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Part I - Overview

1. The partial roof collapse of the Algo Centre Mall (the “**Mall**”) in Elliot Lake on June 23, 2012 (the “**Collapse**”), resulted in the deaths of two respected members of this small community, Lucie Aylwin and Doloris Perizzolo.
2. The terms of reference for the Elliot Lake Inquiry require the Commission to:
 - a. Inquire into and report on events surrounding the Collapse of the Mall, the deaths of Lucie Aylwin and Doloris Perizzolo and the injuries to other individuals in attendance at the mall and the emergency management and response by responsible bodies and individuals subsequent to the Collapse;
 - b. Review relevant legislation, regulations and by-laws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the structural integrity and safety of the Mall;
 - c. Review relevant legislation, regulations and by-laws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the emergency management and response to the collapse of the Mall.
3. The Commission has divided its work into two phases: one, dealing with events prior to the collapse of the Mall on June 23, 2012, and the other dealing with events on and after that date.
4. The Elliot Lake Mall Action Committee (“**ELMAC**”) is a broad based community group made up of people who were injured in the Collapse or who lost their jobs or businesses as a result of it. ELMAC provides these submissions for the second phase of this Inquiry, dealing with the emergency management and response to the collapse of the Mall.
5. The following individual service providers were involved in the rescue and response to the Collapse:
 - a. The Elliot Lake Fire Department (“**ELFD**”) – the local fire department was the first responder to the Collapse;

- b. The Urban Search and Rescue, CBRNE Response Team (“**UCRT**”) – UCRT is a medium urban search and rescue team run by the OPP and was the second responder onsite;¹
 - c. Task Force 3 (“**TF-3**”) – TF-3 is one of Canada’s Heavy Urban Search and Rescue teams and was the last responder onsite;²
 - d. Ontario’s Ministry of Labour (the “**MOL**”) – the MOL provided support and advice to the responding services during the emergency response;³
 - e. The East Algoma detachment of the Ontario Provincial Police (the “**OPP**”) – the OPP activated the emergency plan and maintained site security during the rescue/recovery and the Criminal Investigation Branch investigation.⁴
 - f. The local Emergency (“**EMS**”) – the local EMS was a first responder to the Collapse.
6. It appears that all parties made genuine and well-intentioned efforts to manage the emergency and respond to the Collapse. However, these submissions address the areas that require improvement, namely:
- The responders failed to adhere to the IMS. Responders from UCRT offered inadequate staffing as a reason for the failure, but this explanation is incomplete. Although the ELFD initially set up effective command and successfully implemented an incident action plan, when outside organizations arrived in Elliot Lake they were not integrated into the standard five management functions in every incident: command, operations, planning, logistics, and finance and administration. They operated in an inefficient patchwork arrangement.
 - The most significant failure was a breakdown in communication along the chain of command. Alternative plans were available to Bill Neadles, the lead of TF-3, before he called off the rescue on June 25, 2012, but he was not aware of them, because they were not passed up the chain of command.

¹ Exhibit 5847, Overview Report: Emergency Management response, p. OR_E00000013_0015.

² Exhibit 9278, Can-TF-3 HUSAR PowerPoint presentation, p. CT_E000000582_001.

³ Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28072, lines 3-16.

⁴ Exhibit 7784, Ontario Provincial Police Field Support Bureau After-Action Report, p. CCO_E000000659_008.

- The role of the MOL at emergency scenes was not adequately understood by the responders, including those in command positions. Further, the MOL personnel who attended did not clearly explain their purpose for being on scene. This lack of knowledge and miscommunication caused confusion and affected the efficiency of the rescue operation.
- The members of the Elliot Lake Community Control Group were unable to determine which agency had the authority to demolish private property in order to conduct recovery operations.
- Operationally, there were some unrelated but serious shortcomings, including: (i) the limited safety precautions taken by ELFD prior to rescuers entering the collapse zone, (ii) the lack of reconnaissance of information prior to the arrival of UCRT and TF-3, (iii) TF-3's limited experience and training in crane operations, (iv) the deployment of the LifeLocator outside manufacturing guidelines, (v) the building of unnecessary shores; and (vi) the failure to conduct debriefs and after-action reports.
- The City's Emergency Information Plan lacked a formal approval process for the release of information to the media. In addition, the members of the Elliot Lake Community Control Group were not provided with sufficient training in how to deal with the media during an emergency. As a result, they failed to provide timely, honest disclosure to the public, leaving the public to believe inaccurate information running through the community.
- The family members of Lucie Aylwin and Doloris Perizzolo were not provided with sufficient support, resources and information during the emergency response. In particular, the family members were not provided a private space, protected from the media, and were not informed about the status of the emergency by a designated and official person. Updates were not provided to family members on a regular basis and, in some instances, were provided after already being released to the media.
- Victims of the Collapse did not have access to mental health resources, and in particular psychologists and psychiatrists, after the event. The need for such services after a traumatic event is particularly strong in isolated, rural communities like Elliot Lake where these services are often not available.

- The OPP has made no efforts to advise businesses and individuals who lost property in the Collapse about if their property was recovered and, if so, when they can expect to have it returned. This is a source of stress and frustration.

Part II - Factual Findings

A. Failures in the Command Structure

i. Failure to Follow the Incident Management System

7. The responders from ELFD, TF-3, and UCRT did their best to rescue and later recover Doloris Perizzolo and Lucie Aylwin. However, during the operation their best efforts were stymied by consistent breakdowns in communication and particular individuals' failure to respect the chain of command. Proper communication may have avoided the premature, public announcement that the rescue was over. In an emergency response, the process of communication is detailed in the Incident Management System ("IMS"), which was loosely followed during the rescue and recovery. None of the standard IMS documents were used.
8. In 2005, the SARS Commission identified the need for a single incident management system in Ontario. Through consultations with stakeholders the IMS, a framework for organizing the emergency response to events, was created. It is "that common song sheet, that the responders and those managing a given incident...would use...to manage the emergency". ELFD, TF-3 and UCRT all use the IMS system. Compliance with the IMS is voluntary.⁵
9. Approved on January 30, 2009, the IMS standardizes five management functions in every incident: command, operations, planning, logistics, and finance and administration.
10. Command's responsibilities include ensuring the safety of all responders; determining goals, strategies, objectives and priorities appropriate to the level of response; establishing an appropriate command structure using IMS; coordinating all incident management activities; coordinating overall incident activities with other levels of

⁵ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0022. Examination of Dan Hefkey, transcript of August 8, 2013, pp. 20241-2, lines 17-4 and p. 20249, lines 12-19. Examination of Tony Comella, transcript of September 4, 2013, p. 24019, lines 21-23.

response; providing information to or briefing senior and elected officials as required; approving an incident action plan; and managing sensitive issues arising from the incident.⁶

11. Planning is responsible for developing the incident action plan (“**IAP**”). The IAP tells responders what strategies to implement during a specified period of the operation (the operational period). The operational period is usually no longer than 24 hours and in Elliot Lake it was 12 hours.⁷ It should outline the objectives to resolve the incident, strategies to achieve the objectives, and tactics to implement the strategies in the safest manner possible. Although the IAP may be oral or written, it should be written in complex incidents. Complex incidents have some or all of these characteristics:
- a. prolonged duration that will require major changes in personnel or involve successive operational periods;
 - b. large in scale, requiring a large number of resources;
 - c. involving multiple jurisdictions;
 - d. require special knowledge and/or training to resolve;
 - e. pose a significant risk to the responders or the jurisdiction as a whole;
 - f. have the potential to cause widespread damage or loss of life/injury;
 - g. require a more complex organizational structure; and/or
 - h. necessitate formal planning.⁸

Elliot Lake was a complex incident: all of the characteristics described above were present.⁹

12. Captain Tony Comella, the TF-3 team coordinator and a leader within Toronto Fire, testified that he was the Planning Section Chief and responsible for developing the IAP, however, he believed that an IAP “doesn’t have to be written down formally, at all”. He

⁶ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0036.

⁷ Examination of William Neadles, transcript of September 10, 2013, p. 25215, lines 1-8.

⁸ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, pp. CI_E000000092_0054-55.

⁹ Examination of Dan Hefkey, transcript of October 8, 2013, p. 28740-2, lines 23-21.

explained his reasons for not providing written IAPs: “The luxury of time to write it down for me was not available. However, when I pass information up to the command post, that’s an opportunity for it to be transmitted into paper”.¹⁰

13. The Planning Section’s responsibilities may include collecting, collating, evaluating, analyzing, and disseminating incident information; managing the planning process including preparing and documenting the IAP for each operational period; conducting long-range and/or contingency planning; maintaining incident documentation; tracking resources assigned to the incident; and working closely with Command and members of the general staff to ensure that information is shared effectively and results in an efficient planning process to meet the needs of the incident.¹¹
14. Operations is responsible for implementing the IAP. Its duties include: developing and managing the Operations Section to accomplish the incident objectives set by Command; organizing, assigning, and supervising all resources assigned to an incident, including air operations and resources in a staging area; and working closely with other members of the Command and general staff to coordinate operational activities.¹²
15. Logistics provides supporting resources to the incident. Logistics’ responsibilities include obtaining, maintaining, and accounting for essential personnel, equipment, and supplies beyond those immediately accessible to Operations.¹³
16. Finally, Finance and Administration analyzes the funds and costs of the incident.¹⁴
17. Although all of these functions are important, Command is the only element that must always be established. It is the “first and primary organizational component of the IMS structure”. The other functions are established only if necessary. The IMS is intended to simplify and coordinate emergency response in Ontario by one or more organizations from different jurisdictions to the same event. Successfully integrating responders from

¹⁰ Examination of Tony Comella, transcript of September 5, 2013, p. 24127, lines 23-25.

¹¹ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, pp. CI_E000000092_0040-41.

¹² Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0036.

¹³ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0042.

¹⁴ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0044.

different organizations and jurisdictions under IMS depends on the concept of unity of command.¹⁵

18. Unity of command establishes a single hierarchy across different emergency organizations from different jurisdictions. The line of command and accountability is defined by the expertise and intended role of the individual, not merely by his or her rank, organization or jurisdiction. Each individual is assigned a single supervisor who may or may not come from the same organization or jurisdiction. Unity of command must be maintained in both single and unified command.¹⁶ According to Bill Neadles, a staff inspector with the Toronto Police Service and the site commander for TF-3 in Elliot Lake, it was understood that when UCRT and TF-3 are deployed to the same event, TF-3 would command the incident.¹⁷ Neadles' view seems inconsistent with unity of command, and there is no support for his position in the evidence.
19. The IMS has two models of command: single and unified. Single command applies when the decision-making process is "straightforward and independent". Even when more than one organization responds to an incident, it applies. By comparison, Unified command applies on rare occasions, when the decision-making process is "complex, and interdependent" and when "a single command cannot be established".¹⁸
20. The team members from TF-3, UCRT, ELFD and OPP all seemed to have a firm grasp of the purpose of IMS;¹⁹ however, confusion arose with the distinction between single and unified command. To illustrate Comella, Ryan Cox (a constable with the Ontario Provincial Police and member of UCRT), Paul Officer (the fire chief of the Elliot Lake Fire Department and the Incident Commander in Elliot Lake), all believed that unified command applied. According to Officer, the distinction between single and unified

¹⁵ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, pp. CI_E000000092_0022 & 0032. Examination of Dan Hefkey, transcript of August 8, 2013, pp. 20241-2, lines 17-4 and p. 20249, lines 12-19.

¹⁶ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0030.

¹⁷ Examination of William Neadles, transcript of September 10, 2013, p. 25298, lines 3-21.

¹⁸ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0030.

Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28704-06, lines 20-25.

¹⁹ Examination of Paul Officer, transcript of August 21, 2013, p. 21550, lines 10 to 17.

command depended on the number of organizations responding to the emergency. If only one organization responds, then single command applies; otherwise, it is unified.²⁰

21. The IMS report itself contributes to the confusion about when unified command applies. Under the definition of “Unity of Command” the report states:

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 [emphasis added].²¹

This description suggests that unified command applies when multiple organizations respond to a single event as in Elliot Lake. This inconsistency may account for the confusion of responders, such as Comella who thought the response in Elliot Lake ought to have been an instance of unified command.

22. Each of the five management functions (Command, Operations, Planning, Logistics, and Finance and Administration) has a key role and is responsible for executing particular duties. Certain responders, such as Comella, described the IMS as “flexible and scalable” to justify filling more than one of those key roles in Elliot Lake or to justify not having a person to fill each key role, such as the Planning Sections Chief, during the entire deployment. For example, Comella claimed to fill the role of Safety Officer, Operations Section Chief and Planning Section Chief in Elliot Lake.²²

(a) Command

23. Command is the key and only required piece of the IMS.²³ For a single incident, there is only one Incident Commander (“IC”) regardless of the number of organizations responding to the emergency and of the number of jurisdictions. He or she is “responsible for all incident activities, including the development of strategies and tactics and ordering and the release of resources. The IC has overall authority and responsibility for

²⁰ Examination of Paul Officer, transcript of August 21, 2013, p. 21634, lines 8-13. Examination of Ryan Cox, transcript of August 26, 2013, p. 22432, lines 1-8. Examination of Tony Comella, transcript of September 5, 2013, pp. 24109-10, lines 19-8.

²¹ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0030.

²² Examination of Tony Comella, transcript of September 4, 2013, p. 23923, lines 1-10; p. 23927, lines 6-11 and pp. 24049-50, lines 22-7.

²³ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0036.

conducting incident operations and is responsible for the management of all incident operations at the incident”. The IC takes overall responsibility for managing the incident and leading the response.²⁴

24. Many of the responders held the mistaken belief that each organization had its own IC even though they were all responding to the same incident. This view was shared by Officer, Comella, Neadles and others.²⁵ In Officer’s case, this mistaken belief may have been related to his confusion about whether a single or unified Command applied. When UCRT arrived in Elliot Lake, Officer treated Cox as the OPP Incident Commander and believed that Cox “had the lead on the rescue”. When TF-3 arrived, Officer believed that Bill Neadles was the “overall rescue Incident Commander,” although no such role exists in IMS. Until about June 25th, Officer did not realize that Neadles reported to him. These mistaken beliefs compounded Officer’s confusion.²⁶
25. Officer, who was understood by all to be the incident commander, abdicated most of his responsibilities to Neadles. In complex incidents, such as Elliot Lake, the IMS recognizes that the incident will likely develop through two or more phases of command structure. In the first phase, the local response will act to address the emergency and develop an initial IAP. As the second phase begins, resources are added and the organization expands. At this point, the IMS notes: “This usually involves the staffing of additional IMS functions, transferring Command, and development of a written IAP [emphasis added]”.²⁷ This suggests that it was within the contemplation of IMS’s authors that Command and presumably the position of IC could (and perhaps should) be transferred in the second phase, presumably to someone with greater qualifications, training, and/or experience with search and rescue—the factors used to determine who should exercise incident command.
26. Although Officer acknowledged that TF-3 were experts and that some of the steps that TF-3 were going to take to deal with the Collapse were outside of the ELFD’s

²⁴ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, pp. CI_E000000092_0046-48.

²⁵ Examination of Paul Officer, transcript of August 21, 2013, p. 21672, lines 9-22. Examination of Tony Comella, transcript of September 4, 2013, pp. 24055-7, lines 22-11. Examination of William Neadles, transcript of September 11, 2013, p. 25461, lines 11-20.

²⁶ Examination of Paul Officer, transcript of August 21, 2013, pp. 21672-4, lines 9-12.

²⁷ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0058.

capabilities and resources, Officer believed that he could not transfer IC to Neadles.²⁸ Officer's belief that he could not transfer IC may result from a communiqué from the Office of the Fire Marshal ("OFM") dated November 9, 2005. This communiqué informed Officer and other fire chiefs of TF-3 and how to request its assistance. It also instructed Officer that he must retain Command:

The local municipality requiring assistance maintains command and control and is responsible for consequences, management of the incident, displaced individuals, transportation and community health issues [emphasis added].²⁹

27. The November 9, 2005, communiqué removes the discretion of the fire chief to transfer command to TF-3 even though this appears to be a reasonable action contemplated by IMS. Officer appeared to have no choice but to retain command; however, he found a way around this by appointing Neadles "overall rescue Incident Commander".
28. If Officer had not established incident command, the City of Elliot Lake's Emergency Control Group could have. Every municipality is required to establish an Emergency Control Group (sometimes referred to as a Community Control Group ("CCG")) composed of officials, employees and council members of the municipality as appointed by council. The CCG is required to direct the municipality's response in an emergency, including implementing the municipality's emergency response plan. IMS empowered the CCG to establish incident command and direct the community's strategic response to the incident if necessary. Its emergency response plan made it responsible for supporting the IC with equipment, staff and resources.³⁰

(b) Planning

29. Planning is responsible for developing the IAP and is headed by the Planning Section Chief ("PSC") who is ultimately responsible for developing the IAP.³¹ After Command is established, there are 5 steps to developing the IAP: (1) assessing the situation, (2)

²⁸ Examination of Paul Officer, transcript of August 22, 2013, pp. 21923-6, lines 2-7.

²⁹ Exhibit 5847-00005, Office of the Fire Marshal Resources for Major Incidents, p. ELFD_E000000111_01.

³⁰ *Emergency Management and Civil Protection Act*, R.S.O. 1990 c E.9, as amended and its regulations, s. 12 of O. Reg 380/04. Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0048. Exhibit 8090, City of Elliot Lake Emergency Response Plan, p. CEL_E00015554_0015.

³¹ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, pp. CI_E000000092_0040-41.

establishing incident objectives and strategy, (3) developing the plan, (4) implementing the plan, and (5) evaluating its effectiveness.

30. There was no PSC in Elliot Lake. As Neadles explained:

There really was—there was no one that was assigned to that role. It was undertaken by a couple of different people at different times.

31. Comella attributed the gaps in the IMS structure in Elliot Lake to an understaffed TF-3 team.³² Neadles acknowledged that not having a person who could fill the role of PSC was a significant shortcoming of TF-3 in Elliot Lake.³³ Fortunately, there was no shortage of responders to implement the IAPs developed during the deployment.

(c) Operations

32. Headed by the Operations Section Chief (“**OSC**”), Operations is responsible for implementing the IAP. The OSC’s duties include developing and managing the operations to accomplish the incident objectives set by Command; organizing, assigning, and supervising all resources assigned to an incident, including air operations and resources in a staging area; and working closely with other members of the Command and general staff to coordinate operational activities.³⁴ According to Neadles, Comella was the OSC in Elliot Lake.³⁵

(d) Logistics

33. Logistics provides supporting resources to the incident and is headed by a Logistics Section Chief (“**LSC**”). Logistics’ responsibilities include obtaining, maintaining, and accounting for essential personnel, equipment, and supplies beyond those immediately accessible to Operations.³⁶ According to Commander Michael McCallion, TF-3’s alternative site commander, Martin McCrae was the LSC in Elliot Lake.³⁷

³² Examination of Tony Comella, transcript of September 4, 2013, pp. 24026-7, lines 16-13.

³³ Examination of William Neadles, transcript of September 10, 2013, pp. 25215-7, lines 9-7.

³⁴ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0036.

³⁵ Examination of William Neadles, transcript of September 10, 2013, p. 25301, line 7.

³⁶ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0042.

³⁷ Examination of Michael McCallion, transcript of September 6, 2013, p. 24464, lines 20-23.

(e) Finance and Administration

34. This section did not play a significant role in Elliot Lake.

ii. Failures in Communication

35. Many things went well during the rescue in Elliot Lake, but most witnesses agreed that communication did not. Communication was frequently poor amongst different organizations, within individual teams, to the IC, to the municipality and to the public. The source of inadequate communication can be traced to two things: (1) a general failure from the beginning to respect the function and accountability of Command on the part of Officer and other responders and (2) a failure to follow the procedures established in the IMS.

(a) Failure to Coordinate a Consistent Incident Action Plan

36. ELFD established Command early and effectively. The first IAP had four parts: request additional emergency resources, shut off the utilities, locate victims, and clear debris from the pile. These strategies were accomplished or well in progress by 15:05 on the 23rd.³⁸ As additional organizations responded to the emergency the IMS process fell apart. When different organizations joined the operation, Officer failed to assign responders to the five management functions (Command, Operations, Planning, Logistics, and Finance and Administration). Some of those responders, such as Percy Jollymore, an OPP Inspector, failed to respect Officer's authority as the IC and implemented their own IAPs without his knowledge and approval.

