Incident Analysis and Review

JULY 2-3, 2026

Echo Dale Regional Park

City of Medicine Hat

LIFESAVING SOCIETY®
The Lifeguarding Experts

City of Medicine Hat
Incident Review and Analysis

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Incident Review and Analysis

City of Medicine Hat
Echo Dale Regional Park

LIFESAVING SOCIETY®
The Lifeguarding Experts

About the Lifesaving Society
- Saving lives for over 100 years

The Lifesaving Society is a full service provider of programs, products, and services designed to prevent drowning. The Society saves lives and prevents water-related injuries through its training programs, Water Smart® public education, drowning research, aquatic safety management and lifesaving sport. The Society is a national volunteer organization and registered charity composed of ten provincial/territorial branches, tens of thousands of individual members, and over 4,000 affiliated swimming pools, waterfronts, schools, and clubs.

The Society has been teaching swimming, water safety and water rescue in Canada since 1886. Established in England (1891) as the Swimmers' Lifesaving Society, it became The Royal Lifesaving Society in 1904. Today, it is known simply as the Lifesaving Society. The Lifesaving Society is a leader and partner in the delivery of water safety education throughout Canada and around the world.

Teaching Canadians to save themselves and rescue others

Annually 1,200,000 Canadians participate in the Lifesaving Society's swimming, lifesaving, lifeguard, first aid, and leadership programs. Each year, the Society certifies thousands of instructors who provide the leadership for its training programs. Over 30,000 Canadians earn the Society's Bronze Medallion each year. As Canada's lifeguarding experts, the Lifesaving Society sets the standard for lifeguard training and certifies Canada's National Lifeguards.

Making Canadians Water Smart

The Lifesaving Society focuses Water Smart drowning prevention efforts on people most at risk - like men fishing in small boats - or on those who can make a significant difference, such as parents of young children. The Society delivers Water Smart messages through its swim program, through the media and community action. The Society's Swim to Survive® Program provides the essential minimum skills required to survive an unexpected fall into deep water.

Drowning Research

The Lifesaving Society conducts research into fatal and non-fatal drowning, aquatic injury and rescue interventions. Ongoing research and analysis supports the Society's evidence-based water rescue training and Water Smart drowning prevention education.

Setting the Standard

The Lifesaving Society establishes aquatic safety standards and consults on aquatic safety issues for the aquatic industry, governments and the judiciary. The Society offers a suite of services to help aquatic facility operators maintain and improve safe pool and waterfront operations. The Society performs aquatic safety audits and serves as experts in legal cases involving aquatic safety.

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Introduction, Scope, and Terms of Reference

1.1 Agreement

This Incident Review Analysis was conducted by the Lifesaving Society Alberta and Northwest Territories Branch ("Lifesaving Society") at the request of the City of Medicine Hat ("City"), under the Incident Review Analysis Terms of Reference and Agreement dated June 17, 2026.

The review was undertaken in accordance with the agreed scope, which included examination of relevant incident documentation; assessment of site conditions as they related to the incident; review of applicable operational materials, standards, and procedures; and interviews with selected personnel, witnesses, and responders.

The City remained responsible for the operation, management, supervision, maintenance, and regulatory compliance of the facility and its programs at all times. The Lifesaving Society's role was limited to providing an independent aquatic-safety review and recommendations based on the information available within the agreed scope.

1.2 Purpose

The purpose of this Incident Review Analysis is to identify opportunities to reduce the risk of drowning, non-fatal drowning, and serious water-related injury, with the objective of helping to prevent incidents of a similar nature.

This report documents the information reviewed, the relevant site and operating conditions identified during the review, and the Lifesaving Society's observations and recommendations. Recommendations are intended to support a practical, risk-based approach to aquatic safety that considers prevention, supervision, emergency preparedness, rescue capability, staff competency, facility design, public communication, and ongoing safety management.

The review is systems-focused. It considers how policies, procedures, training, equipment, staffing, environmental conditions, communication, and other operational controls may have influenced the incident or its outcome. It is not intended to assign personal blame or determine legal responsibility.

1.3 Major Incident Management

The City retains responsibility for the immediate management of the incident, including emergency response, site control, notification, reporting, preservation of records, staff support, communications, and any required regulatory, insurance, legal, or privacy-related actions.

Introduction, Scope, and Terms of Reference (cont.)

1.3 Major Incident Management (Cont.)

For an incident involving a fatality, critical injury, missing person, serious rescue, significant public safety concern, regulatory investigation, police involvement, media attention, or an actual or threatened claim, the City should promptly seek direction from its legal counsel, insurer, and applicable authorities. The City should also preserve relevant records and evidence, including incident reports, staff schedules, training and certification records, inspection and maintenance logs, radio or telephone records, photographs, video footage, weather or environmental information, and related communications.

The Lifesaving Society's review does not replace any investigation, notification, report, or corrective action required by law, regulation, insurance policy, employment process, contract, public authority, or internal organizational policy. Alberta OHS guidance treats certain serious incidents as reportable and requires investigation and documentation of circumstances and corrective action.

1.4 Ongoing Support

Following issuance of this report, the Lifesaving Society may provide additional support as agreed with the City. Support may include clarification of recommendations; review of corrective-action plans; staff or leadership debriefs; risk-assessment assistance; review or development of operational procedures, emergency action plans, supervision plans, or training programs; and follow-up safety services.

Implementation of recommendations remains the responsibility of the City. The City should assign an accountable owner, target completion date, required resources, and method of verification for each accepted action. Where a recommendation cannot be implemented, the City should document its rationale, consider reasonable alternatives, and formally assess and accept any residual risk through its own governance and operational processes.

1.5 Disclaimer

This report has been prepared by the Lifesaving Society for the City of Medicine Hat's internal safety-management purposes in relation to the specific incident, location, scope, and information available to the Lifesaving Society at the time of the review. The report reflects the professional opinion of the Lifesaving Society based on the information made available, the agreed scope of engagement, the review team's qualifications and experience, professional judgment, identified assumptions and limitations, applicable safety standards, and applicable law as understood at the time the report was issued.

Introduction, Scope, and Terms of Reference (cont.)

Section 1

1.5 Disclaimer (cont.)

The review was conducted with reasonable professional care and skill. However, the Lifesaving Society does not guarantee any particular outcome, and the report is subject to the limitations identified within it. The Lifesaving Society has relied on information provided by the City and other sources and cannot independently guarantee the completeness or accuracy of all information supplied by third parties. The report does not constitute legal advice, medical advice, or a determination of legal liability. The City should obtain independent professional advice where required.

- City of Medicine Hat Council, administration, employees, and contractors,the affected individual's family or personal representative
- The school division or school board, where applicable
- The City's insurers, brokers, legal counsel, and other professional advisors, where disclosure is reasonably necessary to obtain legal, insurance, regulatory, or other professional advice
- Regulatory, occupational health and safety, public-health, coroner, police, or other authorities, where disclosure is required or appropriate
- Other persons or organizations approved in writing by the Lifesaving Society.

The City may also release the final report, or an appropriate summary or excerpt, publicly. Before voluntary public release, the City will provide the Lifesaving Society with reasonable advance notice and an opportunity to review the proposed material to confirm the appropriate version and identify any necessary redactions or contextual information. This coordination requirement does not apply to disclosure required by law, court order, regulatory direction, or a lawful request from a public authority.

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Incident Analysis Review
REPORT

Introduction, Scope, and Terms of Reference (cont.)

Section 1

1.6 Acknowledgements

The Lifesaving Society acknowledges the cooperation of the City of Medicine Hat, facility leadership, staff, witnesses, responders, and other individuals who provided information or assistance during this review.

The review team particularly recognizes the efforts of personnel who responded to the incident and those who supported the review process. Participation in an incident review can be difficult, particularly where individuals have experienced or witnessed a serious event. The Lifesaving Society appreciates the candour and professionalism of those who contributed information.

This acknowledgement does not constitute an assessment of any individual's actions, performance, responsibility, or legal obligation. The report reflects the information available to the review team within the agreed scope and at the time of writing.

Incident Analysis and Review Process

Section 2

2.1 Review Initiation and Planning

The Lifesaving Society initiated the Incident Analysis and Review under the Terms of Reference and Agreement dated June 17, 2026. The review team confirmed the review purpose and scope, coordinated the on-site agenda with City representatives, and identified relevant documentation, personnel, and site-assessment activities.

Planning focused on the circumstances of the June 15, 2026 incident and the safety systems relevant to prevention, supervision, recognition, emergency response, recovery, and restoration to normal operations.

2.2 Information and Document Review

The review team examined relevant records and operational materials made available by the City and gathered through the review process. These included incident reports, staff statements, the City's event timeline, staffing and deployment information, school-group booking information, patron-count records, training and certification materials, operating manuals, supervision plans, emergency procedures, and available inspection, maintenance, and water-treatment records. The team also considered relevant documentation concerning previous incidents, near misses, safety inspections, complaints, risk assessments, audits, and completed or outstanding corrective actions.

Information was assessed for relevance, timing, consistency, and corroboration. Where records or accounts differed, or information could not be verified, the report identifies the resulting uncertainty or limitation rather than treating the information as established fact.

The City was responsible for the completeness and accuracy of the records and information it provided. Where material documentation was unavailable, incomplete, inconsistent, or received too late to inform the review, the resulting limitation is identified where relevant to the findings or recommendations.

Incident Analysis and Review Process (cont.)

Section 2

2.3 Site and Operational Assessment

Where applicable, the Lifesaving Society completed an assessment of the facility, waterfront, program area, or activity environment as they related to the incident.

The assessment considered the following matters:

- Water depth, boundaries, bottom conditions, entry and exit points, designated activity areas, sight lines, lighting, environmental conditions, and public access.
- Waterfront conditions such as water clarity, currents, waves, wind, weather, shoreline hazards, docks, rafts, boating interfaces, underwater hazards, and emergency access.
- The location, condition, availability, accessibility, and suitability of rescue, first aid, communication, and emergency equipment.
- Signs, rules, public safety messaging, barriers, zone markers, supervision identifiers, and other user-information controls.
- Supervision arrangements, staff positions, surveillance zones, communications, rotations, relief arrangements, and emergency response readiness.
- Relevant safety systems, including inspections, maintenance, hazard identification, defect reporting, emergency procedures, and operating practices.

The site assessment reflects conditions observed at the time of the review. Unless independently verified through contemporaneous evidence, those conditions may differ from conditions at the time of the incident.

2.4 Interviews and Information Gathering

The Lifesaving Society interviewed selected individuals with information relevant to the review. The review team also considered witness and responder information documented in City records. Interviews supported the review team's understanding of the sequence of events, operating context, conditions, and relevant safety controls.

Interview accounts were considered alongside available records, physical evidence, and other information. Recollections that could not be independently verified are identified as reported information. Interview participation was not intended to be disciplinary. This review does not replace an employer investigation, legal process, police investigation, insurer investigation, regulatory investigation, or other formal process.

Incident Analysis and Review Process (cont.)

Section 2

2.4 Interviews and Information Gathering (cont.)

Interview scheduling and participation remain subject to applicable law, collective agreements, employment processes, legal advice, and direction from an authority with jurisdiction.

2.5 Review of Standards and Safety Controls

The Lifesaving Society reviewed the safety controls relevant to the incident against the requirements and practices identified within the scope. This included applicable legislation, regulations, codes, local requirements, organizational policies, operating procedures, contractual obligations, manufacturer instructions, and relevant aquatic safety standards.

The review considered controls related to:

- Governance, risk assessment, hazard identification, and management oversight.
- Facility or waterfront design, maintenance, inspections, hazard controls, and public access.
- Staffing, role clarity, competency, certification, orientation, training, and emergency drills.
- Supervision planning, surveillance, zone coverage, patron management, group supervision, relief, and communication.
- Emergency action plans, rescue procedures, first aid, resuscitation, automated external defibrillators, oxygen, emergency communications, extraction, and EMS access.
- Public rules, safety education, signage, warnings, barriers, and management of foreseeable high-risk activities.

Where practical, the report identifies the source, edition, and relevant section of a requirement or standard relied upon. Standards, legal requirements, or guidance introduced after the incident will not be treated as requirements applicable at the time of the incident, unless specifically identified as such. They may be considered separately as potential improvements for future operations.

Incident Analysis and Review Process (cont.)

Section 2

2.6 Analysis Method

The review team developed a factual timeline based on the available evidence and analyzed the relationship between the incident and relevant controls. The analysis considered whether controls intended to prevent, detect, respond to, or reduce the consequences of the incident were present, suitable, available, understood, implemented, maintained, and effective in the circumstances.

The report distinguishes, wherever practical, among:

- Confirmed facts supported by available evidence.
- Reported information that could not be independently verified.
- Observations recorded during the review.
- Assumptions or limitations affecting the analysis.
- Conditions considered as potentially contributing to the incident or its outcome.
- Findings concerning the design, availability, implementation, or effectiveness of safety controls.
- Recommendations intended to improve safety controls or reduce comparable risks.

The analysis is systems-focused and does not make findings of fault, negligence, legal liability, medical causation, regulatory non-compliance, or individual performance management.

2.7 Recommendations

Recommendations are based on the information available to the review team, professional judgment, relevant safety standards, and the safety controls examined during the review.

Where applicable, recommendations are organized using the four phases of major incident management identified in the Lifesaving Society's Are You Ready? Major Incident Management Workbook: Recognition, Reaction, Recovery, and Restoration to Normality. This approach supports improvements across the full incident cycle, from early identification through response, follow-up, and safe return to operations.

The City remains responsible for determining how recommendations will be implemented. Each accepted action should have an accountable owner, priority, target completion date, resources, completion evidence, and an effectiveness review.

Incident Analysis and Review Process (cont.)

Section 2

2.8 Draft Review and Final Report

The Lifesaving Society provided a draft report to the City for factual review. The draft-review process allowed the City to identify material factual errors, missing records, or relevant contextual information. Written comments should identify the applicable section, proposed correction, and supporting information.

The Lifesaving Society considered substantiated factual corrections. The Lifesaving Society retains responsibility for the final report's methodology, analysis, findings, opinions, and recommendations.

After reviewing the City's written comments, the Lifesaving Society issued the final Incident Analysis and Review Report. The final report outlines the scope, methodology, information reviewed, limitations, observations, analysis, findings, and recommendations relevant to the engagement.

Executive Summary

Section 3

3.1 Incident Overview

On June 15, 2026, an 11-year-old student died following an incident at the supervised swim lake at Echo Dale Regional Park in Medicine Hat, Alberta.

The available records indicated that the facility was operating during a high-demand period involving two school groups: School Group A (CHHS – Cypress Heights High School) and School Group B (Roy Wilson), other patrons, and changing bather numbers. Staff accounts indicate that lifeguard coverage was increased as the number of swimmers grew, including use of multiple elevated-chair positions and a paddle board position. Staff described active lifeguard supervision and intervention during the day, including responding to rough play, tired swimmers, buoy-line use, and other observed safety concerns.

At approximately 1:40 p.m., school group B was asked to begin returning to their buses. Shortly thereafter, a teacher reported that a student had not returned with the group. Aquatic staff made announcements for the student to report to the lifeguard office and initiated a land search of the building, change rooms, surrounding grounds, and nearby park areas.

After staff received information that the student may have last been seen in the water, the response transitioned to a missing-swimmer search. The lake was cleared; aquatic staff initiated shallow- and deeper-water searches; available search and rescue equipment was deployed; and bystanders were asked to assist. Available records indicate that 911 was called at approximately 2:16 p.m. Police, fire, EMS, and other emergency resources attended. Fire-rescue personnel subsequently located the student in the water and initiated resuscitation efforts. The student later died.

3.2 What Worked

Available records and staff accounts identify the following operational and post-incident actions:

- Patron Counts:
  Staff completed and documented half-hour lake and beach counts throughout the operating period. These counts provided a record of changing attendance throughout the day and identified a highest recorded combined count of 147 persons at 12:30 p.m.

- Additional Lifeguard Coverage:
  Additional lifeguards were scheduled in anticipation of school-group attendance. Staff accounts indicate that an Aquatic Lead maintained the additional coverage when a reduction was proposed.

Executive Summary (cont.)

Section 3

3.2 What Worked (cont.)

- Surveillance and Patron Management:
  Staff used elevated-chair and paddle board positions to support surveillance of the lake and beach areas. Staff also communicated regarding patron behaviour and observed concerns.

  Staff intervened with patrons involved in rough play, inappropriate use of buoy lines, and apparent fatigue or swimming difficulty. These actions reflect active supervision and efforts to address emerging risks during a busy operating period.

- Emergency Response:
  Staff initiated land and water searches, deployed available equipment, and communicated with emergency responders as they arrived. Staff also made announcements to support group departure, locate the missing student, clear the lake, and organize the initial response.

- Post-Incident Actions:
  Following the incident, the City closed the facility, took steps to preserve relevant records, gathered available operational records and staff statements, developed an internal event timeline, and initiated a formal internal investigation. Staff debriefing, critical-incident support, counselling, and operational support should also be documented where confirmed by the available records.

  Overall Observation These actions demonstrate the efforts of staff responding in a dynamic, traumatic, and operationally complex environment. The review recognizes the significant impact of the incident on the family, school community, staff, emergency responders, and the broader community.

3.3 Key System Findings

The review identified system-level opportunities to strengthen the following areas:

- Group planning and accountability: Advance booking controls, confirmation of group size, school and group-leader supervision expectations, child-accountability processes, swimming ability information, head counts, and water-to-departure transition procedures.
- Supervision planning: Documented supervision zones, lifeguard position selection, bather-load thresholds, staff relief and rotation, within-call support, and coverage during busy periods and group transitions.

Executive Summary (cont.)

Section 3

3.3 Key System Findings (cont.)

- Waterfront-style operating environment: The swim lake's depth, bottom conditions, sand movement, surface conditions, broad activity area, and reported limitations in underwater visibility require site-specific supervision, prevention, and emergency-response controls. The Lifesaving Society's Waterfront Safety Standards provide relevant guidance for these operating characteristics. Describing the facility as a supervised waterfront for this safety review does not determine its regulatory classification or exclude applicable public-health, pool-operation, or other legal requirements.
- Site-specific controls: Effectiveness of the designated swim area, buoy configuration, depth information, boundary marking, signage, public-address system, lifeguard sight lines, and safety and rescue equipment.
- Training and readiness: Pre-season and early-season site-specific training, mandatory relevant in-service participation, missing-child and missing-swimmer scenarios, group-management procedures, search limitations, and incident-command practice.
  Emergency escalation and command: Clear thresholds for escalation, role assignments, land-to-water search transition, search coordination, emergency-service activation, management of bystander involvement, and unified command with responding agencies.
- Governance and coordination: Clear decision-making authority, accountability, booking and capacity controls, information flow among Aquatics, Parks, Recreation, Fleet Facilities and Asset Management, booking services, and Corporate Safety, inspection ownership, documentation, and corrective-action oversight.

