard and the manager, supervised the pool clearing in the shallow end. At some point as the swimmers were leaving the area, the second lifeguard walked around the southwest corner of the shallow end and went into the office leaving the Supervisor and the first guard to complete the clear. The Supervisor was now on the west side of the pool and as she walked to the middle of the pool, her attention was drawn to two teenagers still playing about in the deep end. Her patience wearing thin, she yelled sharply, ordering them to leave the pool.

By now the first lifeguard was rounding the shallow end and having reached the southwest corner, heard a child calling excitedly to another "Where's Loretta, where's Loretta?"

As she turned toward the pool, she spotted a little girl's body lying on the bottom of the pool. It was on the black swim lane line approximately six feet from the edge and just south from where the buoy line would have been.

Sounding an emergency signal to alert the other guards, she entered the water.

Upon hearing the whistle, the Supervisor who had finished placing the inner tubes against the pool building, rushed to assist. The two lifeguards in the office ran immediately onto the deck.

Loretta's body was brought to the surface and mouth-to-mouth resuscitation was begun. One of the lifeguards returned to the office placing a call to the 911 Emergency Medical System and then returned to the scene.

Resuscitation efforts continued unabated and cardiopulmonary resuscitation (CPR) was commenced when a pulse could no longer be detected. A second call pas placed to EMS to advise that the pulse had been lost.

Within minutes emergency vehicles arrived at the pool. Loretta was placed in an ambulance and with CPR continuing, was rushed to hospital.

At 5:05 pm, four year old Loretta Marques was pronounced dead. An autopsy would confirm that the cause of death was drowning. With her death, many lives were to change forever.

The Aftermath

As news of the accident spread, the media began to contact the pool. Television cameras focused on the scene and images of an empty pool found their way onto newscasts. Staff, following City policy, gave no statements to the media---details of the event, limited as they were, were provided by Police.

I was notified of the drowning at 7:15 pm when a lifeguard called my home. Staff had called my office shortly after 4:30 pm but were unable to reach me. With all the activity at the pool: the giving of statements, the media calls and the fact that the Supervisor had gone to the hospital in

the ambulance, it was only after some time that lifeguards realized that senior City officials had not been reached.

Following a 45 minute drive and not knowing what to expect, I arrived at the pool. Dusk was approaching, the pool was closed and staff were together in the office.

It is hard to describe the sombreness and frustration that filled the air. We talked about the accident and made sure each person had filled out detailed reports. Periodically the phone would ring-calls from the media, some from parents of the staff.

Prior to leaving home I had tried to reach senior staff but without success. My worry was that they or members of City Council would learn about the drowning from television. Just before 10:00 pm the Executive Director of Parks walked into the pool. Living close by he was the first senior official to get word. Shortly after his arrival, we reached the Mayor and informed him of the accident. The Director and I talked for a short while and then decided to let staff go home. Just before 11:00 pm as we finished checking the pool and locked the doors, two police officers arrived. Having not heard officially that the little girl had died I asked the question, hoping for the best but fearing the worst. "She's dead", one of the officers said quietly. With nothing more that could be done, we closed the building and went home.

The "Morning After"

The next day staff met to review the many urgent decisions that would have to be made as we attempted to mange what has to be one of the most severe critical incidents a municipality can face.

From the beginning we assumed that a Coroner's Inquest would be called and based all our actions on this assumption. Recognizing that an Inquest would scrutinize the accident in every detail, we began the length process of securing all information relevant to the drowning.

From this information we provided a detailed accident to the Mayor and Members of Council. We also informed the Community Health Department given that it administers the provincial legislation that governs the operation of municipal swimming pools.

Next, the Commissioner of Parks and Recreation assumed the role of the City's official and only spokesperson concerning the accident. Having only one spokesperson helped to ensure that all information released was accurate, controlled and consistent. The Commissioner not only spoke with the media but had the extremely difficult task of speaking with a member of the victim's family.

A communiqué was given to all staff asking them not to discuss the accidents with the media or public.

We met with the City Solicitor. We discussed potential liability and preliminary legal strategy based on the facts we had to date.

Recognizing the severe emotional impact a drowning can create for staff we made the City's employee counselling services available. This offer of assistance was not limited to any specific timeframe.