37. UCRT set in motion the first IAP without Officer's approval. It was initiated by Ryan Cox, a constable with the OPP and member of UCRT. His strategy was to obtain the necessary resources, human and mechanical, to assess the structure and clear debris. En route to Elliot Lake, Cox looked at photos of the Mall on his phone. He saw that the collapse had taken place in the middle of the structure, that there were heavy concrete slabs in the pile and determined that a crane was necessary. He requested the crane, other

³⁸ Exhibit 8025, Paul Officer's notes, pp. 1-2.

equipment and a structural engineer from Inspector Jollymore. Cox believed that Jollymore was the IC.³⁹

38. Jollymore failed to direct Cox's request to the IC, but informed Officer and other members of the CCG of Cox's request at a meeting on June 23rd at 18:30. Upon hearing of Cox's request, Officer did not specifically task Jollymore with obtaining a crane—a job for Logistics. At that time, he did not believe that a crane had been ordered, but he thought the OPP would take care of it. The OPP did undertake responsibility for ordering it. But nearly four hours later at the next CCG meeting at 22:05, Jollymore informed the CCG, including Officer, that he still had not ordered the crane according to the notes of CCG scribe Natalie Bray. Jollymore claims that he had given the instruction to order the crane before the meeting, despite what Bray's notes say. However, Bray's notes are corroborated by Cox's testimony and notes:

I advised him that we would require a structural engineer, hydraulic crane, rigging equipment, lumber. He [Jollymore] advised that he would request those items as he was just going into a meeting but would like to wait until we are on scene to make the orders [emphasis added].⁴⁰

39. Cox testified that when he arrived in Elliot Lake he met Jollymore and was asked to explain why a crane was required.⁴¹ Given this evidence and the fact that the crane was not ordered until 23:00, Jollymore's evidence that he had given instructions to order the crane before the 22:05 meeting is not credible. ELMAC submits that the Commission ought to find that Jollymore did not give instructions to order the crane until after the 22:05 meeting on the 23rd of June. As a result of Jollymore's delay, the crane was not onsite and operational until after 17:00 on the 24th of June.⁴² This delay may have unnecessarily extended the rescue operation. It is unclear what authority Jollymore thought entitled him to delay the ordering of the crane.

³⁹ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22259-62, lines 13-15 and pp. 22321-2, lines 15-10.

⁴⁰ Exhibit 3743, Notes of Natalie Bray, pp. CEL_E000013925_006-007. Exhibit 6377, Notes of Ryan Cox, p. OPP_E000003614_002. Examination of Paul Officer, transcript of August 21, 2013, pp. 21653-5, lines 23-25 and pp. 21661-2, lines 21-21. Examination of Percy Jollymore, transcript of September 23, 2013, pp. 26866-8, lines 13-2. Examination of Percy Jollymore, transcript of September 24, 2013, p. 26986, lines 13-25. Examination of Ryan Cox, August 26, 2013, pp. 22265-6, lines 20-16 and p. 22289, lines 20-24.

⁴¹ Examination of Ryan Cox, transcript of August 26, 2013, p. 22267, lines 11-16.

⁴² Examination of Ryan Cox, transcript of August 26, 2013, pp. 22321-2, lines 15-10. Examination of Dave Selvers, transcript of September 9, 2013, p. 25008, lines 1-14.

40. In the first hours after the Collapse, Jollymore initiated his own IAP to conduct reconnaissance of the hot zone with a helicopter. Before the CCG meeting on June 23rd at 18:30, Jollymore called for a helicopter to fly over the hot zone. He did not seek approval from the IC. The helicopter caused a hanging beam above the responders to sway. As Captain John Thomas of ELFD described:

A: When this helicopter was flying overhead, there was a beam that we were — I don't know if we were directly underneath it or right next to it. It was swaying a lot more, and there was a set of double doors that were going into the upper part of the hotel right here.

Q: Okay.

A: They were swaying, and he [the safety officer, Ken Barnes] wasn't quite sure if it was going to come down or not. And so he said, okay, we are — we got to get out.⁴³

41. Like the delay in ordering the crane, it is unclear what Jollymore thought entitled him to order the helicopter without the IC's prior approval. Had Jollymore sought Officer's approval, Officer may have considered the negative effect of allowing a helicopter fly above the hot zone and not unnecessarily exposed Captain Thomas and others to further danger. ELFD did not return to the pile on the 23rd as they had exhausted all options. They waited for UCRT and TF-3 to provide additional resources and options.⁴⁴

42. When UCRT arrived on the night of June 23, Officer briefed Cox on what ELFD had done, identified the location of the suspected fatality and potential victim, and passed on information about the condition of the structure. Cox advised Officer that UCRT would try to get equipment to identify signs of life in the pile and come up with a plan.⁴⁵ At this time, Officer did not ask Cox what functions and/or roles UCRT's team could fill in the IMS structure. Nor did he assign any functions or roles to them. Cox's description of what UCRT intended to do appears to have been the IAP in place until TF-3 arrived early in the morning on June 24th.

43. When Jamie Gillespie, an OPP sergeant and UCRT's team lead in Elliot Lake, arrived on the scene, he changed Cox's plan. Rather than lower responders to the pile, he intended to

⁴³ Exhibit 8025, Paul Officer's Notes, p. 4. Examination of Percy Jollymore, transcript of September 24, 2013, pp. 26987-8, lines 1-25. Examination of John Thomas, transcript of August 15, 2013, p. 21067, lines 3-15.

⁴⁴ Exhibit 8025, Paul Officer's Notes, p. 4.

⁴⁵ Examination of Paul Officer, transcript of August 21, 2013, pp. 21662-4, lines 22-14.

lower gas monitoring devices and cameras to perform more reconnaissance before allowing responders onto the pile. Although he made those changes out of concern for the responders, Gillespie did not seek Officer's approval before changing the plan. If he had passed his concern up the chain of command to Officer, he likely would have learned that nearly 12 hours earlier gas and hydro had been shut off, that the scene had been swept for natural gas, that the gas levels were found to be within acceptable limits and that the residual gas was from bleeding lines.⁴⁶ If IMS had been followed and the initial command meeting been held, Gillespie likely would have learned what ELFD had already done.

(b) Failure to Hold Necessary Meetings

44. Upon the arrival of UCRT and certainly by the time of TF-3's arrival, the IC should have held an initial command meeting. Its purpose is to give key officials from different organizations an opportunity to discuss the roles and responsibilities of the various responders, jurisdictional boundaries, the name of the incident, the overall incident management organization, the location of facilities, the operational period length and start time and senior appointments, such as OSC and PSC. An initial command meeting involving TF-3 and UCRT did not happen in Elliot Lake.⁴⁷
45. In addition to the initial command meeting, the IMS identifies several pre-planning meetings that would have improved communication in Elliot Lake. One such mandatory meeting is the tactics meeting in which the OSC, PSC, LSC and Safety Officer can establish tactics to meet current objectives and strategies. Planning needs the results of the tactics meeting to prepare the IAP. The meeting can also be used to establish division boundaries, location of incident facilities, location of identified hazards, and key safety messages for tactical operations. There is no evidence that a tactics meeting took place.
46. After pre-planning meetings are complete, the incident management meets to hold the Planning Meeting, which has three key goals: to share information gathered, to present

⁴⁶ Exhibit 8025, Paul Officer's Notes, p. 2. Examination of Jamie Gillespie, transcript of September 4, 2013, pp. 23819-21, lines 9-4.

⁴⁷ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E00000092_0059. Examination of Jamie Gillespie, transcript of September 3, 2013, p. 23609, lines 9-14.

strategies and tactics with alternatives, and to develop the written IAP. Needles acknowledged that he did not seek UCRT's input in forming any of the IAPs.⁴⁸ The PSC writes the IAP based on the results of the Planning Meeting. The IC will then review, approve and sign the IAP.⁴⁹ Although Officer was given the "broad strokes" of what was taking place in the rescue, no one sought Officer's approval for a single IAP. Nor did he give his approval.⁵⁰

47. Needles, Comella and the other responders who took part in planning the emergency response in Elliot Lake had access to aids. The IMS provides several tools for tracking an incident as it expands: form IMS 201: Incident Briefing, form IMS 203: Organization Assignment List, and/or form IMS 207: Incident Organization Chart. Comella never provided Needles with any documentation as part of the planning process described in the IMS. Nor did he ever provide Needles with a written plan or briefing document.⁵¹
48. As a member of Planning, Comella spent most of his time with the engineer from TF-3 (James Cranford) and the two engineers from the MOL (Roger Jeffreys and Brian Sanders). He maintained notes on soggy pieces of paper and then periodically made electronic notes in his truck. Before he could make those notes, he had to leave the hot zone, exit the Mall and walk to his truck in the southwest corner of the upper parking lot. His notes were not contemporaneous. As a result of his note taking process, the Commission has no record of the advice that the engineers conveyed orally to Comella. There was no system in place to ensure the engineers' advice was captured in the way the engineers intended and passed up the chain of command to those who required it.⁵²

(c) Failure to Hold Operational Briefings

49. After the IAP is approved, it is distributed with assignments at the Operational Briefing to all activated operational resource leaders, like the heads of task forces. The

⁴⁸ Examination of William Needles, September 10, 2013, p. 25300, lines 3-23.

⁴⁹ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, pp. CI_E000000092_0062-63.

⁵⁰ Examination of Paul Officer, transcript of August 21, 2013, pp. 21687-8, lines 5-19.

⁵¹ Examination of William Needles, transcript of September 10, 2013, pp. 25252-3, lines 24-7.

⁵² Examination of Michael McCallion, transcript of September 6, 2013, p. 24465, lines 3-4. Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28745-6, lines 23-11. Examination of Tony Comella, transcript of September 4, 2013, pp. 24044-7, lines 16-22 and pp. 24380-1, lines 1-22.

Operational Briefing is an opportunity for the leaders to ask questions about the IAP before the resources are deployed.⁵³

50. The evidence is that there were no Operational Briefings on the 24th, neither when TF-3 arrived in Elliot Lake relieving UCRT nor when UCRT returned to relieve members of TF-3 at 18:00. According to Gillespie, on June 24th at 16:30 he returned to the scene early for the start of the 18:00 shift. He arrived early to get the tasks to be completed during the next operational period in order to brief his team. Advised that the briefing would take place at 18:00, he and his team arrived at the scene early at 17:35. According to Gillespie, the briefing never happened.⁵⁴
51. Gillespie's perception was that UCRT was not being kept "in the loop," which led to frustration amongst UCRT's responders. Gillespie did not think that he was receiving sufficient information to task UCRT's responders and make them productive.⁵⁵ Gillespie perceived that TF-3's failure to advise UCRT of when command briefings would take place on June 24th contributed to UCRT's absence from participation in command of the rescue.⁵⁶ The failure to hold Operational Briefings was a missed opportunity to exchange information between the two organizations.
52. After the Operations Briefing and the resources are deployed, the responders begin evaluating the progress made. Planning for the next operational period begins immediately under the supervision of the PSC.⁵⁷ Planning is ultimately responsible for collecting information about the development of the incident and the status of resources, combining and evaluating the information, and making it available to those who need it.⁵⁸ Throughout the emergency, responders consistently monitored the progress made and kept an eye on the structural integrity of the building, including one of the beams holding up the escalator, G207, which was beginning to bow.
53. By the morning of June 24th, a crack had formed at the top of the escalators, and throughout the evening of June 24th and the morning of June 25th the bow in beam G207

⁵³ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0063.

⁵⁴ Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23601-2, lines 7-16.

⁵⁵ Examination of Jamie Gillespie, transcript of September 4, 2013, p. 23861, lines 12-25.

⁵⁶ Examination of Jamie Gillespie, transcript of September 4, 2013, pp. 23823-4, lines 20-13.

⁵⁷ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0063-64.

⁵⁸ Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28744-5, lines 8-19. Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0063-64.

had deepened. Comella set up a makeshift device to monitor the escalator's movement. By 10:00 on June 25th, the downward and lateral forces on the beam were too great and could have caused the beam to collapse at any point without warning. Comella decided to remove the responders from the hot zone. The danger was too great. McCallion and Neadles waited for a Plan B to allow them to continue the rescue without exposing the responders to too great a risk. By 15:30 on the 25th, no Plan B had arrived, and Neadles decided to transition the rescue to a recovery. As the IC, it was Officer's decision to change the classification of the operation from a rescue to a recovery, but Neadles made the call without seeking his approval. At a 17:00 press conference on the 25th, Neadles announced that the rescue was over. By 19:00 a Plan B was developing involving heavy equipment from Priestly Demolition. After a call with the Premier (of which the IC was neither informed of nor invited to), the rescue was back on.⁵⁹

54. Had regular tactics meetings and operations briefings been held and responders been encouraged to pass information about alternative strategies upstream, Neadles may not have decided to convert the rescue to a recovery.
55. On Sunday, June 24th, Phil Glavin, a sergeant with the Toronto Police Service and a member of TF-3, was overlooking the hot zone from the parking lot and considering a Plan B. For 12 years, he had worked for Neadles who emphasized the importance of always considering an alternative plan. By contrast, Comella appeared sceptical of the benefits of considering a Plan B.⁶⁰ Glavin had a close familial relationship with Priestly Demolition. He remembered a piece of equipment, the Komatsu PC850, that had been used in the World Trade Centre and wondered if it could reach over the front of the mall into the hot zone. On June 24th, he first contacted Priestly Demolition to see if the Komatsu PC850 was available. It was. Glavin did not mention the inquiries that he had made about the Komatsu PC850 until he spoke with Neadles at 18:00 on June 25th.⁶¹

⁵⁹ Examination of Jamie Gillespie, transcript of September 4, 2013, pp. 23821-2, lines 6-8. Examination of Paul Officer, transcript of August 22, 2013, p. 21806, lines 7-20. Examination of William Neadles, transcript of September 11, 2013, pp. 25447-8, lines 16-1 and p. 25497, lines 20-23. Examination of Michael McCallion, transcript of September 6, 2013, p. 24465, lines 3-4; pp. 24573-7, lines 22-22; pp. 24579-83, lines 21-23; pp. 24598-03, lines 14-1; pp. 24609-12, lines 4-3; pp. 24623-4, lines 10-22; and pp. 24634-5, lines 23-15.

⁶⁰ Examination of Tony Comella, transcript of September 4, 2013, pp. 24030-1, lines 23-24.

⁶¹ Exhibit 6622, Ryan Priestly's Notes.

Examination of Phil Glavin, transcript of October 1, 2013, pp. 27661-6, lines 13-13.

56. While Glavin was considering a Plan B, Gillespie was already noticing that the beam supporting the escalator, G207, was bowing and that the escalator was shifting. Gillespie and Jeffreys developed a plan to put steel shores underneath the bowed beam supporting the escalator. They explained this plan to Comella and Cranford on the morning of June 24th. Gillespie did not know if this plan had made its way up to the IC.⁶²
57. Before Neadles publicly announced the end of the rescue, Cranford had performed calculations to determine whether steel posts could support the bowing beam. At about 14:30, he concluded that they could. The steel posts were available onsite.⁶³ He also devised a method to address the lateral forces on the beam with compression struts. Cranford explained this proposal to Comella.⁶⁴
58. McCallion recalls Comella advising him of the option of using steel to support the beams underneath the escalator; however, based on McCallion's evidence it does not appear that this conversation took place before the 15:00 CCG group on the 25th when Neadles announced that the rescue was transitioning to a recovery.⁶⁵ It seems a breakdown in communication led Neadles to make an unnecessary announcement. Dan Hefkey, the Ontario Commissioner of Community Safety and a signatory to the IMS, conceded that if the planning function had been clearly laid out and responsibility assigned, that a system ought to have been in place to capture Cranford's information.⁶⁶
59. Priestly Demolition arrived in Elliot Lake on June 26th. Before the operation began, an IAP was developed. It was the final IAP and the only one written. Neadles approved the document before it was written, but it was drafted by Ryan Priestly, the owner of Priestly Demolition and the demolitions operator who ultimately gained access to Doloris and Lucie. This plan was signed by Roger Jeffreys, Neadles and Ryan Priestly. The IC did not sign it.⁶⁷

⁶² Examination of Jamie Gillespie, transcript of September 4, 2013, pp. 23821-2, lines 6-8.

⁶³ Examination of James Cranford, transcript of September 9, 2013, pp. 24829-44, lines 13-5.

⁶⁴ Examination of James Cranford, transcript of September 9, 2013, pp. 24919-21, lines 12-20.

⁶⁵ Examination of Michael McCallion, transcript of September 6, 2013, pp. 24597-9, lines 25-7.

⁶⁶ Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28747-8, lines 17-5.

⁶⁷ Examination of William Neadles, transcript of September 12, 2013, pp. 25737-8, lines 1-2. Exhibit 7296, Rescue/Recovery Procedure for 151 Ontario Ave, Elliot Lake. Examination of Roger Jeffreys, transcript of October 3, 2013, pp. 28188-9, lines 25-5. Examination of Ryan Priestly, transcript of October 2, 2013, pp. 27849-50, lines 20-3.

B. The Authority of the MOL in Emergencies

60. The role and powers of the MOL’s inspectors and engineers who attended to the Collapse were the subject of much confusion and misunderstanding. Different agencies and individuals had varied understandings of the MOL’s authority, which often differed, quite significantly, from the way the MOL personnel viewed their own position and authority. This confusion led to two instances in which the MOL was incorrectly blamed for shutting down rescue operations.

i. Varied understandings of MOL’s Authority

(a) MOL

61. Both MOL inspectors, Don Jones and Michel LaCroix (the “**Inspectors**”), understood that they were called to the scene because the Collapse occurred at a workplace. Their primary purpose was to conduct an investigation as to the causes of the Collapse and as to whether there were any violations of the *Occupational Health and Safety Act*, R.S.O. 1991, c. O.1 (the “**OHSA**”). Neither believed that they were called to oversee the safety of the rescue operation; although LaCroix testified that once in Elliot Lake he had a minor role to play in ensuring the safety of the workers.⁶⁸

62. The Inspectors’ understanding of their authority at emergency scenes has remained unchanged from June, 2012. In their view, the OHSA grants inspectors the power to shutdown both rescue and recovery operations due to safety concerns.⁶⁹ Despite this, the Inspectors testified that they would not exercise their powers to shutdown a rescue. If they saw anything unsafe occur during a rescue, they would speak to the rescuer, the rescuer’s supervisor, or the IC to advise them of their concerns. To the best of their

⁶⁸ Examination of Donald Jones, transcript of September 26, 2013, pp. 27380-1, lines 16-8; p. 27386, lines 14-25 and p. 27436, lines 1-5. Examination of Michael LaCroix, transcript of October 3, 2013, pp. 27965-6, lines 13-13; pp. 27973-4, lines 14-3 and pp. 27976-7, lines 17-9.

⁶⁹ Examination of Donald Jones, transcript of September 26 2013, pp. 27423-4, lines 13-2 and pp. 27470-1, lines 24 13. Examination of Michael LaCroix, transcript of October 3, 2013, pp. 27956-7, lines 1 -1 and p. 27963, lines 1-11.

recollection, neither saw anything during the course of emergency response in Elliot Lake that warranted such a warning.⁷⁰

63. Both Brian Sanders and Roger Jeffreys (the “**Engineers**”) understood that as MOL engineers their purpose was to assist the Inspectors in their investigations.⁷¹ Jeffreys testified that although the MOL’s position usually is that their engineers are not to give advice on how to comply with the OHSA, he was specifically instructed by MOL Assistant Deputy Minister Sophie Dennis to “sister up with the organizations that are there...give them whatever help you can”. He understood that she intended him to offer up his services and give the first responders what help he could as a structural engineer.⁷²
64. Like the Inspectors, the Engineers understood in June, 2012 and at the time of their testimony, that by virtue of the OHSA, MOL inspectors have the authority to issue stop-work orders pertaining to rescues and recoveries in any workplace, just as they would in a non-rescue situation.⁷³ If an inspector or an engineer saw something “patently” unsafe during the course of a rescue or recovery operation, he or she would bring the danger to the attention of the rescuer or his or her supervisor. If the workers ignored the suggestions and continued to put themselves in harms’ way, the Engineers were of the view that a stop-work order should be issued in an effort to save lives.⁷⁴
65. The Inspectors did not explain their purpose for being onsite to any of the responders, nor did they inform the responders that they had no intention of shutting down any rescue

⁷⁰ Examination of Donald Jones, transcript of September 26, 2013, pp. 27380-1, lines 24-8 and pp. 27391-2, lines 25-1. Examination of Michael LaCroix, transcript of October 3, 2013, p. 27959, lines 4-23 and pp. 27960-1, lines 16-9.

⁷¹ Examination of Rogers Jeffreys, transcript of October 3, 2013, p. 28050, lines 1-12 and p. 28070, lines 1-5. Examination of Brian Sanders, transcript of October 4, 2013, p. 28320-1, lines 11-1.

