CHAPTER 11

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Introduction

In this chapter, I once again look ahead with recommendations for changes to policies, procedures, and practices supported by the lessons gleaned from the Algo Mall emergency response. I refer the reader to the general comments I made in my introduction to the Recommendations for Part One of this Report. They apply equally to Part Two. In particular, in making the recommendations that follow, I reiterate that I favour a conservative and pragmatic approach:

- Solutions must be cost effective.
- Solutions must be practical.
- Implementation must be reasonably achievable.
- Implementation must be likely to attract consensus, support, and approbation from as broad a cross-section of society as possible.

The nature of the Part Two recommendations, however, is to some considerable extent qualitatively different from those in Part One. Many of my proposals in this part require policy and attitudinal change more than they do legislative or regulatory amendment. Many require collaboration with entities that are, strictly speaking and in the existing legislative context, independent of government.

More specifically, some of my recommendations are meant to provide more rapid provincial advisory assistance and support to smaller municipalities that do not have the financial means to afford the sophisticated systems that large upper-tier municipalities enjoy when faced with a local emergency. Others deal with the underlying philosophy of the Incident Management System (IMS) in existence in the province. Although many of these recommendations have as their genesis the evidence heard during the Commission's hearings, most received strong support from the experts during the policy roundtable sessions. The response of the roundtable participants, therefore, bolstered my confidence in their advisability and viability.

Many recommendations are aimed at making the emergency assistance process more efficient through more rapid response times, assurance of adequate response personnel, training in different rescue techniques, enhanced communications and record-keeping, and adherence to and understanding of the IMS through enhanced training. The recommendations also suggest looking at different approaches or models of emergency response in Ontario and elsewhere and improved synchronicity and co-operation among emergency response organizations.

They also recommend a more sensitive and caring approach to victims and their families.

The Commission recognizes that funding has always been, and will always be, a valid concern to governments at all levels. However, the need for public security and safety requires the reinstatement of federal funding for HUSAR/TF3,* in particular, considering its trans-border responsibilities. It seems unfair that provincial and municipal taxpayers should bear the entire burden of this valuable national asset.

Finally, these recommendations speak to improvements in the Commission process itself and urge a public accounting on the implementation of these recommendations.

* Heavy Urban Search and Rescue Task Force 3.

Recommendations

Provincial organizations and capabilities

There are nine municipal chemical, biological, radiological, nuclear, and explosive (CBRNE) teams located throughout the province with which the Ontario government has memoranda of understanding (MOUs). This arrangement means that they are deployable by the province.

Recommendation 2.1

The capacity to respond to structural collapse emergencies should be increased in Ontario.

Rationale: The vast majority of municipalities have limited or no capacity to provide an urban search and rescue in response to a structural collapse and therefore rely on resources available from the province.

In my opinion, the capacity of provincial urban search and rescue (USAR) resources to deploy to structural collapse incidents in a timely and effective manner is inadequate to serve a province the size of Ontario. Kenora, Thunder Bay, and Hearst are, respectively, 1,900, 1,400, and 900 kilometres by road from Toronto (in round numbers). Elliot Lake, by comparison, is 540 kilometres away. Huge areas in the northern part of the province are accessible only by air. The only assets available for deployment and assistance to municipalities are HUSAR/TF3 and the OPP UCRT,* both located in the Greater Toronto Area. Developing teams of similar expertise and capability that would be available to distant municipalities is a daunting task requiring expensive solutions at a time when, according to roundtable participants, budgets are shrinking.

An analysis of the province's existing USAR overall capability transcends this Commission's mandate, but common sense alone indicates that more USAR assets, with a wider distribution, are desirable to ensure adequate coverage. In any rescue operation, time is always of the essence. As I say, comprehensive solutions are beyond this Commission's capabilities, but certain avenues ought to be explored in crafting at least a partial solution to this complex issue. Those avenues are the subjects of the following recommendations.

The bottom-up approach to emergency management places the responsibility on the municipality before the province. The municipality decides the level of emergency service it will provide, including whether to have USAR capability. However, budgetary considerations determine the level of service. Both to start and to maintain USAR capabilities is an expensive undertaking for any jurisdiction. Fortunately, to date at least, there have been few incidents requiring the attention of the provincial USAR teams and equipment.

* The OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team.

The fact that a USAR team is very expensive, coupled with the reality that it may be deployed only rarely, if at all, makes its funding unattractive for a municipality. To increase the number of USAR teams, whether medium or heavy, will require robust funding support from the provincial government. The province has recognized the need to re-examine the deployment model and has indicated in its Elliot Lake Consolidated After-Action Report its intention to do that.

Implementation: The province should immediately begin its re-examination of the deployment model. This work should be done in collaboration with municipalities and other interested parties.

Recommendation 2.2

The provincial government and others should explore possible collaboration with Ontario Mine Rescue as a partial solution to ensure adequate province-wide capability to respond to structural collapses.

Rationale: Ontario Mine Rescue appears to be an untapped resource that could potentially make a significant contribution to the USAR inventory.

Ontario Mine Rescue has trained and equipped thousands of volunteers who have fought fires, rescued injured personnel, and responded to a wide array of incidents in the province over the past eight decades. It staffs, equips, and maintains a network of mine rescue stations across the province, mainly, though not exclusively, in the north. Currently there are approximately 875 trained volunteers, all of whom are mine employees. Its network covers an area of Ontario that is the most distant from Toronto and therefore the most difficult to reach rapidly by HUSAR/TF3 and UCRT.

A mine collapse is not the same thing as a building collapse. However, both have many commonalities. A rescue at either can involve similar tasks, such as shoring and lifting. Ontario Mine Rescue's province-wide network is fully operational at this time. It presents a rich opportunity for collaboration that should be explored. Alex Gryska, director of Ontario Mine Rescue, indicated a willingness to participate in such a discussion.

Implementation: The province should engage in discussions with Ontario Mine Rescue to collaborate on possible joint initiatives in respect of urban search and rescue.

I note that these discussions have already taken place with HUSAR/TF3. In an article posted online on March 24, 2014, in *Northern Ontario Business*,[1] Mr. Gryska spoke of a possible collaboration with HUSAR/TF3. The province should become an integral part of these discussions. According to the current bottom-up model, it would be the province that would likely deploy Ontario Mine Rescue. With its presence predominately in the northern part of the province, it potentially could play a leading role in a USAR response. In short, it would be ideal if Ontario Mine Rescue resources could be directly and independently deployable by the province.

Recommendation 2.3

The province should initiate discussions to bring the medium urban search and rescue (USAR) teams that currently exist in Ottawa and Thunder Bay into the provincial inventory.

Rationale: The teams in Ottawa and Thunder Bay appear to be strategically situated and potentially ready-to-go additions.

The cities of Ottawa and Thunder Bay each have a medium USAR team, but the province does not have an MOU with either of them, and consequently they are not deployable by the province at this time. Dan Hefkey, commissioner for community safety, informed the Inquiry that the government was taking steps to change that. However, the teams were still not deployable by the province when the roundtables were conducted in December 2013.

Chief John Hay of Thunder Bay Fire Rescue participated in the policy roundtables. Thunder Bay has one of the provincially deployable CBRNE teams. He felt that the CBRNE model of regionally dispersed teams that are deployable by the province worked fairly well and thought it should be studied in the context of USAR. This model appears to provide an expeditious way for the province to expand its capabilities. It also offers a more cost-effective alternative plan to funding a team from scratch. The teams' locations extend the reach of the province's ability to provide timely assistance.

Implementation: The provincial government should negotiate a memorandum of understanding with both Ottawa and Thunder Bay (which both have urban search and rescue teams) that would, among other things, allow the province to deploy those teams on a cost-recovery basis.

Recommendation 2.4

On request, the province should make incident support teams available to incident commanders.

Rationale: An incident commander may become overwhelmed by an event and require management support.

In the bottom-up approach to emergency management, overall command of the event always resides with the local incident commander. Even when considerable provincial resources are brought in, they are there to support the incident commander. However, an emergency response can be complex and of long duration. It is not realistic to expect that a local incident commander will necessarily have at his or her disposal a management

team capable of dealing with a complex incident such as a structural collapse. In those circumstances, the incident commander should be able to request assistance with the management of the emergency. The incident commander should be able to reach out and request the assistance of, for example, a trained logistics person to act as his or her logistics section chief. The person sent would be in charge of logistics but would report to, and be under the command of, the incident commander.

In a similar manner, I see no reason in principle that the incident commander who feels overwhelmed by the size of the event or its duration could not get some help with the management of the entire incident. He or she would still remain the incident commander; the third party brought in to assist would, in effect, serve as the deputy. The deputy would offer suggestions and advice, but it is the incident commander who would have the final word. In certain instances, the deputy could, in fact, assume temporary command to allow the incident commander to get some rest. This expanded role found considerable support at the policy roundtables.

Implementation: Create a pool of persons deployable by the province capable of exercising the five functions of the Incident Management System (IMS).

These individuals could have expertise in some or all of the IMS functions so long as they are properly deployed (e.g., a planning person should not be sent to do the logistics job). The composition of the pool of these resources could be from municipalities and not necessarily exclusively from the province. Larger municipalities, such as Toronto, have dedicated personnel already able to perform those functions for the city.

Knowing how much training might be required so that a logistics person could perform that function at a structural collapse is beyond my expertise. Another possibility would be for the province to create a pool of teams, with each team experienced in the performance of all IMS functions, rather than a pool of individuals. The participants at the roundtables thought the team approach would be a more effective solution.

Recommendation 2.5

The province should examine the model of a volunteer-based emergency response used by the German Federal Agency for Technical Relief (Technisches Hilfswerk, or THW) to determine if it could have any application in Ontario.

Rationale: There may be significant cost savings and other advantages in using a volunteer model, if feasible.

Eva Cohen, the liaison officer for Canada for the German Federal Agency for Technical Relief (Technisches Hilfswerk, or THW), participated in the roundtable. She explained that in Germany, 99 percent of emergency responders are unpaid volunteers from the local community. The volunteers come from all walks of life, not just from the ranks of police, fire, and emergency medical services. The German federal government's role is to fund, equip, and mentor a unified, nationwide structure that guarantees uniform professional standards. The system has been in operation for more than 60 years. The fact that the volunteers are unpaid certainly has its attraction. Ms. Cohen stated that she is working with the City of Ottawa and the County of Renfrew in a pilot project to set up a volunteer emergency response team similar to the THW model.

Implementation: In the short term, the province should monitor the pilot projects currently under way. If they prove meritorious, the province should consider adopting all or some of their elements in the province's emergency response inventory.

Recommendation 2.6

Statutory authority should give jurisdiction to a coroner to authorize entry to a building, by any safe means including demolition, for the purpose of retrieving a body.

Rationale: At present, it appears that no provincial or municipal agency has such authority. This situation is unacceptable.

After Staff Insp. William Neadles announced that the rescue was over and the response had become a recovery, several officials – including Dr. Craig Muir, the regional coroner; Roger Jeffreys, provincial engineer, and others from the Ministry of Labour; Fire Chief Paul Officer; Robert deBortoli from the City of Elliot Lake; and two OPP officers – had a discussion about how to safely recover the bodies that were still in the Mall. The consensus was that there was no such authority, particularly if recovery involves steps going beyond mere entry.

I agree. The only statute which appears to come close to the issue is the *Coroners Act*. It provides:

> 16.(1) A coroner may,
>
> (a) examine or take possession of any dead body, or both; and
>
> (b) enter and inspect any place where a dead body is …
>
> …
>
> (3) A coroner may authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under subsection (1).[2]
>
> …
>
> 16.1(1) The Chief Coroner may appoint any person, in accordance with the regulations, to exercise the investigative powers and duties of a coroner.[3]

These subsections do not authorize a coroner, or anyone else, to break down walls or destroy property in order to make it safe to retrieve a dead body. Some public authority should be able to do that. It is unacceptable that a building in which deceased persons are located and from which they cannot be safely extricated could be turned over to the owner to be dealt with as he or she sees fit, as was proposed on June 25. Fortunately, in this instance, the owner consented in writing to demolition in order to access and remove the victims.

Implementation: Enact an amendment to the *Coroners Act* to authorize such actions.

The *Coroners Act* permits entry on private property to take possession of a dead body. The Act should be amended to authorize the enabling of safe entry by appropriate means.

Incident Management System / chain of command

Ontario has developed, with input from a number of first-responder units and services across the province, a detailed Incident Management System (IMS) doctrine. It presents a standardized organizational structure, functions, processes, and terminology. It is intended to be used, when and if it is ultimately adopted, in all incidents requiring an emergency response. It is, however, optional in two key aspects.

First, although its adoption by emergency management organizations is desirable, it is not mandatory and, indeed, many have not adopted the IMS. For example, most fire services follow a similar, but not identical, system called the Incident Command System. It is therefore possible that a number of organizations responding to an emergency may be using different response systems.

Second, because it is intended to apply to all emergencies, from a single-car accident to a massive earthquake or explosion, it is "scalable," meaning that those who use it can pick and choose which elements of its structure, functions, and processes will be used.