3.4 Priority Actions and Risk Status

Priority risk: The highest-priority risk identified by this review is the potential for delayed recognition of a missing or distressed patron, and delayed or uncoordinated escalation to a structured missing-swimmer response. This risk is increased during high-attendance periods, school-group transitions, changing lifeguard coverage, and conditions in which natural-water visibility and depth limit surveillance and search effectiveness.

Risk status: Action required before comparable operations resume. The City should maintain and document interim controls while it completes a formal risk reassessment and implements approved controls for group management, supervision coverage, emergency escalation, search coordination, site-specific training, and incident-command arrangements. Recommendations are organized throughout this report according to the four major-incident management phases.

Executive Summary (cont.)

Section 3

3.4 Priority Actions and Risk Status (cont.)

Lifesaving Society's four major-incident management phases:

1. Recognition
2. Reaction
3. Recovery
4. Restoration to Normality

Additional recommendations address the broader waterfront safety-management system, including governance, group bookings, site design, supervision, training, equipment, emergency procedures, inspections, and incident tracking.

3.5 Scope and Limitations

The review found inconsistencies in witness recollections and available timelines regarding the student's last confirmed sighting, the first report that the student was missing, the sequence and timing of searches, staffing transitions, and the timing and location of recovery. These differences are understandable in the context of a traumatic, fast-moving event. Where information could not be independently corroborated, the report treats it as reported information rather than an established fact.

This Executive Summary should be read with the detailed timeline, findings, limitations, and recommendations that follow. Its conclusions may require reassessment if material new information becomes available, including verified dispatch records, police or fire-rescue reports, medical information, video, contemporaneous communications, school records, or further witness evidence.

Incident Profile

Section 4

Category	Profile
Incident type	Fatal drowning incident involving a student at a supervised public waterfront.
Incident date	Monday, June 15, 2026.
Incident location	Echo Dale Regional Park swim lake, City of Medicine Hat, Alberta.
Facility type	Municipal public waterfront with a designated swim lake, beach area, lifeguard supervision, and associated park amenities.
Person involved	An 11-year-old student attending Echo Dale Regional Park as part of a school-group visit. To protect privacy, the student is referred to in this report as "the student".
Activity	Recreational swimming during a school-group visit.
Supervision context	The swim lake was lifeguarded. School personnel and other adults were also present in connection with the two school groups. The respective roles, accountability expectations, and student-count processes of aquatic staff, school personnel, and group supervisors are examined in this review.
Operating context	The facility was experiencing a busy period involving more than one school group, other patrons, changing bather numbers, and a transition period as school group A was preparing to leave. Available information indicates that staffing and lifeguard positions were adjusted as bather numbers and conditions changed.
Reported environmental	Staff described favourable weather but murky water, sand movement, depth, and limited underwater visibility. These conditions are relevant to surveillance and underwater-search effectiveness.
Lifeguard Deployment	Staff accounts indicate that elevated-chair positions and a paddle board position were used during the busy portion of the day. The number and location of active supervision positions changed as attendance decreased and school groups began departing.

Incident Profile (cont.)

Section 4

Category	Profile
Initial concern	A teacher reported that the student had not returned with the school group B to its buses. Staff made public-address announcements and initiated a land search of the facility, change rooms, nearby grounds, and other park areas.
Escalation	After staff received information that the student may have last been seen in the water, the response transitioned to a missing-swimmer search. The lake was cleared and aquatic staff initiated shallow- and deeper-water searches using available rescue and search equipment.
Emergency response	Available records indicate that 911 was called at approximately 2:16 p.m. Police, fire, EMS, and other emergency resources attended. Fire-rescue personnel subsequently located the student in the water and initiated resuscitation efforts.
Outcome	The student later died. This report does not address the medical cause of death.
Post-incident actions	Echo Dale was closed. The City initiated internal follow-up, gathered records and statements, provided staff debriefing and critical-incident support, and retained the Lifesaving Society to complete this Incident Analysis and Review.
Review purpose	To identify opportunities to reduce the risk of drowning, non-fatal drowning, and serious water-related injury at Echo Dale and across the City's aquatic operations. The review is systems-focused and is not intended to determine legal liability, negligence, medical causation, or individual performance.

Incident-profile note

Information within this profile is based on the records, witness statements, and staff interviews available to the review. Some details remain subject to verification because accounts differ on the timing of the student's last confirmed sighting, the initial missing-child notification, staffing transitions, search sequence, and recovery details. Those matters are addressed in the timeline, findings, and limitations sections of the report.

Methodology

Section 5

5.1 Review Mandate

The Lifesaving Society Alberta and Northwest Territories Branch conducted this Incident Analysis and Review at the request of the City of Medicine Hat under the Incident Review Analysis Terms of Reference and Agreement dated June 17, 2026.

The review was undertaken to identify practical opportunities to further reduce the risk of drowning, non-fatal drowning, and serious water-related injury at Echo Dale Regional Park and, where relevant, across the City's aquatic operations. The review examined the circumstances surrounding the June 15, 2026 incident; relevant site, supervision, operational, emergency, training, and management systems; and opportunities for improvement.

The Terms of Reference contemplated an analysis of relevant incident documentation, a safety assessment of the aquatic facility as it related to the incident, review of relevant operational literature and applicable guidance, interviews with selected personnel and witnesses, and the preparation of recommendations and follow-up supports.

This is a systems-focused safety review. It is not a police, regulatory, coroner/medical examiner, insurer, employment, disciplinary, or legal investigation. It does not determine medical cause of death, legal liability, negligence, fault, or individual performance.

5.2 Review Team and Dates

The review team consisted of:

Role	Reviewer
Chief Auditor	Jonathan Kusyanto, Executive Director, Lifesaving Society Alberta and Northwest Territories Branch
Secondary Auditor	Courtney Malley, Programs and Services Coordinator, Lifesaving Society Alberta and Northwest Territories Branch

The on-site review and interviews were conducted at Echo Dale Regional Park and with City representatives on July 2–3, 2026. Follow-up interviews and information review were completed after the site visit, including an interview with an Aquatic Leader on July 13, 2026.

Methodology (cont.)

Section 5

5.3 Scope of Review

The review considered:

- The available factual sequence of events before, during, and after the incident.
- The Echo Dale swim lake's physical environment, supervision model, public-information controls, emergency readiness, and operational practices.
- Staffing, lifeguard deployment, qualifications, orientation, in-service training, communication, and role clarity.
- School- and group-use planning, booking information, group-supervision expectations, attendance management, and departure procedures.
- Written policies, operating materials, emergency procedures, records, and safety-management systems relevant to the incident.
- Relevant organizational interfaces among Aquatics, Parks, Recreation, Fleet Facilities and Asset Management, booking services, Corporate Safety, emergency responders, and group leaders.
- Applicable or relevant Lifesaving Society safety guidance and Alberta requirements identified within the agreed scope.

The scope was limited to information reasonably available to the review team. The review did not independently investigate the actions of the school, individual teachers, emergency responders, police, fire-rescue personnel, medical personnel, or other third parties, except to the extent their reported actions informed the aquatic-safety analysis.

5.4 Information Sources

The review team considered information made available by the City, and information gathered through the review process, including:

Source category	Information considered
Incident records	Available incident reports, internal timelines, staff statements, witness information, follow-up notes, and records relating to the emergency response.
Operational records	Available schedules, staffing information, certification and orientation records, facility procedures, supervision practices, group-booking information, and related operational communications.
Safety-management	Available staff manuals, supervision and safety plans, emergency procedures, inspection materials, training and in-service records, water-quality and maintenance materials, public-education materials, and relevant City policies.

Methodology (cont.)

Section 5

5.4 Information Sources (cont.)

Source category	Information considered
Site assessment	On-site examination of the swim lake, shoreline, designated swimming area, access routes, lifeguard positions, sight lines, signage, emergency equipment, communications, emergency access, and environmental considerations.
Interviews	Interviews with lifeguards, an Aquatic Leader, the Aquatic Coordinator, and a Corporate Safety representative, as well as available witness accounts recorded by the City.
Standards and guidance	Relevant Lifesaving Society safety publications, including Waterfront Safety Standards and Are You Ready? Major Incident Management Workbook, together with relevant provincial, municipal, organizational, and site-specific materials made available for review.

The review team assessed information for consistency, relevance, and corroboration. Accounts from staff and witnesses were treated as reported information unless supported by contemporaneous records, physical evidence, or other independent sources.

5.5 Site Assessment

The site assessment examined the aquatic environment and operational context as they related to the incident. It included review of:

- The school group's B apparent arrival, access, and movement pathways.
- The designated swimming area, buoy lines and markers, shore and water entry points, depth transitions, bottom profile, and potential underwater hazards.
- Lifeguard chair and paddle board positions, sight lines, distance to patrons, areas of reduced visibility, and likely supervision challenges.
- Signage, public-address capability, public rules, group information, and communications controls.
- Rescue, first aid, emergency communication, and search equipment; designated treatment areas; and EMS access.
- Natural-water conditions relevant to surveillance and response, including water clarity, depth, sand movement, visibility, glare, weather, wind, waves, noise, and the broader activity environment.

Methodology (cont.)

Section 5

5.5 Site Assessment (cont.)

- Changes to the site, practices, equipment, or controls that may have occurred after the incident.

The site assessment reflects conditions at the time of the review. It does not establish that conditions were identical on June 15, 2026 unless corroborated by contemporaneous records or other reliable evidence.

5.6 Interviews

Interviews were conducted using a trauma- and safety-informed approach. Participants were advised that the review was systems-focused rather than disciplinary; they could identify uncertainty, take breaks, and access available support resources.

Interview questions addressed:

- Roles, qualifications, site familiarity, orientation, training, and in-service participation.
- Normal staffing, positioning, rotations, supervision, communication, and emergency practices.
- Group bookings, anticipated attendance, public education, school supervision, and operational decision-making.
- Individual recollections of the incident, notification that the student was missing, land and water searches, emergency escalation, responder coordination, and post-incident actions.
- Perceived site risks, supervision and communication challenges, and opportunities for improvement.
- Governance, record keeping, cross-department coordination, inspection ownership, and corrective-action management.

The report uses role descriptions rather than personal names wherever possible. Witness recollections are not treated as verified facts without corroboration.

5.7 Analytical Approach

The review used a structured, evidence-informed and systems-based approach.

First, the review team reconstructed a working timeline from the available records and accounts. The team then examined the safety controls intended to prevent, recognize, respond to, and recover from an aquatic emergency.

The analysis considered whether relevant controls were:

- Present and appropriately designed for the site and activity.

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Methodology (cont.)

Section 5

5.7 Analytical Approach (cont.)

- Available and maintained.
- Understood by staff and users.
- Implemented in practice..
- Effective under the conditions described.

The analysis also considered the relationship between the incident and the four major-incident management phases described in the Lifesaving Society's Are You Ready? Major Incident Management Workbook:

1. Recognition: identification of a hazard, distressed patron, missing child, or emerging incident.
2. Reaction: immediate response, communication, rescue, emergency activation, and scene management.
3. Recovery: documentation, debriefing, support, evidence preservation, and post-incident review.
4. Restoration to Normality: return-to-operation decisions, corrective actions, communication, and ongoing support.

Recommendations are organized in relation to these phases, with additional recommendations addressing broader safety-management controls.

The review also applied the Waterfront Safety Standards' risk-management approach: identify risks, assess their source and significance, develop and implement controls, and monitor the effectiveness of those controls. This framework informed the examination of supervision, emergency procedures, staff training, safety systems, inspections, incident tracking, and the natural-water environment.

5.8 Standard of Findings

Classification	Meaning
Confirmed fact	Supported by reliable, contemporaneous, or corroborated information.
Reported Information	A witness or participant account that could not be independently verified.
Observation	A condition observed by the review team during the site assessment or document review.

Methodology (cont.)

Section 5

5.8 Standard of Findings (cont.)

Classification	Meaning
Finding	A systems-focused conclusion supported by the available evidence.
Limitation or uncertainty	A matter the review could not determine because evidence was unavailable, incomplete, inconsistent, or outside scope.
Recommendation	A risk-reduction measure based on available information, professional judgment, relevant safety guidance, and the review team's experience.

The review does not rely on a single-cause model. An aquatic incident may involve multiple interacting environmental, human, operational, and organizational conditions. The identification of a gap or condition in this report does not, by itself, establish that it caused the incident or that any person or organization failed to meet a legal duty.

5.9 Limitations

The review was subject to the following limitations:

- The review team did not have access to all potential external records, including verified emergency-dispatch records, police records, fire-rescue records, medical information, or any records held by the school or other third parties, except where information was provided to the City or review team.
- Witness accounts and available timelines contained differences concerning the student's last known sighting, the initial missing-child notification, staffing transitions, the sequence and timing of searches, and the recovery.
- Some incident records and staff statements were prepared after the event, when participants were experiencing significant stress and fatigue.
- Natural-water conditions, operational staffing, patron numbers, site configuration, equipment, signage, and procedures may have changed between the incident date and the on-site assessment.
- The review did not recreate the incident or conduct a timed or live-water search exercise.
- The review does not substitute for legal, medical, regulatory, insurance, employment, police, fire-rescue, or school-board investigations.

Methodology (cont.)

Section 5

5.9 Limitations (cont.)

These limitations have been considered in preparing the findings and recommendations. Where material uncertainty remained, the report identifies it rather than drawing conclusions beyond the available evidence.

Source Record and Evidence Gaps

Section 6

6.1 Purpose

This section identifies the principal information sources considered during the Incident Analysis and Review and documents material evidence gaps, inconsistencies, and limitations relevant to the findings.

The review team relied on information made reasonably available by the City of Medicine Hat and through the review process. Documents and interview accounts were assessed for relevance, consistency, timing, and corroboration. Inclusion of a source does not mean that every statement within it was accepted as fact. Information that could not be independently verified is identified as reported information, an observation, or a limitation, as appropriate.

6.2 Source Record

Source category	Sources reviewed or	Use in review	Reliability considerations
Incident documentation	Available incident reports, internal time lines, staff statements, witness accounts, post-incident notes, and related correspondence.	Reconstruction of the reported sequence of events; identification of actions taken; comparison of accounts.	Some records were prepared after the incident. Timing and sequence differ among sources.
Staff interviews	Interviews with a lifeguard/shift supervisor, Aquatic Leader, Aquatic Coordinator, and Corporate Safety representative.	Understanding normal operations, training, staffing, group management, site-specific conditions, decision-making, response, and post-incident actions.	Interview accounts reflect individual recollection and perspective. Some interviews occurred weeks after the incident.
Site assessment	On-site inspection of Echo Dale Regional Park completed July 2–3, 2026. At the time of inspection, the facility was closed and the swim lake had been drained.	Assessment of physical layout, lake configuration, staff sight lines, access and egress, emergency readiness, site-specific hazards, and relevant safety controls.	The facility was not operating and the lake was drained. The assessment could not replicate water depth, water clarity, underwater visibility, currents, waves, glare on the water,

Source Record and Evidence Gaps (cont.)

Section 6

6.2 Source Record (cont.)

Source category	Sources reviewed or	Use in review	Reliability considerations
Site assessment (cont.)	The review considered the shoreline, lake basin, designated swimming area, buoy and marker locations where identifiable, access routes, lifeguard positions, signage, emergency equipment, communications, and emergency access.		active patron distribution, live lifeguard operations, or the environmental and operating conditions present on June 15, 2026.
Operational documentation	Available staff manual, safety and supervision materials, emergency procedures, schedules, staff information, orientation and in-service materials, booking information, inspection records, water-quality and maintenance records, and public-information materials.	Comparison of written expectations with reported operations and site conditions.	The review team examined the operational records made available and compared written procedures with staff accounts and other available evidence. The review did not include an exhaustive audit of all records held by the City or third parties. The site assessment occurred after the incident, while the facility was closed and the swim lake was drained; the team therefore could not directly observe incident-date operations or verify the implementation of every written procedure at each relevant point in time.
Group and booking information	Available booking calendars, group-size information, staff accounts, and information concerning booked and unbooked groups.	Assessment of anticipated attendance, staffing planning, group-use arrangements, and communication pathways.	Information available to the review did not provide a complete, independently verified attendance record for all persons at the park and swim lake.

Source Record and Evidence Gaps (cont.)

Section 6

6.2 Source Record (cont.)

Source category	Sources reviewed or	Use in review	Reliability considerations
External response information	Information reported by staff and City representatives regarding police, fire-rescue, EMS, and other responder attendance.	Context for emergency escalation, search coordination, and post-incident response.	The review did not receive or independently review official dispatch, police, fire-rescue, EMS, or medical records.
Standards and guidance.	Lifesaving Society Waterfront Safety Standards; Are You Ready? Major Incident Management Workbook; Alberta public aquatic facility guidance; applicable City and site-specific materials	Framework for reviewing safety systems, incident management, supervision, emergency readiness, risk management, and recommendations.	Standards and guidance were applied as relevant safety references. They do not replace legal requirements or determine legal compliance.

6.3 Evidence Gap Principles

The following principles were applied when evidence was incomplete or inconsistent:

- A later recollection was not treated as more reliable than a contemporaneous record solely because it was more detailed.
- An account was not treated as confirmed unless supported by another reliable source, contemporaneous documentation, physical evidence, or other corroboration.
- The absence of a record was not treated as proof that an action did not occur.
- Differences between accounts were expected following a traumatic and rapidly evolving incident; such differences were documented rather than resolved through speculation.
- Findings are limited to what can reasonably be supported by the information available within the agreed scope.

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Source Record and Evidence Gaps (cont.)

Section 6

6.4 Material Evidence Gaps and Uncertainties

Topic	Evidence gap or uncertainty	Effect on review
Last confirmed sighting	Available accounts differ regarding when the student was last seen, who received or relayed this information, the location described, and whether the information was contemporaneous or later reported.	The review cannot determine a precise last-seen time or location. Search and recognition analysis therefore relies on reported information and examines the systems used to verify and escalate such information.
Initial missing-child notification	Accounts vary regarding the time the student was first identified as absent, information provided by school personnel, and the sequence of announcements and initial search actions.	The review cannot establish a single definitive minute-by-minute start point for the missing-child response.
School-group attendance and accountability	The City advised that both schools attending Echo Dale on June 15, 2026, had been booked. The City Event Timeline records bookings from 11:00 a.m. to 2:00 p.m., and facility documentation indicates that Aquatics anticipated both schools and scheduled additional lifeguards. Staff accounts, however, repeatedly described an additional school group arriving before opening that was not reflected in the schedule they understood to apply that day. The review could not reconcile these accounts with central booking records or establish whether the reported group was separately booked, associated with one of the booked schools, or reflected a difference in information available to operational staff. The accounts were not independently verified; therefore, the review does not conclude that an unbooked group attended or that staffing was inadequate. The City also advised that groups could attend the public swim lake without an advance booking. This does not resolve the discrepancy or establish what attendance information was available to staff before opening.	The review did not receive complete, independently verified records of participant attendance, swimming ability, supervisor assignments, group head counts, or departure accountability for the groups present. These gaps limited the review's ability to establish the number and characteristics of participants, the allocation of supervision responsibilities, and the completeness of group accountability arrangements. The review assesses the City's group-booking, attendance-communication, staffing-planning, and facility-interface controls. It does not determine the school's actions, legal duties, or internal procedures.