⁷² Exhibit 6227, Ministry of Labour Engineering Report: Mall Roof Collapse, p. MOL_E000008060_004. Examination of Roger Jeffreys, transcript of October 3, pp. 28065-6, lines 24-3 and p. 28072, lines 3-16.

⁷³ Examination of Roger Jeffreys, transcript of October 3, 2013 p. 28057, lines 1-23 and pp. 28057-9, lines 24-1. Examination of Brian Sanders, transcript of October 4, 2013, p. 28273, lines 1-23.

⁷⁴ Examination of Roger Jeffreys, transcript of October 3, 2013, pp. 28051-2, lines 23-7; p. 28057, lines 1-23; pp. 28058-9, lines 21-1 and p. 28059-60, lines 21-15. Examination of Brian Sanders, transcript of October 4, 2013, pp. 28274-76, lines 20-13.

efforts.⁷⁵ Jeffreys felt that he clearly told people on the site his purpose for attending the scene and he felt that everyone on scene understood his purpose for being there.⁷⁶

66. All of the MOL personnel who attended the Collapse testified that they could not recall ever having received formal or informal training regarding the role of the MOL during an emergency. None were aware of any legislation, regulation or guideline that would dictate the conduct of a MOL inspector or engineer at the scene of an emergency.⁷⁷

(b) Elliot Lake Fire Department

67. Members of the Elliot Lake Fire Department did not have a cohesive understanding of the MOL's powers at the scene of a rescue. Some were admittedly unsure of the MOL's powers.⁷⁸ Others believed that as long as the operation remained a rescue, under the OHSA, the MOL had "no right on fire ground".⁷⁹ Officer himself, the IC, was uncertain of the MOL's powers when the Collapse first occurred, but during the course of the rescue he was informed by the OFM that the MOL had no power to shut down a rescue.⁸⁰

(c) UCRT

68. Based on their institutional memory and experience, the UCRT team was and is generally united in their belief that the MOL does not have the power to issue a stop-work order during a rescue. Once the rescue has transitioned into a recovery, the MOL has jurisdiction. Members of the UCRT team came to this understanding in the wake of previous deployments, in particular their deployment to an explosion at an apartment building in Woodstock where MOL's authority during a rescue/recovery operation was put in issue.⁸¹ Their understanding is that the MOL's role during a rescue is to advise the

⁷⁵ Examination of Donald Jones, transcript of September 26, 2013, pp. 27398-9, lines 22-7; pp. 27429-30, lines 25-17 and p. 27471, lines 14-25. Examination of Michael LaCroix, transcript of October 3, 2013, pp. 27977-8, lines 15-1.

⁷⁶ Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28201, lines 4-13.

⁷⁷ Examination of Michael LaCroix, transcript of October 3, 2013 p. 27954, lines 7-20; p. 27961, lines 10-16 and pp. 27961-2, lines 17-25. Examination of Roger Jeffreys, transcript of October 3, 2013 p. 28059, lines 2-10 and pp. 28060-1, lines 18-5. Examination of Brian Sanders, transcript of October 4, 2013, pp. 28273-4, lines 24-12.

⁷⁸ Examination of Darren Connors, transcript of August 21, 2013, pp. 21466-7, lines 22-11.

⁷⁹ Examination of John Thomas, transcript of August 15 2013, pp. 21087-8, lines 2-8.

⁸⁰ Examination of Paul Officer, transcript of August 21, 2013, pp. 21651-3, lines 2-7. Examination of Paul Officer, transcript of August 22, 2013, p. 21906, lines 15-19.

⁸¹ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22250-1, lines 19-2. Examination of Dan Bailey, transcript of August 27, 2013, p. 22773, lines 13-23. Examination of Steven Hulsman, transcript of August 28,

rescuers.⁸² Although some members of the UCRT team were unsure of the MOL's powers at the time of the Elliot Lake deployment, after formal and informal debriefs, all the UCRT team members who testified at the Commission are currently of the view that the MOL cannot issue a stop-work order in the course of an active rescue.⁸³

(d) TF-3 and OFM

69. The members of the TF-3 team, including the team leads, had varied understandings of the role of the MOL at the site of the Collapse.

70. On June 24th at 00:01, Neadles sent an email to Chambers of the OFM advising her that the media reported that the MOL was halting the rescue.⁸⁴ Neadles understood at the time of sending this email that the MOL did not have the authority to interfere with a rescue operation but he wanted confirmation from Chambers that his understanding was correct.⁸⁵ Neadles subsequently received confirmation from Chambers and others at the OFM that the MOL had no authority to interfere with a rescue operation.⁸⁶

71. In her testimony, Chambers stated that, in her experience, it would be highly unusual for the MOL to shut down a rescue and she “would find it hard to believe that that would happen”. Contrary to what her emails at the time of the Collapse would suggest, she testified that she understands that the OHSA is the prevailing legislation and that the MOL has the authority to stop a rescue. As a practical matter, however, she would not expect that to happen.⁸⁷

72. Other team members had different views. Although not certain, McCallion believed that the MOL could issue stop-work orders in recoveries but not in rescues. In his view, the

2013, pp. 22905-7, lines 19-19. Examination of Jamie Gillespie, transcript of September 3, 2013, p. 23500, lines 12-24 and pp. 23501-2, lines 24-22.

⁸² Examination of Ryan Cox, transcript of August 26, 2013, pp. 22278-9, lines 23-5. Examination of Jamie Gillespie, transcript of September 3, 2013, p. 23553, lines 10-24.

⁸³ Examination of Patrick Waddick, transcript of August 23, 2013, p. 22104, lines 13-23.

⁸⁴ Exhibit 6662, email SITREP- Update from CCG meeting, p. OFM_P000000219. Exhibit 6699, email MOL, p. OFM_P000000256.

⁸⁵ Examination of William Neadles, transcript of September 10, 2013, pp. 25274-5, lines 13-24.

⁸⁶ Examination of William Neadles, transcript of September 10, 2013, pp. 25275-9, lines 25-16. Exhibit 6664, email SITREP- update from CCG meeting, p. OFM_P000000221. Exhibit 6674, email MOL, p. OFM_P000000231. Exhibit 6690, email MOL, p. OFM_P000000247.

⁸⁷ Examination of Carol-Lyn Chambers, transcript of September 18, 2013, pp. 26126-9, lines 20-25 and p. 26276, lines 2-15.

MOL only has a limited advisory role in rescues.⁸⁸ Comella testified that Jeffreys told him that as long as the operation remained a rescue, the MOL had no jurisdiction.⁸⁹ Cranford, TF-3's embedded structural engineer, believed that the MOL was there to oversee the site and that they had the power, during both rescue and recovery efforts, to issue stop-work orders,⁹⁰ while Captain Chuck Guy understood that the MOL was there to make sure rescuers followed due diligence.⁹¹ Both Neadles and Comella testified that, throughout the operation, they were unsure what the purpose of the MOL inspectors and engineers was at the rescue site and that it was never clarified to them.⁹²

73. TF-3's confusion surrounding the role of the MOL was best exemplified when Comella testified that: "We have 103 team members. Every one of them has a varied understanding of how the Ministry of Labour and how the Province of Ontario assigns assets, et cetera".⁹³

(e) OPP

74. The members of the OPP were equally unsure of MOL's authority. Jollymore was uncertain whether the MOL had the authority to shut down a rescue but was certain that s. 43 of the OHS Act allowed the MOL to make orders during recoveries.⁹⁴ Burns assumed that the MOL were the safety experts and would halt the rescue if it was dangerous.⁹⁵

(f) Ministry of Safety and Correctional Services

75. Ontario's Commissioner of Community Safety, Hefkey initially testified on August 9, 2013, that he would not expect MOL inspectors on scene at an emergency to issue an order under the OHS Act stopping a rescue for health or safety reasons. In his view, the decision to call off a rescue is one for the IC, and the IC alone, to make.⁹⁶

⁸⁸ Examination of Michael McCallion, transcript of September 6, 2013, p. 24497, lines 4-10; p. 24498, lines 19-25 and pp. 24499-00, lines 21-2.

⁸⁹ Examination of Tony Comella, transcript of September 4, 2013, p. 24083, lines 1-10.

⁹⁰ Examination of James Cranford, transcript of September 9, 2013, pp. 24733-4, lines 19-9.

⁹¹ Examination of Chuck Guy, transcript of September 24, 2013, p. 27138, lines 14-23.

⁹² Examination of William Neadles, transcript of September 11, 2013, pp. 25319-20, lines 17-24. Examination of Tony Comella, transcript of September 4, 2013, p. 24083, lines 11-15.

⁹³ Examination of Tony Comella, transcript of September 6, 2013, p. 24383, lines 21-25.

⁹⁴ Examination of Percy Jollymore, transcript of September 24, 2013, pp. 26938-41, lines 2-8.

⁹⁵ Examination of Dale Burns, transcript of August 20, 2013, p. 21274, lines 6-14.

⁹⁶ Examination of Dan Hefkey, transcript of August 9, 2013, p. 20348 lines 5-12.

76. When he returned to testify on October 8, Hefkey stated that the OHSA reigns supreme and that the MOL has the ability to issue a stop-work order in both rescue and recovery situations. He testified that he does not believe that MOL inspectors should impose a different standard or exercise their discretion differently in rescue or recovery situations because the rescuers are workers under the OHSA.⁹⁷

(g) Office of the Premier

77. John O’Leary, a former Manager of Legislative Issues at the Office of the Premier, understood that the MOL would not be the lead agency in the response, but that they would play a support role in a rescue. He did not turn his mind to whether the MOL had the ability to control or stop the way in which a rescue operation was carried out.⁹⁸

ii. Shutdown on the 23rd/24th

78. Based in part on erroneous news reports, responders mistakenly believed that the MOL had shut down the rescue for a period of approximately 30 minutes in the early morning on June 24, 2013.⁹⁹

79. MOL inspectors never shutdown the rescue and were, in fact, not even onsite at the time of the alleged shutdown.¹⁰⁰ Jones testified that he told the police when he first arrived on scene on the early morning of June 24th that the MOL would not be making any shutdown orders.¹⁰¹ Beyond that neither Jones nor, to the best of his knowledge, any other MOL personnel made it clear to TF-3 that they would not be issuing any orders that interfered with the rescue operations.¹⁰²

⁹⁷ Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28749-50, lines 18-9 and pp. 28752-3, lines 1-6.

⁹⁸ Exhibit 8206, email Elliot Lake Mall: MOL Inspection History. Examination of John O’Leary, transcript of September 17, 2013, pp. 25837-8, lines 24-4 and p. 25866, lines 2-14.

⁹⁹ Exhibit 6377, Ryan Cox’s notes, pp. OPP_E000003614_004-005. Exhibit 7280, Howse’s notes, p. OFM_E000000663_004. Exhibit 8044, ELFD Standard Incident Report, p. ELFD_E000002568_0010 and 0016. Exhibit 6619, John Thomas Command Radio Transmissions. Examination of John Thomas, transcript of August 15, 2013, pp. 21089-90, lines 5-24. Examination of Paul Officer, transcript of August 21, 2013 p. 21666, lines 3-18. Examination of Ryan Cox, transcript of August 26, 2013, pp. 22298-9, lines 25-5.

¹⁰⁰ Exhibit 6657, email – Rescue. Examination of Donald Jones, transcript of September 26, 2013, p. 27393, lines 8-24. Examination of Roger Jeffreys, transcript of October 3, 2013, pp. 28111-2, lines 19-3.

¹⁰¹ Examination of Donald Jones, transcript of September 26, 2013, pp. 27395-6, lines 14-12.

¹⁰² Examination of Donald Jones, transcript of September 26, 2013, pp. 27398-9, lines 22-7.

iii. Shutdown on the 25th

(a) 15:00 CCG meeting

80. There is clear evidence, including the testimony of Neadles himself, that on June 25, just prior to 15:00 Neadles made the decision to call-off the rescue.¹⁰³ Neadles announced that decision at a CCG meeting at 15:00.¹⁰⁴ Jeffreys and Jones were the only members from the MOL in attendance at that meeting. Jeffreys explained to the group that the building was highly unstable and 100% overstressed. The scribe made a note stating: “MOL stop order so no one can enter” and “MOL places order”.¹⁰⁵ There is conflicting evidence as to whether it was Jeffreys or Jones who made that statement.¹⁰⁶
81. Jeffreys felt it was clear from this meeting that the order in question would be issued on the owner, at some undetermined point in the future and it would be written so that it would not affect any of the rescue or recovery work.¹⁰⁷
82. After the 15:00 CCG meeting, Jeffreys told Sanders that Jones would be writing orders to the owner on the “remainder of the building” at a later time.¹⁰⁸ Jeffreys did not mention to Sanders whether the order applied to rescue/recovery workers.¹⁰⁹
83. Sanders emailed an update to his supervisor Gabriel Mansour. In that email, after noting that TF-3 had called the rescue off because of unsafe conditions in the collapse zone, he described the condition of the rest of the building and the corresponding order that would be written:

In respect to the rest of the building, there are numerous signs of rust and fatigue throughout the building (many reports and indications of water damage), hence our determination in shutting down the whole facility until an engineer can determine that it is safe to be in, or determines complete demolition of the

¹⁰³ Exhibit 7264, email – HUSAR, p. CT_P00000261. Exhibit 7812, Hefkey notes, p. CCO_E000000034_05. Exhibit 8312, email – Elliot Lake. Exhibit 8313, email – MOL and Elliot Lake. Exhibit 9351, email – Elliot Lake updates. Examination of William Neadles, transcript of September 11, 2013, pp. 25435-6, lines 21-10 and p. 25445, lines 1-6. Examination of Dan Hefkey, transcript of October 8, 2013 p. 28625, lines 8-16.

¹⁰⁴ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_033-34.

¹⁰⁵ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_034-035.

¹⁰⁶ Examination of Donald Jones, transcript of September 26, 2013, pp. 27412-3, lines 1-4. Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28152, lines 4-25. Examination of Natalie Bray, transcript of October 4, 2013, p. 28337, lines 5-25.

¹⁰⁷ Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28152, lines 19-25 and p. 28153, lines 17-23.

¹⁰⁸ Examination of Brian Sanders, transcript of October 4, 2013, p. 28309, lines 3-6 and pp. 28309-10, lines 22-6.

¹⁰⁹ Examination of Brian Sanders, transcript of October 4, 2012, pp. 28325-6, lines 10-6.

structure. Either way, a report from an engineer will be required before we will let them proceed any further.

84. He testified that his intention, when writing this email, was that the order would apply not to the collapse zone, but only to the rest of the building.¹¹⁰ Sanders also testified that “them” referred to the owner in the phrase “before we let them proceed any further”.¹¹¹

(b) Press conference

85. At 17:00 on June 25th, Neadles held a press conference in which it was announced that the rescue would be changing from a rescue to a recovery. He said that the decision was made in consultation with the MOL engineer. He also advised the public that the MOL would be putting an order on the building requiring the owner to hire an engineer to come up with a demolition plan to be approved by the MOL.¹¹²

(c) Confusion Amongst Emergency Responders

86. Following the CCG meeting and the press conference, the role of the MOL in the shutdown on June 25th was, and continues to be, the subject of a great deal of misunderstanding amongst the emergency responders.
87. Officer, the IC, testified that he was advised by Neadles that Jeffreys would put an order on the building, prohibiting people from entering; effectively bringing the rescue to a halt. He believes that Jeffreys attended a command meeting at 13:30 and that there was a verbal stop-work order on the Mall prior to the 15:00 CCG meeting. He understood that this order did not allow anyone, including rescuers, into the Mall.¹¹³
88. From the 15:00 CCG meeting, Neadles understood that an order was being contemplated but he was unsure what the status of the order was at the time of the meeting.¹¹⁴

¹¹⁰ Exhibit 9280, email – Update. Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28162, lines 2-6 and pp. 28163-4, lines 9-2.

¹¹¹ Examination of Brian Sanders, transcript of October 4, 2013, p. 28321, lines 18-22.

¹¹² Exhibit 7208, CBC transcript of June 25, 17:00 Press Conference, pp. CBC_E000000007_0009-0010 and 0014-0015.

¹¹³ Exhibit 8025, Paul Officer’s notes, p. 6. Examination of Paul Officer, transcript of August 22, 2013, p. 21784, lines 11-20; p 21793, lines 8-16; pp. 21815-6, lines 7-22 and p. 21911, lines 2-16. Examination of Paul Officer transcript of September 19, 2013, pp. 26417-8, lines 1-14 and p. 26426, lines 22-25.

¹¹⁴ Examination of William Neadles, transcript of September 11, 2013, p. 25472, lines 4-12.

McCallion thought that if the site was deemed a recovery the MOL would put a stop-work order on it.¹¹⁵

89. Gillespie testified he was told by McCallion at approximately 13:15 on June 25th, in advance of the 15:00 CCG meeting, that the MOL issued a stop-work order and prevented the rescue from continuing.¹¹⁶ McCallion denies conveying that information to Gillespie.¹¹⁷ Gillespie told other members of UCRT that the MOL had shut down the rescue.¹¹⁸ Gillespie later had a conversation with LaCroix and Howse at approximately 20:00 on June 26th, wherein LaCroix told him that the MOL never called off the rescue and that the decision to call off the rescue was made by IC directly.¹¹⁹
90. At 16:30 Jollymore told the OPP that the site had been shut down by the MOL and that a stop-work order had been issued.¹²⁰
91. Based on information she received from Bob Thorpe, a Fire Protection Advisor who was on scene, Chambers sent out an email stating that the building was deemed shut by MOL. She did not ask Thorpe where he got his information from. She later understood that when the mission moved from a rescue to a recovery the MOL issued an order to close the building.¹²¹
92. In response to the press conference at 17:00 on June 25, Hefkey inquired and learned from Dennis at approximately 18:20 that role of the MOL engineer was to assist TF-3 and provide advice, not to shut down a rescue operation. Dennis relayed that Jeffreys did not tell TF-3 to shut down the rescue.¹²²

¹¹⁵ Examination of Michael McCallion, transcript of September 6, 2013, pp. 24704-5, lines 14-4.

¹¹⁶ Exhibit 6378, Jamie Gillespie's notes, pp. OPP_E000003619_025-026. Examination of Jamie Gillespie, transcript of September 3, 2013, p. 23719-21, lines 15-5.

¹¹⁷ Examination of Michael McCallion, transcript of September 6, 2013, pp. 24586-7, lines 15- 7.

¹¹⁸ Exhibit 6378, Jamie Gillespie's notes, pp. OPP_E000003619_025-026. Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23731-3, lines 22-4.

¹¹⁹ Exhibit 6378, Jamie Gillespie's notes, pp. OPP_E000003619_033-034. Exhibit 7554, Minutes of UCRT debriefing, pp. OPP_E000067716_02-03. Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23765-7, lines 5-18. Examination of Michael LaCroix, transcript of October 3, 2012, p. 28019, lines 3-7.

¹²⁰ Exhibit 6404, Dale Burns's notes, p. OPP_E000218615. Examination of Dale Burns, transcript of August 20, 2013, p. 21281, lines 7-19.

¹²¹ Exhibit 7109, email – Significant Development from HUSAR. Examination of Carol-Lyn Chambers, transcript of September 18, 2013, pp. 26159-61, lines 11-17 and p. 26188, lines 4-8.

¹²² Exhibit 7812, Dan Hefkey's notes, p. CCO_E000000034_05. Examination of Dan Hefkey, transcript of October 8, 2013 p. 28625, lines 8-16.

93. Based on a conversation with Neadles, Mantha understood that the shutdown was a decision made by Neadles in consultation with the MOL. On June 27, 2012, Mantha, in a statement to the press, said that the MOL was responsible for temporarily halting rescue efforts.¹²³

(d) MOL's reaction

94. The MOL eventually issued three orders on June 26, preventing anyone from entering the Mall except for personnel involved in the rescue and recovery of Doloris and Lucie. The orders very clearly did not apply to rescue and recovery personnel.¹²⁴

95. All MOL personnel onsite denied that they put an order on the building or discussed putting an order on the building while the rescue was underway. All of them understood that the rescue had been called off by TF-3.¹²⁵ The Engineers testified that they never gave an opinion about the safety of the rescuers, the stability of the building or whether the beam under the escalator could be shored up.¹²⁶

96. All MOL personnel were surprised by Neadles' announcement that the rescue operation had been called off. Some MOL personnel learned on the scene that other responders, the townsfolk and the media thought the MOL was responsible for the shutdown. Others were not aware until after the events that there was a rumour the MOL shut down the rescue efforts.¹²⁷ However, none of the MOL personnel made any attempts to clarify that they had not shut down the operation. Equally, there is no evidence that the MOL, as an entity, ever released a statement clarifying that they never shutdown the rescue operations. Instead, the MOL released an in-house memo to its staff instructing them to

¹²³ Exhibit 8992, email – MPP Mantha w/ questions for MOL. Examination of Michael Mantha, transcript of September 23, 2013, pp. 26783-5, lines 8-9 and p. 26796, lines 13-23.

