CHAPTER 9

After-Action Reports, Debriefings, and Lessons Learned

HUSAR/TF3 fails to conduct an after-action review

The Heavy Urban Search and Rescue Task Force 3 (HUSAR/TF3) did not conduct a formal debriefing, nor did the team ever produce an after-action report.[1] HUSAR/TF3 members universally recognized the importance of debriefings and after-action reports. Moreover, the team's own operating manual, HUSAR Operating Manual 2007,* seems to impose a requirement on it to engage in a debriefing process and critique following any deployment:

> The HUSAR team will terminate the incident by completing the following tasks:
>
> - Assist in the incident debriefing
> - Assist in the incident critique
> - Assist in the preparation of reports and documentation of the incident†

Many factors may have contributed to the absence of a proper debriefing and after-action report, including the fact that HUSAR/TF3 appears not to have conducted debriefings and produced after-action reports following past deployments. However, I am satisfied, based on the evidence set out below, that at least one motivating factor was HUSAR/TF3's defensive attitude toward criticism of possible mistakes and a desire to shield any internal discord about the deployment from review by this Commission.

HUSAR/TF3 misses the opportunity to conduct a debriefing before leaving Elliot Lake

On June 27, HUSAR/TF3 packed up its operations. Before getting on a bus to Sudbury, Staff Insp. William Neadles thanked those present for their efforts, but did not attempt to conduct a debriefing session. He cited fatigue and raw emotions as his justification for this failure, even though he recognized the importance of debriefings:

> It is my belief that … you have to have an opportunity to step away from the event before you can actually engage in a good debrief. So taking them through things now when their emotions are very, very raw wouldn't have accomplished as much as a good debrief after some period of time later was there.[2]

Despite this suggestion that he was merely waiting for the right moment, Staff Insp. Neadles did not attempt to bring the team together for a debriefing once his team had had a chance to rest.

Many HUSAR/TF3 members spent the night in Sudbury and then drove back to Toronto. Again, no debriefing occurred, other than by way of informal and random discussions among team members at dinner and during the ride. Some people slept while others talked. No notes were taken of these conversations and nothing was circulated as a follow-up to educate those not on the bus back with the others, such as Capt. Tony Comella and Sgt. Phil Glavin.[3]

* Exhibit 769. The 2007 manual is noted to be a draft version. Cpt. Comella thought it had been finalized recently, but could not say with certainty: Comella testimony, September 4, 2013, p. 24014.

† Exhibit 769, p. 05. Cpt. Comella suggested that this section of the manual may not necessarily impose a requirement on HUSAR/TF3 to conduct its own debriefing, but instead to co-operate with any debriefing and critique held by the incident commander of an incident involving TF3. For example, had Chief Officer held a debrief, TF3 would have been required to assist him: Comella testimony, September 4, 2013, p. 24017.

HUSAR/TF3 has never conducted debriefings or produced after-action reports

Capt. Comella and Cmdr. Michael McCallion both said HUSAR/TF3 did not normally conduct debriefings or produce after-action reports. Indeed, no debriefings were held for past deployments.[4] Staff Insp. Neadles confirmed this evidence.[5] This practice was followed despite agreement from Staff Insp. Neadles and Capt. Comella that debriefings and after-action reports are useful and potentially beneficial tools for any organization.[6]

Staff Insp. Neadles and Capt. Comella both suggested that the absence of debriefings and after-action reports related to scheduling problems and financial restrictions. They cited the difficulties associated with scheduling a meeting and paying team members from police, fire, and emergency medical services.[7]

It is difficult for me to accept that finances and scheduling were the real reasons behind the lack of a debriefing and after-action report in this case. Indeed, Capt. Comella agreed that there were opportunities to hold a partial debriefing at the hotel in Sudbury or on the bus back to Toronto. No additional costs would have been incurred and no scheduling difficulties created. When pressed, he agreed that cost was not the issue for the Elliot Lake deployment.[8] In the end, he said he simply couldn't offer a reason for the failure to debrief:

> I can't offer a reason why it wasn't done. It would have been an ideal situation. I wasn't with the team when we returned home. I didn't stay in Sudbury. The Site Commanders could have done that if they had chose[n] to. It would have been their decision. They're leading the team at that stage of the game. It would have been an ideal opportunity, perhaps. Certainly on the surface it appears it was a missed opportunity.[9]

Capt. Martin McRae and Cmdr. McCallion, who similarly recognized the importance of debriefing sessions, also initially attributed the absence of one to the difficulties associated with different schedules, different agencies, and the absence of a mechanism to fund such a meeting. When pressed, however, Cmdr. McCallion conceded that it might have been possible, at no additional cost, to have had team members fill out a sheet of paper while they were on the bus back from deployment or otherwise conduct some type of a debriefing while the team was, for the most part, still together.[10]

Staff Insp. Neadles is approached by a team member to discuss deficiencies during the deployment, but no meeting occurs

Don Sorel, one of the riggers during the Elliot Lake deployment, wrote to Staff Insp. Neadles on July 4, 2012.[11] His initial email simply asked whether he was okay and how his vacation was going. In testimony, Mr. Sorel explained that he was aware of the media criticism of Staff Insp. Neadles, someone he had a lot of respect for. He wanted to make sure he was okay.[12]

In addition, however, Mr. Sorel told the Commission that he wished to talk to Staff Insp. Neadles about what he perceived as a lack of self-sufficiency during the deployment. HUSAR/TF3 was supposed to have its own camp, beds, kitchen, water system, and washrooms, but during the deployment a lot of these items were missing. He thought it a bad idea for HUSAR/TF3 to have deployed in this manner. He referred to the mantra, "One bad meal can destroy a mission," saying HUSAR/TF3 was not supposed to eat civilian food (to avoid risks from food poisoning) or have civilians at the rescue scene (something he witnessed). He also saw other potential dangers from failing to have the HUSAR/TF3 camp use its own materials, such as the inability to know where all the team members were when sleeping and resting off-site, and the inability to control what members said to others about the mission.[13]

Staff Insp. Neadles understood that Mr. Sorel wished to discuss areas for improvement, along with a "minor confrontation" that had occurred between Cmdr. McCallion and Mr. Sorel during the rigging process.[14]

In the end, it does not appear that Mr. Sorel was able to bring his concerns to Staff Insp. Neadles's attention, let alone to the rest of the team. Staff Insp. Neadles responded to Mr. Sorel's initial email by expressing great frustration at the way he was being portrayed in the media:

> Don, thanks for the thoughts … I am ok, but a little frustrating to listen and watch them chew my career up and not be able to defend it … but that is the game we are in …
>
> I am off most of this week and next and finally recovering from lack of sleep … all good …
>
> I know you want to meet and Mike [McCallion] and I have talked about this and are more than willing to grab a coffee with you to discuss issues …
>
> I have quit HUSAR (temporarily) until Fire puts the Planning piece in place … I have no records, notes, reports or paperwork from this deployment and it is the most critical thing I need going into a criminal investigation and a Civil law suit … I have fuck all pretty much … but they have their rescue …
>
> Pathetic.[15]

Mr. Sorel wrote back, consoling and praising Staff Insp. Neadles, but also explaining why he wished to discuss what went wrong, and mentioning "fundamental errors made by our team" and "the issue with the O.P.P." He wrote:

> You have no reason to beat yourself up. You at least had the backbone and fortitude to make a most difficult decision based on the expertise of resources you had available.
>
> I want to meet with you and Mike for this reason alone. I like having you and Mike in the command position and want to help keep you there. I do not want to see command revert back to just Fire. I want to offer you my opinion on what I saw and witnessed during the short time I was there. This is to help you both out not to criticise. There were fundamental errors made by our team on the ground and of course the issue with the O.P.P. The O.P.P. issue was supposed to have been addressed after the exercise in Thunder Bay but obviously it wasn't. With your knowledge and expertise we need to keep you as an integral part of the team. You will never stand alone although right now you may feel like you are.
>
> Stand tall, stand proud as the team stands proud around you.[16]

Since no proper debriefing was held, Staff Insp. Neadles and Cmdr. McCallion were left to guess what Mr. Sorel meant when he spoke of fundamental errors and issues with the OPP.[17]

Capt. Comella seeks feedback by email, but few respond

Capt. Comella did attempt to initiate a debriefing process. On July 13, 2012, he sent an email invitation to HUSAR/TF3 seeking feedback on lessons learned from the experience:

> Thanks for a great job done in Elliot Lake!!!!!!!
>
> All team members that responded to Elliot Lake are now asked to take some time to put your thoughts about the call on paper. We are interested in hearing about how you think we did as a team and what lessons that we can learn from the experience. Please compile this information and send it to me at ... at your earliest opportunity. We would like to use this information in our after action reporting and future training initiatives.[18]

Capt. Comella received what he termed a "very poor response" to his request.[19] I agree with his assessment. There were only three written responses to his request. The after-action report contemplated in the email was never produced.[20]

Staff Insp. Neadles did not reply. He told the Commission that, because he was in a command position, he waited, hoping there would be a significant response that he could then review with the other team leaders; he would then have provided his input.[21]

Capt. McRae said he did not respond to the email in writing, but that he and Capt. Comella talked extensively about the incident. He did not feel it necessary to reply in writing.[22]

Cmdr. McCallion did not respond and candidly admitted that he held back in order to avoid scrutiny of his comments during this Inquiry:

> *Q.* Right. Number one, did you respond?
>
> *A.* No, I didn't.
>
> *Q.* How come?
>
> *A.* I felt that this actual inquiry might be something that – my piece would get out and I just didn't want to prejudice what I said there and what I said here.[23]

Mr. Sorel did reply, but only to question the wisdom of self-critique with a pending inquiry and criminal investigation: "Is our self-critique a good idea at this point with a criminal investigation underway? Or a possible inquest?"[24]

Sgt. Glavin, who agreed that a debriefing following the Elliot Lake deployment would have been a good thing, did not respond to Capt. Comella's invitation. He, too, cited the pending inquiry and said he also shied away from a debriefing because he felt it was too little, too late. He told the Commission he thought the debriefing should have occurred as soon as the team got back to Toronto.[25]

Capt. Comella confirmed that one individual, Kent Burtenshaw, did reply.[26] Mr. Burtenshaw was a newer HUSAR/TF3 member, based with Toronto Fire Services. He had previous military experience, having served Canada on three overseas missions. Mr. Burtenshaw provided some minor but helpful suggestions for improvement. He felt the team should have had a guide, such as local police, before driving into town. He made suggestions for better convoy procedures for the drive up. He suggested new tools and equipment for the team, such as properly labelled hard hats, uniforms for drivers, durable laundry bags, and a bag to store respirators when not in use. His most pertinent feedback related to his personal confusion about the command structure and the absence of regular briefings for the HUSAR/TF3 rank and file:

> Passage of information. At no point in the deployment was I ever really sure of the chain of command, and who was fulfilling what role in the higher headquarters. To this day I'm not sure where you [Capt. Comella] or Marty fit into the big picture. It was obvious you were both actively involved in the handling of the team, but [I'm] not sure of what your roles were. I believe a brief at the start of the deployment would have made it much clearer. I arrived very late to the bldg on the Sat night due to my involvement with loading the vehicles. Maybe a brief was conducted prior to my arrival. It is highly likely, though, that at this point in time, the plan still had not been completely formulated due to lack of information. Through[out] the deployment, we were forced to get all of our information from the internet. I believe we should have gotten a daily brief of the overall situation, in order to get the facts, as opposed to the interpretations of the media.[27]

Capt. Comella told the Commission Mr. Burtenshaw's point of view was a valid one, from the "perspective of a brand new team member, in the last year or so." He said the team hasn't had a chance to exercise since the event, but next time it did, HUSAR/TF3 intended to provide more information about the hierarchy, including operational job descriptions. Mr. Burtenshaw's comment "didn't fall on deaf ears."[28] Capt. Comella told the Commission, however, that he could not understand why Mr. Burtenshaw felt he did not have good information during the deployment: "[A]ll he had to do was ask whatever questions that he had, and his direct supervisor would have

given him the answers." Capt. Comella felt that Mr. Burtenshaw had all the information he needed to understand the orders he was receiving.[29]

Capt. Comella also received feedback from Michael Strapko, also with Toronto Fire Services and involved with logistics for HUSAR/TF3.[30] His recommendations appeared to focus chiefly on delays and poor communications. Mr. Strapko considered that there had been an initial lack of urgency:

> Initially, team spirit lacked a sense of urgency. Lollygagging overrode a spirit of emergency response. There were feelings of denial that we would be called off by the OPP as we were for the Windsor collapse.[31]

Mr. Strapko therefore suggested that a portion of the search team, with medics and sufficient equipment, deploy in advance of the rest of the team. The roll-off truck (carrying lumber) could be the last vehicle to arrive, being the slowest, or simply not be deployed. He made other suggestions for getting to the scene quickly and deploying quickly once there, such as having a bus with toilet facilities and allowing certain members to drive directly to the scene instead of waiting for everyone to muster at one place before anyone could depart.[32]

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On the communications front, Mr. Strapko suggested Blackberries for the whole team, for "readiness, research, and ongoing status updates during emergencies," with "wallet cards" listing all team member phone / email contacts.[33] In terms of external communications, Mr. Strapko said "media and public relations were atrocious." He took particular issue with the announcement that rescue efforts were terminated, describing it as "an international public relations disaster." He suggested a strategic approach in the future involving multiple, alternative rescue plans and felt that HUSAR/TF3 should "**NEVER** halt rescue efforts at any point or time" [emphasis in original]. He made several suggestions for better media and public relations, including regular media scrums. HUSAR/TF3's logistics branch, which he was a part of, could be responsible for media and public relations if staffed properly.*

Capt. Comella was asked to comment on Mr. Strapko's criticisms. He could not understand why Mr. Strapko felt there was a lack of urgency in the beginning and said that, from his perspective, he understood that there would most certainly be a rescue: "We were eagerly awaiting our arrival time, that's for sure. We wanted to get here as soon as we could."[34]

Dr. Michael Feldman, the team doctor and an emergency room physician, also replied to Capt. Comella's email. He copied Staff Insp. Neadles and congratulated him on having done an "outstanding job despite relentless media scrutiny" and for "taking the leadership role that he did. When faced with adverse media scrutiny, he remained in the spotlight and was permitted to successfully turn the tables."[35] Dr. Feldman commented positively on the decisions made by HUSAR/TF3 and the machinery available during deployment. He felt that HUSAR/TF3 had made sound, rational, well-informed, and safe decisions regarding rescue efforts, something that "should be conveyed to any public inquiry."[36] He also felt that HUSAR/TF3 had the right machinery during deployment and that the team did not make any mistakes by ordering it too late:

> The heavy machinery (despite media reports that it should have been brought sooner) was suitable mainly for demolition and recovery, not for the sensitive first hours with signs of life in the rubble.[37]

* Exhibit 7816. Mr. Strapko also made suggestions related to laundry, clothing, and hygiene.

In terms of areas for improvement, Dr. Feldman suggested more openness with respect to signs of life. He felt people's expectations could have been better managed by letting them know of the belief that "most or all victims have died." This was something he felt was not well conveyed: "[T]he media might have concluded our decision-making was sound given our realistic assessments of survivability."[38]

Dr. Feldman felt the operational leadership should have stayed in the command tent and that the local fire chief, mayor, or media relations people should have been in front of the cameras: "Bill was doing two jobs, when one would have been more than enough work for him."

Dr. Feldman also made suggestions about media relations and operations. He felt the operational leadership should have stayed in the command tent and that the local fire chief, mayor, or media relations people should have been in front of the cameras: "Bill was doing two jobs, when one would have been more than enough work for him."[39] During testimony, Staff Insp. Neadles agreed with this assessment. He took on roles that did not normally fall to him such as planning officer and media spokesperson. He agreed this overload affected his ability to act as team commander, including during the crucial period from 1:20 p.m. to 3:00 p.m. on June 25.[40]

Dr. Feldman alluded, as well, to potential improvement in the area of medical supplies and medical staffing. With respect to supplies, he cited the fact that HUSAR/TF3 did not have the materials necessary to treat crush injuries during the deployment and had to acquire them from the local hospital:

> Medical supplies: subject to further discussion. You know my thoughts about what we have to keep ready, and we were lucky the hospital replenished our supplies of expired saline and sodium bicarbonate (needed for crush injuries). Will keep working with you on this.[41]

In terms of staffing, he noted that HUSAR/TF3 was "down one or two physicians right now." He suggested training new physicians in order to be certain of filling spots on future deployments.[42]

HUSAR/TF3 views during testimony on areas for improvement

HUSAR/TF3 members who testified were often asked their opinion on what went right and what went wrong during the deployment. Those viewpoints are summarized in this section.

