BRITISH COLUMBIA

Ministry of Justice

VERDICT AT CORONER'S INQUEST

File No.:2011:0422:0039

An Inquest was held at Nelson Courthouse, in the municipality of Nelson

in the Province of British Columbia, on the following dates November 19-24, 2012

before: Matthew Brown, Presiding Coroner,

into the death of SWEATMAN Sheilah Lorraine Wheeler 29 ☐ Male ☒ Female
(Last Name, First Name, Middle Name) (Age)

The following findings were made:

Date and Time of Death: June 29, 2011 1640 hrs

Place of Death: 110M North of Goat River Bridge on Hwy 21 Creston/BC
(Location) (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Drowning

Due to or as a consequence of

Antecedent Cause if any: b) Entrapped under water

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Leg entangled by steel cable

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☒ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 24th day of November AD, 2012

Matthew Brown
Presiding Coroner's Printed Name

Presiding Coroner's Signature

SWEATMAN	Sheilah Lorraine Wheeler
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Matthew Brown
Inquest Counsel:	John Orr
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Family/Cameron Ward, Emergency Management of British Columbia/Richard Meyer, Worksafe BC/Scott Nielsen and Search and Rescue of British Columbia/John Bethell.

The Sheriff took charge of the jury and recorded 19 exhibits. 20 witnesses were duly sworn and testified

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

The jury heard that at the time of her death, Sheilah Lorraine Wheeler Sweatman was a member of the Nelson Search and Rescue (SAR) involved in the search for a missing person on June 29, 2011. The jury heard that SAR groups are located throughout the province of British Columbia and fall under the Provincial Emergency Program (PEP) that exists as part of Emergency Management British Columbia (EMBC) under the Ministry of Justice. SAR members are unpaid volunteers whose funding and training is provided by the British Columbia Search and Rescue Association which is a non-profit society registered in 2002. SAR members are trained for specific specialties such as avalanche response, helicopter-assisted rescues and in this case, swiftwater rescue.

On June 28, 2011, the RCMP attended the Goat River Bridge and noted markings on the concrete abutment and other physical evidence suggestive of a vehicle going into the Goat River. The RCMP surmised that a vehicle belonging to a person reported missing may have entered the water and they contacted EMBC to request assistance from SAR as per the normal procedures when requesting SAR assistance. Over the course of the evening, a team of 21 SAR members were called out with the plan to attend the area the following morning. An RCMP officer testified that during a search of the surrounding area, a white bumper was found down river consistent with the vehicle suspected to be in the river. A helicopter search of the area did not find any evidence of the missing person.

The jury heard that a member of the RCMP Dive Team was contacted to determine if they could assist in the search. The officer gave evidence that the dive team was not able to assist at the time as there was no one in the area. The officer also testified that they would also not have assisted because the current was too strong for their divers based on the initial information he was provided. The officer testified that certain factors such as water speed, depth and temperature are considerations for them when assessing a dive task. In addition, consideration would be given to other risk factors such as debris in the water and in this case, the vehicle in the water that could move or shift.

Of the 21 SAR members, 10 were trained Ground Search and Rescue Technicians (GSAR) while the remaining 11 had been trained in swiftwater rescue. Nine of these had achieved level 3 designation, one had level 1 designation and the Site Leader was a Master Swiftwater Instructor and had a number of rope

and rigging certifications. Certification for swiftwater rescue is recognized by the International Rescue Instructors Authority (IRIA). The jury heard that almost all members involved in the task were trained by the Site Leader who was certified by a Senior Certifying Instructor and current president of Rescue Canada, one of several companies that provide training and certification for SAR members. The jury heard that Miss Sweatman was trained in swiftwater rescue between May and June of 2010.

On the morning of June 29, 2011, the GSAR and swiftwater/flood rescue (SFR) members travelled to the Goat River Bridge in Creston and began their planning and coordination of the proposed task. While the group underwent their planning, the RCMP was advised that a canoeist observed what appeared to be an overturned vehicle approximately 80 meters downstream from the Goat River Bridge. The jury heard that this was further noted by a disturbance in the flow of the river in the area where the canoeist noted the vehicle.

The jury heard that plans for such tasks are done in a collaborative fashion with the entire SAR group but ultimately, the responsibility for the carrying out the task is that of the Site Leader. This planning phase was characterized as a "democracy" by members of the SAR group such that each member had an opportunity to provide input into the task drawing from their training and experience.