The IMS identifies five key management functions: command, operations, planning, logistics, and finance / administration. It suggests that there be a section chief for each of the last four functions, all reporting to the incident commander. It does not, however, require that one person be identified as being responsible and accountable for each of these crucial functions. In Elliot Lake, there was no planning chief, because the only person trained for that function was not available. Capt. Tony Comella testified that planning was "a hat [I] wore from time to time." He also testified that he shared the workload of the planning chief position with Capt. Martin McRae.[4] Capt. McRae testified that he was never the planning chief, and that he did not believe that planning was done by one person.[5] Staff Insp. Neadles testified that there was no one assigned to that role, and that it was undertaken by "a couple of different people at different times." When asked whether one person should be assigned to that role, he responded by saying:

> It doesn't have to be that way. The way IMS is structured, it can be – it can be scalable, movable, compartmentalized. It can be people wearing one hat. It can be – it can be people wearing three hats if that is what it is.[6]

Similarly, the IMS "requires" that an incident action plan be developed. Because all aspects of IMS are optional, however, none is truly required. It appears that no incident action plan was developed in Elliot Lake. Although plans were discussed, they can be described only as vaguely fluid and ill defined. No proximate or ultimate objectives were defined. No timelines were specified. No plans were agreed on by or communicated to all important players until Ryan Priestly, president of Priestly Demolition, wrote down his plan on June 26 and had it signed by provincial engineer Mr. Jeffreys and Staff Insp. Neadles.

The lack of a properly identified planning function may have contributed to the failure of Staff Insp. Neadles to learn, before the rescue operation was terminated on June 25, that James Cranford, engineer with HUSAR/TF3, had developed a possible plan to shore the beam supporting the escalator in a way that could have prevented both vertical and horizontal movement. Mr. Cranford thought that he reported to Capt. Comella, and Capt. Comella did not ask him for the results of his final calculations. If there was an individual responsible for planning, Mr. Cranford would have reported to him or her.

The decision to use a crane to remove the slabs of concrete on the rubble pile appears to have developed almost organically. Its presence on site was not the result of an articulated need that formed part of an articulated plan. Although Cst. Ryan Cox concluded in the very early stages that a crane would be essential, it was not ordered until about 11:15 p.m. on June 23. Staff Insp. Neadles was asked about an update email he sent on June 24 at 1 p.m. which stated that they were setting up "a large crane to assist with some large debris removal." He gave the following evidence about the decision to use it:

> *Q.* And I gather that there had been a decision made to commence some crane operations?
>
> *A.* Yes.
>
> …
>
> *Q.* Mr. Comella gave evidence that he was unaware of what the crane was going to be used for except intuitively. My question to you is who decided that the crane operations were going to commence? Because obviously he didn't.
>
> *A.* Obviously, that falls back to me, and I am not recalling who I spoke to to authorize the use of the crane. Obviously, I did not speak to Sgt. [Jamie] Gillespie, so I'm sort of lost at who and what that purpose was for other than it was setting up. So I knew it had been ordered by Sergeant Gillespie's team to come and I'm going to say that it was starting to put itself into position and to start working.[7]

Capt. Comella, who was seen to be the operations / planning chief from time to time, testified that, when the update was sent by Staff Insp. Neadles, he was not aware of what the crane was going to be used for and did not know what the primary objective of the responders was. The only thing he understood at that time was the shoring operation working toward the pile.[8]

The IMS doctrine is also, on first review, quite complex. The doctrine book is 123 pages long, with 11 chapters. It includes complex charts intended to assist in understanding the doctrine. Many of its features are valuable to those involved in the management of emergency responses. It is unrealistic, however, to expect that the doctrine and all its complexities will be understood by the men and women who are on the ground making the myriad of decisions required in an emergency response.

As an illustration, the IMS allows for command, in rare instances, to be shared among individuals representing different organizations involved in the response. This practice is called the "unified command model." It has been referred to by some as "management by committee." A number of the responders who testified before me, however, had different understandings about the meaning of unified command. Some thought that it referred to a number of different responding organizations having representatives at the decision table, but the final decision being made by one person. Furthermore, there was not agreement among the witnesses about whether unified command was the model used in the Elliot Lake response.

It is apparent to me that there was general confusion in Elliot Lake about who was in charge. Capt. Comella testified that at times he was the safety officer, at times the incident commander, and at times the operations section chief. Although Fire Chief Paul Officer was the incident commander, not all understood or respected that. He, himself, did not grasp its significance until after the Community Control Group (CCG) meeting at 3 p.m. on June 25 when Staff Insp. Neadles declared that the response had become a recovery – a decision which was not his to make. A further example of the lack of understanding of who fulfilled the role of incident commander occurred on June 23, shortly after the collapse. An OPP helicopter was called in to assess the scene. This decision was made without consulting or advising Chief Officer, putting the rescuers in the hot zone at risk from the downdraft and its effect on the beam and the "widow makers" overhanging the rubble pile.

Recommendation 2.7

Whenever a municipal or provincial emergency is declared, its management should contain the following mandatory features, each of which is reduced to writing:

- **a clear chain of command;**
- **defined responsibility and accountability for all in the chain of command;**
- **a clear and consistent line of communication for all responders;**
- **a plan of action determined by the individual in charge after consultation; and**
- **an early and comprehensive briefing of all team members before the plan is carried out.**

Rationale: Optimizing safety and success of the response requires such guidelines.

In my view, the essential elements of managing a complex emergency response, like any other complex task to be carried out by a large number of persons, do not need to be complicated. None of them is overly time consuming. What is required is:

- a clear chain of command. One person must be responsible and accountable for the decisions made, and the roles of each person in the chain must be clearly understood by all;
- a thorough and well-articulated plan, determined after appropriate consultation;
- clear and unambiguous communication of the plan to those who will execute it; and
- a written record documenting each of those prerequisites.

A perfect response – what the Incident Management System strives to achieve – undoubtedly requires more. But a response that works must include at least these features. They should form the essential and mandatory nucleus of the response while more peripheral aspects of the application of IMS evolve, are improved on, and ultimately are incorporated. As Voltaire wrote, the best is the enemy of the good (not a literal but an accepted translation of "*Le mieux est l'ennemi du bien*"). The utility of this nucleus of mandatory features is illustrated by the experience of Ontario Mine Rescue developed over many years of responding to emergencies in underground mines. Although serious and fraught with risk, these emergencies are often not as complex as those faced by the responders in Elliot Lake, since they may not involve more than one responding organization. As Mr. Gryska testified, however, Ontario Mine Rescue has learned that each of these elements is critical to success. One person has to be accountable for decisions. It is no answer to say that preparing a plan is too time-consuming – success requires that the team understand the dangers, risks, and hazards to which it will be exposed. A proper briefing is essential – it ensures clarity and understanding about the mission, where the team will go, and what it will do. Lines of communication that are both clear and easily understood will ensure that necessary information gets where it needs to go. Requiring that each of these things be written down ensures that due consideration is given to the decisions being made (because the act of writing intuitively forces the writer to confirm that what is being written is correct), and that there is no ambiguity about what was decided.

Witnesses at the policy roundtables who spoke to the point were unanimous in expressing the value of a written incident action plan (although not about whether a written plan should be required in all responses). The IMS states that an incident action plan should contain:

1. a statement of objectives, expressing in a measurable manner what is to be achieved;
2. clear strategic direction;
3. the tactics to be employed to achieve each overarching incident objective;
4. a list of resources that are assigned;
5. the organizational structure / chart; and
6. safety guidelines or requirements.[9]

There was no plan, written or oral, that met these standards in Elliot Lake before the Priestly plan on June 26.

The statutory requirements for the declaration of an emergency are useful indicators of when each of the minimum organizational requirements I have recommended, including a written plan, ought to be required. The *Emergency Management and Civil Protection Act* provides for either the head of council (the reeve or mayor) of a municipality or the province (through the premier or the lieutenant governor in council) to declare an emergency.

An emergency is defined, for the purpose of a declaration by the head of a municipal council, as:

> A situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.[10]

An order declaring that an emergency exists throughout Ontario, or any part of it, may be made by the premier or the lieutenant governor in council if the following criteria are satisfied:

> 1. There is an emergency that requires immediate action to prevent, reduce or mitigate a danger of major proportions that could result in serious harm to persons or substantial damage to property.
> 2. One of the following circumstances exists:
>   i. The resources normally available to a ministry of the Government of Ontario or an agency, board or commission or other branch of the government, including existing legislation, cannot be relied upon without the risk of serious delay.
>   ii. The resources referred to in subparagraph i may be insufficiently effective to address the emergency.
>   iii. It is not possible, without the risk of serious delay, to ascertain whether the resources referred to in subparagraph i can be relied upon.[11]

A declaration of emergency will clearly be made only where the incident is significant enough that some thought and planning will be required in order to respond appropriately. I cannot conceive of a situation that is serious enough to justify a declaration of emergency which would not require the minimum elements set out above.

Implementation: A regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act*.

Subsection 14(1) of the *Emergency Management and Civil Protection Act* gives the province authority to make regulations setting standards for the "formulation and implementation of emergency plans under sections 3 and 6" of that statute. Those sections require each municipality, each cabinet minister presiding over a government ministry, and each provincial agency, board, or commission to formulate an emergency plan governing, among other things, "the procedures under and the manner in which employees of the municipality [or, in the case of a provincially declared emergency, "public servants"] and other persons will respond to the emergency."[12] The "emergency" referred to in the statute is an emergency so declared by the respective level of government.

A regulation should be enacted requiring that these plans contain the provisions I have recommended. This objective could be achieved by requiring the incident commander to ensure that each of these requirements is met.

Recommendation 2.8

There should be only one person in overall charge of a response; a "unified command" structure should be avoided.

Rationale: One final decision-maker is essential to avoid conflicts or impasses caused by failure to reach a consensus. The concept of a unified command structure intrinsically contradicts the unity of command doctrine because it fails to ensure that decisions are made by someone who is ultimately responsible and accountable.

The Incident Management System doctrine states:

> IMS operates on a defined and specific command and control structure that provides an orderly line of command and accountability, and which is based on the function to be performed and the expertise of the incident management staff, rather than rank, organization or jurisdiction. To ensure unity of command, each individual should have one clearly designated supervisor, who may or may not come from the same jurisdiction or service.
>
> Command of an incident may be exercised through a single command process when one response organization has jurisdictional or functional responsibility for the incident, or under a unified command process, where multiple response organizations or jurisdictions have jurisdictional or functional responsibility for the incident. Whether the IMS is operating under a single or unified command structure, unity of command must be maintained.[13]

In my view, these two paragraphs contradict each other. There is neither "one clearly designated supervisor" nor "unity of command" where more than one person has responsibility for the command of the incident.

Deputy Chief Ronald Jenkins of the Toronto Fire Service described unified command as "command by committee."[14] Mr. Hefkey, one of the architects of the IMS doctrine, gave this evidence:

> So under unified command, it is operating on the assumption that we – so, again, while we can have disagreements, we've now engaged in a unified command structure because we see the benefits – for the very reasons that you just talked about: I don't know everything that you know and you don't know everything that I know, so we are dependent, co-dependent … As a result, that's why you have a unified command. It is rare, but that's what you have. And it is then – when you enter into that agreement, it's

not – like, again, as was asked, *there is no supreme arbiter to the things. It is: We are committing; you and I are committing to commanding this incident jointly so that we can come to a mutually acceptable conclusion so that your interests and my priorities are all met*, that we do it. But that's where, again, I want to go back, it's not – again, it's not clean, and it's not to say you're going to have – you're going to have harmony one hundred per cent of the time. There are times where there is disagreement but when you decide that you are going to enter into a unified command arrangement that's what you are doing.

…

Q. … a course of action between the two leaders of a unified command, assuming it is two, to disagree is not acceptable; correct?

A. No, they can disagree.

Q. Sorry, if the disagreement results in no decision being made?

A. That's unacceptable.

Q. That's unacceptable.

A. Absolutely, correct.

Q. You – in that particular case you would have a dysfunctional unified command?

A. That is correct.[15] [Emphasis added.]

As I have indicated, the "unified command" structure is not well understood by the men and women who have to work with it on a regular basis. This difficulty is, in my view, because they understand that a system which allows for the possibility of clashing or inconsistent decisions is unworkable.

Capt. Comella testified:

Q. [W]hat is the structure of unified command and who is – how do they arrive at decisions or who is the decision-maker?

A. Well, in this situation, with the people that you have listed, there should be a representative of each one of those agencies within the unified command. Each one of those personnel should be appointed as a Commander or Commander's assistant or second or designate, however they want to deal with that. And then information should be coming upstream to them, from their respective agencies, based on their respective tasks at the time. And that will allow for a clear picture to the commanding group as to overall success of the mission and current status of – probably a more clear understanding of current status.

Q. And does the decision-making lie in the group or does the decision-making lie with a single person?

A. I guess that depends on who you ask that question to. I think that the intention of unified command is that the group will review all of the data and collectively make a decision. *I guess the big question is: What happens if there's a tie? Who's the tiebreaker?* In my opinion and it is only my opinion, I think that the Incident Commander would be the tiebreaker at that point in time, the original Incident Commander.[16] [Emphasis added.]

Staff Insp. Neadles testified:

Q. And what is the decision-making process in a Unified Command? Is there – is it essentially a decision by consensus or is or is there somebody who ultimately sits on top and says this is what we are going to do?