¹²⁴ Exhibit 5052, MOL Field Visit Report. Exhibit 7021, Don Jones's notes, p. MOL_P000000115. Exhibit 9154, MOL Elliot Lake: Abbreviated Chronology. Examination of Donald Jones, transcript of September 26, 2013, p. 27414, lines 19-23 and pp. 27415-7, lines 20-11. Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28153, lines 17-23.

¹²⁵ Exhibit 7021, Don Jones's notes, p. MOL_P000000115. Examination of Donald Jones, transcript of September 26, 2013, pp. 27392-3, lines 14-3; p. 27420 lines 8-12; p. 27424, lines 16-24 and p. 27435, lines 2-5. Examination of Michael LaCroix, transcript of October 3, 2013, p. 28005, lines 8-22 and p. 28012, lines 14-20. Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28148, lines 4-12. Examination of Brian Sanders, transcript of October 4, 2013, p. 28331, lines 23-25 and p. 28332, lines 8-16.

¹²⁶ Examination of Brian Sanders, transcript of October 4, 2013, pp. 28286-7, lines 24-18. Examination of Roger Jeffreys, transcript of October 3, 2013, pp. 28066-7, lines 21-3; pp. 28112-3, lines 18-8 and p. 28144, lines 3-10.

¹²⁷ Exhibit 8302, email – Stmt by HUSAR Commander and Transcript of Press Conf. Examination of Donald Jones, transcript of September 26, 2013, pp. 27392-3, lines 14-3 and pp. 27424-5, lines 16-16.

tell those who inquired that the MOL did not issue orders at any time to stop the rescue operation and that the MOL did issue three orders which did not affect the rescue/recovery efforts.¹²⁸

C. The Authority to Demolish Private Property

97. When it was announced on June 25th that the operation was transitioning from a rescue to a recovery, there was uncertainty amongst members of the CCG and other responders regarding which agency was responsible for ordering the demolition of the Mall and facilitating recovery of Doloris and Lucie.¹²⁹ The crux of the problem was that the Mall was private property owned by Eastwood Mall Inc. (“**Eastwood**”), and there was concern that Eastwood may not cooperate with the CCG to have the building demolished and the bodies removed quickly and with dignity.
98. Each of the following agencies confirmed their own lack of jurisdiction to demolish the building at or around the 15:00 CCG meeting:
- a. TF-3 - Neadles stated at the 15:00 CCG meeting, and later at the 17:00 press conference, that because the operation had changed from a rescue to a recovery, TF-3 no longer had jurisdiction and the site was under the full control of the ELFD.¹³⁰
 - b. The ELFD, the Chief Building Official and the OFM - all understood that their authority to order a demolition on private property expires once the operation changes from a rescue to a recovery.¹³¹
 - c. The Office of the Chief Coroner - the coroner told the group that the *Coroner’s Act*, R.S.O. 1990 c. C.37, did not afford him any power to demolish the building and that he could only enter the Mall once it was deemed safe.¹³²

¹²⁸ Exhibit 8235, MOL House Note – Algo Centre Mall – Fatality/Critical Injury. Exhibit 8313, email – MOL and Elliot Lake. Exhibit 8992, email MPP Mantha w/ questions for MOL.

¹²⁹ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_041. Exhibit 8044, ELFD Standard Incident Report, p. ELFD_E000002568_0011.

¹³⁰ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_033. Exhibit 7208, CBC transcript of June 25, 17:00 Press Conference, p. CBC_E000000007_0009. Examination of Roger Jeffreys, transcript of October 3, 2013 pp. 28169, lines 4-13.

¹³¹ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_041 and 043. Examination of Paul Officer, transcript of August 22, 2013, pp. 21842, lines 1-9. Examination of Roger Jeffreys, transcript of October 3, 2013 pp. 28168-69, lines 19-4.

- d. Emergency Management Ontario - Hefkey confirmed that he did not have the authority, through Emergency Management Ontario, to demolish the building.¹³³
- e. The MOL - Jeffreys told the CCG that the MOL could not order the City of Elliot Lake (“**the City**”) to demolish the building. He was displeased when Neadles announced at the press conference at 17:00 that the MOL would put an order on the building requiring demolition because the MOL does not have the power or authority to order anyone to demolish a building or part of a building.¹³⁴
99. Ultimately, no one at the meeting thought they had the authority to demolish the building because the Mall was private property. It was a common understanding that the only agency or individual who had authority to demolish the building was Bob Nazarian (the sole director and shareholder of Eastwood).¹³⁵
100. This reality created several problems. First, Nazarian was not in Elliot Lake so obtaining his authorization to commence a demolition was challenging. Second, based on previous experience, Officer had concerns that leaving the demolition and the timing of the demolition to Nazarian would be ineffective.¹³⁶
101. Two things happened which made this issue moot to the members of the CCG: Nazarian permitted his lawyer to authorize “whoever” to do what they needed to do to obtain the bodies and, soon after, Neadles announced that the rescue efforts were being resumed.¹³⁷ As a result, the issue of which agency had the power to pursue the recovery was never resolved.

¹³² Exhibit 9449, Roger Jeffreys’s notes. Examination of Paul Officer, transcript of August 22, 2013, pp. 21842, lines 10-13. Examination of Roger Jeffreys, transcript of October 3, 2013, pp. 28170, lines 9-16.

¹³³ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_041. Exhibit 7812, Dan Hefkey’s chronology, p. CCO_E000000034_006. Dan Hefkey, transcript of October 8, 2013, pp. 28630-1, lines 6-15. Paul Officer, transcript of August 22, 2013, pp. 21848-9, lines 16-9.

¹³⁴ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_043. Exhibit 9449, Roger Jeffreys’s notes. Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28181, lines 19-24.

¹³⁵ Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925_036. Examination of Paul Officer, transcript of August 22, 2013, pp. 21846-7, lines 21-6 and pp. 21824-6, lines 10-2. Examination of Roger Jeffreys, transcript of October 3, 2013, p. 28176, lines 7-14. Examination of Brian Sanders, transcript of October 4, 2013, p. 28330, lines 5-18.

¹³⁶ Examination of Paul Officer, transcript of August 22, 2013, pp. 21824-5, lines 12-2.

¹³⁷ Exhibit 9911, Fabris Signed Authority. Exhibit 9449, Roger Jeffreys’s notes. Examination of Roger Jeffreys, transcript of October 3, 2013 pp. 28174 lines 5-20. Examination of Paul Officer, transcript of August 22, 2013, p. 21848, lines 6-13.

D. Rescue Operations

102. The evidence heard during this Inquiry has shown several unrelated operational areas in need of further discussion or improvement:
- a. There were limited safety precautions taken prior to sending ELFD responders into the collapse zone;
 - b. There was no organized reconnaissance whereby information critical for planning the rescue operation could be sent to the Toronto-based emergency service providers who would not arrive onsite until many hours after the Collapse;
 - c. TF-3 does not provide its members with sufficient training in crane operations;
 - d. The results of the ground penetrating radar used in Elliot Lake (the LifeLocator) were unreliable because the device was deployed outside manufacturing guidelines;
 - e. The shores built by TF-3 in the afternoon and evening of June 25, 2012 were unnecessary, ineffective and built for public relations purposes; and
 - f. Neither TF-3 nor the City of Elliot Lake conducted a debriefing or prepared an after-action report of the emergency.

i. Safety of the ELFD Members Entering the Collapse Zone

103. Members of the ELFD were the first responders to the Collapse. The only precautions taken by the ELFD prior to sending its members into the collapse zone were: (i) turning off the utilities; (ii) turning off the gas; and (iii) having the City's Chief Building Official, Bruce Ewald, do a quick assessment of the site.¹³⁸ There is no evidence that a structural engineer performed an assessment of the safety of the building, in particular the collapsed zone, prior to sending in members of the ELFD.

¹³⁸ Examination of Paul Officer, transcript of August 21, 2013, p. 21567, lines 1-16 and pp. 21570-21572, lines 21-8.

104. Approximately half an hour after the Collapse, Fire Chief Paul Officer, the IC, instructed the first ELFD rescue team to enter the collapse zone to look for survivors.¹³⁹ Firefighters John Thomas, William Elliott and Wayne Millett climbed onto the pile and began calling out to potential victims and looking into voids for limbs and body fluids.¹⁴⁰
105. Two minutes later, Officer and Ewald entered the building and viewed the collapse zone from the second floor.¹⁴¹ When Officer saw the condition of the collapse zone, he became concerned about the concrete slabs on top of the escalator that were leaning towards the pile at a 45 degree angle. It appeared that the only thing preventing the slabs from falling onto the pile were vertical concrete slabs holding the leaning slabs in place.¹⁴² However, ELFD personnel were not ordered off the pile at that time.
106. At approximately 15:28, the first ELFD rescue team reported communications with a victim. Firefighters Thomas and Darren Connors testified that they heard responses to their call-outs from on top of the pile.¹⁴³ However, those communications ceased shortly after.¹⁴⁴ By 17:07, Officer felt that his men had exhausted all possibilities and, given the hazards posed to the ELFD members on the pile, Officer ordered the majority of them to pull out at 17:07.¹⁴⁵ Finally, at 18:26, all members of the ELFD were pulled off the pile.¹⁴⁶
107. Officer himself recognized the risks posed by sending his team into the collapse zone so quickly. On August 21, 2012, Officer sent a letter to the Ontario Honours and Awards

¹³⁹ Exhibit 8025, Paul Officer's notes, p. 1. Examination of Paul Officer, transcript of August 21, 2013, p. 21584, lines 19-24.

¹⁴⁰ Examination of John Thomas, transcript of August 15, 2013, pp. 21039-42, lines 12-2.

¹⁴¹ Exhibit 8025, Paul Officer's notes, p. 1. Examination of Paul Officer, transcript of August 21, 2013, pp. 21585-7, lines 12-22. Exhibit 7798, graphic - slab on top of escalator.

¹⁴² Examination of Paul Officer, transcript of August 21, 2013, pp. 21587-90, lines 23-8. Exhibit 7931, graphic – SUV on pile.

¹⁴³ Exhibit 8025, Paul Officer's notes, p. 1. Examination of John Thomas, transcript of August 15, 2013, pp. 21042-7, lines 3-1. Exhibit 8104, graphic – general area where both victims were later located. Exhibit 7524, Darren Connors Witness Statement, p. ELFD_P000001887. Examination of Darren Connors, transcript of August 20, 2013, pp. 21381-8, lines 15-2. Exhibit 8108, graphic – general area where both victims were later located. Exhibit 6296, audio – ELFD radio communications.

¹⁴⁴ Examination of Darren Connors, transcript of August 20, 2013, pp. 21389-91, lines 14-5. Exhibit 8025, Paul Officer's notes, p. 2 at 16:23:24 "Advised base that we have had no contact with the victim for about one hour now."

¹⁴⁵ Exhibit 8025, Paul Officer's notes, p. 3. Examination of Paul Officer, transcript of August 21, 2013, pp. 21621-2, lines 15-6 and pp. 21623-4, lines 14-21.

¹⁴⁶ Exhibit 8025, Paul Officer's notes, p. 4. Examination of Paul Officer, transcript of August 21, 2013, pp. 21626-7, lines 20-20.

Secretariat at the Ministry of Citizenship and Immigration to submit the names of members of the ELFD for consideration. The letter described the instability of the pile, the great risk the ELFD members were exposed to by working on top of the pile, and that, by comparison it took TF-3 a day and a half to shore the building before they were comfortable going onto the pile:

A team of nine firefighters were instructed to enter the collapse zone to look for survivors....Firefighters went to work and the concrete under their feet occasionally shifted.

[...]

After HUSAR's arrival at 6:00 the following morning, it took them a day and a half to shore the building up adequately enough so that their search personnel could safely enter the collapse zone that these firefighters had worked in for approximately four hours the day before.¹⁴⁷

ii. Lack of Organized Reconnaissance

108. Ontario's Commissioner of Community Safety, Dan Hefkey, testified that currently, when an emergency in Ontario takes place far from Toronto, there is no system in place whereby reconnaissance work is done locally to provide individual services like TF-3 and UCRT information such as videos, plans, photos and other information prior to their arrival onsite.¹⁴⁸ Hefkey acknowledged that such a system would be beneficial.¹⁴⁹
109. Organized reconnaissance would have been particularly helpful in response to the Collapse in Elliot Lake since the experienced search and rescue teams were based in Toronto and Bolton (close to Toronto). This is particularly true for TF-3, which, because of its size, aims to leave its base in Toronto within six hours of notification.¹⁵⁰ UCRT aims to deploy sooner with fewer numbers.¹⁵¹

¹⁴⁷ Exhibit 7649, Letter to the Ontario Honours and Awards Secretariat, p. CEL_E000021001_01.

¹⁴⁸ Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28780-2, lines 11-7.

¹⁴⁹ Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28782-3, lines 8-20.

¹⁵⁰ Examination of Tony Comella, transcript of September 4, 2013, pp. 23902, lines 3-16. Exhibit 9278, CAN-TF-3 – Toronto HUSAR PowerPoint presentation, p. CT_E0000000582_003.

¹⁵¹ Examination of Robert Bruce, transcript of August 23, 2013, pp. 21967-8, lines 22-10.

110. UCRT arrived onsite in Elliot Lake at approximately 21:00 on June 23, 2012 – 6.5 hours after the Collapse.¹⁵² TF-3 arrived at approximately 4:30 the next morning – more than 12 hours afterwards.¹⁵³
111. Acting Sergeant Ryan Cox was the first to arrive in Elliot Lake and testified that on the drive up, his reconnaissance was limited to reviewing media photographs of the site on his smartphone.¹⁵⁴
112. According to Comella, the TF-3 coordinator and operations chief during the emergency response,¹⁵⁵ the information conveyed to TF-3 prior to its arrival onsite was limited to grainy photographs from Gillespie and a few phone calls between Gillespie, Neadles and Comella.¹⁵⁶ Similarly, Cranford, the structural engineer retained by TF-3 during the emergency response, only had photographs of the Collapse which he received from Neadles and floor plans he was able to Google on his smartphone.¹⁵⁷

iii. Training in Crane Operations

113. During his overview of the National HUSAR program, the Assistant Deputy Chief Responsible for Emergency Management in Calgary, Coby Duerr, testified that one of the three possible response activities in a search and rescue is “the use of heavy equipment (e.g. cranes) to remove debris”.¹⁵⁸ Indeed, during the search and rescue operation in Elliot Lake, the use of a crane was recognized to be the only way to remove debris from the collapse zone. TF-3’s training in crane operations is not adequate given that crane operations are one of the major methods used in search and rescue operations.

¹⁵² Exhibit 6377, Ryan Cox’s notes, p. OPP_E000003614_003.

¹⁵³ Exhibit 6393, Compilation of TF-3 notes, p. CT_P000001858.

¹⁵⁴ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22259-60, lines 13-12.

¹⁵⁵ Examination of Tony Comella, transcript of September 4, 2013, pp. 23920-1, lines 15-17.

¹⁵⁶ Examination of Tony Comella, transcript of September 4, 2013, pp. 24076-8, lines 13-22.

¹⁵⁷ Examination of James Cranford, transcript of September 9, 2013, pp. 24741-2, lines 4-18.

¹⁵⁸ Exhibit 8102, email - Mall cave in, p. CI_E00000000157_0005. Examination of Coby Duerr, transcript of August 15, 2013, p. 20847, lines 3-23.

(a) UCRT and TF-3 Training in Crane and Rigging Operations

114. The Canadian training standards for structural collapse, amongst other types of technical rescues, is set out by the National Fire Protection Association (NFPA).¹⁵⁹ The NFPA 1670 has three different levels of organizational standards:
- a. *Awareness* – the organization must be able to identify the hazards present in a technical rescue;
 - b. *Operations* – the organization must be able to identify hazards, use equipment, and apply limited techniques to support and participate in a technical search and rescue incident;
 - c. *Technician* – the organization must be able to identify hazards, use equipment and apply advanced techniques to coordinate, perform and supervise technical search and rescue incidents.¹⁶⁰
115. The Texas Engineering Extension Service (“**TEEX**”) of Texas A&M University is one of the organizations that offer training to NFPA standards.¹⁶¹ Level 1 training at TEEX is generally equivalent to the NFPA Awareness and Operations standards. Level 2 training at TEEX is generally equivalent to the NFPA Technician standard.¹⁶² Level 1 provides some in-class rigging training for cranes while Level 2 provides hands-on rigging training with a crane.¹⁶³
116. All members of UCRT are to be trained as Structural Collapse Rescue Technicians.¹⁶⁴ With the exception of UCRT Constables Steve Hulsman and Michael Belgum, who received only Level 1 training in structural collapse at TEEX, all other members of

¹⁵⁹ Examination of Tony Comella, transcript of September 4, 2013, pp. 23931-3, lines 1-5.

¹⁶⁰ Exhibit 9278, CAN-TF-3 Toronto HUSAR PowerPoint presentation, p. CT_E000000582_014. Examination of Tony Comella, transcript of September 4, 2013, pp. 23935-8, lines 2-5 and pp. 23938-40, lines 19-10.

¹⁶¹ Examination of Tony Comella, transcript of September 4, 2013, p. 23946, lines 17-22.

¹⁶² Examination of Tony Comella, transcript of September 4, 2013, pp. 23945-6, lines 23-1 and pp. 23959-60, lines 3-9.

¹⁶³ Exhibit 7834, p. OFM_E0000001538_0017, NFPA 15861 Manual. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22881-2, lines 19-23. Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23472-3, lines 13-14; pp. 23477-9, lines 23-19 and p. 23497, lines 12-14.

¹⁶⁴ Exhibit 7850, UCRT Manual, p. OPP_E000003727. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22883-8, lines 21-11.

UCRT deployed in Elliot Lake received Level 2 training at TEEEX.¹⁶⁵ Since August 2010, all members of UCRT receive training in both Level 1 and 2 at TEEEX, in part, because UCRT management recognized that crane operations are an important component of structural collapse training and that it could not be taught at their own facilities.¹⁶⁶ In addition, all members of UCRT receive training in rope rescue, which includes rigging.¹⁶⁷

117. In contrast to UCRT, TF-3 members are trained in-house to an operational level.¹⁶⁸ TF-3 relies on one of its core agencies, Toronto Water, for Heavy Equipment Control, a term that refers to heavy rigging and crane operations.¹⁶⁹ Comella testified that aside from Don Sorel, a manager with Toronto Water, the only other members of TF-3 with any rigging experience were instructors, who received a 4-hour rigging course that covered crane and hand operations, basic hoisting and rigging.¹⁷⁰ Sorel resigned from TF-3 in January 2013 and, as of the date of his testimony, TF-3 has not found a Toronto Water replacement.¹⁷¹
118. Cranford, the structural engineer called by TF-3 to provide advice on the structure of the Mall and its reaction to the Collapse, had no experience in crane operations prior to arriving in Elliot Lake. He was consequently unable to provide advice to TF-3 on the adequacy of any crane operation strategies like the strategy employed to cut and remove the collapsed beam from the collapse zone.¹⁷²

(b) UCRT and TF-3 Recognition that Crane Operations were Required

119. Cox understood, having seen only Google photographs of the exterior of the Mall similar to the photograph in Exhibit 2114, that a crane would be needed for the rescue operation.

¹⁶⁵ Exhibit 7846, Dan Bailey Employment Records, pp. OPP_E000225580.005 & OPP_E000225580.0025. Examination of Ryan Cox, transcript of August 26, 2013, pp. 22208-9, lines 13-3 and pp. 22217-8, lines 1-1. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22881-2, lines 19-9. Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23479-80, lines 20-2.

¹⁶⁶ Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23478-80, lines 2-11.

¹⁶⁷ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22214-5, lines 16-10.

¹⁶⁸ Exhibit 9278, CAN-TF-3 Toronto HUSAR PowerPoint presentation, p. CT_E000000582_25. Examination of Tony Comella, transcript of September 4, 2013, pp. 23961-3, lines 10-8.

¹⁶⁹ Exhibit 9278, CAN-TF-3 Toronto HUSAR PowerPoint presentation, p. CT_E000000582. Examination of Tony Comella, transcript of September 4, 2013, pp. 23907-8, lines 10-21.

¹⁷⁰ Examination of Tony Comella, transcript of September 4, 2013, p. 24052, lines 12-23 & pp. 24210-3, lines 13-2; Examination of Don Sorel, transcript of October 1, 2013, p. 27533, lines 12-15.

¹⁷¹ Examination of Don Sorel, transcript of October 1, 2013, p. 27597, lines 6-18.

