Emergency ManagementBC

March 16, 2010

Attn: Lara A. Padgett
Occupational Safety & Healthy Administration
Tampa Area Office

Via Fax: 813-626-7015
Pages: 12

Dear Lara A. Padgett:

Re: Coroner's Inquest into Death of BRYNE, Keltie Lee / BCCS File# 1991-164-0023

As per your request please find enclosed a copy of the Verdict of Coroner's Inquest report into the death of the above named individuals. I trust the reports will provide you with the information you require.

If you have any questions or concerns do not hesitate to contact our office at (604) 660-7746.

Yours truly,

Sandy Shi
Data Support and Control Officer

Enclosure

Ministry of Public Safety and Solicitor General | BC Coroners Service | Office of the Chief Coroner, Metrotower II, Suite 800 – 4720 Kingsway, Burnaby BC V5H 4N2 | Phone: 604 660-7745 Facsimile: 604 660-7755 Web: www.pssg.gov.bc.ca/coroners

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT Colwood, B.C.

Case No. 91-164-0023

VERDICT OF CORONER'S INQUEST

JUN 05 1991

Into The Death Of

BYRNE (SURNAME) KELTIE LEE (CHRISTIAN NAME)

Address: [redacted]

WE, THE JURY, having been duly sworn and serving at the inquest into the death of the above stated, on the 30th,1,2,3 and 6th days of April/May 19 91, have determined the following facts:

Age: 20 Sex M ☐ F ☒ Native ☐

Date of Birth: December 6th, 1970 Est. Date of Death: February 20, 1991

Place of Death: Sealand of the Pacific Est. Time of Death: Between 1330 and 1545 hrs.

Place of Injury/Illness: Sealand of the Pacific 1327 Beach Dr., Victoria, B.C. Date and Time: February 20th, 1991 between 1320 and 1330 hrs.

Type of Premise: Oceanarium (in the whale pool) Code [redacted]

Identification Method Visual ☒ Other:

Identified By: Coworkers and by Sealand Manager Al Bolz

MEDICAL CAUSE OF DEATH: Code [redacted]

(I) Immediate Cause of Death: (a) Drowning

DUE TO or as a consequence of

Antecedent Cause, if any, giving rise to the immediate cause (a) above Stating the underlying cause last. (b) Forced submersion by orca (killer) whales

DUE TO or as a consequence of

(c) Falling into the whale pool

(2) Other Significant Medical Causes Contributing to Death:

BY WHAT MEANS: See Page Two Code [redacted]

Classification: Natural ☐ Accidental ☒ 800

Homicide ☐ Suicide ☐

Undetermined ☐

THE JURORS

Signature of Jurors

David Duffus — Foreman

Michael Doyle

Marc R. Pakenham

Wayne Young

Sean Healy

THIS VERDICT was received by me, Dianne Messier, a Coroner

for British Columbia this day of May 6th 19 91.

Presiding Coroner

Dianne Messier

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No. 91-04-0023

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

BYRNE | KELTIE LEE

BY WHAT MEANS:

Keltie Lee Byrne died as the result of an accident on February 20th, 1991. After conducting a whale show at 1305 hrs., a "play" session was initiated by the trainers at the whale pool. After, Ms Byrne picked up her coolers, used for carrying fish, and proceeded along the east side of the inner walkway of the whale pool. For reasons undetermined, she fell into the whale pool at approximately 1320 hrs. and while attempting to get out the whales intervened moving her away from the pool's edge. Rescue attempts with safety equipment by fellow staff members were thwarted by the whales. Over the course of the next ten minutes (approximately), Ms Byrne was submerged repeatedly for varying intervals. After this period, Ms Byrne appeared to be unconscious. Attempts by trainers to bring the whales under control were unsuccessful although for brief periods one or more whales appeared to respond to stationing cues, used to still the whales. Furthermore, distraction attempts were also unsuccessful. Concurrent rescue attempts, including the use of a large net to separate the whales from the victim and the use of a reaching pole and lifebuoy failed. Following that, the net was then weighted and used to drag the pool to recover the body of Ms Byrne. Ms Byrne was removed from the water at 1535 hrs. using the aforementioned net - no life signs were evident. No resuscitation attempts were made and the body was removed from the scene at approximately 1630 hrs.

