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*If I have seen further than others,
it is by standing upon the shoulders of giants.*

Isaac Newton



Experience is clearly the best teacher. Emergency response organizations are not static entities – their composition evolves constantly as newer members replace older ones. Methods and procedures are refined through experience. New protocols emerge. New technologies become available. Training opportunities multiply. In the process, knowledge accumulates. The preservation and dissemination of that accumulated knowledge is essential to ensure effectiveness and efficiency when emergencies occur. No two emergencies will be identical. In that sense, like old generals, we are always prepared to re-fight the last battle but often ill-prepared to win the next. To ensure that we do not repeat the mistakes of others but benefit from the knowledge of their successes and failures, we need to document carefully lessons learned and pass them along to our successors. Thus do we achieve excellence.

I do not consider the thrust of this analysis to be an exercise in negativity, blame, and criticism. If I point out what I think was less than ideal in the Elliot Lake rescue and recovery effort, it is only with a view to ensuring that things will be done better the next time. Of this I entertain not the slightest reservation: All those involved in the aftermath of the Elliot Lake disaster acted with sincere passion and earnest commitment to achieve one goal – rescuing potential survivors.

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The time of death – could a different or more rapid response have made a difference?

It is clear to me that Doloris Perizzolo's death was nearly instantaneous after the collapse. The catastrophic injuries that she received could not possibly have allowed her to survive for any appreciable period of time. However, on all the evidence before me, I believe that it is probable (although by no means certain) that Lucie Aylwin survived the collapse for a period of approximately 39 hours. In a sense, it is bitterly ironic to fervently hope that I am wrong and that the medical evidence is right – that her death occurred a mercifully short time after she was buried in the rubble. Clearly, after 5 a.m. on June 25, it is most unlikely that she was still alive.

The medical evidence I have heard supports the proposition that Lucie Aylwin's injuries were severe, sufficiently so that she likely did not survive the collapse by any significant length of time. But not one of these injuries, taken by itself, was necessarily and irrefutably fatal. Tantalizing signs of her survival appear to contradict the medical evidence. The apparently responsive tapping in reaction to calling out, the muffled voice heard by the responders, and the recurring positive indications given by the well-trained dogs searching the debris pile with their experienced handlers encouraged rescuers and fuelled their efforts. The LifeLocator also gave apparently positive results, but these are ultimately of little value, given the manner in which it was used and the implausibility of some of the readings.

The medical evidence that I review at length earlier in the Report is such that, if it is correct, all the evidence of signs of life testified to by a number of witnesses would have to be discounted. It would be the oddest of coincidences that all signs of life originated precisely where Ms. Aylwin's body was recovered.

Complicating the issue is the fact that the medical evidence is that death was said to likely be near immediate after crushing forces were applied. What I do not know is *when* those crushing forces were applied: immediately after the collapse? or after some later shift in the debris pile overlying her body? I have heard no evidence that there was such a shift, though the possibility exists that one occurred later.

People have often survived similar collapses and have been recovered alive for periods well in excess of the time period with which I am concerned. There were voids in the concrete pile and there likely was water close by. If Lucie Aylwin did survive after the initial collapse, the question will always recur: Had the rescue effort been done in a different way, had it been more rapidly executed, could she have been rescued?

The answer to that question will have to be a vague "maybe" or an imprecise "perhaps." I know that is unsatisfactory, but I cannot provide a better answer.

The speed of the response

Critical to the actions that followed the collapse was the rapid mobilization of emergency and rescue organizations. Time was clearly of the essence. Common sense and the medical evidence presented to the Commission make plain that, if a victim survived the initial trauma of the collapse and was trapped under the rubble, the chances of survival diminished as time advanced. Initially, no one knew who might be injured or trapped in the rubble. The nature of the event clearly required stabilization of the scene, reconnaissance, and dissemination of information.