Source Record and Evidence Gaps (cont.)

Section 6

6.4 Material Evidence Gaps and Uncertainties (cont.)

Topic	Evidence gap or uncertainty	Effect on review
Bather counts and location	Counts were reported at selected times, but the review did not receive a complete continuous record of beach, water, grass, and park occupancy, or a verified record of each patron's location during the group departure period.	The review cannot independently reconstruct exact patron load, distribution, or staff-to-bather exposure at every point during the incident.
Lifeguard deployment and transitions	Staff accounts identify chair and paddle board positions and changing deployment as groups arrived and departed. However, accounts differ on the exact timing of rotations, positions being discontinued, and the number of staff actively guarding or engaged in other duties at key points.	The review evaluates the need for documented, dynamic supervision planning and transition controls rather than making definitive findings about exact staffing at each minute.
Zone plans and surveillance coverage	Staff described zones being adjusted verbally and dynamically. The review did not receive a contemporaneous, documented zone map or position plan showing the coverage arrangement at the time of the incident.	The review cannot verify exact surveillance assignments, blind-spot coverage, or scanning responsibility for every area at each point in time.
Environmental and water conditions	The site inspection occurred after the facility had closed and the swim lake had been drained. Staff described murky water, sand movement, depth, and limited underwater visibility on the incident date; however, the review did not receive complete contemporaneous measurements or records for water clarity, depth at relevant locations, wind, glare, waves, weather, water movement, bottom visibility, or other incident-date conditions.	Environmental and water conditions are considered from reported accounts, available records, and the physical characteristics observable in the drained basin. The review could not replicate or independently quantify the aquatic conditions that existed on June 15, 2026.
Public-address communications	Staff reported concerns about audibility and volume of the public-address system. The review did not receive contemporaneous testing, recordings, or objective measurements of audibility on June 15.	The review identifies the need to assess and verify communication effectiveness; it does not conclude that any particular announcement was not heard.
Emergency communications and dispatch	The available evidence indicates that 911 was called at approximately 2:16 p.m. The review did not receive verified 911 audio, dispatch logs, call records, or responder command logs.	The review cannot independently confirm the precise time, content, sequence, or handling of emergency calls and dispatch decisions.

Source Record and Evidence Gaps (cont.)

Section 6

6.4 Material Evidence Gaps and Uncertainties (cont.)

Topic	Evidence gap or uncertainty	Effect on review
Search sequence and command	Accounts vary regarding the initial land search, transition to water search, marker placement, areas searched, bystander involvement, responder roles, and when command shifted or became shared.	The review does not determine individual command decisions. It identifies the need for clearer escalation, role assignment, search coordination, bystander management, and unified-command arrangements.
Recovery details	Staff accounts differ regarding the timing, location, and sequence of recovery and resuscitation. The review did not receive official fire-rescue, EMS, police, or medical records.	The report does not make a definitive finding on recovery details or medical cause of death.
Equipment status and use	Available accounts describe use of paddle boards, fins, masks, markers, radios, and other equipment. The review did not receive a complete contemporaneous equipment inventory, inspection record, or item-by-item usage log for the incident response.	The review evaluates equipment readiness and suitability at a systems level.
Training and competency documentation	The auditors requested relevant staff training documentation as part of the review. Printed records indicating general in-service training were made available; however, not all requested training records were provided at the time of the analysis. Staff also described Waterfront National Lifeguard training, orientation, shadow guarding, and in-service practices, but the review did not receive a complete, independently verified record of every staff member's training, attendance, competency assessment, and scenario practice immediately before June 15. One lifeguard who worked on the incident date reported that they had not received facility-specific in-service training before the start of the 2026 season, although they had worked at Echo Dale during the previous season.	The review could not verify that all staff assigned to Echo Dale had completed current-season, facility-specific training before working at the lake. This limitation does not establish that no training occurred or that staff lacked valid qualifications. It supports recommendations for clear training participation requirements, documented site-specific content, attendance records, and practical assessment of local emergency procedures.

Source Record and Evidence Gaps (cont.)

Section 6

6.4 Material Evidence Gaps and Uncertainties (cont.)

Topic	Evidence gap or uncertainty	Effect on review
Training and competency records (cont.)	The Aquatic Lead confirmed delivering a National Lifeguard Waterfront recertification session; however, the information available to the auditors did not establish whether attendance was required for all staff assigned to Echo Dale or only those requiring recertification, which staff attended, or what facility-specific training was delivered in addition to the certification assessment.	
Inspection and maintenance records	The review considered available information concerning inspections, water quality, safety equipment, and site conditions. Responsibilities for some physical infrastructure and inspection functions were described as shared among City divisions.	The review identifies the need for clear ownership, documented inspection schedules, and corrective-action follow-up. It does not determine whether a particular inspection was completed or missed unless verified by a record.
Video, photographs, and electronic records	The review did not receive or independently review complete video, surveillance, radio, text, Teams, telephone, GPS, or other electronic records that might assist with a precise time line.	The review relies primarily on available records and reported accounts. Any later-discovered electronic evidence may require reconsideration of the time line or findings.
External agency and third-party records	The review did not independently obtain records from the school, school division, police, fire-rescue, EMS, dispatch, medical providers, insurers, or other third parties.	The review remains limited to the City's information and the agreed scope.

6.5 Site Assessment Limitation

The on-site inspection was completed after the incident, while Echo Dale Regional Park was closed and the swim lake was drained. Accordingly, the site assessment was limited to the physical configuration and observable conditions of the drained facility. It did not recreate active waterfront operations or the water conditions present on June 15, 2026.

Source Record and Evidence Gaps (cont.)

Section 6

6.5 Site Assessment Limitation (cont.)

In particular, the review team could not directly assess water clarity, submerged visibility, depth conditions at the time of the incident, surface reflection or glare, wind or wave effects, active lifeguard positioning, patron distribution, or live communication effectiveness. Any conclusions concerning these matters are based on available records, interviews, site layout, and reported information rather than direct observation of incident-date conditions.

6.6 Records Preservation and Follow-Up

The City should preserve all original and relevant records relating to the incident, including original reports, notes, schedules, training records, booking records, inspections, maintenance records, emails, text messages, Teams messages, radio and telephone information, photographs, video, maps, equipment records, and communications with external agencies.

Records should be retained in accordance with the City's records-retention requirements and any legal, insurance, privacy, police, regulatory, employment, or litigation hold. Original records should not be altered, overwritten, or annotated in a way that obscures the original content.

If material additional information becomes available, the City should provide it to the Lifesaving Society for consideration. The review findings and recommendations may require amendment where new information materially changes the factual record or safety analysis.

6.7 Interpretation of Gaps

The Lifesaving Society acknowledges the City of Medicine Hat's cooperation in providing records, facilitating access to personnel, and responding to requests for information during the review and factual-review process.

The evidence gaps identified in this report describe limitations in the information available to the review team. They do not, by themselves, establish that an action did not occur, that a procedure was not followed, that information was withheld, or that a person or organization is responsible for the incident. They identify information that was unavailable, incomplete, inconsistent, outside the agreed scope, or not independently verifiable at the time of the review.

Source Record and Evidence Gaps (cont.)

Section 6

6.7 Interpretation of Gaps (cont.)

Acknowledging the City's cooperation does not establish that the record set was complete or resolve the specific evidence limitations identified elsewhere in this report. Material additional information will be considered and may require revision of the analysis, findings, or recommendations.

The recommendations are intended to reduce risk despite these uncertainties. They focus on improving the reliability of recognition, communication, documentation, supervision, emergency escalation, search coordination, recovery, and organizational learning.

Event Summary

Section 7

On Monday, June 15, 2026, Echo Dale Regional Park's supervised swim lake was open to the public and was hosting school-group use. Available information indicates that the day involved two school groups, other patrons, changing bather numbers, and an operational transition as school group A prepared to depart.

The Echo Dale Swim Lake half-hour statistics form, dated June 15, 2026, records changing patron numbers throughout the day: 103 persons at 11:00 a.m.; 140 at 11:30 a.m.; 145 at 12:00 p.m.; 147 at 12:30 p.m.; 115 at 1:00 p.m.; 131 at 1:30 p.m.; and 37 at 2:00 p.m. These entries support that the incident occurred during a period of changing bather numbers and a transition as school group A was preparing to depart. The form is identified by a file name referring to May 15, 2026; however, the form itself is dated June 15. This report therefore refers to it descriptively as the "Echo Dale Swim Lake half-hour statistics form, dated June 15, 2026."

Staff accounts indicate that lifeguard coverage was increased as bather numbers rose, with elevated-chair and paddle board positions used during the period of higher recorded attendance. The number and deployment of lifeguard positions changed as attendance declined and school group A began departing. Staff accounts also describe routine lifeguard interventions during the operating period, including addressing rough play, buoy-line use, tired swimmers, and patrons who appeared to need direction or assistance. Staff reported using radio communication and public-address announcements to communicate safety expectations and respond to operational concerns.

The June 15 water-treatment log records treatment-plant and swim-lake chlorine readings for that date. These records were reviewed as part of the operational context. They do not, on their own, establish water clarity, underwater visibility, or the conditions experienced by lifeguards and patrons at the relevant time.

At approximately 1:40 p.m., staff made an announcement for the school group B to prepare to leave and return to its buses. Shortly afterward, a teacher informed aquatic staff that one student had not returned with the group. Staff made one or more public-address announcements requesting that the student report to the lifeguard office. Available accounts indicate that the teacher initially provided limited identifying information and that staff then began a land search of the lifeguard office area, change rooms, building, parking or surrounding areas, boating-lake area, farm area, and other parts of the park.

During the initial search, staff received information that the student may have last been seen in the water. The source, timing, and precise location of this information could not be independently confirmed. Based on this information, aquatic staff transitioned to a missing-swimmer response. Staff cleared the lake, deployed available search equipment, including paddle boards, fins, masks or snorkels, and a marker buoy, and began shallow- and deeper-water searches in the reported last-seen area.

Event Summary (cont.)

Section 7

Available accounts indicate that a shallow-water search was organized with staff, teachers, and bystanders, while lifeguards and aquatic leads conducted deeper-water searches. Bystanders and other adults were asked to assist; the extent and timing of their involvement varied across accounts. The search expanded beyond the initial reported location as staff and later emergency responders assessed areas that had been searched and areas requiring further attention.

Available City information indicates that 911 was called at approximately 2:16 p.m. Police, fire-rescue, EMS, and other emergency resources attended. Staff provided information to responders about the reported last-seen location, the areas searched, and the response actions taken. Staff accounts indicate that command and search responsibilities evolved as emergency responders arrived. The available evidence does not permit a definitive determination of the precise command structure, search sequence, or timing of all responder actions.

Fire-rescue personnel subsequently located the student in the water and initiated resuscitation efforts. Available accounts place this at approximately 3:30 p.m.; however, the review did not receive official dispatch, fire-rescue, EMS, police, or medical records to independently confirm the timing or sequence of recovery and resuscitation. The student later died. This report does not address the medical cause of death.

Following the incident, staff were removed from active duties and received immediate support and debriefing assistance. The City subsequently closed Echo Dale, collected available information and staff statements, provided additional staff support, and retained the Lifesaving Society Alberta and Northwest Territories Branch to conduct this Incident Analysis and Review.

Event Timeline

Section 8

The following time line consolidates available records, staff statements, interviews, and the June 15 half-hour statistics form. Times marked confirmed record are supported by a contemporaneous written record. Times marked reported reflect witness or staff recollections and have not been independently verified. Where accounts differ, the time line identifies the uncertainty rather than selecting one account as definitive.

Time	Event	Source/ confidence
5:45 a.m.	Echo Dale Regional Park gates were opened.	Documented City information.
6:00 a.m.	Parks staff began their morning shift at Echo Dale Regional Park.	Documented City information.
8:00 a.m.	The swim-lake beach was groomed.	Documented City information.
10:00 a.m.	Irrigation work began elsewhere in the park.	Documented City information.
10:40 a.m.	The City time line recorded the arrival of a school group B.	Documented City information; school identified in the City of Medicine Hat Event Time line. Actual group size remains subject to verification.
10:45 a.m.	An Aquatic Lead and an orientation/shadow staff member began shifts.	Documented City information and staff accounts.
11:00 a.m.	Five lifeguards began scheduled shifts. The half-hour statistics form records 63 persons in the lake and 40 on the beach, total 103.	Confirmed head-count record and documented City information.
11:00 a.m.	City booking information records school group B use scheduled from 11:00 a.m. to 2:00 p.m.	Documented City information; group size and attendance require reconciliation with booking and school records.
11:15 a.m.	Additional lifeguards began scheduled shifts.	Documented City information and staff accounts.
11:30 a.m.	The half-hour statistics form records 75 persons in the lake and 65 on the beach, total 140.	Confirmed head-count record.

Event Timeline (cont.)

Section 8

Time	Event	Source/ confidence
11:40 a.m.	The City time line records the commencement of Chair 3 lifeguard coverage.	Documented City information.
11:45 a.m.	Lifeguards made an announcement concerning patrons playing with buoy lines.	Documented City information. Confirmed head-count record.
12:00 p.m.	The half-hour statistics form records 62 persons in the lake and 83 on the beach, total 145.	Documented City information.
12:00 p.m.	Bike-route and change room checks were recorded.	Documented City information.
12:20–1:00 p.m.	The City time line records rotating coverage of Chair 2 and Chair 3.	Documented City information; the source itself identifies some uncertainty regarding specific assignments.
12:20–1:00 p.m.	The City time line records paddle board coverage rotations.	Documented City information.
12:30 p.m.	The half-hour statistics form records 60 persons in the lake and 87 on the beach, total 147, the highest recorded total for the day.	Confirmed head-count record.
1:00 p.m.	The half-hour statistics form records 55 persons in the lake and 60 on the beach, total 115. A water-treatment reading was recorded.	Confirmed head-count record and water-treatment log.
Approximately 1:00 p.m.	A later-reported account stated that another student may have seen the student in the water, "going up and down."	Reported information; timing, source, and location were not independently verified.
1:20–1:40 p.m.	The City time line records Chair 2 coverage and a reported intervention involving a student near the buoys who appeared to require assistance.	Documented City information.

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Event Timeline (cont.)

Section 8

Time	Event	Source/ confidence
Before 1:40 p.m.	Staff accounts indicate that a request was made to reduce lifeguard coverage, but an Aquatic Lead directed that additional coverage be maintained because of school-group attendance.	Reported information; precise timing is uncertain.
1:30 p.m.	The half-hour statistics form records 64 persons in the lake and 67 on the beach, total 131. The City time line records one lifeguard ending their shift and an announcement directing school group B to return to buses.	Confirmed head-count record and documented City information.
Approximately 1:30–1:40 p.m.	The City time line records a further direction or reminder for the school group B to load buses.	Documented City information; this entry requires corroboration because it is not consistently reflected in all staff accounts.
Approximately 1:50–2:00 p.m.	A teacher notified lifeguards that a student was missing. Available accounts indicate that the student's information was recorded and one or more public-address announcements were made.	Reported information and documented City information; exact time remains uncertain.
Approximately 1:52–2:00 p.m.	An announcement was made for the missing student to report to the lifeguard office.	Reported information and documented City information; exact time remains uncertain.
Shortly after notification	An initial land search began. Available accounts describe searches of the facility, change rooms, washrooms, nearby structures, parking or surrounding areas, farm area, and boating-lake area.	Reported information and documented City information.
Approximately 1:55 p.m.	The City time line records that some school-group members left the lifeguard office for the bus after staff were advised that the student may have been found. One lifeguard ended their shift believing the student had been located.	Documented City information; this information should be retained as reported context and not interpreted as confirmation that the student was found.

Event Timeline (cont.)

Section 8

Time	Event	Source/ confidence
2:00 p.m.	The City Event Timeline records 15 persons in the lake and 28 on the beach (total 43). The separate half-hour statistics form appears to record 15 in the lake and 22 on the beach (total 37).	Contemporaneous City records conflict. The discrepancy remains unresolved; neither count is treated as definitive.
2:00 p.m.	Morning Parks staff ended their shifts. A lifeguard shift also ended.	Documented City information.
Approximately 2:00 p.m.	The Parks manager was notified of a possible missing child and travelled to Echo Dale Regional Park.	City records document the notification and travel. The timing is approximate; the manager's arrival time is not established by this entry.
Approximately 2:05 p.m.	An announcement was made to clear the water and direct volunteers to a meeting location.	Reported information and documented City information.
Approximately 2:05–2:10 p.m.	A shallow-water search began near the reported last-seen area.	Reported information and documented City information.
Approximately 2:08 p.m.	A lifeguard entered the water using fins and a mask; a marker was reportedly placed.	Documented City information and staff accounts.
Approximately 2:10 p.m.	Additional lifeguards joined the deeper-water search. An Aquatic Lead also notified the Parks evening shift phone of the missing-child search.	Documented City information and staff accounts.
Approximately 2:15–2:20 p.m.	The Parks Manager arrived on site. One Parks irrigation staff member was also on site; no additional Parks staff arrived on site during this interval	City time line and subsequent City clarification; the Manager's arrival time remains approximate. The irrigation staff member's presence does not establish their arrival time.
2:16 p.m.	An Aquatic Lead called 911.	Documented City information and staff accounts; official dispatch records were not reviewed.

Event Timeline (cont.)

Section 8

Time	Event	Source/ confidence
Approximately 2:25–2:35 p.m.	Fire and police resources began arriving.	Documented City information; exact arrival times should remain approximate unless confirmed by dispatch records.
Approximately 2:30 p.m.	The City timeline records air-search resources arriving at the scene and beginning an area search.	Subsequent City clarification; timing is approximate. The information provided does not establish whether pump deployment occurred or drainage began.
Approximately 2:30 p.m.	City records indicate that Municiple Works (MW) arrived at the scene with pumps for potential swim-lake drainage.	Subsequent City clarification; timing is approximate. The information provided does not establish whether pump deployment occurred or drainage began.
Approximately 2:30–2:40 p.m.	Fire-rescue and police personnel joined or supported the water and aerial/drone search. Staff briefed responders on the reported last-seen area and search activity completed to that point.	Documented City information and staff accounts.
2:58 p.m.	Parks staff were assigned to check trail systems.	Documented City information.
Approximately 2:30–3:20 p.m.	Lifeguards, aquatic leads, firefighters, teachers, and bystanders reportedly continued shallow- and deeper-water searches. Accounts describe linked-arm sweeps, line searches, paddle board support, and search activity extending into deeper and back areas of the lake.	Reported information; participant numbers, exact locations, and sequence vary among sources.
3:23 p.m.	Firefighters directed lifeguards and bystanders to leave the water because of fatigue.	Documented City information and staff accounts.
Approximately 3:28–3:30 p.m.	Firefighters recovered the student from the water and initiated resuscitation efforts. Aquatic staff were moved inside or away from the active scene.	Documented City information and staff accounts; the review did not receive official fire-rescue, police, EMS, or medical records to independently verify exact timing or details.

Event Timeline (cont.)