Staff Insp. Neadles's suggestions for improvement

Staff Insp. Neadles told the Commission he saw room for improvement in the areas of planning, record-keeping, and clarifying the command relationship between UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) and HUSAR/TF3.

Staff Insp. Neadles felt that HUSAR/TF3 had not done a good job in capturing what the team did in terms of planning during the deployment. He agreed that it was a mistake not to have allocated a specific person to the position of planning chief. Division Chief Doug Silver was the only person trained to occupy that position, and he did not deploy. HUSAR/TF3 was "moving towards training more people" for the planning chief position but, at the time of the Inquiry, that process had not yet begun because it involved first finalizing a course on the topic that was being developed in Manitoba.[43]

Staff Insp. Neadles agreed that the planning chief position was important for more reasons than simple record-keeping. The planning chief is also expected to look ahead to next steps – to assist the head of HUSAR/TF3 in that respect. Hence, deploying without a planning chief was a significant deficiency.[44] Without one person holding the position, responsibility for planning was spread out among different people:

> Well, a lot of it rolled up into the responsibility that myself and Mike McCallion took on as the Site Commanders, and some of it took on a role with Tony Comella. He was also tasked with doing some of the planning, and that was just the action plan part of it.[45]

Moreover, although these three individuals allegedly occupied the planning chief position jointly, nobody was assigned the function of keeping a documentary record of the incident, despite HUSAR/TF3 having a cache of forms available for that purpose. Staff Insp. Neadles agreed that the purpose of a good documentary record was not only to look back on the incident after the fact, but also to facilitate a smoother operation during deployment:

> *Q.* And why don't you explain to the Commissioner what the purpose beyond having a documentary record that can be looked at months after the fact, but during the deployment, what is the purpose of documenting all of these things?
>
> *A.* Well, when you change operational periods, it allows the new shift to come on and the rescue squad manager, whoever is in charge of that group of men, would then be able to come to the – to the command tent and find out exactly what has been transpiring both inside that hot zone and potentially outside of that hot zone, so they have got a good – a good picture of what has actually transpired and now with getting their objectives and strategies and tactics – or they would develop the tactics for the going forward to the next operational period for their team to work on.[46]

Staff Insp. Neadles also gave his opinion on how to improve the working relationship between UCRT and HUSAR/TF3. He seemed generally to support the creation of a memorandum of understanding (MOU) governing the relationship and believed that such a process, involving Capt. Comella, was under way.[47] At the time of testimony, his understanding of the UCRT/TF3 command relationship was that OPP UCRT would be in charge during the first operational cycle. Once HUSAR/TF3 was on the scene and operational, UCRT would fall under HUSAR/TF3's overall command. He agreed, though, that not everyone understood the relationship in the same way:

> I am going to qualify it to say I understand it as that … There may have been some misunderstanding of that, because I know some of the OPP members on the ground I think have only come on the team since Trillium and may not be familiar with that. I don't know. But that is the standard process.[48]

Staff Insp. Neadles even conceded that there was confusion within his own team as to the proper command relationship with UCRT. It was pointed out to him that Capt. Comella's evidence contradicted his own. Capt. Comella's expectation at Elliot Lake was that the command structure was a unified command with a leader from all responding agencies. UCRT, said Capt. Comella, would have a command position equivalent to HUSAR/TF3. Staff Insp. Neadles first agreed that he and Capt. Comella had a different understanding of the command structure for joint TF3/UCRT deployments. He then backtracked, suggesting that Capt. Comella might be referring to Chief Paul Officer's level of command, but that, for the whole rescue, "somebody has to make that decision, which is HUSAR." When pressed further, though, he again agreed there was a conflict between what he and Capt. Comella understood the command structure to be.[49]

Cmdr. McCallion's suggestions for improvement

Cmdr. McCallion saw room for improvement in the areas of communications, planning, and documentation.

Cmdr. McCallion thought that communications between the OPP and the command tent could have been improved, although he seemed to attribute fault to the OPP's failure to properly staff its team:

> I feel Sergeant Gillespie was – I'm trying to think how to put this as nice as possible – I think Sergeant Gillespie was overtasked. He was under-resourced. I think he admits he was under-resourced. He only had, I believe, 10 or 12 of his staff there. He was wearing multiple hats and there was no support for him in the Command tent, so I think that – and he had a team of A personality members, some with experience, some with very little HUSAR experience. And I think maybe, in some cases, they were pushing him to make decisions or to get information that he maybe should have gotten or feels he should have gotten in a different manner?
>
> So I think that that communication with Sergeant Gillespie could have been improved on.[50]

Cmdr. McCallion also mentioned a "personality clash" between himself and Sgt. Jamie Gillespie. He wished the two could have discussed the matter since, but then conceded that he personally had not reached out to Sgt. Gillespie.[51]

In terms of media relations, Cmdr. McCallion agreed with the suggestion that HUSAR/TF3 needed a designated media officer: "I think it's important to tell people what you are doing as you do it."[52] Cmdr. McCallion thought that documentation during the deployment could have been improved and, like Staff Insp. Neadles, indicated that if a deployment were to occur today, he would immediately designate someone as planning officer in order to have a scribe and to ensure the proper forms (such as incident action plans and scene assignments) are filled out.[53]

Capt. Comella does not see areas for improvement

Capt. Comella, when asked, was reluctant to suggest that, from the HUSAR/TF3 perspective, anything had gone wrong during the Elliot Lake deployment. He thought that the team "did everything well" and said that he did not know if he could "identify something that was wrong or less efficient."[54]

In the end, he did suggest that communications could be improved: "I guess there was always room for improvement with everything, but I couldn't necessarily pinpoint any particular thing that I would focus on. Communications is always an issue. Better communications, whether that be from a Unified Command cell down."[55] When pressed, he also conceded that it was a problem that he, given his rank, was unaware of the nature of Staff Insp. Neadles's decision to stop – that is, whether the operation would continue as a rescue or as a recovery.[56]

Suggestions for improvement from other HUSAR/TF3 members

Other HUSAR/TF3 members who testified made suggestions for improvement in the areas of planning and documentation, note-taking, HUSAR/TF3 self-sufficiency, media relations, and site security.

Capt. McRae felt that HUSAR/TF3 needed more people trained as planning chiefs. He pointed out that the team already had training on report-writing and the use of forms as part of the planning process, and he seemed to suggest that it simply needed to be better implemented. He also suggested the use of digital recorders for note-taking, pointing to the fact that, in Elliot Lake, it had been difficult to keep notes dry when it rained.[57]

Sgt. Glavin personally would have liked to have kept better notes during the deployment. He thought the response would have been better if a larger HUSAR/TF3 team had deployed. He also felt HUSAR/TF3 should have stuck to the "whole concept of our tent village" – that it should have been more self-sufficient on site. He did not think it would have slowed them much to have brought the additional trailer with tents. He described the negative consequences of having the team scattered about town:

> As it turned out, we had people scattered all over town. There were some in apartment buildings. Some were in the hotel. Some weren't.
>
> I had the pleasure of the first two nights I got to sleep in a bed, and then after that I slept in the cab of my truck.
>
> Had we set up our tents, that's where you start, and if you had to rally another response team quickly, you go back to a tent and you wake them up … you [shouldn't] let your team members out into the general populace; you kept them together.[58]

Sgt. Glavin expressed great confidence in Staff Insp. Neadles and Cmdr. McCallion, and in his team members. When pressed on whether a Plan B should have been in place earlier, given his earlier evidence that it was clear the building was moving, he conceded that earlier consideration of a Plan B would have been prudent, and he appeared to agree that the team needed a planner on board.[59]

Capt. Chuck Guy thought, on the positive side, that HUSAR/TF3 worked "flawlessly in the tasks that they were given." He saw room for improvement in terms of "accountability for some of our members." He referred to one occasion where two members walked from the hotel to the food area, at about the time that the crowd had gotten angry. He thought that if they had run into the crowd, it could have been a big problem. Although it was unusual in Canada to have to worry about the security of the members, he felt that, in the future, HUSAR/TF3 should stick to its ordinary training scenario, which involves setting up camp in a secure area and working in proximity.[60]

The Ontario Provincial Police and UCRT do carry out after-action assessment

UCRT meets for a debriefing on July 4, 2012

UCRT held a debriefing on July 4, 2012. Sixteen members were present, seven of whom were not actually deployed to Elliot Lake. These individuals were Acting Insp. Wayde Jacklin, Staff Sgt. Jim Bock, Sgt. Mike Dolderman, Ad Ferrao, Chuck Reavie, Matt Young, and Sgt. Meshach Parsons. The other nine had deployed. These were Csts. Dan Bailey, Mick Belgum, Brandon Boles, Chris Collins, Ryan Cox, Martin Groleau, Steve Hulsman, Tim Sobschak, and Paul Weber. Sgt. Gillespie, Cst. Patrick Waddick, and Cst. Marc Walsh were not present, despite having deployed.[61]

Following is a summary of some of the perceived positives and points for improvement for the Elliot Lake deployment, as reflected in the minutes of the July 4 debrief.[62] While many points for improvement are mentioned, the most consistent theme was the lack of command and control presence from the OPP perspective, and the difficulties this situation created. Acting Insp. Jacklin confirmed this assessment and told the Commission that, from the OPP perspective, Sgt. Gillespie was multi-tasked. Someone at a higher rank was needed for this deployment to ensure that UCRT's needs were being met at the "big table."[63]

Acting Insp. Jacklin's perspective

Acting Insp. Jacklin made these observations:

- *Ordering the crane*. The crane, requested en route by Cst. Cox, was supposed to be on site by midnight but did not arrive until the next morning.
- *Food and housing*. UCRT had to wait for a restaurant to open before the team members could get food and, until the Office of the Fire Marshal found a closer hotel, UCRT hotel rooms were an hour away. He suggested UCRT should bring tents next time.
- *Relations with HUSAR/TF3*. He expressed frustration with HUSAR/TF3, saying "CTF-03 was to work with UCRT but did [their] own thing."
- *Command and control*. He expressed frustration over a lack of OPP UCRT command and control. He recognized that he should have been on scene and suggested that UCRT needed a Level 2 incident commander (discussed below) to attend similar scenes in the future.
- *Problems with the dogs*. The cadaver dogs wouldn't go onto the pile without a lead, and so there was a need to train cadaver dogs to search off lead. In testimony, he advised that he has already attempted to implement this training.[64]

Sgt. Dolderman's perspective

Sgt. Dolderman made these observations:

- Local OPP command (Insp. Percy Jollymore) was not aware of UCRT capabilities and lacked the capacity to order equipment quickly.
- There should have been an OPP incident command post in place to assist with providing proper information to the media.
- The OPP had difficulty maintaining control and communicating between teams given the absence of a unified command structure.

Staff Sgt. Bock's perspective

Staff Sgt. Bock made these observations:

- *Financial issues.* He referred to financial pressures but indicated that, once a state of emergency was called, "money was released."
- *Command and control issues.* He felt UCRT did not have a "Command or Control" presence, and he needed to ask for a "2 IC" (Level 2 incident commander) specific to the UCRT team in future deployments.
- *Food, housing and logistics.* He referred to problems UCRT experienced in finding food and suggested UCRT may have needed better logistics assistance.
- *Lack of radio contact.* He referred to a lack of proper radio contact with the "command post," which he thought should not have been at the local detachment but on site, and said: "Every team seemed to be on different radio channels, no communication between them."
- *Relations with HUSAR/TF3.* He considered that HUSAR/TF3 needed to apologize to UCRT for the way the team was treated.

Cst. Collins's perspective

Cst. Collins made these observations:

- He referred to the crane having "sat a full day before using."
- He also felt the HUSAR/TF3 workers were helpful and professional, but the "team leaders were not professional."

Cst. Bailey's perspective

Cst. Bailey made these observations:

- *Command and control.* He expressed frustration over the absence of a "structured command." He felt that "[a]ccountability seemed to be in the OFM tent with CTF-03" and felt there were too many HUSAR/TF3 "chiefs on the pile giving orders."[65]
- *Rescue aborted too soon.* He felt that a person could have been pulled out of the pile on Day 2 "if [his team had been] allowed to do so with equipment on scene as requested and stayed to original plan."
- *Local OPP command was not aware of UCRT capabilities.* He felt that the OPP command post did not understand UCRT capabilities.
- *Lack of radio contact.* He said communication was poor and that everybody was on different radio channels, making it a safety issue. He felt HUSAR/TF3 should have provided radios, a recommendation he reiterated during testimony.[66]
- *Media relations.* He felt the OPP should have had its own media person on site. HUSAR/TF3 should not have spoken on their behalf.

Cst. Cox's perspective

Cst. Cox made these observations:

- *Note-taking*. He felt that people were multi-tasked and therefore too busy to take notes.
- *Command and control, and poor relations with HUSAR/TF3*. He expressed frustration with HUSAR/TF3 command, suggesting things went smoothly for the first 15 hours – until HUSAR/TF3 started "calling shots." He referred to "constant battles" with HUSAR/TF3 and expressed disappointment that HUSAR/TF3 got credit for work done by UCRT. During testimony, Cst. Cox added that Sgt. Gillespie was stretched too thin and UCRT was not included in planning decisions.[67]
- *Good engineering assistance*. He felt the engineers were great and did not hamper the mission.
- *Food and housing*. He also mentioned that UCRT was "hungry one night."

Cst. Hulsman's perspective

Cst. Hulsman made these observations:

- *Relations with HUSAR/TF3*. He said the team was "disappointed that they were bullied out of the way by CTF-03." In testimony, he relayed his impression that HUSAR/TF3 felt they could have done without UCRT.[68]
- *Housing*. He pointed out that only half of UCRT's team was able to go, and that the tent trailer did not go with them because of a lack of numbers. In testimony, he explained that the tents, if they had been brought, would have provided sleeping quarters for UCRT if no hotels were available; and he would have placed them closer to the scene, assuming there was room at the scene to camp.[69]

- *Command and control issues*. He stated that the ground workers for HUSAR/TF3 and UCRT worked well with each other and everybody worked very hard. His perception was that the command structure wasn't functioning properly.
- *Shoring and rigging*. He thought that the shoring was well done, despite having to adjust to higher ceilings. The crane rigging, which UCRT carried out side-by-side with HUSAR/TF3 members, went "exceptionally well." No one was injured.[70]

Sgt Gillespie creates a brief after-action report on July 12, 2012

Even though he missed the July 4, 2012, debriefing, Sgt. Gillespie wrote a brief after-action report on July 12.[71] Like his UCRT colleagues, he criticized HUSAR/TF3 command and control during deployment, while being generally positive about UCRT's actions, stating:

> Extensive command and control issues were encountered throughout the operation with CAN TF3 leadership. UCRT members responded quickly and worked in a very professional manner throughout the rescue phase with no significant definciencies [*sic*] in equipment or training to conduct this work.
>
> …
>
> UCRT members worked extremely well together and with CAN TF3 members but were extensively hampered in their efforts by CAN TF3 commanders.[72]

Sgt. Gillespie retreated from this criticism of HUSAR/TF3 command during testimony. He called the comments in his report an "overstatement." He still felt he should have been more involved within the command and control structure, but agreed that he did not suggest this belief to HUSAR/TF3 leadership during the deployment because he preferred to "stay with my members and keep them safe."[73] He attributed his general frustration to a lack of OPP resources:

> I think I was just overly frustrated with not having the proper support there, from our own organization as well as the issues that we spoke about earlier. So, when I say it's an overstatement … it is exactly that. It's – you become far too emotionally involved in these things … It's a regret on my part that I wrote it in that fashion but it is what it is. I've written it that way and I have to account for that.[74]