The Elliot Lake Fire Department, the OPP, the Community Control Group, and the province – rapid and appropriate responses

The Elliot Lake Fire Department's response was prompt and efficient when it arrived on scene a bare few minutes after the collapse. As a first course of action, the firefighters shut off the utilities, thereby eliminating an additional source of danger to a situation that was already unsafe. Chief Paul Officer very quickly activated the Community Control Group (CCG) and contacted the Office of the Fire Marshal (OFM). He set up a command post. The department's accountability system appears to have performed as intended. Tracking of all responding personnel by placing a board against a truck parked immediately in front of the Mall was a simple and effective method of determining the whereabouts of all responders who placed their tags in the "In" or "Out" column opposite their names as they entered or left the hot zone. The chief's instructions to reconnoitre, post spotters, and secure the site were rapid and appropriate. Reconnaissance of the collapse area was quickly carried out to ensure rapid evacuation of the Mall and to render assistance to those who might be injured.

Chief Officer quickly recognized that coping with the emergency was beyond his forces' capabilities and requested the Heavy Urban Search and Rescue Task Force 3 (HUSAR/TF3) activation as well as the mutual aid protocol with Blind River. Although Chief Officer mistakenly felt he could not contact the Provincial Emergency Operations Centre (PEOC) to request HUSAR/TF3 assistance until the City made a formal declaration of emergency, no delay was occasioned by that misconception. In any event, a declaration of emergency was made in a timely fashion.

In my view, dissemination of vital information and notification to all important authorities and ministries was rapid and efficient.

The OPP UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) team left Bolton less than two hours after notification of the collapse and arrived in Elliot Lake between approximately 9:00 and 9:30 p.m. It is my view that the speed of that deployment was remarkable.

All in all, the initial reaction to the collapse was appropriate.

HUSAR/TF3 – could it have deployed more quickly?

HUSAR/TF3 has a mandated “stand-up time,” or mobilization time, of six hours after receiving orders to deploy.

I assume that mandated time to mean that mobilization should not take *more* time to deploy than six hours – an outside limit. Surely, no one would disagree that a shorter deployment time would, if achievable, be desirable. Staff Insp. William Neadles was given the order to deploy HUSAR/TF3 at 4:21 p.m. on June 23, but there had been advance notice of the impending deployment. Slightly before 4 p.m., Capt. Martin McRae knew that the team would be deployed. The loaded tractor trailers left the home of operations at 9:56 p.m. to meet up with the bus transporting the rescuers. Mobilization, therefore, occurred within the six-hour stand-up time. Could it have been done more quickly? Perhaps. The pace certainly does not appear to have been frenetic. Some things could have been done more rapidly, but I cannot say with certainty that they affected the group’s departure time.

Specifically, I note that

- It was only at 5:05 pm. that Capt. McRae called Paul Demy, HUSAR/TF3’s main driver, and instructed him to arrange for the rental of the tractors, as well as obtaining drivers. The team does not own its own tractors.
- There were problems obtaining tractors. The only ones available were located in Mississauga, approximately 25 kilometres away. The drivers left the home of operations at 6:08 p.m. They arrived back at 8:10 p.m., more than four hours after it was learned that there would be a deployment.
- HUSAR/TF3 also did not have designated drivers who possessed the proper qualifications. They were obtained through Don Sorel of Toronto Water (who advised that they would not be obtained from that source in the future as one driver was injured in the deployment). I have not heard evidence of how HUSAR/TF3 currently deals with that issue.
- All team members were required to undergo a brief medical examination at the muster point. I understand the rationale for a cursory examination. One would not want a sick responder to infect the other team members and reduce the team’s effectiveness. But when time is crucial, surely one could assume that someone who is sick will act responsibly, self-report, and decline deployment. Summoning a medical practitioner, a paramedic, or a nurse and carrying out an examination of 30-plus responders must take some time (albeit no evidence was called to describe who was examined, by whom, and the nature of the examination). In fairness, I have heard no evidence showing that the process delayed departure, but if it did, its necessity ought to be revisited.
- The cube van was loaded with 100 kit bags at the home of operations and ready to go to the muster point only at 7:57 p.m. It left at 8:05 p.m. and arrived at the muster point at 8:28 p.m. Capt. McRae testified that the task could reasonably be done in under an hour. I heard no evidence justifying the delay.