A. By the definition of unified command, as I understand it, it is both. You are going to try and come up with every decision by consensus, but one individual would have the veto or the last position to take that if in fact the group either couldn't come up with a viable decision-making process or if that individual was not in agreement with. But that last decision should still lie with the individual who is the lead agency.[17]

A final decision-maker is necessary in any organization for reasons other than the necessity of making a decision when a consensus cannot be achieved. Joint decision making may be a convenient refuge to avoid responsibility or a wish to share its burden. Sole responsibility focuses the mind and the conscience. It eliminates the potential for individuals conflicting orders from a variety of supervisors; it emphasizes accountability, discourages freelancing, facilitates the flow of information, makes the coordination of operational efforts more efficient, and enhances operational safety. The chain of command requires that each responder takes orders from only one superior and gives orders only to a specifically identified person or group immediately below him or her. Each individual participating in the operation reports to only one supervisor, and this practice should apply all the way up the chain to a single individual. All successful organizations work this way. Otherwise, "too many cooks will spoil the broth." In my opinion, the unified command model is notionally and practically unworkable. An army cannot have two generals in command; a ship cannot have two captains. The very concept carries within it the seeds for discord, dysfunction, and, at best, inefficiency. It ought to be discarded.

Implementation: **The Incident Management System should be amended to eliminate the unified command model and require one incident commander at all times.**

Recommendation 2.9

The incident commander, the senior person in the chain of command, in a municipally declared emergency should be either

(a) the person in charge of the initial agency that responds, unless and until that person delegates that authority in writing to another person; or

(b) the person in charge of an agency determined by a matrix that assigns responsibility before an incident on the basis of the agency most closely linked to the type of emergency at issue.

Rationale: **There must be certainty about who is in charge, and local emergencies should be run by either a local authority (unless the local authority does not have the capacity to do so) or the agency best suited to the response.**

Chief Officer was the incident commander throughout the Mall collapse response, but, in practice, he did not make the final decisions on key issues. Perhaps the most obvious example was the decision to call off the rescue, which was made by Staff Insp. Neadles, without consulting Chief Officer. The principle of local authorities being in charge of local emergencies is well founded. Those living and working in the community are best positioned to know the unique character and particularities of their region and better attuned to the likely consequences of the emergency. They should not have to divest control simply because they do not have the physical resources to deliver what is required to deal with the emergency.

Having the incident commander as the person in charge of the initial agency that responds also makes sense from the point of certainty. As I have explained, it is essential that someone be in charge at all times, and that his or her identity be clearly known to all. If the person in charge remains the same, the likelihood of confusion is avoided.

Furthermore, the incident commander – the person in charge – does not have to have technical knowledge of all aspects of the response to fulfill the role. He or she should get advice from those with that knowledge. It would have been perfectly appropriate for Chief Officer to seek advice from Staff Insp. Neadles, Sgt. Gillespie, Cmdr. Michael McCallion, Capt. McRae, Capt. Comella, Mr. Cranford, or Mr. Jeffreys. He could have chosen to get advice only from Staff Insp. Neadles, if he was satisfied that it would be sufficient in the circumstances.

Sometimes, however, the local authority recognizes that he or she does not have the ability to make the necessary decisions, or that his or her agency is not best suited to be in charge of the response, given the particular incident at issue. In those circumstances, the authority should be able to delegate the authority to another individual. That delegation should be in writing. This practice ensures that there is no confusion about who is in charge at any particular time.

Some jurisdictions, such as New York City, employ a matrix that identifies, before an event occurs, which agency (or agencies, if a unified command system will be used) will be in command, based on the type of incident being responded to. In New York City, for example, the primary agency in a structural collapse will be the Fire Department.[18] This seems particularly appropriate in larger centres, where more than one service may respond very quickly. It achieves the primary purpose of certainty of who is in charge, and ensures that the person in charge is from an agency best suited to the type of emergency at issue.

Implementation: A regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act*.

This recommendation should be implemented by the same method as Recommendation 2.7 – by enacting a regulation requiring these provisions in every municipal emergency plan. The plan should state that the incident commander will be either:

(a) the person in charge of the initial agency that responds, unless and until that person delegates that authority in writing to another person; or

(b) the person in charge of an agency determined by a matrix that assigns responsibility before an incident on the basis of the agency most closely linked to the type of emergency at issue.

Recommendation 2.10

The province should put in place strategies that will increase the acceptance and actual use of the Incident Management System (IMS) – including simplifying its language and instituting joint training and exercises – so as to be able to make it mandatory in the near future.

Rationale: The IMS has many positive features, but it will not work unless it is used. Making it an accepted and accessible system requires education, consensus, acceptance, and some simplification.

It is not uncommon for police, fire, and EMS personnel to respond to the same incident. Sometimes, as in Elliot Lake, more than one service is involved in a response. IMS provides for, among other things, an organizational structure that facilitates a coordinated joint effort to manage the incident under a specific command.

As the evidence I heard showed, there is often a cultural resistance on the part of first responders, particularly those in uniformed services, to accept orders from someone wearing a different uniform. This attitude results in silos, with each group of responders acting within its own command structure, moving toward the common goal. This situation can lead to unproductive rivalry, friction, and misunderstanding, including the possibility of groups working at cross purposes and, at a minimum, inefficiently. Properly used, IMS eliminates or at least serves to dismantle these silos.

The IMS doctrine is not written in a way that is easily understandable. It should be simplified, with ambiguities removed, so that the men and women who respond to emergencies can clearly understand what they are being asked to do. The Ontario Mine Rescue handbook, in contrast, is much easier to understand. Consideration should be given to producing a similar handbook to be issued to those who will be asked to respond to emergencies. A simple, practical, portable, waterproof handbook, containing the doctrine's essential elements and its practical application in emergency operations, should be developed to be carried in the back pocket of every first responder.

More importantly, there needs to be adequate training to ensure that the system is understood, both in theory and in practice. IMS courses are now offered by the province. They should be provided to integrated audiences of responders from more than one service. This approach would not only allow relationships to develop, but would also allow those being trained to understand the practical issues faced by members from other services.

Training exercises should also be provided on an integrated basis. Few joint exercises have been organized, even by HUSAR/TF3 and UCRT, although those two groups are likely to work together on any urban rescue emergency of a significant size. Acting under the direction of someone from a different service does not come naturally. Mutual understanding and respect, as well as the elimination of inter-service rivalry, are unlikely to occur if team members have engaged at least in joint simulated exercises.

The ultimate goal should be mandatory adoption of the IMS system by all agencies in the province. It is unrealistic to expect the system to work at maximum efficiency otherwise. It is clear, from the discussions at the policy roundtables, that some agencies are not yet ready to adopt the doctrine. A firm date should, however, be set to ensure that this worthy goal does not drift into oblivion. I would suggest five years hence.

> **Implementation: The province should encourage the appropriate agencies to agree on simplifying IMS. The province should initiate and provide training opportunities, and a regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act* requiring that municipal and provincial emergency plans mandate compliance with IMS within a specific period.**

The Incident Management System was the product of a committee composed of representatives of a number of organizations. That may be one of the reasons behind its somewhat cumbersome nature. A Permanent IMS Steering Committee has, according to the IMS doctrine, responsibility for making amendments to the doctrine. It should be immediately asked to consider its simplification, as I suggested.

IMS training has, hitherto, been provided by the province. This training should be continued and enhanced, because all residents of Ontario would benefit from an emergency response system that is optimally organized and delivered, and because the only way to ensure that all training is the same is to have only one trainer.

Once the necessary improvements and training have been delivered, no later than five years from now, a regulation should be promulgated under subsection 14(1) of the *Emergency Management and Civil Protection Act* requiring that all emergency plans adopted by municipalities and provincial ministries, boards, and commissions mandate compliance with the IMS.

Communications

As previously mentioned, the initial response to an emergency in Ontario, including the management of the media response, is local. However, just as the skills of the local first responders can quickly be overwhelmed by the gravity and complexity of an incident, so too can the ability of a municipality and other local resources to manage the media and communications response for larger-scale operations.

I heard evidence during this Inquiry that the mayor and others on the Community Control Group in Elliot Lake were staggered by the media interest in these events. One witness described it as "baptism by fire."[19] I heard evidence of confusion and indecision about how to communicate the progress of the rescue and the suspected number of casualties to the media, to local Elliot Lakers, and to the public at large.

When the rescue was called off on June 25, management of the communication of that decision to the media and the public was disastrous. The result was uproar and unrest in the local community and the public at large. This situation had a very real effect on the ground for rescue workers and in terms of perimeter security. Ultimately, the OPP did an effective job defusing tension, and the townspeople, understandably incensed at the way the rescue was called off, exhibited commendable restraint.

In Elliot Lake, no one with appropriate experience and training was available to manage (in the non-pejorative sense) the media message. An experienced communicator might well have anticipated the upheaval that could result from a stark announcement that the rescue had ceased shortly after an announcement having been made that signs of life had been detected.

Recommendation 2.11

Provincial media and communications expertise should be made available, either as a stand-alone service or as part of incident support teams, to municipalities during declared emergencies or where provincial resources have been used.

Rationale: For large-scale incidents, the local municipality may lack the ability to effectively manage media and public communications. Poor management of media and communications can seriously undermine rescue efforts.

There was widespread support during the policy roundtables for the provision of media and communications support during similar emergency responses in the future. The City of Elliot Lake, for example, recognized the need for the assistance of a media professional.

I heard evidence during the roundtables that provincial media and communications assistance existed and was used during recent emergencies in High River, Alberta, along with contract assistance from a private company. Benjamin Morgan, Calgary's crisis communications director, told me how he had access to a dynamic group of professionals and communicators, able to "do a great job of keeping the public informed of events." He pointed out that local leaders having able communications and media assistance during an emergency promotes faith and trust in those leaders. Local leadership is not supplanted, but supported and left better able to do its job.[20]

Similar timely assistance should be available for municipalities in Ontario. Effective communication from first responders and the local Community Control Group is critical to the effective management of an emergency. I agree with the following comment from one of the participants during the roundtables. The words ring all too true when one looks back at the experience in Elliot Lake:

> Successful communication could rally the community, provide it much needed info and [be] calming of its public.
>
> But poor communication or no communication could fan emotions, promote rumours and undermine confidence.[21]

Implementation: The Ontario government should identify and develop a pool of communication specialists on call and able to provide expert media and communications assistance, either stand-alone or as part of an incident support team. This assistance should be offered immediately to the municipality in all cases where an emergency has been declared or where provincial resources have been used.

Recommendation 2.12

The Ontario government should make it mandatory to provide private space and regular updates to family members of victims on the progress of rescue and recovery operations during declared emergencies or where provincial resources have been used.

Rationale: Keeping victims' families informed of the progress of a rescue and the status of their loved ones is a question of respect and dignity, but also good incident management.

In the immediate aftermath of the collapse of the Algo Mall, provision of information to the families of victims was intermittent, inconsistent, and at times insensitive. The Collins Hall was the gathering point in Elliot Lake for both the victims' families and the general public. A room, unsuitably small for the purpose, was made available to the families. Robin Kerr, the representative of Victim Services of Algoma, repeatedly had to press the OPP for details on the progress of the rescue. There were long periods where no information was provided.

The families should have been provided with more frequent and more accurate updates, and should not have had to rely on media reports for information on the status of the rescue and their loved ones. This lack of information led to rumour, speculation, and bad feelings, not only with the families but, through those families, to the general public in the small community of Elliot Lake.

When the rescue was stopped on June 25, the families of Ms. Aylwin and Mrs. Perizzolo were told of the stoppage in public, and not in private. Not all the family members were present when the news was first delivered. The announcement was abrupt and lacked sensitivity and discernment.

It was not until the unrest following the events of June 25 that OPP victim liaison officers were deployed to Elliot Lake to assist the Aylwin and Perizzolo families, and a proper private space segregated from the general public was arranged for the victims' families.

The Elliot Lake Mall Action Committee recommended during the roundtables that a dedicated person or persons be assigned to deal with family members throughout an emergency response, with responsibility to provide frequent, timely, and honest updates on progress, before the release of that information to the public and media. I agree.

Implementation 1: A regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act* making specific provisions for the needs of family members mandatory in emergency response plans.

As previously noted, the Ontario government has the authority to make regulations setting standards for the "formulation and implementation of emergency plans under sections 3 and 6" of that statute.[22] The government should use that regulatory power to make it mandatory for emergency response plans to contain specific provisions addressing the needs of families of victims. These needs include the provision of private space for family members and, when operationally practicable, priority in receiving information in as respectful a manner as possible.

Implementation 2: OPP victim liaison officers should be made available to municipalities, as quickly as possible, for all large-scale rescue operations where there are potential victims.

Recommendation 2.13

Training for rescue and recovery operations should stress providing the public with timely and accurate information about casualties and the progress of a rescue operation (subject to legitimate operational requirements).

Rationale: The public's perception of the Elliot Lake emergency response and its reaction would have been more positive and supportive had it been informed in a timely and accurate way about the number of casualties and the progress of the rescue.

Early on in the rescue, it was clear to rescue workers that one person was most likely deceased and another person trapped and possibly alive. The OPP's list of missing persons fluctuated, but rescue workers were fairly confident these were the only two individuals trapped. By contrast, the media continued to report larger numbers of people potentially missing or trapped. This misinformation added unnecessarily to public alarm, fears, and concern.

