SAGE

Seniors' Action Group
of
Elliot Lake

Closing Submissions To The Elliot Lake Commission of Inquiry
Regarding the Algo Mall Collapse, June 23, 2012
Phase 2 of Inquiry Only

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Prepared By Keith Moyer, Chair, on Behalf of Seniors Action Group of Elliot Lake

Opening Remarks

SAGE would like to, once again, express our appreciation to both Mr. Commissioner and the Commission Staff and Counsel for permitting us to participate on behalf of our members and other concerned citizens of Elliot Lake. We have appreciated the opportunity to observe, listen, think outside our daily lives, and to be permitted to actively participate develop and submit our own Recommendations for the consideration of Mr. Commissioner in his final Recommendations to the Province of Ontario.

Thank you.

Background

The collapse of the Algo Centre Mall in June 2012 was a tragedy that effected the lives of most citizens of Elliot Lake in some way. SAGE represents seniors of Elliot Lake, who comprise perhaps the largest demographic of the community. The mall was important to many seniors who depended on its location and convenience for their shopping and some services. However, seniors were not the only citizens effected. SAGE originally became involved due to, what was viewed as, some rather serious shortcomings of what occurred "post collapse".

SAGE felt that, in the interest of truth and, to prevent such a tragedy from ever reoccurring, that it may be able to gather facts and formulate recommendations to the Commissioner, for his consideration and submission to a higher power. A number of SAGE

members are from varied backgrounds which involve construction management and building management as well as Emergency Response, so, it was felt that SAGE could make an effective and meaningful contribution to this Commission of Inquiry.

Executive Summary

We have concluded, that, for the purposes of this Closing Brief, that any difficulties encountered were related to one or more of the following categories: Communications or lack thereof; Command Structure, or lack thereof; and, the Adherence to the Emergency Response Plan, or, lack thereof.

At least one member from our organization has been present at all sessions of the Inquiry hearings and, coupled with the review of documents by many of our members, and reviewing of transcript evidence, SAGE has endeavoured to carefully follow and understand all evidence given and recorded. From this exhaustive undertaking, we have garnered many observations, which shall be articulated later in this brief, and a number of, what we consider, pertinent recommendations for consideration by Mr. Commissioner and his staff and counsel.

It should be emphasized that no member of SAGE has a law degree or legal background and we have done our best to follow the details of the Inquiry as it unfolded and, attempted to gather information and formulate Observations based on what we have heard and seen, in an effort to assist the Commissioner to arrive at his final recommendations, based on some grass roots, common sense observations from people who live here. We apologize for any lacking in correct legal proceeding and wording.

Observations

Observation 1

It appears that during the collapse, individual businesses were not prepared for any emergency, and assisting others to evacuate was

left to well meaning people with the courage top assist where they could. It appears that individual businesses did not have in place, a Fire Safety & Evacuation Plan, as required under the Ontario Fire Code or, a general Fire Safety & Evacuation Plan provided by the owner of the mall.

Observation 2

It appears that despite severe trauma suffered by many mall occupants and related individuals, there seems to be little resources available for followup care and treatment for them on an ongoing basis, and many still suffer the after effects.

Observation 3

From testimony of a rescued mall occupant, it appears that inadequate first response EMS on site was inadequate for the size of the incident and was ill equipped to deal with the potential of the situation. For an example, a gentleman whom has sat in on many sessions of the Inquiry has an obvious need for continued Oxygen therapy and on reaching the ambulance was denied any access to it, and was refused when asked to have someone obtain his own portable supply from his nearby vehicle or, to get it himself. Still, the man was left to sit, with his own oxygen supply, for 45 minutes with visible injuries, for a further 45 minutes.

Observation 4

The Emergency Management and Civil Protection Act spells out the requirements that any municipality must take and plan for, in the event of an emergency situation involving public safety. It would, however, appear that the rules, once made and enacted into law, are left to languish and all powers are abdicated by the Provincial Government to the municipalities as to compliance. The statement was made "We expect compliance but have no means of enforcement".