Section 8

Time	Event	Source/ confidence
Approximately 4:30 p.m.	Critical incident stress-management support or debriefing was provided to staff, teachers, and management.	Documented City information and staff accounts.
8:00 p.m.	City time line records that a water-temperature reading of 20°C was obtained at police request.	Documented City information; no clinical or causal interpretation is made in this report.
June 17, 2026	The City held a critical-incident strategy meeting concerning facility reopening and related response.	Documented City information.
June 17–18, 2026	The City began and continued draining the swim lake.	Documented City information.

Time line Notes and Limitations

- The City of Medicine Hat Event Timeline was reviewed as a source record. It includes operational and preliminary entries compiled by the City. Entries from that document are not automatically treated as independently verified facts.
- The City Event Timeline contains internal qualifiers such as “approximate,” “not sure,” “rough estimate,” and references to information pending further follow-up. Those qualifications have been retained in the characterization of the evidence.
- The City Event Timeline contains apparent clock-formatting inconsistencies, including entries displayed as 02:15 and 02:25 that context indicates occurred in the afternoon. This report uses approximate afternoon times where context supports that interpretation.
- The 2:00 p.m. patron count differs between the City Event Timeline and the separate half-hour statistics form. The discrepancy should be reconciled against the original records.
- The review did not receive official dispatch, police, fire-rescue, EMS, medical, school, radio, telephone, video, or GPS records that could independently confirm every event time, responder action, or search location.
- This timeline is not a finding of legal responsibility, fault, medical causation, or individual performance. It is a structured presentation of the information available to the review.

Facility and Program Context

Section 9

9.1 Facility Overview

Echo Dale Regional Park is a City of Medicine Hat municipal recreation site that includes a supervised public swim lake, designated beach area, associated park amenities, and other recreational areas. For the purposes of this aquatic-safety analysis, Echo Dale is described as a supervised public swim lake with waterfront-style operating characteristics. This description reflects its beach access, swimming-area configuration, depth and bottom conditions, lifeguard deployment, broad activity area, and reported limitations in underwater visibility and search conditions.

The swim lake was operated seasonally with lifeguard supervision during scheduled operating hours. Its waterfront-style operating environment requires site-specific supervision, prevention, and emergency-response controls that account for changing environmental and water conditions, variable visibility, depth, shoreline access, and the possibility of multiple activities occurring within the wider park. The Lifesaving Society’s Waterfront Safety Standards provide relevant professional guidance for assessing these operating characteristics and associated safety controls. These standards are professional safety guidance, not legislation.

Regulatory classification is a separate matter. The City should confirm the facility’s applicable classification and operating requirements with the relevant health authority, using its permits, approvals, design information, and water-treatment arrangements. This report does not conclude that Echo Dale is a “natural pool” within the regulatory definition, nor does it conclude that public swimming pool requirements are inapplicable. The applicable legal and regulatory requirements must be determined by reference to the facility’s design, treatment system, permits, approvals, and the legislation, regulations, and standards in force on June 15, 2026.

On June 15, 2026, the facility was open to public and school-group use. The City’s half-hour records show fluctuating combined lake and beach attendance, with recorded totals ranging from 103 at 11:00 a.m. to 147 at 12:30 p.m. Attendance declined and then increased during the early afternoon before the school-group departure and missing-child response.

The review also considered the Lifesaving Society’s Are You Ready? Major Incident Management Workbook as a framework for analyzing incident recognition, reaction, recovery, and restoration to normality. Applicable Alberta legislation, standards, permits, and approvals are relevant to determining the facility’s regulatory obligations, subject to confirmation of their applicability and the versions in force on the incident date.

Facility and Program Context (cont.)

Section 9

9.1 Facility Overview (cont.)

National waterfront standards published after June 15, 2026, may inform future safety improvements but are not treated as requirements in force on the incident date. The national website lists a July 2026 National Waterfront Safety Standard, which postdates the incident.

9.2 Physical and Environmental Context

The swim lake includes a beach, shoreline access points, lifeguard positions, buoy markers or boundaries, a lifeguard office or operations area, change rooms, public-address capability, and access routes within the broader park.
The on-site assessment was completed after the facility had closed and the swim lake had been drained. The review therefore considered the physical configuration of the shoreline and lake basin, designated swimming area, access and egress routes, lifeguard positions, signage, emergency equipment, communication systems, and emergency access. The assessment did not recreate active operations or the water conditions present on June 15, 2026.

Staff described the lake as presenting natural-water supervision and search challenges, including variable or limited underwater visibility, sand movement, depth, broad patron distribution, and difficulty diving to the lake bottom.
Staff also identified the potential effect of wind, sun, water conditions, patron activity, and the location of swimmers on lifeguard positioning and coverage. These descriptions are reported information; the review did not obtain contemporaneous water-clarity, weather, glare, wave, or depth measurements for the relevant period.

The June 15 water-treatment log records operational water-treatment readings, including swim-lake chlorine readings and treatment-plant information. These records provide operational context only; they do not independently establish underwater visibility, water clarity, or the conditions experienced by patrons and staff during the incident.

9.3 Program and User Context

Echo Dale accommodates public recreation, school groups, day camps, and other organized or informal users. Staff reported that school-group use was more common in June and that groups could attend the public swim lake without an advance booking. The review was advised that group bookings, expected attendance, and related information were communicated through calendars and internal communications. Aquatics staff reported that booking information was not always received early enough to support consistent staffing and operational planning.

Incident Analysis Review
REPORT

Facility and Program Context (cont.)

Section 9

9.3 Program and User Context (cont.)

For June 15, 2026, the City advised that both attending schools had been booked. The City Event Timeline records school-group bookings from 11:00 a.m. to 2:00 p.m., and facility documentation indicates that Aquatics anticipated attendance from the two schools and scheduled additional lifeguards. Staff accounts repeatedly described an additional school group arriving before opening that was not reflected in the booking schedule they understood to apply that day. The review did not establish whether this account referred to a separate group, an additional group associated with a booked school, or a discrepancy between central booking records and the information available to operational staff. The accounts were not independently verified, and the review does not conclude that an unbooked group attended or that a staffing shortfall occurred.

Available information indicates that school groups and other public patrons were present and that bather numbers changed throughout the day. The review did not receive a complete, independently verified attendance list, school supervision plan, swimming-ability information, teacher-to-student assignment record, or group head-count record for the groups present. These limitations prevent a complete reconstruction of participant numbers, group-supervision arrangements, and individual accountability at relevant stages of the visit.

For group visits, safe operation depends on coordinated responsibilities between the facility operator, aquatic staff, group leaders, teachers, parents or guardians, and participants. Relevant controls include booking and attendance confirmation, communication of changes in expected attendance, information about participant age and swimming ability, group orientation, supervision expectations, head counts, communication methods, swim-area rules, and procedures for entry, transitions between activities, and departure.

The distinction between public park access and use of the swimming area, organized activities, and booked services is important when assessing these controls. Access to the public park does not, by itself, establish that a group has booked a service or organized activity, received a swimming-area orientation, or met any applicable group-use requirements. The review considers these

9.4 Operating and Supervision Model

The City advised that Echo Dale normally scheduled a base complement of lifeguards, with additional staffing considered for booked groups, hot weather, weekends, patron load, and operational conditions. Staff reported that lifeguard positions included elevated-chair positions and a paddle board position.

Facility and Program Context (cont.)

Section 9

9.4 Operating and Supervision Model (cont.)

Staff reported that lifeguard positions included elevated-chair positions and a paddle board position. Staff reported that the number and location of active positions could be adjusted based on patron distribution, activity, conditions, bather counts, and supervisory judgment.

Staff described a dynamic approach to supervision in which zones and position assignments were communicated verbally during rotations and could change through the day. The review did not receive a contemporaneous, documented zone map or position plan for June 15. Staff also reported that the paddle board position was used to extend observation and response capability, particularly where an elevated-chair position alone did not provide sufficient coverage.

Available information indicates that lifeguards communicated using radios and direct verbal communication. Public-address announcements were used for general rules, school-group information, patron direction, and emergency communications. Staff reported concerns about the audibility and volume control of the public-address system. The review did not receive a contemporaneous audibility assessment or recording from June 15 and does not determine whether any particular announcement was or was not heard.

The Lifesaving Society's Waterfront Safety Standards emphasize that supervision systems should account for sight lines, blind spots, patron characteristics, water and weather conditions, activities, staff experience, bather load, and the size and configuration of the swimming area. The Standards also identify continuous scanning, effective lifeguard positioning, minimized distractions, regular rotation, and appropriate staffing as core waterfront controls.

9.5 Staffing, Orientation, and Training

Staff reported that Echo Dale lifeguards held, or were expected to hold, current National Lifeguard Waterfront qualifications and applicable first aid certification. Staff also described site-specific orientation and shadow-guarding processes, including review of site procedures, equipment, opening and closing practices, emergency response, and waterfront operating expectations.

Available information indicates that the City provided or planned biweekly in-service training during the operating season, with scenarios including drowning, missing persons, playground incidents, land spinal injuries, and wildlife encounters. Interviews identified variability in individual attendance at Echo Dale in-services, particularly for staff who worked at the site less frequently or whose primary assignment was another facility.

Facility and Program Context (cont.)

Section 9

9.5 Staffing, Orientation, and Training

Staff accounts indicate that no Echo Dale-specific in-service had occurred during June before the incident. Available information did not establish whether site-specific training had been provided during the pre-season period. For the purposes of this review, these are separate observations: the first concerns training delivery during June, while the second concerns whether facility-specific training occurred before the operating season began.
The review considers training, orientation, site familiarity, emergency drills, and competency verification as safety-system controls. This report does not make individual competency or performance findings.

9.6 Governance and Operating Interfaces

Echo Dale's operation involved several City functions, including Aquatics, Parks, Recreation, Fleet Facilities and Asset Management, booking services, Corporate Safety, and management. Interview participants reported that Aquatics was responsible for lifeguard staffing, training, aquatic equipment, and day-to-day aquatic supervision, while Parks and other City functions had responsibilities related to the broader park, physical infrastructure, maintenance, water treatment, and some booking or operational interfaces.

The review identified that the allocation of responsibility for booking controls, site inspection, infrastructure, communication, emergency support, and post-incident coordination requires clear documentation and consistent application. This section describes the reported operating context only; subsequent findings and recommendations address opportunities to strengthen these interfaces.

9.7 Context Limitations

This section is based on information available to the review team, including the City's records, staff interviews, the site assessment, and relevant safety guidance. The facility was closed and the lake drained when the site assessment occurred. The review did not independently verify all booking, attendance, staffing, infrastructure, inspection, school-supervision, or environmental information.

Accordingly, the descriptions in this section should not be read as findings of fault, legal responsibility, regulatory compliance, or individual performance. They provide the operating context for the analysis, findings, and recommendations that follow.

Contributing Factor Analysis

Section 10

10.1 Purpose and Interpretation

The review did not identify or rely on a single root cause. The available evidence indicates that the incident occurred within a combination of interacting patron, environmental, operational, supervision, emergency-response, training, and organizational conditions.

The presence of a contributing condition does not establish that it caused the incident, that any individual or organization failed to meet a legal duty, or that the incident would necessarily have been prevented if that condition had been different. Rather, this analysis identifies conditions that may have affected opportunities to prevent, recognize, respond to, or reduce the consequences of the incident.

The analysis is based on available records, the City's event timeline, staff and witness accounts, the site assessment, and applicable Lifesaving Society guidance. It is subject to the evidence gaps and limitations identified elsewhere in this report.

10.2 Contributing Conditions

Domain	Conditions considered	Potential effect on prevention, recognition, response, or recovery
Patron and group context	Two school groups and public patrons were present; bather numbers changed during the day; school group A was transitioning from the water to bus departure; complete group attendance, swimmer-ability, and individual accountability information was not available to aquatic staff.	These conditions increased the importance of clear group-leader roles, active group supervision, head counts, swimmer-ability controls, buddy expectations, and structured water-to-departure procedures.
Recognition of absence or distress	The student was reported missing during the group's departure. Available accounts differ regarding the time and location of the last known sighting, and the information initially available to staff was limited.	Incomplete or evolving last-seen information may have increased uncertainty regarding whether the student was on land, had left the facility, or may have been in the water. This created a need for clear decision triggers and immediate escalation procedures.

Contributing Factor Analysis (cont.)

Section 10

10.2 Contributing Conditions (cont.)

Domain	Conditions considered	Potential effect on prevention, recognition, response, or recovery
Supervision and deployment	Staff accounts indicate that lifeguard coverage was increased during higher attendance and that elevated-chair and paddle board positions were used. Position assignments and zones were adjusted dynamically and communicated verbally; no contemporaneous written zone plan was available to the review.	Dynamic deployment can be appropriate at a waterfront, but undocumented zones and changing positions may make it more difficult to confirm coverage, transfer identified risks, and maintain consistent surveillance during high-load periods or transitions.
Natural-water environment	Staff described murky water, sand movement, depth, broad swimmer distribution, limited underwater visibility, and difficulty searching to the lake bottom. The on-site review occurred after the lake was drained and could not replicate incident-date water conditions.	Natural-water conditions may limit the ability of surface surveillance alone to detect a submerged or distressed swimmer and may complicate underwater search, rescue, and recovery. These conditions increase the importance of prevention, supervised boundaries, group controls, early recognition, and site-specific search readiness.
Group-attendance information and planning	The City advised that staff were aware of the two schools' planned attendance and that staffing was arranged accordingly. Facility records indicate that additional lifeguards were scheduled. Staff accounts described an additional group arriving before opening that was not reflected in the schedule they understood to apply that day. The relationship between these accounts, central booking records, and information available to staff remained unresolved.	The reported discrepancy was not independently verified and did not establish a staffing shortfall or that booking information contributed to the incident. It identifies an opportunity to clarify processes for communicating attendance changes and assessing groups arriving without advance notice. Public-address concerns were considered separately.

Contributing Factor Analysis (cont.)

Section 10

10.2 Contributing Conditions (cont.)

Domain	Conditions considered	Potential effect on prevention, recognition, response, or recovery
Public-address communications	Staff reported concerns about the public-address system's audibility and volume control. The review did not receive contemporaneous testing or recordings establishing its effectiveness during the incident.	These accounts support testing communication coverage and reliability during normal operations and emergencies. They do not establish that a particular announcement was not heard or affected the incident outcome.
Initial emergency response	Staff made announcements, initiated a land search, cleared the swim lake, deployed equipment, began in-water search activity, and called 911. The response evolved as additional information became available. The review considered existing emergency and missing-person procedures; however, available accounts did not establish a single, definitive sequence or timing for all escalation decisions and response actions.	The sequence reflects staff efforts to manage uncertain and changing information. It supports refining and testing the existing procedures through explicit missing-child and possible missing-swimmer decision triggers, water-clearing criteria, 911 activation, role assignments, and coordinated search arrangements. The recommendation is to strengthen the clarity, consistency, and practical application of the existing process—not to suggest that no process was in place
Search coordination and command	Searches involved lifeguards, aquatic leads, teachers, bystanders, Parks personnel, police, fire-rescue, and other responders. Accounts vary regarding search areas, use of markers, the role of volunteers, communications, and transfer or sharing of command.	Multiple participants and evolving search areas increased operational complexity. Clear incident command, search leadership, communications discipline, search mapping, responder liaison, volunteer management, and unified-command arrangements may improve coordination and reduce ambiguity.
Training and site readiness	Staff reported Waterfront National Lifeguard certification or recertification, orientation, shadow guarding, and in-service activities. In-service attendance varied, and early-season scenario practice was limited. Site-specific training, drills, and competency verification were not fully documented for all waterfront staff.	Site-specific training and practical drills may not have been consistently available to every staff member who could be assigned to the waterfront. This may affect familiarity with facility-specific conditions, roles, search limitations, emergency equipment, group management, and responder integration.

Contributing Factor Analysis (cont.)

Section 10

10.2 Contributing Conditions (cont.)

Domain	Conditions considered	Potential effect on prevention, recognition, response, or recovery
Governance and coordination	Responsibilities were distributed across Aquatics, Parks, Recreation, Fleet Facilities and Asset Management, booking services, Corporate Safety, and external responders. Staff described uncertainty or gaps in booking communication, site and infrastructure ownership, emergency support expectations, and documentation practices.	Distributed responsibilities may create gaps between policy and practice unless decision rights, information flow, inspection ownership, emergency roles, and corrective-action accountability are clearly documented and regularly tested.
Post-incident recovery and learning	The City provided staff support, debriefing, facility closure, and follow-up. The event involved extensive staff, responder, group, and community impact.	The incident underscores the need for a repeatable recovery and restoration framework that addresses staff support, documentation, communications, evidence preservation, reopening decisions, and verification that corrective actions are effective.

10.3 Analytical Summary

The available evidence supports the conclusion that the incident was shaped by interdependent layers of risk rather than a single event or individual action. The principal system-level themes are:

- The need for documented, risk-based supervision zones and staffing escalation tied to more than bather count alone.
- The need for waterfront controls that account for reduced underwater visibility, depth, site configuration, and complex search conditions.
- The need for immediate, structured escalation from a missing-child concern to a possible missing-swimmer response when water involvement is unknown or reasonably possible.
- The need for a clear incident-command and search-management model that can operate until unified command is established with external responders.
- The need for mandatory, practical, early-season, site-specific training and joint exercises involving Aquatics, Parks, and emergency-response partners.

Contributing Factor Analysis (cont.)

Section 10

10.3 Analytical Summary (cont.)

The Lifesaving Society's Waterfront Safety Standards identify risk management, group planning, effective supervision, emergency procedures, staff communication, incident analysis, and continuous evaluation as connected components of safe waterfront operation. The Are You Ready? workbook similarly frames major-incident management as a cycle of recognition, reaction, recovery, and restoration to normality.

The findings and recommendations in the following section are aligned to these contributing conditions and are intended to strengthen the controls available before, during, and after a comparable event.

Finding and Recommendations

Section 11

11.1 Approach

The findings and recommendations in this section are systems-focused. They are based on the information available to the review team, including records, staff and witness accounts, the City's event timeline, site assessment, and relevant Lifesaving Society safety guidance.

The findings do not determine legal liability, negligence, medical causation, regulatory non-compliance, or individual performance. Recommendations identify practical controls intended to reduce the likelihood or consequences of a similar incident.

Recommendations are organized using the four major-incident management phases described in the Lifesaving Society's Are You Ready? Major Incident Management Workbook:

1. Recognition
2. Reaction
3. Recovery
4. Restoration to Normality

Additional recommendations address broader facility, operational, and governance controls. The Waterfront Safety Standards similarly describe risk management as an ongoing cycle of identifying risks, implementing controls, and monitoring their effectiveness.

11.2 Key Findings

ID	Key finding	Contributing conditions considered	Risk implication
KF - 01	The incident occurred during a period of changing patron load and school-group departure activity.	Multiple groups, changing lake and beach occupancy, shifting lifeguard deployment, school departure, incomplete or inconsistent group-accountability information.	A missing child or distressed patron may not be recognized promptly during transitions without defined group-accountability and escalation controls.
KF-02	The swim lake's natural-water environment created supervision and search challenges.	Reported murky water, sand movement, depth, broad activity area, limited underwater visibility, changing environmental conditions, and difficulty searching to the lake bottom.	Continuous surface surveillance cannot reliably compensate for reduced underwater visibility; prevention, group controls, boundaries, and recognition systems require added emphasis.