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No. 91-164-0023

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of:

BYRNE KELTIE LEE

RECOMMENDATIONS OF THE JURY:

TO: Workers' Compensation Board of British Columbia (WCB)
6951 Westminster Highway
Richmond, British Columbia
V7C 1C6

1) The Workers' Compensation Board (WCB) create a specific category for the type of activity conducted at Sealand and other similar businesses and develop safety standards accordingly.

2) The Workers' Compensation Board (WCB) develop a comprehensive and regular inspection program to cover all aspects of workplace and activities at Sealand. A complete record of the inspection will be filed by the Inspector.

3) The Workers' Compensation Board (WCB) shall direct the Application for Compensation and Report of Industry or Industrial Disease (Form 6) and the Employer's Report of Injury or Industrial Disease (Form 7) and the Physician's Report Form to the Occupational Health and Safety Officer for assessment.

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No. 91-164-0023

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

BYRNE | KELTIE LEE

TO: Sealand of the Pacific Ltd.
1327 Beach Drive
Victoria, British Columbia
V8S 2N4

4) At least one staff person be actively monitoring safety in and around the pool areas while the general public is in the area. This person shall not have other duties which could interfere with an immediate response to a breach of safe practice by the general public or Sealand staff.

5) Sealand shall develop a system to quickly and securely isolate one or more whales in the main pool.

6) Sealand commentaries shall include safety messages for the public regarding motion of platform and security around safety barriers.

7) Public safety signs should warn of sudden deck movement.

8) Sealand should consider translating safety signs into the languages of their major clientele.

9) Sealand shall install additional switches, in strategic locations, to trigger the emergency alarm system.

10) Sealand shall install two life-lines around the inner periphery of the whale pool. It should be fixed at regular intervals, and placed at the poolside upper edge of the inner wall and at the lower edge of the inner wall, at, or just below, the water level. This is to provide hand and foot holds in order to ease the exit from the pool.

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No. 91-104-0023

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of:

BYRNE | Keltie Lee

11) Sealand shall consider the use of soft, throwing devices with floating, tangle-free line.

12) Sealand staff shall wear a personal flotation device (P.F.D.) in the immediate pool area (on stage or inside the guard rail). Consideration should be given to a type of device with a combination, inherent buoyancy (i.e. foam) and inflatable buoyancy.

13) All animal division staff shall receive life-saving training to a minimum of Royal Life Saving Society of Canada (RLSSC), Bronze Medallion Award or higher.

14) All animal division staff shall take part, in all aspects, of realistic rescue simulations in the whale pool.

15) All animal division staff shall have safety orientation training, distinct from on-the-job training.

16) All safety and training information will be in writing and distributed to all staff.

17) Containment of whales in the 'module' should be limited to veterinary and husbandry functions only. Separation of the whales for behavioural reasons should be accomplished using partition(s) in the main pool.

ORIGINAL TO REGIONAL CORONER

SEA 001158

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No. 91-164-0023

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

BYRNE | KELTIE LEE

TO: Emergency Room Physicians
c/o Royal Jubilee Hospital
1900 Fort Street
Victoria, British Columbia
V8R 1J8

18) Emergency room physicians shall be thoroughly familiar with current Emergency Health Services (EHS) protocols and literature concerning cold water immersion cases.

TO: Emergency Health Services
1520 Blanshard Street
Victoria, British Columbia
V8W 3E3

19) Emergency Health Services' (EHS) Emergency Medical Assistants should be thoroughly familiar with the asymptomatic nature of prolonged cold water immersion and resuscitation protocols.

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No. 91-104-0023

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of:

BYRNE | KELTIE LEE

TO: The Minister
Department of Fisheries and Oceans
Parliament Buildings
Ottawa, Ontario
K1A 0N5

and

Committee on Whales and Whaling
c/o Ian McTaggart-Cowan
3919 Woodhaven Terrace
Victoria, British Columbia
V8N 1G7

20) Fisheries and Oceans Canada and the Committee on Whales and Whaling develop a regulatory framework and policy for marine mammals in captivity. This framework should be comprehensive and include containment, health and welfare of whales et cetera. Facilities and training regimens should be inspected and assessed from a sound scientific perspective on a semi-annual basis.

