CHAPTER 1

Introduction

Before, you are wise; after, you are wise. In between you are otherwise.

David Zindell, *The Broken God*

It is easy to be wise after the event.

Arthur Conan Doyle, *The Complete Sherlock Holmes*

This second volume of the Report examines the emergency response in the aftermath of the Algo Mall collapse. Unlike Part One, which reviewed a span of more than 30 years, these chapters set out a story of less than a week in duration. Compared to the behaviour of many of the players whose three-decade-long involvement in the Mall's well-being may be questioned and criticized, the emergency response cannot be faulted for lack of praiseworthy intentions, engagement, determination, and, not infrequently, bravery and courage.

During this response, a congruence of errors – some minor, some more important – led to a rescue effort that was no model of perfection. As a result, questions will long persist about the possibility that Lucie Aylwin could have been rescued. As I pointed out elsewhere in this Report, we learn best through experience. A critical analysis of that experience is crucial to identify error or to confirm success. The lessons learned can then be transmitted to others – to improve future responses.

In this part of the Report, I will attempt a detailed narrative of the events that followed the collapse on June 23, 2012. Inevitably, given the varying quality of observation in times of stress, there will be different interpretations of discrete events. That is the nature of human memory, particularly when it is unaided by contemporaneous recording and prompt, careful debriefing.

Doloris Perizzolo's death was unquestionably and mercifully quick. But the extent to which miscues, miscommunications, and mistakes prevented the rescue of Lucie Aylwin is a difficult question. Some medical evidence supports the proposition that death came quickly. However, living for a period of time was not inconsistent with any of the medical indicia discussed by one medical witness. Tantalizing signs may lead one to conclude that it is probable (though by no means certain) that she lived for some time after the initial collapse and might have been found alive had the rescue effort been executed more rapidly and effectively. By 5 a.m. on June 25, however, it is probable (but again, not conclusively certain) that she had died. We will never confidently know the answer to these troubling concerns.

The hearings for this part of the Inquiry lasted 36 days, and I heard 52 witnesses. Many of those witnesses, family members and loved ones in particular, recounted being desperate for information and decried the quality and manner in which it was communicated to them.

I heard from first responders who worked to exhaustion, yet resisted and resented being ordered to stop. I heard from community and first-response leaders who were well-meaning, but often appeared confused about their roles and responsibilities.

I heard from the province's premier, Dalton McGuinty, whose concern and support throughout the ordeal was genuine and constant. He gave hope and renewed determination when the rescue effort had ebbed to its lowest point. I also heard from the region's MPP (Algoma-Manitoulin), Michael Mantha, whose presence, assistance, and moral support to the community was unflagging and tireless and who represented the best of what is expected of our elected representatives.

My analysis of the facts underpinning this narrative follows, along with my recommendations to improve emergency responses. I also describe the process of this Inquiry and make suggestions for future such commissions. Improvement is achieved gradually and incrementally and builds on the shoulders of others. Perfection is an impossibly elusive goal – one that is virtually never achieved. As Vince Lombardi is quoted as saying, "Perfection is not attainable, but if we chase perfection we can catch excellence."

I embark on that analysis with diffidence and some significant reservation, because I am aware of this Commission's lack of expertise in emergency rescue operations. The training and practical experience of many of the first responders was decades long. My learning period, as well as that of Commission counsel, has been brief and purely theoretical.

I am also conscious, as I previously commented, of the perils of judging events in hindsight. Choosing the right path through the thicket is easy when you can look down on it from a high vantage point, but not when you are enmeshed in it on perilous ground. Although hindsight is a dangerous tool in assessing past conduct, it is, however, essential in crafting recommendations. Many witnesses, experts in their own right, commented in their testimony on what they and others should have done differently. Their views are important and valuable, and, in crafting my recommendations, I gave a lot of weight to their opinions.

Unfortunately, the rescue effort that was mounted after the collapse did not save any lives. The measure of a response's effectiveness cannot simply be gauged by whether lives were saved as a result of it. That measure is far too simplistic. An inept rescue may save lives by pure luck or cause the further loss of life; by contrast, circumstances may defeat the best-executed plans.

One constant, however, stands out above all the others: an effective and efficient first-response system is essential to the health, safety, and security of Ontario's citizens. With the integration of Ontario's first-response organizations with those of other provinces, this system is now also essential for all Canadians. Any diminution in the financial contributions of governments – municipal, provincial, or federal – is unwarranted and dangerous. Quite the opposite: those contributions should be enhanced.

The evidence I heard in the second phase of the Inquiry provided me with a view into the world of emergency management and response. This world, I have come to learn, is heavily populated by totally committed, selfless, and courageous men and women. That said, it still remains that few human endeavours cannot be improved upon. Any criticism I make about any aspect of the response to the Algo Mall collapse should not be interpreted as a lessening of my esteem and admiration for our first responders.

Stated in their simplest terms, my principal conclusions for this part of the Inquiry are as follows:

- Doloris Perizzolo's death was nearly instantaneous after the collapse, but it is probable (though by no means certain) that Lucie Aylwin survived under the rubble for a period of up to 39 hours. It is unlikely that she survived beyond 5 a.m. on June 25. There exists a possibility she might have been rescued, but we will never know for sure.
- Local authorities acted promptly and appropriately in the immediate aftermath of the collapse. They assisted in the evacuation of the Mall, helped the injured, and secured the site by shutting off utilities and establishing site control. Provincial authorities were rapidly informed, and assistance was summoned after the declaration of a municipal emergency.
- HUSAR/TF3 could have deployed more rapidly. UCRT's deployment speed was exceptional.
- Both HUSAR/TF3 and UCRT deployment numbers were not optimal, particularly at the command level.
- The lack of an incident action plan was detrimental to the rescue effort.
- The Incident Management System was improperly applied: no one understood or respected its mandated command structure.
- The relationship between HUSAR/TF3 and UCRT was occasionally problematic.
- There was a failure to resort to crane / rigging operations early and consistently – they were relegated to a solution of last resort.
- Record-keeping and note-taking were deficient.
- Communications among responders, with victims' families, and with the media and the general public were poor.
- Although it was proper to remove the rescuers from the building because of the dangerous state of the rubble pile, the rescue was called off, instead of being paused while alternatives were considered.
- The services offered by Ontario Mine Rescue should not have been ignored.
- The role of Ministry of Labour officials was widely misunderstood.
- After-action debriefings and many after-action reports were either non-existent or poorly done.
- Provincial legislation, including the *Coroners Act*, does not allow an official to demolish a building to retrieve a body.
- The premier of Ontario, his office, and other provincial authorities acted with leadership, genuine compassion, and assistance when hope seemed lost.
- Ontario's urban search and rescue system needs a careful re-examination to provide better overall coverage and quality of service.

One final comment: I was informed during the hearings that Fire Chief Paul Officer's nomination of certain of his Elliot Lake firefighters for the Ontario Medal for Firefighter Bravery Award have been put on hold until this Commission has completed its work. These awards should wait no longer. They are richly deserved.