And finally, the following morning the pool reopened for its normal schedule of events. After much discussion, the pool staff indicated they felt confident in their ability to resume their duties competently.
With five weeks left in our summer program, in what was one of the hottest summers in recent memory, we all struggled to find some semblance of normalcy, all while wondering whether lightening could possibly strike twice.

The Coroner's Inquest is Called

As expected, seven days after the accident, we received notification that an Inquest had been scheduled to begin October 21.

In order to gain some first-hand experience and perhaps reduce some of the anticipated stress, our lifeguards attended an Inquest on a different accident, at the Coroner's Court on Grosvenor St in Toronto. This was the exact site where Loretta's death would be probed.

As the Inquest date approached, we focused on developing a pro-active strategy designed to manage the situation as much as possible or at best, to keep in from getting out of control.

Central to this strategy were the messages we felt we had to convey to those in the courtroom as well as the general public through the media which was reporting on the event.

These messages were:

- That this event was unique with a "one in a million" chance of happening.
- That the City's aquatic section and staff were well qualified, competent and had acted in a professional manner.
- That parents have a responsibility to ensure that very young children are adequately supervised when they attend a public pool.
- That rowdyism was a contributing factor in this incident.

Three Days at Coroner's Court

In Ontario, a Coroner's Inquest sets out to establish five facts:

1. Name of the deceased.
2. Date and time of death
3. Place of death
4. Cause of death
5. Circumstances surrounding the death.

Most importantly the Jury seeks to develop recommendations aimed at preventing future accidents similar to the one it is probing.

An Inquest does not assign blame or negligence. However, as one concludes very quickly, damaging evidence uncovered as part of the Inquest, can pave the way for a subsequent lawsuit and, can influence public opinion about how the competency of the City, both before and after the incident.

Coroner's Court in Toronto is set up much like a judicial courtroom. The Coroner sits where a judge would sit. A Jury, made up of ordinary citizens without expertise in the area being probed, sits to one side. Witnesses take the stand and are questioned by the Crown Attorney and lawyers representing various parties. Interested persons may watch the proceedings from the audience.

Members of the press have a designated area from which they report testimony. There were no cameras.

As simple as the Inquest mandate is, the review process to gather the required information is exhaustive. In this situation sixteen witnesses testified under oath, among them:

Loretta's Uncle—He identified her body at the hospital and in so doing, established the first piece of information the Inquest is required to produce—the name of the deceased.

Pathologist—He conducted the autopsy and determined that the cause of death was drowning. No other contributing health factors were found to be present. The Pathologist was asked to estimate the time Loretta was underwater. He testified that he felt she had been underwater for "not less than five minutes but not more than ten minutes". This comment was prominently quoted in the newspaper and probably had the most impact of our staff of any piece of testimony. The image of a swimmer in distress and undetected for that length of time in a supervised pool, is something that no lifeguard is prepared to confront.

Loretta's Mother—Mrs. Marques testified under questioning that she had sent her daughter to the pool on other occasions under the supervision of her 13 year old cousin. Loretta's seven year old brother had often tagged along. She felt that the teenager was a competent babysitter and was comfortable that the pool was adequately supervised by life guarding staff. Further, not being a swimmer herself, she had enrolled Loretta in swimming lessons and based on all of this, felt that Loretta would be safe at the pool.

Loretta's Cousin---She stated that she understood she was responsible for Loretta when she was at the pool but was unaware that the pool had a regulation requiring that children under the age of seven had to be accompanied by an adult.

Pool Supervisor and Lifeguards---Each staff member spent between forty-five and ninety minutes on the witness stand. Much of this time was spent in front of a large diagram of the pool, responding to questions concerning their actions prior to the accident and during the rescue.

The Supervisor was asked to comment on the type of in-service training programs she had held for her staff as well as the numerous incidents of rowdyism at the pool, not only on the day of the drowning but throughout the summer.

Supervisor of Aquatics---As the person responsible for the City's summer swimming program, I was required to testify. I was asked to describe the City's aquatic system, emergency procedures, advertising methods and the rationale for pool entry requirements.