¹⁷² Examination of James Cranford, transcript of September 9, 2013, p. 24725, lines 14-25; pp. 24747, lines 11-13 and pp. 24772, lines 10-22.

Cox had learned through the structural collapse technician course at TEEEX that a crane is usually one of the fastest and safest methods for removing debris from a collapse zone.¹⁷³ Shortly after leaving the UCRT base in Bolton, Cox notified the OPP that he required a crane, rigging equipment that generally comes with a crane, and lumber.¹⁷⁴

120. Similarly, Cranford, who had no experience in crane operations, understood during his first tour of the Mall that the only way to get the collapsed beam out safely was by using a crane.¹⁷⁵ He testified that if he had been provided particular photographs taken on the day of the Collapse (Exhibits 7933 and 7924) en route to Elliot Lake, he would have formed the opinion that a crane would have been the most common piece of equipment to remove the concrete piled on Doloris and Lucie. However, Cranford was never asked for his advice about using a crane.¹⁷⁶
121. Comella testified that, for TF-3, rigging and crane operations are a last resort method.¹⁷⁷ Comella understood, from the pictures he saw prior to arriving in Elliot Lake that the collapse zone was in the middle of the Mall structure.¹⁷⁸ However, he did not know or make efforts to find out whether a crane had been ordered upon his arrival in Elliot Lake and testified that even after arriving in Elliot Lake and seeing the site, ordering a crane would not have been a priority for him.¹⁷⁹

(c) Crane Operations During the Response

122. On June 24, 2012 at approximately 23:50, Cox (UCRT), Waddick (UCRT), Sorel (TF-3) and Law (TF-3) were lowered into the collapse zone to rig and remove concrete slabs from the area.¹⁸⁰ Cox testified that he learned on the morning of June 25, 2013, when the initial four riggers came off the pile for a shift change, that Sorel was the only member of TF-3 with rigging experience.¹⁸¹ Had further crane operations been required, TF-3 would

¹⁷³ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22259-61, lines 24-8.

¹⁷⁴ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22261-65, lines 7-18.

¹⁷⁵ Examination of James Cranford, transcript of September 9, 2013, p. 24763, lines 12-18.

¹⁷⁶ Examination of James Cranford, transcript of September 9, 2013, p. 24787-8, lines 9-25; p. 24747, lines 5-10.

¹⁷⁷ Examination of Tony Comella, transcript of September 4, 2013, p. 23969, lines 12-23 and pp. 24080-1, lines 13-5.

¹⁷⁸ Examination of Tony Comella, transcript of September 4, 2013, p. 24078-80, lines 2-22.

¹⁷⁹ Examination of Tony Comella, transcript of September 4, 2013, pp. 24077-8, lines 23-4 and p. 24079, lines 8-5.

¹⁸⁰ Exhibit 6377, Ryan Cox's notes, p. OPP_E000003614_006-7. Examination of Ryan Cox, transcript of August 26, 2013, pp. 22348-50, lines 15-22.

¹⁸¹ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22361-2, lines 11-6 and pp. 22370-1, lines 13-19.

have been short staffed and under experienced to conduct the operations necessary for the rescue.

iv. LifeLocator

123. During the response to the Collapse, UCRT deployed a type of ground penetrating radar, made by Geophysical Survey Systems Inc. (“GSSI”) and known as LifeLocator III+ (the “LifeLocator”). ELMAC submits that this Commission should make a factual finding that the LifeLocator was not used in accordance with the manufacture’s guidelines and as a result, indications of breathing were likely inaccurate.
124. The LifeLocator works by sending out electromagnetic waves that can be used to recognize movement. A software program in the LifeLocator recognizes regular and repetitive movement at a certain range of frequencies that correlates to the frequency at which humans breathe.¹⁸² The LifeLocator provides a measurement of the distance from the unit to the moving object.¹⁸³
125. The manufacturer recommends that no person be within a 15-metre parameter of the LifeLocator when it is deployed.¹⁸⁴ This warning appears on top of the machine.¹⁸⁵
126. UCRT member Hulsman deployed the LifeLocator twice, at 23:30 on June 24, 2012 and at 4:30 on June 25, 2012.¹⁸⁶
127. Prior to deploying the LifeLocator, Gillespie showed Hulsman the area around which the search dogs had live hits. Hulsman deployed the LifeLocator in that area.¹⁸⁷
128. During the first deployment and at 23:30, the LifeLocator provided four results that indicated breathing at a distance of between 2.7 and 6.2 metres.¹⁸⁸ Hulsman knew that it

¹⁸² Exhibit 9214, February 13 2013 letter from GSSI to Hulsman, p. OPP_E000225606.002. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22980-3, lines 11-18.

¹⁸³ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22999-23000, lines 18-14.

¹⁸⁴ Exhibit 7788, LifeLocator Manual, p. OPP_E000225618_0002. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22964, lines 4-9.

¹⁸⁵ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22968, lines 8-10.

¹⁸⁶ Exhibit 7010, Steve Hulsman’s notes, pp. OPP_E000003617_003 and OPP_E000003617_004. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 22955-6, lines 23-1.

¹⁸⁷ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23008, lines 4-22.

¹⁸⁸ Exhibit 7010, Steve Hulsman’s notes, p. OPP_E000003617_003. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23017-20, lines 24-6.

was impossible for a victim to have been 6.2 metres below the unit.¹⁸⁹ The following circumstances could have interfered with the LifeLocator's results:

- a. Hulsman remained in a crane bucket 20 feet (approx. 6 meters) above the pile during the deployment of the LifeLocator. The bucket may have swayed.¹⁹⁰
 - b. The LifeLocator was resting on a concrete slab but attached to a rope. Hulsman maintained tension in the rope to prevent a breeze from moving it. However, it is possible that the vibration of the rope could have been picked up by the machine.¹⁹¹
 - c. Other rescuers working in or near the collapsed area were within 15 metres of the LifeLocator.¹⁹²
129. On the second deployment at approximately 4:30 on June 25, 2012, Hulsman was able to enter the collapse zone and deploy the LifeLocator without using a rope. However, he did not ensure that he and other responders were more than 15 metres away from the device when it was deployed.¹⁹³ The readings from the second deployment indicated breathing at a distance of between 2.7 and 4.3 meters, which was equally implausible.¹⁹⁴
130. In January 2013, Hulsman contacted GSSI to determine the veracity of the LifeLocator's findings.¹⁹⁵ He sent GSSI three files on which he had identified breathing but was unsure which of the three files contained data collected during the Elliot Lake Collapse.¹⁹⁶
131. GSSI responded on February 13, 2013, advising Hulsman that the breathing indication was likely the result of periodic motion from the workers nearby.¹⁹⁷ The manufacturer came to this conclusion by relying on the finding that the source of the breathing was moving and Hulsman's confirmation via telephone conversation that there were rescuers

¹⁸⁹ Examination of Steve Hulsman, transcript of August 28, 2013, p. 23028, lines 11-22.

¹⁹⁰ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23005-6, lines 6-4.

¹⁹¹ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23007-8, lines 19-3 and p. 23014, lines 3-25.

¹⁹² Examination of Steve Hulsman, transcript of August 28, 2013, p. 23016, lines 1-19.

¹⁹³ Examination of Steve Hulsman, transcript of August 28, 2013, p. 23034, lines 3-25.

¹⁹⁴ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23035-6, lines 16-1.

¹⁹⁵ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23038-40, lines 23-8.

¹⁹⁶ Examination of Steve Hulsman, transcript of August 28, 2013, p. 23040-2, lines 9-3.

¹⁹⁷ Exhibit 9214, February 13 2013 letter from GSSI to Hulsman, p. OPP_E000225606.003.

moving within the range of 4 and 10 meters from the device at the time the measurements were taken.¹⁹⁸

132. In a letter to Commission Counsel, on March 20, 2013, GSSI confirmed, “[t]he results show the certainty (not just a suspicion) that something was moving periodically 6 meters away and that after 50 seconds, it started to move away from the sensor. Based on what we have been told, a logical inference is that the motion is caused by rescue workers in the area.”¹⁹⁹
133. In a further letter of March 28, 2013, GSSI provided the Commission with a full explanation for its assessment that the breathing indication detected by the LifeLocator device was the result of motion caused by rescue workers in the area. GSSI included the following findings, “assuming no knowledge of the situation” and “based solely on the data”:
- a. The LifeLocator was functioning properly;
 - b. At least one object was moving 6 metres from the device;
 - c. The motion was periodic about every 5-6 seconds;
 - d. The object was large enough to be human;
 - e. An object moved away from the sensor, from 6 to about 8 metres; and
 - f. The rate of this movement is consistent with walking.²⁰⁰
134. Unfortunately, GSSI refused the Commission’s request to produce a representative for cross-examination.²⁰¹

v. Unnecessary Shores for Public Relations

135. After the cessation of work in the collapse zone on June 25th and prior to the arrival of the Priestly Crane on June 26th, two types of shores were installed outside of the Mall. These

¹⁹⁸ Exhibit 9214, February 13 2013 letter from GSSI to Hulsman, p. OPP_E000225606.002-3.

¹⁹⁹ Exhibit 9210, March 20, 2013 letter from Wallace to GSSI, p. OPP_E000000125.004.

²⁰⁰ Exhibit 9213, March 28, 2013 letter from Wallace to GSSI, p. CI_E000000128.

²⁰¹ Exhibit 9212, May 2, 2013 letter from GSSI to Wallace. Exhibit 9216, July 24, 2013 Letter from GSSI to Wallace. Exhibit 9215, emails between GSSI and Ault.

shores were ineffective and predominantly installed for the purpose of demonstrating to the public that work was still being done. The public is entitled to candid information with respect to the status of a rescue and should certainly not be deceived about rescue and recovery efforts. As discussed in the media section of these submissions (Section E), the public is entitled to candid information with respect to the status of a rescue and should certainly not be deceived about rescue and recovery efforts.

136. On June 25, 2012, raker shores were installed at the truck loading bays on the north wall of the Mall.²⁰² Hulsman, who began his shift at 17:00, on June 25th, testified that, in his view, the raker shores on the north wall must have been for training purposes only, for two reasons. First, the insertion points on the shores were too low to be effective.²⁰³ Second, the truck loading bays were never identified to UCRT as being a possible point of failure and, indeed, rescuers used the door to the left of the truck bays as an access point to the collapse zone because that area was considered safe.²⁰⁴ Comella admitted that the raker shores were unnecessary as the area in which they were installed was not identified as being subject to collapse.²⁰⁵
137. Upon arriving at the Mall on June 26, 2012, at 10:30, Hulsman noticed that TF-3 had built approximately seven laced-shore boxes outside of Zellers. Hulsman noted that these laced-shore boxes appeared to be for training purposes and were away from the collapsed zone.²⁰⁶ Cox was equally unaware of any structural issues in that area.²⁰⁷ Both Hulsman and Cox testified that the placement of the laced-shore boxes was not effective because the I-beam holding up the concrete was not butted up against the entire length of the boxes' headers. Instead, the I-beam crossed the headers at their mid-point so the parts of the headers on either side of the I-beam were unable to transfer the weight of the concrete over the vertical members of the laced-shore boxes to the floor.²⁰⁸ Comella testified that

²⁰² Exhibit 7943, graphic – exterior shores. Examination of Tony Comella, transcript of September 5, 2013, pp. 24286-7, lines 11-9.

²⁰³ Exhibit 7010, Steve Hulsman's notes, p. OPP_E000003617_005. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23071-2, lines 8-16.

²⁰⁴ Exhibit 7010, Steve Hulsman's notes, p. OPP_E000003617_005. Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23070-1, lines 23-25.

²⁰⁵ Examination of Tony Comella, transcript of September 5, 2013, pp. 24291-2, lines 9-10.

²⁰⁶ Exhibit 7010, Steve Hulsman's notes, p. OPP_E000003617_006.

²⁰⁷ Examination of Ryan Cox, transcript of August 26, 2013, pp. 22367-8, lines 7-15.

²⁰⁸ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23075-7, lines 4-7. Examination of Ryan Cox, transcript of August 26, 2013, pp. 22486-90, lines 7-20.

the laced-shore boxes outside of Zellers served three purposes: (i) to assist the column holding up the structure; (ii) to provide an audible early warning sign of collapse; and (iii) to ameliorate public relations by showing the public that work was being done.²⁰⁹

vi. Protocol for Debriefing and After-Action Reports

138. Ontario's Commissioner of Community Safety, Dan Hefkey, testified that it is important for organizations involved in an emergency to look at their participation in the emergency in a critical manner after the incident so that improvements can be made. Hefkey testified that under IMS protocols, it is the expectation that individual services involved in an incident will conduct a debriefing when the incident is over.²¹⁰
139. Despite acknowledging the importance of debriefs and after-action reports, both TF-3 and the City of Elliot Lake failed to conduct a debriefing or prepare an after-action report of their participation in the Collapse.

(a) UCRT performed a debrief and prepared an after-action report

140. It is standard operating procedure for UCRT to have a debriefing meeting after a deployment.²¹¹
141. On July 4, 2012, less than two weeks after the Collapse, UCRT held a meeting to debrief the deployment in Elliot Lake, notwithstanding that UCRT's lead in Elliot Lake (Gillespie) was absent.²¹²
142. UCRT members understood that debriefing an incident serves the important purpose of determining what worked and what did not so that improvements can be made for future deployments.²¹³

²⁰⁹ Exhibit 7949, graphic – exterior shores. Examination of Tony Comella, transcript of September 4, 2013, p. 24292-5, lines 11-16.

²¹⁰ Examination of Dan Hefkey, transcript of August 9, 2013, pp. 20329-33, lines 6-9.

²¹¹ Examination of Ryan Cox, transcript of August 26, 2013, p. 22428, lines 19-22.

²¹² Exhibit 7554, Minutes of UCRT debriefing.

²¹³ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23082-3, lines 22-6. Examination of Daniel Bailey, transcript of August 27, 2013, pp. 22645-22646, lines 20-8.

(b) TF-3 conducted no debrief and prepared no after-action report

143. Despite the important purpose of debriefings and after-action reports, TF-3 did not produce any debriefing report or any other type of record of what took place in Elliot Lake.²¹⁴
144. A draft “HUSAR Operating Manual 2007” was produced to the Commission. A final version of the manual was not produced though Comella believes that the draft manual was finalized²¹⁵ The HUSAR Operating Manual 2007 is intended to “provide operational direction” with respect to arrangements between Ontario, as represented by the Public Safety Division of the Ministry of the Solicitor General, and Toronto concerning the deployment of TF-3.²¹⁶
145. One of the responsibilities assigned to TF-3 in the manual is the responsibility to terminate the incident by (i) assisting in the incident debrief; (ii) assisting in the incident critique; and (iii) assisting in the preparation of reports and documentation of the incident.²¹⁷ The draft HUSAR Operating Manual 2007 also provides that it will be the responsibility of the local fire department, in consultation with the TF-3 team, to prepare and submit the official reports and documentation of the incident and provide copies to TF-3, the Office of the Fire Marshal and Emergency Management Ontario.²¹⁸
146. Despite the foregoing responsibilities, Comella and McCallion testified that debriefs and after-action reports are not currently part of TF-3’s practice.²¹⁹
147. Comella had no knowledge or involvement with the preparation of any official reports or documentation of the incident.²²⁰ Given that Comella is the team coordinator for TF-3, and was the Operations Chief on the Elliot Lake deployment, if any official reports or documentation of the incident had come to the TF-3 office, Comella would and should

²¹⁴ Examination of Tony Comella, transcript of September 4, 2013, pp. 24008-10, lines 25-19. Examination of Michael McCallion, transcript of September 6, 2013, pp. 24665-6, lines 21-4.

²¹⁵ Examination of Tony Comella, transcript of September 4, 2013, pp. 24013-4, lines 20-6.

²¹⁶ Exhibit 769, HUSAR Operating Manual 2007, p. OFM_E000000145_01.

²¹⁷ Exhibit 769, HUSAR Operating Manual 2007, p. OFM_E000000145_05.

²¹⁸ Exhibit 769, HUSAR Operating Manual 2007, p. OFM_E000000145_05.

²¹⁹ Examination of Tony Comella, transcript of September 4, 2013, p. 24011, lines 4-7. Examination of Michael McCallion, transcript of September 6, 2013, p. 24666, lines 8-13.

²²⁰ Examination of Tony Comella, transcript of September 4, 2013, pp. 24016-9, lines 16-12.

have been made aware of it.²²¹ Comella, McCallion and Neadles testified that TF-3 simply did not have the funding to gather the group together after the event to debrief.²²² However, Comella had no explanation why the team could not have debriefed on the way back from Elliot Lake, either at the hotel the team stayed in Sudbury, or on the bus. Comella and McCallion agreed that these were missed opportunities.²²³ Neadles testified that having a formal debriefing on the bus ride home would have posed two problems: first, some important TF-3 personnel (Comella and Rowlands) did not ride the bus; second, it is difficult to be objective and conduct an effective debriefing immediately after the event when emotions are still raw.²²⁴

148. After the deployment, TF-3 members were asked by Comella to provide feedback.²²⁵ Comella wrote, “[w]e would like to use this information in our after-action reporting and future training initiatives.” Unfortunately, Comella received a very sparse response to his request.²²⁶ Neadles testified that the intention to complete an after-action report simply fell off the rails because people did not respond.²²⁷

(c) The City conducted no debrief and prepared no after -action report

149. Under the Elliot Lake Emergency Response Plan, the CCG is responsible for “ensuring debriefings are scheduled and held and participating in the debriefing following the emergency”.²²⁸
150. DeBortoli and Hamilton were aware that the City is required to conduct a debriefing after an emergency.²²⁹

²²¹ Examination of Tony Comella, transcript of September 4, 2013, p. 24019, lines 1-12.

²²² Examination of Tony Comella, transcript of September 4, 2013, pp. 24011-2, lines 19-4. Examination of Michael McCallion, transcript of September 6, 2013, pp. 24666-7, lines 14-5. Examination of William Neadles, transcript of September 12, 2013, p. 25655, lines 10-23.

²²³ Examination of Tony Comella, transcript of September 4, 2013, pp. 24012-3, lines 5-18. Examination of Michael McCallion, transcript of September 6, 2013, pp. 24667-8, lines 6-14.

²²⁴ Examination of William Neadles, transcript of September 12, 2013, p. 25653, lines 3-20.

²²⁵ Examination of Tony Comella, transcript of September 5, 2013, pp. 24314-5, lines 22-3. Exhibit 7581, email – Elliot Lake.

²²⁶ Examination of Tony Comella, transcript of September 5, 2013, p. 24316, lines 8-11.

²²⁷ Examination of William Neadles, transcript of September 6, 2013, pp. 25657-8, lines 21-19.

²²⁸ Exhibit 8090, City of Elliot Lake Emergency Response Plan, p. CEL_E000155554_0016.

²²⁹ Examination of Robert DeBortoli, transcript of October 7, 2013, pp. 28465-6, lines 22-1. Examination of Richard Hamilton, transcript of October 7, 2013, pp. 28554-5, lines 23-8.

151. In July 2012, Rheume sent out a meeting request to everyone who was involved in the emergency.²³⁰ In response to Rheume’s request, Jollymore sent Rheume and DeBortoli an email advising. “...we are all facing an inquiry, a public inquiry meaning the findings of this would have to be available to them. Normally, this would occur after the inquiry for the reasons I have outlined”.²³¹ As a result of Jollymore’s comments, DeBortoli decided to delay the debriefing.²³² Almost a year and a half after the event, at the time that DeBortoli and Hamilton testified at this Inquiry on October 7, 2013, the City had not yet conducted its mandated debrief.²³³

E. The Release of Information to the Media and the Public

152. The IMS encourages the development of a pre-written Emergency Information Plan to assist in the management of emergency information to the media and the public.²³⁴ The key purpose of emergency information management is to provide “timely and consistent public dissemination of emergency information”.²³⁵
153. Most witnesses agreed that media communications were handled poorly during the response to the Collapse. This is likely due to the fact that the City’s Emergency Information Plan lacked a formal approval process for the release of information to the media, and in any event was not followed with respect to the setup of an Emergency Information Centre. In addition, members of the CCG with media-related roles were not trained sufficiently and were not able to adequately perform their roles or ensure that accurate information was released to the public in a timely manner.

i. The City’s Emergency Information Plan

(a) Approval Process for the Release of Information

154. One important purpose of an Emergency Information Plan is to outline the steps to obtain approval (i.e. who has the authority to approve information) for release.²³⁶ The City of

²³⁰ Examination of Trudy Rheume, transcript of September 26, 2013, pp. 27511-2, lines 23-16.

²³¹ Exhibit 9892, email – Debrief.

²³² Examination of Trudy Rheume, transcript of September 26, 2013, pp. 27512-4, lines 17-9.