The jury heard that the plan was to have two SFR technicians in a tethered duel-pontoon unpowered raft (referred to as a Cataraft) tethered to a rope and rigging system called a tension diagonal. This system consisted of three lines which allowed the Cataraft to move from one side of the river to the other as well as up and down the river. On either side of the river were teams comprised of SFR members with an assigned team leader for each team. The role of each team was to set-up the rope and rigging system on either side of the river following which each team would work in conjunction with the two technicians on the Cataraft to help move the Cataraft over top of the vehicle in the river through the use of the pulley system. The jury heard that because of the distance across the river, two ropes were used as the mainline as the group did not have one long enough to reach across

This rigging system was felt to be strong enough for the two technicians on the Cataraft and they would be able to position themselves over the submerged vehicle and use a pole-mounted camera to look inside the vehicle. If the person was found in the vehicle, the plan was for a tow truck to be used to pull the vehicle from the water. Miss Sweatman was the Team Leader for the Cataraft Team attached to the tension diagonal. She was experienced in operating the Cataraft; however, the Crewmember with her had only been a passenger in previous tasks and had not operated a Cataraft in river conditions. While he had experience rowing, he was not certified to operate a Cataraft.

The jury heard that once in the water, the Cataraft team moved to the right side of the river and attached themselves to the pulley system and tag line. A second Cataraft referred to as a rescue boat entered the water at the same time and set itself up downriver. The Site Leader was positioned on the bridge at the time of the exercise. Communication between the teams and the Site Leader was done through hand-held radios and hand signals.

The jury heard that several attempts were made by the Cataraft team to move in position above the vehicle; however, all attempts were unsuccessful largely because of the strong current. The Cataraft team determined that the vehicle was upside down with the roof caved in and that it was positioned with the

engine facing upstream; viewing directly inside the vehicle to determine if there was someone in it was not possible.

The jury heard that the SFR group requested a tow truck be brought to the area to facilitate removal of the vehicle from the river. The tow truck operator testified that he provided a length of chain and hooks, a J-hook with chain attached, connecting clevises, and a 50-foot coil of wire rope; all items were made of steel. The SFR teams agreed on a plan that included the following: that the Cataraft Team (i.e. Miss Sweatman and the Crewmember) would be brought out to where the vehicle was again and attempt to secure a length of the chain to the undercarriage of the vehicle; then, connect one end of the 50-foot steel cable to the chain with a shackle clevis to ensure that the chain and hook would not be lost if dropped in an attempt; attach a rope throwbag to the opposite end of the steel cable; throw the throwbag to the SFR and GSAR members on the right side of the river who would pull the throw line and steel cable and then attach the steel cable to the tow truck which would then pull the vehicle from the river.

The jury heard from several members of the SFR team during the inquest as well as the Site Leader. Members testified that the steel cable was an unfamiliar tool to all members with the exception of the Site Leader who had used this during a previous activity. Members of the group testified that there was no equipment on site to self-rescue (i.e. cut through the steel cable) in the event that something went wrong; there was also no tool such as a bolt cutter on the tow truck either. Upon questioning of the witnesses, evidence was given that there was no safety plan in place to deal with the steel cable nor was this considered in the planning with the introduction of the steel cable.

The jury heard that the chain and steel cable were placed on the floor of the Cataraft near Miss Sweatman's legs. The Cataraft entered the water in the same fashion as done previously and attached to the pulley system on the right side of the river. When they were positioned over the vehicle, the jury heard that both Miss Sweatman and the Crewmember attempted to attach the chain to the vehicle but were unsuccessful due to the strong current of the river. The Site Leader testified that the strong current and the depth of the vehicle made this operation difficult.

The jury heard that the Cataraft Team returned to the right side of the river and on this occasion, the chain was replaced with the J-hook and chain with a new plan which was to attach the J-hook to the vehicle. When they returned above the vehicle, the Crewmember was able to attach the J-hook to the vehicle. Once completed, the Crewmember radioed to the Site Leader that they were going to connect the cable to throwbag and move away from the vehicle which the Site Leader approved. The Crewmember held onto the J-hook while Miss Sweatman picked up the steel cable and began to uncoil it. The Cataraft began to shift and move slightly downstream turning partially sideways and moments later, the Cataraft turned fully sideways and began to submerge in the river.

The jury heard that the tension diagonal was stretched and the Cataraft continued to submerge further and shortly after, the tension diagonal system broke. During this process of the Cataraft submerging and pivoting very sharply, the jury heard that the steel cable that had been in the Cataraft wrapped around Miss Sweatman's leg when standing at the backend of the Cataraft. The Crewmember testified that he held onto Miss Sweatman for a period of time but as the Cataraft continued to submerge in the river Miss Sweatman was pulled from the Cataraft, he was no longer able to hold on. She held onto ropes connected to the Cataraft but eventually let go of those and began to float downstream connected to the vehicle by the steel cable wrapped around her leg.

The jury heard that the GSAR and SFR members discussed options to attempt a rescue. Both the Cataraft rescue boat and the previously submerged Cataraft boat operated by the Crewmember attempted to move to Miss Sweatman but the current was too strong and pushed both of them away and down river. SFR members attempted to use throw ropes with no success and one SFR member attempted to swim to her but was pushed downstream by the current. Further rescue attempts were called off and Miss Sweatman was presumed drowned; she was recovered the following day.