The OPP Field Support Bureau creates a comprehensive after-action report

The Ontario Provincial Police Field Support Bureau created an after-action report in relation to the overall OPP involvement at the Algo Mall collapse. The Commission's copy is not signed or dated, but is noted as having been submitted by Asst. Supt. Geoff Edwards (director of the Field Support Bureau) and approved by Chief Supt. Robert Bruce (commander of the Field Support Bureau) and Deputy Commissioner Larry Beechey (provincial commander).[75]

The report is divided into six parts:

1. [B]ackground and Chronology of the Event
2. East Algoma Detachment
3. North East Region (RHQ/EOC)
4. Field Support Bureau – UCRT
5. Incident Command
6. Field Support Bureau – EMU (Emergency Management Unit)[76]

Each part includes an overview, along with sections on best practices (defined in the report as actions that were considered beneficial and recommended for future events), lessons learned (which the report defines as action or inaction that was not beneficial to the overall operation), issues, and recommendations.[77]

It is necessary to summarize in detail only the conclusions relating to the East Algoma detachment, UCRT, and incident command. The section on the Emergency Management Unit mentions that "Mobile One" (a mobile Emergency Operations Centre, or EOC) was eventually deployed by the OPP to the Elliot Lake scene and recommends that "thresholds" be established for the activation of EOCs in the future.* The section on the North East Region did not raise issues directly related to improving the rescue and recovery operation.[78]

Recommended areas for improvement for the East Algoma detachment

With respect to the East Algoma OPP detachment that policed Elliot Lake, the report saw the detachment's continued involvement with the Community Control Group as something positive and recommended continued participation in scenario-training on that front. In terms of areas of improvement, the report cited issues related to perimeter security, media relations, and logistics.[79]

The report cited difficulty securing the scene when it became necessary (presumably when the rescue was called off):

> One lesson regards site supervision in relation to when to disengage from rescue and focus on scene security. Front Line Supervisor had difficulty with that issue[.][80]

Logistical problems ensued as more and more OPP resources were deployed to the scene, among them:

- Influx of OPP human resources became logistical problem for accommodations and meals.
- No staging or mustering area. Needed a place where site commander could muster crowd control units.
- Limited space availability for command functions.
- Resource requirements and management, resources like Mobile Command Post 1 was sent however because of the scene there was no place to deploy it … It wasn't until Monday, June 25th that a secure area inside the perimeter clear for deploying the Mobile Command Post.
- Meals and accommodations were not a major issue until Sunday at which time, as a small community, food and rooms for attending resources became a major issue. In place of everyone managing their own units, all of this needed to be coordinated through the Municipal Group. This would have saved a lot of time and frustration for all parties involved.[81]

The OPP recommended that the East Algoma detachment could have benefited from logistics management training, even though the OPP was not in charge of what was termed a "Municipal Emergency."[82]

Meals and accommodations were not a major issue until Sunday at which time, as a small community, food and rooms for attending resources became a major issue.

* Exhibit 7784, pp. 021–3. The report also recommended development of standard operating procedures for "Region / Division EOCs," the need for Region / Division EOCs to conduct a provincial exercise including all locations, and the need for sharing contact information among regional EOCs.

Recommended areas of improvement for UCRT

According to the report, tactical operations went "very well from a UCRT perspective," but several challenges arose.[83]

In terms of best practices (defined in the report as actions that were considered beneficial and recommended for future events),[84] the report considered UCRT's actions to have been positive on numerous fronts:

- *Rapid deployment.* UCRT deployed all available members and resources "very efficiently" and was able to have "the broadest ranges of the unit's capabilities to the scene even though the overall number of responding members was quite low."
- *Quick to develop a plan.* UCRT quickly assessed structural stability and developed immediate and alternative action plans even before arriving on scene – by looking at photographs, figuring out victim information and suspected location, and understanding the type of structure and the potential scale of the rescue operations. "Acquisition of external logistics such as heavy crane equipment and wood shoring was organized before arrival." Rescue efforts began shortly after arrival.
- *Well trained and worked relentlessly.* UCRT's extensive training enabled responding members to begin rescue operations in this very complex scene. The work environment was described as difficult, but "[a]ll deployed members from UCRT worked tirelessly to accomplish the tasks assigned to them, including working extended hours with minimal rest periods." UCRT efforts were described as "professional and safe … [as] recognized by the Ministry of Labour (MOL) inspectors assigned to this incident as overall safety oversight."
- *"Worked seamlessly with most partner agencies."*
- *Communication strategy was "successfully implemented."* The detachment commander was aware of the UCRT mandate, and call-out protocols were followed "perfectly" through the OPP chain of command.[85]

In terms of "lessons learned," which the report describes as action or inaction that was not beneficial to the overall operation,[86] the OPP saw room for improvement for UCRT in the following areas:

- *Availability of non-commissioned officers (NCOs).* Only one of the four UCRT NCOs was available to respond directly to the scene, which resulted in "multi-tasking of unit level Incident Command responsibilities." This problem was compounded by the need for "continuous 24 hour based rescue operations" and continuous input from UCRT command to the overall incident command. The OPP recommended that, in the future, it would be "critical" that leadership gaps be filled.[87]
- *OPP incident command was overtasked and not able to oversee UCRT operations*. The OPP determined that the incident commander, Insp. Jollymore,[88] was not able to dedicate sufficient time to overseeing detachment commander duties, incident command from a detachment perspective, and direct command of the tactical rescue operations headed by UCRT, "specifically the NCO complement that would be responsible for direct UCRT command." The perceived result was the creation of logistics issues and the overtaking of control by HUSAR/TF3:

  > As a result of the shortfalls in OPP Incident Command, this function was directly taken over by an external partner agency and the OPP resources directly involved in the rescue efforts had little to no direct input into the command of this incident. This also created a deficiency in getting heavy equipment and needed resources for the rescue in a timely manner.[89]

- *UCRT's relationship with HUSAR/TF3 was strained and affected the rescue*. The report found that a strained relationship between UCRT and HUSAR/TF3 caused difficulty when it came to "the common goal of assisting those injured and trapped." The difficulty, according to the report, related to HUSAR/TF3 command and the aforementioned "deficiency in the OPP command and control presence." The report states that HUSAR/TF3

took over tactical control from the Elliot Lake fire chief, who had been following the Incident Management System (IMS), and the following leadership difficulties ensued:

  - UCRT was not permitted access to command briefings or input into the rescue operations;
  - information flow between UCRT and HUSAR/TF3 was "next to none";
  - UCRT received "misinformation" from HUSAR/TF3 (not specified); and
- The OPP felt that the UCRT members were as well trained as the HUSAR/TF3 members and that the only difference between the two teams was the amount of members available:

> Both units are comparably trained and capable of completing identical tasks with the exception of the number of personnel that are capable of responding. CAN TF3 was requested at the outset of the incident due to the limited personnel that were available to respond to this incident from UCRT.[90]

Insp. Jollymore was asked about the comment in the report that, because there were shortfalls in OPP incident command, the function was taken over by an "external partner agency" such that the OPP had little direct input into the command of the incident. He saw this role as an indication that UCRT was reluctant to play the role of a mere support agency, but instead wanted its own incident command at the scene. He saw this attitude as going against the IMS concept:

> Well, what this tells me, that even though UCRT is trained in IMS training, that they are not accepting the fact that they fall under that umbrella as a support service in this particular case. They are not accepting that. They are talking about having their own Incident Commander take over the entire incident.[91]

In fact, Insp. Jollymore disagreed with the general thrust of the report. It seemed to him that the OPP wished in the future to take complete control, as opposed to adhering to the IMS structure of incident management.[92]

Sgt. Gillespie was also asked about this section of the report, in particular the OPP assertion that "UCRT was not permitted access to command briefings or input into the rescue operations."[93] He testified that this was how UCRT perceived the situation at the time, although he also said no evidence existed to support the assertion:

> *A.* That's how it was perceived at the time. I wouldn't say there was any evidence to say that they were not permitted, but it would seem that on the first – return to the first shift on the evening of Sunday night … I asked [on] a couple of occasions when the next command briefing would be and it would be continually put off, so I don't know the answer for that, to this day.
>
> *Q.* In your opinion, was that exclusion intentional or just a result of UCRT not having someone in the command centre?
>
> *A.* I think it's both.
>
> Well, I shouldn't say "both," but it felt like it was intentional at the time. I don't know that it was, but it certainly contributed to the fact that we did not have anybody there staffing it.
>
> That certainly contributed to the information flow problem that was identified there.[94]

The OPP then made several recommendations with respect to UCRT, many of which relate to strengthening the command structure during future deployment. Among them:

- The UCRT unit commander staff sergeant or delegate should attend every "critical scale incident" assigned to UCRT.
- A minimum number of NCOs should be created within UCRT to respond to incidents.
- When certain NCOs are unavailable, they should be replaced in an acting capacity by appropriately trained members, and they should not be multi-tasked with other incident responsibilities. If such members are not available within UCRT, they should come from elsewhere within the OPP and "have the skills and abilities to perform these duties" and be familiar with the UCRT mandate and operating procedures.

In the area of incident command, the report called for an inspector to be the UCRT program manager and for the mandatory involvement of a critical incident commander as direct incident commander of UCRT resources:

> 1. Establish policy that initiates the mandatory involvement of level one or level 2 Critical Incident Command for direct Incident Command of UCRT resources at appropriate scale based on the circumstances of the incident.
> 2. Establish the Inspector program manager of UCRT as an Incident Commander for these incidents. This commissioned officer is very familiar with the UCRT capabilities, personnel, and standard operating procedures.[95]

Sgt. Gillespie explained in testimony that it was his recommendation to Acting Supt. Edwards that the OPP put critical incident commanders into the command position for large-scale USAR and CBRNE incidents. He explained that critical incident commanders have more training than incident commanders: "It's the higher level of training for incident commanders within the OPP."[96] Based on his observations at the Elliot Lake scene, Sgt. Gillespie felt that a critical incident commander would have had more experience in running large-scale incidents, and potentially a better understanding of needs and capabilities. The overall result would be a greater OPP presence at the command centre and better access to information.[97]

The report then made recommendations related to issues such as note-taking, rigging and crane operations, debriefings, and further training. These included:

- expanded training to more members of UCRT in rigging and crane operations;
- ensuring that post-incident debriefing sessions are conducted with as many members present as possible among those who attended the scene, especially those of critical importance to the operations phase;
- creation by UCRT of a critical incident note-taker or scribe position;
- training for incident commanders on how a state of emergency is declared and how resources are paid for. The use of two heavy cranes during the Elliot Lake rescue effort was cited as an incident showing that incident commanders require more information on how to deploy such resources:

  > Educate existing Incident Commanders in the areas of CBRNE and USAR and the role / needs of UCRT in such incidents. Specific to incident two heavy cranes were critical to the rescue effort and were requested immediately. While these items are very costly to acquire, knowledge of how a declared state of emergency and how these resources are paid for at the end of the incident would have been beneficial for the Incident Commander making this decision.[98]

The report also made recommendations on "External Relationships." Again, emphasis was placed on the OPP maintaining a command and control presence in future events. The recommendations include:

- a formal debrief with HUSAR/TF3 and UCRT command level members present;
- maintenance of command and control of incidents of this nature by "initiating a strong and continuous OPP incident command presence with local officials"; and
- development of a linkage between UCRT and the Criminal Investigation Bureau (CIB) early on, to "ensure UCRT members [have] knowledge of critical pieces of evidence … and ensure that they are secured during the demolition phase and protected."[99]

Recommended areas of improvement for "command and control" for overall OPP presence at Elliot Lake deployment

Despite having canvassed the issue to a great extent in other sections of the report, the OPP dedicated an additional section to assessing issues of command and control related to the Elliot Lake deployment. Again, the focus was on maintaining a strong OPP command presence for future deployments.

The report painted a picture of confusion over who was in command during the Elliot Lake deployment:

> The event was being managed by a detachment commander [Jollymore] [who] took on the role of Incident Commander. There were two Level 1 Incident Commanders on site for this event, working days and nights. Upon discussion with both day and night commanders it was clear that roles and responsibilities were not identified or known to commanders. Day and night commanders assumed they were responsible for arranging personnel for access points and logistics – something done by a logistics officer. An inspector detachment commander was overall lead and both day and night Incident Commanders were S/Sgt's. No Incident Command organization and the command post at the time was an NCO office in detachment along with a small boardroom.
>
> Level Incident Commanders did not know HUSAR mandate or how they fit in the response / command and control triangle. On site Incident Commanders did not have established roles and responsibilities, the host detachment commander assuming overall command and of Town, site and exterior issues caused an issue as he was not available or on site most of time. Incident Commanders not readily identifiable at the scene (lots of white shirts walking around), Incident Commanders did not have proper protective equipment to be on site (hard hat, safety toes).[100]

The OPP therefore made the following recommendations with respect to command and control:

- ensuring that incident commanders are familiar with and educated about incident command and unified command;
- reorganization of incident command and major incident response procedures for similar events in the future. This reorganization would include properly trained incident commanders – "trained to today's standards and … familiar with OPP resources" and establishment of an OPP emergency response presence "from day one at the scene and not 4 days later";
- development of regional training sessions with "regionally identified incident commanders" for events that require UCRT;
- proper supervision of incident commanders to establish who they are accountable to;
- involvement of the Field Support Bureau to take control of large-scale events and become more involved in operations and deployments;
- creation of a running log of agencies and support members at the scene;
- creation of a questionnaire or similar document to allow officers and supporting agencies to provide recommendations at the scene:

  > A simple form with drop area can make us more efficient in dealing with these things in the future, lots of officers and supporting agencies probably have ideas which we will never hear or learn.

- provision of equipment to incident commanders and a better way to identify them at the scene, beyond just a "traffic vest or armband."[101]

OPP Chief Supt. Bruce recommends strengthening the OPP command presence in future deployments

Chief Supt. Bruce, who approved the OPP after-action report, was, at the time of his appearance before the Commission, the commander of the OPP's Field Support Bureau. Although in his testimony he did not comment directly on the after-action report, he did discuss areas for OPP improvement following the Elliot Lake deployment. He provided suggestions for improving UCRT/TF3 co-operation through training, but focused mainly on strengthening the OPP command presence in future deployments involving UCRT.

On the topic of UCRT/TF3 co-operation, Chief Supt. Bruce favoured the creation of a memorandum of understanding covering UCRT/TF3 collaboration during future deployments.[102] He also suggested that the two agencies should engage in joint training as an opportunity, among other things, to address any past frictions. He pointed to the fact that the OPP worked "seamlessly" with HUSAR/TF3 when deployed to Goderich.*

Chief Supt. Bruce also explained the OPP's desire to improve the command structure for future deployments like Elliot Lake.[103] It is unclear from his evidence, though, whether he wanted the OPP to be subordinate to, equal to, or in charge of the rescue operation should HUSAR/TF3 and UCRT deploy together in the future.

First, he explained the incident command structure within the OPP. The OPP has a range of incident commanders: incident commanders, critical incident commanders, Aboriginal critical incident commanders, and public order commanders. A critical incident commander must be above the rank of staff sergeant, already be a first-level incident commander, and have successfully completed a 20-day course and mentoring program. A critical incident commander would typically be contemplated for high-risk incidents involving an integrated OPP response (multiple OPP units working as one). He gave the example of a hostage-taking.[104] Regular incident commanders, on the other hand, need the minimum rank of sergeant, but can be of any rank above that. Incident commanders take a 10-day course and are involved in any incident considered a "major incident," defined as involving the use of resources beyond local detachment capabilities.†

Chief Supt. Bruce then explained that, for future events like the Elliot Lake collapse and rescue, a "Unified Command structure" needs to be created with a "major Incident Commander" with overall command "so that … every agency is represented by their Incident Commander and reports down through their chain" with the "overall Incident Commander … responsible for the overall operation."[105] He did not specify who would be the overall incident commander but seemed to suggest that it would depend on the nature of the deployment. He provided the example of the 2002 World Youth Day in Toronto to explain his preferred command model. At that event, given the presence of an internationally protected person, the RCMP had an incident command to protect the Pope. However, the Pope passed through many jurisdictions (including Toronto Police and OPP). In those instances, according to Chief Supt. Bruce, the command structure was a unified command but with ultimate decisions being made by the RCMP:

> [O]ur Incident Commanders would run a section and report to us, but the decisions at the end of the day, once we have had our input, will be made by the RCMP, whoever that Incident Commander is."[106]

* Bruce testimony, August 23, 2013, p. 22145. In August 2011, a tornado caused the structural collapse of a warehouse in Goderich. An individual was killed and needed to be recovered: Gryska testimony, September 23, 2013, pp. 26677–8.