OPP Insp. Percy Jollymore was concerned about releasing a statement that someone was deceased because he did not want to make a mistake. Chief Officer and others from the Community Control Group did not agree with this approach but deferred to the OPP's greater experience in dealing with coroners. The OPP's policy appears to be that it cannot confirm a death without an official pronouncement from the coroner or a medical doctor unless there are evident signs, such as decapitation or decomposition. The result was that inaccurate information was provided to the public. For example, at 1 p.m. on June 24, the public was told by press release that there had been no confirmation of loss of life.[23]

The OPP's rigid policy on confirmation of death is not suited to the rescue and recovery milieu. It essentially means deaths cannot be confirmed until rescue operations have ceased and a coroner has been provided access to the bodies. Instead, to the full extent possible, the public should be informed of the truth. In Elliot Lake, from very early on, the truth was that rescue workers believed there to be one victim potentially alive and one that was likely deceased.

Chief Officer told me, when asked about lessons learned, that with hindsight he would have been "much more forceful" in conveying, clearly and precisely, that there was one casualty and one individual they hoped could be saved.[24] By failing to do so, media rumours of more victims persisted and added to the community's sense of confusion, desperation, and helplessness. I agree with Chief Officer's assessment.

In addition, the public was provided with sporadic and incomplete information about how rescue efforts were proceeding and how truly dangerous and complicated the rescue operation was becoming. Clear and timely information would have made the June 25 stoppage appear justified and understandable.

The importance of full, frank, timely, and early disclosure to the public, where at all possible, cannot be overstated. Underestimating the public's ability to deal with complicated and difficult news is unjustified in my view, absent overriding concerns involving such things as public security and valid investigative imperatives. Unrest and mistrust of public officials ensue when secrecy prevails. Even when information needs to be withheld, the public has a right to be told why that information cannot be given out – and it usually understands.

Implementation: **Future training for all players in the field of rescue and recovery, as well as municipal officials, should stress the importance and means of providing, to the fullest extent possible, accurate and timely information to the public. The Elliot Lake experience would be an illustrative and useful case study.**

Recommendation 2.14

Where multiple agencies are present at a rescue operation, they should have continuous access at the command level to common-frequency radios or communications equipment.

Rationale: **The various agencies at a rescue operation need the ability to communicate quickly during emergency response.**

The evidence at the Inquiry was that the OPP, UCRT, HUSAR/TF3, and the Elliot Lake Fire Department all operated on different radio frequencies during the rescue and recovery efforts. Sgt. Gillespie was given a HUSAR/TF3 radio, but other members of UCRT were not.

The absence of interoperability of communications equipment led to a certain amount of confusion and inefficiency in the Elliot Lake deployment. For example, I refer to the incident where the OPP helicopter was ordered by Insp. Jollymore to hover above the collapse zone and take pictures. The Elliot Lake Fire Department was forced to evacuate the collapse zone because the helicopter downdraft was causing dangerous movement.

Chief Officer attempted to contact the OPP but did not have a direct radio linkage. If he had, he could have waved off the helicopter more quickly. Different teams were literally not on the same wavelength.

I am aware that inter-agency communications equipment incompatibility has long been the subject of public discussion and debate in this province and elsewhere. It is clearly beyond this Commission's competence to suggest practical solutions to a problem that has hitherto eluded experts. Nevertheless, in an era where technological innovations in the field of electronic communications have developed at prodigious rates of speed, I have difficulty understanding why interoperability strategies have not been crafted to attenuate or eliminate the problems.

Quite obviously, not all responders need to hear all the electronic traffic being generated. The airwaves would quickly jam up and render communications impossible. Nevertheless, when multiple agencies respond and when command responsibilities transcend individual organizations, common sense dictates that operational team leaders should be able to communicate easily with one another and up the command chain. Individual first-line responders need to understand their orders, even if they are being directed by a superior from a different service. Above all, the incident commander needs direct and effective lines of communications with those below him or her.

I am of the view that authorities involved in emergency response urgently need to investigate and develop means to achieve inter-service interoperability and compatibility on a provincial level. Examples already exist. I was informed, for example, that the City of Toronto has a joint emergency services channel open to police, fire, and EMS. It is possible to switch to that channel to allow all three agencies to talk during an event. The Office of the Fire Marshal has played a role during past emergency responses, bringing additional radios to the emergency response scene. The OFM radios have a common channel that can be used to enable interoperability of radio systems among different response agencies.[25]

At the policy roundtables, there was widespread support for the notion that different agencies at an emergency response needed common communications technology in order to break down the silos between organizations and to deal, in real time, with urgent operational issues.

> **Implementation 1:** Emergency response agencies in Ontario under the aegis and leadership of the Ministry of Community Safety and Correctional Services should be brought together to explore new technologies and to develop communications equipment, systems, and protocols to enhance interoperability during joint rescue and recovery deployments.

> **Implementation 2:** In the interim, the Office of the Fire Marshal should continue to maintain a cache of common-frequency radios and/or additional communications equipment to be distributed to the upper command levels of all agencies involved with rescue efforts. Joint training should incorporate use of common-frequency communication.

Recommendation 2.15

Specialized rescue workers must be trained to accept the need for contemporaneous record-keeping during an emergency response. To facilitate the process, waterproof notebooks should be provided and consideration should be given to the acquisition of hands-free recording technology.

Rationale: With the exception of police and the Elliot Lake Fire Department, the rescue and recovery organizations involved in the deployment, in particular HUSAR/TF3, do not appear to have a culture of note-taking during operations. The reason may be related to the practical difficulties associated with note-taking at an emergency scene.

Note-taking by rescue workers during this deployment was subpar, at best. Notes were produced long after the fact, or not at all. Times were off, sometimes significantly. Key events went unrecorded entirely. Although certain individuals (often those from the policing milieu) took good notes, the vast majority of those involved with rescue efforts quickly abandoned attempts to take proper notes or never attempted the process at all. Some blamed the wet environment.

I emphasize elsewhere in these recommendations the important potential for improvement that flows from debriefings and after-action reports. Good notes are essential to that process. The ability surely exists to equip rescue workers with the technology to take hands-free, voice-transmitted notes. I leave the choice of technology to the experts, but cannot stress enough the importance of taking good notes for understanding what happened and improving on it.

Implementation: Emergency Management Ontario, the Office of the Fire Marshal, HUSAR/TF3, and UCRT should explore the purchase of hands-free note-taking technology (audio recorders) to be provided to rescuers during rescue operations to supplement or to replace written field notes. Waterproof-paper notebooks and waterproof pens are inexpensive and widely available. Training must stress the importance of contemporaneous note-taking.

HUSAR/TF3 (Heavy Urban Search and Rescue Task Force 3)

In this section, I make recommendations that are intended to improve how HUSAR/TF3 responds to structural collapses. These recommendations flow from the evidence and hopefully should be taken as constructive criticism. It would be unrealistic to think that an undertaking as big as the HUSAR/TF3 response to Elliot Lake could be done in a manner that left no room for improvement.

Recommendation 2.16

HUSAR/TF3 should conduct debriefings in a timely fashion following any deployment.

Rationale: HUSAR/TF3 should critically evaluate its own performance in a deployment to ensure that matters needing improvement are identified and addressed.

Debriefings are meetings typically held very shortly after an event, where the participants discuss their own group's performance and that of other responders in applicable circumstances. They are a critical part of the learning process. A debriefing usually includes those persons who attended an incident on behalf of the organization as well as some supervising personnel. The purpose is to identify and discuss those aspects of the response that were done well and those that were not. Overall, the aim is to learn from the event, so that future deployments do not repeat past mistakes. In debriefings, strategies are developed to eliminate or mitigate the mistakes in addition to building on those aspects that were identified as successes.

HUSAR/TF3 did not hold a debriefing after the Elliot Lake deployment, despite having had opportunities to do so. Moreover, the evidence was that HUSAR/TF3 does not conduct debriefings. The reason cited for this absence is primarily financial. There does not appear to be any source of funding that would cover the cost of bringing the team together after the fact. Based on the evidence heard, it seems clear that debriefings could have been conducted at the hotel the team stayed at in Sudbury on the way home. Alternatively, it could have been done on the bus travelling back to Toronto. Neither opportunity would have required any additional funding since the province was already paying for the team's time. Less satisfactory but useful nevertheless, one could have been conducted by correspondence (electronic or traditional). No explanation was offered for these missed opportunities.

I strongly encourage that this practice change. No one has disagreed with the value that a debriefing holds for an organization. The province, which to date has been the primary deploying agency of HUSAR/TF3, has a direct interest in the quality of the services for which it is contracting.

Implementation: The memorandum of understanding between the province and HUSAR/TF3 should be amended to provide that HUSAR/TF3 must conduct debriefings in a timely fashion following any provincial deployment.

HUSAR/TF3's current memorandum of understanding with the province runs until March 31, 2017. It can be amended with the consent of both parties. HUSAR/TF3 and the province should be able to come to an agreement to ensure that debriefings are done. HUSAR/TF3, the Office of the Fire Marshal and Emergency Management (OFMEM), indeed all the citizens of Ontario, want the team to be as effective as possible whenever it is deployed. This type of opportunity to improve should not be lost.

Recommendation 2.17

HUSAR/TF3 should create an after-action report in a timely fashion following any deployment. In the case of a provincial deployment, the after-action report should be submitted to the Office of the Fire Marshal and Emergency Management (OFMEM).

Rationale: The after-action report documents the successes and failures of a response, as well as steps to be taken to improve performance in the future.

This recommendation is the companion of Recommendation 2.16. The evidence disclosed that, like debriefings, HUSAR/TF3 does not prepare after-action reports. The after-action report can be seen as an extension of a debriefing, where an analysis of the problems identified leads to strategies to deal with them. It creates a documentary record of the plans to improve the group's performance and sets a standard against which progress can be measured.

Implementation: The memorandum of understanding between the province and HUSAR/TF3 should be amended, if necessary, so that HUSAR/TF3 is required to create an after-action report and to provide it to the OFMEM in a timely fashion after a provincial deployment.

The MOU states that the City of Toronto is to provide the minister with a written report at least once a year, or more frequently as the minister directs. The report is to include, pursuant to article 8.3:

- training that the City has provided to members of the provincial HUSAR team;
- an account of all occasions on which the provincial HUSAR team has been used; and
- anything else reasonably requested by the minister.[26]

The only documentary record of the deployment at Elliot Lake that was provided to the province was the invoice. It did not provide details of what took place. Article 8.2(c) could be relied on to request an after-action report; however, it has not been used in that fashion to date. Either through reliance on article 8.2(c) or an amendment to the MOU, after-action reports should be provided to the OFMEM. The after-action reports would allow it to be informed of problems and of the progress in resolving them. If the problem involves training issues, then the OFMEM could either provide that training or, presumably, arrange for it.

Recommendation 2.18

HUSAR/TF3 and UCRT (the OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) should enter into a memorandum of understanding with each other that clearly sets out the command structure under which they will operate when jointly deployed.

Rationale: A clearly defined and well-understood chain of command is essential to the safety and success of the response.

These two specialized teams have not trained together frequently and have been jointly deployed on only a few occasions. There is no formal protocol governing how they will operate in these circumstances.

At Elliot Lake, there were different expectations about what the command structure between them should be. Both teams were there in support of the local authorities and were therefore under the command of Chief Officer, who was the incident commander. It was clear to all that, because of their expertise, the two teams would be the backbone of the Operations Section.

The question became who would lead the Operations Section. In the past, there had apparently been discussions about formally defining their roles and command. However, these discussions did not produce tangible results, as was evidenced by the divergent and often contradictory views that witnesses expressed about how UCRT and HUSAR/TF3 should interact in a command structure. For example, even within HUSAR/TF3, there were differing views expressed about the relationship between it and UCRT. Capt. Comella's expectation at Elliot Lake was that the command structure would be one of unified command, with a leader from all responding agencies. In such a scenario, Capt. Comella felt UCRT would have a command position equivalent to HUSAR/TF3. Staff Insp. Neadles, on the contrary, expected that the UCRT team would have a presence in the command tent but that it would fall under the direction of HUSAR/TF3. In addition, as I have previously noted, the members of UCRT expressed frustration with the command and control of HUSAR/TF3. Some members of UCRT described "constant battles" and other frustrations with the command and control of HUSAR/TF3.

The evidence heard at the Inquiry clearly showed the need for a formal agreement specifying the command structure when the teams are jointly deployed. Indeed, this proposal received support from high levels within both the OPP and HUSAR/TF3, including Chief Supt. Robert Bruce and Staff Insp. Neadles.

Implementation: HUSAR/TF3 and UCRT should enter into an MOU that clearly states what the command structure will be in joint deployments.

At the policy roundtables, it was suggested that a better way to achieve this clarity and understanding of the command structure would be through joint-training opportunities where both teams could work together as a team and build relationships. However, no joint training had taken place in the more than 17 months that had elapsed from the time of the collapse until the roundtables on December 5, 2013. There are no plans for future joint training. Failing joint training, an MOU would at least clarify the relationship in a joint deployment. Ideally, both should occur.

Recommendation 2.19

HUSAR/TF3 should implement procedures to ensure that qualified section chiefs are available for deployment.

Rationale: The team needs to know in advance that these positions can be filled.

This recommendation deals with leadership staffing. The Elliot Lake deployment disclosed two different problems with staffing: an inability to properly staff a leadership position (the planning section chief), and an overall low turnout. I have outlined earlier how the deployment suffered from the lack of a properly trained planning section chief. At the time of the deployment, the team had only one such member, and he was not available to deploy. Since Elliot Lake, two additional individuals have been trained and certified as planning section chiefs. The team's management recognized and rectified this deficiency. However, addressing a lack of qualified personnel is one thing; ensuring availability to deploy is another.