The jury heard that the two technicians on the Cataraft, including Miss Sweatman were both trained in, and familiar with the rope system being employed. The ropes used were designed for river use and could be cut with a standard knife. The entire operation was considered to be a training exercise and was filmed by cameras supplied by a television production firm. As well, a helmet fitted with a camera was worn by Miss Sweatman who was the Team Leader on her Cataraft. The jury viewed the entire video for the purposes of the inquest.

The jury heard that there are several principles referred to as "Absolutes" that were developed by the IRIA; these are standard operating procedures to be used in operations similar to this one. Among the 13 Absolutes are the following; "Never operate in swiftwater/flood conditions that you are not prepared to self-rescue; never tie into a rope system without personal release capability; always look around and assess the moving water environment before initiating a task' and always have a backup plan".

As mentioned earlier, the jury heard that the tension diagonal system broke which, during testimony, one of the Team Leader's stated that this was in part because the knot created by the two ropes being connected created a weakness in the system. Further, when the boat began to submerge, it increased a load on the line. Evidence provided by an investigator from Worksafe BC indicated that the rope system was overloaded because of the strong water current against the submerged Cataraft as well as the pulling action of the vehicle.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: Emergency Management British Columbia (EMBC) and the British Columbia Search and Rescue Association (BCSARA)

1. That Emergency Management British Columbia (EMBC) expand the existing Swift Water Task Force to include members of search and rescue operations as well as the RCMP, BC River Guides Association, BC River Outfitters Association, Worksafe BC and any other appropriate stakeholders.

   Presiding Coroner Comment: *The jury heard that since Miss Sweatman's death, a Task Force was created to review swift water operations in BC; however, this group did not include a number of stakeholders involved in day to day search and rescue operations.*

2. That EMBC and BCSARA develop universal standards for swift water rescue and recovery training to ensure consistent language and training applications. These universal standards would require all swift water training providers to conform to these prescribed standards.

   Presiding Coroner Comment: *The jury heard that there are several companies that provide swift water training across the country. The jury heard that a "unified syllabus" would assist in ensuring uniformity of qualifications and terminology in cou*rses which would translate to consistent language during operations.

3. That EMBC and BCSARA develop universal standards for swiftwater rescue and recovery equipment.

   Presiding Coroner Comment: *The jury heard that there are no universal standards for swiftwater rescue and recovery equipment and further, that available equipment depends on what each SAR community has at their disposal.*

4. That an audit be conducted of all Search and Rescue (SAR) communities by BCSARA to ensure that each SAR community has the required equipment (including personal protective equipment) and training for their respective communities based on their unique areas. Where it is determined that there is a lack of the required equipment and/or training for that area, immediate consultation with BCSARA and EMBC must occur to determine the steps to obtain equipment and/or training with the goal of safety of all SAR members in BC.

   Presiding Coroner Comment: *The jury heard that the availability of equipment depends on the unique needs of each community in British Columbia as well as funding and resources.*

5. That EMBC review and evaluate funding models to better support SAR operations, training and equipment similar to Volunteer Fire Departments' funding.

Presiding Coroner Comment: *The jury heard that there is diversity in funding for SAR groups in BC and that funding comes from sources such as fundraising and/or gaming grants both of which differ from one community to another.*

6. That Swift Water teams use only their own equipment during search and rescue operations whenever possible. If any unfamiliar equipment is introduced into a task, a proper risk assessment must be completed. The appropriate tools for self rescue and companion rescue must be immediately accessible.

Presiding Coroner Comment: *The jury heard that not all members of SAR had used the steel cable in a rescue and recovery operation previously and that there was no discussion or risk assessment to discuss the possible risks when introducing the equipment into the task. The jury heard that there were no tools at the site to have used for self rescue or rescue by other SAR members. The jury heard that planning must include risk management strategies.*

7. That the Volunteer Policy and Procedures Manual specifically the policy for "Utilization of SAR Volunteers for SAR Activities Policy" be reviewed by EMBC to clarify and amend, where required, the roles and responsibilities of varying agencies involved in SAR activities. These groups include but are not limited to SAR, policing agencies, Coroner, Parks Canada. BC Ambulance and Fire Services.

Presiding Coroner Comment: *The jury heard that there was some confusion around roles and responsibilities within the Incident Command Structure (ICS). That is, it was unclear who was responsible for the site activities on the day of the task.*

8. That during an operation, a specific Safety Officer be designated whenever possible. This Safety Officer's position will be their sole function.

Presiding Coroner Comment: *The jury heard that role of Safety Officer was not delegated to any individual at the site. Evidence was given that by default, the Search Manager fulfills the role of Safety Officer but greater clarity would have assisted the group.*

9. That EMBC with the assistance of the SAR stakeholders develop a standardized risk assessment tool for use in Swift Water operations.

Presiding Coroner Comment: *The jury heard that there is no standardized risk assessment tool during these operations. The jury heard that planning with an accepted risk matrix is critical to the safe and ongoing delivery of SAR activities.*