† Bruce testimony, August 23, 2013, pp. 22139–40. The Aboriginal critical incident commander would have the same requirements as the critical incident commander, along with greater familiarity with Aboriginal issues. The public order commander would be staff sergeant or higher and would have training and certification related to public order events, typically crowd control and big demonstrations. See also Exhibit 841, which provides a description of OPP "Major Incident Command." That document does not, however, reflect the recent changes to incident command mentioned by Chief Supt Bruce: Bruce testimony, August 23, 2013, p. 22154.

Later in his testimony, Chief Supt. Bruce again attempted to explain his idea of an ideal command structure in the context of a "unified command." It was again not clear from his evidence whether he felt the OPP would have overall command of an Elliot Lake–type deployment, a shared and equal command with an entity such as HUSAR/TF3, or a role subordinate to it. He seemed to recognize that in Elliot Lake, Chief Officer was the overall incident commander, but this opinion, again, was not clear from his evidence.[107]

What is clear, however, is that the OPP intends to beef up its own command presence for any future UCRT deployments. Chief Supt. Bruce said there have been changes implemented as a result of lessons learned at Elliot Lake. When UCRT is deployed in the future, an inspector in emergency management will deploy with them as incident commander. Structural collapses are now categorized as high-risk events (where they would have been only major incidents before) such that a critical incident commander must be assigned. This role, he said, would allow the local police to focus on local issues while the critical incident commander focuses on the overall rescue operation.[108] He pointed out that, for the Elliot Lake deployment, a staff sergeant should have held the UCRT command but, in fact, Sgt. Gillespie was the highest-ranking UCRT officer present, something he described as a failure on his (Chief Supt. Bruce's) part to ensure a proper command structure. With the new changes, a staff sergeant would be unit commander for UCRT, with a person of higher rank in the position of overall OPP incident commander.[109]

When UCRT is deployed in the future, an inspector in emergency management will deploy with them as incident commander. Structural collapses are now categorized as high-risk events (where they would have been only major incidents before) such that a critical incident commander must be assigned.

Four incident commanders have already received additional training, at the Level 2 command level, on how UCRT works. A commander trained to this level, and with this knowledge of UCRT, will be deployed at the next event of this nature.[110]

Chief Supt. Bruce said this new command structure, for future deployments of a similar nature, would also solve the problem (mentioned in the after-action report) associated with a perceived lack of support for the detachment and for Insp. Jollymore, whom he referred to as the incident commander. He pointed out that Insp. Jollymore would not have had intimate familiarity with UCRT capabilities. In the future, a critical incident commander would have that familiarity.[111] Chief Supt. Bruce later added that he felt the crane might have been ordered sooner if the UCRT unit had an inspector as incident commander and that person had ordered the crane. The UCRT inspector, unlike Insp. Jollymore, would already have known how to access that resource without having to research the matter.[112]

In summary, Chief Supt. Bruce thought that command, control, and communications could have been improved at the Elliot Lake scene. Although he felt the result would have been the same from an operational perspective, the OPP's suggested improvements to command and control "would have put people in the right positions … it would have had the elements that were there properly represented at [the] command table. That would have limited or eliminated a lot of confusion as far as the communication and things like that."[113]

In keeping with the OPP's focus on perceived failings in establishing a command presence, Chief Supt. Bruce also felt that media relations would have been improved with a stronger command and control structure:

> I think when you have a very good command and control structure, the media at least will gravitate to and understand that that's where the information should come from, and while they'll want to ask other people, they'll know that they can qualify it with that command.[114]

The City of Elliot Lake and the Elliot Lake Fire Department

The City of Elliot Lake fails to hold a debriefing despite a requirement to do so

The City of Elliot Lake failed to conduct a debriefing following the Algo Mall emergency response. The evidence clearly indicates that the calling of this Commission was the major impetus behind the failure to do so. As with HUSAR/TF3, I find it difficult to avoid the strong suspicion that City officials sought to avoid scrutiny of the conclusions reached in any debriefing or after-action report by the Commission or other interests.

The City of Elliot Lake was aware that a debriefing was required pursuant to its emergency response plan.[115] Part 8 of the plan, entitled "Phasing Out Operations & Terminating Emergency," states:

> A debriefing which will focus on the strengths, opportunities and challenges of the emergency response activities will occur within five working days of the official termination of the emergency response. Recommendations must be documented and assigned for action within a reasonable timeframe with follow-up by the CEMC [Community Emergency Management Coordinator] as appropriate. The City of Elliot Lake ERP [Emergency Response Plan] will be revised accordingly.[116]

The idea of holding a debriefing session did come up in July at a Community Control Group meeting, but Mayor Richard Hamilton suggested that it did not happen because there were difficulties getting people together. He insisted that the intent was not to avoid scrutiny:

> [I]t was decided at that time with the Inquiry, you know, happening and such that that debriefing was probably best left until the emergency was called off.
>
> *Q.* And was there a concern that the Inquiry would have the findings of any such debriefing eventually if you held it before the Inquiry was held?
>
> *A.* Not in my mind, no.
>
> *Q.* Anyone else's?
>
> *A.* Not that I am aware of.[117]

Chief Administrative Officer Robert deBortoli was also aware that a debriefing was required following the conclusion of an emergency. He said, however, that, because these were "special circumstances," the City would "debrief once everything was concluded."[118] Although he did not explain what he meant by "special circumstances," Mr. deBortoli was referred to emails between Insp. Jollymore and Trudy Rheaume, the emergency management coordinator, flowing from Ms. Rheaume's attempt to schedule a debriefing.[119] In those emails, Insp. Jollymore raises the point that, if the debriefing were held before the Inquiry, the results would need to be disclosed to the Inquiry.[120] Insp. Jollymore wrote the following to Ms. Rheaume on July 26, 2012:

> Trudy a couple of things before I respond to this. A [*sic*] hour is far to [*sic*] short. The Emergency is still in place. Just to prepare for this would take hours of time. A full review of the Emergency Plan and everyone's role, what we did and how it worked.
>
> This is something that needs a [fair] amount of thought and review. *In addition we are all facing an inquiry, a public inquiry meaning that the findings of this would have to be available to them.*
>
> Normally this would occur after the inquiry for the reason I have outlined. I just completed one for a Barricaded person a[n] event that was done in 4 hours and the Debrief took 2 and half hours.[121] [Emphasis added.]

Mr. deBortoli insisted, like Mayor Hamilton, that this possibility did not influence the decision to not hold the debrief:

> No. I don't think there is anything wrong. If we had done a debrief and whatever the findings were would have been – that there would have been no issue with having that information brought forward.[122]

Ms. Rheaume confirmed that the general practice pursuant to the emergency response plan was to have a debriefing. A debriefing was scheduled, but when it was learned that an Inquiry would take place, the decision was made to have the debriefing "later." Referred to her email exchange with Insp. Jollymore, she told the Commission that she was directed by the CAO to postpone the debriefing:

> It seemed plausible to delay it [the debriefing] because of the inquiry, and then the inquiry would most likely help out with the debriefing in providing us with answers as to what went well and what could be improved upon. And through direction from the CAO, that is what we decided to do."[123]

Suggestions for improvement from the City

At the hearings, certain City of Elliot Lake officials were asked their opinion on what went well and what could have been done better during the rescue and recovery operation.

Mayor Hamilton suggested that the City could have used more assistance when it came to media relations. He pointed to the existence of the OPP trailer that he recalled arriving on scene three days after the collapse. He called it the media control station and said the City could have used something like it earlier on. The City did not have TVs, monitors, or similar technology in its control centre. Instead, a few individuals, including Mr. Hamilton, took notes and communicated with the media via telephone.[124] He described the amount of work he had to do just dealing with media inquiries:

> *Q.* Who were you called to or what media organizations do you recall being contacted by?
>
> *A.* I think if I told you the ones I wasn't contacted by it would be a shorter list, quite frankly. It was – I was getting contacted by media outlets that I had no idea even existed, as far away as Houston, Texas. I was getting media inquiries from Europe, from those right across the country, all the major news chains, both television, newspapers, radio stations. And in fact, we were lining them up in ten-minute increments, and we were going for two or three or four hours at a time.
>
> *Q.* Have you ever had to do that before?
>
> *A.* Absolutely not. It was frightening.[125]

Mayor Hamilton thought more assistance on this front would have been useful for a small town like his dealing with a "big-city tragedy."[126]

Mayor Hamilton and Ms. Rheaume both commented on the requirement in the plan for members of the Community Control Group to keep personal logs of their activities. Mayor Hamilton told the Commission that he simply did not have the time to do so:

> All I can say to that is I would be doing nothing but a log, because I was on the phone almost steady with either media outlets, with various government agencies, with various government people. I had Mayors from all over the country calling me … I would be writing a perpetual log and actually not doing my job.[127]

Ms. Rheaume agreed that not all members of the Community Control Group kept logs. She pointed out that these were people who did not normally attend to emergencies and were under an enormous amount of stress. Keeping a log did not come naturally. She herself tried to keep one and found that her notes were "all over the place." She agreed, however, that notes are useful and felt there should be training on this point in the future.[128]

Mr. deBortoli saw little room for improvement, other than in the areas of communications and media relations. He felt, in hindsight, that everybody involved gave 110 percent and did a very good job. He saw only "minor, minor areas" for improvement, such as gaps in communication, and suggested that, in the future, the City would definitely get someone to assist with media relations: "It was certainly a baptism by fire from that aspect."[129]

The Elliot Lake Fire Department also fails to hold a debriefing session

Chief Officer testified it was the Fire Department's practice to hold a debriefing after a large event, but one was not held after these rescue efforts ended. When the incident ended on June 27, 2012, half of his team left for holidays. People needed to rest. As fire chief, he actually took advantage of the mutual aid system to have other departments cover his fire hall for that weekend.[130]

Even after a rest period, no debriefing was held or even attempted. Chief Officer agreed debriefing was a useful tool for bringing information to the table – spotting what could be done better and what was done well, and trying to make improvements. Despite these benefits, he did not hold the debriefing because, for emotional reasons, his firefighters did not want to open up to the experience again:

> I was a little concerned bringing it forward and there didn't – typically, the guys have absolutely no issue doing these … [after-action reports], but in this particular case, there seemed to be very little interest in doing it and I think that the fire fighters didn't want to open up to the experience again.
>
> *Q.* For emotional reasons?
>
> *A.* Yes.[131]

Suggestions for improvement from the Elliot Lake Fire Department

Chief Officer was asked during testimony whether he saw areas for improvement. His initial answer was that he could not think of any because everyone at the scene was working toward the same goal, without friction:

> [T]here was no bickering, there was no fighting on the scene. Everybody that showed up on that scene tried to drive the event to move it forward … in the direction that we needed to go, and that is the rescue."[132]

Chief Officer did, however, suggest that communications with the media, community, and families could have been improved. With hindsight, he said, he would have "been much more forceful" in getting in front of a camera to convey that there was one casualty, but another individual they hoped to recover. He felt that more openness about these issues would have helped. He could relate to the families' and the community's feelings of helplessness, having at times felt helpless during the operation.[133]

Chief Officer also suggested that UCRT's role was perhaps not acknowledged to the extent it should have been. He actually took the time shortly after the event to issue a press release that, among other things, thanked the UCRT team for its efforts. He felt they were a little "overshadowed" and wished to thank the members for their work.[134]

Chief Officer also felt that some of his firefighters deserved recognition for their bravery. Since the Algo Mall response, he has taken the time to nominate nine firefighters who spent the majority of their time on the pile at the start of the emergency response for the Ontario Medal for Firefighter Bravery Award, given by the Ontario Honours and Awards Secretariat. That application is on hold until this Inquiry is completed.[135]

Chief Officer also saw room for improvement in the area of note-taking. He intended to make a recommendation to the Ontario Association of Fire Chiefs that more training be provided for scribes. Following the deployment he noticed that, on occasion, what was written down by his scribe was not 100 percent accurate. He saw a tendency

to write down what the scribe thought was happening. He also wished there could have been more information in the notes.[136] As well, he felt that he should have allocated a scribe to the officers who covered for him as incident commanders when he was not on the scene.[137]

When Capt. John Thomas of the Elliot Lake Fire Department testified, he told the Commission that he saw many positives but also saw room for improvement in the areas of communication with the public and media relations. In terms of positives, he felt the Elliot Lake Fire Department's relationship with HUSAR/TF3 was excellent. He did not personally experience any communication problems or personality conflicts. The relationship with UCRT was equally good. UCRT did not attempt to usurp the Fire Department's incident command, sought input, and behaved in a professional manner. He did not see friction between UCRT and HUSAR/TF3, nor did he see bad judgment calls or bad advice from either entity.[138]

Capt. Thomas, like Chief Officer, did feel, however, that communications with the public were not handled well. The media did not provide accurate information. Citizens should have been given updates, including the fact that the rescuers were inside the building on the rubble pile. He was particularly troubled by the misconception that existed during the rescue about the number of potential victims being as high as 31. He described those figures as "out of whack." He himself, from the beginning, never thought the number was more than three or four bodies in the collapse zone.[139]

The Office of the Fire Marshal creates an after-action report with suggestions for substantial change to Ontario's search and rescue model

Officials from the Office of the Fire Marshal (OFM) who were present at the Elliot Lake scene held a final meeting before leaving. It was a brief and informal discussion, short of a proper debriefing session, and amounted to a non-systematic canvassing of views about what went right and wrong. No formal debriefing session was ever held. One was scheduled, cancelled, and never rescheduled.[140]

The OFM nevertheless produced an after-action report dated November 14, 2012.[141] The report made substantial suggestions for improvement related to quicker response throughout Ontario for structural collapses, clarification of roles and responsibilities in relation to HUSAR/TF3, mandatory imposition of the Incident Management System (IMS) throughout Ontario, and improvements to leadership capabilities during large-scale emergency response situations.

In terms of improving response times in Ontario, the OFM after-action report noted that HUSAR/TF3 was originally created in response to potential terrorist attacks in chiefly urban settings. Since its inception, however, the team has been deployed exclusively for domestic, non-terrorist emergencies in smaller centres such as Elliot Lake, Woodstock, Goderich, and Windsor and in areas quite a distance from Toronto. The OFM therefore suggests the creation of light and medium urban search and rescue teams spread throughout the province for "early reconnaissance and on-ground expertise in advance of the arrival of advanced USAR capabilities." The following passages capture the OFM's suggestions:

> [T]he USAR response model in Ontario should be re-evaluated to effectively and efficiently serve the entire province.
>
> Consideration should be given to establishing a first-response USAR capability at the "light" and "medium" levels amongst fire services across Ontario. This would provide for early reconnaissance and on-ground expertise in advance of the arrival of advanced USAR capabilities. This could be accomplished

> through similar arrangements as exist for the six Level 2 teams that support the Level 3 CBRNE / Hazmat teams across the province.
>
> Given the withdrawal of federal funding for HUSAR teams (Toronto), it may be timely to re-examine Ontario's response needs for structural collapse expertise and resources. Consideration should be given to geographic distances (i.e. response times), the ability to provide lighter, faster teams for early assessment and stabilization of collapse scenes on a geographically distributed basis. Historically, particularly since 9/11, focus has been on urban centres (i.e. Toronto) with infrastructure that is potentially a target of terrorist activity. We now know through experiences such as: Elliot Lake, Woodstock, Goderich, and Windsor that the same capabilities are critical as applied to unintentional/ accidental collapses. OPP UCRT has light-medium USAR capabilities, but from one location in southern Ontario. Reconfiguration of fire service-based capabilities and redistribution of funding to establish, for example, three medium teams (MUSAR) equipped and trained to this recognized level of response, would allow for a complement to OPP UCRT as well as faster reach within the province.[142]

The OFM after-action report also saw room for improvement in the areas of HUSAR/TF3 training and clarification of roles and responsibilities. The current HUSAR/TF3 memorandum of understanding places the responsibility for training on the OFM and Emergency Management Ontario (EMO) in one instance, but on the OFM and the City of Toronto in another. This situation is then complicated by the fact that, in the field, the Provincial Emergency Operations Centre (PEOC, a non-participant in training) coordinates the activities of HUSAR/TF3 and other agencies. The report also notes that the MOU does not address whether HUSAR/TF3 should be coordinated by the OFM or EMO, while the City of Toronto has historically taken the position that the team is coordinated by neither of these entities but, instead, by the HUSAR/TF3 team leader. The OFM suggests that this practice is inconsistent with current IMS protocol, which dictates that the local jurisdiction retains command and control. Given this confusion about training and coordination, the OFM suggests that the MOU and the HUSAR operating manual be revised to "clearly distinguish the respective roles and responsibilities of the OFM, EMO and the City of Toronto HUSAR Team in relation to complex emergencies" and the streamlining of the governance model for the HUSAR / CBRNE teams.[143]

The OFM after-action report also noted that, pursuant to section 9.2(a) of the *Fire Protection and Prevention Act, 1997*, it is the fire marshal's duty to investigate "the cause, origin and circumstances of any fire or of any explosion." The OFM suggests that, as this investigation often involves working closely with demolition experts and dealing with failed structural elements, consideration should be given to having the OFM be the lead response for all building collapses and that the OFM response model be augmented as follows:

> The response model (team) be augmented by other OFM staff with emergency response command experience, a communications expert (from within OFM or ministry), and a representative from EMO to facilitate communication between emergency responders during response / recovery phases and the EOC (consequence management) and within government via the PEOC.[144]

The OFM report also made recommendations relating to IMS and leadership assistance during major incidents. These include the following:

- Mandatory adoption of the Incident Management System for all provincial agencies, including municipal emergency response agencies and other agencies with the potential for involvement in a major emergency: "All agencies should be able to demonstrate adoption of IMS through the attainment of training specified by the province" (i.e., provide training records).
- Development of criteria to determine the circumstances under which senior government officials attend an emergency operations scene and the impact of their presence on the broader IMS hierarchy (i.e., clearly define the role of those officials within that hierarchy).