- On June 23, members of HUSAR/TF3 were on a training exercise in Rouge Valley. They were assembled on location, and their bus left at 4:50 p.m. to arrive at the home of operations at 5:35 p.m.. At that location, they picked up their vehicles, returned home to pick up their gear, and returned to their muster point where, at 9:15 p.m., they picked up their kits. They left the muster point by bus at 9:30 p.m. to meet up with the tractor trailers and convoy up to Elliot Lake.
- All in all, it may be that the difficulties and delays I have mentioned delayed the group's departure somewhat, but quantifying time lost is difficult. At 8:23 p.m., Staff Insp. Neadles informed Carol-Lynn Chambers, the manager of Emergency Planning and Strategic Development, OFM, that the departure would be held up by at least 30 to 60 minutes because of a tractor delay. Even if it had not encountered problems getting the rental tractors, the team would not have been ready to leave at 8:30 p.m. because issuing the kits to the team members was finished only at 9:15 p.m.

Deployment numbers could have been higher

HUSAR/TF3 – less than half, and no planning section chief

A full HUSAR/TF3 deployment consists of 76 team members plus eight drivers, with a task force / site commander in overall charge and section chiefs for each of the main Incident Management System (IMS) categories: operations, planning, logistics, and finance / administration. In fact, only 33 team members and three drivers deployed.

Staff Insp. Neadles was in overall command. Capt. Tony Comella described his own role, from time to time, as being safety officer, operations section chief (which he viewed as an advisory function only), and occasional planning section chief. Cmdr. Michael McCallion expected that he was being deployed as the medical manager but became a site commander in Elliot Lake, alternating for Staff Insp. Neadles. Capt. McRae was used mostly as logistics section chief.

The planning section chief who should have been deployed was not available. This situation undoubtedly contributed to the lack of planning I have described elsewhere in this Report.

UCRT – less than half, and no staff sergeant

On the day of the collapse, the ideal UCRT available complement was 23 with a staff sergeant as unit commander, an urban search and rescue sergeant, and an administrative / operational support sergeant. In fact, however, only 10 members and two medics were actually deployed, with Cst. Ryan Cox in charge until Sgt. Jamie Gillespie could attend. There was no staff sergeant available. This situation meant that an officer could not be both in the command tent to take part in planning discussions and in the hot zone to supervise the work being done.

In my opinion, the fact that the actual number of responders who went to Elliot Lake was less than half of potential was not, in and of itself, the cause of the difficulties experienced in the rescue. Rather, as I will describe below, the problem was not with the workers in the hot zone, but with the poor dynamics of the command structure, fundamental misunderstandings about the role of individuals within that structure, and the failure to implement IMS as it was designed.

The rescue operation

The Incident Management System (IMS) is an ideal construct, a model designed to be scaled and adapted to the imperatives of any particular emergency response. Both UCRT and HUSAR/TF3 personnel were extensively trained in its theory and application. Other organizations, such as the Elliot Lake Fire Department, possessed at least passing familiarity with its concepts. And yet, despite its inculcation across the broad spectrum of all emergency responders, its application to the Elliot Lake emergency was very much wanting.

No incident action plan

One of the most important tenets of the IMS is the establishment of an incident action plan. It is to be developed by the Planning Section but is approved by the incident commander.

As stated previously, the purpose of the plan is to provide all incident supervisory personnel with direction for the actions that are to be implemented in the course of the emergency response. A written plan should be used when dealing with complex incidents and should be developed at a planning meeting. It should be followed by an operations briefing to ensure that everyone in the emergency response structure is aware of the strategy and tactics that will be employed in the execution of the plan.

Under IMS, the Planning Section is intended to develop the incident action plan and may include roles such as collecting, evaluating, analyzing, and disseminating information related to the emergency response. The Planning Section's roles could also include maintaining incident documentation, tracking resources assigned to the incident, and conducting long-range and/or contingency planning.