Finding and Recommendations (cont.)

Section 11

11.2 Key Findings

ID	Key finding	Contributing conditions considered	Risk implication
KF-03	Supervision positions and zones were adjusted dynamically, but the review did not identify a contemporaneous documented zone plan for the incident period.	Position changes based on bather load and staff judgment; elevated-chair and paddle board positions; verbal hand overs; changing patron distribution.	Informal or undocumented coverage arrangements can create uncertainty about surveillance responsibility and coverage during periods of high load or transition.
KF-04	Facility records indicate that Aquatics anticipated the two booked schools and scheduled additional lifeguards. Staff reported an additional group arriving before opening that was not reflected in the schedule available to them. This account was not independently verified or reconciled with central booking records and does not establish a staffing shortfall or contribution to the incident.	Varying attendance information, limited swimming-ability information, and unclear group-supervision and head-count processes.	Where expected attendance, participant swimming ability, supervision assignments, or group head-count arrangements are incomplete or not communicated consistently, operational staff may have limited information for assessing group-specific risks and planning appropriate controls.
KF-05	The initial missing-child response involved announcements and a land search before a structured missing-swimmer response was activated.	Limited initial information, uncertainty about last-seen location, land-search deployment, evolving reports that the student may have been in the water.	Delay or uncertainty in escalation can extend the time before the aquatic area is cleared, emergency assistance is activated, and a coordinated water search begins.
KF-06	Staff initiated search actions and emergency escalation; however, the available evidence identifies uncertainty in command, search coordination, bystander roles, and interface with external responders.	Multiple staff, teachers, bystanders, Parks staff, fire-rescue, police, evolving search areas, unclear command transfer.	A complex search can become fragmented without preassigned roles, a search map, communications discipline, defined bystander-management procedures, and unified-command arrangements.

Finding and Recommendations (cont.)

Section 11

11.2 Key Findings

ID	Key finding	Contributing conditions considered	Risk implication
KF-07	Staff described orientation, waterfront certification, and in-service practices; opportunities exist to strengthen early-season, mandatory, site-specific scenario training.	Recertification training was delivered. Available information did not establish individual participation in Echo Dale-specific in-service training or whether that training addressed site-specific operating and emergency-response considerations.	Staff may have varying familiarity and practical readiness for site-specific missing-swimmer, group-transition, and major-incident procedures.
KF-08	The incident identified cross-department operational interfaces requiring clearer ownership and coordination.	Shared responsibilities among Aquatics, Parks, Recreation, Fleet Facilities and Asset Management, booking services, Corporate Safety, and external responders.	Gaps in responsibility, information flow, inspection ownership, emergency support, and corrective-action tracking can weaken safety controls.
KF-09	The City provided significant post-incident staff support; a formal, repeatable major-incident recovery and restoration framework is needed.	Staff distress, closure decisions, communication needs, documentation, counselling, debriefing, facility recovery, and continued operational impacts.	Without a defined recovery plan, staff support, evidence preservation, communications, reopening decisions, and organizational learning may be inconsistent.

The Waterfront Safety Standards emphasize risk-based waterfront supervision, documented safety systems, group-use planning, emergency procedures, staff training, inspections, incident analysis, and controls appropriate to the site's physical and operating conditions.

11.3 Recognition Phase

Finding R-1 - Group accountability and transition controls

Observation: The missing-student concern arose during a school-group departure. The review did not have sufficient school-specific attendance, participant-accountability, swimming-ability, and departure records to fully reconstruct the group's water-to-departure arrangements.

The City advised that both schools were booked. Staff accounts nevertheless described an additional group arriving before opening that was not reflected in the booking schedule they understood to apply that day. The relationship between those accounts and the booking information remained unresolved. The review does not identify unbooked school attendance as a confirmed condition of the incident.

Finding and Recommendations (cont.)

Section 11

11.3 Recognition Phase (cont.)

Contributing conditions considered: Two schools; changing lake and beach counts; school-group departure activity; uncertainty concerning the student's last confirmed sighting; limitations in the participant-accountability information available to the review; and an unresolved difference between staff accounts of anticipated attendance and booking information.

Recommendation R-1 - Implement a formal group-use and accountability protocol.

Before a school, camp, organized group, or other high-volume youth group enters the waterfront:

- Booking and access: Define which organized activities and services require advance booking or notification. Establish a process for assessing groups arriving without advance notice, including participant numbers, age and swimming ability, supervision arrangements, lifeguard coverage, and operating conditions. Specify who may authorize additional controls, delayed swimming-area access, or restrictions based on assessed risk and City policies. Distinguish public park access from swimming-area access, organized activities, and booked services.
- Group information and supervision: Require group leaders to provide participant numbers, age range, adult-supervisor names, emergency contact arrangements, relevant swimming-ability or accommodation information, and planned arrival and departure times.
- Pre-entry orientation: Require the aquatic supervisor and group leader to confirm supervision roles, head-count responsibility, buddy expectations, boundaries, signals, emergency procedures, and designated meeting and departure points.
- Head counts and accountability: Require documented head counts before water entry, at scheduled intervals, before transitions, and before departure.
- Missing participant notification: Require group leaders to notify the aquatic supervisor immediately when a participant is identified as missing, including whether the participant was last known to be on land, in the water, or is of unknown whereabouts.

Priority: Critical

Accountable owner: Recreation Manager, Superintendent Recreation Services, and Aquatics Coordinator, with support from the Parks/Recreation booking lead.

Completion evidence: Approved procedure, group booking form, leader checklist, staff training record, and pilot implementation records.

Finding and Recommendations (cont.)

Section 11

11.3 Recognition Phase (cont.)

Effectiveness measure: 100% of organized youth groups have a completed booking and accountability record before entering the waterfront.

Finding R-2 - Supervision planning and documented coverage

Observation: Staff described making appropriate adjustments to lifeguard positions as attendance and activity changed. However, zones and coverage were reported to be communicated dynamically and verbally; a contemporaneous documented zone plan was not available.

Contributing conditions considered: Broad waterfront setting, changing bather distribution, reduced underwater visibility, multiple activity areas, rotation and relief arrangements, elevated chairs, paddle board positions, and group transitions.

Recommendation R-2 - Adopt a documented dynamic supervision plan.

Develop a site specific supervision plan that:

- Maps all standard and alternate lifeguard positions, zones, blind spots, priority areas, boundaries, entry and exit points, and rescue focal points.
- Defines the minimum number of active lifeguards and the required positions for specified conditions, including normal operations, school groups, high bather load, windy or reduced-visibility conditions, recreational-equipment use, and group departure.
- Includes a documented escalation matrix based on bather load, age, swimming ability, group type, environmental conditions, activity, sight lines, and staff experience, not attendance alone.
- Requires the shift supervisor to record active positions, bather counts, significant changes, and any variance from the standard plan.
- Requires a formal relief and handover process, including transfer of identified risks, high-risk patrons, group status, equipment deficiencies, and coverage assignments.

Priority: Critical

Accountable owner: Recreation Manager, Superintendent Recreation Services, and Aquatics Coordinator, with support from the Parks/Recreation booking lead.

Finding and Recommendations (cont.)

Section 11

11.3 Recognition Phase (cont.)

Completion evidence: Approved zone map, supervision matrix, daily deployment log, and supervisor training record.

Effectiveness measure: Audits demonstrate that active positions and supervision zones are documented and match the conditions present.

Finding R-3 - Recognition of distressed or missing patrons

Observation: Staff intervened with several patrons during the day. The incident demonstrates the importance of layered systems for rapid recognition of a distressed patron, missing child, or missing swimmer.

Contributing conditions considered: Natural-water visibility limitations; reported last-seen information was incomplete; school-group transition; unclear group head-count processes; dynamic staff positioning; and difficulty distinguishing a missing child from a child who may have left the waterfront.

Recommendation R-3 - Establish immediate missing-person and missing-swimmer decision triggers.

Revise the missing-person procedure to require that, when a child or vulnerable patron is reported missing:

Develop a site specific supervision plan that:

- The group leader is asked structured questions using a scripted checklist: full name, description, clothing, swimming ability, medical information, last known time, last known location, companions, whether the person entered the water, and whether they may have left the site.
- The shift supervisor immediately assumes or assigns incident command.
- The swim area is cleared immediately when the last known location is in the water, unknown, or cannot be confirmed within a defined short interval.
- The supervisor activates the missing-swimmer response and contacts 911 immediately when there is any reasonable possibility that the missing person is in the water. Requires the shift supervisor to record active positions, bather counts, significant changes, and any variance from the standard plan.
- Search activities begin only after roles, search areas, communication methods, and safety limits are assigned.

Finding and Recommendations (cont.)

Section 11

11.3 Recognition Phase (cont.)

Priority: Critical

Accountable owner: Superintendent Recreation Services, Aquatics Coordinator, Corporate Safety, and Echo Dale Aquatic Leads.

Completion evidence: Revised emergency procedure, decision aid, emergency call script, staff orientation record, and documented scenario drill.

Effectiveness measure: Drill evaluation shows prompt classification, water clearing, emergency activation, role assignment, and search coordination.

Additional recommendations address broader facility, operational, and governance controls. The Waterfront Safety Standards similarly describe risk management as an ongoing cycle of identifying risks, implementing controls, and monitoring their effectiveness.

11.4 Reaction Phase

Finding RE-1 - Emergency activation and incident command

Observation: Staff initiated a land search, cleared the lake, began water-search activity, deployed equipment, called 911, and communicated with responders. The review identified uncertainty regarding the timing of escalation, command roles, and the transition to external response.

Contributing conditions considered: Multiple agencies and City departments; changing information; incomplete last-seen details; bystander involvement; search activity on land and water; and uncertain responder roles.

Recommendation RE-1 - Establish a site-specific major-incident command system.

Create a site-specific major-incident command system that applies until formal transfer or unified command is established. The system should identify:

Finding and Recommendations (cont.)

Section 11

11.4 Reaction Phase (cont.)

- Incident Commander: overall authority, emergency activation, liaison with responders, decision to close or clear the waterfront.
- Water Search Lead: assignment and tracking of qualified in-water search personnel, search pattern, marker placement, equipment, and rescuer rotation.
- Land Search Lead: assignment and tracking of land-search areas, staff deployment, and communication of cleared areas.
- Communications Lead: 911 call, radio discipline, incident log, responder liaison, public-address messaging, family and management notifications.
- Bystander and Crowd-Control Lead: shoreline control, patron evacuation, volunteer exclusion or use only under an approved plan, and protection of search access.
- Documentation Lead: time log, search map, equipment deployment, key decisions, and transfer-of-command record.

Train staff to use role cards or an incident-action checklist that can be activated immediately.

Priority: Critical

Accountable owner: Superintendent Recreation Services, Aquatics Coordinator, Corporate Safety, Parks, and Fire-Rescue liaison.

Completion evidence: Revised emergency procedure, decision aid, emergency call script, staff orientation record, and documented scenario drill.

Effectiveness measure: Drill evaluation shows prompt classification, water clearing, emergency activation, role assignment, and search coordination.

Finding RE-2 - Search procedure and bystander management

Observation: Staff, teachers, and bystanders participated in search activities. Accounts indicate uncertainty about who was directing search activity, which areas had been searched, when volunteers should enter or leave the water, and the relationship between lifeguard and responder search efforts.

Finding and Recommendations (cont.)

Section 11

11.4 Reaction Phase (cont.)

Contributing conditions considered: Natural-water depth and visibility; limited underwater search capability; number and fitness of volunteers; changing search areas; equipment availability; and responder arrival.

Recommendation RE-2 - Develop a missing-swimmer search plan specific to Echo Dale.

The plan should:

- Identify immediate search zones based on last-known-point information, water movement, depth, visibility, hazards, and likely movement paths.
- Define marker placement, grid or sweep methods, search-map use, search-area documentation, and rescuer rotation.
- Specify which staff may conduct in-water searches and the required qualifications, equipment, communication, and safety limits.
- Require a rapid search-area briefing and continuous search-log updates.
- Prohibit unassigned public entry into deep-water or underwater search activity. Bystanders may be directed to shore-based roles only where safe, supervised, and authorized.
- Include procedures for receiving and documenting new last-seen information without losing control of the search plan.
- Be jointly reviewed and practised with Fire-Rescue, Police, EMS, Parks, and other relevant City responders.

Priority: Critical

Accountable owner: Superintendent Recreation Services, Aquatics Coordinator, and Fire-Rescue liaison.

Completion evidence: Written search plan, site map, equipment inventory, training record, and joint tabletop plus live simulation.

Effectiveness measure: A joint exercise demonstrates that qualified staff can establish a controlled search, maintain a search map, manage volunteers, and transfer information to responders.

Finding and Recommendations (cont.)

Section 11

11.4 Reaction Phase (cont.)

Finding RE-3 - Emergency equipment and communications readiness

Observation: Available accounts describe use of paddleboards, fins, masks or snorkels, markers, radios, and other equipment. Staff also identified concerns about public-address audibility and communications during the emergency.

Contributing conditions considered: Waterfront size, depth, low visibility, distance from shore, emergency access, multiple search locations, public-address limitations, and need for rapid information transfer.

Recommendation RE-3 - Verify and enhance emergency equipment and communications.

Complete a documented site-specific equipment and communications review before comparable operations resume. At minimum, review:

- Rescue craft, paddle boards, rescue tubes or cans, throw assists, reaching poles, spine boards, first aid supplies, AED, oxygen where determined appropriate, masks, fins, snorkels, marker buoys, radios, megaphones, incident command kit, and emergency lighting or backup communications.
- Equipment locations, inspection frequency, readiness status, defect reporting, and staff access.
- 911 access, emergency address and GPS information, responder meeting point, EMS access route, emergency-call script, and radio interoperability or liaison process.
- The public-address system's coverage, audibility, volume control, backup options, and staff use procedures.
- Emergency communication with group leaders, Parks staff, booking staff, and management.

Priority: High

Accountable owner: Superintendent Recreation Services, Aquatics Coordinator, Parks, Fleet Facilities and Asset Management, and Corporate Safety.

Finding and Recommendations (cont.)

Section 11

11.4 Reaction Phase (cont.)

Completion evidence: Equipment inventory, inspection schedule, communications test, defect register, emergency call script, and staff practice record.

Effectiveness measure: Monthly readiness audits show all required equipment is present, functional, accessible, and staff can demonstrate its use.

11.5 Recovery Phase

Finding RC-1 - Evidence preservation, documentation, and incident learning

Observation: The City gathered statements and developed a timeline after the incident. The review identified differing accounts and evidence gaps related to the last known sighting, notification, staffing, search sequence, and external response.

Contributing conditions considered: High-stress event, delayed statement preparation, multiple responding agencies, evolving information, lack of a single contemporaneous incident log, and incomplete access to external records.

Recommendation RC-1 - Establish a major-incident documentation and evidence-preservation protocol.

The protocol should require:

- Immediate preservation of records, video, radio and telephone logs, schedules, head counts, training records, inspection records, equipment records, weather and water information, communications, and photographs.
- A single incident log maintained from the start of the response by an assigned documentation lead.
- Use of role-specific factual report forms completed as soon as reasonably possible after staff are relieved, without requiring staff to take forms home unless directed by legal counsel.
- A search map identifying reported last-known point, markers, areas searched, search methods, personnel, and changes in command.

Finding and Recommendations (cont.)

Section 11

11.5 Recovery Phase (cont.)

- A controlled process for obtaining, storing, and reviewing staff and witness statements.
- A post-incident evidence checklist and legal/insurance notification checklist.

Priority: High

Accountable owner: Superintendent Recreation Services, Corporate Safety, Aquatics Coordinator, and City records/privacy lead.

Completion evidence: Approved protocol, forms, secure storage process, staff training record, and annual exercise.

Effectiveness measure: Post-exercise review confirms that required records are preserved and a complete incident package can be assembled within 24 hours.

Finding RC-2 - Staff and family support, communications, and return-to-work

Observation: Major waterfront incidents impose significant psychological stress on directly involved staff, supervisors, and responding personnel. Accounts indicate uncertainty about access to immediate defusing, counselling, employee-assistance resources, family-liaison processes, and

Recommendation RC-2 - Establish a major-incident staff and family sup port protocol.

The protocol should require:

- Immediate defusing and practical support for directly involved staff, including relief from duty, access to water, food, shelter, and a quiet space.
- Access to qualified counselling, employee assistance, CISM resources, and follow-up support.
- A designated family liaison and separate communication process for staff, group leaders, public, media, and Council.

Finding and Recommendations (cont.)

Section 11

11.5 Recovery Phase (cont.)

- Return-to-work assessment, modified duties where appropriate, phased scheduling, and supervisor check-ins.
- Structured staff debriefing focused separately on psychological support and operational learning.
- Follow-up contact at defined intervals, including 72 hours, one week, and additional intervals as appropriate.

Priority: High

Accountable owner: Human Resources, Corporate Safety, Recreation leadership, and CEM

Completion evidence: Approved protocol, support-resource list, communication templates, return-to-work process, and staff orientation record.

Effectiveness measure: Following any major incident, support contacts, debriefing, and follow-up are documented and completed within defined timelines.

11.6 Restoration to Normality Phase

Finding RN-1 - Reopening and operational restoration

Observation: Following the incident, the facility was closed and the lake was later drained. Interviews identified uncertainty about closure decisions, staffing support, facility reopening, and the relationship between aquatic and broader Parks/Recreation operations.

Contributing conditions considered: Safety-system review requirements, staff readiness, site remediation, evidence preservation, public communication, equipment replenishment, inspection needs, and residual risk.

Recommendation RN-1 - Adopt a formal reopening and restoration

Before reopening the swim lake or resuming comparable operations, require documented confirmation that:

Finding and Recommendations (cont.)

Section 11

11.6 Restoration to Normality Phase (cont.)

- Immediate hazards and evidence-preservation requirements have been addressed.
- The site has been inspected and any physical, equipment, signage, boundary, or access deficiencies have been corrected or controlled.
- Emergency equipment has been inspected, replenished, and returned to readiness.
- Staff have completed required training and scenario practice.
- Group-booking controls and escalation processes are active.
- Staff wellness and return-to-work considerations have been assessed.
- Public, group-user, media, and stakeholder communication plans are approved.
- Residual risks are documented and formally accepted by the appropriate City authority.

Priority: Critical

Accountable owner: Recreation Director or delegated executive authority

Completion evidence: Signed reopening checklist, risk assessment, corrective-action register, staff training records, equipment readiness records, and executive approval.

Effectiveness measure: No reopening occurs until all critical actions are complete or an equivalent interim control and formal residual-risk acceptance are documented.

Finding RN-2 - Corrective-action governance and effectiveness review

Observation: The incident identified safety improvements requiring coordination among multiple City functions. Without assigned ownership, timelines, and effectiveness checks, recommendations may not result in durable operational change.

