Office of the OMBUDSMAN

Report

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Ombudsman Report

An Investigation into the Provision of Emergency Human Services following the 200 Wellesley Street Fire

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TORONTO

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1.0 Executive Summary

1. On September 24, 2010, a fire broke out on the 24th floor of 200 Wellesley Street, Canada's largest social housing building. Firefighters took eight hours to extinguish the six-alarm blaze. More than 1,700 residents had to be evacuated. Many were vulnerable with no one to stay with.

2. The City's Emergency Planning Unit (EPU), which is part of the Shelter, Support, Housing and Administration Division (SSHA), was responsible for providing emergency human services during the aftermath of the fire. EPU set up reception centres, provided food, shelter and temporary housing for many tenants.

3. The Ombudsman initiated an investigation after receiving complaints about the City's response and hearing concerns about whether the City's policies and procedures were appropriate given the vulnerable nature of many in this social housing population. She issued a notice of investigation to the City Manager on March 28, 2011.

4. The Ombudsman concluded that there was significant confusion in the days and weeks following the fire. The confusion was caused by a lack of communication at all levels. Tenants and some City staff responders reported receiving little information, particularly in the early days. Information was not shared consistently among City staff on the ground. Some decisions were made without the knowledge of the Incident Commander who was in charge. There was little communication between the Wellesley operations centre and the second reception centre on McCaul Street.

5. The Ombudsman found that there was poor communication at shift change, compounded by erratic and insufficient record keeping.

6. Many of the City staff responders did not have the necessary training, which led to wasted and misplaced efforts.

7. The investigation found the plans and external resources that EPU has for dealing with vulnerable residents were inadequate. While EPU does not have charge of external partner agencies, the Ombudsman expressed concerns about their capacity to adequately address the myriad of special needs present among these evacuees.

8. There were difficulties mobilizing community agencies to partner with the City in assisting residents. Once residents were moved out

of temporary care centres to Long Term Care Homes or other locations, EPU staff were unsure who was responsible for them.

9. The Ombudsman found the method of assigning hotels slow and ineffective. Changes were made to the existing procedure, without consulting the Incident Commander. Some tenants were obliged to accept rooms far from the neighbourhood, exacerbating their sense of dislocation and stress.

10. Fear, misinformation and exaggeration occurred when the issue of bedbugs was raised. Rumours abounded about requiring residents to bathe, change clothes and abandon their belongings before being allowed to go to hotels. None of this was true.

11. The evidence showed that, for the first three weeks, the City would only distribute two tokens per day to tenants. This meant residents had to travel from their hotels to the reception centre to collect their daily allotment, using up their tokens just to get to and from the centre. The token and voucher distribution desk was inadequately staffed.

12. When tenants did not reside in the reception centres, they could access food vouchers. They were not always given a choice of food vouchers and many felt the food for which the vouchers were issued did not address residents' dietary restrictions.

13. When the agency normally charged with food services in an emergency was not initially available, a single public servant had to coordinate all aspects of food service for two days at two locations, for hundreds of people, many with dietary restrictions.

14. The City's emergency plan says in-kind donations will not be accepted or will be sent to an external agency. That procedure was not followed. Substantial resources were devoted to this function. Staff were taken away from the core response to set up and run donation centres.

15. The role and authority of the Incident Commander and the hierarchical chain of command was not respected. The lack of clarity regarding the EPU's role resulted in persistent confusion between it and the Toronto Community Housing Corporation.

16. The Vulnerable Populations Protocol referred to by City staff remains in draft 18 months after the Wellesley Street fire. The Ombudsman found this to be unreasonable. She concluded that the continuing absence of a protocol and clear directives is

unacceptable, particularly in light of the vulnerable residents in question.

17. Duplication and contradictions translated into unnecessary costs. The absence of documented procedures contributed to the communication breakdowns.

18. There were inconsistent responses to elected officials. At the time, there was no protocol describing their role or defining their engagement with public servants during emergencies.

19. The Ombudsman found a lack of clarity about OEM's role on site at major incidents such as 200 Wellesley. She found it troubling that OEM refused the first request of EPU, only to offer help later, when the urgency had abated.

20. There was initial delay in SSHA's response to the Ombudsman's requests. She looked at whether the delay was reasonable. The investigation found SSHA failed to keep the Ombudsman's office informed in a timely manner.

21. The Ombudsman made 15 recommendations. They included the need for:

- a Vulnerable Populations Protocol
- clarification and documentation about the roles of the Office of Emergency Management and the Emergency Planning Unit
- the City to confirm that the Incident Commander, or an alternate, is the single decision-making authority
- a senior manager to liaise with elected officials
- a protocol for communications with staff responders from different divisions.
- a single system of record keeping
- a policies and procedures manual and information training for staff responders
- partnerships to be set-up with external agencies to handle in-kind donations
- evacuees to receive timely and accurate information.

22. The Ombudsman also recommended that debriefings be conducted in a more coordinated manner and that the City Manager ensure senior public servants respond in a timely way to Ombudsman requests.

2.0 List of Acronyms

519: The 519 Community Centre

CCAC: Community Care Access Centre

EHS: Emergency Human Services

EMS: Emergency Medical Services

EPU: Emergency Planning Unit

EOC: The Emergency Operations Centre

FLOP: Finance, Logistics, Operations and Planning

IMS: Incident Management System

LTCHS: Long Term Care Homes and Services

McCaul: McCaul Exam Centre, University of Toronto

OEM: The Office of Emergency Management

OSF: Operational Support Function

PFR: Parks, Forestry and Recreation

SSHA: Shelter, Support, Housing and Administration

TCHC: Toronto Community Housing Corporation

TDSB: Toronto District School Board

TESS: Toronto Employment and Social Services

TTC: Toronto Transit Commission

3.0 Introduction

23. On September 24, 2010 a fire broke out on the 24th floor of Canada's largest social housing building. It took Toronto Fire Services approximately eight hours and five million gallons of water to extinguish the six-alarm blaze. There was extensive fire and water damage in the north tower of the building, where the fire occurred.

24. The fire resulted in the evacuation of 1,200 registered tenants and approximately 500 to 700 additional unregistered residents. It required the provision of emergency human services (EHS), organized through the Emergency Planning Unit (EPU) within the Shelter, Support and Housing Administration (SSHA) Division.

25. I received complaints about the City's response which raised concerns about whether EPU's processes were appropriate given the social housing population.

4.0 The Investigation

26. My office made preliminary enquiries with City staff about the response and EPU processes in general.

27. I initiated an investigation on my own motion into the City's EHS response, issuing a notice of investigation to the City Manager on March 28, 2011.

28. My office reviewed documents about the response, related policy, procedures and applicable legislation. We interviewed over forty witnesses including a range of public servants, elected representatives, non-City staff response partners and 200 Wellesley tenants.

29. The investigation considered the following issues:

    i. EPU emergency response processes;
    ii. Whether appropriate policy and procedures exist to deal with vulnerable populations;
    iii. Whether the delay by SSHA in responding to my office's requests was reasonable.

5.0 The Context

5.1 200 Wellesley and St. Jamestown

30. 200 Wellesley Street is a TCHC building located in St. Jamestown[1], one of the most densely populated communities in Canada[2].

31. 48% of households are considered low-income[3] compared to Toronto's overall rate of 18%. Virtually all of residents rent their homes (99%)[4].

32. Approximately 64% of the residents are immigrants, 26% of whom have arrived within the last five years. 42% of residents speak languages other than English or French in their homes. The largest proportion of racialized persons are South Asian, Filipino, Black, Chinese and Korean[5].

33. TCHC reports that their buildings are home to more people with serious mental illnesses than any other entity in Ontario, including mental health care facilities.[6]

34. St. Jamestown has 18 high-rise apartment buildings. Of these, 200 Wellesley is the largest, with two connected towers on the north and south. There are 29 floors in each and 712 apartment units.

5.2 The City Emergency Management Framework

5.2.1 The Office of Emergency Management

35. The Office of Emergency Management (OEM) is the coordinating agency responsible for emergency plans and preparedness for the City. It reports to the Deputy City Manager for Cluster B[7], while EPU

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[1] Statistics Canada defines St. Jamestown as the area bounded by Wellesley St. to the south, Sherbourne St. to the west, Bloor St. E. to the north and Parliament St. to the east. 2006 data. *Census Tract Profile:* Tract 0065.00 available online at www12.statcan.gc.ca/censusrecensement/2006/dp-pd/prof/92-597/P3.cfm?Lang=E&CTCODE=1076&CACODE=535&PRCODE=35&PC=M4X1G3

[2] The Wellesley Institute states that the population density is 64,636 people / km^2 compared with Toronto's overall density of 866 people/ km^2. www.wellesleyinstitute.com/wp-content/uploads/2011/11/Voices-of-Multicultural-Youth-Wellesley-Institute.pdf

[3] *Ibid*, at p. 4.

[4] Statistics Canada, *supra* note 1.

[5] *Ibid.*

[6] Connelly, J. and Roberts, A. *Toronto Community Housing's Mental Health Framework*, Nov 5, 2009, p. 4. Available at http://www.torontohousing.ca/webfm_send/6515/1

[7] The administrative structure of the City of Toronto has at its head, the City Manager, and divides the administration into three clusters: Citizen Services Cluster A, Citizen Services Cluster B and the Internal Services Cluster C. Each Cluster is headed by a Deputy City Manager.

reports to the General Manager of SSHA, who in turn reports to the Deputy City Manager for Cluster A.

36. OEM would typically be activated for larger emergencies and planned events such as cultural festivals and gatherings where protests are anticipated, such as the G20.

37. When activated, OEM's Emergency Operations Centre (EOC) becomes the off-site base for the response, providing high-level coordination and ensuring the business continuity of City operations.

38. The Director of OEM says that about 95% of emergency responses can be managed on site by the divisional responders without their involvement.

39. She described OEM's role as strategic and EPU's as tactical.

5.2.2 The Emergency Planning Unit

40. In the event of a disaster or public emergency, EPU is responsible for providing emergency human services[8] to the public.

41. If the emergency is a "neighbourhood-level emergency", one smaller than a major public emergency but which results in displacement requiring emergency supports, EPU will lead the emergency human services response. Generally, these will be in the case of a single building experiencing a fire, loss of power or a gas leak. EPU may also be called in to assist in other emergencies, such as a pandemic or a train derailment.

42. In the case of a major emergency, (one that would “likely strain the City’s capabilities and require a broad range of assistance”)[9] OEM, as the City’s large-scale emergency planning body, takes the lead in a strategic and coordinating function, and EPU provides emergency human services.

43. EPU provides for needs relating to shelter, food, clothing, the documentation of evacuees, and other services, such as child-care or transportation. It may include the establishment and management of a reception centre, but for shorter emergencies, EPU will provide assistance through a mobile unit. In 2010, EPU responded to 37 situations ranging from gas leaks to a request from the Province to

[8] Referred to in some City documentation as "mass care."
[9] Caring for Toronto Residents Displaced as a Result of Neighbourhood Emergencies, SSHA Staff Report March 30, 2010. Adopted by Council May 2010.

assist with Haitian Canadians returning home after the 2010 earthquake.

44. EPU responds to the urgent needs of people. Immediate medical care and long term housing are not EPU's responsibility. EPU works with paramedics, police, fire and OEM. Throughout, EPU remains the lead on the emergency *human* services aspect of the response.

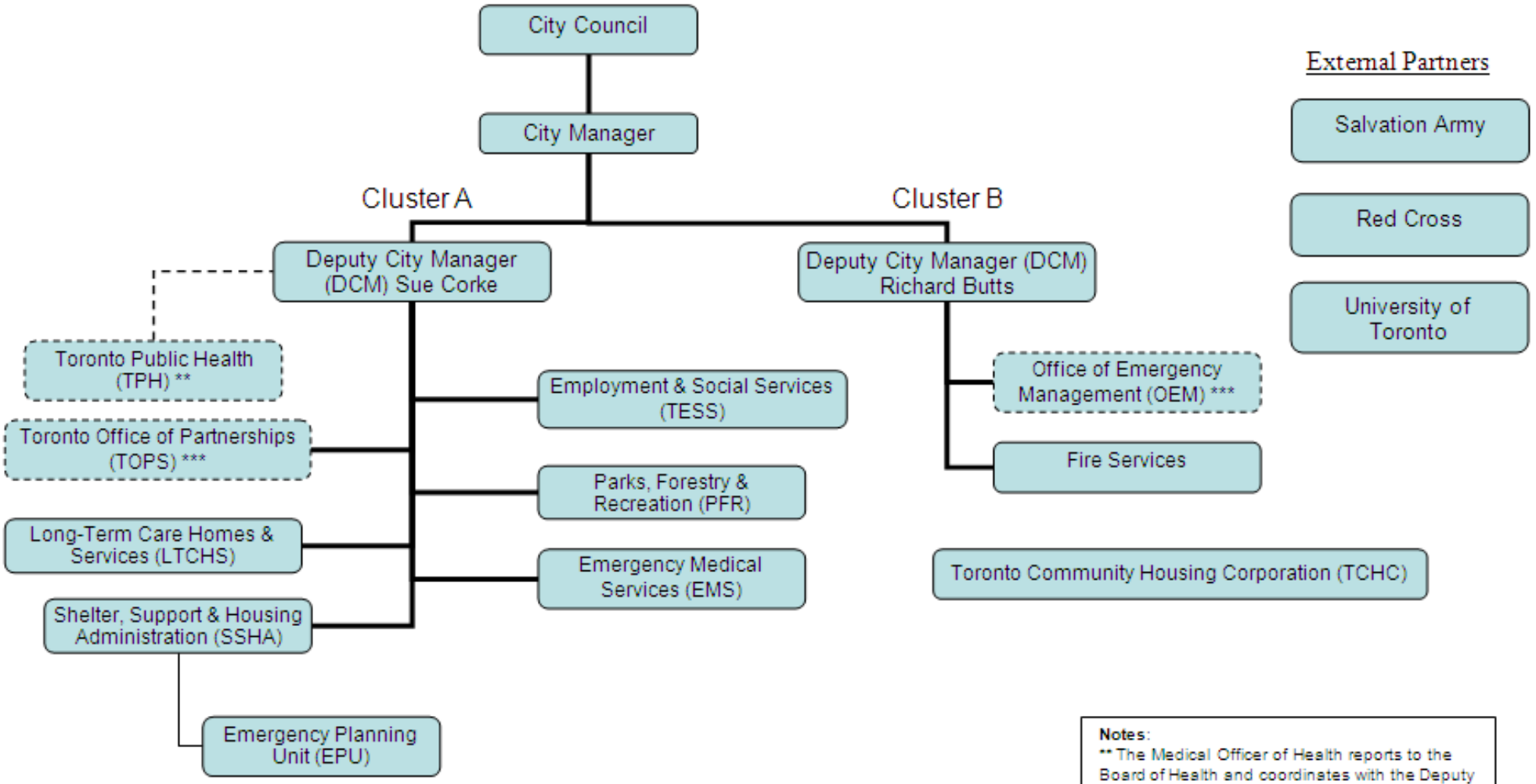
45. EPU's complement is six, with four positions filled at the time of the fire. It has the capacity to mobilize divisional responders[10] from 12 divisions that will release up to 200 employees to work under EPU direction. It relies most heavily on Toronto Employment and Social Services (TESS), but also on Children's Services, SSHA and the public libraries.

46. The response to the Wellesley fire involved numerous City and external partners. The chart that follows provides information about the key partners involved.

[10] The term "divisional responders" is used throughout this report to differentiate the staff within City divisions such as Toronto Employment and Social Services (TESS) or Shelter, Support, Housing and Administration (SSHA) from City staff that are outside the divisional structure, such as those at the Toronto Community Housing Corporation (TCHC).

Partners involved in the 200 Wellesley Response

Organizational Chart as of September 24, 2010



This is not a comprehensive list, but reflects the partners mentioned in this report.

Notes:
** The Medical Officer of Health reports to the Board of Health and coordinates with the Deputy City Manager on administrative matters

*** Within the Deputy City Manager's office

5.2.3 Authority

47. The provincial *Emergency Management and Civil Protection Act,* RSO 1990, c E.9 (the Act) requires every municipality to have an emergency management program that Council shall adopt. It gives requirements of the program such as having a plan, training and exercises, public education and identification of the hazards and risks to public safety in that municipality.

48. The City of Toronto Municipal Code, Chapter 59 sets out structural and functional requirements for the City's emergency management. It dictates the membership of four legislated committees.[11]

49. Chapter 59 sets requirements for the frequency of meetings and quorum as well as how and when an emergency can be declared. It also sets out the delegation of authority to the Mayor in emergencies.

50. These two pieces of legislation give SSHA the responsibility for providing emergency human services to the public in the event of an emergency.

5.2.4 The City of Toronto Emergency Plan

51. The City of Toronto Emergency Plan (Plan) sets out the methodology by which the City can mobilize in the event of an emergency. It is administered by OEM.

52. OEM is also responsible for ensuring that there is ongoing training, testing and review of the Plan. It must ensure that there are adequate staffing levels, equipment and expertise.

53. The Plan goes into further detail about the committees required by the Act, and the responsibility of each committee.

54. It outlines risk assessment needs and the constant feedback process of preparing for emergencies before, during and after actual emergencies occur. It sets out the general process for emergency response and activation.

55. The Plan also sets out a “heat chart" of emergency levels from normal to level three. This is to assist in identifying when OEM will

[11] The Toronto Emergency Management Program Committee (TEMPC); the Control Group; the Working Group; and the Joint Operations Team. Regulation 380/04, of the *Act*, Part II Municipal Standards also sets out the requirement for TEMPC.

be activated and the level of support required. The chart has been revised since the Wellesley fire.

56. The Plan introduces 16 Operational Support Functions (OSF), ranging from animal care to debris management. The details of these functions are contained in separate documents used to support the Plan.

5.2.5 The "Mass Care" Operational Support Function

57. The Mass Care OSF states that it is to "meet the urgent needs of people and their pets once they are out of immediate danger of a disaster or emergency situation either declared or non-declared."

58. This sets out SSHA's responsibility for providing emergency human services and EPU's responsibility for coordination. EPU can respond whether there is a declared emergency or not.

5.2.6 The Emergency Human Services Policy

59. In May 2010, City Council approved the SSHA report entitled "Caring for Toronto Residents Displaced as a Result of Neighbourhood Emergencies: Review of Recent Events and Proposed Strategies."

60. This report is referred to by SSHA as the "EHS policy."

61. In addition to confirming the roles of divisional partners, the policy established a $500,000 non-program account to be made available during an emergency for EHS expenses.