And yet, I have heard no evidence of the development of an incident action plan. One may have existed as a concept in the minds of Staff Insp. Neadles, Cmdr. McCallion, or Capt. Comella, but it was certainly not reduced to writing in any form. Chief Officer, as incident commander, was not involved in the development of a plan in any way. It was not the subject of a briefing to the individuals who made up the rescue teams or explained to others whose expertise could have helped: the HUSAR/TF3 engineer, James Cranford, for example; or to Ministry of Labour personnel on site, such as provincial engineer Roger Jeffreys. Accomplished tasks and tasks left to be performed were not posted anywhere. Contingencies and alternatives were not outlined, even in rudimentary form.

The Elliot Lake Fire Department, HUSAR/TF3, and UCRT have all adopted the IMS as their emergency management tool but, in fairness, none of its features is mandatory. And yet, in a complex rescue operation such as the one in Elliot Lake, it seems to me that the creation of an action plan should have been a top priority. The failure to do so flawed the emergency response.

A simple whiteboard in a prominent command location outlining the mission's incident action plan would have been a rapid and convenient method of informing all participants of the mission's progress, of achieved objectives, and of projected action. In Elliot Lake, there was no written action plan promulgated and positioned for all to see. Systematic shift-change briefings did not occur regularly, leaving many individual responders in the dark about the overall objectives of the exercise.

A written action plan was eventually produced, but not by anyone in the command structure – it was drafted and executed by crane operator Ryan Priestly after his equipment was ordered.

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No one properly understood the command structure or the role of supporting organizations

There was widespread confusion about the identity and role of the incident commander. Even those who understood who the incident commander was nevertheless made important decisions without consulting him. The confusion permeated all who were involved in the rescue operation, beginning with Chief Officer. But he was far from being alone. Staff Insp. Neadles took on the role of incident commander and communications spokesperson. Communications from the Premier's Office and from Dan Hefkey, the commissioner for community safety, bypassed Chief Officer completely after the rescue operation was initially called off. Mr. Cranford, the HUSAR/TF3 embedded engineer, admitted he did not know who the incident commander was. He thought that he reported to Capt. Comella, and, through the muddle, his plan to shore up the beam supporting the escalator was never communicated up the chain of command. Insp. Percy Jollymore at one point declared himself the incident commander.

Lack of understanding and agreement between HUSAR/TF3 and UCRT

Before the Elliot Lake collapse, there was no protocol or understanding about the nature of the relationship between HUSAR/TF3 and UCRT when they jointly responded. HUSAR/TF3 leaders assumed that, once their team was on site, they would be in overall command of operations. UCRT would simply be an alternative team working on the pile. Being relegated to this function created ill-feeling and confusion. UCRT had no presence in the command tent and no voice in the elaboration of strategy and in the eventual decision to stop the rescue.

Cranes and rigging operations could have started sooner

Despite a very early request by Cst. Cox for a crane, one was ordered only at the end of the day on June 23. Millennium Crane's owner and operator Dave Selvers could have put his equipment on the road much earlier, but the late call made gathering of his forces and equipment more difficult. Similarly, there was evidence that, once a decision was made to use the Priestly equipment, the request for its mobilization could have been made more quickly.

Staff Insp. Neadles seems to have played no role in the decision to involve the Millennium Crane in rigging operations.

In effect, very little progress in reaching Ms. Aylwin and removing the material overlying her body was achieved by HUSAR/TF3, other than by participating in the crane and rigging operation suggested by UCRT. The Elliot Lake Fire Department members were initially on the debris pile removing materials, but were called off because of safety concerns. The same concerns caused the ceasing of the Millennium crane operations. Only the Priestly equipment finally managed to remove that debris on the early morning of June 27. By that time, Ms. Aylwin had surely died. The shoring operations performed by HUSAR/TF3 and the "tunnelling" toward the debris pile ultimately achieved very little. There seemed to be no purpose to the construction of shoring within the Mall except to get safely to the debris pile, but I heard of no plan about what was to be done once the team got there.