SEA 001160

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT COLWOOD B.C.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

BYRNE	KELTIE LEE

PRESIDING CORONER'S COMMENTS

This Inquest concerned the death of Keltie Lee Byrne who was twenty years of age on the date of her death February 20th, 1991. The Inquest commenced on the 30th of April, 1991 at 9:30 a.m. Evidence was heard on the 30th of April, May 1st, 2nd, 3rd and 6th. The Jury completed their verdict at 11:00 p.m. on the 6th of May following nine hours of deliberation. Nineteen witnesses gave evidence under oath at the proceedings. Twenty-nine exhibits were filed.

Mr. John Orr appeared as Coroner's Counsel. Mr. Orr was assisted by Margaret Currie a law student at the University of Victoria. Mr. Chris Considine appeared on behalf of Mr. Bob Wright, owner of Sealand of the Pacific Ltd. Mr. Kevin Murray appeared on behalf of the Workers' Compensation Board.

Deputy Sheriffs Harry Groom and Carol Scott assisted at the Inquest.

Mrs. Pat O'Brian was the Court Reporter.

SUMMARY

Keltie Lee Byrne was employed as a trainer by Sealand of the Pacific Ltd. 1327 Beach Drive, in the City of Victoria. At approximately 1:25 p.m. on the 20th day of February, 1991 following a play session with the three whales in the whale pool, Haida, Nootka and Tillicum, Keltie was walking on the inside walkway of the pool area. Evidence indicated that she fell into the waters of the pool for an unknown reason and while attempting to pull herself out of the pool up onto the pool's edge she was pulled into the water by one of the whales.

Keltie was a physically fit young woman, a strong swimmer and made several attempts to exit the pool only to be thwarted by the whales manoeuvres. Co-workers attempted to distract the whales away from Keltie but were unsuccessful in doing so. She was thrown a life ring and offered a life hook to attempt to retrieve her from the waters. Their efforts again were unsuccessful.

Keltie was pulled under water by the whales and was able to return to the surface only to be pulled under again. Continual efforts were made by Sealand staff to assist her but were repeatedly unsuccessful. On her final return to the surface she was unresponsive. Due to the extreme state of excitement of the whales none would respond to commands to return to the module area and allow retrieval of Keltie's apparently lifeless body. Eventually at 3:30 p.m. with the aid of a dragging net she was removed and her body was transported to Royal Jubilee Hospital where death was officially pronounced at 4:16 p.m. that date.

The Jury made twenty recommendations relating to the evidence given at the Inquest.

SEA 001161

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT COLWOOD B.C.
Case No. 91-164-0023

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

BYRNE	KELTIE LEE

BACKGROUND TO RECOMMENDATIONS

Recommendations #1, #2 and #3:

Evidence clearly indicated that prior to the 20th of February, 1991 neither the trainers nor Workers' Compensation Board inspectors recognized a risk relating to the practices of the trainers while working with or near the whales confined in the whale pool. Recommendations number 1 relates to the creation of a specific category for the type of activity conducted at Sealand as well as at other similar operations. At the present time Sealand is classified as a "C" classification which relates to tourist resorts. There is no classification that relates to businesses similar to that of Sealand. Further, regarding recommendation number 1 the Jury felt that following the establishment of such a classification that safety standards be developed relating to such an operation.

Evidence indicated that following an inspection no inspection report is filed by the inspector unless orders are written. Inspections may be prompted by claims which indicate a need for inspection of work practices. As few reports were filed by employees inspections had not been carried out on a basis as regular as the Jury felt would be appropriate considering the type of operation Sealand is.

Recommendation number 3 relates to evidence heard which indicated that when an employee of Sealand files a claim to the Workers' Compensation Board for injuries received on the job, the Occupational Health and Safety Department receives the employer's report of the incident. The employee involved completes a report which is forwarded to the claims department. The physician who attends the employee completes a report which is also sent to the claims department. Therefore the Occupational Health and Safety Department does not receive all three reports and as evidence suggested it is possible that the severity of the incident may not be identified as the opportunity to compare these reports is not possible.