- Development of a team (or teams) of experienced fire service command officers from within the mutual aid systems to support local jurisdictions during prolonged incidents and to provide direct guidance and support when the expertise of the local jurisdiction is limited. (The OFM proposed a model resembling the one used by police services in similar circumstances.)[145]

With respect to the IMS, the OFM noted that incident command was used by Chief Officer during the Elliot Lake deployment, but that not all parties fully adhered to the system. No one particular agency existed to ensure the system was successfully implemented. In the absence of a designated lead, the HUSAR/TF3 team leader took on a number of roles "including that of overall incident commander, and communications spokesperson." As proof, the OFM pointed to the "fact that the Premier and the Commissioner of Community Safety communicated directly with the HUSAR team leader." If the Incident Management System had been used properly, the HUSAR/TF3 lead (Staff Insp. Neadles) would have been a "sector chief reporting to the Incident Commander who would have been the fire chief for emergency response purposes." The fire chief would then have been responsible for communicating with the Provincial Emergency Operations Centre. This incomplete implementation of the IMS was viewed in the after-action report as having "detracted from effective coordination, communications, and decision making between emergency responders, the EOC, and provincial agencies."[146]

This incomplete implementation of IMS was viewed in the after-action report as having "detracted from effective coordination, communications, and decision making between emergency responders, the EOC, and provincial agencies."

The report also noted that, while the deployment of the commissioner for community safety (Dan Hefkey) to the scene was generally positive, his presence created even more confusion about roles and responsibilities of the City of Elliot Lake and the provincial government.[147]

The OFM reiterated the importance of adopting an IMS throughout the province:

> It is important to note that the current IMS doctrine has not been formally adopted by all agencies and responders in Ontario. Participation is voluntary and not required by legislation; therefore its overall effectiveness in a multi-jurisdictional response is limited.[148]

Suggestions for improving victim services

Algoma Victim Services

Algoma Victim Services held a debriefing for staff and volunteers on July 18, 2012.[149] Robin Kerr, the executive director of Victim Services of Algoma, explained, though, that this event was a "critical incident stress debriefing." A counsellor and two other individuals were brought in. It was not an operational debriefing, but an "emotional debriefing so that we can move on, hopefully, from the four days that we were here at the Collins Hall." No operational debriefing ever occurred.[150]

During testimony, Ms. Kerr made some suggestions for improvement in the area of victim services. She suggested first that the families of victims need to be kept separate from the general public and be provided with the assistance of more dedicated individuals. Her staff changed constantly. The families of the victims in Elliot Lake did not have a constant, dedicated presence and the necessary privacy.[151] While there was a place at the Collins Hall to speak to the families in private, it was not very big. It could fit only two or three people at a

time. For the most part, the families occupied the same space as the general public, which did not play out well, especially when the announcement was made that the rescue would be stopped. Ms. Kerr described the chaos at that point in time:

> Again, the anger, the disbelief, the shock. So by having the general public and the families all in one room, they fed off of each other. So if the general public became distraught, which might have been – the families maybe could have dealt with the information differently had they been given that opportunity to do it privately, but here was horrible news being given to them in front of the public. They weren't given that opportunity to digest this information privately and to work with the police or whomever there.
>
> So the anger that maybe came from the community fuelled through everybody, and the whole hall became angry and distraught, and it really was chaos. We were doing our best to put out as many fires, for lack of a better term, that we could to hold people together.[152]

Ms. Kerr also suggested that it would have been beneficial to have the involvement of OPP victim liaison officers at an earlier point in time.[153] When the OPP made the decision to send victim liaison officers to assist the families on June 26, things improved substantially for the families. They no longer needed to be at the Collins Hall, and Ms. Kerr understood that, by all accounts, these officers took good care of the families.[154]

Ms. Kerr also agreed that emergency response plans should contain provisions relating specifically to caring for family members of victims or possible victims.[155]

Finally, Ms. Kerr saw room for improvement in creating a plan for the set-up of the Collins Hall. She felt it took time to get the hall properly organized and to bring in food and similar items. Although the City did provide food and a staff member, Ms. Kerr said it was, in fact, the community as a whole that came together to organize the hall.[156]

The families see room for improvement

"We should have had updates on an hourly basis, not every eight, ten hours or at least tell us the truth, you know what I mean? If you don't think it's going well, tell us, and if it's going well, tell us."
– Darrin Latulippe

Darrin Latulippe, Doloris Perizzolo's son-in-law, felt that he and his wife, Teresa, were treated well in some respects during the rescue efforts but not in other respects. He was happy that they were provided somewhere to go during the rescue (presumably a reference to the Collins Hall). This arrangement allowed, for example, for a bond to be created between the two families.[157]

Mr. Latulippe was critical of the Red Cross and Algoma Victim Services. He felt those organizations should have provided more support at the critical point in time when Staff Insp. Needles announced that the rescue would be called off. Mr. Latulippe's impression was that these agencies, at this critical time, were on their Blackberries, as opposed to stepping up to provide victim services.[158]

He felt, as well, that the families should have received hourly updates, as opposed to every eight to 10 hours. He candidly stated that the families wanted the truth on the progress of the rescue:

> We should have had updates on an hourly basis, not every eight, ten hours or at least tell us the truth, you know what I mean? If you don't think it's going well, tell us, and if it's going well, tell us.
>
> Don't just say yeah, we're making progress, we're doing this, we're doing that. That's not what we want to hear. We want concrete answers, are you going to get them? What are you doing? How close are you? … That's what we wanted to know and nobody would tell us. We got most of our information off the radio.[159]

Réjean Aylwin, the father of Lucie Aylwin, was also critical of the way updates were provided on the state of the rescue. His view was that information was provided to the media before the families received it.[160]

Mr. Latulippe was also critical of the way in which the bad news about the rescue being stopped was communicated to the two families. This communication was done by Staff Insp. Neadles, Insp. Jollymore, and Mayor Hamilton and, therefore, was less within the control of Victim Services. Mr. Latulippe nevertheless felt this aspect was not handled well. His wife was told the news when sitting by herself in a public space. The family was not given a chance to get together. He was particularly critical of the fact that the news of the rescue stoppage was communicated in a public place. It should have been done in a private space, with all the family present. Providing the news in public at the Collins Hall was "like telling somebody that your family died in a car accident while you are sitting at a hockey game."[161]

Gary Gendron, Lucie Aylwin's fiancé, thought that, as a family member of a victim, he was lucky that institutions such as Canadian Tire and No Frills provided air mattresses, sleeping bags, water, and fruit. He spoke of some small bit of help from police officers and counsellors, including the Red Cross, but thought there should have been more involvement from the City: "It was pretty much just friends, family and the community that held us up." He testified that the Member of Parliament and Member of the Legislative Assembly were of assistance, but not the City councillors.[162]

Like Mr. Latulippe, Mr. Gendron also felt the families needed more regular updates, provided first to the families:

> No, they were telling us they'd give us an update every two to four hours. That wasn't true. We would get – sometimes it would take six hours before we'd get information, and then they would go to the media before they'd come to the family. That's wrong … I think the families should know more information before the media should know the information.[163]

Mr. Gendron even went so far as to suggest that the families should have had radio/CB access to allow them to follow what was going on inside the building, at least to some extent. He also felt the families of the two victims, once identified, should have been restricted to a different area from the public, as became the case on Monday and Tuesday when they were sent to a separate location. Before that, the victims' families were located with the rest of the public at the Collins Hall.[164]

"We would get – sometimes it would take six hours before we'd get information, and then they would go to the media before they'd come to the family. That's wrong … I think the families should know more information before the media should know the information."
– Gary Gendron

The point of view of these family members stands to be contrasted with Insp. Jollymore's impression of how the victims' families were treated. He felt the OPP did a good job in keeping the families of the victims informed of what was going on during the rescue. He told the Commission he made sure that his counterpart on the nightshift went to the Collins Hall every two hours to provide an update and reassure the families that they were being given updated information "as best we knew it." He said he also arranged for the Critical Trauma Support Team to assist even though this role was usually beyond their scope of duties. Eventually, a "public liaison team" was assigned directly to the families (presumably a reference to the OPP's victim liaison officers): "It really helped once we identified the two families because it allowed us to narrow our focus and supply resources directly to them."[165] He gave the following summary of his involvement in assisting the families:

> So about 35 times – there is 35 issues where I either went to the families, or I was looking after the families or making notations about how the families were being looked after between Saturday … when the mall collapsed and Monday evening.[166]

The Millennium crane's owner and operator provides suggestions for improvement and criticizes perceived limits in HUSAR/TF3's skill set

Dave Selvers, the owner of Millennium Crane as well as the crane's operator, created a report about his involvement with the Elliot Lake deployment, despite being a civilian actor at the scene. Mr. Selvers was critical at times of different individuals and agencies, and he made suggestions for improvements in the future.[167] He was also critical of many aspects of the rescue operation. The observations, criticisms, and suggestions for improvement that he made related to a wide range of topics – including, but not limited to, crane operations.* He focused to a large degree on what he perceived as gaps in the HUSAR/TF3 skill set, particularly in the areas of rigging and steel shoring.

First, Mr. Selvers said that he received incorrect information when initially informed about the operating radius (distance from the exterior of the Mall to the collapse site). If he had had the correct information, he would have contacted the 165-tonne crane operator sooner, because the individual had a long distance to travel to the site.[168] He suggested that, in the future, it would be useful to have a picture or video in order to better understand the layout of the site.[169]

Mr. Selvers was also critical of the time it took to request the services of Millennium Crane. He noted that the first call he received was at 11:15 p.m. on June 23, almost nine hours after the collapse.[170] In testimony, Mr. Selvers explained that, if he had been called around the time of the collapse, he might have made it to the site from Sault Ste. Marie by 9 or 10 p.m. that evening (he arrived in Elliot Lake at 11:15 the next morning). He could then have been hoisting by midnight or 1 a.m. He would have been mobilizing in daylight hours, without the adverse weather that developed later that night.[171] He stressed the importance of having the right heavy equipment on site, including cranes and a suspended work platform, and quickly dispatching that equipment:

> It is imperative that heavy equipment manned with experienced operators be properly deployed in any state of emergency. Vital equipment includes Cranes of adequate capacity capable of hoisting debris as well as multiple personnel (suspended work platform). A suspended work platform will permit an aerial means of access into a hole or recessed / collapsed area. We want to minimize exposure to shredded and hanging debris so as to prevent un-necessary injury to rescue workers.
>
> Earth moving equipment i.e. Dozer(s), Excavator(s), Pay-loaders and Boom attached Shears are additionally crucial.
>
> Cranes and Earth Moving equipment are vital components in any rescue operation. And must be immediately dispatched.

Mr. Selvers directed some harsh criticism toward HUSAR/TF3 based on his impression that its presence was redundant. He felt that all that was required for this operation was the large crane, the OPP, and the ironworkers – or, as he put it: "O.P.P. in the hole, Iron Workers unhooking on the outside … ALL ELSE WAS REDUNDANT AND NON-PRODUCTIVE." He said the following about the Toronto HUSAR/TF3 team:

> With no intentions of malice or bias and with all due respect to H.U.S.A.R. personnel I do not see any purposeful function other than to amass a budget (political waste). They were of no use whatsoever in a situation such as this. The fact that they didn't even call for cranes is proof of their incapability. How did they think they were going to lift the debris off any survivors? How did they assume their approach into

* It should be noted that not all of Mr. Selvers's criticisms are included, only those that I perceived as worthy of mention and flowing from Mr. Selvers's particular expertise and experience.

> the hole without using a suspended aerial approach? This team did not have any idea as to the means required to perform this operation. Again this is a personal "seasoned" observation with no malicious intent toward anybody's ability or character.
>
> …
>
> The only productive effort was that of the Ontario Provincial Police and Millennium Crane crew. All else was redundant and ineffectual. There was no evidence that the H.U.S.A.R. team was capable or even suitable for this type of operation. Being questioned as to why we had brought a suspended work system was proof that there was no skilled people on site.
>
> …
>
> … [A]ll the individuals involved in the Heavy Urban Search and Rescue Team displayed limited efficiency. Was this the result of a poorly organized game plan? Was it due to poor communication? Was it because of a lack of leadership or an inattentive rescue team?[172]

Mr. Selvers was also critical of the command structure (or the lack thereof). He was unsure who was in charge at the scene. He noted, for example, that more than once and by different people, he was told to pack up and leave the scene:

> Protocol … who is in charge? Only the party/individual responsible for making call to contractors is authorized to release the same entities. Throughout this operation many different person's [*sic*] were giving orders resulting in poor communications (potential for further complications). The Ontario Provincial Police were exceptional in there [*sic*] communication and overall were competent in their work and given the fact that Millennium was working directly with the O.P.P. there was no confusion and efficient communication.
>
> …
>
> A major problem evident on this site was the fact that too many people were relaying too many different messages.
>
> In a situation such as this or in any disaster situation it is vitally important that ONE person be the Designated Planner. From this point, if required, there will be designated messengers assigned to relay information to each work group involved in the rescue operation. Each work group messenger will also be responsible for the gathering of information and status reports relayed back to Designated Planner … all of whom will maintain audio / visual contact with each other.[173]

In his testimony, Mr. Selvers reiterated his concerns about the command structure. He told the Commission that, during the operation, he went into the HUSAR/TF3 tent on a few occasions and noticed information being exchanged with no real solutions being offered. He saw a lot of people not doing anything and looking for direction. He did not see a designated planner on site. He became frustrated because he never knew "what directive was going to be fired at me next" and by the fact that everybody was "congregated and huddled" in the command tent. Nobody came to him for a progress report or to ask him about next steps.[174] Mr. Selvers agreed that a possible solution might be joint training between crane operations such as his and the UCRT and HUSAR/TF3 teams.[175]

During his testimony, Mr. Selvers was critical of the fact that HUSAR/TF3 used only wood shoring during its operations. He felt that his team was actually better equipped. Indeed, he explained that this fact was the impetus for the conclusion in his report that HUSAR/TF3 was of no use when he first arrived on scene:

> [I]t was beyond me as to why they were using wood to shore up concrete and steel when we had arrived with HSS beams, you know, a thick gauge angled material, cable lashing up to five-eighths and half-inch turf. We had everything we needed to shore up this structure, even to add to the structure, and nobody wanted to consider it.

