

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: ***Geraghty v. City of Port Coquitlam***,
2005 BCSC 326

Date: 20050310
Docket: S78427
Registry: New Westminster

Between:

Kelly Geraghty

Plaintiff

And

City of Port Coquitlam

Defendant

Before: The Honourable Mr. Justice Burnyeat

Reasons for Judgment (In Chambers)

Counsel for Plaintiff

S. T. Cope

Counsel for Defendant (City of Port
Coquitlam)

D.J. Bell

Date and Place of Trial

February 28, 2005
New Westminster, B.C.

[1] Pursuant to Rule 18A of the **Rules of Court**, the Defendant applies to dismiss the claim of Ms. Geraghty. In the Statement of Claim, Ms. Geraghty claims to have been injured when she collided with another swimmer at the Hyde Creek Aquatic Complex (“Complex”) on September 11, 2002. The Action is defended by the City on the basis that nothing it did or failed to do caused the accident and that, at all times, the Complex and all of its facilities were reasonably safe for those using the Complex and the standard of care and of supervision taken by the City was reasonable in the circumstances.

[2] Ms. Geraghty describes herself as an experienced swimmer who had been swimming lengths on a fairly regular basis although this was only the second time that she was at the Complex. She states that her regular “swimming program” consisted of the following consecutive elements: (a) twenty lengths of Australian crawl; (b) ten lengths of flutter board kicks; (c) four to six lengths of breast stroke; (d) twenty lengths of back stroke; (e) twenty lengths of swimming with a pool buoy gripped between her legs; and (f) twenty additional lengths of Australian crawl. Ms. Geraghty states that, while working on the first three elements of her swimming program, she noticed a “slower moving Asian female swimmer” who displayed “a tendency to wander outside of what would be a proper line of travel and she periodically stopped midstream.” As this swimmer eventually left the swimming pool and went to where the whirlpool was located in the Complex, Ms. Geraghty took no steps to advise the pool personnel about this swimmer or to speak directly to her.

[3] At her Discovery, Ms. Geraghty stated that she did a “flipturn” which gave her “. . . the opportunity as you’re turning to check the pool ahead of you before you go

back onto your back.” and, as to whether there were other swimmers in the same fast lane, Ms. Geraghty stated: “not that I saw”. In her affidavit, Ms. Geraghty states that she moved into the backstroke component of her swimming program and she was approximately half way down the swimming lane when she was struck in the head probably by the head by the female swimmer whom she “suspected” had entered the pool at the deep end and had “swam in a manner that put her on a collision course with me”. After the incident, Ms. Geraghty attempted to speak to the swimmer but states “her manner of reply indicated that her command of the English language was severely limited.” Ms. Geraghty states that the swimmer left the pool by using the middle ladder, walked past Mr. Western who was on duty that day and returned to the whirlpool area.

[4] Ms. Geraghty states that she could not complete her swimming program because of nausea, that a large “goose egg” appeared on her head, and that her legs were becoming “mottled”. She left the pool and, after observing that one attendant (Mr. Western) was looking toward the wading pool area and away from the lap pool, she then approached Ms. Henri as Ms. Henri was the closest pool attendant. Ms Geraghty states that she spoke to Ms. Henri and indicated that she had been injured and needed assistance and that Ms. Henri took her to the First Aid room, applied ice to the goose bump and attended on her for approximately 30 minutes. Ms. Geraghty states that, despite the fact that she pointed out to Ms. Henri that the other swimmer had just gone to the whirlpool area, Ms. Henri made no immediate effort to locate and identify the other swimmer. In this regard, I accept

that it was the primary concern of Ms. Henri to attend to the treatment of Ms. Geraghty.

[5] A January 29, 2003 report from her ophthalmologist indicates that Ms. Geraghty is complaining of blurred vision and poor focusing in the left eye after the incident and that she suffered a concussion and some neck problems since the time of the incident.

[6] Both Ms. Henri and Mr. Western have their Red Cross certifications as water safety instructors as well as their National Lifesaving Society certification as lifesaving instructors. Both were working at the Complex that day. They described their duties as involving “standing on the pool deck and scanning the lap pool, the hot tub, and the leisure pool to ensure that patrons were following the rules of the Facility.” As there were fewer than forty patrons in the facility during their shift, they were required “by practice” to have only one lifeguard on the pool deck at a time. They described their “main responsibility” as follows:

. . . to scan all areas of the facility and determine none of the patrons of the facility are in distress or danger. We are trained in our life guarding courses to sweep the Facility with our eyes such that we observe every area of the Facility every 20 to 30 seconds. Lifeguards are trained to stand in [an] area the City refers to as the “pivot point”. The pivot point is an area immediately adjacent to the fast lane of the lap pool from which vantage point a lifeguard can turn and view the whole Facility and all three poolsThe City has installed mirrors in the Facility to eliminate a lifeguard’s blind spots while standing at the Pivot Point. . . . Lifeguards are trained to rove from the Pivot Point from time to time so as to get better vantage points, but most of the time on the pool deck should be spent at or near the Pivot Point. While at the Pivot Point, lifeguards spend most of their time facing the lap pool. There is no life guarding chair in the Facility as guards are not meant to be stationary.