Recommendations #4 to #17:

As previously mentioned many of the employees and management of Sealand did not identify a risk and certainly did not predict an incident such as that which occurred on the 20th of February, 1991. Several recommendations made by the Jury related to an improvement in safety practices, both for the public as well as the employees of Sealand. There was a focus on recovery of persons who inadvertently fall into the whale pool especially concentrating on equipment such as additional life rings, life hooks, ladders in the seal pool, portable ladders in the whale pool area etc. The Jury in addition recommended that personal flotation devices be mandatory for those persons working in the immediate pool area both on the stage or inside the guard rail.

Evidence was heard by Dr. Paul Spong, a whale researcher of twenty-four years who has been recognised in both Canada and the United States as an expert on orca behaviour which he attained while

SEA 001162

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT COLWOOD B.C.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of:

BYRNE | KELTIE LEE

studying orcas both in the wild and in captivity. Dr. Spong's evidence was not only interesting but certainly did provide a full understanding of how orca behaviour may be affected by varying environmental conditions. His evidence gave a very good balance to the Inquest in that it became clear that perhaps there may be a misinterpretation of the whales behaviour by the trainers, as the information given to them and the knowledge they acquire relate to their interpretation of "normal behaviour". Dr. Spong stated that it is his opinion that isolation of the whales within the module for long periods of time may deprive them of normal sensory stimulation and therefore impose severe sensory deprivation. He stated that he felt that such deprivation would be physiologically and functionally damaging to the whales and may well be the key to understanding the behaviour of the whales as displayed when Keltie fell into the whale pool on the 20th of February, 1991. Recommendation number 17 by the Jury focuses upon the module.

Recommendation #18:

Evidence was heard at the Inquest that the physician who was in communication with the emergency health services emergency medical assistant was not thoroughly familiar with the current emergency health services protocol and literature concerning cold water immersion cases. The emergency physician stated that he indicated to the emergency medical assistant that any attempts to resuscitate would be likely without benefit however he denied stating that he gave a direct order not to resuscitate. This is in contravention of the protocol of the emergency health services. The Jury questioned the emergency physician about his knowledge of successful resuscitations of persons who had been immersed in cold water for a lengthy period of time. The emergency physician stated that he was aware of successful attempts in young children but that he was unaware of successful resuscitation of adults.

Testimony was heard from Dr. D. Cavers who performed the post mortem examination on the deceased. Dr. Cavers stated in his evidence that his examination determined that the cause of death was drowning. External incision wounds were noted on the lower thigh from which there was no bleeding nor was there bruising around the incision wounds. Dr. Cavers stated that this indicated that the incision wounds were sustained following death. The incision wounds were determined to have been caused by whale teeth and were sustained prior to the body being removed from the whale pool.

Recommendation #19:

Again this recommendation was made as evidence indicated that emergency medical assistants may not be thoroughly familiar with the asymptomatic nature of prolonged cold water immersion and resuscitative protocols. And again, one must consider Dr. Cavers' evidence relating to the incision wound and one would conclude that the ultimate outcome would not have differed in any event.

Recommendation #20:

Evidence indicated that at the present time there is no regulatory framework or policy in Canada relating to marine mammals in captivity. The evidence strongly indicated the need for such a

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT COLWOOD B.C.

Case No 91-164-0029

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST

Into The Death Of:

BYRNE | KELTIE LEE

framework which needs to be comprehensive and should include policies relating to containment, health and welfare of marine mammals. Facilities such as Sealand of the Pacific Ltd. which presently house whales should be inspected on a semi-annual basis. The inspection should relate not only to the facility's structure but as well to the training regimes of the staff of the facilities. The inspection should be assessed from a sound scientific perspective.

This incident received much public attention specifically relating to the opinions expressed regarding the maintaining of whales in captivity. Differing philosophies have been expressed publicly both for and against this practice. The Jury was instructed at the onset of the Inquest that the purpose of the Inquest was to determine who the deceased was, how, when, where and by what means she came to her death and most importantly to make recommendations that may well prevent a similar incident from recurring. The Jury was informed it was not my intention to allow evidence relating to the varying philosophical views of maintaining whales in captivity. They were reminded that the Jury was a fact finding body summoned to hear evidence and examine the facts as they existed on February 20th, 1991. The Jury members were advised that it was not their responsibility to agree or disagree with these varying philosophies as other agencies have that responsibility. I instructed them that they must be both impartial and unbiased and was assured by all that indeed each was.