Observation 5

The UCRT group under the OPP appear very well qualified and equipped and capable of very rapid response in the event of a disaster, however, are under manned and under funded, and, are too centralized to respond in a timely manner to locations in Ontario which are remote from their Bolton location. In addition, due to the limited manpower, they are at times, forced to call in HUSAR out of Toronto, yet further, too centralized. In addition, the current rank of command in the field appears to be that of Staff Sargent, whom is also a working member of the crew on the scene, however, the command rank under HUSAR has been reported as Staff Inspector. Because of the para military nature of any police involved unit, the question of Rank becomes an issue, which it should not be, and UCRT ends up, despite highly specialized training, as subservient to HUSAR, simply by way of the amount of "gold braid" present in the field.

Observation 6

It became evident that, due to the remoteness from Bolton HQ for UCRT, there was little data available as to sources of materials that would be required on arrival and, sources of heavy equipment that may be required to be brought in to allow them to proceed.

Observation 7

Throughout the testimony of both the local Incident Commander and specialized rescue team members arriving on site, it appeared that the Command Structure was in somewhat of a disarray, with no clear cut lines of "who was in charge". The local Fire Chief was first to respond and assume command, as he should have, but, later, it appeared that process command was surrendered to the command of HUSSAR [TF3]. The fact that UCRT was first on the scene, well before TF3, and were possibly equally qualified at least to the capabilities of TF3, they became invisible in the process except for the grunt work on the site. Indeed, it was apparent that the Incident Commander was not even aware of UCRT's existence and, appeared to view them as

an "advance" team of TF3. Once the TF3 members arrived, the Incident Commander turned the rescue effort over to the "experts" under a "Unified Command" structure, but indicated these experts to be TF3 only. At that point, UCRT was basically left out of the Command Structure and received orders through TF3, with, little input from themselves.

It also was evident that the UCRT team was reporting through a local Cluster Inspector from the OPP, who had little knowledge of their mandate or capabilities. When requested to order materials and equipment while the initial team was en route, he deferred the requested action until they arrived and TF3 was on scene, causing needless delay.

Indeed, the decision to move the operation from a "Rescue" to a "Recovery" was not made by the Incident Commander, but, by a "Committee" through the Community Control Group, based on information from the TF3 Commander and the Ministry of Labour, who, at the time, had no jurisdiction. The Incident Commander said he was "over ruled", which he legally could not have been.

It later in testimony, became clear that TF3 members, although highly skilled, did not possess the required Certification that the USRT team had, yet, overshadowed the incident and made decisions in a vacuum, with little of no input from the real qualified team, USRT.

<u>Observation 8</u>

It became apparent that radio communications on the site became difficult due to all teams involved [fire, UCRT, TF3, OPP, etc, all operating on proprietary radio frequencies. At times, there were needless delays in physically "running" orders from one team to another, or, back through Incident Command.

Observation 9

When listening to various rescue workers on site, it became apparent that they had difficulty keeping track of times and actions for evidence note taking or debriefing, due to long hours of intense activity, and being unable to stop and record notes, thus, having to rely on memory during down times to recall activities. As we have witnessed, despite the best efforts possible, these people were left with gaps in their recollection due to this.

Observation 10

From evidence presented, it would appear that the Ontario Ministry of Labour was determined to take control of the site, even prior to any of their personnel arriving on the scene. They immediately, after being advised of the incident, told local officials to "not enter the site until they arrived". The Incident Commander was made aware of efforts by the Ministry [though rumour at the time] to take control of the site due to "safety". He had to contact the Fire Marshall's Office to be assured that they [the Ministry] did NOT have this authority. There was an Exhibit produced that at this time, cannot be found, which was the actual Order from MOL, which effectively shut down the "rescue" and made it a "recovery", however, it appeared [from memory at this time] to allow workers to reenter for "Recovery/Rescue" operations. It is understood that MOL does have jurisdiction over a "Recovery" operation, but does not have authority over a "Rescue". If memory is correct, this "Order" was perhaps, not valid, since it was a contradiction in terms. It was either a "Recovery" or it was a "Rescue". How could it have been both? This confusion has caused delay and friction on a rescue site before Elliot lake, and is unnecessary.

Observation 11

From testimony from witnesses on the ground during the operation, it became evident that the whole thing became a series of individual "Kingdoms" and each commander on the ground wanted to be "King". The theory of "Command" and protocol became more

important then the task at hand, and decisions were made within individual groups and then a lobbying effort to get support was undertaken. Differences in opinion caused needless delay and frustration for those on the ground. In short, it became a "pissing match", and, above all, the official Incident Command was left as an after thought.