[7] Between 12:00 noon and 1:00 pm, the lap pool is reserved for “lengths swimming only”. During that time, the lap pool is divided into three areas by a system of floats. At the shallow end, where most people enter the pool, the areas are designated with signs indicating “fast”, “medium” and “slow”. The signs also state in English: “please stay to the right, if you are constantly passed, please move to a slower lane”. The lap pool is 25 metres long and 13.74 metres wide with the “fast” and “slow” lanes measuring 4.74 metres wide and the “medium” lane measuring 4.26 metres wide. I find that the lap pool at the Complex was laid out in that manner and that the signs were in place on September 11, 2002.

[8] In their affidavits, Ms. Henri and Mr. Western both state that their practice was that, if they saw a patron who was not following the rules of the Complex, they would attract that person’s attention by “yelling, clapping, tapping on the pool ladders or waving” or by “waiting for them at one of the ends of the pool”, drawing their attention to the rules and, after speaking to the swimmer, keeping a “. . . close eye on them to see that they are obeying the rules as I had explained them.”

[9] At his Discovery, Mr. Western stated that a lifeguard would be relieved from being at the Pivot Point about every 15 minutes and that the lifeguard who was coming to serve at the Pivot Point for a further 15 minutes would “exchange information” such as “watch this kid or that old guy” “who to watch” “Just things like that kid looks kind of weak, watch him as he goes into the deep end, stuff like that.”

[10] Neither Ms. Henri nor Mr. Western saw the collision between Ms. Geraghty and the unknown swimmer. Regarding the day in question, Ms. Henri states:

On the day of the Accident I did not see any swimmer who appeared to be in difficulty. I did not see any swimmers change lanes in the lap pool when they should not. I did not see any swimmers going in the wrong direction. I do not recall having to speak to any patron with respect to violations of the rules of the Facility.

[11] Regarding the day in question, Mr. Western states:

At no time during my shift on the day of the Accident did I see a swimmer travelling the wrong way or width-wise in the fast lane of the lap pool. I have never seen a swimmer swimming width-wise in the lap pool. At no time during my shift on the day of the Accident did I see a swimmer who was swimming too slowly for the fast lane.

[12] Both also state that, in their experience as Aquatic Leaders, neither had ever witnessed the “head to head collision between swimmers in a lap pool of the type alleged to have occurred in the present matter.” There was no other evidence about accidents which may have occurred at the Complex other than the report of this incident which was contained in a “Minor Incident Report Form” completed by Ms. Henri which provided this “Detailed Account of Incident:

Apparently Kelly [Geraghty] was swimming backstroke from shallow to deep. When another patron (lady) (looked for this lady to see if she was okay but could not find her) swam into Kelly - head-on – going the wrong direction.”

[13] At his Discovery, Mr. Western stated that, prior to September 11, 2002 he had seen “people bang into each other” “Occasionally” or “Maybe once every couple of weeks”. He further stated that, if someone was hurt, then “we would assist them if they needed” but if they were not hurt: “. . . we’d maybe keep an eye if someone was – if someone was swimming the wrong direction, we might talk to them, but usually they’d just sort it out themselves.”

[14] Dale Miller is the Executive Director, B.C. and Yukon Branch of the Lifesaving Society. A accepted him as an expert to provide an opinion about whether the City

had a sufficient number of lifeguards on the pool deck at the time of the accident, whether it was reasonable to designate the “Pivot Point” as the position at which lifeguards were to base themselves, whether Ms. Henri and Mr. Western were suitably trained to manage their responsibilities of identifying hazards and preventing accidents, and the expectation on lifeguards regarding the monitoring of patrons in the pool areas in terms of their frequency of scanning a facility.