There appears to be an ingrained reluctance on the part of HUSAR/TF3 to consider the utility and effectiveness of using cranes in structural-collapse events. At best, the use of cranes is considered a last resort. Only Mr. Sorel had training and expertise in this area. Certainly, HUSAR/TF3 training in this area is non-existent or very limited.

Staff Insp. Neadles knew of Priestly Demolition's existence and its capabilities even before Sgt. Phil Glavin refreshed his memory after the rescue was called off. Even then, resort to Priestly's services came only after the intervention of the Premier's Office.

Little or no record-keeping or contemporaneous note-taking

A major problem encountered by Commission counsel in its task of presenting evidence to the Commission was the poor state of contemporary record-keeping as the operation developed. The Community Control Group had a scribe assigned from the outset – and a record was maintained – but the two principal rescue groups, HUSAR/TF3 and UCRT, did not have a scribe. Memories were left to be refreshed only by the notes of individuals involved in the rescue effort. Unfortunately, most of these notes were not contemporaneous. They were created long after the events they purported to record. The difficulty is understandable. Maintaining a contemporaneous record as one's efforts are directed at the prime objective of rescuing individuals is not the first priority. Compiling notes at shift end, when one is exhausted, both physically and mentally, is not easy. In those circumstances, it is not surprising that evidence conflicted in relation to the timing and nature of significant events. The lack of properly kept notes is evident when one attempts to decipher the sequence of events following the noon press conference on June 25. Everyone – Chief Officer, Staff Insp. Neadles, Cmdr. McCallion, Capt. Comella, the engineers, and others – gave differing accounts of what led to the decision to order everyone out of the building.

Of course, the need for accurate record-keeping is not to assist the Commission in its attempt to recreate an accurate narrative. Its importance lies in its instructional value for future responders. Assigning scribes to accompany the important players during the Elliot Lake operation should not have been difficult. It is not a task that requires special training. Scribes could have been recruited from volunteers, or from local firefighters, the OPP, or municipal employees.

The creation of a contemporaneous record maintained in the command tent is also important to inform a new team at the beginning of its operational period of what has been done and what remains to be done in relation to any aspect of the incident action plan. The form of that record is not of primary importance. It could be written on the side of a truck or on sheets of paper, so long as it is clear for all to see. In fairness, the photographic evidence does show a whiteboard in the command tent enumerating tasks accomplished and tasks to be completed *for a specific shift*. It did not, however, extend beyond that time period, and it certainly did not outline the entire incident action plan.

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Communications weaknesses

It is probably trite to state that an effective communications strategy is critical to any emergency response incident. Never have the means to communicate effectively been so sophisticated, efficient, easily accessible, and relatively inexpensive as they are today. But there is a world of difference between ready access to the tools of communication and the effective implementation of a communications strategy during a deployment. Responders need, above all, to communicate with one another in order to understand the mission's objectives and to know what their specific assigned tasks are. Commanders are in constant need of information about the progress of all aspects of the evolution of the rescue. The left hand needs to know what the right is doing. Local officials, the media, victims' families, and the general public must be kept informed.

From a communications perspective, a number of aspects of the Elliot Lake deployment fell far short of ideal.

Among responders

I have heard no evidence that the responders to the Elliot Lake tragedy lacked for sophisticated hardware and software systems. But effective communication need not depend exclusively on complex equipment. The responding organizations – the OPP, the Elliot Lake Fire Department, UCRT, HUSAR/TF3, Emergency Medical Services – all operated on different radio frequencies. Short of exchanging portable telephones, they had no way of communicating directly one with the other to exchange information. When the OPP helicopter's downwash threatened the precarious stability of the hot zone, persons on the debris pile could not wave it off directly.

The responding organizations – the OPP, the Elliot Lake Fire Department, UCRT, HUSAR/TF3, Emergency Medical Services – all operated on different radio frequencies. Short of exchanging portable telephones, they had no way of communicating directly one with the other to exchange information.

The incident commander had no means of rapid direct communications with responding organizations (apart from firefighters) except by speaking to them in person. One of the stated purposes of the Incident Management System is to allow responders from different organizations to work together effectively. This objective will continue to be hindered until the province addresses the inherent difficulties in communication among responders arising from a lack of common radio frequencies.