Each Juror was selected for his expertise relating to matters that arose during the proceedings. The questions asked by the Jury were excellent and contributed greatly to the evidence. It is hoped with the implementation of the recommendations future deaths in a similar circumstance will be prevented.

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT Western Communities (Colwood), B.C.

Case No.

VERDICT OF CORONER'S INQUEST

Into The Death Of

Byrne — SURNAME
Kellie Lee — GIVEN NAME

Address: [redacted]

WE, THE JURY, having been duly sworn and serving at the inquest into the death of the above stated, on the 30th, 1, 2, 3 & 4th days of ~~April~~/May, 1991, have determined the following facts:

Age: 20 Sex M ☐ F ☑ Native ☐

Date of Birth: December 6th, 1970 Est. Date of Death: February 20th, 1991

Place of Death: Sealand of the Pacific Est. Time of Death: between 1330 and 1545 hrs

Place of Injury/Illness: Sealand of the Pacific Date and Time: February 20th, 1991 btwn. 1330 and 1545 hrs

Type of Premise: 1327 Beach Dr. Victoria BC. (in the whale pool) → Oceanarium Code [redacted]

Identification Method Visual ☑ Other:

Identified By: Coworkers and by Sealand Manager: Al Bolz

MEDICAL CAUSE OF DEATH: Code [redacted]

(1) Immediate Cause of Death: (a) Drowning.

Antecedent Cause, if any, giving rise to the immediate cause (a) above Stating the underlying cause last. (b) DUE TO or as a consequence of spinal submersion by orca (killer) whales, falling into the whale pool.

(c) DUE TO or as a consequence of

(2) Other Significant Medical Causes Contributing to Death:

BY WHAT MEANS: Code [redacted]

Classification: Natural ☐ Accidental ☑
Homicide ☐ Suicide ☐
Undetermined ☐

THE JURORS — Signature of Jurors

David Duffus — Foreman
MICHAEL DOYLE
MARC B. PARENHAM
WAYNE YOUNG
Sean Healy
[redacted]

THIS VERDICT was received by me, DIANNE MESSIER, a Coroner for British Columbia this day of MAY 6 1991.

Dianne Messier
Presiding Coroner

SEA 001166

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.
Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

Byrne | Kellie Lee

By what means:

Kellie Lee Byrne died as the result of an accident on February 20th, 1991. After conducting a whale show at 1305 hrs, a "play" session was initiated by the trainers at the whale pool. After, Ms. Byrne picked up her coolers, used for carrying fish, and proceeded along the east side of the inner walkway of the whale pool. For reasons undetermined, she fell into the whale pool at approximately 1320 hrs. and while attempting to get out the whales intervened moving her away from the pool's edge. Rescue attempts with safety equipment by fellow staff members were thwarted by the whales. Over the course of the next ten minutes (approximately), Ms. Byrne was submerged repeatedly for varying intervals. After this period, Ms. Byrne appeared to be unconscious. Attempts by trainers to bring the whales under control were unsuccessful, although for brief periods, one or more whales appeared to respond to stationing cues, used to still the whales. Furthermore, distraction attempts were also unsuccessful. Concurrent rescue attempts, including the use of a large net to

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

Byrne | Kellie Lee.

By what means (con't).

Separate the whales from the victim and the use of a reaching pole and lifebuoy ~~xxxxx~~ failed. Following that, the net was then weighted and used to drag the pool to recover the body of Ms. Byrne. Ms. Byrne was removed from the water at 1535 hrs using the aforementioned net - no life signs were evident. No resuscitation attempts were made and the body was removed from the scene at approximately 1630 hrs.

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

Byrne. | Kellie Lee.

Recommendations of the Jury:

To: Workers' Compensation Board of British Columbia (WCB)
6951 Westminster Highway
Richmond, BC.
V7C 1C6

1) The Workers' Compensation Board (WCB) create a specific category for the type of activity conducted at Sealand and other similar businesses and develop safety standards accordingly.