Expert Witnesses---Two expert witnesses, Jerry Mings of the Canadian Red Cross Society and Doug Ferguson of the Lifesaving Society were asked to use their expertise to critique staff's performance before, during and after the accident, compared with the performance that would normally be expected by persons with equal qualifications and responsibilities. Messrs Ming's and Ferguson's comments focussed on the need for tighter entry requirements for patrons, improved pool clearing techniques and increased training in scanning methods.

After two and one half days of preamble, testimony and summation, the Jury retired to consider its recommendations.

The Jury Recommends

The Jury delivered eleven recommendations:

1. Children under seven years of age must be under the direct supervision of a responsible person 16 years or older.
2. Children who are less than 6 inches above the shallow end depth must not be admitted to public swims.
3. Station an attendant at the entrance to ensure age and height requirements are enforced.
4. All guards on deck during a pool clear.
5. Lines on the bottom to be no more than 6 inches wide.
6. At least one male lifeguard on duty at all times.
7. Post all regulatory signs inside and outside the pool area.
8. Post a sign stating that the guards have the authority to expel persons threatening the safety of others.
9. Publish all rules in brochures and flyers given to the general public.
10. Introduce a water safety education program into the schools at the grade one level.
11. Consider installing a handrail around the shallow end of the pool and banning inner tubes, float boards etc. during public swims.

The City has implemented most but not all of the recommendations. Recommendation #2 for example, was deemed to be too restrictive and was not implemented.

On balance we feel that City pools are now safer as a result of Loretta's tragic death.

Putting it in Perspective

With the Inquest complete it was time to try to put everything into perspective. While it will never be known when or how Loretta became separated from her brother and cousin, nor will it ever by ascertained why lifeguards failed to spot her until it was too late, we have concluded the following;

- The City's aquatic program met or exceeded all standards as required by law.
- That of the day of the accident the staff on duty had followed accepted supervision and rescue techniques.
- That because there are sufficient checks built into Etobicoke's systems, it is reasonable to assume that chances of a recurrence of this tragedy are remote.

However the drowning at Shady Brook is judged, we must be ever mindful of the impact that it has had on those it touched directly;

Loretta's Family---one can't truly imagine the sorrow felt by a family having lost a loved one in such a sudden and unexpected way.

The Supervisor and Lifeguards---Aquatic staff everywhere prepare for the day when they will be confronted with a life-threatening situation. The loss of a swimmer is a burden which each of them will carry in their own way, for the rest of their lives.

The City---The impact on Etobicoke can be viewed in a number of ways. A drowning is such a traumatic, public and negative event that the reputation of the City's aquatic system and staff are immediately placed in question. As events following the accident unfold and preparation of the inquest becomes more intense, one comes to realize the enormous energy and resources that are consumed by this process. New projects must be delayed and routine work is impacted. And

finally, once a lawsuit is concluded or an out-of-court settlement reached, only then is the total financial cost of the tragedy revealed.

The Seven Lessons of Shady Brook

This drowning brought the following into sharp focus. These lessons can be applied to any supervised aquatic environment:

1. **Tragedy can occur when you least expect it.** Loretta drowned during a relatively quiet public swim in a well-supervised municipal pool. Water clarity was good and the staff were highly qualified and were performing their duties correctly. If a tragedy can happen under such "ideal" circumstances as these, it can happen anywhere and any time.
2. **The public puts its unqualified trust in the lifeguard.** Loretta's mother testified that she set comfortable sending her daughter to the pool because it was supervised and because she was enrolled in swim lessons. She trusted that the system would protect her. Because aquatic staff are entrusted so freely with the care and safety of others, every effort must be made by those in charge, to ensure that this public trust is upheld.
3. **Young children require direct supervision and their guardian must understand and fulfill this role.** Lifeguard-bather rations don't take into account the ages of swimmers in the pool. It is clear that when young children are present, the supervision provided by lifeguards must be supplemented by that of others who are fully committed to fulfilling their ole as guardians.
4. **Rules must be enforceable, posted and enforced.** Simply put, if rules can't be enforced they are meaningless. If they are not communicated, they can't be obeyed. If they are not enforced, they do not exist.
5. **Supervision of the pool must be uninterrupted because victims can be very difficult to stop.** A possible reason why Loretta was not spotted was that she may have shown no visible signs of being in distress. She may have slipped quietly to the bottom of the pool while staff where busy clearing the pool. Supervision may have been compromised by the actions of the disruptive teenage boys in the deep end. Such circumstances underline the need for continuous and uninterrupted supervision as well as the refinement of victim recognition skills.
6. **The power of the Media is not to be underestimated.** Since widespread media coverage of a drowning in a public pool is inevitable, the best that can be hoped for is that the reporting will be balanced. A review of media reports reveals that Etobicoke fared reasonably well. Headlines such as "Public Pool Safety Slammed", "Tot Underwater at Least Five Minutes" appeared along with "Rowdyism Blamed in Tot's Drowning" and "Stop Small Children Swimming Alone—Inquest Jury Says". Regardless of the coverage there is no escaping the fact that the media shapes the public's perception of how a critical incident like a drowning is handled.
7. **Tragedy often follows a series of events, each not significant in itself, but potentially disastrous when combined.** They are in the news almost daily--- tragedies that seem to result from a combination of circumstances each so innocuous that it often goes unnoticed. The drowning at Shady Brook illustrates this "lightning rod" effect:
    - A four year old girl is sent to a public pool under the supervision of a young cousin.
    - The children are admitted to the pool even though a rule requires that a four year old be accompanied by an adult.