Implementation: Those team members identified as section chiefs for operations, logistics, and planning should be included in the rotational on-call system currently in place for the team's site commander.

Staff Insp. Neadles deployed to Elliot Lake because he was the site commander on call. This practice allowed the organization to know and count on the fact that, if the call came, he would be available to go. Deputy Chief Ronald Jenkins, the project leader for HUSAR/TF3, said at the roundtables that collective agreements could be an issue with adopting this type of procedure in the case of non-management team members. However, he thought all persons in the leadership roles were, in fact, management in their home services. This uncertainty should be removed for other members of the team occupying key leadership functions.

The particulars of organizing a proper roster and its training requirements are matters properly left to HUSAR/TF3's experience and knowledge.

Recommendation 2.20

HUSAR/TF3 should implement procedures to reduce or eliminate the unpredictability of the size of the team it is able to muster following a call-out.

Rationale: Leaving the size of the team to chance is not prudent planning.

The team membership is over 100. At the roundtables, Deputy Chief Jenkins put the number at approximately 130. When the call-out happened on June 23, 2012, the team deployed 33 members. This turnout was low and may well have been even lower had it not been for the fact that the team was conducting training that day.

I recognize that every response does not require a full team deployment. The number of members required, as previously discussed, is subject to several variables. According to the MOU, a full deployment is 68 members; the HUSAR/TF3 PowerPoint presentation notes that a provincial deployment is 76 members. To field a full team, therefore, would require a turnout of approximately 50 percent. This number should be contrasted with the roughly 25 percent that ultimately deployed to Elliot Lake. Clearly, steps should be taken to ensure that it can field enough members to be able to function effectively.

With the exception of the lack of a planning officer, I do not feel that the low turnout affected the response. However, that may not always be the case.

Implementation: HUSAR/TF3 should implement a series of point-in-time evaluations to get a better understanding of its ability to field an adequate team and take any remedial steps that the surveys call for.

Ontario Mine Rescue conducts a series of point-in-time evaluations. These are simply a survey of all the trained responders at a particular site. They are called and asked: "If there was an incident right now, would you be able to respond?" In this way, the organization gets a feel for their staffing requirements.

HUSAR/TF3 could do the same and similarly get an understanding of these trends. For example, it might reveal that typically they get 50 percent response. This would provide a baseline from which to work. How team management deals with the results of the surveys is a matter for its discretion and experience. I acknowledge that it could be a complicated issue involving collective agreements and funding.

Another technique was described by Chief John Hay of the Thunder Bay Fire Department. He informed the policy roundtables that in Thunder Bay they do cold calls. The team members are called in without forewarning but they are not told that it is simply a dry run until they arrive. When they do arrive, they engage in training. He does these cold calls for the purpose of making sure that, when the time comes, he can mount as full a team as possible. Chief Hay determined that, to be able to obtain two 10-person teams to sustain a 24-hour operation, he needs to have 40 trained responders.

Recommendation 2.21

The HUSAR/TF3 site commander should be supplied with a scribe on all deployments.

Rationale: A scribe's notes will allow a site commander to make a full account of his or her actions and decisions.

Staff Insp. Neadles said that, because of the low turnout, he did not feel he could take a rescuer away from the site to act as his scribe. The lack of a scribe clearly handicapped his ability to reconstruct events and explain important decisions during the deployment. This situation was exacerbated by the sparse documentary record kept by HUSAR/TF3 generally.

Implementation: The position of scribe, although important, does not necessarily require a trained team member. Less qualified members or a civilian could fill this position.

The position of scribe requires note-taking ability, not rescue skills. It is important that the role be filled. I see no reason why the position should be filled only by a trained rescuer. The overwhelming majority of Staff Insp. Neadles's time was spent outside the hot zone. The scribe could come from the ranks of those members who have yet to qualify to work in the hot zone, it could be a driver, or it could be a civilian. It seems to me that this issue was a big problem with a relatively simple solution.

Recommendation 2.22

HUSAR/TF3 should ensure that it has access to qualified drivers to transport the cache of equipment on deployment.

Rationale: A delay in securing drivers could delay the deployment time; an inability to get drivers could ground the team's equipment.

The evidence disclosed that the team looks to its lead driver, Paul Demy, to line up both the drivers and the tractors needed to transport the equipment. In this case, he had difficulty obtaining drivers. The team turned to Don Sorel from Toronto Water to arrange for drivers. In the past when the team came up short through Mr. Demy, Toronto Waste had supplied drivers. This arrangement, I understand, was simply an informal one. As discussed earlier, it appeared that it ended shortly after this deployment. I do not know if steps have been taken to ensure a back-up plan for drivers. This issue needs to be addressed.

Implementation: HUSAR/TF3 should ensure that there is an alternative pool of drivers available if the primary source is not able to provide an adequate number.

These simple details must be worked out and planned for prior to call-out, not during a deployment.

Recommendation 2.23

HUSAR/TF3 should explore additional sources for tractor rentals.

Rationale: As with the tractor drivers, any delay in securing tractors can potentially delay the time of departure for the team.

Mr. Demy also experienced trouble tracking down the tractor rentals needed to pull the equipment trailers. The tractors were ultimately located in Mississauga, roughly 25 kilometres from the base of operations. According to an email sent by Staff Insp. Neadles, the delay in getting the tractors delayed the departure by 30 to 60 minutes. The delay would have been much greater had the deployment occurred on a weekday morning at the height of rush hour.

Implementation: HUSAR/TF3 must improve the rapid availability of tractors.

Little evidence was led concerning the rental protocol in place in 2012. I heard no evidence concerning the number and location of leasing companies in proximity to the home of operations. I am consequently unable to make specific recommendations to correct this situation, but, left unremedied, it may mean serious delays in mobilization.

Recommendation 2.24

HUSAR/TF3 team members should receive training for rigging operations.

Rationale: The cranes of Millennium Crane played a significant role in advancing the progress of reaching the victims, which required trained riggers to complement the hoisting by Millennium.

HUSAR/TF3 personnel made it very clear when they testified that cranes and rigging operations are a method of last resort. It would appear that HUSAR/TF3 team members currently do not receive rigging training. It is not part of the core training courses. Members of HUSAR/TF3 who have completed Rescue Systems 2 would have received between four and six hours of rigging training, according to Capt. Comella. However, those team members would generally be the instructor group that received their training before it was done in-house, in approximately 2005. The team relied on Mr. Sorel for its rigging capability. In contrast, UCRT was more willing to embrace rigging. Its members had received rigging training because they had taken the course identified as Rescue Systems 2 at Texas A&M Engineering Extension Service. It appears obvious to me that circumstances may necessitate the use of cranes at a structural collapse. Unless the team members are trained to rig, they will not be able to use a crane. In Elliot Lake, it was only because Mr. Sorel was present on the deployment that HUSAR/TF3 had some capacity for such operations. By not training for rigging operations, HUSAR/TF3 is limiting the tools and solutions it can use to save lives.

Implementation: HUSAR/TF3 should make rigging a core skill that all current and new members must acquire.

I am mindful that this recommendation does not come without cost. How this additional training is phased in will be a management decision. The goal, however, should be that, as soon as possible, the team should develop the capability to field enough of its members to be able to sustain 24-hour rigging operations if required. This does not mean that everyone in the deployment has to be able to rig tomorrow. In a recovery, there is no premium on speed. In a rescue, however, speed could make the difference between life and death. Safety concerns may preclude rigging; lack of training should not.

Recommendation 2.25

Standard operating procedure for HUSAR/TF3 should require fully documented incident planning, which is provided to supervisory personnel.

Rationale: The deployment had significant communication issues within HUSAR/TF3. This requirement of fully documented incident planning is intended to ensure that communication of this critical information takes place and is clear.

I have commented on the lack of communication surrounding the incident action plan. This problem could have been avoided if HUSAR/TF3 had used its own incident planning documents. These forms contemplate that an incident action plan will be completed following each formal planning meeting conducted by the incident commander and the staff. The plan is to be reproduced and given to all supervisory personnel. It describes the general objectives for the incident, including variations. It includes a list of assignments, what was accomplished last operational period, and what must be accomplished this operational period.

Implementation: HUSAR/TF3 should use its own forms.

The evidence established that there currently exists a more recent version of the planning documents described. These documents are available in hard copy as well as electronically. This recommendation does no more than exhort HUSAR/TF3 to follow its own protocol. With a trained planning officer on deployment, this practice should be standard operating procedure.

Recommendation 2.26

HUSAR/TF3 should receive adequate funding to ensure that it is properly equipped and trained to respond to structural collapses in a timely manner with sufficient personnel and expertise. The Joint Emergency Preparedness Program (JEPP) funding should be reinstated by the federal government.

Rationale: Without adequate funding, HUSAR/TF3 will not be able to fulfill its intended function in the future.

The federal government established the National Urban Search and Rescue Program in 2001.[27] It provided aid to member teams through JEPP. HUSAR/TF3 received significant financial support from JEPP. According to the written submission of the City of Toronto for the policy roundtables, the JEPP funding varied from year to year, from a high of $1.4 million to a low of $460,000. In 2012, HUSAR/TF3 received $300,000 from the province, $400,000 from the City of Toronto, and $468,000 in federal funding.

At the roundtables, there was unanimous support for the HUSAR/TF3 program as well as recognition of the problem created by the cancellation of the JEPP funding. The province in its written submission at the roundtables put it this way:

> Ontario's risk – including its current building infrastructure, geography and make up of its communities – presents challenges that would most effectively and efficiently be addressed by a HUSAR team. HUSAR has the ability to address a massive structural collapse and provide extended substantial response … The loss of JEPP funding from the federal government may pose fiscal challenges for the continuation of the HUSAR team.

The roundtable discussions made clear that a HUSAR team is needed as part of a federal / provincial program. There is a need for a team that can be self-sustaining for lengthy periods. The Calgary HUSAR team, which responded to the fires in Slave Lake, had to be totally self-sustaining for 16 days.

The federal government has not restored its funding. Canada's heavy urban search and rescue resources continue to struggle in its absence. At the policy roundtables, Coby Duerr of Calgary's TF2 team stated that, without funding from the federal government, the heavy teams in Canada are "holding on for dear life."[28] He advised that Calgary's TF2 team has been unable to compensate for the loss of federal funding:

> **The Commissioner:** Has Alberta solved the TF2 funding problem with the absence of Federal funding?
>
> **Mr. Duerr:** No, we have not. So we have done as much as we – we have lobbied as much as we can to the Federal entities and to try and re-establish funding through some form that exists or does not exist that needs to be created.[29]

A number of the recommendations I make in this part come with a cost. For example, in order for HUSAR/TF3 to be able to respond with a full provincial team, membership may need to be increased. This expansion will lead, in turn, to increased training and equipment costs.

Implementation: JEPP funding should be re-established. The City of Toronto and the province should re-examine and readjust the current funding model to ensure that HUSAR/TF3 not only survives but also can implement these recommendations.

HUSAR/TF3 is a national, provincial, and municipal asset. All three levels of government have a shared interest in its healthy existence. Fortunately, HUSAR/TF3 is not deployed frequently because, to date, structural collapses have been relatively rare events. However, when they do occur, lives can depend on the quality of the rescue. These dedicated and brave rescuers need the financial support of all levels of government to do their job. In Ontario, Canada's most populous province, the only heavy urban search and rescue asset is operating without any financial support from the federal government. This lack of federal funding is unacceptable, short-sighted, and arguably reckless. The obligations to fund urban search and rescue capabilities should not be borne by the province and municipalities alone.

UCRT (The OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team)

As the narrative and analysis sections of this Report highlight, there is much to be commended in the deployment of UCRT in response to the Algo Centre collapse – including the rapidity and obvious urgency of its mobilization and the team's early recognition of the need for a crane. However, one aspect of its deployment merits appraisal and commentary. The recommendation I make below addresses my concern.

Recommendation 2.27

The OPP should implement a duty roster requiring

(a) a minimum number of commanding officers who can serve in the command structure of an emergency response and represent UCRT therein; and

(b) a sufficient number of commanders who can lead UCRT forces on the ground and be available to respond in a deployment.

Rationale: UCRT must ensure the constant availability of a senior commander in the structure of its emergency response as well as appropriately ranked commanders to lead the UCRT forces on the ground.

The conceptual command structure at the time of the deployment of UCRT was as follows: the unit commander, a staff sergeant, was in charge of the entire UCRT team; below the unit commander, the USAR and the CBRNE elements of the team were each led by a sergeant; in addition, there was a fourth sergeant in an administrative and operational support role.

The staff sergeant in command of UCRT was unavailable to deploy to Elliot Lake. The sergeants in charge of the USAR and the CBRNE elements of the team were on vacation. Accordingly, as the administrative sergeant, Sgt. Gillespie was the highest-ranking officer to deploy with the team.[30] As I described earlier in this Report, the lack of higher-ranking UCRT officers caused a number of issues during the emergency response.

Even though UCRT was performing essentially the same operational function as HUSAR/TF3, it did not have any material representation or input at command meetings or in the development of the strategy of the response. For example, Chief Officer, the incident commander, did not even consider anyone from UCRT to be part of the command structure at all.[31] He thought UCRT got "rolled up" into HUSAR/TF3 within the command structure.[32] Because he was alone in the command of UCRT, Sgt. Gillespie had to choose between commanding his forces on the ground and participating in the command of the emergency response. He chose the former, a decision which I do not criticize.