> And when I saw people trying to approach the rubble from inside the building, and obviously they were trying to shore something up, but wood isn't going to do it. If the building were to torque in one way or another and twist, that wood is not going to hold up to it. You know, they were framing; they had wooden posts. And wood does have a good structural strength to it, but it doesn't have the tensile elasticity because of its brittleness that steel would.
>
> So it wasn't going to compensate for any torsional dynamic loading in the – in the structure itself. That would only be – you can only accommodate that with a steel structure or guide wires. That is where the lashing would have come into play.
>
> But when I saw that nobody wanted to use, implement professional ironworkers, I knew that I was working with people who weren't well versed in this industry.[176]

It was suggested to him that HUSAR/TF3 uses wood shoring because it provides an early warning sign if the structure is about to collapse – one can hear it cracking and bending.* He disagreed, saying the collapse would follow immediately on any cracking sound:

> [Y]ou would hear the crack, and it would come down. It would be immediate. Once you hear that crack, it would be immediate … There is no tensile elasticity with wood. It just snaps.[177]

Staff Insp. Neadles was referred to Mr. Selvers's comments. With respect to HUSAR/TF3's use of wood for shoring, he said HUSAR/TF3 never used steel shoring. He knew that engineer James Cranford and Capt. Comella discussed the use of steel shoring, but he thought it was merely a discussion. He seemed to think that HUSAR/TF3 lacked the ability to work with steel shoring, perhaps confirming Mr. Selvers's impressions at the scene:

> *Q.* Okay. So it [steel shoring] was an avenue being explored, or was it just being talked about for its own sake?
>
> *A.* As far as I know, it was just being talked about.
>
> *Q.* So it would be pretty much of a waste of time between the two of them?
>
> *A.* Well, … we would have to ask how they are going to do that, because *obviously we don't have any experience with steel. None of our rescue teams have experience with steel.*
>
> *Q.* Okay, so there would be nobody on the TF-3 team that would be trained to construct steel shores?
>
> *A.* Not to my knowledge, no. It is not in our training at all.[178] [Emphasis added.]

Staff Insp. Neadles also agreed with Mr. Selvers's comments about HUSAR/TF3's lack of expertise with rigging: "[I]t's something that we aren't expert in because that is not part of our NFPA [the US National Fire Protection Association] standard, so we have not undertaken a rigging ability."[179]

Staff Insp. Neadles was also asked about Mr. Selvers's comments on the lack of organization and leadership. He said that he did not even recognize Mr. Selvers as someone he saw in Elliot Lake. I find this response surprising and somewhat confirmatory of Mr. Selvers's evidence that HUSAR/TF3 command was not highly attuned to the rigging work that was undertaken. Staff Insp. Neadles did agree with Mr. Selvers's suggestion that it was vitally important that one person be designated as planner, and that such a person was missing from this deployment.[180]

* This suggestion was put forth as the justification for use of wood shoring by Capt. Comella during his testimony: Comella testimony, September 5, 2013, pp. 24114, 24238–9. At pp. 24238–9, Sgt. Comella states: "Steel is not a preferred material for a rescuer; it is for construction but we use wood as an early warning system. So if we had a choice we would rather build a more robust wooden structure that would give us early warning of movement and continued movement than we would to have a steel structure that would give us basically no warning and a catastrophic failure which is our understanding of a steel failure."

Otherwise, Staff Insp. Neadles took issue with many of Mr. Selvers's criticisms. While Mr. Selvers may have perceived that people on the ground were standing around, Staff Insp. Neadles told the Commission that HUSAR/TF3 members could just as well have been awaiting new orders. He felt that Mr. Selvers had no business going into the command tent and probably had no permission to venture into prohibited zones to do his own assessments. Not being an engineer, he was not really in a position to assess the stability of the structure. Staff Insp. Neadles also objected to Mr. Selvers's criticism of HUSAR/TF3 for not having ordered a crane – HUSAR/TF3 knew that the OPP had already done so.[181]

Ministry of Community Safety and Correctional Services

The Ministry of Community Safety and Correctional Services' After-Action Report

The Ministry of Community Safety and Correctional Services (MCSCS) produced its Elliot Lake Consolidated After-Action Report. The final version of this report is dated September 27, 2013, more than a year following the events in question and the calling of this Inquiry.[182] Mr. Hefkey, the commissioner for community safety, was asked why it took so long to produce the report. He explained that it was a consolidated report that required input from individual divisions. The ministry had also failed to produce the document in its draft form to the Commission despite a request to do so and provided no satisfactory explanation for the late disclosure of the contents of this report.[183]

The report indicates that an Oversight Committee was established to consolidate lessons learned from areas of the ministry involved with providing resources to support the municipal response to the Mall collapse. Five after-action reviews – from five areas of the ministry (the commissioner for community safety, the Corporate Communications Branch, Emergency Management Ontario, the OPP, and the Office of the Fire Marshal) – were used to create the consolidated report.*

The focus of the MCSCS after-action report was on the "opportunities for improvement in supporting a municipality's response to future incidents and is not intended to detract from the positive elements of the response to the Elliot Lake mall collapse." The positive aspects of the response, according to this consolidated report, included:

1. The timely authorization and mobilization of HUSAR and other rescue assistance sent to the collapse; and
2. Support by the OFM and EMO to community officials as they managed the incident and its effects.[184]

The ministry saw opportunities for improvement in three areas: roles and responsibilities, deployment and coordination of provincial resources, and public communications and internal information-sharing. The ministry stated that its intention in the consolidated report was to establish a multi-jurisdictional committee to act on the recommendations set out in it and to review and consider the findings and recommendations of this Commission.[185]

* Exhibit 9912, p. 002. The OFM and OPP reports have been summarized. Repetition of the points made in those reports will be avoided, if possible.

The summary of the after-action report that follows should be read with care because I am concerned that it may have been based on incomplete details about the rescue and recovery operation. For example, when he gave evidence, Mr. Hefkey, one of its authors, appeared not to know that there were delays related to the ordering of the Millennium crane, that the Millennium crane was actually able to lift the slabs that had fallen on Lucie Aylwin, and that the rescuers had come to within only two slabs of reaching her. I discuss Mr. Hefkey's perception of the facts below.

Perceived deficiencies and recommendations related to roles, responsibilities, and use of the Incident Management System

The report stated that during the deployment there was insufficient understanding of the roles and responsibilities of the provincial and municipal responders, and that the IMS was not being applied consistently. Despite this statement, the report asserted that deficiencies related to roles and responsibilities and the application of the IMS did not create any delay or hamper rescue efforts:

> To be clear, any deficiencies in clarity and coordination of roles and responsibilities or any failure to strictly adhere to policies and procedures did not result in a delay in response time or encumber the efforts of the rescuers to the mall collapse. Still, the following deficiencies may have caused some confusion among some responders during the response.*

After repeating some of the concerns raised by the Office of the Fire Marshal relating to HUSAR/TF3 activation and training and the role of the OFM in investigating structural collapse, the MCSCS after-action report saw specific deficiencies related to the Elliot Lake deployment in the following areas:

- "The effectiveness of IMS was not maximized because no single person was understood to be incident lead by all responders." This situation "may have detracted from effective coordination, communications, and decision-making."
- "The role of political representatives and/or senior bureaucrats arriving on the scene was not clearly understood and added to the complexity of the incident." It was seen as a positive action that the commissioner for community safety attended on scene, but his direct contact with HUSAR/TF3 late on June 25, 2012, created confusion among some responders as to roles and responsibilities.
- There was a public perception that the Ministry of Labour ordered the rescue stoppage, when in fact an MOL engineer was merely assisting in providing expert advice alongside the HUSAR/TF3 engineer.
- There was confusion about jurisdiction over the collapse site at the conclusion of the rescue operation. It was unclear if the MOL, the Office of the Chief Coroner, the local municipality, or the OPP had "predominance of purpose." Because of the uncertainty, "there was concern expressed by some responders that the site might be turned over to the owner to deal with removal of the deceased along with the demolition of the building."[186]

The consolidated after-action report therefore made the following recommendations:

- "Validate" the continued use and adoption of the IMS in Ontario emergency response and incident management and, following consultation, "determine opportunities to evolve and/or further the adoption and continued application of the IMS in Ontario." (This recommendation is unlike the Office of the Fire Marshal's recommendation for mandatory adoption of the IMS.)

* Exhibit 9912, p. 008. Again, it must be borne in mind that the MCSCS and the authors of the report appear to have had no knowledge of the delays in ordering the Millennium crane on the first day of the rescue and of the importance of that crane to the rescue efforts.

- Enhance Ontario's ability to support the municipal response to building and structural collapse events by developing a new building and structural collapse response model. (The report gave the example of deployment of urban search and rescue teams of different levels – echoing, it seems, the recommendations made by the OFM.)
- Create an "interoperable telecommunications capability" by seeking additional bandwidth for public safety purposes, presumably so that all responders can be on the same band-width during a response.
- Provide guidance to local first responders to ensure that an appropriate command structure is established at the initial stages of a response, and to ensure mutual understanding of the command structure when local first responders and provincial teams interact.
- Clarify definitions of terms such as "emergency response," "emergency management," "IMS," "unified command," "unity of command," and "incident command" to ensure these definitions are reflected in all plans.
- Review emergency response plans to clarify the province's role during an incident that is not a provincially declared emergency.
- Consider the creation of municipally, regionally, and/or provincially based incident support teams, staffed with personnel with experience in the management of complex incidents. Such teams would supplement local resources where an emergency overwhelms a local municipality's ability to respond to an incident.[187]

In terms of deployment and coordination of provincial resources, the report stressed the importance of ensuring that the right people and resources arrive at the scene in the most expeditious way possible. The report stated that the decision-making process to deploy HUSAR/TF3 and UCRT was "rapid and effective" and accomplished in a timely manner, considering the geographic distances involved. However, the ministry saw room for improvement in terms of coordination of command between the two teams and noted that a question had arisen about whether there should have been a separate commander for each of the HUSAR/TF3 and UCRT teams or whether there should have been a single commander for the two combined.[188]

The report therefore recommended ways of improving the working relationship between the two entities, including the creation of additional opportunities for joint training and interaction between UCRT and HUSAR/TF3. These initiatives would focus on the relationship between urban search and rescue and the incident management structure that would be in place when both teams deploy together.[189]

The report also noted that there was an absence of a single lead to coordinate all the liaison supports for the provincial entities on the ground. People had been deployed from the OPP, the OFM, Emergency Management Ontario, the MOL, the MCSCS Communications Branch, the Office of the Chief Coroner, and the Office of the Premier. The report suggested there was also a lack of understanding of the roles and responsibilities of these entities. It therefore recommended:

- early engagement of an EMO field officer with the municipal officials and deployment as necessary;*
- review of existing arrangements that assist in identifying provincially based personnel and equipment available for deployment; and
- engagement with the MOL to distinguish between the legislated role of MOL engineers and inspectors and the "possible provision of advice and assistance in support of deployed urban search and rescue resources at the scene of an incident."[190]

* Former Ontario premier Dalton McGuinty specifically raised the faster deployment of an EMO official to the scene as an area for potential improvement: McGuinty testimony, October 9, 2013, p. 28971.

Perceived deficiencies and recommendations related to public communications and internal information-sharing

The MCSCS report referred to internal and external shortcomings in provincial communications. The document suggested that the Elliot Lake incident revealed a need for a "coordinated municipal-provincial approach to public communications." This approach would allow the practitioners to focus on the response operation, while ensuring better communication with respect to the emotional climate, the political situation, and the rationale for decisions.[191]

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The report noted that communications worked well in Elliot Lake once it was decided to have a provincial spokesperson on site to provide media outreach, but this practice did not begin until June 26. Before that, several problems were noted, including:

- the absence early in the incident of a single person to coordinate media relations on the province's behalf;
- limited communications support for local officials and responders. For example, the HUSAR/TF3 lead participated in multiple media requests and town hall sessions at a time when significant operational demands also existed;
- early media reports based on inaccurate information because journalists and the public were not receiving timely and accurate information;
- a lack of coordination among provincial communications staff from MCSCS, Cabinet Office, and the Office of the Premier;
- fluctuating numbers of persons reported missing "leading to public speculation and increased anxiety, which should be noted is a reoccurring problem in these types of situations"; and
- a lack of a robust and effective strategy to handle social media and mitigate public speculation and concerns.[192]

In terms of areas for improvement, suggestions in the report included:

- immediate establishment of a coordinated approach to internal and external communications;
- review and revision by the MCSCS's Communications Branch of its provincial communications strategy to take into account both municipal and provincial protocols and interests;
- immediate identification of a provincial communications lead and protocol for critical incidents;
- increased capacity to provide communications via social media; and
- revision of the HUSAR/TF3 memorandum of understanding with the City of Toronto to clarify communications roles when HUSAR/TF3 is deployed.[193]

Commissioner for community safety's commentary on the MCSCS after-action report and areas for improvement

Mr. Hefkey was questioned on both the consolidated after-action report and his opinion on areas for potential improvement in emergency response flowing from the Elliot Lake deployment.

Mr. Hefkey acknowledges that the MCSCS report did not question HUSAR/TF3 deployment speed

Mr. Hefkey was questioned about the fact that the after-action report produced by his ministry did not take issue with the speed of HUSAR/TF3's deployment. The team did not leave Toronto until 9:35 p.m., seven-and-a-quarter hours after the collapse and about six hours after the formal request. When pressed on whether this was the best that could be done, Mr. Hefkey said: "You always strive to do better." However, he pointed to the HUSAR/TF3 MOU, which called for the team to be up and running in a six-hour window, implicitly suggesting that the HUSAR/TF3 deployment speed was acceptable.[194]

Interestingly, Mr. Hefkey suggested that a source of delay for HUSAR/TF3 may have been the fact that members were either off-duty or needed to first find replacements before they could deploy. Although he agreed lives were at stake and there was a need for rapid deployment, he said there was an understanding with the City of Toronto with respect to the need to find replacements and to ensure that, before HUSAR/TF3 helps outside Toronto, Toronto itself is not left vulnerable:

> [T]he understanding that we have with the City of Toronto is that those resources, those specialized resources, … could be sitting in the Fire Hall, but that that person could potentially be a member of that particular team that will go to a fire, and they go as a team to those fires. And so what you don't want to do is create risk and create a vulnerability within your own municipality in order to go to another municipality to address the emergency that is there.
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> …
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> Again, the understanding that we have with the City of Toronto is that they are committed and have invested significant resources and time and money to creating this Heavy Urban Search and Rescue team, and that that team, in order for that team now to deploy outside of its jurisdiction, the City itself is saying, "We don't want to create a vulnerability to our community as a result of saying, 'Yeah. We'll help with the provincial capability.'"[195]

It seems clear to me that an important factor in defining a deployment time frame of six hours is a considered accommodation to Toronto's concern about its potential vulnerability, in preference to the need to prioritize a distant immediate emergency. The actual time required to assemble equipment and personnel is not the principal criterion. It was pointed out to Mr. Hefkey that the evidence indicated that getting the kit together took only about an hour, and he was again pressed on why it was acceptable for HUSAR/TF3's departure to be delayed to accommodate the hypothetical needs of the City of Toronto. He seemed reluctant to agree that Toronto's needs took precedence, to a degree, over the provincial need for HUSAR/TF3 deployment and said the provincial government is currently looking at whether the province's urban search and rescue capabilities need to be structured differently in order to allow for more rapid deployment to areas outside Toronto.[196]

Although his answer on this point was not entirely clear, Mr. Hefkey appears to have given direction to the Office of the Fire Marshal and Emergency Management Ontario to study whether the province needs more medium-sized urban search and rescue teams, as opposed to – or in addition to – the heavy team.[197]

Mr. Hefkey's testimony shows he did not know what the Millennium crane was used for and that delays in ordering it affected the rescue

Mr. Hefkey was taken through the evidence about ordering the crane, including Cst. Cox's evidence that Insp. Jollymore waited to order the crane until 11:15 p.m. on the Saturday, despite the need having been recognized at 5:30 p.m. The crane, in turn, did not arrive until 11:15 a.m. the next day. His attention was also drawn to Mr. Selvers's evidence that, if the crane had been ordered immediately, hoisting might have begun as early as midnight. Mr. Hefkey was clearly unaware of the delays associated with ordering the crane.[198]