2) The Workers' Compensation Board (WCB) will develop a comprehensive and regular inspection program to cover all aspects of workplace and activities at Sealand. A complete record of the inspection will be filed by the Inspector.

3) The Workers' Compensation Board (WCB) shall direct the Application for Compensation & Report of Industry or Industrial Disease (Form 6) and the Employer's Report of Injury or Industrial Disease (Form 7) and the Physician's Report Form to the Occupational Health and Safety Officer for assessment.

ORIGINAL TO REGIONAL CORONER

SEA 001169

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.

Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
into The Death Of

Byrne | Keltie Lee.

Recommendations con't. Page 2.

To: Sealand of the Pacific Ltd.
1327 Beach Drive
Victoria, BC
V8S 2N4

4) At least one staff person be actively monitoring safety in and around the pool areas while the general public is in the area. This person shall not have other duties which could interfere with an immediate response to a breach of safe practice by the general public or Sealand staff.

5) Sealand shall develop a system to quickly and securely isolate one or more whales in the main pool.

6) Sealand commentaries shall include safety messages for the public regarding motion of platform and Security around safety barriers.

7) Public safety signs should warn of sudden deck movement.

8) Sealand should consider translating safety signs into the languages of their major clientele.

SEA 001170

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.
Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
into The Death Of

Byrne | Kellie Lee

Recommendations cont.. Page 3.

9) Sealand shall install additional switches, in strategic locations, to trigger the emergency alarm system.

10) Sealand shall install two life-lines around the inner periphery of the whale pool. It should be fixed at regular intervals, and placed at the poolside upper edge of the inner wall and at the lower edge of the inner wall, at, or just below, the water level. This is to provide hand and foot holds in order to ease the exit from the pool.

11) Sealand shall consider the use of soft, throwing devices with floating, tangle-free line.

12) Sealand staff shall wear a personal flotation device (PFD) in the immediate pool area (on stage or inside the guard rail). Consideration should be given to a type of device with a combination, inherent buoyancy (ie foam) and inflatable buoyancy.

13) All animal division staff shall receive life saving training to a minimum of Royal Life Saving Society of Canada (RLSSC), Bronze Medallion Award, or higher.

14) All animal division staff shall take part, in all aspects, of realistic rescue simulations in the whale pool.

ORIGINAL TO REGIONAL CORONER

SEA 001171

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.
Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

Byrne | Kellie Lee

Recommendations con't

15) All animal division staff shall have safety orientation training, distinct from on-the-job training.

16) All safety and training informations will be in writing and distributed to all staff.

17) Containment of whales in the 'module' should be limited to veterinary and husbandry functions only. Separation of the whales, for behavioral ~~reasons~~ reasons, should be accomplished using partitions in the main pool.

To: Emergency Room Physicians
c/o Royal Jubilee Hospital
1900 Fort Street
Victoria, BC

18) Emergency room physicians shall be thoroughly familiar with current Emergency Health Services (EHS) protocols and literature concerning cold water immersion cases.

SEA 001172
ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.
Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

Byrne | Kellie Lee

Recommendations cont. Page 5.

To: Emergency Health Services
1520 Blanchard Street
Victoria BC

19) Emergency Health Services' (EHS) Emergency Medical Assistants should be thoroughly familiar with the asymptomatic nature of prolonged cold water immersion and resuscitation protocols.

To: The Minister
Department of Fisheries and Oceans
Parliment Buildings
Ottawa, Ontario
K1A 0N5

and

Committee on Whales and Whaling
c/o Ian McTaggart-Cowan
3919 Woodhaven
Victoria, BC.

ORIGINAL TO REGIONAL CORONER

CORONER'S COURT OF BRITISH COLUMBIA
HELD AT B.C.
Case No.

FINDINGS and RECOMMENDATIONS as a RESULT of the INQUEST
Into The Death Of

Byrne | Kellie Lee

Recommendations con't Page 6

20) Fisheries and Oceans Canada and the Committee on Whales and Whaling develop a regulatory framework and policy for marine mammals in captivity. This framework should be comprehensive and include containment, health and welfare of whales etc.. Facilities and training regimens should be inspected and assessed from a sound scientific perspective on a semi-annual basis.

ORIGINAL TO REGIONAL CORONER

SEA 001174