²³³ Examination of Robert DeBortoli, transcript of October 7, 2013, p. 28465, lines 15-21.

²³⁴ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0091.

²³⁵ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0090.

²³⁶ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0091-2.

Elliot Lake developed an Emergency Information Plan (an Annex to the Emergency Response Plan). Its goal is to ensure the release of accurate information to the news media and issue authoritative instructions to the public as well as respond to and redirect individual requests for reports on information concerning any aspect of the emergency. The City's Emergency Information Plan does not contain a formal approval process for the release of information to the media and public and is not clear that Command must have an important role in that process, particularly when it comes to the release of information about casualties and fatalities.²³⁷

155. Under the IMS system, communications going to the public or media should be approved by Command.²³⁸ Robert Bruce, the Chief Superintendent of the OPP, testified that having a stringent command, control, communication structure with the media officer at the command table allows for the control of information, and an understanding of what information the media is looking for and what information can or cannot be released.²³⁹ Having a strong command structure should also help to diminish false information released to the public. This is because the media understands that the command structure is a body that releases all concrete information regarding the incident. Although the media may still ask other people for information, they know that any information coming from another source can be qualified or explained by Command.²⁴⁰
156. Although IC Officer was a member of the CCG and participated in discussions with respect to the release of information to the public, he testified that he would have been hard pressed to overrule the Mayor or CAO at the CCG.²⁴¹ Officer understood that his role as IC did not allow him to trump the wishes of the CCG with respect to media releases.²⁴² Trudy Rheaume, the Community Emergency Management Coordinator,

²³⁷ Exhibit 8087, City of Elliot Lake - Emergency Response Plan - Annex Section II Index, p. CEL_E000155551_0021-36.

²³⁸ Examination of Dan Hefkey, transcript of August 8, 2013, pp. 20253-5, lines 9-6. Exhibit 968, Incident Management System (IMS) - Guidelines for the Application of IMS at EOCs - Annex a to the IMS Doctrine for Ontario, p. CEL_E000018629_011. Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0033.

²³⁹ Examination of Robert Bruce, transcript of August 23, 2013, pp. 22179-82, lines 21-1.

²⁴⁰ Examination of Robert Bruce, transcript of August 23, 2013, p. 22183, lines 1-9.

²⁴¹ Examination of Paul Officer, transcript of September 19, 2013, p. 26409, lines 1-25 and pp. 26410-11, lines 24-18.

²⁴² Examination of Paul Officer, transcript of September 19, 2013, pp. 26410-11, lines 24-18.

confirmed Officer's understanding that the IC does not have a veto power over decisions made about media releases.²⁴³

(b) The Emergency Information Centre

157. The City's failure to establish a well-staffed and well-equipped Emergency Information Centre, in accordance with its own Emergency Response Plan, contributed to the release of inaccurate information during the emergency response and the failure to recognize and correct inaccurate information.
158. According to IMS, an Emergency Information Centre requires appropriate staff and equipment to support its level of activities. Staff typically includes Assistant Emergency Information Officers. Equipment would generally include furniture, electrical power support, maps and contact lists, and electronic equipment (microphone, computer, phones, fax machines, radios, televisions, etc.).²⁴⁴
159. The City's Emergency Response Plan provides for the establishment of an Emergency Information Centre that serves to coordinate the release of accurate information to the news media, issue authoritative instructions to the public, respond to and redirect individual requests for or reports on all information concerning any aspect of the emergency and monitor news coverage and correct erroneous information.²⁴⁵ The Emergency Information Plan provides that, at a minimum, the Emergency Information Center should have a TV, a recording device, a radio, and a computer, all of which to monitor news events for accuracy.²⁴⁶
160. Unfortunately, the City did not follow its own Emergency Information Plan when it came to the set-up of the Emergency Information Centre. Hamilton testified that it would have been helpful to have established a more sophisticated "media control station" for the CCG to help control the information going out to the public but also to be aware of what

²⁴³ Examination of Trudy Rheaume, transcript of September 26, 2013, p. 27518 , lines 15-25.

²⁴⁴ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0094.

²⁴⁵ Exhibit 8090, City of Elliot Lake Emergency Response Plan, p. CEL_E000155554_0013.

²⁴⁶ Exhibit 8087, City of Elliot Lake - Emergency Response Plan - Annex Section II Index, p. CEL_E000155551_0025.

information was being put out there from other sources.²⁴⁷ He explained that instead, the media team had very limited resources:

We didn't have TV sets and monitors and Twitter and all of the new age technology inside the control centre. What we, in essence, had was myself, Christine, Kate with a notebook and me with a BlackBerry, and that was our view to the world when it came to the media.²⁴⁸

ii. Media-Related Roles during an Emergency

(a) The CCG

161. One of the roles of the CCG is to gather information about the status of an emergency and ensure that pertinent information regarding the emergency is forwarded to the Emergency Information Officer and released to the public.²⁴⁹ DeBortoli understood that one of the roles of the CCG was to keep the public properly and accurately informed of what is going on²⁵⁰ and testified that press releases and statements made at press conferences were done with the approval of the CCG.²⁵¹

(b) Matuszewski as Emergency Information Officer

162. Section 14 of O. Reg 380/04 provides that every municipality shall designate an employee of the municipality as its Emergency Information Officer who shall act as the primary media and public contact for the municipality in an emergency.

163. The role of the Emergency Information Officer includes the organization of both the messaging that the CCG wishes to share with the public, and the messaging that the CCG wishes to share with the media.²⁵² Although the dissemination of information can be delegated to a number of other persons (for example, a communications person for

²⁴⁷ Examination of Richard Hamilton, transcript of October 7, 2013, pp. 28560-1, lines 9-15.

²⁴⁸ Examination of Richard Hamilton, transcript of October 7, 2013, p. 28561, lines 3-8.

²⁴⁹ Exhibit 8090, City of Elliot Lake Emergency Response Plan, p. CEL_E000155554_0016. Examination of Robert DeBortoli, transcript of October 7, 2013, pp. 28472-3, lines 22-7.

²⁵⁰ Examination of Robert DeBortoli, transcript of October 7, 2013, p. 28376, lines 21-23 & p. 28423, lines 8-11.

²⁵¹ Examination of Robert DeBortoli, transcript of October 7, 2013, pp. 28436-8, lines, 17-24.

²⁵² Examination of Dan Hefkey, transcript of August 8, 2013, pp. 20153-5, lines 15-1. See also: Examination of Coby Duerr, transcript of August 15, 2013, pp. 20903-4, lines 25-11.

families, a communications person for media, etc.), the communications message must be consistent and must fit within the total purpose defined by incident command.²⁵³

164. The Elliot Lake Emergency Response Plan provides that the tourism manager take on the role of Emergency Information Officer, and in this case, Kate Matuszewski did take on that role.²⁵⁴ Matuszewski has been the Emergency Information Officer since October 2011 but, unfortunately, has not yet had any media training.²⁵⁵

(c) Ouimet as Site Media Spokesperson

165. Under the Elliot Lake, Emergency Response Plan, the Site Media Spokesperson, (usually a Police Official appointed by the CCG) is responsible for finding a place for the media to assemble and ensure that they do not affect ongoing operations.²⁵⁶ In this case, Christine Ouimet was appointed by the CCG as the Site Media Spokesperson.²⁵⁷
166. The Emergency Information Officer and the Site Media Spokesperson worked together on press releases for the CCG.²⁵⁸

(d) The Mayor as the Official Media Spokesperson

167. Under the Emergency Information Plan, which is Annex II to the City of Elliot Lake's Emergency Response Plan (the "Emergency Information Plan"), the Mayor is expected to act as the Official Media Spokesperson and is expected to:
- a. Provide vital information to the media, general public, and other concerned audiences in a timely, complete and accurate manner (unless legally restricted);
 - b. Provide assurances to the media, general public and other concerned audiences that the emergency is being managed effectively;
 - c. Build public confidence;

²⁵³ Examination of Dan Hefkey, transcript of August 8, 2013, pp. 20434-7, lines 13-4.

²⁵⁴ Exhibit 8090, City of Elliot Lake Emergency Response Plan, p. CEL_E000155554_0032. Exhibit 8087, City of Elliot Lake - Emergency Response Plan - Annex Section II Index, pp. CEL_E000155551_0022-CEL_E000155551_0023. Examination of Paul Officer, transcript of August 22, 2013, pp. 21915-6, lines 23-19.

²⁵⁵ Examination of Trudy Rheaume, transcript of September 26, 2013, pp. 27503-4, lines 24-15.

²⁵⁶ Exhibit 8090, City of Elliot Lake Emergency Response Plan, p. CEL_E000155554_0031.

²⁵⁷ Examination of Paul Officer, transcript of August 22, 2013, p. 21914, lines 9-22.

²⁵⁸ Examination of Robert DeBortoli, transcript of October 7, 2013, pp. 28497-8, lines 21-4.

- d. Interact with the media in a positive, cooperative and respectful manner, even when dealing with “bad news” issues; and
 - e. Liaise with the Emergency Information Officer to keep informed and up-to-date on the status of the emergency and its effect on the community.²⁵⁹
168. Prior to the Collapse, the Mayor’s media-related experience was limited to bi-monthly interviews by local media sources. The Mayor did not have experience dealing with larger media sources, nor did he receive any media related training.²⁶⁰
169. During the emergency response, information was released to the public through press releases, press conferences and occasional one-on-one interviews with the Mayor.²⁶¹
170. In the initial stages of the emergency, Mayor Hamilton acted as the sole spokesperson for the CCG.²⁶² However, that role transitioned to a team approach during the following days and by at least, 17:00 on June 25, 2012, the Mayor’s role at press conferences was limited to providing an introduction while the more substantial matters were handled by Neadles and Jollymore.²⁶³
171. The Assistant Deputy Chief Responsible for Emergency Management in Calgary, Duerr, testified that the role of Official Media Spokesperson should not typically be performed by someone who has another key role in the incident (for example, the IC, the Operations Chief, the Planning Chief, the Logistics Chief or the Finance and Administration Chief) because it is a time-consuming and expert-intensive role.²⁶⁴

(e) The CAO as the Manager of Emergency Operations

172. Under the Emergency Response Plan, DeBortoli, the CAO, was the manager of the Emergency Operations Centre and was responsible for, amongst other things, “approving

²⁵⁹ Exhibit 8087, City of Elliot Lake - Emergency Response Plan - Annex Section II Index, p. CEL_E000155551_0022.

²⁶⁰ Examination of Richard Hamilton, transcript of October 7, 2013, pp. 28531-2, lines 24-4. Exhibit 9913, Elliot Lake Emergency Management Training and Exercise Records.

²⁶¹ Examination of Robert DeBortoli, transcript of October 7, 2013, p. 28473, lines 8-17.

²⁶² Examination of Paul Officer, transcript of August 29, 2013, p. 23404, lines 10-13.

²⁶³ Examination of Richard Hamilton, transcript of October 7, 2013, pp. 28533-4, lines 5-8. Examination of Paul Officer, transcript of August 29, 2013, p. 23404, lines 14-22. Exhibit 7923, June 25, 2012 17:00 Press Conference recording. Exhibit 7208, CBC transcript of June 25, 2012 17:00 Press Conference, p. CBC_E000000007_0002- CBC_E000000007_0003.

²⁶⁴ Examination of Coy Duerr, transcript of August 15, 2013, pp. 20903-5, lines 25-11.

in conjunction with the Head of Council, major announcements and media releases in consultation with the CCG and Emergency Information Officer”.²⁶⁵

173. DeBortoli testified that his media experience before this incident was limited to several occasions related to normal day-to-day activities within the community and his media training was limited to components of municipal administration and municipal management courses.²⁶⁶ During DeBortoli’s tenure with the CCG, prior to this emergency, the CCG had never had to release information about a fatality, nor had they received any training with respect to the issue.²⁶⁷

(f) Additional resources

174. It is not surprising that City officials were overwhelmed by media-related communications issues when faced with this very public and media-covered emergency.

175. DeBortoli testified that, with the benefit of hindsight, one of the areas that could have been improved during this emergency was communication:

...We identified, I think, even during the process, and I will just go back to the communications aspect of it, that you know, there were some gaps there that, you know, we could have probably have been more proficient. I think now if we ever have an event as such, we will definitely -- you know, having gone through the experience, we'll definitely get somebody to assist is us in media relations. It was certainly a baptism by fire from that aspect....²⁶⁸

176. Hamilton agreed with DeBortoli that the CCG could have used the assistance of someone with more experience dealing with the media.²⁶⁹

177. Three days into the emergency, on the afternoon of July 26, 2012, Hamilton spoke with the Premier to request additional communications support on the ground, and as a result O’Leary was sent to provide such support.²⁷⁰ Hefkey was also dispatched to Elliot Lake on June 26th to, amongst other things, help with communications and be the “face that

²⁶⁵ Exhibit 8090, City of Elliot Lake Emergency Response Plan, p. CEL_E000155554_0020. Examination of Robert DeBortoli, transcript of October 7, 2013, p. 28376, lines 2-23.

²⁶⁶ Examination of Robert DeBortoli, transcript of October 7, 2013, p. 28432, lines 11-2.

²⁶⁷ Examination of Robert DeBortoli, transcript of October 7, 2013, p. 28470, lines 9-19.

²⁶⁸ Examination of Robert DeBortoli, transcript of October 7, 2013, p. 28469, lines 10-19.

²⁶⁹ Examination of Richard Hamilton, transcript of October 7, 2013, p. 28561, lines 16-25.

²⁷⁰ Examination of Dalton McGuinty, transcript of October 9, 2013, pp. 28951-2, lines 6-16. Exhibit 8424, email - RE.

spoke to the media on a regular basis” on behalf of both the provincial and municipal levels of the rescue operation.²⁷¹

iii. Some failures to provide timely and honest disclosure

178. During the emergency response in Elliot Lake, the information provided to the public through the media was not as accurate or timely as it ought to have been, as is demonstrated by the examples below.

(a) Release of Information about Victims and Casualties

179. The information released to the media with respect to the number of victims in the collapse zone and their status was not timely or honest.

180. In particular, on June 23, 2012, Officer received a call from Hamilton advising him that MCTV was reporting 30 people trapped in the Collapse. Within the first hour, Officer knew they did not have 30 victims trapped.²⁷² Similarly John Thomas testified that he knew as of June 23, 2012, when he first climbed on the pile (at 15:28) that it would not have been possible that upwards of 30 people were in the collapse zone.²⁷³ Thomas believed that it would have been three or four at the most.²⁷⁴

181. At approximately 16:37 on June 23, 2013, a member of EMS pronounced one of the suspected victims deceased after attempting to find a pulse on a limb found in the rubble pile. The rescuers were confident that the deceased person was an older female, not Lucie.²⁷⁵

182. During a CCG meeting at 8:00 on June 24, 2012, the CCG discussed whether and how much information should be released about the suspected victims of the Collapse.²⁷⁶ DeBortoli testified that Jollymore discouraged the group from publicly announcing that a

²⁷¹ Examination of Dalton McGuinty, transcript of October 9, 2013, pp. 28950-1, lines 14-5.

²⁷² Examination of Paul Officer, transcript of August 22, 2013, pp. 21719-20, lines 9-6

²⁷³ Examination of John Thomas, transcript of August 20, 2013, p. 21169-71, lines 23-11.

²⁷⁴ Examination of John Thomas, transcript of August 20, 2013, p. 21171, lines 9-11.

²⁷⁵ Examination of Paul Officer, transcript of August 21, 2013, pp. 21614-6, lines 7-14. Exhibit 6336, Natalie Quinn’s notes, p. ELFD_P000001955. Exhibit 3743, Natalie Bray’s notes, p. CEL_E000013925-003. Exhibit 6397, Percy Jollymore’s notes, p. OPP_E000081947_0008.

²⁷⁶ Exhibit 3743, Natalie Bray’s notes, pp. CEL_E000013925_16-17. Examination of Robert DeBortoli, transcript of October 7, 2013, pp. 28473-4, lines 18-9.

deceased person had been found until the person was identifiable by name and a coroner had verified that the person was deceased. That advice was followed by the CCG.

183. There was no adequate explanation of why a qualified version of the rescuers' findings could not have been released, at least to the families. DeBortoli understood Jollymore's reasoning to be that there was no guarantee that the limb that lacked a pulse was still attached to the rest of the victim's body. In other words, it was possible that the limb had been severed but that the victim to whom the limb belonged was still alive. DeBortoli understood that Officer wanted to release a qualified statement that there was a *potential* fatality in the area.²⁷⁷ Officer testified that he wanted to release the information that they had located one deceased elderly female and one other potential victim in the collapsed area.²⁷⁸ When cross-examined, Jollymore agreed that he objected to the release of a statement that confirmed a fatality and identified the victim but testified that he would not have objected to a statement that described the limb that had been found.²⁷⁹ Hamilton testified that the group with the most media related experience in similar events was the OPP and, in most cases, it was their advice that the CCG followed.²⁸⁰
184. At 9:00 on June 24, 2012, a press release was issued stating, "at this time, no casualties have been reported or confirmed". No information was released about the number of suspected victims.²⁸¹ Similar information was released during a 13:00 press conference on June 24, 2012: "There is no confirmation on any loss of life. This is still a rescue effort". Again, no information was provided about the number of suspected victims.²⁸²
185. Indeed, the news that rescuers had likely found one deceased victim was not released until 24 hours after the discovery. During a closed meeting before a 17:00 press conference on June 24, 2012, the media issue of whether to release information about the deceased victim was discussed. Both Officer and Neadles were of the view that the information should be disclosed and that on-going honest information was important.²⁸³

²⁷⁷ Exhibit 3743, Natalie Bray's notes, pp. CEL_E000013925_004 and p. CEL_E000013925_009. Examination of Robert DeBortoli, transcript of October 7, 2013, pp. 28407-12, lines 17-2.

²⁷⁸ Examination of Paul Officer, transcript of August 22, 2013, pp. 21713-7, lines 3-17.

²⁷⁹ Examination of Percy Jollymore, transcript of September 24, 2013, pp. 26894-6, lines 24-18.

²⁸⁰ Examination of Richard Hamilton, transcript of October 7, 2013, p. 28584, lines 12-18.

²⁸¹ Exhibit 9306, June 24, 2012 City of Elliot Lake press release.

²⁸² Exhibit 9299, June 24, 2012 City of Elliot Lake press release.

²⁸³ Exhibit 6336, Natalie Quinn's notes, p. 1973. Examination of William Neadles, pp. 25357-8, lines, 10-9.

During the 17:00 press conference, information that there may be a fatality was finally released.²⁸⁴

(b) Release of Information about “Signs of Life”

186. In the event that information is released to the public or to the media relating to “signs of life,” such information must be qualified to ensure accuracy. The evidence shows that during the response to the Collapse, no indicator of positive signs of life was completely reliable.
187. As described above, two members of the ELFD described hearing mumbled communications in response to questions posed by rescuers from the collapse zone at approximately 15:30 on June 23, 2012.
188. In addition, on June 24, at 9:30, two members of TF-3 described hearing a tapping sound from within the pile in response to requests to tap.²⁸⁵
189. The pathologist, Dr. Queen, testified that he could not rule out the possibility that Lucie may have been alive an hour after the Collapse when the mumbling sound was heard, but that it was highly unlikely that Lucie would have been alive 20 hours after the Collapse when the TF-3 rescuers heard tapping sounds.²⁸⁶
190. During the response to the Collapse, two trained canines who were deployed on the pile indicated a live hit. On June 24, 2012, at 12:10, TF-3 canine Ranger indicated a live hit after searching the pile.²⁸⁷ Nine hours later, at 21:30, UCRT canine Dare indicated a live hit again in approximately the same area.²⁸⁸
191. Canine searches can be unreliable because it is unknown how good the canines are at distinguishing between a live person and a recently deceased cadaver. Wayde Jacklin, the training coordinator for the OPP’s canine program, testified that he was not aware of

²⁸⁴ Examination of William Neadles, pp. 25358-60, lines, 20-2. Exhibit 9309, June 24, 2012 City of Elliot Lake Press Release.

²⁸⁵ Examination of Scott Fowlds, transcript of September 19, 2013, pp. 26315-25, lines 17-24.

²⁸⁶ Examination of Dr. Martin Queen, transcript of September 20, 2013, pp. 26558-9, lines 14-2.

²⁸⁷ Exhibit 6242, Scott Fowlds’s notes, p. 181-2. Examination of Scott Fowlds, transcript of September 19, 2013, pp. 26330-6, lines 2-190. Exhibit 9672, graphic – general area where both of the victims were later located.