Just as important, it became evident during testimony that Mr. Hefkey, and therefore presumably all those involved in creating the MCSCS after-action report, seemed to think the Millennium crane was not able to lift the slabs that had fallen on Ms. Aylwin. He was not aware that the crane had been moving slabs and that there were only two left to move before reaching Ms. Aylwin:

> *Q.* Would you not agree, sir, that if the crane had been called earlier such that Mr. Selvers' crew had been able to be there, if you accept his evidence, up and hoisting by midnight on the 23rd, that that could have made a difference?
>
> *A.* So I go back to, again, I was not part of the detailed operations and the implementation of the tactics. But if the question is would that crane have assisted, well, again, it was there on the Sunday, and it was used. Again, when they looked at it, my understanding – and I stand to be corrected, but my understanding was that its capacity, it couldn't – given its limitations, it wasn't able to move the slabs …
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> …
>
> *A.* Again, I go back to at that point in time, I'm sure that the individuals who were, again, looking after this operation didn't know it was just two slabs, and they –
>
> *Q.* The evidence, again, is that they thought it was only two slabs, so that there is a note when they pulled out that Sergeant Gillespie thought it was only two slabs, and there is a note in his book when they went back on the 27th, it was only two slabs.[199]

Mr. Hefkey also seemed confused about which crane was removing slabs, suggesting that the Priestly crane tried and could not move them. Commission counsel needed to correct his understanding and explain that the Millennium crane was removing slabs and actually had greater reach than the Priestly crane when it came to doing that type of work.[200] He eventually agreed that, in writing the report, he understood that the Millennium crane couldn't actually move slabs from the rubble pile: "It was my – yes … that is my belief."[201]

Despite contradicting this evidence, Mr. Hefkey was still reluctant to agree that, if the crane had arrived earlier, it might have made a difference in recovering Ms. Aylwin. The following passage demonstrates clear confusion about the facts and an evident reluctance on the part of the ministry to accept the possibility that mistakes were made. When pressed on the fact that ordering the crane faster might have made a difference, Mr. Hefkey first, and wrongly, suggested that it did not because shoring needed to happen before the crane could be used. He then followed up with the suggestion that the crane did not matter because Ms. Aylwin died instantaneously:

> *Q.* When you wrote this report, it was your belief that the Millennium Crane was unable to lift slabs of concrete from the rubble pile?
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> *A.* Yes.
>
> *Q.* Okay. Recognizing, if you could accept for a moment that that's incorrect – and we could play a video for you if you want to see it – that the Millennium Crane was, in fact, able to lift the slabs off and that when they did uncover Ms. Aylwin's body, they only had to lift two more slabs, do you agree with me that if the crane had got there earlier and had been able to commence earlier, that that might have made a difference to Ms. Aylwin?
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> *A.* No.
>
> *Q.* Why not?
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> *A.* Because I go back to the fact that they were – in fact, the rescuers when they were arriving there were actually working the pile, as was described before about there was shoring that was being done. There were activities that were being done. So as they were doing it, then the crane came at that point, and then it was able to effect what it was able to do.

> *Q.* Well, sir, is what you are telling me based on what you think happened? Because the evidence that we have heard at this Commission is, as the Commissioner said, the crane was working, removing the slabs at the same time as the shoring was going on, and the UCRT crew was there in the evening of the 23rd and worked through the night of the 23rd and into the morning of the 24th, and throughout that time, they were both shoring and doing other things.
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> The crane didn't arrive until 11 o'clock in the morning on the 24th and couldn't get up and running for a few hours after that.
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> But if the crane had been there and up and working, able to do work by midnight on the 23rd, is it your evidence that you believe that that would not have made a difference to Ms. Aylwin?
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> *A.* Because then we find out that Ms. Aylwin perished minutes after.
>
> *Q.* Well, sir, with respect, that is a question that the Commissioner is going to have to decide …[202]

It was far from clear whose opinion Mr. Hefkey relied on to reach his conclusions. He mentioned having spoken to Chief Supt. Bruce from the OPP and the fire marshal, both individuals who were not actually on scene. In the end, he agreed that the Commission, after having heard the evidence first hand, was in a much better position to understand what actually occurred.[203]

Overall, I am left with serious concerns about the accuracy and reliability of the ministry's after-action report. It is based on misconceptions and errors about events during the operation. It starkly illustrates the consequences of failing to conduct proper debriefings and the importance of accurate record-keeping. It is difficult to resist the suspicion that its conclusions are, to some degree, motivated more by a desire to deflect criticism than to discover and acknowledge plain facts.

Despite confusion about the command structure in Elliot Lake, Mr. Hefkey feels the IMS appropriately placed the burden on the local municipality to establish the command structure

Mr. Hefkey agreed that there was significant confusion during the Elliot Lake deployment over who was exercising the incident commander role and about the command structure generally.[204] It was pointed out to him that, even among the experts (UCRT and HUSAR/TF3), there was a lack of clarity about who played what role, whether there was a unified command structure or a single command, and what these concepts meant.[205]

In contrast with witnesses from the OPP and HUSAR/TF3, Mr. Hefkey felt the single command model should have been used in Elliot Lake because it was a "single site" and a "unidirectional or unidimensional" mission. His view of the appropriate command structure in Elliot Lake was as follows. Chief Officer was the incident commander. Staff Insp. Neadles was the chief of operations and reported to Chief Officer. Someone should have occupied the positions of planning chief, logistics chief, and finance and administration officer (perhaps the same person for all three positions), and those individuals (or that person) would have reported directly to Chief Officer instead of through Staff Insp. Neadles. If someone holding one of those positions needed a rest, a designated replacement should have been chosen. In addition, Mr. Hefkey agreed that it should have been clear to everybody involved who was occupying what position.[206]

Despite clear evidence that the rescue effort overwhelmed Elliot Lake's capacity, Mr. Hefkey told the Commission it was still his expectation that the local municipality, big or small, understands how to set up a proper command structure, no matter how complex and difficult the operation.[207]

Mr. Hefkey's answers reveal a potential shortcoming of the IMS when smaller municipalities find themselves faced with large-scale incidents and large rescue operations, as evidenced by the following exchange:

> *Q.* It is clear from the evidence, and it seems reasonable, that Chief Officer said this is beyond this town's capacity. We need to call in – I think in his evidence he said call in the experts. He called in the experts. Is it the expectation of the IMS team, the drafters, that Chief Officer would then decide who the Logistics Chief was, who the Planning Chief was, who the Operations Chief was, and they would all report to him?
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> *A.* That is correct.
>
> *Q.* Did anybody ever tell Chief Officer that?
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> *A.* That I don't know.
>
> *Q.* Certainly – and we'll look at the evidence, but certainly there seems to be no suggestion anywhere in the evidence that any of the members of TF-3 or UCRT told Chief Officer that he was supposed to put this team in place.
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> *A.* That is correct.[208]

Mr. Hefkey continued on, saying there was a need to ensure that "every time we bring a provincial resource to bear on a municipal emergency, there is that clarity." He told the Commission that it should be possible for a local official such as Chief Officer to know who would be a good logistics chief, ops chief, planning chief, and finance chief by having "conversations … before an incident." He felt that the people holding these positions did not need to be subject matter experts, but merely needed to communicate with the subject matter experts. Citing the "extensive Mutual Aid structure," he said the expectation was not that the municipality have all the resources necessary, but that it "reach out to their communities … prior to the event," by which he meant reaching out to neighbouring towns.[209] Mr. Hefkey's insistence on the need for clarity is commendable and that goal is desirable. However, it will simply be clarity for clarity's sake if it is not accompanied by knowledge and expertise.

The very nature of catastrophic events is that they are unpredictable both in terms of time and scale. The immediacy and scale of an emergency such as the one in Elliot Lake will inevitably nearly overwhelm a small municipality's capabilities. When provincial resources are deployed, an expectation that a local fire chief or police chief, in the heat and confusion of a developing crisis, will in very short order designate the persons who are to occupy important IMS functions appears impractical to me. These are difficult decisions that should be left to trained experts. Surely the commander of a team such as HUSAR/TF3 or UCRT will have the expert knowledge and experience to at least suggest the identity of the holders of those responsible positions. Advance conversations in a mutual aid context may identify available common resources but cannot realistically be of much assistance in determining IMS roles. If the local responsible person is to remain the titular holder of the position of incident commander, what the IMS lacks, in my opinion, is the rapid deployment of expert advisory staff, seconded to command headquarters, to provide advice and to assist in the liaison with expert deployed resources.

Mr. Hefkey appears to misunderstand the appropriate command structure for UCRT/TF3 joint deployments

As noted above, Mr. Hefkey explained the IMS expectation that the local municipality create the command structure for all emergency response operations, no matter how complicated. Ironically, Mr. Hefkey himself was not able to say what the appropriate command structure would be during a joint UCRT/TF3 deployment.

Mr. Hefkey was referred to Staff Insp. Neadles's statement that UCRT fell under HUSAR/TF3 direction during joint operations. He was asked if this assumption was correct. Mr. Hefkey provided a rather convoluted answer, essentially saying his expectation was that different groups within operations, such as UCRT and HUSAR/TF3,

would interact frequently and have discussions about tactics. He did not agree that command automatically fell to HUSAR/TF3. He expected that HUSAR/TF3 and UCRT would have a "conversation" about the operations chief issue and, hopefully through additional training, the respective roles could be hammered out at some point during the deployment:

> So here is my expectation. When these two teams deploy, my expectation is that they would have a conversation with each other and decide how are we going to wrestle this issue of Ops Chief, how are we going to wrestle that. And what we are hoping, and as you see one of our lessons learned is let's have more conversations, either through training, through exercises, or just through the interface between those two teams so they can have those conversations before the actual event.[210]

Mr. Hefkey agreed there was no protocol, written or unwritten, between UCRT and HUSAR/TF3 as to their command relationship during a joint deployment. He felt the only thing that mattered was that there be one person in the operations chief position. According to Mr. Hefkey, UCRT and HUSAR/TF3 should have had a conversation during the Elliot Lake deployment and come to an agreement on who held the operations chief position. HUSAR/TF3 erred in simply dictating the command structure to the OPP UCRT team.[211]

As Mr. Hefkey struggled with his explanation of the dynamics of the relationship between HUSAR/TF3 and UCRT and their determination of a command structure during a joint deployment, he appeared to have overlooked the very point he had previously attempted to make: Those decisions belong to the local incident commander.

Mr. Hefkey comments on additional errors in the application of IMS during the Elliot Lake deployment

During his testimony, Mr. Hefkey referred to what he felt were additional terminological and practical errors in the application of the IMS during the Elliot Lake deployment.

As a first example, Mr. Hefkey felt that Cmdr. McCallion should not have referred to himself as the site commander. The term does not show up in IMS doctrine. It is a term that applies when there are many sites within the same municipality. In addition, it would be wrong to refer to Sgt. Gillespie as the operations section chief for his particular team – although he did maintain control over his unit.[212]

Mr. Hefkey also agreed that, because Chief Officer was the incident commander, he made the final decisions on the game plan for the rescue. Thus, when Staff Insp. Neadles made the decision to put in shoring at 6:15 a.m. on June 24, without telling Chief Officer, this decision was a mistake. So, also, was Staff Insp. Neadles's decision to stop the rescue mid-afternoon on June 25 without sharing the decision with Chief Officer until he later announced it at the Community Control Group meeting. Pursuant to IMS structure, Staff Insp. Neadles, as operations chief, should have spoken to Chief Officer, as incident commander, and obtained his prior concurrence.[213]

Mr. Hefkey was also referred to the evidence of HUSAR/TF3's engineer, Mr. Cranford (who thought Capt. Comella, Staff Insp. Neadles, and Cmdr. McCallion shared command but did not know their actual roles); and to that of the MOL engineer, Roger Jeffreys (who said he did not know who was in charge). Mr. Hefkey agreed there should have been a briefing before the rescue efforts began in which all of this information was set out. Because the decision to stop the rescue was based exclusively on engineering advice, Mr. Hefkey agreed it was all the more important that these individuals understood the command structure. He did not feel it was always necessary, though, for the engineers to give their advice directly to the operations chief and the incident commander. This approach might make sense if the information was complex and the individual conversing with the engineers, in this case Capt. Comella, was uncomfortable relaying it alone. He agreed there might be a "broken telephone" problem with too many intermediaries and that it was usually best to get information from the source. In terms

of best practices, the decision about whether to speak directly to the engineers was the incident commander's call to make.[214]

Mr. Hefkey was referred to Staff Insp. Neadles's evidence that there was no single planning chief – that the role was divided among himself, Cmdr. McCallion, and Capt. Comella. He said that, in order to avoid confusion, ideally there would be a single person in that position, and he agreed this situation was a serious deficiency during the Elliot Lake deployment.[215]

Mr. Hefkey also agreed that it was a mistake not to have created an incident action plan. One was supposed to have been created and updated for each operational period (or shift) in order to constantly re-evaluate the rescue efforts. The plan did not need to be elaborate, but would have been important because it allowed people to know what was expected of them and for an eventual analysis of the success of the mission.[216]

Another mistake, Mr. Hefkey said, was the absence of an initial command meeting, a step described by the IMS doctrine as "essential to provide key officials with an opportunity to discuss and concur on important issues." Even if brief, the meeting would be at a point in time when one should "document all important decisions and directions." The IMS doctrine describes the initial command meeting as an opportunity, *inter alia*, to discuss and agree on issues such as roles and responsibilities, jurisdictional boundaries, overall incident management organization, and senior appointments. Mr. Hefkey agreed that such a meeting would have helped sort things out in advance of the Elliot Lake rescue efforts.[217] He further agreed that briefings help facilitate information flow. The fact that UCRT did not brief HUSAR/TF3 on its arrival, and vice-versa during the mission, was a weakness.[218]

Mr. Hefkey further agreed that the IMS calls for a written incident action plan when the incident is a "complex incident."[219] The IMS doctrine defines that type of incident as having some or all of the following characteristics:

- prolonged duration that will require major changes in personnel or involve successive operational periods;
- large in scale, requiring a large number of resources;
- involving multiple jurisdictions;
- requiring special knowledge and/or training to resolve;
- posing a significant risk to the responders or the jurisdiction as a whole;
- having the potential to cause widespread damage or loss of life / injury;
- requiring a more complex organizational structure; and
- necessitating formal planning.[220]

Mr. Hefkey agreed that all these characteristics were present during the Elliot Lake deployment.[221] He also agreed that it would have been appropriate for a contingency plan to be in place before the decision was made to stop using the crane to remove slabs. The creation of such a plan typically falls to the planning chief under the IMS.[222]

Mr. Hefkey agreed that note-taking was important not only at the individual police officer or firefighter level, but also in terms of "incident documentation" showing what the plan was, the steps taken, what was achieved, and next steps. He agreed that none of the forms found in the IMS forms package was used during this incident, despite past efforts by the Office of the Fire Marshal and Emergency Management Ontario to share that documentation and to provide examples of what it looks like when filled out.[223]

On the importance of information management, the IMS doctrine refers to collection, collation, evaluation, and dissemination of information. Mr. Hefkey agreed this kind of management was something a planning chief would have ensured. He agreed that oral advice from the engineers, for example, created a problem for information management because it left no record and did not document and confirm that those who required the information received it. He agreed, as well, that it was a flaw in the information management situation.