Recommendation RN-2 - Establish a corrective-action governance process.

Finding and Recommendations (cont.)

Section 11

11.6 Restoration to Normality Phase (cont.)

Create a corrective-action register that includes:

- Recommendation or finding reference.
- Risk addressed and priority.
- Accountable executive and operational owner.
- Required resources and dependencies.
- Interim controls.
- Target completion date.
- Completion evidence.
- Effectiveness measure and independent reviewer.
- Residual-risk assessment and approval, where applicable.

Provide quarterly progress reporting to the appropriate City leadership and governance body until all critical and high-priority actions are verified effective.

Priority: High

Accountable owner: Recreation leadership and Corporate Safety

Completion evidence: Approved corrective-action register and quarterly status reports.

Effectiveness measure: All critical and high-priority actions are verified effective, not merely marked complete.

11.7 Additional Recommendations

Additional Recommendation A-1 - Waterfront design and risk assessment

Complete a comprehensive, multidisciplinary waterfront risk assessment before the next operating season or before comparable operations resume.

Finding and Recommendations (cont.)

Section 11

11.7 Additional Recommendations

The assessment should consider and document the following matters, evaluate relevant hazards and existing controls, and identify any additional measures required to manage the assessed risks:

- Lake depth profile, bottom contour, drop-offs, search limitations, and potential options to reduce or better control high-risk deep-water areas.
- Swimming-area size, shape, boundaries, buoy configuration, ropes or continuous boundary lines, depth markers, and separation from other park or water activities.
- Lifeguard sight lines, elevated-chair locations, paddle board routes, blind-spot controls, emergency access, and rescue focal points.
- Entry and exit routes, shoreline layout, group gathering areas, lifeguard office location, public flow, and access-control options.
- Signage, warnings, safety rules, child-supervision expectations, swimmer-ability controls, life jacket availability, buddy expectations, and emergency information.
- Communications infrastructure, including public address, radios, emergency phones, and responder access.

Priority: Critical

Accountable owner: Parks, Recreation, Aquatics, Fleet Facilities and Asset Management, Corporate Safety, and qualified aquatic-safety advisor

Completion evidence: Written risk assessment, site plan, prioritized capital and operational action plan, and approval record.

Additional Recommendation A-2 - Booking and capacity governance

Centralize or formalize the process by which group bookings, attendance changes, unplanned groups, and facility capacity decisions are communicated to Aquatics

The process should:

- Establish a single authoritative booking calendar accessible to Aquatics and Parks.

Finding and Recommendations (cont.)

Section 11

11.7 Additional Recommendations (cont.)

- Define lead times for group booking, staffing assessment, and approval.
- Require approval by an Aquatic supervisor before any group exceeds established thresholds or a late booking is accepted.
- Define how unbooked groups will be managed, including refusal, delayed entry, modified access, additional staffing, or other controls.
- Use capacity measures that reflect total site demand, swimmer load, age, ability, group structure, activity, supervision quality, and environmental conditions—not simply beach and water counts.
- Require documented confirmation that sufficient qualified lifeguards, equipment, and group-supervision controls are in place before the group enters the waterfront.

Priority: Critical

Accountable owner: Recreation and Parks Management, Recreation booking lead, and Aquatics Coordinator.

Completion evidence: Approved booking policy, shared calendar, escalation process, and booking audit trail.

Additional Recommendation A-3 - Staff competency and interdepartmental exercises

Implement a mandatory pre-season competency program for all Echo Dale staff and relevant Parks personnel before the facility opens each season. Include practical assessment and joint exercises involving:

- Supervision zones and position changes.
- School and camp group arrival, orientation, head counts, and departure.
- Missing child and missing swimmer.
- Water clearing, 911 activation, emergency communications, search coordination, and responder handover.
- Use of rescue craft, masks, fins, marker buoys, first aid supplies, AED, oxygen where applicable, and incident-command materials.

Finding and Recommendations (cont.)

Section 11

11.7 Additional Recommendations (cont.)

- Staff, public, and media communication.
- Parks and Aquatics roles, emergency access, trail searches, and support to a major incident.

Attendance should be mandatory for staff assigned to Echo Dale, including staff who work there infrequently. Staff who cannot demonstrate site-specific competency should not be assigned to a supervision role at the waterfront until remediation is completed.

Priority: High

Accountable owner: Parks and Recreation Management, Aquatics Coordinator, Echo Dale Aquatic Leads, Corporate Safety, and CEM.

Completion evidence: Annual training plan, attendance records, competency checklist, exercise debriefs, and remediation records.

Additional Recommendation A-4 - Standards, manuals, and practice alignment

Review and update the Echo Dale Facility Operating Manual, staff manual, supervision plan, emergency procedures, group-use procedures, inspection forms, and training materials to ensure that written expectations match actual operational practice.

The review should identify:

- Procedures that are no longer used or cannot be implemented.
- Informal practices that should be standardized and documented.
- Role ambiguity between lifeguards, Aquatic Leads, Parks staff, booking staff, and emergency responders.
- Required equipment, inspection frequency, and defect-escalation processes.
- Version control, annual review, staff acknowledgement, and change-communication requirements.

Finding and Recommendations (cont.)

Section 11

11.7 Additional Recommendations (cont.)

Priority: High

Accountable owner: Aquatics Coordinator and Corporate Safety

Completion evidence: Controlled document set, annual review schedule, staff sign-off, and audit of operational alignment.

11.8 Implementation Priorities

Priority	Target Time line	Required Action
Critical	Before comparable operations resume	R-1, R-2, R-3, RE-1, RE-2, RN-1, A-1, and A-2.
High	Before the next operating season.	RE-3, RC-1, RC-2, RN-2, A-3, and A-4.
Ongoing	Quarterly and annually	Corrective-action monitoring, drills, incident trend review, policy review, staff competency verification, and risk reassessment.

11.9 Follow-Through

The City should assign an accountable owner, due date, required resources, completion evidence, and effectiveness measure to every accepted recommendation. Completion should not be treated as closure until the City has verified that the new or revised control is implemented, understood, used in practice, and effective under operating conditions.

Where the City chooses not to implement a recommendation, it should document its rationale, identify alternative controls, assess the residual risk, and obtain approval from the appropriate authority.

Appendices

Section 12

Appendices form part of this confidential Incident Analysis and Review Report. They are intended for the City's internal safety-management, governance, legal, insurance, and regulatory purposes. Distribution must be limited to those with a legitimate need to know. Personal information, witness statements, medical information, and other restricted records are maintained separately in the City's controlled evidence file and are not reproduced in this report.

Appendix A: Document and Sources Reviewed

A. 1 Purpose and Scope

This appendix identifies the principal documents, records, interviews, site observations, and reference materials considered during the Incident Analysis and Review.

The list is not a legal production index, a complete evidence inventory, or a record of every document held by the City of Medicine Hat or any third party. It reflects information made available to the Lifesaving Society within the agreed scope of review.

A source being listed does not mean that every statement within it was accepted as fact. The review team assessed information for relevance, timing, consistency, and corroboration. Where information could not be independently verified, it was treated as reported information or identified as a limitation.

A. 2 Document Status Definition

Status	Meaning
Reviewed	The item was reviewed and informed the report's analysis, findings, or recommendations.
Considered	The item was available and considered for context, but was not relied upon as a primary basis for a finding.
Referenced	The item was cited as safety guidance, standards, or background material.
Not available	The item was identified as potentially relevant but was not available to the review team within the scope or time frame of the review.
Restricted	The item contains personal, medical, employment, legal, police, insurer, or other sensitive information and is retained separately in the City's controlled evidence file.

Appendix A: Document and Sources Reviewed (cont.)

A. 3 Terms of Reference and Review Materials

ID	Document or Source	Date/version	Status	Relevance and use
A-01	Incident Review Analysis Terms of Reference and Agreement between the Lifesaving Society Alberta and Northwest Territories Branch and the City of Medicine Hat	June 17, 2026	Reviewed	Established the purpose, scope, process, responsibilities, and deliverables for the review.
A-02	Incident Review Analysis on-site agenda, briefing notes, site-inspection checklist, and review planning materials	July 2–3, 2026	Reviewed	Guided site assessment, document review, interviews, and preliminary debrief.
A-03	Lifesaving Society review-team notes and working analysis records	July–August 2026	Restricted	Working materials used to organize evidence, document observations, and develop analysis. Not reproduced in the report.
A-04	Lifesaving Society Comprehensive Audit Report	2022	Considered	Read before the analysis for historical context and background knowledge. Not relied upon in developing the report's analysis, findings, or recommendations.

A.4 Incident, Timeline, and Operational Records

ID	Document or source	Date / version	Status	Relevance and use
A-05	City of Medicine Hat Event Time line	June 15, 2026 and follow-up entries	Reviewed	Provided City-compiled operational chronology, including Parks activity, staffing, reported emergency actions, and follow-up events. Entries were treated as documented City information unless independently corroborated.

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Appendix A: Document and Sources Reviewed (cont.)

A. 4 Incident, Timeline, and Operational Records (cont.)

ID	Document or source	Date / version	Status	Relevance and use
A-06	Available incident reports, internal summaries, follow-up notes, and staff statements	June 15, 2026 and following days	Reviewed	Considered in the Event Summary, Event Time line, evidence-gap analysis, and contributing-factors analysis.
A-07	Echo Dale Swim Lake half-hour statistics form	Form dated June 15, 2026	Reviewed	Provided recorded lake and beach counts at half-hour intervals. The electronic filename refers to May 15, 2026; the report refers to the document based on the date recorded on the form itself.
A-08	Water Treatment Plant Daily Water Readings	Week of June 15, 2026	Reviewed	Considered as operational water-treatment context. Not used as evidence of underwater visibility, water clarity, or incident causation.
A-09	Staff schedules, shift information, duty assignments, and position information available for review	June 15, 2026	Reviewed	Considered for staffing context, shift changes, lifeguard deployment, rotation, and transition analysis.
A-10	Booking calendars, school-group booking information, and reported attendance information	June 2026	Reviewed / considered	Considered for group-use planning, anticipated attendance, staffing, and communication analysis. Complete independent group attendance and accountability records were not available.
A-11	Opening, closing, inspection, head-count, water-treatment, and equipment-check records were made available for the review	June 15, 2026 and surrounding period	Reviewed / considered	Considered for operating context, safety-system review, and evidence-gap analysis.

Appendix A: Document and Sources Reviewed (cont.)

A. 5 City Operational and Safety Management Documents

ID	Document or source	Date / version	Status	Relevance and use
A-12	Echo Dale and City Aquatics staff manual(s)	Version(s) made available to the review	Reviewed	Considered for staff roles, supervision expectations, safety systems, emergency procedures, and practice alignment.
A-13	Echo Dale safety and supervision plan	Version made available to the review	Reviewed	Considered for staffing, lifeguard positions, supervision zones, bather counts, communication, and emergency response.
A-14	Emergency action plans and missing-person / missing-swimmer procedures	Version(s) made available to the review	Reviewed	Considered for emergency escalation, water clearing, search procedures, role assignment, emergency activation, and responder coordination.
A-15	Facility operating procedures, standard operating procedures, and relevant departmental policies	Version(s) made available to the review	Reviewed / considered	Considered for operating controls, governance, facility responsibilities, staffing, training, inspections, and corrective-action processes.
A-16	Public education, public-address, signage, admission, and group-use materials	Version(s) made available to the review	Reviewed / considered	Considered for patron communication, rules, group orientation, child-supervision messaging, and facility information controls.
A-17	Staff orientation, shadow-guarding, certification, recertification, in-service, drill, and competency records made available for review	2025–2026 and previous operating periods	Reviewed / considered	Considered for training, site familiarity, missing-swimmer readiness, staff qualifications, and evidence gaps.
A-18	Equipment inventories, inspection records, maintenance records, defect reports, and repair information made available to the review	2026 operating period	Reviewed / considered	Considered for emergency equipment, rescue readiness, site maintenance, inspection ownership, and evidence gaps.

Appendix A: Document and Sources Reviewed (cont.)

A. 5 City Operational and Safety Management Documents (cont.)

ID	Document or source	Date / version	Status	Relevance and use
A-19	Water-quality, sanitation, anti-entrapment, and related aquatic operating plans	Version(s) made available to the review	Considered	Considered as operational context; not relied upon to establish incident-date visibility or causation.
A-20	Previous audits, inspections, near-miss records, incident records, complaints, and corrective-action information made available for the review	Available historical records	Considered	Considered for broader safety-management context and organizational learning.

A. 6 Interviews and Witness Information

ID	Document or source	Date / version	Status	Relevance and use
A-21	Aquatic Lead / Supervisor interview	July 13, 2026; telephone interview	Reviewed	Considered for site operations, staffing, supervision, group activity, incident response, search coordination, training, and post-incident support.
A-22	Lifeguard / Shift Supervisor interview	Post-incident interview	Reviewed	Considered for frontline supervision, positioning, patrol and scanning practices, school-group arrival, communications, search activity, and site-specific risks.
A-23	Aquatic Coordinator interview	Post-incident interview	Reviewed	Considered for staffing, training, booking process, organizational oversight, support, and operational interfaces.
A-24	Corporate Safety representative interview	Post-incident interview	Reviewed	Considered for governance, safety-management systems, documentation, inspection ownership, corrective action, and organizational learning.

Appendix A: Document and Sources Reviewed (cont.)

A. 6 Interviews and Witness Information (cont.)

ID	Document or source	Date / version	Status	Relevance and use
A-25	Available lifeguard, aquatic staff, witness, teacher, group-leader, and responder accounts compiled by the City	June 15, 2026 and subsequent period	Reviewed / restricted	Considered as reported information for time line reconstruction and contributing-factors analysis.
A-26	Additional City management, Parks, Fleet Facilities and Asset Management, booking, and operations information provided during meetings or follow-up communications	July–August 2026	Reviewed / considered	Considered for operational context, interdepartmental roles, site information, booking controls, response support, and post-incident actions.

A. 7 Site Assessment and Physical Evidence

ID	Document or source	Date / version	Status	Relevance and use
A-27	On-site inspection of Echo Dale Regional Park	July 2–3, 2026	Reviewed	Considered the shoreline, drained lake basin, designated swim area, access routes, lifeguard locations, signage, equipment, communications, emergency access, and broader park interface.
A-28	Site photographs, sketches, maps, and annotated notes produced or reviewed during the assessment	July 2–3, 2026	Restricted / reviewed	Considered for physical layout, sight lines, locations, access, rescue equipment, and site-specific hazards.
A-29	Lake depth information, diagrams, and site map material made available to the review	Version/date as provided	Considered	Considered for physical context and the review of swimming-area configuration.

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Appendix A: Document and Sources Reviewed (cont.)

A. 7 Site Assessment and Physical Evidence (cont.)

ID	Document or source	Date / version	Status	Relevance and use
A-30	Reported incident-date photographs, video, CCTV, drone, telephone, radio, GPS, or other electronic records	June 15, 2026	Not available / restricted where held	The review did not receive a complete, independently verifiable set of electronic evidence sufficient to reconstruct every event time, search area, or responder action.

A. 8 External Agency and Third-Party Information

ID	Document or source	Date / version	Status	Relevance and use
A-31	Police records, statements, and investigative materials	June 15, 2026 and following	Not available / restricted	Not independently reviewed. References in this report are limited to information provided by City records or interview accounts.
A-32	Fire-rescue records, command logs, water-search records, and incident reports	June 15, 2026	Not available / restricted	Not independently reviewed. Reported responder actions were considered only through available City records and witness accounts.
A-33	EMS dispatch, ambulance, medical, hospital, coroner, or medical-examiner records	June 15, 2026 and following	Not available / restricted	Not independently reviewed. This report does not determine medical cause of death or clinical matters.
A-34	911 audio, dispatch logs, and emergency-call records	June 15, 2026	Not available / restricted	Not independently reviewed. The reported 2:16 p.m. call time is based on available City information and staff accounts.
A-35	School, school-division, student, family, and group-leader records	June 15, 2026 and following	Not available / restricted	Not independently reviewed, except where information was reflected in City records or witness accounts.
A-36	Insurance, legal, employment, privacy, and regulatory materials	June 15, 2026 and following	Not available / restricted	Outside the scope of this safety review unless specifically provided and authorized for review.

Appendix A: Document and Sources Reviewed (cont.)

A. 9 Standards and Reference Material

ID	Document or source	Date / version	Status	Relevance and use
A-37	Lifesaving Society, Waterfront Safety Standards	Revised July 2004	Referenced	Used as aquatic-safety guidance for risk management, personnel and supervision, emergency procedures, safety systems, waterfront operation, and safe environment.
A-38	Lifesaving Society, Are You Ready? Major Incident Management Workbook	Version available to review	Referenced	Used as the framework for Recognition, Reaction, Recovery, and Restoration to Normality.
A-39	Lifesaving Society Alberta and Northwest Territories, Alberta Public Pool Safety Standards	Edition available to review	Referenced / considered	Used as relevant comparator guidance for safety systems, supervision, emergency readiness, training, inspection, and incident management.
A-40	Applicable City, provincial, municipal, and other regulatory materials identified within the review scope	Current or historical as applicable	Considered	Considered where provided or relevant. This appendix is not a comprehensive legal or regulatory compliance index.

A. 10 Records Not Attached to the Report

The following categories of records are intentionally not appended to the distributed report because they may contain personal information, sensitive employment information, legal material, medical information, or information subject to police, insurer, privacy, or other restrictions:

- Full witness statements and interview transcripts.
- Personal contact information and identifiable student information.
- Staff personnel, certification, employment, performance, and medical records.
- Police, fire-rescue, EMS, dispatch, hospital, coroner, or medical-examiner records.
- Legal advice, insurer communications, litigation materials, and privileged documents.
- Unedited working drafts, internal notes, and preliminary City timeline files.
- Unredacted incident photographs, video, CCTV, drone footage, radio recordings, and other electronic evidence.

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Appendix A: Document and Sources Reviewed (cont.)

A. 10 Records Not Attached to the Report (cont.)

These materials should be retained by the City in a controlled evidence file, subject to applicable records-retention, privacy, legal-hold, insurer, and regulatory requirements.

Appendix B: Interview Register

B. 1 Purpose and Confidentiality

This register identifies interviews and interview-based information considered during the Incident Analysis and Review. It is provided to demonstrate the range of perspectives considered by the review team without disclosing unnecessary personal information.

Interview summaries, detailed notes, recordings, contact information, full witness statements, and other identifiable information are not reproduced in this report. These materials should be retained separately by the City of Medicine Hat in its controlled evidence file and disclosed only where authorized or required.

Interviews were conducted as part of a systems-focused safety review. They were not disciplinary interviews and were not intended to determine fault, legal liability, negligence, medical causation, or individual performance.

B. 2 Interview Method

Interview participants were advised of the review's purpose, confidentiality limitations, and systems-focused approach. Participants were encouraged to identify uncertainty, state when they did not know or could not recall information, request breaks, and access available support resources.