62. The policy states that ordinarily, there is a two week limit on EHS support, but that it can be extended if the evacuees are "low-income." An operational definition of low-income eligibility criteria has not yet been developed.

63. The fire at 200 Wellesley was the first instance in which SSHA was able to test the new EHS policy.

5.2.7 Incident Management System

64. An emergency response will always establish an Incident Management System (IMS). IMS is a standardized response system which aims to establish a simple, unified order of command for the multiple response partners coming together to work as a team.

65. The Plan describes IMS as a “recommended best practice to be used in the event of a major emergency and the roles and responsibilities that fall within this response system.”

66. The Incident Commander is at the top of the response hierarchy and ensures a unified command structure. This person will assign the four leads within Finance and Administration, Logistics, Operations and Planning (FLOP). They in turn will have other staff reporting to them. Responders report only to their direct lead.

67. The system is hierarchical and employs regular check-in meetings, called “business cycle meetings” where leads come together at set times throughout the response, to provide updates and plan. This reduces cases of competing direction and "freelancing" that can otherwise occur.

6.0 The Facts

6.1 The Story of the 200 Wellesley Response

68. On Friday, September 24, 2010, at approximately 5:00 p.m. a fire started on the 24th floor in the North Tower. Fire and emergency responders attended and tenants were evacuated.

69. EPU Coordinator A was on call that night and received a page from the police public safety unit at 6:17 p.m., asking EPU to attend. EPU Coordinator A went to the Wellesley Community Centre, where evacuees had begun to congregate. Toronto Community Housing Corporation (TCHC) and Parks, Forestry and Recreation (PFR) staff were there, with TCHC staff beginning a registration process.

70. Coordinator A took charge of the emergency human services at the Wellesley Community Centre. Upstairs, the Coordinator set up the operations centre, the organizational hub for EPU’s response. Downstairs, Coordinator A established a reception centre where tenants could eat, sleep and receive other supports and information.

71. Coordinator A called divisional responders to attend on site. Coordinator A asked the Red Cross, who began to carry out the registration process, using the required provincial forms. Red Cross also provided cots, pillows and blankets.

72. Coordinator A assigned rooms for different purposes, such as a space for pets and an area in the gym for cots. EPU Coordinator B and the EPU Manager were also present.

73. TCHC requested that a medical area be set up, and Toronto Emergency Medical Services (EMS) arranged for a doctor from its base hospital to attend that night. Over the next few days, volunteer physicians from the University of Toronto staffed the centre.

74. Local and provincial politicians attended the reception centre, including mayoral and councillor candidates.[12]

75. When it became evident that tenants would not be returning home that night, most tenants made arrangements to stay with family and friends. 128 households had nowhere to go.

76. The Wellesley Community Centre did not have capacity for all the evacuees. Coordinator A mobilized a second reception centre to handle the overflow volume of evacuees. The University of Toronto Coordinator of Emergency Planning, agreed to use the McCaul Exam Centre (McCaul) as a second reception centre. Divisional responders were sent to the site to prepare it for evacuees, who subsequently arrived by bus. The University of Toronto Coordinator of Emergency Planning estimates 150 evacuees stayed there at its peak, over the four day period it was open.

77. EPU had staff from SSHA locate large blocks of hotel rooms and TCHC determined which tenants should be placed where, and in what order. Due to a major conference and a marathon, there was limited hotel availability in the downtown core. A few tenants were moved to hotels on Sunday September 26, but large groups of tenants did not start being moved to hotels until the Monday (September 27) following the fire.

78. Some very vulnerable tenants were moved to City long-term care homes the night of the fire. TCHC also sent approximately 20 tenants to stay in vacant rooms at St. Michael's hospital.

79. Although the Salvation Army generally partners with the City to provide food, they did not have capacity to do so until September 27. From Friday to Monday, food was ordered from restaurants.

80. Both elected representatives and TCHC helped by ordering food on the Friday night and Saturday morning. At that point, a manager

[12] The fire occurred one month before the 2010 municipal election, and an election campaign was underway at the time of the fire.

from Long Term Care Homes and Services (LTCHS), who sits on EPU's "food committee," took responsibility for procuring and coordinating the serving of food. She arranged for meals from Saturday lunch through Monday, when she transferred that responsibility to the Salvation Army.

81. Public Health attended the Wellesley and McCaul reception centres. They checked for food safety and other health conditions such as sanitation and sleeping arrangements.

82. Donations of money, clothes and furniture began coming in, for which donation centres were set up.

83. The City distributed TTC tokens and food vouchers to residents. Assistance was provided with obtaining mail, social assistance, and psycho-social support. The EPU chartered TTC buses to transport evacuees.

84. McCaul was closed on Tuesday, September 28. Tenants who were there either moved back home, returned to the Wellesley Reception Centre, or were placed in hotels.

85. By Saturday, October 2, the first tenants in the South Tower began returning home.

86. Some tenants who could not return home, did not want to stay in hotels, and refused to leave the reception centre. On October 6, the City ended its shelter role and stopped providing food on site. They continued to staff the reception centre during the day, but it closed at 9 p.m.

87. In November, while TCHC continued to transfer tenants home, EPU provided support through hotel shelter, and reception centre services such as providing TTC tokens, food vouchers, information and donation cheques.

88. The reception centre was formally closed on February 7, 2011. EPU staff returned to regular duties four months after the fire.

89. EPU continued to authorize tokens and vouchers, distributed by TCHC until August 17, 2011.

6.2 Communication

6.2.1 Residents' Experience

90. Residents reported communication challenges, although the specifics differed widely.

91. While residents complained about a lack of information during the first days following the fire, the City made efforts to provide updates through bulletins, website, media releases, tenant meetings and a tenant hotline.

92. One resident, Mr. A, explained that although he was able to stay with family in the first weeks after the fire, he would return to the Wellesley Community Centre every day “trying to figure out what was going on.” He cannot read and was unsure of what the signage said. He relied on neighbours to provide him with instructions and updates. He described his experience as “walking around like a zombie,” showing up early each morning and trying to discern what was happening.

93. Another resident, Ms. B, complained about the lack of information. She works evenings and attends college by day. On the night of the fire, she sat outside the Wellesley Community Centre and received no information about what she should do. Around 2 a.m., she gave up and went to a family member’s apartment.

94. The next morning, Ms. B attended Wellesley Community Centre and attempted to obtain medical care. She said that the staff member was “very nice,” but had no information for her. She added that there was a long line-up and she was told the doctor would be there some time that day, but only for a few hours. Ms. B ultimately attended a pharmacy to obtain her medication.

95. She said the communication of information was poor. On Saturday there was one announcement but she could not hear it, due to the noise. There were information desks, but she said no one had information to provide. Ms. B explained that sometimes, the response team announced there would be an update at a particular time, but she could not stay on site due to her work and school commitments. She said she relied on a neighbour for information.

96. Other residents my investigator interviewed stated that the “ground-level” staff with whom they interacted, although courteous, did not seem to have information about what was happening. Tenant Mr. C explained that no one with answers was on the first floor, and

residents were not given access to staff on the second floor of the Wellesley Community Centre.

97. Tenant Mr. D had a similar experience. He reported that he slept on the pavement outside the Wellesley Community Centre, in spite of a physical disability. He wanted to speak with the group he called "the God bunch" on the second floor, but the police officer on site explained that if he went upstairs, they would have to arrest him. Mr. D asked the police what he would need to do to be placed in jail for a few days, so that he could have a bed and food, which he states was more than he had at the reception centre.

98. Residents complained that they received different information from different City employees. Ms. B was told staff would call her on her cell phone when they had a hotel for her, while another staff said she had to be present at the reception centre or a hotel room would not be assigned.

99. Other residents mentioned that they would be told one day to move back home, only to be told later that they were not moving back.

100. Some said that they were told they would be given access to their apartment belongings at a particular time, to then be told by other staff that this was not the case.

6.2.2 Communication with the McCaul Reception Centre

101. Divisional and TCHC responders reported communication problems between the operations centre at Wellesley Community Centre and McCaul.

102. Open for four days, no EPU staff attended McCaul at any point.

103. McCaul was staffed mainly by TESS and TCHC staff. The reception centre manager on duty was to be in regular contact with EPU operations centre. Staff reported this did not always happen. TESS Manager A, worked at McCaul and stated:

> My overall impression at the McCaul site was that there was difficulty with communication to the Wellesley site. It was hard with no immediate responses from them, whether by phone or email. This was because things were always so chaotic over there [at Wellesley].

104. The former CAO of TCHC, explained that the communications logistics to McCaul were delayed, because it was off site. This meant that communications were not getting through consistently. TCHC responded by sending a team to give an in-person update to residents at McCaul.

105. Coordinator A, on call the night of the fire, had arranged for divisional staffing of McCaul, but did not personally attend. Coordinator A subsequently understood that TESS responders on site experienced a lack of support and felt "out of the loop." Coordinator A said that some staff at McCaul received updates from residents before they received them from EPU.

106. In hindsight, Coordinator A said that EPU should have assigned a dedicated person from the operations centre to communicate with the Wellesley and McCaul reception centre managers.

107. The University of Toronto Coordinator of Emergency Planning said he assumed a de-facto coordinator role, attending meetings at the Wellesley Community Centre, during the time McCaul was open.

108. Coordinator C said that some of the communication problems were improved through the University of Toronto Coordinator of Emergency Planning's work, but noted that he should not have been responsible for assuming this role, but "this time it worked out despite our efforts."

109. The EPU Manager agreed there was poor communication between McCaul and Wellesley.

> I think what happened was there was so much at Wellesley that [EPU coordinators] were pulled down more to that tactical operation stuff at Wellesley, so we lost the connection with McCaul. ...
>
> And I regret that there was a lot of emails that I don't think were completely responded to. After a lot of thinking about that, had we set up an operation centre off site to support both sites that would have helped a lot.

6.2.3 Communications and Record Keeping

110. There were reports of communication problems within the Wellesley Community Centre as well. The former CEO of TCHC, noted that the structure of EPU was unclear to her and after the

operations centre was set up, they did not communicate what had been set up, such as the dedicated phone line.

111. Coordinator B noted that it is important to brief divisional staff responding to the emergency but that this did not happen. Coordinator B explained that each person was keeping their own log, but that going forward, EPU now has "position logs" so that the person coming on shift can read the updates documented by the individual being relieved.

112. Responders reported a lack of continuity between shifts. Staff coming on shift did not always receive a proper briefing. TESS Manager B explained that it took time to get up to speed, and that even with an oral briefing, she would only get an update on the major events. She developed a practice of reviewing the log books, but does not know if others did.

113. EPU staff commented on the difficulty of communications, largely due to having TCHC involved. Coordinator A noted that decisions were being made "above [the EPU Manager's] head" and were not communicated back to EPU. This was particularly evident with respect to the donations centre and the housing priority list.

114. The Community Recreation Supervisor explained that information did not make its way to the PFR staff, and that they were not part of decision making, although the Wellesley Community Centre and the PFR staff working the Community Centre were his responsibility.

115. The Community Recreation Supervisor believed it was his decision to keep the Wellesley Community Centre open the night of the fire, contrary to EPU's understanding that this had already been authorized following a conversation with a director in PFR. My investigator asked if he ultimately received a request to use the Wellesley Community Centre. He said that nothing had ever reached him, although he acknowledged it may have gone to more senior PFR.

116. Communication difficulties within EPU were also reported. Three days into the response, EPU established a devoted e-mail account which could be accessed by all EPU staff. Coordinator A reported not being told about the e-mail account and learning about it from the reception manager on shift. The reception centre manager explained all key information had been on the special emergency e-mail account. Coordinator A said that this was embarrassing as

EPU coordinators were supposed to be the ones with access to information that would then be shared with divisional responders.

117. A similar problem occurred when Coordinator A was taken off the schedule to set up a donations centre and was not included on EPU communications for that period of time. From the donation centre on Jarvis Street, there was no access to the e-mail account. Although Coordinator A carried a smart-phone, the information was not conveyed. When Coordinator A returned to work as lead in the operations centre, it took time to get up to speed.

118. The EPU Manager explained that her communications were only to "whoever was there at the time to get things done." She recognized a communications problem and also noted “we should have given our support divisions more information."

119. She suggested that in future she would "be a lot stronger about central communication" and ensure that all information is coming through the central e-mail account, but noted that in the beginning of an emergency response, there will always be some "communication glitches."

120. My investigator was also told about communication challenges within the EPU due to personality conflicts. Staff reported that during the response, one of the three EPU coordinators refused to speak to another colleague and spoke disparagingly about that person to others. Staff said this may have affected the transfer of information between shifts, and did not help the response. There was agreement that EPU got the job done, but some members of the team thought the personality conflict prevented them from doing an even better job.

121. The EPU Manager is aware of these issues and is addressing them. Staff have reported that the problem has improved somewhat since the Wellesley response.

122. While the Wellesley operations centre used technology to communicate and keep records, witnesses had concerns about the paper-based record-keeping at the Wellesley reception centre.

123. Staff crossed names off a list, or pulled tenant registration forms out of a banker's box and made notes on them. All relevant information had to be written on the provincial forms.

124. Some logs were kept regarding important incidents or decisions. Handwriting was difficult to read. Staff in senior positions reportedly kept their own handwritten notes in personal notebooks.

125. EPU has checklists for each responder position's responsibitilies. These contain a description of that particular role and a checklist of tasks to be completed while on shift. At the Wellesley response, these checklists were either not used, or were used but not returned, as they did not form part of the records.

126. A hostel services manager from SSHA, said that employees on one shift would start a task, such as making a list of tenants for some purpose, and expect it to be completed on the next shift. He said employees would come back three days later to their next shift and find the task outstanding.

127. The EPU Manager stated she would like assistance from a business analyst to go through EPU practices to formalize them.

128. She noted that her team has been looking for ways to improve the record-keeping. She explained that they have looked at software programs, with the intent of adapting them for EPU needs.

129. The EPU Manager said that there is no timeline for computerizing the response system, but that one of her staff was working on prioritizing tasks and setting timelines.

6.3 Accommodating Vulnerable People

130. Witnesses commented at length on residents' vulnerabilities. EPU staff said they were able to adequately deal with them, and had processes in place to do so. Coordinator C said that EPU "brings the voice of the displaced people" to a response, and that their strength was in working with this group.

131. Some divisional responders, who were not part of EPU, did not share this view.

132. The police inspector on site the night of the fire stated that “the city staff were not prepared for the level of special needs in this building" and noted that he himself had "never experienced so many clearly needy people with nowhere to go." He compared the response to the 2008 Sunrise Propane explosion, and noted that in that instance, most residents had insurance and could stay with family or friends. He believed the City was not prepared for the scope of the 200 Wellesley emergency.

6.3.1 The Vulnerable Populations Protocol

133. EPU is a member of the Vulnerable Populations Working Group along with representatives from Police Services, EMS, Public Health, the Toronto Centre Community Care Access Centre (CCAC), Toronto Central Local Health Integration Network and others such as hospitals.

134. The EPU Manager explained that since the 200 Wellesley fire, the group has refined their terms of reference, which are currently in draft form. According to the draft, the group's role is, "to enhance health and psycho-social supportive care response during declared and non-declared emergencies where residents are evacuated from their homes."

135. The SSHA debriefing report (paragraph 328), states that EPU activated CCAC "as per the Vulnerable Populations Protocol." When my investigator asked for a copy, she was given an undated three-page document, titled "DRAFT Position Paper City of Toronto Emergency Services With Shelter, Support Housing Administration AND Community Care Access Centre."

136. EPU informed my office that it was written in 2009.

137. The document has an incomplete flow chart, with comments such as "[How] does the process end?" It notes that in response to the incidents of the "past year" (2008), including the Sunrise Propane explosion, the Secord Fire and the Queen Street fire, there is a need to improve support to vulnerable populations.

138. The draft document briefly sets out a protocol in which the SSHA contacts the CCAC on-call who provides information on the location and the risks associated with the vulnerable clients in the building (e.g. Ms. S uses an oxygen tank). It notes CCAC staff may also be asked to attend at the response.

139. Since the fire, the protocol has not been finalized, although the SSHA General Manager provided three documents to my office on March 24, 2012.

140. Two of the documents were new.

141. A two page "note" clarifies responsibilities of EMS and CCAC, with some expansion of their roles and introduces a defined role for Public Health in providing psychological first aid, which was not

referenced in the 2009 protocol. It says that more health service providers may be added to the protocol.

142. A second two-page chart sets out similar information with details on how each support is to be activated.

6.3.2 EPU Processes for People who are Vulnerable

143. EPU staff explained that the Vulnerable Populations Working Group has put processes in place to deal with vulnerable populations. This involves activating the City's LTCHS as well as CCAC, the provincial agency coordinating personal care.

144. In the case of a larger scale or more significant emergency, EPU may make a request for CCAC to attend on site. CCAC must authorize a move to the City's long term care homes.

145. Witnesses reported problems with the processes in place for vulnerable evacuees at 200 Wellesley.

146. The EPU Manager stated that the CCAC person on-call was "new" and not aware of the process by which CCAC would be activated to assist the EPU response. Coordinator A, who called the CCAC on the night of the fire to obtain assistance, explained that CCAC provided a list of about 60 "frail seniors" at 200 Wellesley. It did not attend on site until a day later.

147. The former LTCHS General Manager, reported that this was the first time her division had been activated, pursuant to the voluntary agreement they had established within the Vulnerable Populations Working Group. She clarified that only a few evacuees were actually admitted to LTCHS homes, and that only CCAC could admit individuals into LTCHS homes.

148. The former LTCHS General Manager explained that the protocol for activation requires EPU to contact her by telephone. Instead, she was sent an e-mail at 12:16 a.m. on September 25, which she did not pick-up at that point. She then received a call from LTCHS staff, alerting her to the situation. She subsequently responded to the EPU e-mail.

149. The former LTCHS General Manager's e-mails from the day after the fire state that she wanted to re-visit the process for LTCH activation. She informed my office that there was a need to clarify the decision-making processes and to have defined roles assigned.

150. The EPU Manager said that LTCHS representatives attended meetings and conducted exercises with EPU, discussing their role. She said it took "a lot of convincing" to obtain LTCHS support for the Wellesley response.

6.3.4 Need for Medical Care

151. There were reports from TCHC and tenant witnesses that EPU did not meet the needs of vulnerable tenants, and that when they did, it was only due to the intervention of others such as TCHC or the Councillor's office.