With victims' families

Communications with the victims' families were inadequate and inconsiderate, particularly during the earlier stages of the deployment. The families were not segregated, but essentially treated no differently from members of the public at the Collins Hall. They received news about their loved ones at the same time as the general public; indeed, they were treated rather shabbily by Insp. Jollymore, who told them he "was doing them a favour"¹ and being polite by attending at the Collins Hall to give them information. The manner in which family members were advised of the decision to call off the rescue was insensitive. Only later in the process were family members provided with separate commercial offices and given constant OPP liaison assistance.

With the general public and the media

Lack of a well-structured communications strategy aimed at the general public led to a real apprehension of civil unrest in Elliot Lake and required that responding units take steps to ensure their own safety as well as that of their equipment. Directions had to be given to create a security cordon around the Algo Mall to prevent the possible unauthorized entry by members of the public.

Frequent, well-publicized, and regular informational sessions about work being done in the hot zone did not occur. Instead of information being channelled through a single source, information was provided to the press and the public, at various times, by the mayor, Staff Insp. Neadles, and even Mr. Hefkey. Consequently, members of the public, and even some first responders, were getting information (and misinformation) through the media.

Calling off the rescue done too hastily and with inadequate consultation or consideration of other options

At 12:05 p.m. on June 25, Staff Insp. Neadles was publicly reporting that someone was still alive under the rubble, but that rescuers had to be removed from the pile and crane operations had to stop because of the danger of a further collapse. He also indicated that they were still working and moving forward. But within two hours, everyone was ordered out of the building. Although that decision cannot be questioned because it

was based on the best professional advice available at the time, further consultation should have taken place to determine whether other possible solutions might be available. By approximately 2 p.m., the decision was made that no options remained but to declare the operation a recovery and no longer a rescue. That decision was announced at the 3 p.m. Community Control Group meeting, when Staff Insp. Neadles stated that the operation was being turned back to the Elliot Lake Fire Department. No effort seems to have been made to explore other options despite the fact that Mr. Cranford had considered means to shore the beam under the escalator and had informed Capt. Comella accordingly. Mr. Jeffreys appears not to have been consulted about options. Mr. Selvers believed that crane operations were still possible, but he was not consulted at all. Staff Insp. Neadles had no experience with steel shoring and did not explore this method further. Ontario Mine Rescue was not even considered.

That this decision was made and announced without Chief Officer's explicit concurrence shows the extent to which the command structure had become degraded.

What is particularly difficult to understand is why it was deemed urgent or necessary to announce a definitive end to the rescue. It would have been comparatively much easier simply to say that rescuers were taking a pause in their efforts because of safety concerns and pulling back temporarily while other options were being explored.

Ontario Mine Rescue not utilized

Ontario Mine Rescue (OMR) has been in existence since 1929. The depth of its experience and expertise is indisputable. Although some aspects of its training, skills, and capabilities would not have assisted the Elliot Lake operation, others were clearly and directly applicable. I refer specifically to shoring, high-angle rescue and rappelling, use of and access to thermal imaging equipment, cribbing and stabilization, and other areas. Its qualifications closely parallel those of HUSAR/TF3 and UCRT.

Qualified personnel and leadership were available from Sudbury and could have been on site in Elliot Lake within two-and-a-half hours. On learning of the collapse, Candys Ballanger-Michaud, the president and chief executive officer of Ontario Mine Rescue, placed a call to the Elliot Lake mayor's office to offer its services, but he was not reachable. A call was made to the Ministry of Labour's Operations Division. The OMR offer went unheeded. Mr. Hefkey advised Staff Insp. Neadles to consider "mining type resources." When specifically asked to consider OMR, Staff Insp. Neadles was resolutely against the idea because he believed that it did not have the expertise and training in a structural collapse. How he came to hold that belief is difficult to discern from his answers to Commission counsel except that it was a conclusion he and Cmdr. McCallion came to in discussions. It is clear to me that he had no idea about OMR's capabilities and expertise.