UCRT did not participate in key decisions during the operation, including the decision to call off the rescue. It was not in a position to provide any input to Chief Officer or anyone else in the command structure. Given UCRT's depth of training and experience, its omission from the command structure was detrimental to the operation generally.

In addition, UCRT's absence from the command tent likely contributed to the frustration expressed by many of its members about uncertainty related to the command structure during the emergency response, the lack of briefings, and the manner in which they perceived they were being treated by HUSAR/TF3 command personnel. UCRT contributed ably to the operational elements of the Elliot Lake rescue operation. By having properly trained and appropriately ranked officers in its command structure, many of those frustrations could have been alleviated.

In any future deployment of UCRT, there should be a sufficient number of properly trained and appropriately ranked commanders to: (a) represent UCRT in the command structure of the emergency response; and (b) command the UCRT forces on the ground. In my view, the OPP should establish a duty roster to ensure that an adequate number of UCRT leaders are available to participate in any deployment of the team at all times. Establishing a duty roster for this purpose will prevent UCRT from being in a position where only one of its four sergeants is available to deploy with the team.

It is clear that the OPP is alive to these issues and intends to beef up its own command presence for any future UCRT deployments. In its after-action report, it noted that it is "critical" that the above-described leadership gaps be filled, and the report makes a number of recommendations with respect to command and control of UCRT which I summarized earlier in this Report.[33] Those recommendations appear entirely logical and well reasoned.

Implementation: **The OPP should implement a duty roster requiring that a sufficient number of properly trained and appropriately ranked commanders will be available to respond in any deployment to:**

(a) represent UCRT in the command structure of the emergency response; and

(b) command the UCRT forces on the ground.

Speed of response

By its very nature, the response to an emergency must be as rapid as possible. In any collapse situation, the difference between a successful rescue and a tragedy may be a matter of minutes.

Recommendation 2.28

There should be more training of HUSAR/TF3 and UCRT members on the utility and capability of cranes in rescue operations.

Rationale: **HUSAR/TF3 and UCRT members should have a better understanding of the utility and capability of crane operations in responding to a structural collapse. This understanding will allow Ontario's rescuers to identify when a rescue situation calls for a crane.**

I have previously commented on Cst. Cox's early recognition of the necessity for a crane to assist in rescue operations. His request for one came soon after the deployment of UCRT. Conversely, I have found it concerning that the leaders of HUSAR/TF3 did not similarly recognize its evident utility. For example, on viewing a photograph showing the debris pile consisting of large pieces of concrete slabs and an SUV, Staff Insp. Neadles testified he would not likely have ordered a crane:

> *A.* Well, that picture doesn't tell me a lot. It doesn't tell me I need a crane or I don't need a crane … I don't – I can't put that picture in perspective. Just seeing that picture, I don't have a depth gauge on where that is in the mall, where it sits, how it fits or … if the victims are perceived or found or anything located anywhere near this. I don't know.
>
> *Q.* Well, if you had received information that what you are looking at here is part of the collapse zone, and we have got people under that material, would that change anything for you?
>
> *A.* You are asking me to speculate. Would I have? Possibly but possibly not. I probably would not have ordered a crane.[34]

Cmdr. McCallion candidly acknowledged that he did not have the necessary knowledge of crane operations to know whether a crane could be useful to the rescue based on photographs of the site. He testified as follows:

> *Q.* Right. Would you not think that it would be prudent to make that call [to request a crane], rather than have 7 hours go by, when you could see for yourself, and then make the call? You've lost 7 hours.
>
> *A.* Sure.
>
> *Q.* It may have caused you some money but that's really the only downside, is it not?
>
> *A.* Well, no, because you – part of our training is not to utilize crane operation as part of our primary assessment or primary ability to get into, sort of, rescue victims and also, how would I know what – I'm not a crane operator, I don't know what the mechanics or the engineering requirements of a crane are so how would I know based on those pictures, what type of crane I would require?[35]

The subsequent crane operations in Elliot Lake vividly illustrate their utility. Cmdr. McCallion's response makes plain that knowledge of, and training in, crane operations is essential. In fairness, when Cmdr. McCallion left for Elliot Lake, it was his expectation that he would be the medical manager. It was only after he arrived in Elliot Lake that his role changed and he became a site commander for the first time. However, he does confirm that, according to current training, resort should not be made to crane operations, at least initially.

Similarly, Capt. Comella testified that ordering a crane would not have been a priority for him, even on seeing the photographs of the collapsed zone.[36]

Dave Selvers, who has made a career as a crane operator, testified that, from photographs showing slabs, an automobile, and other debris on the pile, it would have been clear to him that a crane would be needed to remove material from the collapsed zone:

> *Q.* Tell us from your experience whether you would know whether a crane would be required in order to remove that type of debris from a hole like this …
>
> *A.* Immediately.
>
> *Q.* … And why do you say that Mr. Selvers?
>
> *A.* There is no other way of removing material of that – that size and that weight, including an automobile. It has got to come straight out of the hole. Nothing is going to be taken out – well, in order to remove that stuff, you must have to bust it into pieces no more than 50 pounds of piece for a human being to safely remove. And that is going to take quite a long time.[37]

I have recommended that HUSAR/TF3 make rigging a core skill that all new and current team members must acquire. The OPP, in its after-action report, called for expanded training to more members of UCRT in rigging and crane operations. It is my recommendation that this training include educating these rescuers on the utility and general capability of crane operations.

Implementation: HUSAR/TF3 and UCRT should educate their members on the utility and general capability of crane operations. This training would allow both teams to recognize those circumstances when crane operations represent a superior strategy. If the teams have rigging skills, then they would have the tools to implement the strategy.

Recommendation 2.29

HUSAR/TF3 should send advance teams to a collapse site ahead of the full team.

Rationale: Advance teams provide opportunities for valuable reconnaissance and other preparation for rescue operations.

I have already commented favourably on the rapid mobilization of UCRT. An integral part of the team's effective and speedy deployment was the fact that Cst. Cox departed for Elliot Lake ahead of the rest of his team, and he was given authority over the team until his superior officer arrived in Elliot Lake. By not waiting for the entire team to be ready to depart its base in Bolton, Ontario, Cst. Cox was able to:

1. conduct reconnaissance work while en route to Elliot Lake, including reviewing photos of the scene on the Internet;
2. assess the need for essential equipment, material, and services and request their procurement;
3. arrive in Elliot Lake early to be briefed by the emergency response leaders on the ground; and
4. be in a position to brief his team on its subsequent arrival in Elliot Lake and immediately begin the process of developing a plan to continue the reconnaissance.

Understandably, as a heavy response team, HUSAR/TF3 cannot deploy as rapidly as UCRT. Given that characteristic, HUSAR/TF3 should, where possible, deploy a smaller group of members in advance of the larger team. This advance deployment would allow the team to get a first-hand appreciation of the scale of the emergency response work ahead of it and to better assess the additional resources it may require. It could work in conjunction with the UCRT advance team, if UCRT is deployed, and with local responders to gain early intelligence about the scale of the emergency and to conduct joint reconnaissance. Work on an incident action plan could begin at this early stage without waiting for all teams to arrive.

Implementation: The memorandum of understanding between the Province of Ontario and the City of Toronto in respect of HUSAR/TF3 should require, where possible, that HUSAR/TF3 have an advance team of its members deployed in advance of the balance of the team.

Recommendation 2.30

The OPP (and all initial first responders) should forward as soon as possible to the deployed rescue team any photographs that have been taken of an emergency.

Rationale: Photographs will assist rescuers in assessing the emergency scene and in determining the need for additional resources.

Insp. Jollymore ordered Cst. Dale Burns to photograph the collapsed zone both from the air and from the ground. However, these photographs did not find their way to the rescuers who were, at that point, making their way to Elliot Lake. Cst. Cox did not see Cst. Burns's photographs until he arrived in Elliot Lake himself.

Good photographs can be of considerable assistance in the reconnaissance of the site of an emergency response. Cst. Cox was able to identify the need for, among other things, a crane and a structural engineer from the photographs that he saw on the Internet. The photographs taken by Cst. Burns, because of their quality, would almost assuredly have been very useful to Cst. Cox and to the members of HUSAR/TF3. Throughout the hearings, I relied heavily, as did all counsel, on the photographs that were taken by Cst. Burns in the hours after the collapse.*

In addition, it would have been useful for rescuers to have these photographs for forwarding to related service providers. Mr. Selvers testified that photographs would have been of material assistance to him:

> *Q.* Would photos would have been a help to you?
>
> *A.* It would have been a big help, yes.
>
> *Q.* And why is that?
>
> *A.* It would give us a better understanding other than a somewhat distorted media perspective. Okay. If we had things emailed to us, it would – it would just – it would make our calculations, our assumptions, a word I don't like to use – but it would be more precise.
>
> *Q.* And when you say "a distorted media perspective", is that a reference to the imagery you told us earlier you had seen on the television?
>
> *A.* Correct.[38]

In addition, Staff Insp. Neadles testified that photographs more clearly showing an SUV in the collapse zone would have influenced his decision about ordering a crane.[39]

Digital photography allows for the rapid electronic transmission of high-quality images. Those images hold information that is critical to the trained eye of the rescuer. In my view, those who could use the images the most should be the first to see them.

Implementation: The OPP should adopt a policy of forwarding, as quickly as possible, any photographs taken of a scene that will be the site of an urban search and rescue operation to rescuers being deployed to that scene. Organizations such as the Office of the Fire Marshal or Emergency Management Ontario should similarly advise local responders.

* For a collection of some of the most representative and useful photographs, please see Exhibit 7924.

Recommendation 2.31

HUSAR/TF3 should mobilize and deploy with all practicable speed. Impediments to rapid deployment should be eliminated.

Rationale: In any rescue scenario, time is always of the essence. In the current deployment practices of HUSAR/TF3, there appear to be opportunities for increased efficiencies and mobilization speed.

Currently, HUSAR/TF3 has a benchmark deployment speed of six hours from call-out to mobilization.[40] It mobilized in just less than six hours in response to the Mall collapse in Elliot Lake.

The team members underwent physicals before boarding the buses

When HUSAR/TF3 team members assembled at their muster point in Toronto, they received a brief physical from either a doctor or a paramedic, in which the team members discussed their health with the medical professional. The purpose of the physical was to ensure they were healthy enough to undertake the arduous tasks ahead.[41] More specifically, these physicals are considered necessary to prevent illness from spreading and incapacitating a significant proportion of the response team. That is a desirable objective, but it must be weighed against the importance of a rapid response.

I am of the view that it is a step that could be eliminated and replaced with a self-reporting obligation requiring that members disqualify themselves if they feel ill or are exhibiting any symptoms of illness or a communicable disease. In addition, a thorough annual medical examination should be a prerequisite for service as a team member if one is not now required.

The team received a briefing before departing

After team members received a physical, they were briefed on the information available by the site commander.[42] This debriefing is something that could easily be done en route on the team bus – particularly so considering the team's commanders, including Staff Insp. Neadles and Cmdr. McCallion, travelled to Elliot Lake on the bus.

The vehicles travelled in a convoy

The HUSAR/TF3 support vehicles met up with the team bus at a Petro-Canada station north of Toronto in order to travel to Elliot Lake in a convoy. I fail to see the benefit of the team's vehicles travelling in a convoy. In this age of GPS technology and widespread cellular phone availability, there is, on the one hand, a diminished prospect of getting lost or being slowed in circuitous routes. On the other hand, there is great benefit in arriving at an emergency scene as quickly as possible.

Difficulties in arranging for transport vehicles

As I described earlier in the Report, the team encountered the following obstacles in arranging for transport vehicles:

- There were difficulties in arranging for the rental of tractor transport vehicles.
- There were difficulties encountered in securing the services of drivers for the tractor transport vehicles.

- The closest available tractor transport vehicles were located in Mississauga. Consequently, the drivers had to be driven to Mississauga to pick up the vehicles, and then had to return to the muster point.

Earlier recommendations address the logistical improvements that can be made to the way in which HUSAR/TF3 organizes its transportation requirements. These improvements are imperative. The Elliot Lake deployment occurred on a weekend. It does not take much imagination to consider what the delay would have been had the need for tractors been on a busy workday morning. Traffic congestion at that time of day would have caused additional substantial delays getting tractors to the home of operations.

Contrast with the rapid response of UCRT

The rapid response of UCRT presents a rather stark contrast. Sgt. Gillespie acted with commendable good judgment and haste in mobilizing his team, even though he had to break with UCRT protocol by doing so before his superior officers had approved his decision. He testified that he made this decision "based on the urgency, that the facts were that people were trapped and we needed a response so I did not expect any issue. I was unable to get a hold of my chain of command so I made that decision on my own."[43]

Sgt. Gillespie quickly delegated command of the team to Cst. Cox, who could go to Elliot Lake sooner than the rest of the team. The other members of UCRT rapidly mobilized and arrived in Elliot Lake in impressive time.