152. If residents are displaced without access to medication upon which they rely, EPU practice is to have them contact their pharmacy or physician. The EPU Manager stated:

> As part of our response, when people don't have their medication, what we ordinarily do is ask them to call the pharmacy, see if they can get their personal medication, call their doctor, if it's critical, but we don't know what's critical. Some medications we understand you don't need right away. We consulted with Public Health and they agreed that our policy should be that people should be calling their doctor or pharmacy if it's critical medication they will know it, you can send them to hospital. That's the approach we took with [TCHC]. [TCHC] said we're not comfortable with that and [the EMS chief] said do you want me to bring a doctor? And we originally said no, but [TCHC] said yes, can you please bring a doctor.

153. The Deputy Fire Chief's notes taken the night of the fire confirmed it was TCHC's request that led to setting up a medical clinic. He asked EMS to coordinate with their field doctor.

154. The EMS field doctor attended that night and called in two other doctors. They evaluated and treated 56 patients and wrote approximately 250 prescriptions between 10:45 p.m. on September 24 and 6:00 a.m. on September 25th. TCHC staff ran the prescriptions to 24-hour pharmacies and delivered them to evacuees.

155. The EMS field doctor said most people were experiencing anxiety in some part related to chronic medical conditions that they were

normally able to keep under control.

> There were residents with diabetes, mental health issues. I'm not sure which was most critical – It's true that diabetics can quickly decline without insulin, but with severe mental health issues it can mean people may quickly not be able to care for themselves…
>
> [200 Wellesley] alerted me to huge issue of mental health issues in the community. People need access to care in order to stay well. Gaps should be avoided – some people are hanging on by a thread. It may be a bit dramatic, but I thought some persons should be followed by a family physician and social worker.

156. The EMS field doctor explained the benefit of having residents cared for on site. It prevented a backlog of patients to area hospital emergency rooms. He stated that following this emergency, EMS and its partners have developed a "wellness centre" model for future responses. The EPU Manager also discussed this solution, with which her team has cooperated.

157. The EMS field doctor expressed concern about the continuity of care. After closing the EMS led-clinic the morning after the fire, he tried to contact Public Health, but they explained it was not a public health emergency, so they would not step in. He received an assurance from someone on site that care would continue, but was disappointed to hear that the medical centre was not staffed that morning.

158. A group of volunteer medical residents staffed the medical centre later that day. The EPU Manager felt there was a loss of control and potential liability in having a medical centre on site.

159. The former TCHC Director of the Community Health Unit explained that although it may not have traditionally been SSHA's role to set up a medical centre, medication and health were “a key source of chaos for tenants.” She says that TCHC assumed the role, because it needed to happen.

160. The former CAO of TCHC agreed and said 200 Wellesley was unique in its population and that TCHC had to “constantly impress” this fact on EPU.

6.3.5 Vulnerable Residents' Needs

161. The Councillor's staff and tenant Mr. C both reported a senior with dementia had refused to leave the Wellesley Community Centre. The Councillor's staff found he had urinated in his clothing and was distressed. Mr. C reported that he helped to bathe the man, and the Councillor's staff arranged, through the on-site medical centre, for him to stay at a hospital until he was transferred to a senior's home.

162. Mr. E, a resident with significant health challenges was moved late the night of the fire to a long-term care home. He reported that the only way he was identified as vulnerable was because one of the agency volunteers knew him and told the City Councillor.

163. Mr. E complained about the two LTCHS homes to which he was transferred while displaced. He complained that initially there was a delay in providing food and that only cots were available, despite his special medical needs. He also said he did not receive medical attention until he went into distress and a doctor realized he had been off his required medication for days.

164. The former LTCHS General Manager clarified that the vast majority of tenants housed in LTCHS were there short term, and were not actually admitted. My investigator asked EPU what degree of oversight or follow-up they have once a resident is placed outside the reception centre. EPU did not know.

165. TESS Manager A recalled a shift at McCaul. She was concerned with the number of vulnerable persons there at the time, and contacted EPU operations centre to insist that some of the residents be moved out of the shelter environment. One of these was an elderly woman with mobility issues and an open wound that required daily treatment.

166. She described a man with multiple health conditions requiring medication. She found that he was not well and had been sent to the hospital a number of times and following each visit, he returned to McCaul. Manager A said the resident had been under-medicating himself to stretch his supply so she arranged for more medication. She was shocked by this man's circumstances.

167. The University of Toronto Coordinator of Emergency Planning corroborated Manager A's comments, and said that although he was told that "higher functioning" persons would be brought to

McCaul, he witnessed a lot of vulnerability.

> They were supposed to be bringing higher functioning people to McCaul – though my impression was that they were not fully capable in this state of emergency. I'm sure when not in a state of emergency these people were functioning, maybe not highly functioning, but still enough to be independent. But when they are thrown into an emergency situation as chaotic as this one, then they become much less capable. And this is arguably worse than someone who is known to be incapable because they are harder to treat. I saw vulnerable people, people with physical and mental illnesses…The ambulance had to come two or three times the first night to take people away.

6.4 Appropriateness of Services

168. EPU is responsible for the provision of food, shelter, clothing and transportation for displaced residents. Its processes were complained about in relation to the residents affected.

6.4.1 Hotel Assignments

Standard Protocol

169. EPU called their usual process for assigning hotels a "first-come, first-served" model. They explained the process did have some exceptions. For example, they would take note of residents with children or pets and ensure accommodations were appropriate (e.g., kitchenettes to warm bottles and pet-friendly rooms).

170. EPU staff told my investigator that they would typically scan the reception centre to look for persons with visible disabilities and give them priority in assigning hotel rooms. They acknowledged that this practice had limitations and might miss "invisible" disabilities, but they also hoped for self-disclosure.

171. Residents identified as vulnerable by CCAC may be sent to other facilities such as long term care homes.

172. SSHA staff use the following criteria to select hotels:

1) rooms within an approved price-range;

2) availability for an adequate length of time (to prevent moving from hotel to hotel); and

3) a large block of rooms available, for easier resident communication and transportation.[13]

Variation in Protocol

173. At the 200 Wellesley evacuation, the EPU protocol was modified. The former CEO of TCHC explained that a first-come, first-served protocol did not appropriately accommodate tenants with special needs.

174. The EPU Manager said the SSHA General Manager told her that TCHC would be handling the hotel assignments.

175. SSHA and TCHC leads agreed to an arrangement in which the former would provide a list of suitable hotels with availability. TCHC would create a prioritized list of tenants, taking into consideration specific vulnerabilities.

176. There were many complaints about the length of time it took to place residents. There were also complaints that some of the "call-outs" of hotel assignments occurred in the early morning hours at the reception centre.

177. EPU staff complained that it took TCHC too long to assemble their priority lists. TCHC attributed some of the delay to SSHA, saying that it took a long time for them to advise TCHC of hotel availability.

178. Ms. B was one of numerous witnesses to give evidence that hotel placements were often announced early in the morning. She explained that this required people to wait, sometimes all night. One night, she had an exam the next morning and asked staff to tell her if her name was on the list. She was told it was not, but she was instructed to wait, in case a room became available. She gave up around 2:00 a.m. and slept on the floor at her place of work.

179. EPU staff were very concerned about the late hotel announcements. The EPU Manager explained that normally in responses, EPU will dim the lights in the reception centre by 11:00

[13] Subsequent to this investigation, SSHA informed my staff that they also consider the location of the hotel, with preference to hotels in the immediate vicinity of the evacuation.

p.m. so that evacuees can get to sleep in the cot area. However, due to the delay with hotel assignments, the lights remained on.

180. EPU staff suggested the problem was that TCHC was prioritizing rooms for people who were not on site and not easily found. TCHC released some rooms to tenants present, but not all of them. This resulted in unused hotel rooms that the City was billed for, while tenants slept on cots at the reception centre.

181. EPU staff insisted that if the first-come, first-served model had been used, it would have addressed the needs of the tenants being sheltered in the reception centre first.

182. The ward Councillor expressed concern that the hotel placements did not adequately address the needs of her constituents, citing one example of a mother with three young children placed at a hotel at Lawrence and Yonge. After the Councillor's office interceded, a closer hotel was found.

183. The former CEO of TCHC also noted a push from SSHA to encourage tenants to stay at hotels that were more distant, such as in Scarborough or by the airport.

184. There were reports of confusion when TCHC and EPU staff both worked on tasks. For example, EPU normally files provincial registration forms by tenant apartment number. TCHC took these forms and placed them in order of tenant needs, to assist in prioritizing tenants for hotel placement.

185. However, divisional responders on the next shift found the stack of pink forms and did not know about TCHC's plan. They took the slips back and re-filed them according to apartment number, losing the prioritized order in which TCHC had placed them. The prioritizing was slowed down by this mix-up.

186. The former CEO of TCHC said TCHC staff had begun writing the name of the hotels to which residents were assigned on the provincial forms. EPU staff said this was incorrect and the forms had to be manually re-written by a TCHC employee.

187. The EPU Manager said the SSHA General Manager asked her what she would have done differently with the hotel assignments. She told him the EPU system was to provide rooms for the individuals in front of them, not for a prioritized list of individuals who were not present at the reception centre.

188. Following the Wellesley response, no plan has been developed for future TCHC evacuations.

189. My investigator also asked the SSHA General Manager about a plan. He said:

> If it happened again tonight – absolutely I know what would happen. I would sit down with [the acting CEO of TCHC] and say, OK this is how we did it last time, let's figure out how we do it this time. Because he's got experience, I've got experience. And that's why the [EHS] policy is written the way it is. It's not a how-to manual… you have to manage based on principles. That's what I think we did, to be fair. It would be a hundred times easier because [the acting CEO of TCHC] and I would sit down and go over what happened last time and just go from there. Obviously at some point soon we will have something more formal in place.

6.4.2 Bedbugs and Attitudes

190. One of the most disputed areas of fact in this investigation was the issue of bedbugs.

191. A number of apartments at 200 Wellesley experienced bed-bug infestations prior to the September 24, 2010 fire. Toronto Public Health had made it the site of a bedbug pilot project to reduce infestation rates.

192. On September 27, 2010, SSHA found blocks of hotel rooms for tenants unable to stay with friends and family.

193. At 3:36 p.m. that day, a Public Health inspector e-mailed the EPU Manager and copied the Health Hazards Manager. She states in part:

> As per our conversation today, I wanted to highlight some issues that may present as a public health concern if not addressed…
>
> Bed bugs may present as a problem for both patrons and workers. Any person may bring bed bugs on them if they came from a heavily infested unit prior to the fire. The bed bugs may also be introduced by way of all the donated clothing. Further none of the linens can be laundered to destroy bed bugs that may be in clothing or linens.

194. Earlier that day, the Public Health inspector provided bedbug information to emergency responders entering tenant apartments and said her e-mail was following up on that. The Public Health inspector clarified that only persons in heavily infested units had a risk of carrying bedbugs.

195. She did not identify any concern about tenants moving to hotels.

196. At 4:03 p.m. the EPU Manager sent an e-mail to the General Manager of SSHA saying that the "big issue unfolding now" was bedbugs. She reported that they had been reported by Public Health and that there "may be a [Public Health] concern about process to move people into hotels."

197. At 6:30 p.m., the EPU Manager sent an e-mail to the acting Chief Medical Officer saying:

> We have just been made aware of the fact that 200 Wellesley is one of the pilot projects of [Public Health] due to the severe infestation of bed bugs. [Public Health] told us we need a process before moving tenants because bed bugs were found at the reception centre by [Public Health]. I don't know the process or our ability to do much from here. Can we proceed to move tenants to hotels…

198. The health hazards staff interviewed by my investigator asserted that contrary to the e-mail, they found no bedbugs at either reception centre. All stated that there was no Public Health request for a process regarding bedbugs before moving tenants. They confirmed that their health hazards group would be the only one tasked with such an issue.

199. Public Health staff agreed that they would not have flagged the transfer of 200 Wellesley tenants to hotels as a concern.

200. For a number of hours, EPU waited to obtain Public Health approval before moving residents to hotels. The on-call Public Health Manager wrote back at 8:01 p.m. that residents could be moved. The arrangement going forward was that Public Health would receive a list of the hotels in which tenants were placed, and would follow up on any complaints about bedbugs.

201. The Health Hazards Manager and the EPU Manager did not know if a list was ever sent, although the former knew who to contact if a bedbug complaint arose from a hotel. Only one such complaint

occurred. Public Health investigated and found a mild infestation that was likely already present at the hotel.

202. The former CEO of TCHC and the former General Counsel for TCHC, along with the Councillor and her staff recalled a suggestion circulating that residents should be bathed and put in clean clothing before being moved to a hotel.

203. Both the former CEO of TCHC and the former General Counsel for TCHC recalled separate conversations with Coordinator B, and expressed their disbelief and refusal to engage in such a practice. Coordinator B did not recall the conversations or the suggestion of bathing residents, but said whatever information Coordinator B provided was what had been given by others and only recalls waiting for the final approval from Public Health.

204. Some issues with responders' attitudes in general were reported. Resident Mr. F said that about 80% of the staff were "nice" but some were not good at dealing with upset people, which is what many tenants were at that time. He said that some of the staff treated people like they were "refugees or children."

205. The Councillor's staff said that she observed a mentality of "policing" the residents in the reception centre. She said staff would deny people an extra blanket or pillow, and insist that a hungry adult complaining about small dinner portions was given the same portion as a child, because "everyone should get the same." She said common sense was not used and she had to advocate for many small accommodations.

206. In most cases, it is difficult to identify the City staff involved in residents' complaints. As noted above, there were complaints from TCHC about divisional responders. However, there were also complaints about TCHC staff. Both TESS Manager B and the University of Toronto Coordinator of Emergency Planning mentioned that TCHC staff at McCaul were not as empathetic and compassionate as divisional responders, and that residents appeared to prefer dealing with divisional responders.

207. The majority of City employees interviewed said that there were significant mental health challenges within the population of evacuees. There were some reports of difficulty in dealing with tenants experiencing these challenges.

208. For example, TESS Manager B described a tenant who was inconsolable, thinking her cat had died in the fire. An employee kept

telling her that they had her cat, it was alive and not to worry. She remained upset and at one point police encouraged her to leave the facility temporarily to calm herself. TESS Manager B explained that they ultimately found out that the woman owned two cats and one of them had died. She explained that the resident's feelings were discounted due to perceived mental health issues.

6.4.3 Food

209. Residents reported there was a lack of food that suited their medical or religious dietary needs. Many displaced tenants could not afford to eat at restaurants. They had to rely on the City to provide access to food that met their restrictions.

210. In the first three days of the response, "take-out" food was ordered. Most of the residents my investigator spoke with said that it did not suit their medical needs.

211. Mr. F is a vegetarian with diabetes, and was offered "a lot of fruit" which he said would have "skyrocketed his blood sugar." He would eat only a biscuit and a piece of fruit.

212. Ms. B, Mr. D and Mr. A each said that they could not eat the food on site due to medical restrictions.

213. Mr. D says that he ate only two meals in three days and when he did attempt to eat the roast chicken he was given, it was raw inside.

214. A similar critique came from the local Operating Unit Manager for TCHC. She said the food that arrived was not culturally appropriate. The Operating Unit Manager for TCHC received complaints about the repeat meals of pizza and that it was not sensitive to the Ontario Disability Support Program diets of many of the residents. Asked what was appropriate, she said:

> I know there was a large Somali Muslim population, so by having conversations with different groups, you can figure out how to serve them more. Halal is always a safe bet. Pizza doesn't always cut it. Several days of McDonald's vouchers is not adequate for everyone and their dietary requirements.

215. The EPU Manager said she was disappointed with options at times.

> One day I cringed, breakfast was muffins, cinnamon buns – it was the only thing they could get that day.

216. Ordinarily, the Salvation Army would assist with food, and is best equipped to deal with dietary restrictions. However, due to other commitments, they were unavailable to assist for three days. EPU had a difficult time locating the Emergency Food Committee members[14] to handle food procurement and serving it.

217. My investigator spoke with an LTCHS manager, who is a member of the Emergency Food Committee. She was called Saturday morning following the fire and was the only Food Committee member available to assist.

218. The LTCHS Manager explained she went to great lengths in ordering food from franchisees serving halal. She said there was no opportunity to do more.

219. She arranged for McCaul to bus residents to a University of Toronto cafeteria, and organized three meals a day for the evacuees at Wellesley Community Centre. She made sure that halal and vegetarian options were available at each meal. She said there was no more accommodation possible, given the emergency circumstances.

220. In addition to procuring food for a large group, three times a day, she was also responsible for ensuring it was hygienic and served safely.

221. The LTCHS Manager explained that those with low-salt or cholesterol diets had some options, and that their restrictions would not be life-threatening. She would have more concern if there were people with renal-diets or gluten allergies, but she was not advised of any serious health concerns, and would have been able to guide residents on appropriate choices from the food she had ordered.

222. Three days into the response, the LTCHS Manager handed over the food responsibility to the Salvation Army.

223. She said the Food Committee is attempting to split the food procurement and food serving functions into two roles and that if a situation arose in the future where the Salvation Army could not help, the City ought to have more individuals trained to assist in that role.

[14] The Emergency Food Committee is composed of representatives from Public Health, the Salvation Army, EPU and food services staff from each of Long Term Care Homes and Services, Hostels within SSHA, and Children's Services.

6.4.4 Token / Voucher System

224. Residents not staying at the Wellesley reception centre were permitted two $5.00 vouchers per day at one of four locations (Pizza Pizza, McDonalds, Tim Hortons or Metro grocery). They could also obtain, on request, two TTC tokens per day.

225. The EPU Manager and Coordinator B stated that the vouchers were not meant as a complete substitute for all meals, but were a supplement to residents' own means of buying food.

226. Mr. F gave most of his vouchers away, as the only ones he received were for Tim Hortons and McDonalds and he did not believe that he could eat at those places given his dietary needs.

227. Mr. D relies on social assistance and complained about the difficulty he had feeding himself, even with the daily $10.00 vouchers. The fire happened at the end of the month when his funds were depleted.

228. The EPU Manager said that the vouchers were for appropriate restaurants and stores. She explained that EPU must obtain vouchers from restaurants with many locations across the city for flexibility. The restaurants have been approved by the Food Committee, with dieticians and nutritionists involved that have confirmed there are adequate healthy options at each of the designated locations. The recent addition of a Metro grocery store and Tim Hortons to the list of approved suppliers was done to expand the options.

229. The EPU Manager said that residents would be given a choice of voucher. Some residents stated the opposite. Ms. B stated that she could only use the Metro vouchers due to her dietary restrictions, but sometimes received Tim Hortons and McDonald's vouchers, which she gave away.

