What Went Wrong

The Official Report of the Committee.

1. OVERVIEW

"The June 15th Disaster," which occurred last year in mid-June, horrified the nation and prompted outraged demands for accountability. How could such a tremendous multifaceted catastrophe have occurred, and who was at fault? This Committee's investigation revealed numerous instances of human error and systemic lapses, as well as unforeseen technical failures, a possible curse, and simple bad luck.

2. PRELIMINARY NOTES

The final casualty tally has yet to be determined, as hundreds of the fatalities were later discovered to be mannequins from the nearby roller coaster testing grounds. Further complicating matters, hundreds of what were initially thought to be mannequins proved to be corpses. Also, while there were thousands of injuries, many were minor, consisting of scratches or the severing of already-withered limbs.

Several aspects of the disaster, such as the elevators designed to only go up, the highly flammable sprinkler system, and the past-expiration meat pies, will not be discussed here, as they have been well documented during the extensive initial reporting of the tragedy.

Some crucial information is still unknown, due to the Director's amnesia since being struck by the toppling file cabinet, which then tumbled into the sinkhole, taking with it vital records and the combination to the vault, which contains the encryption keys. Nevertheless, the Committee, after interviewing hundreds of witnesses, employees, contractors, and officials, and reviewing thousands of documents, photos, videos, blueprints, and poems, is able to enumerate the following factors which led to the cascading series of failures.

3. MISTAKES & NEGLIGENCE

• The cog railway was not designed to be operated in temperatures above 85 degrees, or below 75 degrees. Both temperature extremes were exceeded on the day in question. The on-site meteorologist

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FIG. 1 *The incorrectly designed evacuation tunnel led directly into the rendering vat.* **FIG. 2** *Unfortunately, this distress message, made from medication on the roof of a car in Parking Lot B, was too small to be seen by passing aircraft.* **FIG. 3** *Bargain-priced parts had been sourced from metal fatigue.com.* **FIG. 4** *The dance leader is still haunted by what he witnessed at the Consolidation Ramp.* **FIG. 5** *Despite the protests of the Chaplain's summer intern, flimsy wooden crates were used to store the anthrax powder.* **FIG. 6** *The silo was rated to store only melons with a radius not exceeding 4.75 in.*