> **Implementation: HUSAR/TF3 should, in its training exercises and logistical planning, seek to mobilize itself with all practicable speed. It should re-examine its pre-deployment procedures and take measures to ensure the rapid availability of transport vehicles. The six-hour benchmark to deploy should be viewed as the outside limit of permissible mobilization time, not a target.**

Ministry of Labour

I heard evidence during the Inquiry of widespread confusion about the role and powers of Ministry of Labour (MOL) engineers and inspectors at the scene of a rescue or recovery operation. This confusion existed among the rescue workers but also within the ministry itself. At the outset of the rescue, a false rumour circulated that the MOL had ordered a stop to rescue efforts. Many openly questioned whether the ministry actually had the power to do so. Throughout the rescue, uncertainty about the MOL's role and powers persisted. When the stoppage occurred on June 25, suggestions again circulated that the MOL had shut down the rescue, when in fact the decision had been made by Staff Insp. Neadles. Further confusion ensued with respect to MOL jurisdiction at the scene once rescue efforts had ceased.

I also heard concern expressed during the roundtables, notably from the fire protection community, that the mere presence of MOL personnel at the scene of a rescue or recovery can have an unnerving effect on incident commanders, causing them to potentially second guess decisions.

MOL employees, including experienced ones such as the provincial engineer, Mr. Jeffreys, expressed uncertainty about the scope of ministry powers and how to use them at a rescue or recovery operation. He suggested that, at a recovery operation, he would at least threaten to issue a stop work order if his warnings about a clearly dangerous situation were ignored. He also suggested that, in a rescue situation, there was an "implied statement," flowing from the fact that first responders cannot refuse unsafe work, that the MOL would not act to stop a rescue unless something was "patently unsafe." I heard different opinions from others. Everyone seemed to be formulating their own opinions with little guidance.

Although far from a regular occurrence, it was not the first time that Ministry of Labour personnel had been present during ongoing rescue or recovery operations. Mr. Jeffreys had been asked and had provided input on how to safely proceed with recovery operations in the past. Scott Campbell, a participant at the roundtables from the Ministry of Labour, said that he too has been at a rescue or recovery scene and drawn potential hazards to the attention of the local incident command. Mr. Gryska of Ontario Mine Rescue, whose experience comes from mine rescues, said the Ministry of Labour typically stayed away from the scene until rescue or recovery was complete. No one was aware of a situation where the MOL had actually ordered work stoppage at a rescue or recovery operation.

The situation will arise again. Ministry of Labour personnel will again be present at the scene of an ongoing rescue or recovery, and the same confusion will arise. To my knowledge, no one from the Ministry of Labour and no one from search and rescue has been trained on the role and powers of the ministry at an ongoing rescue or recovery operation. Individuals questioned on the scope of MOL powers essentially engaged in their own exercise of statutory interpretation and perceived common sense. The result was confusion.

Recommendation 2.32

Ontario should clarify the roles and responsibilities of Ministry of Labour inspectors and engineers at the scene of an ongoing rescue or recovery effort.

Rationale: The role of the Ministry of Labour at ongoing rescue and recovery operations remains a source of confusion and has the potential to impede future emergency response operations if not clarified.

The Ministry of Labour prepared a useful submission outlining the roles and powers of MOL personnel at an emergency scene.[44] As indicated, the scene of a rescue or recovery operation has been deemed by the courts to be a workplace.[45] The *Occupational Health and Safety Act* (OHSA) applies at all times to all workplaces under provincial jurisdiction and may be enforced by the MOL.[46] Thus, an inspector at the scene of a rescue who finds that a provision of the OHSA is being contravened can order compliance, even going so far as to issue a stop-work order.[47]

Sections 43 and 44 of the Act stipulate that certain workers, such as police and firefighters, cannot refuse to work in dangerous circumstances if the danger is inherent in their work or is a normal condition of employment, or if refusing the work would directly endanger the life, health, or safety of another person.[48] I am not aware of any corresponding limitation or guidance related to the power of inspectors to issue stop-work orders at the scene of a rescue or recovery.

Some roundtable participants advocated for the abolition of the MOL power to stop a rescue or recovery operation. This option would mean that first responders would have no workplace safety protection at all. I do not think it would be wise as a matter of policy. I agree with the following conclusion from the Ontario Labour Relations Board:

> [W]orkers who engage in inherently dangerous work for the benefit of the public have a right to expect that their employers and the Ministry of Labour will be especially vigilant in ensuring that all reasonable precautions consistent with the performance of their duties will be taken.[49]

I do, however, find a pressing need for clarification, education, and guidance about the role of the MOL at rescue and recovery operations. If anything, the publicity surrounding the perceived role of the ministry in shutting down rescue efforts in Elliot Lake has added to the confusion about the role and powers of MOL inspectors and engineers at emergency scenes.

> **Implementation:** The Government of Ontario should develop guidelines and training on the role and powers of MOL personnel at both rescue and recovery operations. The guidelines and associated training should be provided to all key actors in the rescue and recovery milieu, including the Office of the Fire Marshal, Emergency Management Ontario, HUSAR/TF3, UCRT, MOL, other urban search and rescue teams, and the municipalities.

Guidelines must be created to set out the role and powers of MOL inspectors and engineers at the scene of rescue or recovery operations. Those guidelines should set out when it is appropriate for a ministry inspector to offer advice and what steps the inspector or engineer might take if that advice is not heeded. The guidelines should draw a clear distinction between the role of the MOL at the scene of a perceived rescue (where there are potential live victims) and its role at a recovery (deceased victims only). Logically, the permissible risk would be greater where people's lives can still be saved.

The training materials and guidelines should make it clear that the MOL continues to have jurisdiction at a rescue or recovery operation but will not, as a rule, use the power to stop work unless certain conditions have been met. The guidelines should take into account the primary role of the incident commander at the scene, and the obvious fact that he or she is far more likely than MOL inspectors to have expertise in rescue or recovery operations, or access to that expertise. Any guidelines should include close collaboration and communication between ministry personnel and the incident commander and appropriate deference to the specialized expertise of the rescue workers. MOL personnel might be encouraged to provide advice and be an extra set of eyes for hazard-spotting, while leaving the decision to stop the rescue, to the fullest extent possible, with the local incident commander.

Recommendation 2.33

The Ministry of Labour should use section 21 committees to further ensure that first responders are knowledgeable about the role and authority of the ministry and how it compares and contrasts with their own responsibilities during an emergency.

> **Rationale:** Section 21 committees, created pursuant to the corresponding section of the *Occupational Health and Safety Act*, were described during the roundtable process as useful forums for addressing outstanding issues in the area of workplace safety.

Under section 21 of the OHSA, committees have been set up to advise the Ministry of Labour on specialized occupational health and safety matters. They are referred to as section 21 committees and are co-chaired by labour and management representatives from the occupational field that is the focus of the committee. The Ministry of Labour works collaboratively with these committees and they regularly develop guidance materials.

Committees exist for firefighters and for police. A health care committee exists, with a subcommittee dealing with emergency medical services issues.

During the roundtables, I saw support for using the section 21 committees as a vehicle for better understanding how the MOL and rescue workers can work together at an ongoing rescue or recovery scene.

> **Implementation:** Existing or new section 21 committees should be used to initiate dialogue among emergency responders in Ontario and the Ministry of Labour in order to develop the guidelines and training discussed in the preceding recommendation.

Debriefings and after-action reports

As I stated earlier in these recommendations, debriefings and after-action reports are a critical part of the learning process. They usually include those persons who attended the incident on behalf of the organization, along with some supervising personnel. The purpose of a debriefing is to identify and discuss those aspects of the response that were done well and those that were not. Overall, the aim is to learn from the event and improve, so that future deployments do not repeat past mistakes. Debriefings and after-action reports allow the development of strategies to eliminate past errors and to build on successes.

Recommendation 2.34

Timely debriefings and after-action reports should be mandatory for all agencies and organizations involved in rescue and recovery operations where an emergency has been declared or where provincial resources have been called in to assist. The after-action reports should be shared among all agencies involved.

> **Rationale:** The opportunity for improvement from debriefings and after-action reports is too important to waste, and too important not to share among all agencies involved.

I have already discussed HUSAR/TF3's failure to debrief and produce an after-action report, but it was not the only agency to fall short in this regard. UCRT held a debriefing, although certain key players were absent, and the OPP produced a comprehensive after-action report relating to all elements of OPP involvement in Elliot Lake. Deployed Ontario Fire Marshal officials did meet, albeit informally, and the Office of the Fire Marshal (OFM) did produce a comprehensive after-action report. Otherwise, I saw an unfortunate lack of discipline when it came to ensuring that proper debriefings and after-action reports were produced. Many excuses were provided. None were acceptable.

The City of Elliot Lake failed to hold a debriefing despite a requirement to do so in its emergency response plan. No after-action report was produced, and the City's emergency response plan did not require that one be created.

The Elliot Lake Fire Department did not hold a debriefing or create an after-action report.

The Ministry of Community Safety and Correctional Services (MCSCS) produced a consolidated after-action report, but not until a year after the event. It did not contain input from HUSAR/TF3 and also contained important misunderstandings of the facts.

The Ministry of Labour played an important role throughout the rescue and recovery efforts, and several MOL inspectors and engineers were deployed to the scene during the rescue and recovery efforts. Despite this involvement, the ministry did not hold a debriefing session or produce an after-action report and, to my knowledge, the MOL was not consulted for input into the after-action report produced by the MCSCS.

All these agencies should have held debriefing sessions immediately or shortly after the event, and should have created after-action reports. These reports, in turn, should be shared among all agencies involved. If Ontario is to learn from its mistakes, and from its successes, in emergency response, these silos must be broken down. The various agencies involved in any large-scale emergency response must be able to learn from each other even when – indeed, especially when – things have not gone as smoothly as hoped and tensions exist.

> **Implementation:** The Office of the Fire Marshal and/or Emergency Management Ontario should have dedicated staff or private consultants whose duty it is to facilitate timely debriefings and the creation of after-action reports by all agencies involved, and to assist with their distribution. This should be limited to emergency response operations following declarations of emergency and/or use of provincial resources.

The Inquiry Process

Every commission of inquiry hopes all its recommendations, in their entirety, will be implemented by governments and other public institutions. However, commissions have only the power to make recommendations. It is for others to decide which recommendations to implement and the timing and method of that implementation. There may be valid reasons for non-adoption, ranging from fiscal imperatives to altered circumstances.

Nonetheless, substantial public funds are expended on inquiries of this nature. Much time and effort has been devoted to ensure that my recommendations are cost-effective, practical, and reasonably achievable. The Commission also aimed to ensure that implementation was likely to attract consensus, support, and approbation from a cross-section of society.

Recommendation 2.35

The Government of Ontario and other institutions identified in this Report should issue a public report within one year on their response to these recommendations and what steps, if any, they are taking to implement them.

> **Rationale:** The residents of Elliot Lake and all Ontarians have a right to know whether these recommendations are being implemented and, if they are, how they are being implemented.

I believe the residents of Ontario, and Elliot Lake in particular, have a right to know the extent to which governments and other public institutions will implement the recommendations and the reasons for any deferral or rejection. They should not have to hunt through a series of disparate websites and dense publications to understand what the results of this process have been.

In the Toronto Computer Leasing Inquiry, Madam Justice Denise Bellamy recommended: "At the first Council meeting after the first anniversary of the release of this report, the Mayor should report to Council on progress made in implementing the report's recommendations."[50]

The Commission of Inquiry into the Decline of Sockeye Salmon in the Fraser River (2012) recommended:

> An independent body such as the office of the Commissioner of the Environment and Sustainable Development should report to the Standing Committee on Fisheries and Oceans and to the public as follows:
>
> …
>
> By Sept. 30, 2015, on the extent to which and the manner in which this Commission's recommendations have been implemented.[51]

Similarly, the Missing Women Commission of Inquiry recommended:

> That the provincial government appoint an independent advisor to serve as a champion for the implementation of the Commission's recommendations. The appointment should take effect within 12 weeks of release of the Report.[52]

Indeed, in November 2013, the British Columbia government issued a status report on its implementation of the Missing Women Inquiry's recommendations.[53]

I believe that this recommendation is in keeping with the spirit of the premier's recently reiterated commitment to lead the most open and transparent government in the country.

Recommendation 2.36

The Ministry of the Attorney General should prepare and keep current a tool-kit of policies and relevant documents for newly appointed commissioners and administrative staff.

When my appointment as Commissioner of this Inquiry was announced, I had no previous experience relating to this type of endeavour. Before the Order in Council creating the Commission was promulgated, I met with senior personnel of the Ministry of the Attorney General at a time of transition within the ministry. The appointment of a new deputy attorney general was imminent, and many individuals occupied acting positions.

What I needed most as I assumed my position was a clear road map of what lay ahead for me – a comprehensive "handbook" for newly appointed commissioners, outlining government policies and practices on everything ranging from human resources to budget management. This area was largely "terra incognita" for me. The advice I received from government was gracious and generous, but short on detail. One of the first questions I was asked was how much time I thought the Commission would require to do its work and what I thought the budget should be. I was totally unequipped to even begin to formulate answers to these questions.

Time and money are any Commission's constant worries and unrelenting realities. The *Public Inquiries Act, 2009*,[54] now provides that the Order in Council fix the date for the delivery of the report and that the minister sets the budget.

Initially, I could and did provide some meaningful input into the Commission's mandate, but I felt ill-equipped to provide advice on anything else.

> **Rationale:** To assist newly appointed commissioners and administrative staff in the efficient creation, organization, and administration of commissions of inquiry.