230. The majority of the concerns were about the processes for token and voucher distribution.

231. Initially, a resident living at a hotel would need to attend at the reception centre daily to receive two tokens and two vouchers. Residents would "burn up" the tokens getting to and from the reception centre. Ms. B explained that she had to travel from a hotel in north Toronto back to the centre each day for updates, and had to travel to school and work.

232. The TCHC COO at the time of the fire stated that the token process needs to be streamlined. He said it did not make sense to have people travel daily. He said there was a lack of flexibility with the City's approach.

233. TCHC and the EPU disagreed over who was responsible for the daily nature of allotments. Although TCHC staff say this was at EPU's insistence, the EPU Manager stated that this is not the usual process and she would have preferred to give affected tenants larger quantities. She suggested that TCHC requested the daily distribution due to uncertainty about when residents could return home. She said TCHC did not want to give the impression that people might not return home for some time, if that was not true.

234. The former CEO of TCHC denies this. There is a record in the meeting minutes from October 8, 2010 that shows TCHC requesting the distribution of vouchers for a one week period to "reduce the amount of times needed to come to the community centre."

235. For three weeks, individuals had to come to the reception centre daily to receive tokens and vouchers. Two witness accounts differed on this point. One resident said that he received a week of tokens and vouchers at the outset, and Coordinator B's understanding was that they would give out a week of tokens and vouchers.

236. Residents complained that it was difficult to obtain tokens and vouchers at the reception centre, as the desk was not always staffed. Mr. F said:

> Vouchers and tokens were given out during only a couple of hours per day, at irregular times. To make sure you got this, you needed to be on site all day. If they gave these out between 3-5 p.m. and you missed this slot, you could not get additional tokens the next day to compensate.

237. The former CEO of TCHC made a similar observation. She said the desk was often unstaffed, and TCHC frequently distributed their own supply of tokens.

6.5 Donations

238. Torontonians responded quickly and generously with donations.

239. The room allocated to clothing donations at the Wellesley Community Centre quickly filled up, and residents began lining up in the stairway to access donations.

240. A day later, on September 26, the donation room closed and a new one was set up at the 519 Church St. Community Centre (519).

241. City messaging to the public noted that there was no capacity for further clothing donations, and monetary donations would be preferred. On October 4, a larger donation centre opened at 257 Jarvis. The 519 closed and the Jarvis site remained open for four months.

242. TESS staff were primarily responsible for the City's donation response, receiving cash, cheques and gift-card donations, in addition to in-kind donations.

6.5.1 Deviation from the Donation Plan

243. In the City's Emergency Plan, the Operational Support Function (OSF) for Donations states in-kind donations "are *not* to be accepted" due to the resources required.

244. Documents reviewed and witnesses interviewed confirmed that the former Mayor requested a donation response to the large number of Torontonians expressing the desire to help.

245. When the donations at 519 grew beyond EPU's capacity, the EPU Manager assigned staff the task of finding a community partner to run the function.

246. At the same time, the SSHA General Manager stated that he felt political pressure to set up a new donations centre.

247. He assigned Coordinator A to set one up at 257 Jarvis. When the EPU Manager discovered that Coordinator A had been instructed to set up that donation centre, she stopped the search for community partners.

248. Coordinator A estimates being taken off duties at the operations centre at Wellesley on September 30, and working for the better part of a week to get the donation centre set up.

249. EPU staff said that losing one of the three coordinators was difficult. When Coordinator A returned to regular duties the following week,

Coordinator A explained it was hard to act as lead, and it took time to get up to speed.

6.5.2 Difficulties at the 257 Jarvis Donations Centre

250. The set-up at 257 Jarvis, in a former roller-rink without bathrooms, floor drains, proper lighting or air circulation, was difficult. Coordinator A called in tradespeople, contractors, health and safety, and negotiated with the adjacent hotel to use their washroom and kitchen facilities for staff. Coordinator A had to train staff on safety and procedures.

251. TCHC Manager, and TESS Manager A were in charge of the donations function. Approximately six staff from TCHC and six divisional responders were scheduled on each shift at the outset.

252. TCHC experienced difficulty with some of the divisional responders on site. TCHC Manager and the former CEO of TCHC said some divisional staff were inflexible. TCHC Manager explained that, for example, some would turn evacuees away if they did not have approved identification. She said that this was not appropriate for an emergency and staff needed to assist residents by accepting alternate means to verify identity.

253. TCHC Manager said the bigger problem was that divisional responders stopped showing up for their shifts at the donation centre. At one point, the schedule had TCHC and divisional responders alternating days. However, TCHC Manager found that she had to have TCHC staff attend every day. Ultimately, TCHC took over the function.

6.5.3 The City's Role in Running a Donation Centre

254. There was unanimous rejection of the idea that the City should run "pop-up" donation centres. One manager commented:

> I feel that a third party should deal with donations, it shouldn't be our role. We needed to find additional information on how to handle donations, like what kind of gloves we need to use to handle the donations, what grade they should be, etc. and this detracted us from managing the response.

255. This manager's observations were supported by the EPU staff. All of them expressed that in future, there should be an arrangement with an external agency. However, without one in place at the

Wellesley response, responders agreed that the City had no choice but to take on this role.

6.5.4 Monetary Donations

256. The Toronto Office of Partnerships reported on the 200 Wellesley donations in a December 21, 2010 internal audit report. Nearly $180,000 in monetary donations and just under $10,000 in gift cards were received.

257. There were some errors with monetary donations. Of the 77 cash and cheque donations received, only 34 receipts were prepared. Similarly, out of 48 gift card donations, only 23 receipts were provided.

258. The audit report states that there was confusion about monetary donations, as numerous groups involved were soliciting and receiving donations. Some donations, for example, went to the Red Cross who distributed these funds through TCHC.

259. The Toronto Office of Partnerships audit states a preference for one point of contact for donations, preferably through their office directly.

6.6 City Roles

6.6.1 TCHC and EPU

260. The EPU Manager stated this emergency was the first time it had been deployed for the evacuation of a TCHC building. Private landlords usually take a "hands-off" approach and focus on their building, letting EPU tend to the needs of evacuees. TCHC had a different approach and a commitment to assisting their residents.

261. Witnesses gave accounts of duplication and contradictions in the work between TCHC and EPU, and confusion as to who was the lead. One witness called the response a "two-headed beast." Others reported overt conflict between the heads of the two groups.

262. The former CEO of TCHC explained there seemed to be an assumption that those involved in the emergency knew the protocol. She said that they did not. She did not understand the EPU reporting structure, and thought her main contact was the General Manager of SSHA.

263. On the night of the fire, the CEO of TCHC was called to a meeting and told that an EPU command centre was being established. She says she told the EPU Manager that she was unclear on EPU's role. The EPU Manager gave her a copy of the emergency human services "protocol" (Appendix A). The CEO of TCHC said the document was not a protocol and did not set out how the response would be organized.

264. She said communication with EPU was initially poor. She would attend at the designated meeting time and no meeting would happen. When meetings did take place, she found they gave updates on silos of activity but no one was connecting the actions into one articulated plan.

265. She stated that TCHC started making its own plans, as they felt EPU was not well organized. She said that when EPU told them what they were working on "I would say, we are beyond that now." She reported that TCHC went into a level of detail that EPU did not, and gave examples such as procuring physicians and battery chargers for wheelchairs.

266. The CEO of TCHC was unclear about who was in charge. She explained that initially, she learned that the EPU Manager was, but it became clear that the EPU Manager had to obtain authorization for the decisions that needed to be made.

> I was very unclear in terms of who could make the ultimate decision. I'm still not clear to this day. [The EPU Manager] would say [a decision] was with [the City Manager] or Public Health. I saw her role as lead coordinator but not lead. I didn't see the structure there.

267. The CEO of TCHC thought the EPU Manager reported directly to the City Manager's office, and said that she had escalated some matters to him directly as a result. She did not know that the EPU worked within SSHA.

268. The EPU Manager did not feel EPU understood its role in relation to TCHC.

> That was the question that came up several times: who was actually in charge? And at one point, I don't know that I was sure who was in charge. Was it me? Was it TCH? Was it my GM? Was it the Councillor? And it became quite confusing. Although physically I was there, I don't think I was calling the shots at one point.

…

> At the beginning, I think I felt I was fully in charge, as with every response. When a lot of the TCHC staff came on, [the former CEO of TCHC], her lawyer, they were all talking to staff, the Mayor was involved. I had called my GM who did come to the scene. I don't know if it was two days later or whatever. He started working directly with [the former CEO of TCHC]. So they were doing some planning and direction. He kept me informed, though I don't think it was done in a formal way. Then the City Manager was talking to [the former CEO of TCHC], they talked to [the SSHA General Manager], there was a lot of informal planning, decision making that was not formally documented or passed down to staff. It's very uncomfortable because I need to know how to direct staff, because I was hearing things from them that I need to know about right?
> …
>
> When the Mayor brings [TCHC CEO] in and then gives me direction, I'm confused. So, once [CEO of TCHC] and [the SSHA General Manager] came on board, they made all the decisions, and I didn't have that authority.

269. The EPU Manager believed a source of the problem was that the Toronto Public Service was not aware of the City Emergency Plan. She would like to see more training, similar to mandatory occupational health and safety training.

270. EPU and TCHC set up separate command centres. The EPU centre was on the second floor wing, while TCHC set up a separate centre in the other wing of the building.

271. The EPU Manager explained that further complicating who was in charge, was her own limit of authority:

> [The limit of my authority] hasn't been laid out. ..That's an area that I do have a bit of discomfort with, because I think the expectation is we can do anything, but I can't as a manager, and if I'm in a situation where I've got a fire chief, a mayor, a [City Manager], a [Deputy City Manager], am I making decisions for EHS? Should that be a higher level? Am I committing resources that other divisions aren't prepared to offer up? What is my authority level, I think needs to be clarified. And if there are things that I can't decide, who does decide?

272. There were cases where TCHC and EPU both took charge of the same task, with varying results. The Hostel Services Manager recalled transportation issues, such as TCHC turning away a TTC bus that EPU had ordered.

273. Similarly, TESS Manager B reported being involved in a discussion with TCHC about who would pay for taxis that TCHC had ordered to transport residents. TCHC had the mistaken impression that EPU would pay.

274. The EPU Manager reported a problem in which the Toronto District School Board (TDSB) offered to provide assistance to children. She connected the TDSB with TCHC and understood TCHC would follow up. She later discovered this did not happen, and instead TCHC asked the Red Cross to purchase school kits for children for which the City was billed.

275. In the early hours of the response, TCHC set up a registration desk to process residents, before the Red Cross was on site. Coordinator A asked TCHC to stop, as he knew that it would be confusing and frustrating to have people register twice. He said the Red Cross registration was required in order to obtain provincial cost recovery. Despite this request, TCHC continued its practice.

276. EPU's practice is to only engage volunteers from approved partner organizations like the Red Cross or the Salvation Army. Initially, TCHC allowed some volunteers on site, including tenant representatives from other buildings, and in at least one case, the spouse of a TCHC staff person. The EPU Manager told TCHC they could not allow unauthorized volunteers due to insurance and risk.

277. When it was time to return some tenants to their homes, the EPU Manager said EPU wanted to provide information and distribute apartment keys at tenants' hotels, before transporting them back to their homes.

278. TCHC staff wanted tenants moved to Wellesley Community Centre first, where they would receive information and keys as a large group. EPU's plan was eventually adopted. TCHC staff had spent a day planning the alternate process, and expressed upset when the EPU's plan was implemented. The EPU Manager noted that the tension from this situation lingered.

6.6.2 Post-Fire Working Relations with TCHC

279. As the lack of understanding about the TCHC and EPU roles was a commonly-identified problem, my investigator asked what steps had been taken to address the challenges.

280. In January 2012, the EPU Manager said that she had drafted a letter to TCHC for the SSHA General Manager's signature, seeking clarification as to who they should be meeting with to develop an emergency protocol.

281. The SSHA General Manager told my investigator he was not sure if he had sent the letter, and the acting TCHC CEO did not recall receiving it.

282. SSHA held a senior management debriefing November 9, 2010, and hosted a second one for other divisional responders November 16, 2010. TCHC was not invited to either session and held its own internal debrief without EPU.

283. No EPU / TCHC protocol or joint arrangement was in place, when six months after the 200 Wellesley fire, another TCHC fire occurred in a different building, requiring evacuation.

284. Coordinator B and the EPU Manager recalled the SSHA General Manager directing EPU to use a process they said was outside EPU practice. They reported the General Manager told them that all TCHC requests for support would be communicated from the acting TCHC CEO to the SSHA General Manager, who would then speak to the EPU Manager.

285. Simultaneously, staff from TCHC also contacted the on-call coordinator, Coordinator B, directly. Although there were some enquiries about EPU support, no actual request was made in this case.

286. The SSHA General Manager did not recall this event.

287. After this second TCHC evacuation, no protocol or agreement was put in place.

288. When asked, 16 months after the Wellesley fire what he would do if such an event occurred again, the SSHA General Manager said that he would talk to the TCHC CEO and would decide how to proceed. The SSHA General Manager said that there would be a plan in place "at some point."

6.6.3 The Participation of the Office of Emergency Management

289. EPU and other responders explained that the 200 Wellesley response highlighted a lack of clarity and obvious confusion about how and when OEM should be activated.

290. One OEM emergency coordinator recalled participating in a 2008 neighbourhood emergency response at 2 Secord Ave. She remembered that three OEM staff participated in that response, reporting to the EPU Manager. OEM staff coordinated meetings and acted as liaison with other partners to make sure information was being shared. EPU staff verified this account.

291. OEM had less involvement in 200 Wellesley. The EPU Manager and the OEM Emergency Coordinator who was on call the night of the fire provided nearly identical recollections. The EPU Manager told the OEM Emergency Coordinator that she needed OEM's help setting up the Wellesley operations centre "just like you did at Secord." In response to that request, the OEM Emergency Coordinator called her supervisor, who made a series of telephone calls to staff on site. The OEM Director determined that OEM would not activate at that point.

292. The OEM Emergency Coordinator was surprised that she was not deployed. Two OEM staff visited the Wellesley Community Centre on the Monday and Tuesday following the fire. They reported back to the OEM Director that, three days into the response, it appeared that EPU had operations under control. Two OEM staff were sent to work at the donations centre for a period of time but OEM did not have any further involvement.

293. The EPU Manager reported that some days later, OEM offered support, but at that point, EPU had established its processes. The OEM Director was in contact with her superior and with the SSHA General Manager but not with the EPU Manager.

294. The Police Inspector expressed surprise that OEM was not involved in an emergency of such magnitude. He saw a need for "critical thinking, planning – long term City resource issues." He said strategic planning at a senior level was missing. Although the staff on site did a good job, he thought they were fully occupied with tactical practical work. He said that OEM played this role in the Sunrise propane explosion but that the evacuation at 200 Wellesley was unique due to it involving a population with a high volume of critical care needs.

295. EPU staff agreed that there was a key role OEM could have played and noted that an ongoing issue with OEM is establishing the threshold for activation.

296. The OEM Director explained that OEM was activated for the propane explosion because, based on a “hazard perspective,” it was clearly an emergency and it involved more unknowns.

297. After the experience with 200 Wellesley, the OEM Director arranged for OEM to work with partners including EPU, to establish a new "heat chart" also called the "Emergency Levels Protocol" that clarified when and how OEM would be activated (Appendix B).

298. The EPU Manager suggested that in spite of the recent work on activation levels, she felt there was a continuing lack of clarity. She gave the example of one criterion she is required to consider before OEM will be activated, namely, the number of divisions involved, but she noted that even very small EHS responses can involve numerous divisions.

299. The OEM Director said that, following a series of discussions about the appropriate role of OEM on emergency response sites and the decision to revise the heat chart, if another emergency similar to the 200 Wellesley fire occurred, OEM would be activated. This was re-iterated in a September 30, 2011 letter to the SSHA General Manager:

> In hindsight and with the G20 experience under our belt, if a similar "Wellesley-type incident occurred tomorrow", I would deploy OEM staff to the emergency site in a Liaison role and would activate the EOC staffing functions and branches to a scale commensurate with the challenges presented by the incident.

300. The OEM Director noted that the 200 Wellesley event was used as a case study for OEM training. A number of other witnesses mentioned this, and expressed some frustration that OEM did not participate in the response as requested, but was now using the event as a case study to train responders.

301. OEM was not invited to the City response partners' de-brief, hosted by SSHA. When the OEM Director received the SSHA draft report, she requested a number of changes, including acknowledgement that the emergency human services response was part of the City's overall Emergency Plan.

6.6.4 The Role of Elected Representatives

302. Some witnesses felt the ward Councillor played a key role, while others believed her involvement interfered with the City response.

303. The Councillor and her staff were on site every day of the response. They were involved operationally by advocating for tenants with special needs, or visiting hotels with staff to ensure they were appropriate for residents.

304. The Councillor reported that although she was included in the early meetings, on the second day, the EPU asked her to leave and said the meetings were not open to her. The Councillor believes that the role of elected representatives is unclear.

305. As the fire occurred one month before a municipal election, other political candidates attended on site, some providing pizza or asking for tours of the facility. One mayoral candidate contacted the EMS base-hospital doctor, asking him to return to the site the day after the fire, to provide additional care.

306. The EPU Manager explained that an emergency response should be run by a trained team adhering to a coordinated plan.

307. Managers concurred. One of them stated that it is not the role of politicians to direct public servants in an emergency response.

> And when they bring in a councillor, it throws the dynamics off. A lot of people don't deal with councillors so it was very intimidating. No one is going to do the career limiting move of saying "I'm sorry councillor, talk to her" and no one was very clear what the roles were. So we had very senior staff, and the councillor and the mayor showing up, that were all talking directly to staff, and we lost that structure.

308. EPU staff said that they have a protocol of notifying Councillors about emergencies in their ward. There is varying involvement, but usually, EPU will encourage Councillors to attend public meetings to help get information updates to their constituents, as they are a trusted and known public figure to the community. This role was not documented at the time.[15]

[15] After this investigation concluded my office was provided with three documents dated January 12, 2012 to the Mayor and City Councillors. They include a letter of that date, a revised heat chart setting out "Councillor Notification & Roles in an Emergency" dated November 24, 2011 and a briefing note dated December 14, 2011 explaining Councillor roles outlined in the heat chart. These documents are attached at Appendix D.

309. The EPU Manager explained that there are plans to conduct Councillor education on emergency human services procedures in 2012.