On the afternoon of June 25, HUSAR/TF3 had no Plan B. Despite that, no effort was made to contact OMR. Failure to even consider using its services, either from the outset or when HUSAR/TF3 had run out of ideas, will always lead to the unanswered question: Had OMR's expertise been sought at the outset and its capabilities utilized, would the result of the rescue attempt have been different?

Failure to even consider using OMR's services, either from the outset or when HUSAR/TF3 had run out of ideas, will always lead to the unanswered question: Had OMR's expertise been sought at the outset and its capabilities utilized, would the result of the rescue attempt have been different?

Confusion about the role and actions of the Ministry of Labour

Throughout the rescue operations, there was a widespread belief, both in Elliot Lake and even in Toronto, that a Ministry of Labour order had prevented entry onto the collapse site. Later, many were also clearly of the belief that evacuation of the Mall stemmed from MOL orders. Staff Insp. Neadles went so far as to state publicly that “our authority did end when the building was deemed unsafe by the ministry and other structural engineers.”² Although the ministry did, ultimately, have that authority, the ministry clearly never exercised it or threatened to exercise it. There was widespread confusion about the MOL’s powers and near-universal misinformation about the existence of MOL orders stopping the rescue effort. The site of a rescue is clearly a workplace, and the *Occupational Health and Safety Act* applies, even though MOL engineers and inspectors believed that the exercise of discretion was warranted and considerable deference was to be accorded to the rescuers’ expertise.

MOL engineers and inspectors provided useful advice throughout and acted most responsibly. They never interfered with the progress of the rescue efforts.

After the operation

Poor debriefing; delayed MCSCS after-action report

A good debrief should not be considered to be an exercise in negativity and criticism. Rather, it is an opportunity to foster the free flow of information between participants to provide as contemporary a record as possible of observations, experiences, and emotions – recounting decisions made and results obtained – with a view to the eventual analysis of that information and its potential applicability to future events.

In my opinion, the value of a good debriefing lies in its relative immediacy after the relevant event. Memories are vivid and fresh, and revisionism has not had an opportunity to creep in.

In my opinion, the value of a good debriefing lies in its relative immediacy after the relevant event. Memories are vivid and fresh, and revisionism has not had an opportunity to creep in. Next to the maintenance of a proper record (via note-taking and scribes), it constitutes the best method for the transmittal of information vital to ensuring preparedness for future incidents.

After the events of June 23–27, important opportunities for meaningful debriefing were missed. I am skeptical of the reasons advanced for the failure to debrief, particularly because the relevant policies and literature as well as the experience of the responders consistently emphasized the importance of the process. Fatigue or lack of funds were advanced as convenient excuses, but I am much more inclined to the belief that fear of criticism and reproach, as well as a

desire to mask the existence of intra-organizational discords, were the principal agents motivating their absence. Indeed, some witnesses admitted as much.

The City of Elliot Lake, the Elliot Lake Fire Department, the Ministry of Labour, and HUSAR/TF3 all neglected to engage in this critical process. The Ministry of Community Safety and Correctional Services produced a consolidated after-action report dated September 27, 2013, more than *one year* after the events. The OPP Field Support Bureau also prepared an after-action report. The Commission’s copy is undated.

The Office of the Fire Marshal prepared an illuminating and carefully reasoned after-action report on November 14, 2012, that recommended, *inter alia*, the creation of light and medium search and rescue teams spread throughout the province for early reconnaissance and on-ground expertise ahead of the arrival of advance USAR capabilities; communications support; the mandatory adoption of IMS; coordinated training; and the streamlining of governance models in relation to complex emergencies.

The Coroners Act

After rescue efforts were stopped, a problem arose relating to the safe and dignified removal of the victims' remains. This situation led to a recognition that there was no statutory authority to make a building safe (by demolition, for example) in order to remove a body. Fortunately, the matter was quickly resolved by obtaining the owner's consent to a controlled demolition to make entry safe.