²⁸⁸ Exhibit 6374, Dan Bailey’s notes, p. OPP_E000003608_002. Examination of Ryan Cox, transcript of August 26, 2013, pp. 22337-9, lines 1-7 and p. 22346, lines 9-12. Exhibit 9265, graphic – general area where both victims were later located. Examination of Dan Bailey, transcript of August 27, 2013, pp. 22747-8, lines 5-18.

any definitive answer to the point when a search dog can distinguish the scent from someone who is recently deceased from that of a living person.²⁸⁹ In addition, the OPP does not keep track of its canines' success rates.²⁹⁰

192. Duerr, the Assistant Deputy Chief Responsible for Emergency Management in Calgary, testified that he would want corroboration of a canine's hit with some other evidence, for example, audio corroboration from an acoustic listening device or visual corroboration using a camera.²⁹¹
193. Dr. Queen testified that it was highly unlikely that Lucie could have been alive 22 hours after the Collapse, when Ranger gave an indication that a live person was buried under the rubble or 31 hours after the Collapse when Dare indicated on a live person.²⁹²
194. As described above, the indications of breathing that were identified during the deployment of the LifeLocator on the evening of June 24 and morning of June 25 were unreliable. More importantly, they were known to be unreliable by members of UCRT and TF-3. Hulsman, the UCRT member who deployed the LifeLocator, understood very well that he was using the LifeLocator outside of the manufacturer's recommendations.²⁹³ Hulsman testified that he advised Gillespie that on the first deployment, at 23:30 on June 24, the LifeLocator had four different readings, one of which could not be correct.²⁹⁴ Gillespie testified that he understood that the LifeLocator was being deployed outside of its recommended use and he therefore placed a low amount of confidence in the results.²⁹⁵ Gillespie testified that he advised Comella that the LifeLocator had indicated a positive result for breathing but could not remember if he advised Comella that the results might not be reliable.²⁹⁶ Comella testified that he was not aware that the LifeLocator was being operated contrary to the manufacturer's recommendation.²⁹⁷

²⁸⁹ Examination of Wayde Jacklin, transcript of August 27, 2013, pp. 22598-601, lines 8-3.

²⁹⁰ Examination of Wayde Jacklin, transcript of August 27, 2013, p. 22605, lines 5-9.

²⁹¹ Examination of Coby Duerr, transcript of August 15, 2013, pp. 20850-1, lines 9-7.

²⁹² Examination of Dr. Martin Queen, transcript of September 20, 2013, p. 26559, lines 5-15.

²⁹³ Examination of Steve Hulsman, transcript of August 28, 2013, pp. 23014-5, lines 23-25.

²⁹⁴ Examination of Steve Hulsman, transcript of August 28, 2013, p. 23031, lines 2-25.

²⁹⁵ Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23641-2, lines 1-2.

²⁹⁶ Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23642-3, lines 3-11.

²⁹⁷ Examination of Tony Comella, transcript of September 4, 2013, p. 24199, lines 15-22.

195. Hulsman also reported the results of the second deployment at 4:30 on June 25 to Gillespie.²⁹⁸ Gillespie testified that he had more confidence in the second set of results because the LifeLocator was deployed without being attached to a rope. He reported to McCallion that the LifeLocator showed signs of breathing but did not qualify those results.²⁹⁹ McCallion testified that although Gillespie did not advise him that the LifeLocator had been operated outside of the manufacturer's recommendations, Comella or someone else from TF-3 had advised him that if the results of the LifeLocator were accurate, it would have put the location of the victim below surface level, which was not possible.³⁰⁰ McCallion also testified that he advised Neadles that the LifeLocator's readings put the alleged victim below surface level but that there was the potential of a live victim.³⁰¹ Neadles testified that he believed (but was not sure) that McCallion advised him about both the first and second deployment of the LifeLocator when he came back on shift on the morning of June 25, 2012.³⁰² Neadles could not recall whether McCallion had advised him that the LifeLocator's results indicated a victim below surface level, but he was prepared to accept McCallion's evidence on point.³⁰³
196. During the press conference at noon on June 25, 2013, the CCG released information about the results of the LifeLocator. In doing so, they failed to qualify the finding of "signs of life":

This morning around 4 o'clock, the OPP utilized a piece of equipment that they have to again determine that there was [sic] signs of life from the one same location that we had indicated yesterday.³⁰⁴

197. When asked to elaborate on the signs of life, Neadles provided:

Well, the piece of equipment that the OPP has is called a life detector – and it has the capability to - it is sort [of] x-ray machine that can look through the concrete slabs and can determine on the machine whether there is someone breathing within that structure or within that void. And they did come up with that positive sign again.³⁰⁵

²⁹⁸ Examination of Steve Hulsman, transcript of August 28, 2013, p. 23062, lines 16-24.

²⁹⁹ Examination of Jamie Gillespie, transcript of September 3, 2013, pp. 23684-5, lines 14-24.

³⁰⁰ Examination of Michael McCallion, transcript of September 6, 2013, pp. 24535-9, lines 16-10.

³⁰¹ Examination of Michael McCallion, transcript of September 6, 2013, pp. 24539-40, lines 11-8.

³⁰² Examination of William Neadles, transcript of September 11, 2013, pp. 25380-1, lines 16-13.

³⁰³ Examination of William Neadles, transcript of September 11, 2013, pp. 25381-2, lines 14-10.

³⁰⁴ Exhibit 6962, Transcript: CP24 News Conference Updating Elliot Lake Mall Collapse, p. CO_P000001243.

³⁰⁵ Exhibit 6962, Transcript: CP24 News Conference Updating Elliot Lake Mall Collapse, p. CO_P000001244.

198. Neadles agreed that he did not qualify the results of the LifeLocator in any way shape or form. When questioned about this statement, Neadles testified that he believed the information he provided to the public was solid and factual and that he had no recollection that McCallion qualified the results when he provided them.³⁰⁶

(c) Release of Information about Stopping the Rescue on June 25

199. As described above, between approximately 13:20 and 13:50 on June 25, Neadles made the decision that the Mall was an unsafe work zone for the TF-3 members to continue the rescue operation.³⁰⁷ As a precaution, the TF-3 members were withdrawn from the building at approximately noon on June 25th.³⁰⁸ Between 13:20 and 13:50 on June 25, Neadles ordered that the TF-3 members would not be returning inside the building.³⁰⁹ Neadles testified that when he made that order, it was his belief that the decision was that the rescue was suspended, not that it was over.³¹⁰ Unfortunately, when articulating the message to others, including members of the CCG, Chambers, the victim families, and the media, Neadles conveyed that the rescue was over, not on hold.³¹¹

200. In particular, during the press conference at 17:00 on June 25, 2013, Neadles made the following statement:

[...] I had to remove the, the members of the team and the OPP from the structure. Having done that, uh, that then turns the facility back to the local authorities and, uh, that's when the Ministry of Labour becomes actively involved in the position and the Ministry of Labour then, will now put an order on the building for that the owner must now hire an engineering firm to come up with a, a plan that's approved by the Ministry, to, uh, to des-, have the destruction of that area, taking into consideration that there are still two bodies in that building. Um, the, the demolition company that may, may, that would be hired certainly would have to put into the plan on how they would deal with the integrity of a very respectful removal of the deceased that are within that building currently.³¹²

³⁰⁶ Examination of William Neadles, transcript of September 11, 2013, p. 25412, lines 21-24 and p. 25418, lines 1-9.

³⁰⁷ Examination of William Neadles, transcript of September 11, 2013, pp. 25431-2, lines 23-8.

³⁰⁸ Exhibit 6393, Compilation of TF-3 notes, p. CT_P000001865. Examination of Tony Comella, transcript of September 5, 2013, p. 24249, lines 8-21. Examination of William Neadles, transcript of September 11, 2013, pp. 25397-403, lines 9-15.

³⁰⁹ Examination of William Neadles, transcript of September 11, 2013, pp. 25431-2, lines 23-8.

³¹⁰ Examination of William Neadles, transcript of September 11, 2013, p. 25442, lines 1-11.

³¹¹ Exhibit 7109, email – Significant Development from HUSAR. Examination of William Neadles, transcript of September 11, 2013, pp. 25451-5, lines 22-6.

³¹² Exhibit 7208, CBC transcript of June 25, 17:00 Press Conference, p. CBC_E000000007_0009.

201. Part of the problem was the fact that the team commander of TF-3, Neadles, was attending CCG meetings, pre-press release meetings, and playing the role of media spokesperson. Instead, he ought to have concentrated on managing the rescue operation and, in particular, trying to find other options to continue the rescue once it was determined that the rescuers could no longer safely continue the rescue operation from inside the Mall.³¹³ Hamilton, the Mayor and Official Media Spokesperson, could and should have been the one to deliver the news about the decision to pull rescuers from the pile.

F. The Treatment of Family Members During the Emergency Response

202. The IMS provides that the needs of persons with special interests in the emergency, like relatives and friends of those deceased and missing, must be taken into consideration during the dissemination of emergency information.³¹⁴ Much can be learned from the experiences of the Perizzolo and Aylwin families during the emergency response to the collapse of the Mall. Family members coping with news about a loved one in serious danger must be handled with a great amount of care, dignity and honesty. Unfortunately, during the emergency response to the Collapse, family members were not provided with a private space free of media inquiries. They were not assigned an official and continuous person or persons to provide them with updates and information on the status of the rescue operation. They were not provided with regular, timely and honest updates on the status of the rescue operation and in some cases, only learned critical information through the media.
203. Ms. Teresa Perizzolo, Doloris' daughter, was advised at 14:30 on June 23, 2012, through a phone call from one of her friends that there had been a collapse at the Mall.³¹⁵ Having been unable to contact her mother by telephone, at 14:45, Ms. Perizzolo arrived at the scene and saw her mother's van parked in front of the mall.³¹⁶ At approximately 15:30, her husband, Mr. Darrin Latulippe, joined her.³¹⁷

³¹³ Examination of William Neadles, transcript of September 11, 2013, pp. 25448-51, lines 21-12; pp. 25451-6, lines 22-16 and transcript of September 12, 2013, pp. 25658-60, lines 20-22 and pp. 25744-7, lines 24-4.

³¹⁴ Exhibit 887, Incident Management System (IMS) for Ontario December 2008, p. CI_E000000092_0090.

³¹⁵ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19865-6, lines 21-5.

³¹⁶ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19866-8, lines 25-20.

³¹⁷ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19869-70, lines 2-25.

204. Mr. Gary Gendron, Lucie's fiancé, and her parents, Mr. and Mrs. Rejean and Rachelle Aylwin similarly received a telephone call from a friend of Lucie's at approximately 14:45 advising that there had been a collapse at the Mall and that Lucie had not been seen since.³¹⁸

205. Until approximately 16:00, family members were waiting in the Mall parking lot for their loved ones, at which point, they were directed by a police officer to proceed to Collins Hall.³¹⁹ The family members proceeded to Collins Hall, which they described as chaotic:

Q: So who was operating Collins Hall, was it this Victim's Services group?

A: (Mr. Latulippe) At that point I didn't see anybody operating it. It is just we got there and we were asking for answers and there was nobody to really give us any answers.

Q: Was there anybody there who was able to direct you where to go?

A: (Mr. Latulippe) No. There were police officers, but they didn't -- I believe there was one or two police officers. They had no information either. They were just, I guess, told that we were coming to the Collins Hall and to meet there.

206. Shortly thereafter, six volunteers from Victims Services Algoma ("VSA"), a community-based volunteer organization whose services were engaged by the O.P.P., arrived at Collins Hall, followed by Robin Kerr, the executive director at 19:00.³²⁰ VSA offers practical assistance, emotional support, information and referrals to any victim they are supporting.³²¹

207. At some point between approximately 20:00 and 23:00 on June 23, 2012, it became obvious to at least Latulippe and Kerr, that there were only two families consistently waiting for news of a family member: the Perizzolos and the Aylwins.³²² Throughout the day on June 24th, Kerr became familiar with the Perizzolos and the Aylwins, and would have been able to separate the family members from the general community.³²³ However, no efforts were made at the Collins Hall to separate the family members of

³¹⁸ Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, pp. 19965-6, lines 6-2. Examination of Gary Gendron, transcript of August 8, 2013, pp. 20019-20, lines 13-17.

³¹⁹ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19870-3, lines 6-12.

³²⁰ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27298-9, lines 14-8. Exhibit 6402, Robin Kerr's notes, p. VSA_P000000001.

³²¹ Examination of Robin Kerr, transcript of September 25, 2013, p. 27924, lines 21-24.

³²² Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19876-7, lines 17-22.

Examination of Robin Kerr, transcript of September 25, 2013, pp. 27306-7, lines 23-3.

³²³ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27315-6, lines 22-18.

Doloris and Lucie or to create a space for them to be alone or have some privacy.³²⁴ Kerr testified that there should have been a space for the family members to have some privacy.³²⁵

208. Announcements from the OPP about the status of the rescue were made infrequently and impersonally, to the entire group at Collins Hall.³²⁶ Indeed, the family members often received new information on the status of the rescue from the media instead of receiving updates from the authorities:

A: (Mr. Aylwin) Each time there was a news conference at the municipal level, it was directly broadcast on the radio. And sometimes they would come after and to tell us something or sometimes they didn't come at all.³²⁷

209. In the words of Latulippe:

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

A. Don't just say yeah, we're making progress, we're doing this, we're doing that. That's not what we want to hear. We want concrete answers, are you going to get them? What are you doing? How close are you? How -- what steps are you taking? That's what we wanted to know and nobody would tell us. We got most of our information off the radio.³²⁸

210. On the evening of June 23, 2012, Inspector Percy Jollymore attended Collins Hall to advise that TF-3 was on their way to the scene from Toronto and to release the officers at the hall to get some sleep. VSA was left in charge of the hall but Jollymore assured Kerr that Sergeant Esposto would attend the hall to provide periodic updates.³²⁹ Those updates did not occur.³³⁰ At 3:30, on June 24th, having received no updates from the OPP, or anyone else in a position of authority, Kerr attended the OPP detachment to request that a

³²⁴Examination of Robin Kerr, transcript of September 25, 2013, pp. 27301-2, lines 15-10; p. 27304, lines 3-11 and p. 27316, lines 19-22.

³²⁵Examination of Robin Kerr, transcript of September 25, 2013, p. 27317, lines 2-9.

³²⁶Examination of Robin Kerr, transcript of September 25, 2013, p. 27304, lines 3-11.

³²⁷Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, p. 19974, lines 6-10. See also the Examination of Gary Gendron, transcript of August 8, 2013, p. 20030, lines 7-22.

³²⁸Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, p. 19939, lines 10-25.

³²⁹Exhibit 6402, Robin Kerr's notes, p. VSA_P00000001. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27309-10, lines 3-22.

³³⁰Examination of Robin Kerr, transcript of September 25, 2013, p. 27310, lines 15-24.

police officer attend the hall to provide the family members with an update.³³¹ The OPP detachment was closed but Kerr managed to flag down an officer to request that someone attend the hall.

211. Esposto finally arrived for the first time at Collins Hall at 5:30 on June 24. It had been 6.5 hours since the previous update. Esposto's update was brief and outdated. He announced that TF-3 was on their way and that they would be arriving early in the morning.³³² In fact, the evidence shows that TF-3 had arrived onsite an hour earlier that morning.³³³
212. No one in a position of authority advised the Aylwins that members of the ELFD believed they had communications with Lucie on June 23, 2012.³³⁴ No one advised the Aylwin and Perizzolo families that, as described above, very early on in the rescue, it was learned that a member of EMS had pronounced that one of the suspected victims was deceased.³³⁵
213. As McCallion testified:

I think – I think at one point during the Community Council meeting when they had the discussion about the family, I said, “Don’t lie to them. Tell them exactly what we’re telling you, that one of the victims all we can see is an arm and a leg, and we totally suspect that she’s passed away.”

And the other one, it's been X number of hours since we've had any type of indication that she was alive and from what I could see, that there was very slim hope that she was still alive.

[...]

...the best information you can give someone in that position is the truth. And I don't think they were getting that.

And that's—that's wrong. I think that's – that's – they should have been told exactly what we were seeing and not giving anybody false hope.³³⁶

³³¹ Exhibit 6402, Robin Kerr's notes, p. VSA_P000000001. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27309-10, lines 3-22.

³³² Exhibit 6402, Robin Kerr's notes, p. VSA_P000000001. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27312-3, lines 9-1.

³³³ Exhibit 6378, Jamie Gillespie's notes, p. OPP_E000003619. Exhibit 7545, Stephenson Engineering HUSAR timelines, p. SE_E000000060. Exhibit 6393, Compilation of TF-3 notes, p. CT_P000001858.

³³⁴ Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, pp. 19974-5, lines 24-11.

³³⁵ Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, pp. 19992-3, lines 17-11. Examination of Paul Officer, transcript of August 21, 2013, pp. 21614-6, lines 7-14. Exhibit 6336, Natalie Quinn's notes, p. ELFD_P000001955. Exhibit 3743, Natalie Bray's notes, p. CEL_E000013925-003.

³³⁶ Examination of Michael McCallion, transcript of September 6, 2013, p. 24640-2, lines 19-13.

214. Update announcements were made to the general public at Collins Hall, without ensuring that all family members were present. When Kerr asked Sergeant Esposto to wait to make the announcement until she could run outside to make sure everyone (and in particular the Perizzolo family) could receive the information, Sergeant Esposto advised Kerr that she should not make that request again. He would make announcements and the information could be shared by others.³³⁷
215. At 9:00 on June 24, 2012, Kerr spoke with Inspector Jollymore and asked to have more frequent updates for the families. Jollymore apologized that no one had provided continuous updates during the previous evening and stated he would make sure that they would occur more frequently.³³⁸ Following this conversation, the updates occurred more frequently. Constable Hicks was dedicated to providing updates to Collins Hall and would speak with the families personally.³³⁹ Similarly, during the evening of the 24th to 25th, Esposto attended Collins Hall every 2-3 hours until approximately 6:30 on June 25th.³⁴⁰ However, continuous updates from the OPP or any other authority ended there.
216. Kerr testified that Hamilton, the Mayor and Official Media Spokesperson, responsible for “providing vital information to the media, general public and other concerned audiences [emphasis added]”, did not attend Collins Hall on June 23 or 24th.³⁴¹
217. On the morning of June 25, 2012, Kerr requested that someone attend Collins Hall to provide an update, but was told that there were no updates to provide. Kerr requested that an officer attend just to convey what little information they did have.³⁴²
218. Kerr testified that more frequent updates would have provided family members with an opportunity to ask questions, to let them know that progress was being made and they were involved in the event.³⁴³ She testified that when regular updates are not provided to victims of catastrophic events from someone in uniform (or with some sort of visible

³³⁷ Examination of Robin Kerr, transcript of September 25, 2013, p. 27313, lines 2-17.

³³⁸ Exhibit 6402, Robin Kerr’s notes, p. VSA_P000000001. Examination of Robin Kerr, transcript of September 25, 2013, p. 27314, lines 8-25.

³³⁹ Examination of Robin Kerr, transcript of September 25, 2013, p. 27315, lines 2-21.

³⁴⁰ Examination of Robin Kerr, transcript of September 25, 2013, p. 27318, lines 1-7.

³⁴¹ Examination of Robin Kerr, transcript of September 25, 2013, p. 27317, lines 16-18. Exhibit 8087, City of Elliot Lake - Emergency Response Plan - Annex Section II Index, p. CEL_E00015551_0022.

³⁴² Exhibit 6402, p. VSA_P000000001.0002. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27323-27322, lines 25-11.

³⁴³ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27313-27314, lines 24-7.

authority), they start to feel disassociated and disrespected by the police and are more susceptible to rumors and speculation. Kerr testified that it was important that victims of crime receive updates from someone in uniform or with a badge so that the victims know that the police are working with them to resolve the crisis.³⁴⁴

219. At 12:00 on June 25, 2012, a press conference was held in which it was announced that there were still signs of life in the pile. The families received no prior notice of this announcement before hearing it on the radio.³⁴⁵ The family members became upset that the information had not been shared with them prior to it being made public. Mr. Aylwin asked Kerr to contact the police to have someone attend Collins Hall with an update. Kerr drove to the OPP detachment but was told that Jollymore was busy with the press conference and would attend when able.³⁴⁶
220. At approximately 14:00 on June 25, Jollymore entered Collins Hall to provide an update.³⁴⁷ This was the first time that anyone with authority had attended Collins Hall with an update in 7.5 hours.³⁴⁸ Jollymore provided an update to those at Collins Hall which mirrored what was said in the press conference, without any further detail.³⁴⁹ The family members were not separated for the purpose of receiving the update about the tapping noise that had been heard from the pile.³⁵⁰
221. McCallion testified that if he had been the one providing that news to the family members, he would have explained that the rescuers used a piece of equipment that penetrates the ground much like radar and it has determined that there is the possibility of breathing in that area but that there is a degree of unreliability in the calibration of the machine.³⁵¹
222. Kerr described a heated exchange between Jollymore and the family members:

³⁴⁴ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27323-27324, lines 12-25.