6.7 Staff Resources

310. In an emergency response, EPU staff rotate to provide 24-hour coverage. The EPU Manager was occasionally relieved by an SSHA Director. EPU and divisional responders worked 12 hour shifts.

311. The issue of whether EPU is adequately resourced was raised by numerous witnesses. When EPU is not responding to an emergency, they work on policy, planning, training and development. EPU staff reported that with frequent emergencies, some of long duration, non-emergency responsibilities are dropped and tasks left incomplete.

312. Coordinator C explained the careful tension the unit attempts to maintain in terms of resources, saying "a balance between a state of readiness and resources is very tricky to achieve because incidents like 200 Wellesley don't happen every day." While EPU's strength is its ability to pull staff from other divisions, Coordinator C explained there is a concern that it will become increasingly difficult to do so, with staffing reductions across the public service.

313. The EPU Manager stated that the regular loss of staff resources to emergency responses is responsible for a lack of formalized processes. EPU refers individuals with questions about their operations to the "EHS Policy" approved by City Council in May 2010. There is no protocol, manual or procedures setting out the operational processes required to implement the policy.

314. EPU wishes to develop a policy and procedures manual, along with a staff handbook. They also hope to develop a high-level plan to show how the City conducts emergency services. The EPU Manager said:

> We don't have timelines set to do those. We have good intentions and then an emergency happens. And then because we don't have a lot of staff, we get side tracked with tending to the emergency that could be for weeks, months.

315. The size of the unit also means that when longer emergencies occur, all staff respond. The Hostel Services Manager said that four

employees cannot carry the workload required in a response like 200 Wellesley and that anyone working consecutive 12-hour shifts will become exhausted and may not make good decisions.

316. Similarly, TESS Manager A reported that the response was "chaotic" and staff sometimes worked without breaks. She suggested that although staff were doing their best, the toll became evident.

317. While some divisional responders were released from their core job to work exclusively on the emergency, others continued to fulfil their regular duties, on days they were not at the emergency. TESS Manager B recommended the City implement a policy to release divisional staff from their regular duties for the duration of the emergency.

6.8 Training

318. Emergency management training programs are run through OEM five times a year. It is a four day course for senior divisional responders. A course for supervisors was run for the first time in 2010 prior to the Wellesley fire. There is other training that has been developed by EPU, but not yet delivered. When an emergency occurs, untrained staff may be called to cover less skilled positions.

319. There were reports from those involved in the response that staff were sometimes inadequately trained. The Hostel Services Manager said some people show up for a shift with no experience. Coordinator B agreed that at times divisional responders would arrive on site with no training, and said that "a five minute briefing is all we give them usually when they arrive" although she said newcomers are to be placed with a more experienced person to observe.

320. Coordinator C explained that "just-in-time training" is provided on site but said that sometimes the level of fatigue affected the transition to a new shift, as the person leaving would be so tired, the transfer of information to the next shift might not be done. Coordinator C explained that there was huge pressure to get the new staff "on the floor."

321. The University of Toronto Coordinator of Emergency Planning's contemporaneous notes of the response noted certain shifts where staffing was "thin" and "inexperienced." He felt there were times he was running the centre and was training or coaching the staff. He

also thought some staff appeared unfamiliar with acting in a management capacity and noted an absence of briefing at shift change.

322. The EPU Manager said that some shifts had an excess of experienced responders but the next shift might have none.

323. Following the Wellesley response, EPU now uses "in-tact teams" sent by a single division at a time so there is more control over the composition of the teams.

324. The Community Recreation Supervisor noted that his staff on site had not received any training. He noted the deficit, as he felt PFR staff had the best knowledge of the physical space, and connections with the community.

325. The EPU Manager acknowledged problems with PFR and said that Coordinator A is to develop terms of reference on procedures when it takes over a PFR facility.

6.9 Debriefs

326. In addition to the two debrief meetings hosted by SSHA, separate debrief meetings were held, including ones by the Red Cross, EMS, PFR, TCHC and TESS.

327. Neither TCHC nor OEM were invited to the SSHA City responders' debrief. TCHC held its own debrief sessions.

328. The August 26, 2011 SSHA debrief report titled, “Review of the 200 Wellesley Emergency Human Services Response,” (Appendix C) used information presented at a number of debrief meetings to inform its conclusions.

329. The stated purpose of this report is to:

> ...reflect on the emergency human services response provided, particularly in the days immediately following the evacuation, in order to identify the systems and processes improved, acknowledge the issues have been raised, and determine the lessons learned in the actions to be taken to make our response even better in the future.

330. The report provides a description of the fire and the emergency human services response. It states that while there is room for improvement, overall, the emergency human services policy was implemented successfully.

331. The SSHA report suggests that there were some challenges and divides those into five categories:

- Roles and responsibilities in the emergency human services policy;
- Establishing the reception centre;
- Providing shelter for displaced residents;
- Providing supports for displaced residents;
- Staffing and human resources.

332. Challenges are framed generally, without reference to specific events. The report suggests that the lessons learned at 200 Wellesley have been used to enhance subsequent emergency responses. It does not provide any details about the specific changes made in subsequent responses. It says there should be a more strategic approach to communication with community partners that would facilitate referrals. No specific incident is mentioned.

333. The report suggests next steps. There are no timelines or assignments. The General Manager of SSHA said that the timelines were contained in the EPU workplan.

334. The EPU Manager's covering letter for the workplan states that the activities listed are to fulfil the EHS Policy approved by Council in 2010 and that "some address issues following the 200 Wellesley response."

335. The workplan, dated June 14, 2011, is titled, "Emergency Human Services Work Plan: 2011 Goal: To provide Emergency Human Services." It is a chart of activities, organized into nine "objectives" sections with quarterly time-frames.

336. The activities in the workplan are not the same as the "next steps" identified in the debrief report. For example, the report says that a protocol will be developed in partnership with TCHC for responding to emergencies in their buildings.

337. No activity in the workplan mentions TCHC or social housing. Five of the nine objectives and 20 of the 44 activities are flagged as relating to issues identified at 200 Wellesley.

338. In addition, the debrief states that a bedbug protocol will be developed in partnership with Public Health to address bedbug

issues during an emergency situation. The workplan does not mention bedbugs or Public Health.

339. There are other examples of workplan activities not matching with the debrief report. The debrief report does not refer to the workplan. The workplan does not mention the debrief report.

6.10 Delay

340. On November 9, 2010, my investigator met with the SSHA General Manager and the Director of Program Support to ask about EPU processes and the apparent gap in policy and procedures that would apply to social housing / vulnerable populations.

341. The General Manager said there would be a debrief meeting that afternoon. He agreed to send a summary of the meeting to my investigator, as well as a "business plan or protocol" to address the process for a social housing population.

342. My staff followed up with him on five occasions over the ensuing four and a half months. It often took multiple attempts to receive a response.

343. On September 12, 2011, my office learned that the debrief document had been circulated. It was dated August 26, 2011.

344. In January 2012, my investigator learned of a revised report, dated December 13, 2011.

345. When commenting about the delay, the General Manager said that a ten month wait was "pretty fast for things around here."

> Keeping any type of long term project going in this environment is almost impossible. I have to wait for comments as well. And a lot of time in 10 months is waiting to hear back from people.

346. The General Manager said he was "on record" as saying that he had given his best estimate for completion and explained there was no guarantee because of having to prepare the budget for the new administration.

347. The General Manager said that he kept my office informed. He explained that because my office had not imposed a timeline and had told him on November 9, 2010 that we were not currently

investigating, he did not think there was an expectation for anything to be completed by a certain time.

348. He thought that my office's decision to investigate ignored the political context of a new administration and explained that the staff assigned to do the debriefing document, had been re-assigned to another task for the Mayor's office.

349. When asked about an update on the protocol for social housing, the General Manager was initially unsure to what my investigator was referring. He said he would follow up. My office received no further information on the protocol until March 24, 2012, when three documents were sent:

1) A two page note explaining the new processes in place, namely, adding to the roles of EMS and CCAC and clarifying the role of Public Health
2) A chart documenting the response roles and responsibilities of EPU, EMS, CCAC and Public Health
3) The terms of reference for the Vulnerable Populations Working Group.

7.0 Ombudsman Findings

350. Emergencies by their nature vary and are unique in level of crisis and danger. This emergency was on a scale rarely experienced by the City of Toronto. Firefighters took some eight hours to bring the fire under control and evacuated approximately 1,700 people.

351. It was the first emergency response of such magnitude activated under the new Emergency Human Services policy, led by the Emergency Planning Unit. It was also the first emergency on such a scale led by the Emergency Planning Unit that involved coordination with the Toronto Community Housing Corporation.

352. The commitment and dedication of EPU staff was evident throughout this investigation. Their work is one of great importance and personal sacrifice.

353. The EPU staff welcomed this investigation as an opportunity to improve their service, and were consistently cooperative and helpful.

354. Despite all these factors, there are serious lessons to be learned.

7.1 Communication and Training

355. Some decisions on the emergency response were made without the involvement or input of the Incident Commander. Yet, she was the response lead.

356. Despite the efforts of the City to provide updates, residents and employees reported a lack of information provided to them throughout the emergency, particularly in the early days.

357. Information was not conveyed by EPU to Parks, Forestry and Recreation. Staff from that division who were on site were unsure of their role in relation to the response and were not consulted on decisions affecting the property and programs at the location.

358. EPU experienced internal communication problems. Information was not shared consistently among coordinators, leading to frustration and obvious difficulties.

359. Inter-personal conflict among the three EPU coordinators responsible for running the operations centre, rendered communications even more challenging.

360. The operations centre was slow in conveying information to McCaul. It was sometimes treated as an afterthought, despite the fact that over 100 evacuees, many of whom were vulnerable, were present there for some four days.

361. Although a City staff would be assigned the Reception Centre manager role on each shift with accompanying authority, reports about poor communication from the Wellesley operations centre to McCaul and the lack of experience by staff at McCaul raises serious concerns about the proper oversight of that location.

362. Record keeping throughout the response was uneven and inefficient.

363. The lack of proper records at the reception centres led to a lack of continuity and inferior communications, particularly in transferring key information from one shift to the next.

364. EPU relies on trained staff responders from other divisions. Yet, many were not prepared and lacked proper training.

365. Although orientation programs are available, many divisional responders attend on site without having participated in them.

366. The "just-in-time training" that the divisional responders receive on site is minimal and shift change transfers provided insufficient information to the next shift.

7.2 Addressing a Vulnerable Social Housing Population

367. The plans and external resources that EPU has for dealing with vulnerable residents are inadequate. EPU does not have charge of these partner agencies, but there are concerns about the adequacy of these agencies' capacity in such emergency responses.

368. The Vulnerable Populations Protocol referred to by City staff, remains in draft 18 months after the 200 Wellesley Street fire.

369. Medical care on site was critical for reasons of immediate care and efficiency. Yet, EPU was initially reluctant to agree to a medical clinic, due to concerns about risk management. One was only established because of TCHC's insistence.

370. McCaul had vulnerable evacuees on site who required significant care, yet the necessary medical supports were absent. Residents were told they could take a chartered TTC bus to the Wellesley site to avail themselves of the services there. The lack of medical support at McCaul, combined with the reported lack of medical support for residents transferred to a City-run long-term care facility, raises grave concerns about care for vulnerable residents displaced by an emergency.

371. There were procedural difficulties mobilizing partners such as the Community Care Access Centre and Long Term Care Homes and Services.

372. While it is valuable to include these organizations in the response, there may be limitations in what they can accomplish.

373. EPU believed that more than food and beds would be provided by Long Term Care Homes and Services. These residents were considered too vulnerable to be placed in hotels or to remain at the reception centre.

374. However, only a handful of evacuees were formally admitted into Long Term Care homes. The remainder were there for short-term accommodation.

375. Once tenants were transferred to a long-term care facility, EPU staff were unsure as to who was responsible for them.

376. This raises the question as to who is in fact responsible for these very vulnerable residents and why they appear to be falling through the cracks.

7.3 Appropriateness of Services

7.3.1 Hotel Assignments

377. EPU describes its hotel assignment protocol as "first-come, first-served." Exceptions include priority for residents with disabilities, children and pets.

378. At the Wellesley response, a different process was used to assign hotels that was protracted and inefficient.

379. The hotel assignment system must be formalized and improved, particularly in view of the confusion and conflict between TCHC and EPU.

380. The SSHA General Manager and the former CEO of TCHC changed EPU's standard practice without consulting the EPU Manager. This circumvention of the process showed a complete disregard for the incident management system. It also ignored the very person assigned authority to oversee the entire emergency human response.

381. Moving children, seniors and other vulnerable adults at 2:00 a.m. is unreasonable in the circumstances. Residents without hotel assignments were disrupted, and kept awake unnecessarily.

382. Tenants were obliged to accept rooms that were far from the neighbourhood, due to the lack of availability of nearby hotels. While the City's selection criteria are entirely reasonable, the impact in this situation created hardship for residents.

383. Yet, the SSHA debrief report notes that tenants in future emergencies are to be encouraged to take more remote hotels, due to higher rates of availability. Staying a distance from home further compounds the trauma of being displaced, most particularly and especially for TCHC residents who are often marginalized and vulnerable.

384. Six months after the Wellesley fire, the TCHC experienced another fire at one of its buildings requiring the evacuation of residents. SSHA has yet to complete the Vulnerable Populations Protocol.

385. Such inaction is troublesome and unacceptable, given the extreme vulnerability of the social housing population.

7.3.2 Bedbugs and Attitudes

386. Fear and stereotyping played a significant role in the issue of bedbugs. Misinformation and exaggeration about information provided by Public Health abounded.

387. There was no evidence that Public Health staff expressed concern about transferring residents to hotels.

388. Yet, the story grew to mythic proportions. It was rumoured that Public Health had found bedbugs on site and insisted on a protocol before placing residents in hotels.

389. None of this was true.

7.3.3 Food

390. Contrary to unconfirmed reports and complaints that the food ordered on the first weekend was not culturally appropriate, my investigation confirmed that food orders were supplied by halal restaurants.

391. The Food Committee is charged with determining appropriate food. It must document its decisions and create a clear protocol. A diet of pizza, chicken and muffins for a period of days is not appropriate.

392. A lone public servant was charged with coordinating all aspects of food service for the first two days. There were hundreds of people to feed, many with dietary restrictions, at two reception centres.

393. There must be adequate resources and a clear plan in place, including contingency measures when agency partners are unavailable.

394. TCHC staff and elected representatives provided the first two meals to displaced tenants. This added to the impression that EPU was not in charge of the response.

7.3.4 Token and Voucher Distribution

395. EPU states the Food Committee ensured that vouchers are from restaurants with an adequate selection of healthy food choices. If the Food Committee believes that healthy choices are available from fast-food establishments, it should inform residents about those options.

396. Tenants were not always given a choice of vouchers. Without choice, the voucher system is less likely to be appropriate, even if there are "healthy choices" possible at each restaurant. Vouchers to a pizza restaurant will not work for someone with gluten or lactose allergies.

397. For three weeks, residents were made to travel from their hotels to the reception centre to collect two TTC tokens and their daily allotment of vouchers. Residents staying out of the neighbourhood would use up the two tokens just to get to and from the centre.

398. The token and vouchers desk was inadequately staffed and according to witnesses, often no one was available at the desk.

399. My review also identified inconsistencies and a lack of understanding by responders, as to the numbers of tokens that could be allotted to residents.

400. The system was inefficient and frustrating for everyone involved.

7.4 Donations

401. The donations plan stipulates that in-kind donations will not be accepted or will be sent to another agency. That plan was not followed.

402. Substantial resources were committed to this issue. Redeployment of staff badly depleted resources dedicated to the emergency.

403. There is no partnership with any community agency to handle donations, an obvious gap that needs to be addressed.

404. The Public Service is not trained to handle or equipped to manage donations, nor, arguably, should it be.

405. There were many problems associated with donations, including a lack of process for receiving money and poor accompanying documentation.

7.5 City Roles

7.5.1 Senior City Staff

406. There is a general lack of awareness about the City's emergency response preparedness and the roles of OEM and EPU, particularly by City staff who may be called on to participate in an emergency response.

407. The role and authority of the Incident Commander is not respected. A clear chain of command, so critical to successful emergency responses, was not followed.

408. While team coordination is a key ingredient to response efforts, even that seemed wanting. Senior managers made some decisions without consulting with the Incident Commander.

409. Senior managers' roles must be prescribed in relation to the Incident Commander or alternative structures sought.

7.5.2 TCHC

410. TCHC staff were not familiar with EPU’s role or its services. This resulted in persistent confusion between the two organizations and plagued the efficient operation of the emergency response throughout.

411. There was a failure to respond appropriately to the widely identified problems between TCHC and EPU.

412. No protocol has been developed since the response to the 200 Wellesley Street fire.

413. The SSHA General Manager's response that, faced with a similar emergency, he and the CEO of TCHC would talk and sort out the plan based on their experience at Wellesley, does not address the serious coordination and communication problems uncovered by this investigation. In fact, similar problems will inevitably arise in the future with such a casual attitude.

414. The policy provided to EPU partners was inadequate. The absence of documented procedures contributed to serious communication breakdowns.

415. There was duplication and contradiction which translated into unnecessary additional costs.

7.5.3 The Role of the Elected Representative

416. Politicians will inevitably become involved in a community emergency.

417. The difficulty was that, at the time there was no protocol describing their role or defining the interface with the Public Service in emergencies. This resulted in inconsistent practice with elected representatives variously being included or excluded.

418. The lack of clarity led to frustration and confusion. The absence of an articulated protocol also resulted in inefficiencies and detracted from the primary responsibility of attending to evacuees' needs. [16]

7.5.4 The Role of OEM

419. There is a lack of clarity about OEM's role at major incidents such as 200 Wellesley.

420. Despite OEM's efforts to re-develop their activation protocol following the events of 200 Wellesley, there remains confusion as to how it works with respect to their deployment on site for major incidents.

421. There was a breakdown in communication between OEM and EPU. It is troubling that OEM refused the request of EPU when it was needed most, only to offer help later, when the urgency had abated. The OEM Director, like others, acted on the advice of emergency responders other than the Incident Commander, exacerbating the confusion.

422. OEM's involvement was negligible, yet they participated in a smaller neighbourhood emergency. Their participation seems erratic and there appears to be no threshold or standard.

423. OEM has acknowledged that at any future emergency on a scale such as 200 Wellesley, it would provide support.

424. While it is understandable, given OEM's lack of participation, EPU failed to include OEM in the debrief process. There is a real tension between the two groups that must be addressed.