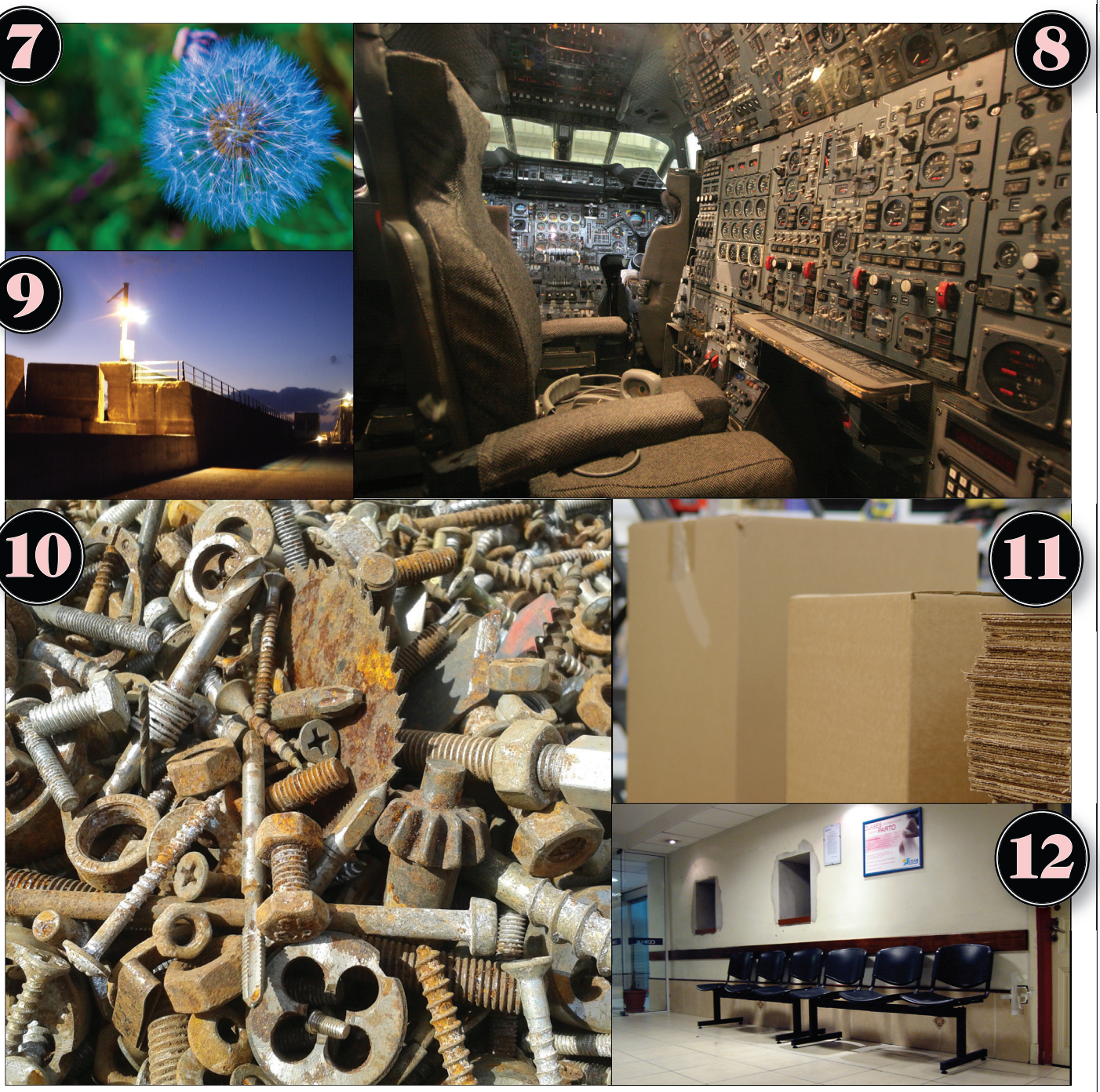

FIG. 7 *The "anomaly" at the Resource Center resulted in great loss of life, as well as the loss of thousands of stock photos similar to this one.* **FIG. 8** *Adding to the chaos as the situation deteriorated was the cafeteria's overly complicated soda machine.* **FIG. 9** *The sole survivor in Zone 6 insists that most of the casualties were caused by a large "something" that crawled out of the evaporation pond.* **FIG. 10** *Crucial actuator module components were later recovered from the stomach of a technician with a compulsive swallowing habit.* **FIG. 11** *Cardboard, whether flat or assembled into boxes, proved to be of little use in diverting the magma flow.* **FIG. 12** *The waiting area of the Rectification Building. A dozen people took shelter here, but after only 20 minutes, several resorted to cannibalism.*

claims that his thermometer had been stolen by gang members, though this claim is unsubstantiated.

• Testing determined that the concrete used throughout the complex had an unacceptably high percentage of filler such as newsprint, human hair, cigarette butts, coffee grounds, and other foreign substances.

• The alarm horns had been deactivated by the Comptroller the day before, as a way to "economize on alarm horn electricity" and "save wear and tear on the parts that make the honking sound."

• Contrary to generally accepted guidelines, the grandstand was built at a precarious angle on a steep, marshy slope overlooking an area full of brambles. 97% of the bolts were missing. Some had been replaced by carrots, which have poor tensile strength and stress resistance.

• The oxen were ill-tempered after having not been fed for two days. In addition, the one named "Trouble" was well-known for its propensity to charge at people wearing red, yellow, brown, white, black, blue, green, or teal.

• Engineers neglected to include a governor on the revolving restaurant's speed control mechanism, enabling it to reach a rate of upwards of 150 revolutions per minute prior to disintegration.

• Several witnesses who reported fumes coming from the gazebo moments before the calamity say that their concerns were dismissed as "usual gazebo outgassing."

4. BAD LUCK & UNFORESEEN CIRCUMSTANCES

• In a case of unfortunate timing, Oily Rag Storage Area 1 and Oily Rag Storage Area 2 were struck by lightning simultaneously. By this point, Oily Rag Storage Area 3 was already in flames due to the rioting.

• Entomologists have testified that no one could have anticipated the off-schedule cicada swarm. In addition to the crowds being panicked by the clouds of large insects, the sustained loud buzzing generated a resonant frequency that fatally weakened the dam.

• Someone inadvertently bumped the control panel of the tunnel boring machine, changing its course by 38 degrees and sending it directly underneath the reactor (which had just gone out of warranty).

• The tremors caused by the collapse of the Main Auxiliary Pavilion Annex caused the Command Center's book of emergency codes to fall into a toilet, rendering it illegible.

• The temp hired to answer the phones that day spoke only Dutch.

5. BLAME

Many people share blame for "The June 15th Disaster." However, since most of those individuals perished in the incident, the list of those still alive who should face justice is brief:

• Operational Coordinator "Sleepy Louie" (no last name available)

6. CONCLUSION

It is the Committee's hope that the findings of this impartial report will spur various organizations, agencies, and legislatures to make the changes necessary to ensure that a tragedy of this magnitude will never happen again. Assuming that won't occur, the Committee stands ready to assess the failings of hundreds of people whose negligence will contribute to next year's large-scale calamity, tentatively titled "The August 19th Horror."