Observation 12

From testimony from some teams involved in the rescue, included in the rescue, including UCRT, OPP, and Elliot Lake Fire Department, a complete debriefing was undertaken after the event, to identify how things had been done, where mistakes may have been made, and to identify areas where improvements could be made in the event of another deployment. TF3, on the other hand, undertook no such debriefing and one of their witnesses even hinted that there was little or nothing that they could improve upon.

Observation 13

After three Ministry of labour inspectors testifying, two pre collapse, and one post collapse, they have shown a complete incompetence to the job at hand, regarding the conditions at the mall. All, including the gentleman who attended after the collapse, have appeared to approach their duties in a lax, routine, and unconcerned manner, with no sense of accountability. None have given any impression, during testimony, of credibility, or conscience diligence, in the undertaking of their duties, or even proper and adequate background or training for the duties they are responsible for.

Observation 14

TF3 does no training using heavy equipment of any kind, including crane rigging. And, unless a member has training to the "Rescue Systems 2" level, there are no qualified individuals to perform such tasks. It was not testified to as to how many TF3 members, if any, have been certified to the level of "Rescue Systems 2".

Observation 15

It was testified to by almost all TF3 members called, that they were required to be subjected to a "cursory medical examination" or "physical" at the Mustering Centre, prior to being permitted to deploy. Most of TF3's members were Toronto Fire Personnel, who have a very physically demanding day job, and are required to maintain a high level of physical fitness. It is highly doubtful that they are subjected to a "medical check" prior to each fire or rescue call to which they are dispatched during a working shift.

Recommendations

All recommendations are shown as a separate attachment.

General Comments

Communications

Witness after witness, when asked by various counsel, what they felt would be a critical recommendation they would like to see made and implemented, they almost to the individual, responded; COMMUNICATION, COMMUNICATION, COMMUNICATION.

Perhaps never more was there a critical need for improved communication, then during the Algo Mall collapse and the on going operations for rescue and recovery.

These witnesses ranged from the public inside the mall at the time of the collapse, the families of victims of the catastrophe, the concerned general public, the first responders, up to and including the teams of rescuers working on the rubble pile, and, the Incident Commander himself.

We, who live in Elliot Lake, witnessed the proceedings from the safety of the street, or, the comfort of our living rooms watching for news

bulletins on television or the internet. We heard conflicting reports of a yet unidentified fatality, then possibly even more. We heard conflicting reports of people who were as yet, unconfirmed to be missing. We heard and watched City run News Conferences, at which, the Mayor sat almost silent; the named Communications Coordinator was basically unknown and invisible, while proceedings were directed, controlled and dictated by the CAO, who was, according to the Emergency Response Plan of the City, in charge of only the Community Control Group or CCG. It was usually he who responded to press questions or, he directed questions to various specialists who came from afar to undertake the rescue operation. It would appear reasonable that these individuals would have been more productive and even have preferred to be out on site as opposed to answering questions from the press. One must only recall the recent flooding disaster in Calgary and the public communications from their mayor to see how things here SHOULD have been done.

The general public, who stood vigil along the street, awaiting news of the victims was shut out of any meaningful information, and were left to rumour and whatever they could learn on their own. Nobody designated by the ERP ever was noted on the street, presenting updates. The only time anyone from the city ever showed up was the mayor and CAO when some high ranking official came to town and spoke on the street, to the press cameras, of course, from the safety of a cordoned off scrum. Most added little to the public's need to know, and focused more on political "spin". What little information did "leak" out of city hall was either media spin or rumour and much false hope was spread without any verification.

Instead of these specialists channeling their known information up through the Incident Commander and to the Mayor, whom is identified as the head of the CCG and the Official Spokesperson for the operation, they were left to attempt to explain what they were facing and doing to a press, who, in some instances, sought to slant and sensationalize the news. For the public, holding vigil on the street, even these news casts were not available, and they were forced to rely on second or third hand information. Not until some senior official from the Province or OPP arrived did the Mayor appear on the

street, and that was usually to introduce them and let them speak to the people. No regular briefings were communicated to the people awaiting news on the street.

The families of victims spoke of being told next to nothing and ignored as to news of the fate of their loved ones, and were told that they were being done a favour to be told the smattering of news they did get, again from people that would have been more use on the site then taking the place of those who should have been communicating.

We have been made aware of communications between a few members of council itself, who were never given any information as to what was happening on the ground, so that they could at least try to keep questioning constituents informed.