[16] Appendix D.

7.6 SSHA Debrief Report

425. The SSHA report attempts to address “challenges” that arose and propose actions but it is nebulous to the point of meaningless.

426. There are numerous examples throughout the debrief document of vague statements such as communication being “less effective than it could have been” with community partners or “some confusion and lack of clarity around decision making, accountability, and the IMS structure.”

427. There is no description of the actual problems that occurred and their accompanying solutions for future improvement.

428. No timelines for the follow up were articulated. The General Manager said these were contained in the EPU workplan.

429. There are numerous examples of next steps in the debrief report that do not align with the tasks set out in the workplan. Some next steps are not even mentioned.

430. Of course, this is hardly surprising, given that the workplan is dated June 14, 2011, over two months before the first draft of the debrief report. There is in fact no relationship between the two documents described.

7.7 Delay

431. The SSHA General Manager failed to keep my office informed. It often took multiple attempts to receive a response.

432. The ten month delay in receiving the debrief report is unreasonable. That my office has not been provided with a Vulnerable Populations Protocol, over a year and a half later is unacceptable.

433. The SSHA General Manager expressed confusion when asked about the Vulnerable Populations Protocol he had promised more than one year ago. Even if he had forgotten that commitment, my March 28, 2011, notice letter explicitly noted that as one of three issues for investigation. Eighteen months later no plan or protocol are in place.

434. I take some issue that both versions of the debrief report were sent to my office only after we heard of their existence from another party who already had a copy.

435. The SSHA General Manager comments that I ignored the political reality of the time, that ten months was “pretty fast” and that it is “almost impossible” to complete long-term projects on schedule. These comments are highly troublesome in light of the issues and the population concerned.

8.0 Ombudsman Conclusions

436. Toronto Municipal Code Chapter 3, 3-36 provides that the Ombudsman, in undertaking an investigation, shall have regard to whether the decision, recommendation, act or omission in question may have been:

A. Contrary to law;
B. Unreasonable, unjust, oppressive or improperly discriminatory;
C. Based wholly or partly on a mistake of law or fact;
D. Based on the improper exercise of a discretionary power; or
E. Wrong.

437. I have considered those definitions in reaching my conclusions.

438. It was unreasonable that there was no protocol for serving vulnerable residents at the time of the Wellesley Fire.

439. Some 18 months after the Wellesley fire, the continuing absence of a protocol and clear directives are unacceptable.

440. Hotel assignments were implemented inefficiently and the process was unreasonable.

441. The City's decision to open donations centres, contrary to its Emergency Plan, was problematic.

442. The delay by the General Manager of SSHA in providing my office with information was unreasonable, as was his oversight to respond in a timely manner.

443. The method and frequency of token and voucher distribution was unreasonable.

444. The poor communications between the Wellesley operations centre and McCaul, along with the lack of trained managers at McCaul was unreasonable. The impact resulted in ineffective oversight.

9.0 Ombudsman Recommendations

445. Taking into account all of the evidence gathered through this investigation, I make the following recommendations:

1. That directives be established documenting the role of the Office of Emergency Management and the Emergency Planning Unit in emergencies.

2. That the City Manager confirm the Incident Commander is the single point of decision-making authority for emergency human services responses or provide an alternative.

3. That the City Manager ensure a senior manager is available to act as a liaison with elected officials during emergencies.

4. That a protocol be established for future emergencies regarding inter-divisional communications for staff responders.

5. That a single system of record keeping be established to transmit key information between shifts and that this be done in accordance with the City Clerk's "Responsible Record-Keeping Directive" of August 22, 2011.

6. That the Emergency Planning Unit develop a Policies and Procedures Manual, and appropriate information for divisional responders.

7. That the Vulnerable Populations Protocol be finalized in consultation with relevant expertise such as the Centre for Addictions and Mental Health.

8. That recommendations 1-7 be completed no later than December 1, 2012.

9. That the City Manager establish partnerships with external agencies to handle in-kind donations for future emergencies.

10. That the City Manager ensure all staff responders are aware of the City's Emergency Plan and are adequately trained in emergency human services.

11. That recommendations 9 and 10 be completed no later than June 30, 2013.

12. That evacuees displaced by emergencies be provided with timely and accurate information to the extent possible.

13. That debriefs and lessons learned be done in a coordinated and timely manner.

14. That the City Manager ensure senior public servants respond in a timely way to Ombudsman requests and hold them to the standards set out in his August 4, 2011 directive.

15. That all draft protocols and documents referenced in recommendations 1 through 7 be provided to my office for review prior to finalizing them.

10.0 The City's Response

446. Before issuing my final report, I notified the City of my tentative findings and recommendations and provided it with an opportunity to make representations, pursuant to section 172(2) of the *City of Toronto Act, 2006*

447. Following discussion with City officials in which context and facts were clarified, the City Manager responded in writing.

448. The City is in agreement with my 15 recommendations and the timelines associated with them. The City Manager noted that the recommendations support and strengthen the City's own internal review of the response as well as the City's response for future emergencies.

449. The City's response acknowledged that the 200 Wellesley Street fire was "extremely complex and challenging, involving many vulnerable individuals with significant needs" and commended the City's first responders for their exceptional work and their success in "keeping our City and residents safe." The City Manager noted that the City's response to the incident was "unprecedented" and included hundreds of staff redeployed from their usual duties.

450. The City is strengthening its emergency preparedness plans and the City Manager noted that he "welcome(s) the Ombudsman's assistance in this important review process. Your findings will be used to improve our planning and operational processes."

451. In particular, the City noted that the OEM is refining its planning and response roles and documenting these. Similarly, the EPU will "enhance and consolidate" existing materials into a manual to be

distributed to parties involved in City emergency responses and planning.

452. The City confirmed that the Incident Commander is the single point of decision-making authority for all emergency human services. The City Manager will be taking immediate action to clarify roles and responsibilities between the City and its Agencies, Boards, Commissions and Corporations. He expressed confidence that in "future emergencies of this scale, response will meet all of our expectations and all parties will have a clear understanding of decision making and authority."

453. A senior manager will be assigned to act as liaison with elected officials during emergencies, and the City Manager will provide a memorandum to Councillors clarifying the appropriate point of contact for them in future responses.

454. The Vulnerable Populations Protocol will be enhanced and finalized within my recommended timeline.

455. A Request for Proposal will be issued to find an external partner with expertise in handling in-kind donations, for future responses.

456. Record keeping protocols will be established in accordance with City Clerk directives and an "enhanced inter-divisional communication plan" created to improve future responses. The processes surrounding the 'Residents First' principle for communications will be reviewed to ensure their effectiveness.

457. Training for staff responders will take place and the City Manager will make staff aware of those training dates.

458. The City Manager will also issue further communication to public servants to ensure they are aware of the process in Ombudsman investigations and the standards by which they should respond to requests from my office.

(Original signed)

_____

Fiona Crean
Ombudsman
May 1, 2012

Appendix A

City of Toronto Emergency Human Services Policy
Approved by Council on May 11 and 12, 2010

Emergency Human Services (EHS) is an organized response to the urgent needs of people and their pets once they are out of immediate danger of a disaster or emergency situation. The primary services provided as part of Emergency Human Services include providing emergency accommodation, food, registration and inquiries, personal support services and operation of a Reception Centre for residents evacuated from their homes. The Emergency Human Services response is coordinated by Shelter, Support and Housing Administration (SSHA) and delivered by pre-identified City divisions and agencies with pre-determined roles that come together to provide these services to residents in times of emergencies.

1. Scope

An emergency is defined in the City of Toronto's Emergency Plan as a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces or nature, a disease, or other health risk, an accident or an act whether intentional or otherwise. A major public emergency is any emergency that will likely strain the City's capabilities and require a broad range of assistance.

Emergency Human Services are also provided in an emergency which is smaller in scope than a major public emergency but which results in residents being displaced from their homes and requiring emergency accommodation and other supports. For example this could include a neighbourhood fire, widespread power outage, gas leak, or other public health threat. Such incidents would be considered Level 1 or Level 2 emergencies in the City of Toronto Emergency Plan and do not usually result in the formal activation of the Emergency Operation Centre or the City of Toronto Emergency Plan response.

This Emergency Human Services Policy is intended to guide the emergency response and services provided to residents during both small and large scale emergency situations. Services provided will be adjusted to respond to the scale and nature of the emergency as required. Where appropriate, assistance will be provided for emergency accommodation and income supports through regular service operations.

2. Relation to the City of Toronto Emergency Plan

This policy will guide the Emergency Human Services Operational Support Function of the City of Toronto's Emergency Plan.

3. Relation to the Rooming House Emergency Response Plan

The City also has a Rooming House Emergency Response Plan to respond to sudden or imminent closures of rooming houses where the emergency relocation of residents may be required. Through this plan, a Follow-up Relocation and Support Worker is responsible for assisting residents during a closure and helping them to find new housing, and for sudden closures, the Canadian Red Cross provides 72 hours of emergency services including accommodation, food etc. When requested under the terms of the plan, or at the discretion of the General Manager of SSHA, the Emergency Human Services Policy will be activated to provide additional assistance.

4. Coordination

The Emergency Planning Unit of the Shelter, Support & Housing Administration Division is responsible for coordinating all aspects of the Emergency Human Services policy.

Where appropriate, SSHA will convene an Emergency Human Services Coordination Committee immediately following the establishment of the Reception Centre, with representation from all of the Divisions involved in providing the response. The Committee will meet periodically to coordinate logistics related to staffing and operations of the Reception Centre and provide advice and guidance related to services provided to affected residents.

5. Notification and Initial Response

SSHA will be notified of the requirement for Emergency Human Services response by the Public Safety Unit of Toronto Police Service or Toronto Fire Services, or through the established emergency notification system by the lead service as appropriate. Information will be provided regarding the nature of the emergency, location, health and safety considerations, the number of people involved and the estimated duration of the evacuation.

SSHA Emergency Planning Unit will:

- Respond to the site, assess the situation and determine the level of service required. The deployment of staff and resources will be dependent on the size and scope of the emergency.

- Report to the Incident Commander and become part of the Unified Command Structure at the site.

- Begin to deliver immediate curb-side assistance as required.

- Contact appropriate supporting Divisions and community organizations to deploy staff and assist with response through the established notification process. Notification lists are tested and updated frequently.

- Contact the local Councillor to provide information on the incident.

- Coordinate as required with appropriate lead personnel from emergency responder Divisions regarding affected residents.

- Establish Reception Centres for displaced or affected residents, as necessary, in existing facilities. A facility may be any available City facility, community centre, school, library, or any building which is deemed suitable to support the response and is outside the affected area.

6. Registration

Upon arrival at the reception centre, residents will be requested to register their names and address. The purpose of registration is:

- To provide a screening process to ensure that services are available and provided to only people affected by the emergency and to maintain privacy and security for displaced residents

- To reunite family members who may become separated in an emergency, assist with missing person reports and may be used by hospitals to locate family members

- To allow the City of Toronto to communicate with and provide information to displaced residents whether they remain at the centre or have accommodation elsewhere

- To determine staffing levels, meals, and levels of service

Only if consent is given can information about registered residents affected by the emergency be provided to friends, family or others.

7. Services Provided at Reception Centres

The following services will be provided as appropriate:

- Water and food provided through various sources and methods and appropriate to the particular environment and conditions. If appropriate, on-site meal services will be provided through partnership with the Salvation Army.

- Immediate overnight accommodation as well as assistance to access temporary alternate accommodation (including motels and hotels), if no other accommodation is available to them.

- Emergency kits with emergency personal care supplies (soap, toothbrush, socks, etc.) provided to residents.

- Emergency clothing or referral for clothing, as necessary.

- Land lines and/or cell phones available at reception centres for use by residents to contact friends and family.

- Coordination with emergency services for the retrieval of vital medication, important documents and pets requiring rescue.

- Coordination and communication of information about the emergency situation, status of event, condition of homes, using the 'residents first' principle. Standard information handouts will be provided to residents with key phone numbers for services and supports. At the time of an emergency more specific event related information sheets will also be developed and distributed. Information will also be provided through resident meetings where appropriate.

- Meal service, or meal vouchers if required for registered households.

- Assistance to find alternate housing or referral to housing help services for longer term housing solutions if relocation is required.

- Assistance to contact residents' insurance provider. As soon as possible following the emergency incident, the Insurance Bureau of Canada will be requested to notify their members of the emergency incident and those insurance companies involved will be encouraged to meet with their clients at the Reception Centre where space will be made available for this purpose.

- Care of unattended children and emergency pet care.

- Emotional support, crisis support and referrals will be provided by Toronto Public Health.

- Assessment for emergency financial aid will be provided by Toronto Employment and Social Services.

8. Eligibility and Length of Support Services

The primary aim of the Emergency Human Services policy is to provide immediate, temporary services in response to an urgent emergency situation, and connect residents to existing mainstream services for longer-term needs.

All affected residents will be provided with assistance, information and referrals to community services at the Reception Centre.

All registered residents are eligible to receive a range of supports, including temporary accommodation, food, and transportation assistance, for up to 14 days following the emergency incident, if required. Residents will be encouraged to make other arrangements or to stay with friends and family wherever possible.

In order to receive accommodation and other supports, residents will be required to provide information and complete all necessary documents regarding their insurance coverage within the first three days for the purpose of cost recovery.

Households which meet assessed low-income eligibility criteria will be eligible for continued supports, including accommodation, food and transportation assistance, after 14 days.

An assessment form will be filled out by residents to determine eligibility for accommodation and related supports after 14 days. These supports will not be provided where it is clear that residents have sufficient resources to look after themselves.

9. Reception Centre Operation

The operation of a Reception Centre is intended to provide a safe location for residents to congregate and access services immediately following an emergency incident. Longer-term information sharing and service provision, if required, may be provided through a variety of other mechanisms.

After the first 24 hours following the emergency incident, the hours of operation of the Reception Centre may be reduced based on assessed need, at the discretion of the General Manager of Shelter, Support and Housing Administration.

Following resolution of the immediate evacuation and initial registration of displaced residents, the Reception Centre may remain operational for up to 14 days after the emergency incident, as needed, to provide information, service referrals and conduct needs assessments for continued supports.

If fewer than 20 residents per day attend the Reception Centre for two or more consecutive days, the Reception Centre may be closed, or scaled back to an alternate location, at the discretion of the General Manager of Shelter, Support and Housing Administration.

In exceptional circumstances, the Reception Centre may remain operational for more than 14 days, at the discretion of the General Manager of Shelter, Support and Housing Administration.

Once the Reception Centre is closed, a telephone information line will be maintained, in coordination with 311, to provide information and service referrals to displaced residents until they are able to reoccupy their homes.

10. Emergency Incident Building Repair Committee

An Emergency Incident Building Repair Committee will be established by SSHA, as required, immediately during an emergency incident to oversee a coordinated City response to ensure a speedy resolution to building repairs and allow residents to return to their homes. The committee will be chaired by SSHA and involve, at a minimum, Toronto Fire Services, the Fire Marshal's Office, Toronto Building, Municipal Licensing and Standards, Legal Services, Toronto Public Health, and representatives from other relevant organizations as required.

11. Roles of Supporting Divisions

Shelter, Support and Housing Administration

SSHA Emergency Planning Unit is responsible for coordinating the Emergency Human Services policy and response and coordinating operation of the Reception Centre. SSHA divisional staff outside of the Emergency Planning Unit also play a supporting role in the Emergency Human Services response and are responsible for providing services which include but are not limited to:

- assisting with setup and operation of the Reception Centre
- staffing Reception Centres as required
- assisting displaced residents to access emergency accommodation
- assisting displaced residents to find alternate housing, if required
- assisting with registration and eligibility assessments
- communication, notification and outreach to affected residents as required
- providing personal support to affected residents as needed, including referrals to other support services/agencies
- participation in de-escalation of reception centre
- participation on advisory bodies and working groups regarding Emergency Human Services

The Emergency Human Services response would not be possible without collaboration and support from SSHA's many partners. Other City Divisions will participate on advisory boards and working groups regarding Emergency Human Services, as appropriate. In addition, they are responsible for providing services which include but are not limited to the following:

Employment and Social Services

- assisting with setup, operation and coordination of the Reception Centre
- staffing Reception Centres as required

- assisting with registration and eligibility assessments
- issuing financial assistance and/or assistance in kind which may include the issuance of vouchers, drug cards, TTC tickets
- communication, notification and outreach to affected residents as required
- providing personal support to affected residents as needed, including referrals to other support services/agencies
- liaising with community partners to support affected residents
- participation in de-escalation of reception centre

Children's Services

- developing and delivering child minding and/or emergency child care services at Reception Centres, as required
- communicating and liaising with child protection agencies
- assisting with developing and delivering recreation programs for young children
- providing staff support at Reception Centres as required
- providing staffing for provision of food at Reception Centres, coordinated by the Food Services Committee

Toronto Public Health

- providing advice and instruction on health and safety matters
- monitoring for health hazards, food safety, potable water and sanitation
- ensuring infection control measures are in place to prevent or control communicable diseases
- providing psychosocial interventions for displaced residents and responders

Long -Term Care Homes and Services (LTCHS)

- providing immediate short-term care and accommodation (including personal care and overnight accommodations) for displaced seniors in one of the long-term care homes, through the LTCHS-EMS-CCAC voluntary agreement, and working with the affected persons' families and Toronto area CCACs to search out longer term solutions for displaced seniors who need ongoing care on the next CCAC business day
- providing staff support to the Reception Centre if individuals are not admitted to short-term accommodation at LTCHS through the above-noted voluntary agreement
- providing and/or assisting to arrange transportation for vulnerable populations who need to utilize short-term services, care and/or accommodation
- liaising with CCACs and other long-term care and retirement organizations affected by the emergency to assist in finding the best short-term and long-term solutions for affected residents
- providing staffing for provision of food at Reception Centres, coordinated by the Food Services Committee

Municipal Licensing & Standards

- developing and delivering a pet care plan for Reception Centres

Parks, Forestry and Recreation

- making available community centres as reception/evacuation centres
- establishing and providing ongoing maintenance and housekeeping to Reception Centres
- providing staff as required to maintain centres when in use
- assisting with the provision of recreation activities for Reception Centres

Strategic Communications

- developing and implementing a communications plan to provide updates to residents, stakeholders and the media. This will include tenant advisories, media releases, and media relations services.

Toronto Office of Partnerships

- assisting with coordination and distribution of donations.

311 Toronto

- providing information and responding to inquiries from residents as required.