Mr. Cranford had additional information about the ability to shore the failing beam with steel shoring, which he shared with no one. He gave only Capt. Comella information on the means to brace the escalator and beam against lateral forces. He told no one else. If the planning function had been clearly laid out and responsibility assigned, there ought to have been a system in place to capture that information.[224]

Mr. Hefkey accepts that the IMS being optional presented challenges, but does not agree that the system was overly complex

Mr. Hefkey was questioned on the fact that the IMS was still only optional. Although he hesitated to admit that the ability to selectively pick and choose among IMS principles at an incident like Elliot Lake created a danger, he did agree that it created a "challenge" and that following all of the dictates of the IMS would make things safer.[225]

Mr. Hefkey was also initially reluctant to agree that the IMS was lengthy and complex. He thought the roles were fairly intuitive. He was pressed by Commission counsel on the apparent complexity of the IMS doctrine. I confess that I found his answer rather confusing:

> *Q.* And I said simpler because, using Inspector Neadles as the example, he obviously is familiar with IMS, but had difficulties applying it in this particular situation. Without being critical of him, is one of the problems its apparent complexity, and could it not be made simpler?
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> *A.* Well, and that is what we are going to do for us. We are going to go back to that same group who contributed to the document that we have been referring to, and we are going to ask them, say, Okay. We have got this issue. Folks are not applying the Incident Management System. How do we get to that culture of compliance so that people are actually using it and not just using it for the sake of we have created a rule, and so now it has to be so, but more we have got this document, and it makes good sense. It is sound operationally.
>
> And so for you, the person who would use this, perhaps not in a complex incident, but in a relatively simpler incident, that, you know what, yeah, it makes sense, and I see how I can work this and how I have got all of the aspects of incident management covered.
>
> *Q.* And I assume you'll be interested in what the Commissioner has to say on these issues as well?
>
> *A.* Yes. And that is why one of our lessons learned is to keep the committee who is working on these After-Action Reports and tracking and implementing our lessons learned, but the other role is for them to now take into consideration the recommendations coming from Phase II and the roundtables for the Commissioner and then seeing how those can be implemented.[226]

Ministry of Labour

Apart from its report on the cause of the collapse, the Ministry of Labour did not produce a stand-alone after-action report related to its involvement in the rescue and recovery operations. The comments from MOL witnesses on areas for improvement were limited, but all agreed that they had never received training on the ministry role at the scene of an ongoing rescue. All three MOL witnesses essentially formulated their own opinions on the scope of their powers and when and how to exercise them.

Notes

1 Comella testimony, September 4, 2013, pp. 24009–10.
2 Neadles testimony, September 12, 2013, pp. 25652–3.
3 Neadles testimony, September 12, 2013, pp. 25652–5; Glavin testimony, October 1, 2013, pp. 27746–7; Comella testimony, September 5, 2013, p. 24365; McCallion testimony, September 6, 2013, pp. 24665–6; McRae testimony, September 25, 2013, pp. 27265–6.
4 McCallion testimony, September 6, 2013, pp. 24665–6; Comella testimony, September 4, 2013, pp. 24010–11.
5 Neadles testimony, September 10, 2013, p. 25208.
6 Neadles testimony, September 12, 2013, pp. 25655–6; Neadles testimony, September 10, 2013, pp. 25208–9; Comella testimony, September 4, 2013, p. 24011.
7 Neadles testimony, September 12, 2013, pp. 25655–6; Neadles testimony, September 10, 2013, pp. 25209–10; Comella testimony, September 4, 2013, pp. 24011–12.
8 Comella testimony, September 4, 2013, pp. 24012–13.
9 Comella testimony, September 4, 2013, p. 24013.
10 McCallion testimony, September 6, 2013, pp. 24666–8; McRae testimony, September 25, 2013, pp. 27266–7.
11 Exhibit 7555.
12 Sorel testimony, October 1, 2013, pp. 27600–1.
13 Sorel testimony, October 1, 2013, pp. 27601–5, 27608 and 27612–13.
14 Neadles testimony, September 12, 2013, pp. 25666–7.
15 Exhibit 7555.
16 Exhibit 7555.
17 Neadles testimony, September 12, 2013, pp. 25673–6; McCallion testimony, September 6, 2013, p. 24687.
18 Exhibit 7581.
19 Comella testimony, September 5, 20133, p. 24316.
20 Neadles testimony, September 12, 2013, p. 25658.
21 Neadles testimony, September 12, 2013, pp. 25656–8.
22 McRae testimony, September 25, 2013, pp. 27267–8.
23 McCallion testimony, September 6, 2013, p. 24699.
24 Exhibit 7585; Sorel testimony, October 1, 2013, pp. 27594–5.
25 Glavin testimony, October 1, 2013, pp. 27747–50.
26 Comella testimony, September 5, 2013, pp. 24319–21.
27 Exhibit 7584.
28 Comella testimony, September 5, 2013, pp. 24320–1.
29 Comella testimony, September 5, 2013, pp. 24322–3.
30 Exhibit 7816; Comella testimony, September 5, 2013, pp. 24323–4.
31 Exhibit 7816.
32 Exhibit 7816.
33 Exhibit 7816.
34 Comella testimony, September 5, 2013, p. 24367.
35 Exhibit 7588.
36 Exhibit 7588.
37 Exhibit 7588.
38 Exhibit 7588.
39 Exhibit 7588.
40 Neadles testimony, September 12, 2013, p. 25660.
41 Exhibit 7588.
42 Exhibit 7588.
43 Neadles testimony, September 12, 2013, pp. 25668–70; September 10, 2013, pp. 25217–18.
44 Neadles testimony, September 12, 2013, pp. 25670–1; September 10, 2013, pp. 25216–17.
45 Neadles testimony, September 10, 2013, p. 25219.
46 Neadles testimony, September 10, 2013, pp. 25219–20.
47 Neadles testimony, September 12, 2013, pp. 25676–7.
48 Neadles testimony, September 12, 2013, pp. 25674–6.
49 Neadles testimony, September 12, 2013, pp. 25677–80.
50 McCallion testimony, September 6, 2013, p. 24670.
51 McCallion testimony, September 6, 2013, pp. 24671–2.
52 McCallion testimony, September 6, 2013, pp. 24676–7.
53 McCallion testimony, September 12, 2013, pp. 24672–6.
54 Comella testimony, September 5, 2013, p. 24317.
55 Comella testimony, September 5, 2013, p. 24317.
56 Comella testimony, September 5, 2013, pp. 24317–18.
57 McRae testimony, September 25, 2013, pp. 27269–70.
58 Glavin testimony, October 1, 2013, pp. 27750–2.
59 Glavin testimony, October 1, 2013, pp. 27752–5.
60 Guy testimony, September 24, 2013, pp. 27139–43.
61 Exhibit 7554. See Exhibit 7579 for Sgt. Gillespie's list of UCRT members in attendance at the Elliot Lake deployment.
62 Exhibit 7554. All references in this subsection are to this document unless otherwise noted.
63 Jacklin testimony, August 27, 2013, pp. 22652–3.
64 Jacklin testimony, August 27, 2013, p. 22659.
65 See, also, Bailey testimony, August 27, 2013, pp. 22818–21.
66 Bailey testimony, August 27, 2013, p. 22832.
67 Cox testimony, August 26, 2013, pp. 22434–5.
68 Hulsman testimony, August 28, 2013, pp. 23085–6.
69 Hulsman testimony, August 28, 2013, pp. 23086–7.
70 Hulsman testimony, August 28, 2013, pp. 23087–9.
71 Exhibit 7579; Gillespie testimony, September 3, 2013, p. 23800.
72 Exhibit 7579.
73 Gillespie testimony, September 3, 2013, pp. 23800–1.
74 Gillespie testimony, September 3, 2013, p. 23803.
75 Exhibit 7784.
76 Exhibit 7784, p. 005.
77 Exhibit 7784, p. 005.
78 Exhibit 7784, pp. 011–12.
79 Exhibit 7784, p. 009.
80 Exhibit 7784, p. 009.
81 Exhibit 7784, pp. 009–010.
82 Exhibit 7784, p. 010.
83 Exhibit 7784, p. 013.
84 Exhibit 7784, p. 005.
85 Exhibit 7784, p. 014–15.
86 Exhibt 7784, p. 005.
87 Exhibit 7784, p. 015.
88 Jollymore testimony, September 24, 2013, pp. 26951–3.
89 Exhibit 7784, p. 015.
90 Exhibit 7784, p. 015–16.
91 Jollymore testimony, September 24, 2013, pp. 26951–3.
92 Jollymore testimony, September 24, 2013, pp. 26957–8.
93 Exhibit 7784, p. 016.
94 Gillespie testimony, September 4, 2013, pp. 23823–4.
95 Exhibit 7784, pp. 016–17.
96 Gillespie testimony, September 3, 2013, p. 23796.
97 Gillespie testimony, September 3, 2013, pp. 23797–8.
98 Exhibit 7784, pp. 016–17.
99 Exhibit 7784, p. 017.
100 Exhibit 7784, p. 019.
101 Exhibit 7784, pp. 019–20.

[102] Bruce testimony, August 23, 2013, pp. 22132–3.
[103] Bruce testimony, August 23, 2013, p. 22137.
[104] Bruce testimony, August 23, 2013, pp. 22137–8.
[105] Bruce testimony, August 23, 2013, p. 22141.
[106] Bruce testimony, August 23, 2013, p. 22142.
[107] Bruce testimony, August 23, 2013, pp. 22184–7.
[108] Bruce testimony, August 23, 2013, pp. 22146–8; Jacklin testimony, August 27, 2013, pp. 22653–4.
[109] Bruce testimony, August 23, 2013, pp. 22150–1; Jacklin testimony, August 23, 2013, pp. 22147–9; Jacklin testimony, August 27, 2013, p. 22653.
[110] Jacklin testimony, August 27, 2013, pp. 22653–4.
[111] Bruce testimony, August 23, 2013, pp. 22150–1.
[112] Bruce testimony, August 23, 2013, pp. 22159 and 22162.
[113] Bruce testimony, August 23, 2013, p. 22180.
[114] Bruce testimony, August 23, 2013, pp. 22181–3.
[115] Hamilton testimony, October 7, 2013, p. 28555.
[116] Exhibit 8090, p. 042.
[117] Hamilton testimony, October 7, 2013, pp. 28555–6.
[118] deBortoli testimony, October 7, 2013, p. 28466.
[119] Exhibit 9892.
[120] deBortoli testimony, October 7, 2013, p. 28466.
[121] Exhibit 9892.
[122] deBortoli testimony, October 7, 2013, p. 28466.
[123] Rheaume testimony, September 26, 2013, pp. 27511–4.
[124] Hamilton testimony, October 7, 2013, pp. 28560–1.
[125] Hamilton testimony, October 7, 2013, p. 28566.
[126] Hamilton testimony, October 7, 2013, pp. 28560–1.
[127] Hamilton testimony, October 7, 2013, pp. 28562–4.
[128] Rheaume testimony, September 26, 2013, pp. 27514–15.
[129] deBortoli testimony, October 7, 2013, pp. 28467–8.
[130] Officer testimony, August 22, 2013, pp. 21863–4.
[131] Officer testimony, August 22, 2013, pp. 21864–6.
[132] Officer testimony, August 22, 2013, p. 21868.
[133] Officer testimony, August 22, 2013, pp. 21868–9.
[134] Officer testimony, August 22, 2013, p. 21870. See Exhibit 7510 for Chief Officer's press release thanking UCRT.
[135] Officer testimony, August 22, 2013, pp. 21870–2.
[136] Officer testimony, September 19, 2013, pp. 26406–7.
[137] Officer testimony, August 22, 2013, p. 21873.
[138] Thomas testimony, August 20, 2013, pp. 21166–71 and 21206–7.
[139] Thomas testimony, August 20, 2013, pp. 21166–71 and 21206–7.
[140] Chambers testimony, September 18, 2013, pp. 26204–6.
[141] Exhibit 7785.
[142] Exhibit 7785.
[143] Exhibit 7785.
[144] Exhibit 7785.
[145] Exhibit 7785.
[146] Exhibit 7785.
[147] Exhibit 7785.
[148] Exhibit 7785.
[149] Exhibit 6402.
[150] Kerr testimony, September 25, 2013, p. 27356.
[151] Kerr testimony, September 25, 2013, pp. 27356–8.
[152] Kerr testimony, September 25, 2013, pp. 27341–4.
[153] Kerr testimony, September 25, 2013, pp. 27356–8.
[154] Kerr testimony, September 25, 2013, pp. 27350–1.
[155] Kerr testimony, September 25, 2013, pp. 27359–60.
[156] Kerr testimony, September 25, 2013, pp. 27359–60.
[157] Latulippe testimony, August 7, 2013, p. 19937.
[158] Latulippe testimony, August 7, 2013, pp. 19938–9.
[159] Latulippe testimony, August 7, 2013, p. 19939.
[160] Réjean Aylwin testimony, August 7, 2013, p. 19995.
[161] Latulippe testimony, August 7, 2013, p. 19940.
[162] Gendron testimony, August 8, 2013, pp. 20053–5.
[163] Gendron testimony, August 8, 2013, pp. 20053–5.
[164] Gendron testimony, August 8, 2013, pp. 20055–6.
[165] Jollymore testimony, September 24, 2013, pp. 27024–5.
[166] Jollymore testimony, September 24, 2013, p. 27026.
[167] Exhibit 6246.
[168] Exhibit 6246, pp. 002–003.
[169] Exhibit 6246, p. 011.
[170] Exhibit 6246, p. 013.
[171] Selvers testimony, September 10, 2013, pp. 25104–5.
[172] Exhibit 6246, pp. 007, 012, 013.
[173] Exhibit 6246, pp. 010, 012 and 013.
[174] Selvers testimony, September 10, 2013, pp. 25118–21.
[175] Selvers testimony, September 10, 2013, p. 25121.
[176] Selvers testimony, September 10, 2013, pp. 25110–11.
[177] Selvers testimony, September 10, 2013, pp. 25227–8.
[178] Neadles testimony, September 12, 2013, pp. 25681–2.
[179] Neadles testimony, September 12, 2013, p. 25699.
[180] Neadles testimony, September 12, 2013, pp. 25684–7.
[181] Neadles testimony, September 12, 2013, pp. 25688–704.
[182] Exhibit 9912.
[183] Hefkey testimony, October 8, 2013, pp. 28658–60.
[184] Exhibit 9912, p. 002.
[185] Exhibit 9912, pp. 006–007.
[186] Exhibit 9912, pp. 008–009.
[187] Exhibit 9912, pp. 009–10.
[188] Exhibit 9912, p. 011.
[189] Exhibit 9912, pp. 011–12.
[190] Exhibit 9912, p. 012.
[191] Exhibit 9912, pp. 012–13.
[192] Exhibit 9912, p. 014.
[193] Exhibit 9912.
[194] Hefkey testimony, October 8, 2013, pp. 28661–3.
[195] Hefkey testimony, October 8, 2013, pp. 28662–5.
[196] Hefkey testimony, October 8, 2013, pp. 28665–7.
[197] Hefkey testimony, October 8, 2013, pp. 28668–70.
[198] Hefkey testimony, October 8, 2013, pp. 28671–5.
[199] Hefkey testimony, October 8, 2013, pp. 28671–5.
[200] Hefkey testimony, October 8, 2013, pp. 28678–9.
[201] Hefkey testimony, October 8, 2013, pp. 28682 and 28684.
[202] Hefkey testimony, October 8, 2013, pp. 28684–7.
[203] Hefkey testimony, October 8, 2013, pp. 28684–8.
[204] Hefkey testimony, October 8, 2013, pp. 28693–7.
[205] Hefkey testimony, October 8, 2013, pp. 28704–9.
[206] Hefkey testimony, October 8, 2013, pp. 28704–9.
[207] Hefkey testimony, October 8, 2013, pp. 28693–7.
[208] Hefkey testimony, October 8, 2013, pp. 28693–7.
[209] Hefkey testimony, October 8 2013, pp. 28697–9.
[210] Hefkey testimony, October 8, 2013, pp. 28710–2.
[211] Hefkey testimony, October 8, 2013, pp. 28712–16.
[212] Hefkey testimony, October 8, 2013, pp. 28716–18.
[213] Hefkey testimony, October 8, 2013, pp. 28718–20.
[214] Hefkey testimony, October 8, 2013, pp. 28720–5.
[215] Hefkey testimony, October 8, 2013, pp. 28726, 28740.
[216] Hefkey testimony, October 8 2013, pp. 28728–31.

[217] Hefkey testimony, October 8, 2013, pp. 28742–4; Exhibit 887, p. 059.
[218] Hefkey testimony, October 8, 2013, p. 28748.
[219] Hefkey testimony, October 8, 2013, p. 28741.
[220] Exhibit 887, p. 055.
[221] Hefkey testimony, October 8, 2013, p. 28742.
[222] Hefkey testimony, October 8, 2013, pp. 28731–3.
[223] Hefkey testimony, October 8, 2013, pp. 28734–6.
[224] Hefkey testimony, October 8, 2013, pp. 28744–8; Exhibit 887, p. 071.
[225] Hefkey testimony, October 8, 2013, pp. 28758–60.
[226] Hefkey testimony, October 8, 2013, pp. 28760–4.