The decision to use the Priestly equipment

Sgt. Glavin's knowledge about the existence and capabilities of Priestly Demolition was fortuitous and extremely useful when he spoke to Staff Insp. Neadles about it. And yet, Staff Insp. Neadles already knew of its capabilities and ability to dismantle a building with precision. He had worked with the company before. Priestly Demolition is well known in the Toronto area and has a depth of experience. I would have expected it to figure prominently in HUSAR/TF3's inventory of potential external resources. Clearly, it did not.

Armed with his refreshed knowledge, Staff Insp. Neadles could inform the Premier's Office and various other authorities that there were means whereby the rescue operation could be resumed without endangering rescue personnel.

The assistance of the premier

The premier's evident concern, leadership, and insistent encouragement to explore this last possibility of rescue gave renewed hope to the victims' families and to the community. He was instrumental in developing the missing Plan B. He was supported in his genuine determination to help Elliot Lake and its citizens by members of his staff, as well as the other provincial authorities who acted quickly to give effect to his commitment.

General observations

It is beyond this Commission's mandate and capabilities to inquire into, comment, and make recommendations about the overall framework of Ontario's emergency response system, except to the extent that this framework had an impact on the search and rescue effort at Elliot Lake. It is a framework that evolved gradually and organically, with some renewed impetus after the events of September 11, 2001.

Despite that limitation, I venture the opinion that the system, particularly in the area of urban search and rescue, is in need of rationalization, organization, and integration. Although I recognize that emergency response is, philosophically, a "ground-up" system, overall control at the provincial level is rendered difficult by the compartmentalization of a great diversity of resources. Local ownership and control over those resources means that they become more widely available only after local needs are met. HUSAR, an amalgam of the City of Toronto's many departments (fire, police, water, and others), is designed to serve Toronto first and its services are shared through the instrumentality of MOUs, not legislation. Similarly, UCRT belongs exclusively to the OPP. Ontario Mine Rescue operates entirely independently. Some cities have self-contained light and medium USAR response units completely uninvolved in anything but the loosest form of coordinated structure, such as mutual aid agreements with adjoining municipalities.

In the area of urban search and rescue, Ontario possesses a number of "silos" or "towers" that co-operate to some limited extent, but only at the whim and goodwill of individual municipalities or organizations. By their nature, they are anchored to their parent municipalities or organizations and jealous of their autonomy, their

expertise, and their independence. This insular and protective attitude does not foster efficiency. It impedes identifying, developing, and disseminating evidence-informed practices or the brokering and encouragement of effective methodology.

In the Elliot Lake deployment, there was occasional discord and tension between two specialist organizations that should, optimally, have worked together harmoniously and in a synchronized manner; they did not always do so, despite many commonalities in training and experience. That friction was more evident at the senior levels. The “troops” worked together well and with mutual respect.

In addition, it is worthwhile to reflect on the sheer size of this province and the difficulties created by the huge distances between southern Ontario’s relatively sophisticated network of emergency response organizations and the province’s northern communities. An emergency like the one in Elliot Lake occurring in Timmins, Kapuskasing, or Hearst, for example, would present enormous logistical challenges, particularly during the winter season. Similar considerations apply to northwestern Ontario. The existence of USAR hubs in those regions is markedly absent, although Thunder Bay might more easily become one, should the provincial government consider entering into an MOU to that effect with the municipality. Thunder Bay Fire Rescue has developed capabilities and experience related to industrial accidents, high- and low-angle rescue, and confined-space emergencies.

Conclusion

The Elliot Lake rescue effort will not be remembered in the annals of the discipline of emergency management and response as a model to be emulated. But it will be of considerable utility going forward if it is considered a learning experience. True learning occurs through the honest recognition of error and the sincere determination to avoid repetition. I was privileged, through the Commission process, to have met or learned of men and women of great sincerity, courage, and strength of character who forthrightly admitted error and expressed their resolve to learn from that recognition. They are truly engaged on the road to excellence.

Notes

- ¹ Exhibit 6402, p. 2; Latulippe testimony, August 7, 2013, pp. 19885–6; Kerr testimony, September 25, 2013, pp. 27328–30.
- ² Exhibit 9341, p. 2.