³⁴⁵ Exhibit 6402, Robin Kerr's notes, p. VSA_P00000001.0002. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27325-6, lines 21-24.

³⁴⁶ Exhibit 6402, Robin Kerr's notes, p. VSA_P00000001.0002. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27326-8, lines 25-9.

³⁴⁷ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27325-6, lines 12-24.

³⁴⁸ Exhibit 6402, Robin Kerr's notes, p. VSA_P00000001.0002. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27328-9, lines 12-3.

³⁴⁹ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27330-1, lines 16-6.

³⁵⁰ Examination of Robin Kerr, transcript of September 25, 2013, p. 27333, lines 2-7.

³⁵¹ Examination of Michael McCallion, transcript of September 26, 2013, pp. 24644-6, lines 23-8.

The families were asking why he couldn't come sooner, why they had to wait until after the press conference, and he informed them that his attendance was out of the kindness of his heart. He did not have to come and speak to them. It was not his role, and he was doing that to be polite.³⁵²

223. Jollymore remembered having a number of exchanges with Mr. Latulippe, including a heated exchange on June 25, 2012, but did not recall telling the family members that he was doing them a favour by attending Collins Hall to provide them with an update.³⁵³
224. Following the meeting at 14:00, Kerr and the family members (with the exception of Teresa Perizzolo) left Collins Hall for a few hours as they had been told that it would be quite a few hours before a further update would be provided.³⁵⁴
225. At approximately 16:00, Jollymore, Neadles and Hamilton returned to Collins Hall and announced that the MOL believed that the Mall was too unstable to continue the rescue. The only family member present at the time was Teresa Perizzolo.³⁵⁵ Kerr was not present during the first announcement.
226. Once Kerr and other members of the Aylwin and Perizzolo families arrived, they were informed in front of the entire group that the MOL had deemed the building to be unsafe and that they were going to “demolish with dignity” in order to recover the bodies.³⁵⁶ Mr. Gendron understood that the rescuers would be leaving Elliot Lake.³⁵⁷
227. During the announcement at or around 16:00 on June 25th in Collins Hall, there was no effort made to: (a) determine whether all of the family members were present during the announcement; or (b) provide a private space for the family members to receive the news that rescue efforts were being called off.³⁵⁸ Kerr also testified that Jollymore, Neadles

³⁵² Exhibit 6402, Robin Kerr’s notes, p. VSA_P00000001.0002. Examination of Robin Kerr, transcript of September 25, 2013, pp. 27329-30, lines 20-3. Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19885-6, lines 6-7.

³⁵³ Examination of Percy Jollymore, transcript of September 24, 2013, pp. 26924-33, lines 17-13.

³⁵⁴ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27333, lines 13-25. Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19903-19904, lines 3-21.

³⁵⁵ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19905

³⁵⁶ Exhibit 6402, p. VSA_P00000001.0002; Examination of Robin Kerr, transcript of September 25, 2013, pp. 27336, lines 4-24. Examination of Gary Gendron, transcript of August 8, 2013, pp. 20038-20039, lines 23-22

³⁵⁷ Examination of Gary Gendron, transcript of August 8, 2013, p. 20040, lines 13-16

³⁵⁸ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27342-27343, lines 20-9

- and Hamilton did not, in her view, take sufficient time to answer questions from the public and the family members after the news was delivered.³⁵⁹
228. Collins Hall cleared out after the announcement that the rescue was over and it was officially closed at 21:00 on June 25.
229. Mr. Latulippe and Ms. Perizzolo then returned home and were left to deal with the events of the emergency on their own until the morning of June 26.³⁶⁰ Similarly, the Aylwins went to their daughter's house to decide what their next course of action would be.³⁶¹
230. No authority figure advised the Perizzolo family when the rescue was resumed.³⁶² Indeed, it was Mr. René Fabris who advised Mr. Latulippe that the emergency responders were going to proceed with another rescue plan on the evening of the 25th.³⁶³ The Aylwins were not advised that the rescue had been resumed until the morning of June 26th, when they attended at the mall area.³⁶⁴
231. On the morning of June 26, 2012, Victim Liaison Officers with the OPP took over the care of the family members.³⁶⁵ Kerr testified that Victim Liaison Officers should have become involved with the families days earlier and that she probably could have requested that this be done.³⁶⁶
232. Mr. Latulippe testified that at least up until August 7, 2013, when he testified during the Inquiry, he was never provided with any information that would suggest that Doloris had died instantly.³⁶⁷ However, the coroner's evidence, including contemporaneous documents, suggests that the Perizzolo family were advised that Doloris was killed "almost instantly".³⁶⁸

³⁵⁹ Examination of Robin Kerr, transcript of September 25, 2013, p. 27347, lines 1-3.

³⁶⁰ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19913-19914, lines 18-14; pp. 19926-19927, lines 24-17 and p. 19928, lines 7-24.

³⁶¹ Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, pp. 19983-19984, lines 25-12.

³⁶² Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, p. 19923, lines 4-8.

³⁶³ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19922-3, lines 6-8.

³⁶⁴ Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, pp. 19984-5, lines 25-19.

³⁶⁵ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27349-50, lines 24-18.

³⁶⁶ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27350-1, lines 19-1 and p. 27358, lines 21-23.

³⁶⁷ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19936-7, lines 11-8.

³⁶⁸ Exhibit 9246, email – Body Release, p. MB_E000000001_02. Exhibit 9254, Coroner's Phone Log, p. MB_E000000002. Examination of Marc Bradford, transcript of August 29, 2013, pp. 23219-20, lines 15-16.

233. When asked whether Kerr had any recommendations about how to improve the role of VSA and the treatment of the family members throughout this emergency, Kerr suggested that the family members should have been separated from the general public and should have been provided information by one or more constant individuals so that the family members felt as comfortable as possible with them.³⁶⁹
234. In response to the same question, Latulippe testified that:
- a. The family members should have received updates on an hourly basis;³⁷⁰
 - b. The updates that were provided to family members should have been more detailed and straightforward;³⁷¹
 - c. The authorities who made the announcement on June 25th that the rescue was going to be stopped should have ensured that all of the family members were present and in a private space prior to delivering the news;³⁷²
 - d. Ms. Perizzolo should not have been alone at Collins Hall when she received the news on June 25th that the rescue was over. She should have been comforted and consoled until her family arrived.³⁷³
235. The Aylwins and Mr. Gendron also commented that information should have been provided to the families before the media.³⁷⁴ In addition, the Aylwins noted that during the time they spent at Collins Hall, there was no protection from the media when they entered or exited the building.³⁷⁵

G. Need for Mental Health Services after a Tragic Emergency

236. Given the traumatic nature of the Collapse and the number of people affected by it, the City and the province should have provided more mental health services to help the victims of the Collapse. Although counseling services were provided and are helpful,

³⁶⁹ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27356-7, lines 14-8.

³⁷⁰ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, p. 19939, lines 10-25.

³⁷¹ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, p. 19939, lines 10-25.

³⁷² Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19940-2, lines 1-8.

³⁷³ Examinations of Teresa Perizzolo and Darrin Latulippe, transcript of August 7, 2013, pp. 19938-9, lines 3-9.

³⁷⁴ Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, p. 19995, lines 13-22. Examination of Gary Gendron, transcript of August 8, 2013, pp. 20054-6, lines 15-12.

³⁷⁵ Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, pp. 19985-8, lines 20-3.

trained psychologists and psychiatrists were needed to deal with those most affected by the Collapse. This need is particularly strong in rural or isolated communities, like Elliot Lake, where these types of mental health services are often unavailable. It is important that communities touched by trauma have a full complement of mental health professionals available to them as they rebuild. This need was pointed out to McGuinty who acknowledged that both historically and during his tenure as Premier, including the time of the Collapse, there have been ongoing issues providing medical services for people in Northern Ontario.³⁷⁶

237. The eye-witnesses and family members who testified all suffer from ongoing nightmares, bad memories and have difficulty sleeping. The eyewitnesses report adverse reactions to loud noises. Lucie's fiancé, Gary Gendron, testified that he has been affected such that he has been unable to work since March 2013.³⁷⁷
238. Victim Services Algoma ("VSA") was summoned by the OPP to the scene; however, their role was not to provide mental health services. Robin Kerr, the Executive Director of VSA, testified that their mandate is to provide emotional support, practical assistance, information and referrals to victims of crime.³⁷⁸ If a victim is in need of counseling or other mental health services, VSA will refer them to East Algoma Counseling Centre, Algoma Family Services, or East Algoma Mental Health. Kerr is unaware whether there are psychologists or psychiatrists on staff at any of those agencies.³⁷⁹
239. Adam Amyotte, a manager at the Bargain Store who was an eyewitness to the Collapse, told the Commission that there are minimal psychiatric and psychological resources in Elliot Lake. To the best of his knowledge, there is no psychiatrist who practices in Elliot Lake on a permanent basis. He is aware that a psychiatrist from Sudbury schedules appointments in Elliot Lake periodically but it is difficult to get an appointment.

³⁷⁶ Examination of Dalton McGuinty, transcript of October 9, 2013, pp. 28978-9, lines 21-7.

³⁷⁷ Examination of Adam Amyotte, transcript of August 7, 2013, pp. 19782-3, lines 23-12. Examination of Jean-Marie Marceau, transcript of August 7, 2013, pp. 19809-10, lines 20-14. Examination of Yves Bérubé, transcript of August 7, 2013, p. 19839, lines 6-11 and pp. 19842-3, lines 18-15. Examination of Jason Morrissey, transcript of August 7, 2013, pp. 19858-9, lines 24-8. Examinations of Darrin Latulippe and Teresa Perizzolo, transcript of August 7, 2013, p. 19953, lines 3-15; pp. 19953-4, lines 24-8 and p. 19958, lines 14-20. Examinations of Rejean and Rachelle Aylwin, transcript of August 7, 2013, p. 19997, lines 6-12 and p. 19999, lines 16-23. Examination of Gary Gendron, transcript of August 8, 2013, pp. 20057-8, lines 1-15.

³⁷⁸ Examination of Robin Kerr, transcript of September 25, 2013, p. 27293, lines 21-24.

³⁷⁹ Examination of Robin Kerr, transcript of September 25, 2013, pp. 27363-4, lines 22-6.

Amyotte understands that the province did not make additional psychiatric or psychological services available for victims in the wake of the Collapse. Counseling services were offered through the Algoma Counseling Centre; however, Amyotte understands that the centre is run by social workers, not trained psychologists or psychiatrists.³⁸⁰

H. Recovering Property

240. Some of the personal property of people who worked or owned businesses in the Mall, including inventory and cash boxes, was recovered by responders in the weeks following the Collapse. The OPP were responsible for collecting that property. They have not contacted the people whose property they recovered. Business owners and employees remain uncertain as to whether their property has been recovered and, if it has, where it is being held and when it will be returned to them.
241. Yves Bérubé was the only business owner in the Mall who testified in Phase II. He owned “Kreations and Things”, a store in the Mall which sold women’s clothing and costume jewelry. As a result of the Collapse he lost his entire inventory and the contents of his cash register. No one ever explained to him what happened to his inventory or cash register.³⁸¹
242. During the course of the rescue and demolition, responders brought IDENT Officer Burns jewelry and cash trays from businesses in the Mall. Burns testified that the jewelry was logged as evidence and can be tracked. He photographed the contents of the cash trays. In response to a question at the Commission asking why none of the property was returned to its owners, Burns testified that it is still premature for any of the evidence to be returned.³⁸²
243. It is common practice for the OPP to keep a catalogue of property that was removed from a scene. Sergeant Bickerton is the officer in charge of maintaining such catalogs. Inspector Jollymore testified the evidence recovered is still required for the OPP’s

³⁸⁰ Examination of Adam Amyotte, transcript of August 7, 2013, pp. 19786-8, lines 22-1.

³⁸¹ Examination of Yves Bérubé, transcript of August 7, 2013, p. 19834, lines 14-16 and p. 19842, lines 5-17.

³⁸² Examination of Dale Burns, transcript of August 20, 2013, p. 21297, lines 11-17 and pp. 21298-9, lines 18-23.

ongoing investigation and the OPP is still in the process of reviewing whether they can identify the owners of some of the collected evidence.³⁸³

244. The failure to return property to business owners located in the Mall at the time of the Collapse is the source of a great deal of stress and frustration for these individuals. Although it is acknowledged that some of this evidence may be valuable in the course of the OPP investigation, concerted efforts should be made to determine who the property belongs to and to contact those individuals to notify them that their property is subject to an investigation. Those persons should be given an estimation of when their property will be returned. This would relieve some of the stress and anxiety associated with an already trying time.

³⁸³ Exhibit 6396, Percy Jollymore's notes, p. OPP_E000081945_025. Examination of Percy Jollymore, transcript of September 24, 2013, pp. 26970-1, lines 6-4.

Part III – Recommendations

A. Mandatory IMS

- Although the Commissioner of Community Safety believes that following all of the procedures of the IMS would result in greater safety for responders and those being rescued, the IMS is voluntary.³⁸⁴ It should be mandatory.
- The current IMS manual is 141 pages long. It should be simplified into a readily and easily accessible resource for municipalities and responders.
- Many, if not all, responders believed that unified rather than single command applied in Elliot Lake. The IMS manual should be clarified to emphasize that the presence of more than one organization at an emergency does not necessarily mean that unified command applies.
- Paul Officer testified that until June 25th, two days after the Collapse, he did not realize that Bill Neadles and TF-3 reported to him. His confusion may account for his failure as the IC to follow the basic steps of IMS. When expert organizations such as UCRT and TF-3 arrive at an incident and do not intend to receive Command from the local responder, they should identify the steps required under IMS and propose responders within their organizations who can fulfill the management and staff roles under Command, Planning, Operations, Logistics, and Finance and Administration. If more than one expert organization responds to a single incident, they ought to coordinate amongst themselves to determine who amongst them is best positioned to fulfill the various management and staff roles and provide that information to the IC.
- Officer believed that he could not transfer Command to Neadles, a view which is consistent with the OFM's November 9, 2005, communiqué, but seemingly at odds with the IMS. The OFM should determine whether it is truly practical to require fire chiefs to retain management and control of the incident and prohibit fire chiefs from transferring command when appropriate.

³⁸⁴ Examination of Dan Hefkey, transcript of October 8, 2013, p. 28759-60, lines 23-1.

- Comella explained that he did not have “the luxury of time” to write IAPs, although they were required in the circumstances. It is expected that there is never the luxury of time in an emergency. A scribe should be assigned to the PSC to write down the IAP, if the PSC is unable to perform the task himself or herself. In addition, responders should receive clearer information about when a written IAP is required.
- Gillespie tried to patch TF-3 and UCRT’s communications systems together but did not have cables that fit TF-3’s portable radios.³⁸⁵ UCRT and TF-3 should ensure that they have the necessary infrastructure to patch into each other’s communications systems and those of local responders throughout the province.
- Bob Thorpe from the Office of the Fire Marshall was on scene by 18:08 before either UCRT or TF-3. In complex search-and-rescue incidents involving several organizations from different jurisdictions and in which the local responders intend to retain command, we recommend that someone from the OFM be present early in the emergency response to guide the IC through the proper implementation of the IMS system, including assigning functions and roles to the various organizations and individual responders and ensuring the initial command meeting, tactical meetings and appropriate debriefings take place.
- Phil Glavin’s personal relationship led to his knowledge about the Komatsu PC850, which was eventually used to recover Doloris and Lucie. Search and rescue teams should maintain an electronic database of companies who possess useful equipment, including their technical specifications.
- The province should fund staff training for municipalities to develop emergency response plans.

B. Recommendations relating to Understanding the Authority of the MOL

- It is imperative that responders, including MOL personnel themselves, gain a better understanding of the role of the MOL at emergency scenes in order to prevent the spread of miscommunication and to increase the efficiency of emergency responses. The role of

³⁸⁵ Examination of Jamie Gillespie, transcript of September 3, 2013, p. 23598-9, lines 10-6.

the MOL and other government agencies who might be involved in responding to emergencies should receive thorough training about their role and powers at an emergency scene. This recommendation was endorsed by Hefkey at the Commission.³⁸⁶

- The role of the MOL at an emergency scene should be addressed, either through guidelines or regulation, and explained in IMS training. This way all team leads will thoroughly understand the power of government agencies in rescues and recoveries and ground level responders have at least a passing understanding of the MOL's role. In anticipation of the Inquiry, the MOL put together a report outlining the roles and powers of MOL personnel in emergency events.³⁸⁷ This guide could be a helpful tool going forward in clarifying the role of the MOL to both MOL personnel and other responders.
- It is unusual for MOL personnel to attend active rescues and recoveries. MOL personnel have not had much experience dealing directly with rescuers and they appear to have assumed that the rescuers knew more about their role and purpose onsite than they did. Further, the presence of the MOL on the scene appeared to make some of the first responders nervous, particularly when they did not understand the purpose and authority of the MOL at the site.³⁸⁸ Upon attending to the site of a rescue or recovery, MOL personnel should seek out ICs and team leaders to explain their purpose for attending the scene so that this information is trickled down through the ranks. It should be made clear to the rescuers that the MOL does not intend to issue a stop-work order. This will also lessen the anxiety and confusion at the site, leading to a more unified rescue effort.

C. Recommendations Related to the Demolishment of Private Buildings

- It should be made clear to Community Control Groups in communities across Ontario which agency(ies) is(are) empowered to order or undertake the demolition for a building in order to facilitate a recovery. If no such power exists under existing statute or regulation, it should be recommended that such legislation be enacted. This clarification will ensure the expedient and respectful recovery of bodies and assist in bringing closure to families and the community.

³⁸⁶ Examination of Dan Hefkey, transcript of October 8, 2013, pp. 28756-7, lines 13- 1.

³⁸⁷ Exhibit 9907, *The Occupational Health and Safety Act*, the Ministry of Labour and Emergency Operations Report dated September 6, 2013.

³⁸⁸ John Thomas, transcript of August 15, 2013, pp. 21090-1, lines 24-2.

D. Recommendations for Best Practices in Rescue Operations

- Emergency Management Ontario should set up a system of organized reconnaissance whereby information can be sent to Toronto-based emergency service providers when the emergency is located far from Toronto.
- TF-3 should require its members to have more training in crane operations.
- The results of ground penetrating radar should not be relied upon when the device is used outside of the manufacturers recommended guidelines.
- During the response to an emergency, rescuers should not be required to spend time and resources on unnecessary work for public relations purposes.
- Each of the individual services involved in an emergency should be required to conduct a debriefing and prepare an after-action report of the emergency in a timely manner.

E. Media Related Recommendations

- The approval process for the release of information to the media must be clearly outlined in a municipality's Emergency Response Plan or its Emergency Information Plan. The approval process should accord with IMS practices which require Command to approve the release of information to the media. Direction from Command is particularly critical when information is being released about casualties and fatalities.
- The CCG members in Elliot Lake were overwhelmed by news releases containing inaccurate information and by decisions about when and how soon to release critical information about the emergency response. CCG members in rural communities and particularly members with media-related roles should either receive better media training to be able to deal with the media in the context of an emergency; or, should be provided with support staff to help navigate media inquiries throughout an emergency response. The media training provided to CCG members must include training on how to set up an effective Emergency Information Centre which is capable of monitoring the accuracy of news stories and must include training on the importance of disclosing information to the media in a timely and accurate manner.

F. Recommendations for Dealing with Family Members of Victims in an Emergency

- Best practices for dealing with the family members of deceased or missing persons (“**Family Members**”) during an emergency dictates that they should be provided with a separate, private space to wait during the Emergency which is protected from media inquiries. In addition, a dedicated person or persons should be assigned to Family Members throughout the emergency response and should ensure that they are provided with frequent, timely and honest updates throughout the emergency response. In particular, Family Members must be advised of events critical to the emergency response prior to the release of such information in the media.

G. Recommendation for Increased Mental Health Services After a Tragic Emergency

- Mental health resources, and in particular psychologists and psychiatrists, should be made available and easily accessible to the victims of large-scale traumatic events, such as occurred in Elliot Lake. These services are required to help victims and the community cope and recover. This need is particularly strong in isolated and rural areas where these services often do not pre-exist.

H. Recommendations Related to the Recovery of Personal Property

- The OPP should make a concerted effort to:
 - a. identify what personal or business-related property they recovered from the Mall;
 - b. determine who that property belongs to;
 - c. notify those persons whose property they have recovered; and
 - d. provide those persons with an estimation of when that property will be returned to them.
- This course of action would relieve the business owners and employees of the Mall of some of the stress and anxiety they have suffered since the Collapse.