It was not the job of the Incident Commander to stop and speak with the press or concerned citizens. The Emergency Response Plan clearly spells out whom it should have been.

There were various testimonies as to difficulties with communications on the site itself, because of incompatible radio frequencies; decisions being made at lower levels of the chain of command, rather then the Incident Commander; conflicts on the ground appearing to be the result of what cannot be described other then a "testosterone contest " between various groups of professionals on the ground, due to some sort of "Who's really in charge" perceptions.

We see instances of the first group to arrive for the rescue from out of town who were simply assumed to be an advance group of another and larger group who had been requested by the first group. Who they were was not known by anyone, even their own so called IC on site, who was a member of the same organization. The Incident Commander had never heard of them and was unaware they were a separate entity. The public were never told that there were two groups of experts arriving who would coordinate and work together. Almost nobody was aware that the first to arrive group of outside rescue

personnel was almost shut out of operational planning and relegated to "also rans".

We heard of instances of interference from a Crown Ministry, who, unless the operation was declared a "Recovery" as opposed to a "Rescue" by the Incident Commander himself, has no business other then advisory, in the whole thing. Why they sat in CCG meetings, influencing the members thereof, instead of funneling their concerns only through the Incident Commander alone yet is a mystery.

While SAGE has made a number of recommendations for the consideration of Mr. Commissioner, we would emphasize that the progress of those tasked with the rescue and recovery of victims would have been much better had simple COMMUNICATION been practiced by all concerned. There is a definite need to strengthen all aspects of communications at all levels.

Command Structure

It became evident that the rescue operation quickly deteriorated into confusion, with an almost total lack of an organized and defined command structure, that was clearly defined and adhered to.

It was supposed to be clear, under the conditions of the City of Elliot Lake Emergency Response Plan [the ERP] that the one and only Incident Commander, was the Elliot lake Fire Chief, in this instance.

Due to the complicated and highly specialized technical nature of this incident, it became obvious and logical, that this Command would have to rely on advice and input from highly skilled rescue specialists, whom had been requested. The Commander was given to believe that HUSAR [TF3] was whom had been dispatched. However, the first specialized team who arrived on site was the OPP UCRT team, who the Commander, by his own testimony, had never heard of, and likely assumed that they were simply an advance team of TF3. It should be noted that TF3 had been requested to deploy by UCRT, and not the opposite way around.

This team had requested a crane and shoring materials over the phone, while still in transit to the scene, through the local OPP Cluster Inspector, whom they regarded as their reporting command in Elliot Lake, however, he appeared to disregard the request, thus, requiring delay upon their arrival, and the use of human resources from then Elliot Lake Fire Department to acquire them when UCRT arrived. There was no evidence from the Incident Commander that he was ever made aware of this needless delay, which could have been avoided.

Hours later, TF3 arrived, and apparently due to higher ranked members and commanders thereon, and the assumption on the part of the Incident Commander that they were actually one team, he turned Operational Command over to the TF3 Commander. The TF3 Commander, by his own testimony, assumed that in a joint deployment of TF3 and UCRT, TF3 naturally took over all command. There is no written policy to verify this assumption. As time went on, it became apparent that the TF3 Commander assumed full Incident Command, rather then reporting through the Elliot Lake Fire Chief, the official Incident Commander.

The TF3 Commander appears to have done most of his "reporting" to the Incident Commander, through the Community Control Group [CCG], instead of much direct communication. The TF3 Commander was only onto the actual "pile" twice; once upon arrival and once prior to leaving the scene, and relied on mostly verbal reports from others, listed by him as commanders, on the TF3 team. There were only two written action plans ever introduced into evidence, and both of these were prepared and presented by a crane company and the demolition company, and the TF3 Commander kept no notes himself, and subsequently, during testimony, had "no recall" as to what happened or when it did. He spent most of his time between press conferences; CCG meetings; and, sitting in the command tent, rarely venturing out onto the site.
While the decision to cease the rescue operation was made by himself, based on advice from what he testified as "eminent catastrophic collapse of the building from his embedded engineer and the engineer from the MOL". His embedded engineer had testified

that, although unstable, he made no pronouncement of "eminent catastrophic collapse". He also based his decision on advice from his field commanders, to whom he appeared to abdicate all field decisions, while never appearing to personally verify anything. The decision to cease rescue operations was not the TF3 Commander's decision to make, but was only that of the official Incident Commander. This became more evident when it was the TF3 Commander who made the announcement of ceasing rescue operations at a press conference, rather then this information coming from the Incident Commander as it should have, however, it was apparent, both from reaction of the Incident Commander, and earlier testimony from him, that he was not in agreement with it.