[15] I accept the following opinions expressed by Mr. Miller and adopt the same as findings of fact:

- (a) The City had a sufficient number of lifeguards on the pool deck at the time of the accident. Mr. Miller states that, according to provincial regulations and industry standards, the ratio of lifeguards to patrons as set out in the **Swimming Pool, Wading Pool and Spray Pool Regulation**, B.C. Reg. 289/72 pursuant to the **Health Act** R.S.B.C. 1996, c. 179 at s. 76 (c) states that “there should be one lifeguard for each 100 persons in the pool area and the increased vigilance” but that, within the aquatics industry, the ratio ranges from one for every thirty-five patrons to one for every fifty patrons. Accordingly, I find that the ratio of one lifeguard for every forty patrons that was in place that day was in accordance with provincial regulations, industry standards, and what was reasonable in the circumstances.
- (b) Taking into account the design of the Facility, the Pivot Point was appropriate as the best location for the lifeguard to view the main pool, the leisure pool, and a whirlpool in a continuous scanning movement. After a review of the photographs in evidence, I accept his opinion in this regard.
- (c) I find as fact that the two lifeguards were suitably trained to manage their responsibilities. I accept the opinion of Mr. Miller in this regard. Both held their National Lifeguard Service award, the industry standard in Canada for lifeguard training so that both would have had to complete their training at the Bronze Medallion level (20 hours of training) and then the Bronze Cross level (a further 20 hours of training).

- (d) I also accept the opinion of Mr. Miller regarding the role of the lifeguards in identifying hazards and preventing accidents. In this regard, Mr. Miller was of the opinion that, the “purpose and function of the lifeguard with respect to the identification of hazards and prevention of accidents” can be described as:

the identification of hazards and prevention of accidents are the main objectives of a lifeguard. In contrast to the common public perception, very little of a swimming pool lifeguard’s time is spent in rescue mode. They are trained to identify pool areas, patrons and activities of risk and eliminating the possibility of injury to pool users.

Accident prevention is accomplished through enforcement of pool rules, educating patrons, influencing patron behaviour, ensuring a safe environment and continually scanning the activity area for potential problems. It is not, however, expected that a lifeguard will see everything that happens in the pool at all times.

A certain level of personal responsibility is placed on patrons such as parents directly supervising their young children and patrons ensuring their activity does not endanger the safety of themselves and others. The lifeguard’s regular scan of the pool and deck areas cannot physically allow them to observe all activity as it happens.

- (d) Regarding the expectations of lifeguards with respect to monitoring the patrons in the pool area in terms of the frequency of their scanning of the facility, Mr. Miller stated:

Scanning is the systematic visual observation of the facility, its patrons and their activities. The purpose of a scan is to view the full area of responsibilities several times per minute in order that potential incidents can be anticipated and prevented, or that when an incident occurs, the lifeguard can react within seconds. Based on the number of lifeguards on deck and their area of responsibility; the number of

lifeguards and their location; the facility design and layout; and the supervision zone of the lifeguard, the length of time for a full scan can vary, but typically it is expected to be 10 to 20 seconds.

I find that the scanning of the Complex which was in place that day was in accordance with what was viewed as typical and what was viewed as appropriate by Mr. Miller. I find that to be the case.

DISCUSSION AND CASE AUTHORITIES

[16] Pursuant to either the common law or the **Occupiers' Liability Act** R.S.B.C. 1996, c. 3379 ("Act"), the City had a duty to make the Complex reasonably safe. However, the City cannot be called upon to be an insurer of the safety of all users of the Complex:: **Malina v. Bartsch**, (1985) 49 B.C.L.R. (2d) 33 (B.C.S.C.) at para. 76. The standard of care imposed on an operator of a pool is no higher than the standard of care imposed upon any other occupier: **Atley v. Popkum Waterslides Ltd.**, [1992] B.C.J. (Q.L.) No. 282 (B.C.C.A.) at p. 3.

[17] The statutory duty of care imposed by s. 3 of the **Act** requires the City to: ". . . take that care that in all the circumstances of the case is reasonable to see that a person . . . on the premises . . . will be reasonably safe in using the premises." That duty of care applies in relation to the "condition of the premises", the "activities on the premises", and the "conduct of third parties on the premises".

[18] Prior safe use is to be considered with respect to whether an occupier has complied with the standard of care to be expected in the circumstances: **Jolley v. Pacific National Exhibition**, [1986] B.C.J. (Q.L.) No. 2284 (B.C.S.C.). In this

regard, the City did not introduce into evidence any records maintained for the Complex which would outline accidents, safety violations, etc. other than the evidence of Ms. Henri and Mr. Western and other than a record of the incident involving Ms. Geraghty. Accordingly, I find that I am not in a position to take into account any alleged prior safe use to reach a conclusion about whether the City had complied with the standard of care to be expected in the circumstances.

[19] The mere occurrence of an accident does not give rise to the presumption of negligence. Rather, Ms. Geraghty must prove on a balance of probabilities that some act or some failure to act on the part of the City has caused the injury complained of: **Bauman v. Stein**, [1991] B.C.J. (Q.L.) No. 548 (B.C.C.A.).