Purchasing and Materials Management

- providing emergency purchasing on a 24/7 basis and ensuring City purchasing policies and procedures are followed in emergency situations.

Facilities Management

- providing logistical support related to the operation of Reception Centres as required.

Transportation Services

- providing vehicles and staffing for logistical support in moving supplies and equipment and set-up and take-down of Reception Centres.

Information & Technology

- providing hardware and support in establishing work stations and network capacity at Reception Centres.

Toronto Building

- responsible for the inspection and assessment of building and coordination of remedial actions required to remove unsafe conditions.

Appendix B

OEM Emergency Levels "Heat Chart"

Levels	Operational Implications	Actual Events	Planned Events
Level 0 NORMAL	Business as usual Normal operations		
LEVEL 1 MINOR INCIDENT	**Site:** managed by Emergency Services/Divisions	Yonge Street/ Gould Fire (2011)	Santa Claus Parade (Annually) Pride Parade (Annually)
LEVEL 2 MAJOR INCIDENT	**Site:** Managed by Emergency Services /Divisions **Site:** Site Incident Commander may request support from OEM 'On-Call' **Site:** May request the activation of the EOC **EOC:** May be Activated	Queen Street Fire (2008) H.S.E. Hickson Fire – Chemical Court (1998) Finch Avenue Bridge Washout (2005) 2 Secord Avenue (2008) Wellesley Street High-rise Fire (2010)	Caribana Festival (Annually) International Indian Film Academy (2011)
LEVEL 3 EMERGENCY INCIDENT	**EOC:** is Activated Emergency poses a danger of major proportions to life and property, and/or threatens social order and ability to govern, and/or a declaration of an emergency by another level of government.	G20 Summit (2010) Sunrise Propane Explosion (2008) Northeast Power Outage (2003) SARS (2003)	G20 Summit (2010) Pan American Games (2015)

Appendix C

DRAFT

Review of the 200 Wellesley Emergency Human Services Response

Office of the General Manager
Shelter, Support and Housing Administration

August 26, 2011
Updated December 13, 2011

Introduction and Purpose of the Review

On September 24, 2010, a six alarm fire in a Toronto Community Housing building at 200 Wellesley Street East forced the evacuation of approximately 1,200 residents from their homes. This was a significant neighbourhood emergency event, and was one of the largest such neighbourhood level emergencies in Toronto in recent memory both in terms of the number of people displaced from their homes, the duration of the evacuation and the scale and complexity of need of the residents.

The Emergency Human Services response that was provided involved many different services from across the City coming together to meet the urgent needs of people and their pets once they were out of immediate danger and to provide help at a time of dire need. Thankfully, no one died as a result of the fire.

A Reception Centre was opened on September 24th at the Wellesley Community Centre to provide accommodation, food and address other urgent needs of the evacuated residents and their pets. A secondary site was also opened at the University of Toronto to accommodate more residents. Ongoing supports were provided to residents for 14 days, at which time all residents were assessed as low-income given that they were in receipt of rent-geared-to-income assistance, and supports were extended for the duration of their displacement, as per the Emergency Human Services Policy approved by City Council. The majority of residents returned home by December, and any remaining displaced tenants after that point were supported by TCH until they could return home.

The purpose of this review is to reflect on the Emergency Human Services response provided, particularly in the days immediately following the evacuation, in order to identify the systems and processes that can be improved, acknowledge the issues that have been raised, and determine the lessons learned and the actions that can be taken to make our response even better in the future.

This was the first neighbourhood-level emergency requiring full activation of the Emergency Human Services policy since the policy was approved by Council in May 2010, and the first time that the new Emergency Human Services non-program account was in place during an emergency. The staff report can be found at http://www.toronto.ca/legdocs/mmis/2010/ex/bgrd/backgroundfile-29017.pdf, and a summary of the policy is included in this report as Attachment 1.

The Emergency Human Services response, as approved by Council, is part of the City's Emergency Plan, and can be activated for neighbourhood-level emergencies which result in residents being displaced from their homes. Such incidents would be considered Level 1 or Level 2 emergencies in the City of Toronto Emergency Plan and do not usually result in the formal activation of the Emergency Operation Centre or the City's Emergency Plan response. The Emergency Human Services response is coordinated by SSHA, and provided in partnership with a range of Divisions and community agencies.

This review is an opportunity to assess how the EHS policy worked and identify any areas for improvement. As well, this was the first time there was an emergency response of this nature where the landlord was a social housing provider and had information, knowledge and staff resources to commit to the response effort. This was a great help in providing an Emergency Human Services response, but also very different than previous experiences and did raise some challenges which had not been encountered previously. The review will also explore these challenges and identify possible solutions for similar situations in the future.

While this report identifies some of the areas where there are opportunities for improvements, it is important to acknowledge that, overall, the Emergency Human Services policy as approved by City Council was implemented successfully and affected tenants were provided with food, shelter and other needed supports in a time of personal crisis. Staff responded to the unique circumstances of this emergency to come up with flexible and innovative solutions to issues as they arose and used the space available at the Reception Centre as effectively as possible to provide services in a respectful and caring manner to a large number of vulnerable residents with complex needs who were displaced from their homes.

The response to the fire at 200 Wellesley and the support provided to tenants at the Reception Centre at the Wellesley Community Centre in the weeks and months that followed would not have been possible without the cooperation, hard work and dedication of many staff from a wide range of partner organizations who worked both at the Reception Centre and behind the scenes. We would like to take this opportunity to thank all of the staff, volunteers and community partners who assist with the response, including:

- Shelter, Support and Housing Administration (SSHA)
- Toronto Community Housing (TCH)
- Toronto Employment and Social Services (TESS)
- Children's Services
- Long Term Care Homes and Services (LTCHS)
- Toronto Public Health (TPH)
- Municipal Licensing and Standards (MLS) Animal Services
- Parks, Forestry and Recreation (PFR)
- Strategic Communications
- Toronto Office of Partnerships (TOP)
- Human Resources (HR)
- Facilities and Real Estate (F&RE)
- Emergency Medical Services (EMS)
- Toronto Fire Services (TFS)
- Toronto Police Service (TPS)
- Office of Emergency Management (OEM)
- 311
- Toronto Public Library (TPL)

- Toronto Transit Commission (TTC)
- Toronto Central Community Care Access Centre (CCAC)
- Ontario Hospital Association (OHA)
- Red Cross
- Salvation Army
- The 519 Church Street Community Centre
- University of Toronto

Since the emergency event on September 24, 2010, various groups have come together to debrief about their experiences and the services provided. This review incorporates feedback from these debriefings together with comments and observations provided by the Ombudsman's Office. Issues and challenges were raised by these debriefings, including those held with the Cluster A Senior Management Team, the Emergency Human Services Steering Committee, the Red Cross, University of Toronto, emergency medical responders and feedback provided by the Office of the Ombudsman.

Challenges and Issues Raised

This review reports on a number of challenges that have been identified by participants and stakeholders involved in the 200 Wellesley Emergency Human Services Response. The challenges and issued identified which are covered below fall into the following five areas:

1) Roles and Responsibilities in the Emergency Human Services Policy
2) Establishing the Reception Centre
3) Providing Shelter for Displaced Residents
4) Providing Supports to Displaced Residents
5) Staffing and Human Resources

For each challenge identified, a summary of the issue is provided, along with the proposed next steps and possible solutions identified to help address similar situations in the future.

Summary of Next Steps

The results of the review demonstrate that the overall implementation of the Emergency Human Services policy was effective. Opportunities for improvements have also been identified, and policies and protocols will be reviewed and strengthened based on the lessons learned from the response at 200 Wellesley, to ensure an even more effective response to future emergencies.

The regular emergency response cycle includes a standard review of the response provided, debriefing with participants and making appropriate changes to policies and processes following the conclusion of an emergency response. Lessons learned from 200 Wellesley have already been used to enhance responses at subsequent emergencies, such as the evacuations in January at 1455 Lawrence W. and 35 St. Denis. Work is also

underway to address many of the issues identified, including discussions regarding implementation of electronic client registration and coordination of medical services in partnership with the Toronto Central LHIN. Other partner divisions and agencies have also begun work to review their response procedures and improve them based on the experience at 200 Wellesley. This work will be ongoing to address these and other issues identified by this review. These lessons will be reflected in the next version of the Emergency Human Services Operational Support Function (OSF) under the City's Emergency Plan.

The next steps identified through this review which are discussed in further detail in the report are:

- Improve awareness of the EHS policy and provide additional training
- Work to improve the awareness and implementation of the Incident Management System in place during an emergency
- Further develop relationships with landlords to increase their awareness of the EHS response, including work with TCH
- Work to inform councillors and their staff of the EHS policy and their role in an emergency
- Enhance the protocol for identification and uniforms for staff at Reception Centres
- Develop a protocol for communication with existing community networks and partners in the local neighbourhood during an emergency
- Review procedures for providing supplies at Reception Centres
- Implement procedures for a centralized EHS Operations Centre (EHSOC) for large emergencies
- Review the process for registration of residents and work towards an electronic registration system
- Ensure that the process for allocating hotel spaces is used in future emergencies
- Improve communication about temporary shelter options available during emergencies
- Develop a protocol to address bed bug issues during emergencies
- Establish a protocol for provision of prescriptions and medical services
- Review the process for distribution of tokens and vouchers
- Develop a protocol to address distribution of in-kind donations
- Clarify policies around eligibility for supports and demobilization of services
- Develop an education campaign regarding the importance of tenant insurance
- Review protocols related to staffing levels, orientation and scheduling
- Review policies regarding the use of volunteers
- Work with HR to review the policy on Stand-by/Call-in pay

Review Findings

1) Roles and Responsibilities in the Emergency Human Services Policy

Need for Awareness and Training on the New Policy

The Emergency Human Services Policy was approved in May 2010. Immediately following adoption of the new policy, all emergency preparedness efforts in the City were directed at G20 planning. The 200 Wellesley fire happened shortly thereafter. Many of the recommendations in the policy regarding communication and training are therefore still being developed and implemented and communication about the new policy has not yet been as widely distributed as originally intended. Therefore, some partners involved in the response were not fully aware of the new EHS policy and its implications for their response.

Follow-up and next steps:

SSHA will continue work to make Divisions across the City aware of the EHS policy and to assist partner Divisions to review and enhance their response processes as needed. Additional efforts will be made to involve other Divisions in the Emergency Human Services response, where appropriate, and identify Divisional contacts to communicate with when assistance is needed. SSHA will also continue to develop and implement a new training module for staff who may be redeployed to assist during an emergency to make them aware of the Emergency Human Services policy and the role they may be asked to play in such a response. This training will be complimentary to and coordinated with the City's Emergency Management Program.

Recognition and Implementation of the Incident Management System (IMS)

During an emergency response, existing organizational charts and structures are set aside and replaced by an established Incident Management System (IMS) which clearly sets out the roles of those involved in the emergency response. IMS is an internationally recognized and standardized framework for managing an emergency response that identifies an organizational structure, specific roles and responsibilities, decision making processes and other key management functions. Having a well-defined IMS structure in place assists in ensuring that when staff from different Divisions and multiple organizations with separate management structures come together to provide a coordinated response, the lines of reporting and decision making are clear at the emergency site. It also ensures that there is a designated back-up for each role, so that there is someone to fulfill that role on-site at all times and the primary responders have relief when they are not on duty. It has been identified that at 200 Wellesley there was some confusion and lack of clarity around decision making, accountability, and the IMS structure.

Follow-up and next steps:

To improve clarity of roles, responsibilities and decision making structures, further work will be done to improve the awareness and implementation of the Incident Management System in place during an Emergency Human Services response to ensure that everyone involved understands the IMS structure and what their role within it is. SSHA will continue to work with the OEM to identify how they can support the EHS response and their role at the Reception Centre.

Displaying an illustration, such as an erasable laminate poster, of the IMS structure with specific individuals identified in the various roles in a prominent location at the Reception Centre site, and ensuring that all staff on site have had an orientation to the structure, would assist in promoting awareness of the operating structure and lines of accountability.

Landlord Relationships

The importance of using the Incident Management System was particularly highlighted during the 200 Wellesley response due to the unique nature of this emergency, in which the landlord, Toronto Community Housing, was very involved in the emergency response. In this case, two large organizational structures of TCH and the City were involved in the same response, which led to some confusion because roles and responsibilities were not clearly understood and agreed upon. However, regardless of who the landlord is and what level of involvement they have, there is a need to ensure they understand the services provided by the City and their role in assisting tenants.

Follow-up and next steps:

SSHA will continue to work with OEM to develop an education campaign, as identified in the EHS staff report, to inform landlords and property managers of private, social and supportive housing about the importance of emergency preparedness, their responsibilities during an emergency and how the City can help them to support residents displaced from their buildings. SSHA will look for opportunities to provide this information to all social housing providers through regular training.

In addition, as the largest social housing provider in the city, a protocol will be developed in partnership with TCH for responding to emergencies in their social housing buildings. The protocol will clearly articulate how and when the City's Emergency Human Services response is activated and how TCH staff fit into the IMS structure and the Emergency Human Services policy.

Identification and Registration of Staff

All staff and agency volunteers who are involved in the Emergency Human Services response should be registered and easily identified. It has been identified that this did not

always occur during the 200 Wellesley response and this caused some confusion about who on-site was involved in the response. All involved personnel should be required to wear standardized uniforms which clearly identify that they are part of the response and which organization they are from. This includes management and executive staff who may be working at or visiting the site, as well as volunteers. SSHA has vests for Emergency Human Services staff to clearly identify them on-site.

Follow-up and next steps:

The protocol for identification and uniforms will be reviewed and enhanced, along with the registration processes for all participating staff and service organizations. Any identified improvements will be implemented for future emergency responses. Business practices will also be established regarding the on-site storage and distribution of approved identification/uniforms.

Involvement of Community Partners

The primary aim of the Emergency Human Services policy is to provide immediate, temporary services in response to an urgent emergency situation, and connect residents to existing mainstream services for longer-term needs. In the case of the 200 Wellesley response there were a wide range of services and community agencies in the nearby community that were available and willing to provide support to residents, however communication with these local agencies was not as effective as it could have been. A more strategic approach to communication with these community partners and coordination of available resources would facilitate referrals to these needed community services for residents.

Follow-up and next steps:

SSHA Emergency Planning staff will continue to work with the Community Crisis Response Program staff in Social Development, Finance and Administration to develop a protocol for assessing existing local community networks during an emergency response and developing a communication plan.

2) Establishing the Reception Centre

Provision of Supplies

Critical key supplies for staff and residents are needed on-site at the Reception Centre within hours of the emergency, such as registration forms, water, TTC tokens, taxi chits, emergency cell telephones, basic food supplies and water. Emergency Response staff who are first on scene carry ready bags stocked with these supplies needed for the first hours of the emergency. At the request of the City, the Red Cross is designated to provide kits of personal needs supplies to displaced residents, which occurred at 200 Wellesley. Feedback was received from some response staff that some key supplies were not available during the initial set-up of the Reception Centre.

Follow-up and next steps:

Procedures for providing supplies at the Reception Centre will be reviewed to ensure these supplies are available at Reception Centres in an organized and timely fashion. Procedures for supplying kits of clothing and personal hygiene items within the first 12 to 24 hours of the emergency in circumstances where people are not able to return home to obtain personal belongings and clothing will also be reviewed and improved as required.

Operation of Multiple Reception Centre Sites

Because of the scale of this emergency, Reception Centres were located at several sites for the first few days, to accommodate all the residents who needed shelter. This caused some confusion and communication issues between the two sites.

Follow-up and next steps:

In future, the EHS Operations Centre will be enhanced as a centralized location to oversee all Reception Centre sites, to ensure centralized coordination of information for the EHS response, adequate resource management and staffing at all Reception Centre sites, and enhanced communication processes between Reception Centre sites.

Registration of Residents

Establishing a quick and efficient system for registering displaced residents in the immediate aftermath of an emergency is critical. There are currently procedures in place to ensure all residents are registered, and registration of residents occurred according to established procedures. This is a paper based system which relies on manual record keeping by staff and residents to present paper registration documents in order to receive service. It has been identified that an enhanced system for ongoing electronic resident records would assist in coordinating information about services and supports for residents over the duration of the response.

Follow-up and next steps:

The registration process and forms will be reviewed to identify where there can be improvements to ensure that such a system is available to record basic information of all residents immediately after the emergency, through an electronic system where possible, which can then be augmented later with information about service and support needs. The process for identifying contact information for family or friends in the community so that residents can be contacted and provided with information after they have left the Reception Centre will also be reviewed for possible enhancements.

3) Providing Shelter for Displaced Residents

Prioritization of Clients for Emergency Hotel/Motel Use

While it is preferable for displaced residents to make arrangements to stay with friends and family in the community, there are often people with special needs who require specific care or vulnerable individuals who do not have community supports. These individuals required assistance with temporary accommodation.

During this evacuation, the CCAC was activated, as per the Vulnerable Populations Protocol, to ensure people with special needs and mobility issues were assisted to find temporary accommodation in long-term care homes and were offered additional supports at the Reception Centre.

When it became clear that all other residents would not be able to return to their homes in the short term and would need to be provided access to emergency hotel rooms, TCH staff attempted to prioritize placement of tenants into hotel rooms by level of need. However, because many of these tenants had already relocated to the community and TCH did not have current contact information, they were difficult to locate and communicate with. This caused some difficulties in allocating hotel space efficiently and effectively to tenants.

Follow-up and next steps:

While those who are more vulnerable should be give priority to receive hotel accommodations, in future responses there needs to be a balance between using available resources expediently and prioritizing residents based on need. The current process for allocating hotel spaces should continue to be followed in future emergencies.

Use of Hotels/Motels

During this emergency, a large number of hotels made rooms available to displaced residents. The hotel operators were very accommodating and cooperative in assisting these residents in a time of crisis, and we would like to thank them for their assistance. There were also some challenges, particularly in managing the geographical distance between where reservations were available and affordable and where the emergency occurred. Because the building where the fire occurred was located downtown, and the majority of available hotel rooms are located outside the downtown area, some residents chose not to take advantage of this service. Balancing the available units with demand was challenging and time consuming for staff.

There was also a perception by some that the City was slow to offer hotels as accommodation immediately after the emergency while residents were accommodated at the reception centre in the first few nights. This is not uncommon during an emergency as it sometimes takes up to 24- 48 hours to ascertain how long tenants will have to be out of their homes. In this case, information about how long tenants would be out of their

apartments and the decision to move people into hotels was made by TCH rather than SSHA staff.