When the TF3 Commander was questioned by the counsel for the OPP, he clearly identified himself as the "Person in charge", but, knew, or could not recall what was happening on the site and did not demand progress updates or day to day briefings, either verbal or written, from his appointed field commanders.

The Command Structure appears to have simply fell apart, and became a war of wills between TF3, UCRT, and the MOL, with the official Incident Commander being left as an "also ran".

Emergency Response Plan

The Emergency Response Plan [ERP] appeared to become a document that was all but forgotten, both prior to the incident and during the aftermath of the collapse. The last testified to "exercise" mentioned by Mr. DiBartoli during his testimony, was a "desk top" exercise involving a bomb threat at the local hospital, in either late 2011 or early 2012. A "desk top" exercise is fine, for purposes of a review of what are the steps required and by whom, in the event of an emergency, however, they are no substitute for actually getting out there and physically going through the steps required. With the exception of an all in exercise in 1996, testified to by Captain John Thomas, there was no mention of any other exercises, desk top or otherwise between the two, despite the requirement under the Act to conduct same annually.

The Elliot Lake Fire Department responded as they should to the incident, and, Chief Officer assumed incident command, as he should have, however, after it was realized that the fire department was not equipped to deal with such an incident of this type or magnitude, the entire ERP seemed to be ignored, in favour of "making it up as they went along".

For instance, the ERP clearly spells out that the Alternate to the Mayor under the ERP, is automatically, the Deputy Mayor. Mr. DiBartoli testified that the Deputy Mayor, along with any other council members present at a CCG meeting, were ordered to leave the meeting, citing that "there were too many people in the room". It would appear obvious that, a person, named in the ERP was not a good choice to ask to leave, while others, who may not have had an immediate responsibility were allowed to remain.

Under the ERP, the Mayor is the designated individual to "speak and communicate on behalf of the community". The Mayor, instead, felt that his responsibility was to sit at Press Conferences, which were usually "moderated" by the CAO; take phone calls from distant press organizations; and, stand beside visiting officials while they addressed the press and limited public. As mentioned previously, under the heading of "Communications", the bulk of the local population was not at home watching press conferences, but standing vigil outside the scene or, at Collins Hall. Just perhaps, the inclusion of the Deputy Mayor could have allowed one of the two to get out in the street and "communicate" with the local public?

The ERP clearly identifies the Command Structure with the local Fire Chief as Incident Commander, but, in many cases, especially those involving critical decisions regarding the rescue, he was left out of the loop also. It appears that, during the initial stages of the operation, the Incident Commander was not even aware that he was dealing with two, not one, team of experts in rescue operations, assuming that TF3 and UCRT were one in the same.

Little evidence was introduced as to the required initial training for those listed in the Annex to the ERP, and nothing regarding required

upgrading training. Both are required under legislation.

Legislation also requires that a full "debriefing" be undertaken within some five days after an incident. To date, only the Elliot Lake Fire Department has undertaken an informal debrief, while the City itself has done nothing, preferring to await the outcome of the Inquiry recommendations. It was mentioned in correspondence from OPP Inspector Jollymore, that perhaps such documented debriefing could be used as "evidence" at the Inquiry?

Likewise, Legislation requires that every person on the Annex for the ERP, keep a personal log of all activities undertaken during the incident. With the exception of notes taken by a "scribe" at CCG meetings, no such logs from any City staff were presented. The Mayor went as far as telling the Commission that he "did not have time" to comply with the Legislation.

The makeup of the ERP is based on listed requirements laid out in both Legislation and the Incident Management System [IMS] prepared by the Province. The author, Mr. Hefkey, of this document testified that this was called a "Doctrine" as opposed to a legal requirement. In other words, a "theory". He told the Commission that it was not "mandatory" for any municipality to follow this "doctrine" and they could choose to utilize only portions of same, as they felt they wanted too. Had this "doctrine" been a mandatory requirement instead of a "maybe yes, maybe no" situation, perhaps the incident may have had a different result?