[20] I find that the lap pool was laid out in a manner to meet the standard of care to be expected in the circumstances. The three lanes in the lap pool were wide enough to accommodate swimmers swimming in opposite directions within any of the three lanes. I also find that the lanes were wide enough to allow considerable variation from a swimmer swimming in an exact straight line without that considerable variation resulting in a swimmer straying into the path of another swimmer coming from the opposite direction. As well, the markings at the bottom of the pool allowed swimmers to accurately gauge whether they were straying from their “side” of the lane.

[21] I also find that the signage which was in place met the standard of care to be expected in the circumstances. While the signs were only in English, I am satisfied that this is all that was required of the City and that anyone reading the signs would

be aware that there were “fast”, “medium” and “slow” lanes and that slow swimmers would be encouraged to move to a “slower lane”. The question which then arises is whether the supervision procedure in place met the standard of care to be expected in the circumstances.

[22] I adopt the opinion of Dale Miller that the City had in place supervision procedures which would meet the standard of care to be expected in the circumstances. In this regard, no expert evidence was adduced by Ms. Geraghty to challenge the opinion of Mr. Miller. The question which arises is whether the standard of supervision was present the day when the incident occurred. There is nothing before me which would allow me to conclude that it was not.

[23] Ms. Henri and Mr. Western were alternating being on the “Pivot Point” that day. I find that both were at or close to the Pivot Point and both were scanning the entire Complex about every 10 to 20 seconds. I find that this was reasonable supervision in the circumstances of the particular type of activity that was being undertaken at the time when Ms. Geraghty was present at the Complex.

[24] Ms. Geraghty submits that, the fact that Ms. Henri and Mr. Western did not observe the errant behaviour of the unknown swimmer and the fact that Ms. Henri and Mr. Western did not observe the actual incident should be taken as proof that the standard of supervision required of the City was not being met that day. I am satisfied that this amounts to a presumption of negligence merely because an accident has occurred. That presumption can not be supported at law or on the facts as I find them.

[25] In defining a reasonable standard of care, I must take into consideration the nature of the undertaking, its inherent risks, and the appreciation of those risks by Ms. Geraghty: McLachlin J., as she was then, in ***Malina***, *supra*, citing with approval the judgment of Labrosse J. in ***Hagerman v. Niagara Falls*** (1980), 29 O.R. (2d) 609 (Ont. H.C.J.) at p. 613.

[26] The City had to take reasonable care to see that those swimmers swimming laps in the Complex would be reasonably safe. One inherent risk would be that a swimmer would swim too slow and be overtaken by another swimmer. A further inherent risk would be that a swimmer either would suddenly swim out of their side of the lane into the path of an oncoming swimmer who would not be in a position to avoid contact or would occupy the wrong part of a lane and would come upon a swimmer who was not in a position to see the oncoming swimmer by virtue of the type swimming stroke that was being undertaken by that swimmer at the time. While I am satisfied that Ms. Geraghty showed appropriate care for herself that day, a participant such as Ms. Geraghty would appreciate that there was some risk of an errant swimmer. However, I also find that the City took reasonable steps to minimize these possibilities by providing a reasonable method of supervision and that that method of supervision was in place on the day of the accident.

[27] In concluding that the City took reasonable care to see that persons such as Ms. Geraghty were reasonably safe on the premises, I am satisfied that the nature of the undertaking, its inherent risk, and the appreciation of those risks by Ms. Geraghty are such that what was in place that day was reasonable in the circumstances and that it was being followed by both Ms. Henri and Mr. Western. I

find that the accident which injured Ms. Geraghty took place despite the fact that the City had taken reasonable care to make sure that a swimmer such as Ms. Geraghty would not be injured. I can make no finding of negligence merely because an accident occurred.

[28] I find that the City has met the onus of showing that there was a reasonable supervision scheme in place and that this was being followed on the day of the accident. The City has called convincing evidence to allow me to conclude that the supervision was in existence that day. The City has established that there was routine compliance with the scheme. This allows me to infer observance on the day in question. However, I am satisfied that the evidence goes further. I find actual compliance with the supervision scheme instituted by the City.

DECISION

[29] The claim of Ms. Geraghty is dismissed. The City of Port Coquitlam will be entitled to its costs on a Party and Party (Scale 3) basis. If the provisions of Rule 37 of the **Rules of Court** apply, then the parties will be at liberty to apply for further directions about the question of costs.

“G.D. Burnyeat, J.”
The Honourable Mr. Justice G.D. Burnyeat