Follow-up and next steps:

In the future, communication will be enhanced to tenants about the benefits of hotels available in suburban areas which are well-connected with public transit.

There will also be improved communication about the policies in place regarding the need to accommodate residents in temporary shelter at the Reception Centre until there is further information about the severity of the emergency and the length of time that evacuation will be required, in order to appropriately manage expectations.

Bed Bugs

When residents are displaced from their homes, they are given shelter in community centres, emergency shelters and hotels. Some residents may be dealing with bed bug infestations in their homes which could affect the new accommodation to which they are relocated.

Follow-up and next steps:

A protocol will be developed in partnership with Toronto Public Health to address bed bug issues during an emergency situation which balances the need to control the spread of bed bugs with respect for the privacy and dignity of residents who are going through a crisis situation.

4) Providing Supports to Displaced Residents

Provision of Prescriptions and Medical Services

In incidents where residents are evacuated from buildings very quickly, without the ability to retrieve important personal items, many people need to replace urgent prescription medications. In the case of 200 Wellesley, there was also a need for many residents to receive some medical and home support care, given the vulnerability of the population. This was the first time that a medical support service with physicians was established on site, with the assistance of the CCAC. The implementation of these services could be more quickly and effectively coordinated in the future.

Follow-up and next steps:

Current procedures for replacing medication will be reviewed and the Vulnerable Populations Working Group will assist in establishing a protocol going forward regarding when and how these services are provided. EMS will work with the Vulnerable Populations Working Group, SSHA and other partners, such as the Ontario Hospital

Association, to establish a protocol for coordination of medical assistance at Reception Centers.

Dispensation of Tokens and Food Vouchers

During an emergency situation, residents are initially provided daily with TTC tokens and food vouchers, as necessary. Residents are required to come to the Reception Centre each day to pick up their vouchers and tokens, until it has been established that the emergency will require residents to be displaced for more than a few days, after which token and food voucher allocation is issued weekly. In this case, due to the time it took for TCH to assess how long tenants would remain out of their homes and the need for TCH to communicate this message to tenants, there was a longer than usual delay in shifting to a weekly pick-up. This was identified as a source of anxiety and inconvenience for residents.

Follow-up and next steps:

Processes for distribution of tokens and food vouchers will be reviewed to determine if changes are needed.

Donations

During a large emergency like the one at 200 Wellesley, there is often an outpouring of support from the public who want to help those residents who have been displaced from their homes with donations. SSHA has been working in partnership with the Office of Partnerships to develop policies and protocols to accept and distribute donations of cash and gift cards.

Many residents are often moved to make in-kind donations of used clothing and household goods for people who have often lost, or have no access to, their possessions. A large number of donations were received during 200 Wellesley, and a decision was made to open a donations centre, staffed by EHS Operations Centre staff, to facilitate distribution of donated goods to residents in need. While this donations centre ran well, the question has been raised as to whether engaging a community agency with expertise and experience in collecting, sorting and distributing second-hand goods, could perform this function.

Follow-up and next steps:

Work is ongoing to refine and finalize donations protocols with the Toronto Office of Partnerships, including the Donations Management OSF as part of the City's Emergency Plan.

Going forward, SSHA will explore the development of a protocol to address distribution of in-kind donations, including how community agencies may be able to assist in the operation of a donations centre in the future.

Ending Supports for Residents

Due to the long-term nature of the evacuation of residents, and given the size of TCH's portfolio, they were able to make some vacant units available to displaced residents to stay in temporarily. This was somewhat of a unique situation which caused some confusion about whether those residents were still entitled to receive other Emergency Human Services such as TTC tokens and food vouchers. It has been identified that greater clarity is needed in determining when residents are no longer eligible for services and how response services are demobilized.

Follow-up and next steps:

During the response, it was clarified that while residents are in temporary accommodations, including being temporarily relocated, they are entitled to continue to receive other supports. However, once residents' units have been given the okay and residents move back into their permanent accommodation, they are no longer eligible to receive Emergency Human Supports. Going forward, the policy around eligibility for supports and demobilization will be reviewed and clarified.

Tenant Insurance

In assisting residents after the emergency, it became clear that very few had any form of tenant insurance to assist them in replacing belonging damaged in the fire.

Follow-up and next steps:

SSHA will continue to work on the recommendation identified in the Emergency Human Services staff report to work with OEM to develop an education campaign to inform residents about the importance of maintaining up to date home insurance for both tenants and homeowners, and about the importance of understanding exactly what coverage is provided by their insurance policies in relation to unexpected emergencies. This will be developed with the participation of the insurance industry and will build upon the existing emergency personal preparedness education campaign.

5) Staffing and Human Resources

Staff Deployment and Scheduling

When an emergency occurs, staff are deployed from multiple divisions to work in shifts at the Reception Centre. It is important that Divisions have a plan in place to be able to deploy staff quickly, and that staffing resources are used as efficiently as possible to meet needs while respecting that staff are being diverted from their regular duties. It is also important that staff who are being re-deployed are clear about their role and responsibilities and that information about these responsibilities is provided clearly at each shift change to ensure consistency. These areas could have been improved in the 200 Wellesley response, as there was some difficulty in deploying staff from all partner

Divisions quickly and a lack of clarity for some response staff regarding their role on-site.

Follow-up and next steps:

Protocols for determining staffing levels at Reception Centres and scheduling procedures will be reviewed for any needed improvements. SSHA will work with supporting Divisions to ensure response plans are in place to deploy staff efficiently and effectively during emergencies. SSHA will also continue work to clearly define the roles of all Reception Centre staff and ensure that this information is communicated to participating Divisions both before and during emergencies. Protocols for orientation, on-site training and communicating information during shift changes for re-deployed staff will also be reviewed for possible enhancements.

Use of Volunteers

During an emergency response, often members of the community wish to assist the residents affected by volunteering their time. While such generosity and compassion for their neighbours is always appreciated, it is important to ensure that volunteers on site are a seamless part of the IMS structure and are contributing to the response rather than becoming an additional issue to be managed. During 200 Wellesley, TCH had community volunteers participating in various capacities. Existing EHS policy which has been established in consultation with the City's Legal and Human Resource staff, is to work through non-profit organizations such as the Red Cross and the Salvation Army who are delegated responsibility to train, provide and supervise volunteers for specific tasks.

Follow-up and next steps:

Existing Human Resources policies regarding use of volunteers during emergencies will be reviewed to identify any issues and/or needed enhancements, including the Volunteer Management OSF as part of the City's Emergency Plan.

HR Policies

Because this was the first emergency human services response using the new policy, there was some confusion about implementation of HR policies, particularly regarding non-union compensation for overtime. Additionally, the EHS report recommended that Human Resources review Standby/Call In and Emergency Pay provisions for non union staff and report back to the Employee and Labour Relations Committee with any recommendations, which has not yet occurred.

Follow-up and next steps:

Based on the experience at 200 Wellesley, there should now be greater clarity regarding these policies, which will be communicated to staff at the beginning of any future

emergency response. SSHA will work with Human Resources and other affected Divisions on the review of the Standby/Call In and Emergency Pay policy and report back to Committee with any recommendations.

Conclusions

Overall, the implementation of the Emergency Human Services policy was effective. A Reception Centre and supports were provided to residents for 14 days, at which time all residents were assessed as low-income given that they were in receipt of rent-geared-to-income assistance, and supports were extended for the duration of their displacement. A large group of very vulnerable residents were provided with food, shelter and other needed supports in respectful and caring manner in a time of personal crisis and were provided with support until they were able to return to their homes. This was the result of tremendous collaboration, flexibility and responsiveness of the many Divisions and organizations who participated in the response to provide much needed services to the many vulnerable residents who were displaced from their homes.

This was the first time that the full Emergency Human Services policy approved by Council was implemented, and the first event which allowed the new policy to be tested during a full-scale emergency. Policies and protocols identified above will be reviewed and strengthened based on the lessons learned from the response at 200 Wellesley, to ensure an even more effective response to future emergencies.

Attachment 1
Overview of the Emergency Human Services Policy

Emergency Human Services (EHS) is an organized response to the urgent needs of people and their pets once they are out of immediate danger of a disaster or emergency situation.

The primary services provided as part of Emergency Human Services include providing emergency accommodation, food, registration and inquiries, personal support services and operation of a Reception Centre for residents evacuated from their homes.

The Emergency Human Services response is coordinated by Shelter, Support and Housing Administration (SSHA) and delivered by pre-identified City divisions and agencies with pre-determined roles that come together to provide these services to residents in times of emergencies.

Emergency Human Services are provided to residents during both small and large scale emergency situations. Services provided are adjusted to respond to the scale and nature of the emergency.

Services provided at a Reception Centre may include:

- Meal service, or meal vouchers if required
- Temporary alternate accommodation
- Emergency personal care supplies and clothing
- Assistance to contact friends and family
- Coordination with emergency services for retrieval of vital medication and important documents.
- Care of unattended children and emergency pet care.
- Emotional support, crisis support and referrals provided by Toronto Public Health.
- Assessment for emergency financial aid provided by Toronto Employment and Social Services.
- Referral to housing help services for longer term housing solutions if relocation is required

The primary aim is to provide immediate, temporary services in response to an urgent emergency situation, and connect residents to existing mainstream services for longer-term needs.

All registered residents are eligible to receive supports for up to 14 days following the emergency incident, if required. Households which meet assessed low-income eligibility

criteria will be eligible for continued supports, including accommodation, food and transportation assistance, after 14 days.

The full policy is available at:
http://www.toronto.ca/legdocs/mmis/2010/ex/bgrd/backgroundfile-29017.pdf

Appendix D

TORONTO

Memorandum

John W. Livey, F.C.I.P.
Deputy City Manager

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Loretta Chandler
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TO: Mayor Rob Ford and Members of Council

FROM: John W. Livey, Deputy City Manager

DATE: January 10, 2012

SUBJECT: **Councillor Notification and Roles in an Emergency**

At the City's Executive Committee Meeting on May 24th, and on June 14th and 15th, 2011, Councillor Berardinetti moved a motion on "Aftermath of Japanese Earthquake" which prompted the following City Council decisions:

1. *City Council request the Director of the City of Toronto's Office of Emergency Management, to review any changes to protocols and action plans made by Emergency Management Ontario since undertaking the review directed by the Ministry of Energy.*

2. *City Council request the Acting Deputy City Manager, Cluster B to develop a communications protocol to be used by City Councillors, that would identify how the public would receive communications during an emergency.*

In response to Decision 1, Emergency Management Ontario continues to investigate the lessons learnt from the events of Japan. The Office of Emergency Management anticipates the release of those findings and subsequent action plans at the Nuclear Emergency Management Coordinating Committee in April of 2012 of which the City of Toronto is a member.

In response to Decision 2, I am pleased to enclose the "Councillor Notification and Roles in an Emergency" Protocol and Briefing Note. The Protocol outlines:

- How Councillors will be notified during emergencies
- Roles of the Mayor and Councillors during an emergency in its initial and subsequent stages

Members of Council are encouraged to please review these protocols and become familiar with them as they are currently being followed by our emergency services, operational Divisions, Strategic Communications and the Office of Emergency Management as they apply to the Emergency Levels of an Incident.

If you have any questions or need more information, please contact Loretta Chandler at the Office of Emergency Management (416)338-8746 / lchandl@toronto.ca).

John Livey, F.C.I.P.
Deputy City Manager, Cluster B

Encl.

TORONTO

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BRIEFING NOTE

Date: December 14, 2011

Office of Emergency Management

Councillor Notification & Roles in an Emergency

Issue/Background:

Most emergencies are managed at the Site by Emergency Services and City Divisions and are considered routine operations. Some Divisions already have pre-established notification procedures with Councillors. For example, Toronto Fire Services and Shelter, Support and Housing Administration (Emergency Human Services) have canvassed Members of Council to develop pre-established notification protocols for routine operations.

Emergencies of greater magnitude do happen from time to time and require an emergency management response structure beyond Normal Daily operations. The response required by City of Toronto Councillors must be appropriate to the magnitude of the incident as defined in the Emergency Levels classification. It is important for Councillors to understand and support the coordinated and timely management of information.

Every effort should be made to maintain a streamlined information management process and avoid the passing of inaccurate, conflicting and/or misleading information to the Public, City Staff, and the Media. At the City's Executive Committee Meeting on May 24th, and on June 14th and 15th, 2011, Councillor Berardinetti moved a motion on Aftermath of Japanese Earthquake which prompted the following City Council decision:

1. City Council requests the Acting Deputy City Manager, Cluster 'B' to develop a communications protocol to be used by City Councillors that would identify how the public would receive communications during an emergency.

The City of Toronto's Office of Emergency Management (OEM) recently conducted a review of Toronto's Emergency Plan including its Notification Levels Operational Support Function (OSF). At the most recent September 8th meeting of the Toronto Emergency Management Program Committee (TEMPC), Loretta Chandler, Director, Office of Emergency Management (OEM) presented the Draft ***Councillor Notifications – Emergency Levels*** and ***Councillor Roles and***

Emergency Information tables.

- **Page #1 of 2: Councillor Notifications - Emergency Levels**
- **Page #2 of 2: Councillor Roles & Emergency Information**

These two tables outlined:

1. How Councillors will be notified during emergencies.
2. Roles of the Mayor and Councillors during an emergency in its initial and subsequent stages.

Key Points:

Further to the Emergency Management Working Group (EMWG) meeting held on June 27th, 2011 and comments received as well as discussions which were held at the September 8th TEMPC meeting, a consolidated table was developed. This one page ***Councillor Notification & Roles in an Emergency*** table was also reviewed, revised and approved at the EMWG meeting held on October 31st. The approved table is attached with the following columns:

COLUMN #1: Emergency Levels

Four Emergency Levels

- Level 0 (Normal)
- Level 1 (Minor Incident)
- Level 2 (Major Incident)
- Level 3 (Emergency Incident)

COLUMN #2: Operational Implications

Operational implications at the Site and/or Emergency Operations Centre escalated through the four Emergency Levels.

COLUMN #3: Councillor – Notification Protocol

Outlines the usual Councillor Notifications that would occur during the communications outlined in the Emergency Levels "heat table" which was approved by EMWG (February 28th, 2011).

- City Clerk's Office to Notify Mayor and affected Members of Council of Incident as required
  (If Mayor declares an emergency, City Clerk's Office to Notify Members of Council)

COLUMN #4: Councillor – Roles in an Emergency

Outlines the specific information that Councillors would be provided through notifications from Strategic Communications.

In addition, this column details the key roles that elected officials have during an emergency incident, in particular the link between the community and our emergency services:

- Assist with relaying information to Ward residents
- Attend Community or Evacuee Meetings (i.e. Reception Centre)
- Reassure constituents
- Support action taking place in the community
- Liaise back through Mayor concerns from within the Ward
- Follow the leadership and requests of Mayor

COLUMN #5: Sample Events – Severity
Examples of events by Emergency Level severity.

Summary:

The Emergency Management Working Group completed its review and approved the attached ***Councillor Notification & Roles in an Emergency*** table on October 31st, 2011. This table was presented to the Toronto Emergency Management Program Committee for final approval on Nov. 24 and subsequent circulation to the City's elected officials. Details found within this table will also be incorporated into the Notification Levels Operational Support Function and the City's Emergency Plan.

Prepared by: **John Livey, Deputy City Manager,**
Loretta Chandler, Director, Office of Emergency Management

Approved

Councillor Notification & Roles in an Emergency

November 24, 2011

Emergency Levels	Operational Implications	Notifications	Roles	Sample Events – Severity
LEVEL 0 NORMAL	▪ Business as Usual ▪ Normal Operations	▪ Division(s) on Site will continue to follow established Internal Notification / Escalation Procedures	▪ No Action required	▪ House Fire ▪ Vehicle Accident ▪ Road Closure
LEVEL 1 MINOR INCIDENT	▪ **Site:** Managed by Emergency Services / Divisions	▪ Division(s) on Site will continue to follow established Internal Notification / Escalation Procedures	▪ Generally No Action required	▪ Localized Power Failure ▪ Yonge & Gould Fire (2011)
LEVEL 2 MAJOR INCIDENT	▪ **Site:** Managed by Emergency Services / Divisions ▪ **Site:** Site Incident Commander (IC) may request support from Office of Emergency Management (OEM) 'On-Call' ▪ **Site:** May request the Activation of the Emergency Operations Centre (EOC) ▪ **EOC: May be Activated**	▪ Division(s) to Notify Deputy City Managers (DCMs) of the incident and confirm Direction and Future Notifications ▪ Division(s) to Notify Strategic Communications of incident ▪ Strategic Communications to Notify Mayor and Members of Council of Incident	▪ Strategic Communications to Notify Mayor and affected Members of Council of Incident ▪ Site to provide updates to Councillors and 311 Toronto as needed Councillor Roles: ▪ Assist with relaying information to Ward residents ▪ Attend Community or Evacuee Meetings (Reception Centre) ▪ Reassure constituents ▪ Support action taking place in the community ▪ Liaise back through Mayor concerns from within your Ward ▪ Follow the leadership and requests of the Mayor	▪ Queen Street West Fire (2008) ▪ H.S.E. Hickson Fire – Chemical Court (1998) ▪ Finch Avenue Bridge Washout (2005) ▪ 2 Secord Avenue (2008) ▪ Wellesley High-Rise Fire (2010)
LEVEL 3 EMERGENCY INCIDENT	▪ **Emergency Operations Centre (EOC):** is Activated Emergency poses a danger of major proportions to life and property, and / or threatens social order and ability to govern, and / or a declaration of an emergency by another level of government	▪ Office of Emergency Management (OEM) to Notify Deputy City Manager (DCM), Cluster 'B' who in turn Notifies the City Manager and Mayor ▪ Deputy City Manager (DCM), Cluster 'B', City Manager and Mayor discuss Direction and Next Steps ▪ City Clerk's Office to Notify affected City Councillors, as required ▪ Deputy City Manager, Cluster 'B' and Office of Emergency Management (OEM) to Notify Members of Control Group / Emergency Management Working Group ▪ If Mayor declares an emergency, City Clerk's Office to Notify Members of Council	▪ Strategic Communications communicates critical information from the Emergency Operations Centre (EOC) and City officials to Members of Council, 311 Toronto, City staff, community leaders, residents, businesses and the media. ▪ If Mayor declares an emergency, City Clerk's Office to Notify Members of Council	▪ G-20 Summit (2010) ▪ Sunrise Propane Explosion (2008) ▪ Northeast Power Outage (2003) ▪ SARS (2003)

Approved by Emergency Management Working Group – October 31, 2011