Appendix "A"

This Appendix provides reference to testimony presented and Exhibits introduced, as they relate to our Observations, presented earlier in this brief. SAGE apologizes for what may appear to be a rather random, and perhaps, arbitrary layout of references, however, what is presented is the result of many hours of exhaustive and, at times, mind numbing review of testimony presented, by dedicated volunteers, all laypersons, with no legal background or, the resources of a legal backup team. All have done their best.

Observation 1

See Amyotte; Page 19770 line 16 thru Page 19782 line 16, inclusive. Appendix "B" {attached} Page 19786 line 22 thru Page 19788, line 1, inclusive. See Marceau; Page 19795, line 23 thru Page 19801 line 14.

Observation 2

See Amyotte; Page 19782 line 24 thru Page 19785 line 22 inclusive.

Observation 3

See Marceau; Page 19801 line 20 thru Page 19805 line 25.

Observation 4

See Hefkey; Page 20116, line 1 thru Page 20118, line 11; Page 20136, line 3 thru Page 20137 line 3; Page 20250 line 1 thru Page 20251 line 3.

Observation 5

See Const. Waddick, Page 113, line 1 thru Page 115 line 4. See Const. Cox, Page 112 line 7 thru Page 113 line 20. See Const. Bailey, Page 281, line 17 thru Page 282 line 7; Page 317 line 9 thru Page 321 line 1; Page 327 line 1 thru line 6; Page 156 line 12 thru Page 167 line 1.

Observation 6

See Waddick, Aug, 23, Page 21982, line 12 thru 21985 line 11 & Exhibit 6379. See Page 222210, line 3 thru Page 22368, line 2.
See Cox, Aug 26, Page 22266, line 11 thru Page 22268 line 21.

Observation 7

See Waddick, Page 22046, line 11 thru Page 22047, line 4
See Cox, Aug 26, Page 22253, line 19.Page 22278, line 17 thru Page 22280 line 17.

Observation 8

See Officer, Aug 21, Page 21420, line 1 thru Page 21422, line 25; Page 21545, line 20 thru Page 21546, line 2.

Observation 9

See testimony of all UCRT members and various notes presented in exhibits from each.
See Neadles testimony and there is no evidence of any meaningful or complete notes of any kind.

Observation 10

See Officer, Aug. 22, Page 21700, line 21 thru Page 21702, line 15.
See Cox, Aug 22, Page 22248, line 8 thru Page 22257, line 22.
See Waddick, Aug 23, Page 2205, line 19 thru Page 22027, line 14. & Page 22076, line 1 thru Page 22090, line 3, inclusive.

Observation 11

See General Comments, Command Structure Above.

Observation 12

See Sorel, Oct. 1, Page 98, line 19 thru line 23; Page 218, line 7, thru Page 222, line 6 inclusive.

Observation 13

See Jones, Sept. 23; basically, his entire testimony showed a lack of knowledge of what was happening on site, and even as to what his actual "authority" was.

Observation 14

See Sorel, Oct. 1st, Page 14, line 6 thru Page 15, line 11.

Observation 15

See testimony of almost any TF3 member that was deployed to Elliot Lake.

Appendix "B"
Fire Safety Plan
The Ontario Fire Code

2.8.2.1 (1)
A fire safety plan shall include
a) **the emergency procedures to be used in case of fire, including**
i) sounding the fire alarm,
(ii) notifying the fire department,
(iii) **instructing occupants on procedures to be followed when the fire alarm sounds,**
(iv) **evacuating occupants, including special provisions for persons requiring assistance,**
(v) the procedures for use of elevators, and
(vi) confining, controlling and extinguishing the fire,
b) the appointment and organization of designated supervisory staff to carry out fire safety duties,
c) the training of supervisory staff and instruction of other occupants in their responsibilities for fire safety,
d) documents, including diagrams, showing the type, location and operation of the building fire emergency systems.
e) the holding of fire drills,
f) the control of fire hazards in the building,
g) the maintenance of building facilities provided for the safety of occupants, and
h) the provision of alternative measures for the safety of occupants during any shutdown of fire protection equipment and systems or part thereof.

2.8.2.1 (3)
The fire safety plan shall be kept in the building in an approved location.

2.8.2.9 (4}
The fire safety plan shall be reviewed as often as necessary, but at intervals not greater than 12 months, to ensure that it takes account of changes in the use and other characteristics of the building

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All Members of SAGE
The Citizens of Elliot Lake who encouraged us, supported us, and inputted