Interview topics varied according to each participant's role but generally included:

- Role, qualifications, site familiarity, and operational responsibilities.
- Normal staffing, supervision, communication, training, and emergency practices.
- Group bookings, school visits, patron management, and operational planning.
- Recollections of the June 15, 2026 incident and response.
- Site conditions, risks, safety controls, and opportunities for improvement.
- Post-incident support, documentation, governance, and organizational learning.

Statements and recollections were treated as reported information unless corroborated by contemporaneous records, physical evidence, or another reliable source.

Appendix B: Interview Register (cont.)

B.3 Interview Register

ID	Participant Role	Interview Date	Format	Interviewer	Primary Topic considered	Use in review
IR-01	Aquatic Lead / Supervisor	July 13, 2026	Telephone	Lifesaving Society Secondary Auditor	Site operations; staff roles; lifeguard positioning; group attendance; public-address communications; missing-child notification; land and water search; emergency activation; responder coordination; staff support; site risks; training; governance.	Event Time line; Facility, Program and Operating Context; Source Record and Evidence Gaps; Contributing Factors Analysis; Findings and Recommendations.
IR-02	Lifeguard / Shift Supervisor	Post-incident review period	Interview	Lifesaving Society review team	Waterfront supervision; chair and paddleboard positions; scanning; radio communication; patron interventions; school-group arrival; public announcements; reported missing-child response; water search; equipment; environmental conditions; training; suggested improvements.	Event Summary; Event Time line; supervision, training, environment, and search analysis; Findings and Recommendations.

Appendix B: Interview Register (cont.)

ID	Participant Role	Interview Date	Format	Interviewer	Primary Topic considered	Use in review
IR-03	Aquatic Coordinator	Post-incident review period	Interview	Lifesaving Society review team	Aquatics oversight; staffing; training; booking process; group attendance; operations; incident notification; post-incident support; organizational interfaces; corrective actions; design and policy considerations.	Facility, Program and Operating Context; Contributing Factors Analysis; governance, staffing, training, booking, recovery, and restoration recommendations.
IR-04	Corporate Safety representative	Post-incident review period	Interview	Lifesaving Society review team	Safety governance; roles and accountability; safety systems; incident reporting; standards awareness; inspections; documentation; staffing; emergency-response concerns; organizational learning; corrective-action oversight.	Governance analysis; evidence gaps; Findings and Recommendations; implementation and follow-through.
IR-05	Aquatic staff and lifeguard witness accounts	June 15, 2026 and post-incident period	Written statements and accounts compiled by the City	City process; reviewed by Lifesaving Society	Staff positions; bather load; patron behaviour; group departure; missing-child notification; land search; water search; equipment use; responder arrival; recovery; post-incident actions.	Event Summary; Event Time line; Contributing Factors Analysis; evidence-gap identification.

Appendix B: Interview Register (cont.)

ID	Participant Role	Interview Date	Format	Interviewer	Primary Topic considered	Use in review
IR-06	School, teacher, group-leader, patron, responder, and other witness information reflected in City records	June 15, 2026 and post-incident period	Written accounts or reported information	City process; reviewed by Lifesaving Society where available	Reported last-seen information; group departure; missing-child notification; search activity; emergency response; scene conditions.	Time line reconstruction and identification of uncertainty. The review did not independently interview all third-party participants.
IR-07	City management, Parks, Recreation, Fleet Facilities and Asset Management, booking, and operations information provided during review meetings	July–August 2026	Meetings, briefings, and follow-up communications	Lifesaving Society review team	Site operation; booking processes; physical infrastructure; Parks support; water treatment; emergency support; closure; lake drainage; post-incident actions.	Facility and Program Context; Event Time line; governance, operational-interface, and restoration recommendations.

B. 4 Reliability and Limitations

The following limitations apply to interview-based information:

- Some interviews and statements were completed after a serious and traumatic event, which may affect recall, sequence, and perceived timing.
- Participants had different roles, locations, assignments, and access to information.
- Accounts differ on several material details, including the last known sighting, timing of the missing-child notification, lifeguard deployment changes, search sequence, responder arrival, command roles, and recovery.
- The review did not independently obtain or review complete police, fire-rescue, EMS, dispatch, medical, school, or other third-party records.
- The review did not treat an interview account as a confirmed fact unless it was corroborated by another reliable source.

Appendix B: Interview Register (cont.)

B. 4 Reliability and Limitations

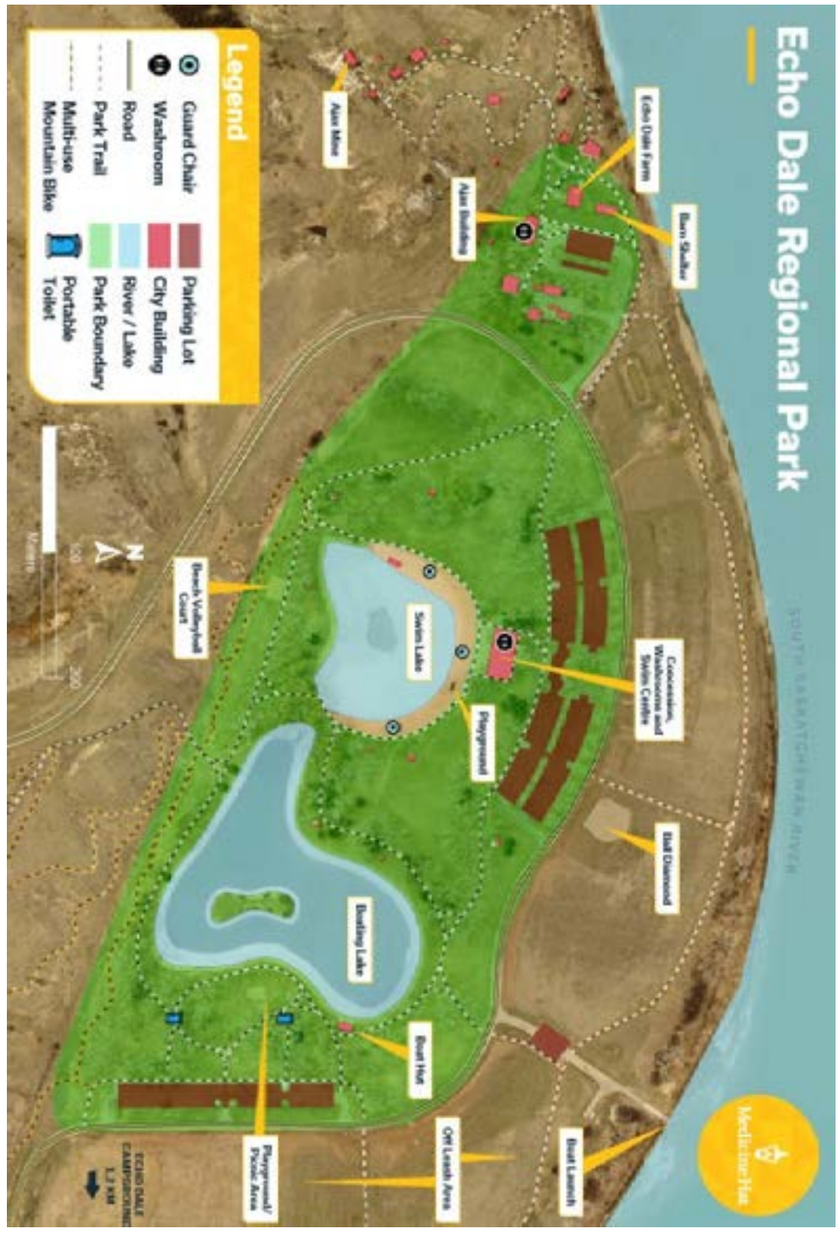
These limitations are addressed in the Source Record and Evidence Gaps section, Event Timeline, Contributing Factors Analysis, and Findings and Recommendations sections of the report

B. 5 Handling of Interview Materials

Detailed interview notes and related source materials should be retained in the City's restricted evidence file. They should not be appended to, quoted from, or distributed with the report unless disclosure is authorized by the City and appropriate legal, privacy, insurance, employment, and regulatory considerations have been addressed.

The Lifesaving Society Waterfront Safety Standards identify staff communication, incident tracking, analysis, emergency procedures, and post-incident support as integral components of waterfront safety management. This register supports traceability of the review process while protecting the privacy of participants.

Appendix C: Site Map and Photographs



Appendix C: Site Map and Photographs (cont.)



Photo 1: right hand entrance pathway from the parking lot to the lake .



Photo 2: View from Chair 3 position.



Photo 3: View from chair 2 position.



Photo 4: Underwater drain.



Photo 5: Beach rule sign, posted at various locations around lake.



Photo 6: Exposed inlet.

Appendix C: Site Map and Photographs (cont.)



Photo 7: Underwater hazard.



Photo 8: Pool deck - Rocks at the back of the lake.



Photo 9: Creek leading from Swim Lake to Boat Lake.



Photo 10: Left side of lake, including Chair 1, Chair 2, and the playground.



Photo 11: Right side of lake, including Chair 2 and Chair 3



Photo 12: View from front of lake to back of lake.

Appendix D: Standards and Guidance Cross Reference

D. 1 Purpose and Use

This appendix identifies the principal safety standards and guidance considered in developing the report's findings and recommendations. It is intended to show the relationship between the review's system findings, risk-reduction measures, and the applicable or relevant sources of aquatic safety guidance.

This cross-reference is not a legal compliance assessment and does not determine whether the City, its staff, any group leader, or any other party complied with legislation, regulation, policy, contract, or professional obligation. The Lifesaving Society's Waterfront Safety Standards are safety guidance and recommendations; they do not replace applicable legislation, municipal requirements, or the City's own approved operating procedures.

Where a standard or guidance source was published or amended after June 15, 2026, it should be used only as a future improvement reference and not as a retrospective requirement.

D. 2 Reference Sources

ID	Source	Edition/ Date	Primary use in this review
S-01	Lifesaving Society, Waterfront Safety Standards	Revised July 2004	Waterfront risk management, supervision, staff training, emergency procedures, safety systems, group use, equipment, inspections, and safe environment.
S-02	Lifesaving Society, Are You Ready? Major Incident Management Workbook	Available version reviewed	Major-incident management framework: Recognition, Reaction, Recovery, and Restoration to Normality.
S-03	Lifesaving Society Alberta and Northwest Territories, Alberta Public Pool Safety Standards	Edition available to review	Relevant comparator for aquatic safety-management concepts, including staff training, supervision, emergency readiness, inspections, incident documentation, and safety systems.
S-04	City of Medicine Hat, Echo Dale operational documents	Current and historical documents provided to review	Review of written site-specific procedures, staffing, supervision, group use, emergency response, training, and inspection practices.

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Appendix D: Standards and Guidance Cross Reference

D. 2 Reference Sources (cont.)

ID	Source	Edition/ Date	Primary use in this review
S-05	City of Medicine Hat, Event Time line and incident records	June 15, 2026 and follow-up records	Incident reconstruction, staffing, head counts, operational activity, response sequence, and evidence gaps.
S-06	City of Medicine Hat, half-hour statistics form	Dated June 15, 2026	Recorded lake and beach counts; operational context.
S-07	City of Medicine Hat, Water Treatment Plant Daily Water Readings	June 15, 2026	Water-treatment operational context; not relied upon as proof of water clarity or underwater visibility.

D. 3 Finding and Recommendations Cross-Reference

Report finding / recommendation	Relevant standard or guidance	Reference	Alignment
Group booking, attendance, and accountability controls	Waterfront operators should require groups to notify the owner/operator in advance and use group information to prepare staff and the group for safe waterfront use. Group safety planning should identify defined supervision roles.	S-01, Safety Systems - Admission Policies and Group Admissions, pp. 22–23	Supports advance booking, group-size confirmation, leader responsibilities, supervision expectations, swimmer-information controls, orientation, head counts, and departure procedures.
Group leader supervision and child accountability	Waterfront safety guidance recognizes that groups require defined safety systems and supervision roles, including teachers, group leaders, and parents.	S-01, Group Admissions, p. 22; Groups, p. 8	Supports assigning and documenting group-leader roles before entry, during water activity, and at departure.

Appendix D: Standards and Guidance Cross Reference (cont.)

D. 3 Finding and Recommendations Cross-Reference (cont.)

Report finding / recommendation	Relevant standard or guidance	Reference	Alignment
Clearly documented supervision zones and staffing deployment	Supervised waterfronts should establish systems for effective supervision of all persons and activities. Lifeguard positions should eliminate blind spots, and staffing should reflect site layout, weather, bather load, ability, activity, danger areas, and equipment.	S-01, Supervision Systems for Supervised Waterfronts, pp. 23–24	Supports a documented zone map, bather-load and risk-based staffing matrix, active-position log, handover process, and staff relief requirements.
Lifeguard positioning, scanning, vigilance, and rotations	Lifeguards must continuously scan their assigned areas. Operators should minimize distractions and provide regular rotations and breaks from vigilance tasks.	S-01, Minimize Distractions, Lifeguard Positioning, Vigilance, and Scanning, p. 23	Supports formal position assignments, scan expectations, rotation intervals, relief coverage, and management of non-supervision duties.
Natural-water risks, boundaries, and designated swimming area	Swimming areas and beaches should be clearly designated. Operators should consider water and weather conditions, hazards, site layout, boundaries, rescue response, and supervision needs when designing the swimming area.	S-01, Designating the Waterfront, p. 28; Waterfront Risks, pp. 7–8	Supports multidisciplinary review of depth, lake configuration, buoy lines, ropes, markings, hazard controls, sight lines, and lifeguard response routes.
Missing-child and missing-swimmer escalation	Emergency procedures should be documented, site-specific, practised, and appropriate to expected incidents. Specialized procedures may be required for missing persons and other high-consequence events.	S-01, Emergency Procedures, pp. 17–18	Supports a structured decision aid, immediate escalation thresholds, rapid water clearing, role assignment, emergency activation, and site-specific missing-swimmer response.
Emergency action plan and incident command	Emergency procedures should identify signals, water-clearing procedures, staff and bystander roles, emergency-services contact, treatment and extraction points, required equipment, notifications, and media practices.	S-01, Emergency Procedures, p. 18	Supports an incident-command system, role cards, communications lead, search lead, crowd-control lead, documentation lead, and responder liaison.

Appendix D: Standards and Guidance Cross Reference

D. 3 Finding and Recommendations Cross-Reference (cont.)

Report finding / recommendation	Relevant standard or guidance	Reference	Alignment
Controlled search procedure and bystander management	Emergency procedures should define the roles of responding staff and bystanders. Waterfront staff should develop procedures appropriate to the site and expected incidents.	S-01, Emergency Procedures, pp. 17–18	Supports a controlled water-search plan, search-area map, qualified search roles, volunteer safety limits, and unified-command arrangements with responders.
Rescue, search, first aid, and communications equipment	Supervised waterfronts should have emergency communication, rescue aids, throwing assists, reaching poles, spineboards, first aid supplies, designated treatment areas, and rescue craft where distance from shore warrants. Additional equipment may include diving equipment, binoculars, oxygen, and AED.	S-01, Required Emergency Equipment, pp. 18–19	Supports site-specific review of paddleboards, search equipment, rescue gear, radios, marker buoys, first aid, oxygen/AED, emergency phone access, and equipment inspections.
911 activation and EMS access	Waterfront emergency communications should provide rapid access to emergency services, posted emergency information, and an emergency-call script containing site location and access instructions.	S-01, Contacting Emergency Services, p. 19	Supports a written emergency-call script, GPS/address details, responder meeting point, emergency-access route, and communication redundancy.
Staff orientation, competence, and in-service training	New and returning staff should receive orientation before supervision duties. In-service training should include emergency procedures, supervision, recognition, rescue, equipment use, first aid, and facility-specific practices.	S-01, Orientation Training and In-service Training, pp. 14–15	Supports mandatory pre-season Echo Dale orientation, site-specific competency assessment, missing-swimmer scenarios, practical equipment drills, and mandatory attendance for staff assigned to the waterfront.

Appendix D: Standards and Guidance Cross Reference

D. 3 Finding and Recommendations Cross-Reference (cont.)

Report finding / recommendation	Relevant standard or guidance	Reference	Alignment
Facility supervision standard	Supervised waterfront operators should establish a supervision standard addressing staff fitness, skills, training, and processes for removing or replacing staff who cannot meet supervision requirements.	S-01, Aquatic Facility Supervision Standard, p. 15	Supports a City-approved Echo Dale supervision standard and competency verification before staff are assigned to supervision roles.
Staff communication and large-group notification	Staff communication systems should provide information needed to maintain safety, including notification of large groups and equipment conditions.	S-01, Staff Communication, p. 16	Supports a shared booking calendar, daily operational briefing, group-risk notification, equipment-status updates, and defined communication routes between Aquatics, Parks, booking staff, and management.
Facility operating manual and practice alignment	Waterfronts should maintain a comprehensive Facility Operating Manual documenting operating standards, expectations, policies, and procedures for safe operation.	S-01, Facility Operating Manual, p. 20	Supports review and revision of the Echo Dale manual, staff manual, supervision plan, emergency procedures, inspection forms, version control, and annual staff acknowledgement.
Public rules, signage, and group orientation	Waterfront rules should be documented, communicated through signs and public education, and tailored to facility risks. Signs should identify supervision requirements, safe-use rules, and hazards.	S-01, Waterfront Safety Rules and Signage, pp. 20–22	Supports review of signs, public-address messages, group orientation, child-supervision expectations, boundaries, lifejacket availability, emergency signals, and water-safety messaging.
Incident reports, trend analysis, and corrective action	Supervised waterfronts should document and analyze injuries and rescues. Information should be used to evaluate and modify emergency procedures, safety systems, staff training, and other practices.	S-01, Incident Tracking and Analysis, p. 25; Risk Management, p. 11	Supports a major-incident documentation protocol, evidence-preservation process, corrective-action register, trend analysis, and effectiveness reviews.

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Appendix D: Standards and Guidance Cross Reference

D. 3 Finding and Recommendations Cross-Reference (cont.)

Report finding / recommendation	Relevant standard or guidance	Reference	Alignment
Inspection, maintenance, and readiness	Waterfront areas, recreational equipment, and emergency equipment should be inspected regularly. Deficiencies should be documented, corrected, or controlled.	S-01, Inspections and Testing and Emergency Equipment, pp. 26–27	Supports clearly assigned inspection ownership, documented inspection schedules, defect escalation, equipment readiness checks, and reopening verification.
Critical incident stress support	Persons involved in serious injury incidents should have access to Critical Incident Stress Management education and support.	S-01, Critical Incident Stress, p. 19	Supports a formal staff-support, counselling, defusing, debriefing, follow-up, and return-to-work protocol.
Recognition, Reaction, Recovery, and Restoration to Normality	Major incident management involves four phases: recognition, reaction, recovery, and restoration of normality. Plans should be built, trained, tested, and reviewed across the organization.	S-02, Four Common Phases of a Major Incident; Recovery and Restoration of Normality	Supports organizing recommendations around the four phases and implementing a major-incident framework that includes prevention, response, staff support, documentation, reopening, and follow-up.
Major-incident planning and emergency roles	Major-incident planning should define roles, responsibilities, communications, documentation, resources, and decision-making authority.	S-02, Preparedness; Response and Follow-Up	Supports role cards, incident-command structure, internal and external communication plan, documentation lead, recovery checklist, and joint training.
Reopening and restoration	A facility return-to-normal plan should address staff debriefing, equipment and resource replacement, revised schedules, public communication, and management authorization to reopen.	S-02, Recovery and Restoration of Normality	Supports a written reopening checklist, staff readiness assessment, equipment replenishment, corrective-action verification, residual-risk acceptance, and executive approval.