- The little girl, a non-swimmer strays from her guardian and finds her way into deep water
- A distraction diverts the attention of one of the lifeguards while the pool check is underway.

Each of these circumstances by themselves would probably have been insignificant. They represent situations which are handled successfully at pools all the time. It is only because they occurred in deadly combination that they became a prescription for tragedy.

Checklist to Successfully Manage a Drowning Incident

"Your ability to successfully manage a drowning is determined well before the accident ever occurs"

Prior to a Drowning

Polices, Procedures, Practices

- Establish formal policies and procedures and record them in a Staff Manual.
- Ensure that polices make sense and that rules for the public are enforceable.
- Provide staff with the policies and procedures for which they are responsible, in writing.
- Review regularly and update as required.
- Check to see that procedures are being followed and rules are being enforced.
- Role-play incidents to test policies and procedures.

Training

- Develop a staff training program with specific goals, formal agendas, training standards and regularly scheduled training sessions and meetings.
- Staff attendance must be compulsory
- Keep records of each training session.
- Require staff to sign that they have attended the session and have understood what is being taught.
- Ensure that staff meet required standards and those that don't, require remedial training until they are successful.

Risk Management

- Implement a risk management program which monitors not only rescue procedures but also maintenance programs and equipment checks.
- Correct hazards and replace faulty equipment immediately upon discovery.

After a Drowning Occurs

- Assume a public Inquiry will be called and that your organization will be sued. Take a pro-active approach to managing events prior to and during the inquest and litigation.
- Encourage staff at all levels to cooperate fully with authorities.
- Obtain signed statements from all staff involved.
- Appoint an official spokesperson
- Issue a communiqué to staff outlining the basic facts instructing them not to discuss the incident with the media or others and requiring that all requests for information or comment, be referred to the official spokesperson.
- Obtain copies of witness reports from the authorities.
- Record weather, lighting, water clarity and other conditions on the day of the event.
- Construct a detailed time sequence of events on the day of the accident---starting when the staff arrived at work. This should include staff activities, before, during and after the incident plus their positions, movements and distractions while on duty.
- Contact Legal counsel. Request a meeting to assess the situation and plan strategy
- Keep logs of all communication and all meetings.
- Confirm the qualifications of all staff involved.
- Obtain a copy of facility maintenance reports which deal with water clarity, chemistry, equipment repair etc.

- Gather copies of staff job descriptions, agency and facility training programs, job contracts and staff manuals which deal with policies, procedures, operations and responsibilities. Public program and promotional material may also be required.
- Obtain records of the content, frequency and attendance at all pre-service and in-service training sessions.
- Collect all media reports of the incident
- Ensure your legal counsel meets with staff to prepare for the inquiry.
- Support staff at all times (those directly involved and all others). Make counselling services available.

After the Public Inquiry

- Notify all staff of the outcome and of the jury's recommendations.
- Implement the recommendations as required as well as any other safety improvements that your organization develops.
- Use the incident as a training topic in order to learn from the experience and avoid it being repeated.