Commissioner Sidney Linden, in his *Report of the Ipperwash Inquiry*, recommended that "the Ministry of the Attorney General create a permanent secretariat or repository of administrative expertise and best practices related to public inquiries to provide more comprehensive operational support and guidance to commissioners and administrative staff."[55]

I echo that recommendation.

This will not be Ontario's last commission of inquiry. For the benefit of future commissioners, I recommend the preparation of a comprehensive "kit" that could be given to a newly announced commissioner, even before the official Order in Council, containing such things as:

- a mini-library of previous commission reports;
- current literature on the conduct of commissions of inquiry, such as Professor Ed Ratushny's very useful book *The Conduct of Public Inquiries*;[56]
- jurisprudence relating to past commissions of inquiry;
- an outline of current government legislation, regulations, policies, and practices relevant to the administration of public inquiries;
- a current inventory of reliable service providers available to commissions of inquiry which government and previous commissions have used (e.g., reporting and transcription services, data management experts, media consultants, and audio-visual specialists); and
- a compendium of best practices, to which previous commissioners and government representatives could be asked to contribute.

A copy of the 2012 Draft Public Inquiries Guide prepared by Ministry of the Attorney General, Corporate Services Management Division, was provided to the Commission's executive director shortly after her recruitment. It covers specific administrative and logistical issues involving the creation and operation of inquiries. My staff's suggested modifications to it have already been discussed with ministry staff. The draft guide contains useful information for the person retained to manage a commission, such as identifying the different branches of government responsible for facilities, technology services, or financial matters including setting up the delegation of authority. However, it does not contain any of the elements of the "kit" described above.

> **Implementation:** The Ministry of the Attorney General should prepare and maintain an up-to-date tool-kit of policies and relevant documents for newly appointed commissioners and administrative staff.

Recommendation 2.37

The Ministry of the Attorney General should appoint an independent assessment officer and pay the accounts of the Participants' lawyers as expeditiously as possible.

Rationale: To prevent any delays and controversy during the proceedings.

As I indicated in my discussion of the Inquiry Process, the fees and disbursements of the Participants' lawyers were not paid in a timely manner at the beginning of the Inquiry. These fees are usually heavily discounted in comparison with the fees normally charged by law firms to commercial clients (or in comparison with fees normally regarded as reasonable by the courts when assessing costs in civil proceedings). In addition, when a commission holds hearings in as remote a location as Elliot Lake, the disbursements borne and carried by the Participants' lawyers can be substantial.

To prevent any unnecessary delays and controversy during the proceedings, I recommend that, once the government agrees to provide funding to Participants at an inquiry following a recommendation to that effect by the Commissioner, it appoint its independent assessment officer and pay Participants' lawyers' accounts for fees and disbursements as expeditiously as possible.

Recommendation 2.38

In imposing a deadline for the work of an inquiry, the Ministry of the Attorney General should consider a reasonable period for the set-up of the inquiry.

Rationale: To ensure that the deadline is realistic and avoid requests for extension of time.

Although I fully recognize the right and responsibility of the government to impose a deadline on the work of an inquiry, such a deadline must be a realistic one, given the mandate and scope of work. It must also take into account all the "setting up" that needs to take place before the actual work can begin. As discussed, staff must be retained, offices located, computers rented. Competent and experienced counsel cannot simply drop everything to begin work instantly on an inquiry. Offices do not magically appear.

I would recommend, therefore, that any deadline imposed by the government include a reasonable period of set-up time and that the government ensure that its resources are in place to assist the inquiry in the basic organizational phase of its work. In the case of this Commission, I found the government was slow or ill-equipped to assist with essential prerequisites such as location of suitable office space, accounting services, and the securing of specialized resources.

Summary of Recommendations

Provincial organizations and capabilities

Recommendation 2.1

The capacity to respond to structural collapse emergencies should be increased in Ontario.

Recommendation 2.2

The provincial government and others should explore possible collaboration with Ontario Mine Rescue as a partial solution to ensure adequate province-wide capability to respond to structural collapses.

Recommendation 2.3

The province should initiate discussions to bring the medium urban search and rescue (USAR) teams that currently exist in Ottawa and Thunder Bay into the provincial inventory.

Recommendation 2.4

On request, the province should make incident support teams available to incident commanders.

Recommendation 2.5

The province should examine the model of a volunteer-based emergency response used by the German Federal Agency for Technical Relief (Technisches Hilfswerk, or THW) to determine if it could have any application in Ontario.

Recommendation 2.6

Statutory authority should give jurisdiction to a coroner to authorize entry to a building, by any safe means including demolition, for the purpose of retrieving a body.

Incident Management System / chain of command

Recommendation 2.7

Whenever a municipal or provincial emergency is declared, its management should contain the following mandatory features, each of which is reduced to writing:

- a clear chain of command;
- defined responsibility and accountability for all in the chain of command;
- a clear and consistent line of communication for all responders;
- a plan of action determined by the individual in charge after consultation; and
- an early and comprehensive briefing of all team members before the plan is carried out.

Recommendation 2.8

There should be only one person in overall charge of a response; a "unified command" structure should be avoided.

Recommendation 2.9

The incident commander, the senior person in the chain of command, in a municipally declared emergency should be either

(a) the person in charge of the initial agency that responds, unless and until that person delegates that authority in writing to another person; or

(b) the person in charge of an agency determined by a matrix that assigns responsibility before an incident on the basis of the agency most closely linked to the type of emergency at issue.

Recommendation 2.10

The province should put in place strategies that will increase the acceptance and actual use of the Incident Management System (IMS) – including simplifying its language and instituting joint training and exercises – so as to be able to make it mandatory in the near future.

Communications

Recommendation 2.11

Provincial media and communications expertise should be made available, either as a stand-alone service or as part of incident support teams, to municipalities during declared emergencies or where provincial resources have been used.

Recommendation 2.12

The Ontario government should make it mandatory to provide private space and regular updates to family members of victims on the progress of rescue and recovery operations during declared emergencies or where provincial resources have been used.

Recommendation 2.13

Training for rescue and recovery operations should stress providing the public with timely and accurate information about casualties and the progress of a rescue operation (subject to legitimate operational requirements).

Recommendation 2.14

Where multiple agencies are present at a rescue operation, they should have continuous access at the command level to common-frequency radios or communications equipment.

Recommendation 2.15

Specialized rescue workers must be trained to accept the need for contemporaneous record-keeping during an emergency response. To facilitate the process, waterproof notebooks should be provided and consideration should be given to the acquisition of hands-free recording technology.

HUSAR/TF3 (Heavy Urban Search and Rescue Task Force 3)

Recommendation 2.16

HUSAR/TF3 should conduct debriefings in a timely fashion following any deployment.

Recommendation 2.17

HUSAR/TF3 should create an after-action report in a timely fashion following any deployment. In the case of a provincial deployment, the after-action report should be submitted to the Office of the Fire Marshal and Emergency Management (OFMEM).

Recommendation 2.18

HUSAR/TF3 and UCRT (the OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) should enter into a memorandum of understanding with each other that clearly sets out the command structure under which they will operate when jointly deployed.

Recommendation 2.19

HUSAR/TF3 should implement procedures to ensure that qualified section chiefs are available for deployment.

Recommendation 2.20

HUSAR/TF3 should implement procedures to reduce or eliminate the unpredictability of the size of the team it is able to muster following a call-out.

Recommendation 2.21

The HUSAR/TF3 site commander should be supplied with a scribe on all deployments.

Recommendation 2.22

HUSAR/TF3 should ensure that it has access to qualified drivers to transport the cache of equipment on deployment.

Recommendation 2.23

HUSAR/TF3 should explore additional sources for tractor rentals.

Recommendation 2.24

HUSAR/TF3 team members should receive training for rigging operations.

Recommendation 2.25

Standard operating procedure for HUSAR/TF3 should require fully documented incident planning, which is provided to supervisory personnel.

Recommendation 2.26

HUSAR/TF3 should receive adequate funding to ensure that it is properly equipped and trained to respond to structural collapses in a timely manner with sufficient personnel and expertise. The Joint Emergency Preparedness Program (JEPP) funding should be reinstated by the federal government.

UCRT (The OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team)

Recommendation 2.27

The OPP should implement a duty roster requiring

(a) a minimum number of commanding officers who can serve in the command structure of an emergency response and represent UCRT therein; and

(b) a sufficient number of commanders who can lead UCRT forces on the ground and be available to respond in a deployment.

Speed of response

Recommendation 2.28

There should be more training of HUSAR/TF3 and UCRT members on the utility and capability of cranes in rescue operations.

Recommendation 2.29

HUSAR/TF3 should send advance teams to a collapse site ahead of the full team.

Recommendation 2.30

The OPP (and all initial first responders) should forward as soon as possible to the deployed rescue team any photographs that have been taken of an emergency.

Recommendation 2.31

HUSAR/TF3 should mobilize and deploy with all practicable speed. Impediments to rapid deployment should be eliminated.

Ministry of Labour

Recommendation 2.32

Ontario should clarify the roles and responsibilities of Ministry of Labour inspectors and engineers at the scene of an ongoing rescue or recovery effort.

Recommendation 2.33

The Ministry of Labour should use section 21 committees to further ensure that first responders are knowledgeable about the role and authority of the ministry and how it compares and contrasts with their own responsibilities during an emergency.

Debriefings and after-action reports

Recommendation 2.34

Timely debriefings and after-action reports should be mandatory for all agencies and organizations involved in rescue and recovery operations where an emergency has been declared or where provincial resources have been called in to assist. The after-action reports should be shared among all agencies involved.

The Inquiry Process

Recommendation 2.35

The Government of Ontario and other institutions identified in this Report should issue a public report within one year on their response to these recommendations and what steps, if any, they are taking to implement them.

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The Ministry of the Attorney General should prepare and keep current a tool-kit of policies and relevant documents for newly appointed commissioners and administrative staff.

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In imposing a deadline for the work of an inquiry, the Ministry of the Attorney General should consider a reasonable period for the set-up of the inquiry.

Notes

1 Ian Ross, "Mine Rescue considers search-and-rescue partnership," *Northern Ontario Business* (24 March 2014) online: Northern Ontario Business <www.northernontariobusiness.com>.

2 *Coroners Act*, RSO 1990, c 37, ss 16(1), 16(3), as amended by SO 2009, c 15, s 8.

3 *Coroners Act*, RSO 1990, c 37, s 16.1(1), as amended by SO 2009, c 15, s 8.

4 Comella testimony, September 4, 2013, p. 23924.

5 McRae testimony, September 25, 2013, pp. 27210–11.

6 Neadles testimony, September 10, 2013, pp. 25215–16.

7 Neadles testimony, September 11, 2013, pp. 25335–6.

8 Comella testimony, September 5, 2013, p. 24167.

9 Exhibit 887, p. 054.

10 *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, ss 1, 4(1).

11 *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 7.0.1(3), as amended by SO 2006, c 13, s 1(4).

12 *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 5.1(1), as amended by SO 2002, c 14, s 7, SO 2006, c 35, Schedule C, s 32(3).

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14 Ronald Jenkins Transcript, December 5, 2013, p. 65.

15 Hefkey testimony, August 9, 2013, pp. 20438–9, 20472.

16 Comella testimony, September 4, 2013, pp. 24055–6.

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22 *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 5.1(1), as amended by SO 2002, c 14, s 7, SO 2006, c 35, Schedule C, s 32(3).

23 Exhibit 8109, p. 015; Officer testimony, August 22, 2013, pp. 21728–30, 21733–5; Officer testimony, September 19, 2013, p. 26409; Bruce testimony, August 23, 2013, pp. 22191–2; Exhibit 6336, p. 61.

24 Officer testimony, August 22, 2013, pp. 21868–9.

25 Chambers testimony, September 18, 2013, pp. 26070, 26103, 26139, 26144.

26 Exhibit 768.

27 Duerr testimony, August 15, 2013, p. 20836.

28 Coby Duerr transcript, December 5, 2013, p. 232.

29 Coby Duerr transcript, December 5, 2013, p. 142.

30 Gillespie testimony, September 3, 2013, pp. 23506–8.

31 Officer testimony, August 22, 2013, p. 21783.

32 Officer testimony, August 21, 2013, p. 21674.

33 Exhibit 7784, p. 015.

34 Neadles testimony, September 10, 2013, pp. 25264–5.

35 McCallion testimony, September 6, 2013, pp. 24478–9.

36 Comella testimony, September 4, 2013, p. 24079.

37 Selvers testimony, September 10, 2013, pp. 25112–13.

38 Selvers testimony, September 9, 2013, pp. 25011–12.

39 Needles testimony, September 10, 2013, pp. 25265–6.

40 McRae testimony, September 25, 2013, p. 27207.

41 Comella testimony, September 4, 2013, pp. 24061–2.

42 McRae testimony, September 25, 2013, p. 27196.

43 Gillespie testimony, September 3, 2013, pp. 23512–3.

44 Exhibit 9907.

45 *R v Port Colborne (City),* [1992] OJ No. 2555 (Ont Ct J).

46 Exhibit 9907.

47 *Occupational Health and Safety Act,* RSO 1990, c O.1, ss 57(1), (6).

48 Exhibit 9907, p. 005.

49 *OPSEU Loc. 321 and Ministry of Labour (Re)* [1992] O.O.H.S.A.D. No. 9 at para 5.

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