Appendix D: Standards and Guidance Cross Reference

D. 3 Finding and Recommendations Cross-Reference (cont.)

Report finding / recommendation	Relevant standard or guidance	Reference	Alignment
Water treatment and water-quality records	Water quality is a critical operational component; regular testing, documentation, corrective action, and closure where water is unsafe are expected.	S-01, Water Quality and Water Testing, p. 26	Supports maintaining treatment and testing records, but does not establish underwater visibility or explain the incident.
Safety-management and risk-control cycle	Waterfront risk management should identify hazards, evaluate risks, develop and implement controls, and monitor/evaluate results.	S-01, Risk Management Process, p. 11	Supports the corrective-action register, prioritization, resource allocation, effectiveness review, and periodic reassessment of residual risk.

D. 4 Source Application Note

The standards and guidance above were used to inform the review's safety analysis and recommendations. They should be read together with:

- Applicable legislation, regulations, bylaws, and codes.
- The City's approved policies, operating procedures, collective agreements, and contractual obligations.
- Manufacturer instructions for equipment.
- Current professional, medical, legal, insurance, occupational health and safety, and privacy advice where required.

This appendix does not replace those requirements or create a legal standard of care. The City should verify the current status, edition, and applicability of all legal, regulatory, and organizational requirements before implementing recommendations.

Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc.

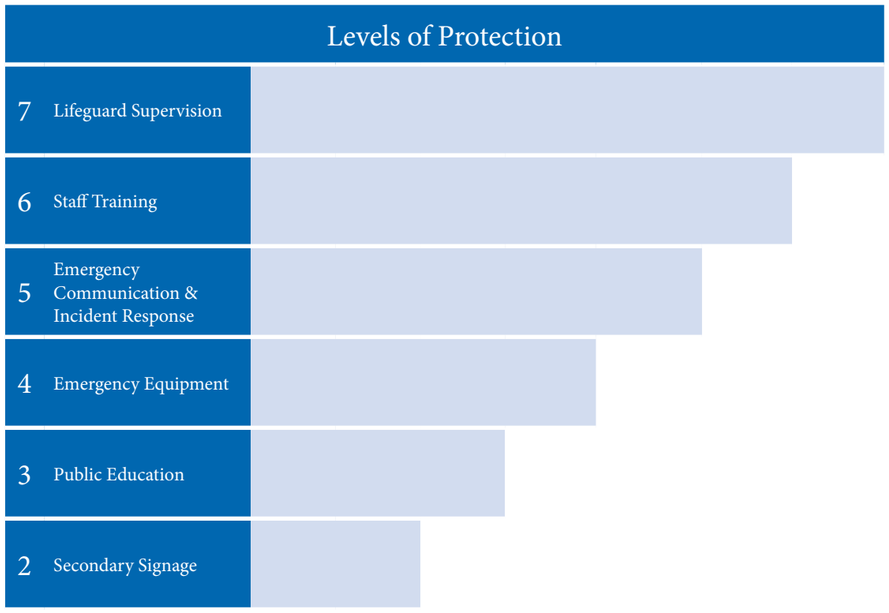
LIFESAVING SOCIETY®
The Lifeguarding Experts

Principles of Waterfront Risk Management

Levels of Protection

At unsupervised waterfronts, users are responsible for their actions and behaviours while in, on, and around the water. While owners and operators cannot control behaviour in this setting, they can support informed decision-making through education efforts like signage and public awareness initiatives.

Waterfront safety can be achieved in a variety of ways and through varying levels of protection. The following chart outlines seven levels of protection that owners/operators can consider implementing based on available resources and capacity.



Note: All other levels of protection are recommended regardless of whether the waterfront is supervised by lifeguards.

Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)

Primary and Secondary Signage (Level 1 & 2 Protection)

A critical part of maintaining waterfront safety is promoting public awareness of any rules or potential risks. Clear and appropriate signage should be the primary method used for providing warnings (e.g., for diving prohibitions or water depth). Owners/operators are responsible for warning users about waterfront hazards that may be unknown or not immediately apparent.

Primary signage is positioned at a conspicuous point where users access the general area, typically between the parking area and the waterfront. This placement provides the best opportunity to capture users' attention before entering the beach area.

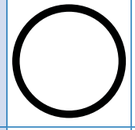
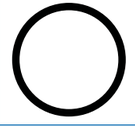
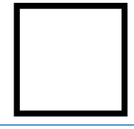
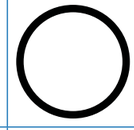
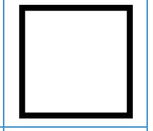
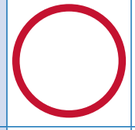
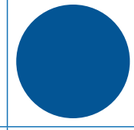
Secondary signage is positioned at specific areas of concern, such as directly on the beach. Because many users may not stop to read primary signage that lists rules upon entry, additional signage in hazardous areas must be conspicuous and should preferably use graphic symbols to overcome language and comprehension barriers.

It is also highly recommended that signage be:

- Placed to promote readability.
- Located where the width of the travel pathway is minimal.
- Installed at approximately 1.7 m above ground level (i.e., the average adult line of sight).
- Positioned in areas free from visual distractions.
- Kept clear of obstructions, including vegetation.

In addition to placement, signage design elements affect visibility and comprehension. The table below illustrates recommended signage guidelines, including standard shapes, colours, and example layouts.

Signage Guidelines

Class	Prohibitive	Permissible	Warning	Safety	Mandatory Action	Information
Shape						
Colour						
Symbol	Black	Black	Black	White	White	White
Background	White	White	Yellow	Green	Blue	Blue
Enclosure	Red	Green	Black	White	White	White

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Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)

Public Education (Level 3 Protection)

Providing educational materials and information can help prepare the public for safe waterfront use. Some ways to approach this could be:

- Rack cards in local retail outlets.
- Rack cards at beach entrances.
- Local radio public service announcements.

Owner/operators may also choose strategic days where park staff provide key safety messaging, such as:

- No lifeguard on duty.
- Keep children within arm's reach and maintain active supervision.
- Know your swimming ability and stay within your limits.
- Be aware that weather conditions can change quickly, including the wind and water conditions.
- Avoid using inflatable devices (e.g., air mattresses); if you fall off, let it go and swim to shore.
- Check and follow posted beach signage.
- Non-swimmers should wear a life jacket.

Emergency Equipment (Level 4 Protection)

The decision to provide public rescue equipment in case of an emergency requires careful consideration. Potential issues such as theft and vandalism must be taken into account. Options include making equipment available at all times or having park staff deploy equipment during operational hours only.

Emergency Communication and Incident Response (Level 5 Protection)

In the event of an injury or aquatic emergency, access to emergency services may be required. This can be facilitated by providing one or more of the following:

- Local emergency service phone numbers.
- Directions to the nearest emergency services.
- An emergency phone.
- Public access to rescue or first aid equipment.
- Access to park staff trained and equipped for first aid and water rescue.
- Compliance with occupational health and safety requirements for staff working in or around water.

It is recommended that signage clearly indicate the location that emergency services should be directed to, particularly for users unfamiliar with the area.

Staff Training (Level 6 Protection)

In the absence of full lifeguard services, trained park staff can provide initial emergency assistance until fire or emergency medical services arrive.

Additional training may include prevention, recognition, and response procedures. Training levels should align with staff roles, comfort in aquatic environments, and the level of risk they are prepared to assume. Standardized water rescue training programs can be beneficial and may be customized to reflect specific waterfront environments and staff readiness.

A key component of this layer is ensuring personnel are provided with rescue equipment appropriate to their training level, and that such equipment is readily accessible and properly maintained.

One option for enhancing supervision is the Lifesaving Society Beach Attendant Program. Certified beach attendants are trained to provide Water Smart® public education, support rule enforcement, implement emergency procedures, and perform shallow water rescues. They monitor waterfronts but do not provide continuous surveillance at the same level as lifeguards.

Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)

Lifeguard Supervision (Level 7 Protection)

The need for lifeguard supervision should be determined based on risk. Waterfronts with higher risk profiles, greater user volumes, or more severe environmental conditions should strongly consider lifeguard presence.

Key considerations include:

- Approximately 99% of drowning in Canada occur in areas without lifeguard supervision.
- Many incidents occur where lifeguards are present but outside supervised hours or designated areas.

In alignment with its mandate of drowning prevention, the Lifesaving Society recommends lifeguards at all waterfronts. However, owner/operators must base this decision on budget constraints and a comprehensive risk assessment. Where lifeguard services are implemented, organizations should evaluate their capacity and expertise to establish and maintain an effective surveillance system. Risk management must be continuously evaluated, planned, and maintained.

Even when certified national lifeguards are present, the public must take personal responsibility for their safety. All layers of protection remain necessary regardless of supervision.

Drowning is preventable. Creating a Water Smart® culture requires a collective community effort.

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Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)

Waterfront Sample Signage Content

Topic	Sample Symbol	Potential Messaging
		Children under 8 must be actively supervised at all times; caregivers must be 16 years or older, in the water, and within arm's reach.
		1 caregiver for every 4 children under 8.
		Anyone not toilet trained must wear waterproof swimwear or a swim diaper.
		Do not enter if you are under the influence of drugs or alcohol.
Admission		Individuals with diarrhea or a history of diarrhea over the previous two weeks should not use the lake.
		Proper swimwear required.
		Notify staff of any medical conditions.
		No lifeguard on duty: Swim at your own risk.
		Hours of operation:

Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)

Waterfront Sample Signage Content cont.

Topic	Sample Symbol	Potential Messaging
Water Area and Use Safety		Swim only in designated swim areas.
		Play safe.
		No diving.
		No glass.
		Swim with a buddy; do not swim alone.
		Walk on docks and slippery surfaces.
		Danger: cold water.
		Sudden drop offs and uneven bottom.
		Conditions change quickly without warning.
		No lifeguard on duty: Swim at your own risk.

Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)

Waterfront Sample Signage Content cont.

Topic	Sample Symbol	Potential Messaging
Safety Information		Depth of swim area: _m/_ft
		AED location:
		Emergency phone location:
		First aid kit location:
		Rescue equipment is located:
		Exit the lake immediately at the first sign of lightning or thunder.
		In an emergency, call 911. (Provide the location of the waterfront)

ADMISSION POLICY

YOUR LOGO HERE

- Children under _ require active supervision at all times; caregivers must be __ years or older, in the water, and within arm's reach
- 1 caregiver is required for every 3 children under the age of _
- Children 0-3 years and anyone incontinent must wear a water resistant swim diaper; Individuals who have experienced diarrhea in the past 2 weeks should not use the pool
- Consult your doctor prior to use of the pool if you have a serious medical condition
- Children must be __ years of age or older to access the facility alone
- People who appear to be afflicted with cuts, skin disease, communicable diseases, colds, fever, infection or other physical ailments are prohibited from entering the water
- Individuals under the influence of alcohol or drugs should not use the facility
- Abusive language or treatment of others will not be tolerated

RULES WILL BE ENFORCED FOR YOUR SAFETY AND ENJOYMENT

EMERGENCY INFORMATION

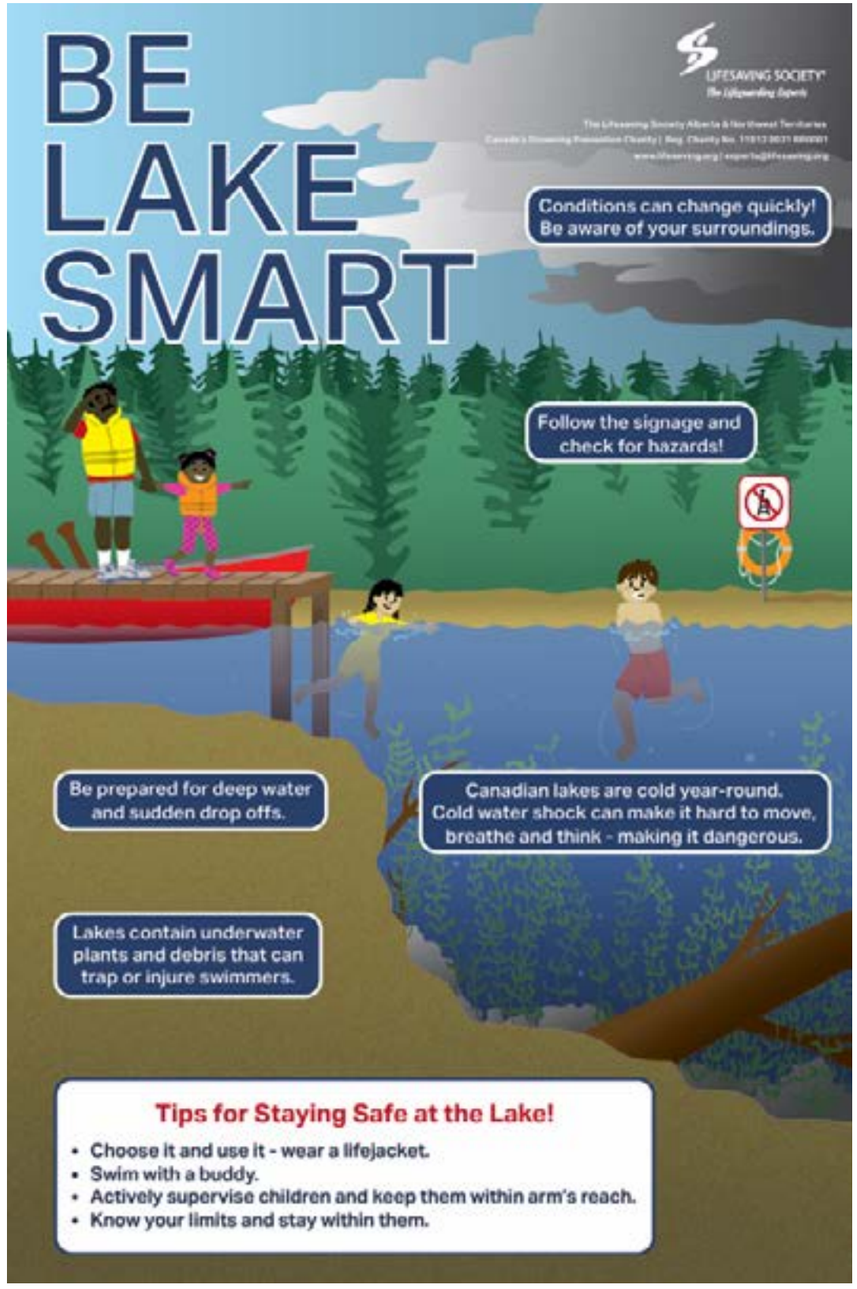
- Notify staff in the event of injury or emergency
- Notify staff of medical conditions
- Fire alarms are located next to all emergency exits
- 1 long whistle blast - clear the pool immediately

The "INSERT AFFILIATE NAME HERE" is an affiliate delivery partner of the Lifesaving Society, Canada's Drowning Prevention Charity

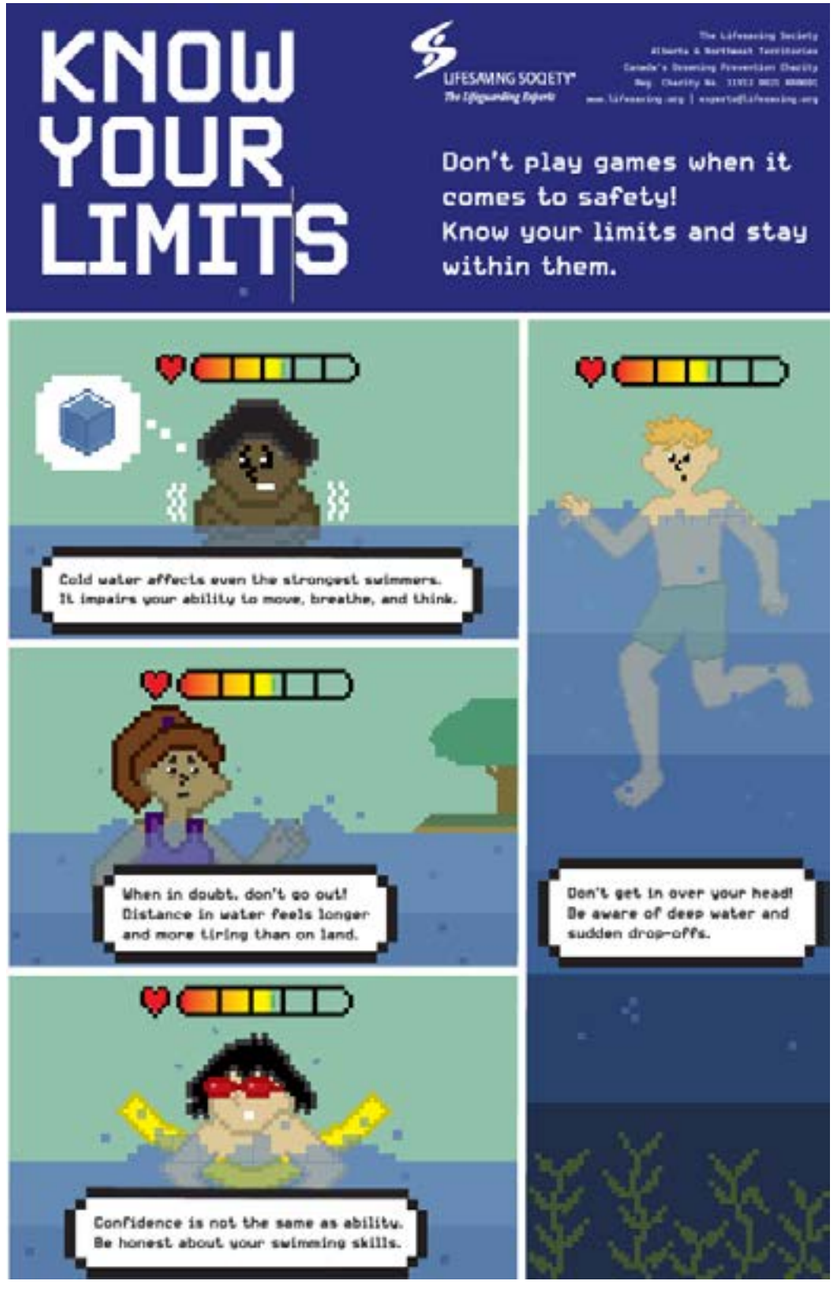
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Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)



Appendix E: Principles of Waterfront Risk Management, Signage, Public Education Material, etc. (cont.)



Publications of the Lifesaving Society are available from any Branch office. Inquiries from outside Canada should be directed to the National Office.

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