Canadian Nuclear Safety Commission | Commission canadienne de sûreté nucléaire

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Global Public Affairs Independent Review of the Canadian Nuclear Safety Commission's Response to the January 12, 2020 Pickering False Alarm and CNSC Management Response

Examen indépendant effectué par Global Public Affairs de l'intervention de la Commission canadienne de sûreté nucléaire lors de la fausse alerte à Pickering, le 12 janvier 2020, et réponse de la direction

Public Meeting

Réunion publique

Scheduled for:

17 June 2020

Prévue pour :

17 juin 2020

Submitted by:

CNSC Staff

Soumis par :

Le personnel de la CCSN

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Canada

Summary

- On January 12, 2020, Emergency Management Ontario issued a false public alert related to the Pickering Nuclear Generating Station. The Canadian Nuclear Safety Commission (CNSC) was one of the organizations who responded, issuing communications to the public to confirm that the alert was false.
- The CNSC conducts lessons learned following events to support continuous improvement and readiness. In addition to its usual post-event evaluation of the false alert response, the CNSC engaged an independent third party, Global Public Affairs (GPA), to review the CNSC's communications response. The recommendations were consistent with the internal CNSC review and have been incorporated into the CNSC action plan to enhance emergency preparedness. Most actions are now complete with all remaining underway. The GPA review and the management response to the recommendations are the focus of this CMD.

Résumé

- Le 12 janvier 2020, Gestion des situations d'urgence Ontario a émis une fausse alerte au public concernant la centrale nucléaire de Pickering. La Commission canadienne de sûreté nucléaire (CCSN) a été l'une des organisations qui sont intervenues, en diffusant des communications au public pour confirmer que l'alerte était fausse.
- La CCSN examine les leçons retenues à la suite d'événements afin d'appuyer l'amélioration continue et de renforcer l'état de préparation. En plus de l'évaluation habituelle qu'elle mène après les événements, la CCSN a demandé à un tiers indépendant, Global Public Affairs (GPA), d'examiner les communications qu'elle a faites pendant la fausse alerte. Les recommandations de GPA, qui étaient conformes à celles tirées de l'examen interne de la CCSN, ont été intégrées au plan d'action de la CCSN visant à améliorer l'état de préparation aux urgences. Les mesures sont maintenant presque toutes terminées. Le présent CMD porte sur l'examen de GPA et la réponse de la direction aux recommandations.

There are no actions requested of the Commission. This CMD is for information only

The following items are attached:

- Global Public Affairs Independent Review of the Canadian Nuclear Safety Commission's Response to the January 12, 2020 Pickering False Alarm and CNSC Management Response

Aucune mesure n'est requise de la Commission. Ce CMD est fourni à titre d'information seulement.

Les pièces suivantes sont jointes :

- Examen indépendant effectué par Global Public Affairs de l'intervention de la Commission canadienne de sûreté nucléaire lors de la fausse alerte à Pickering, le 12 janvier 2020, et réponse de la direction

WalkerSisttie, Rhonda

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GLOBAL PUBLIC AFFAIRS

FROM INSIGHT TO IMPACT

Independent Review of the Canadian Nuclear Safety Commission's Response to the January 12, 2020 Pickering False Alarm

May 2020

Prepared by Global Public Affairs

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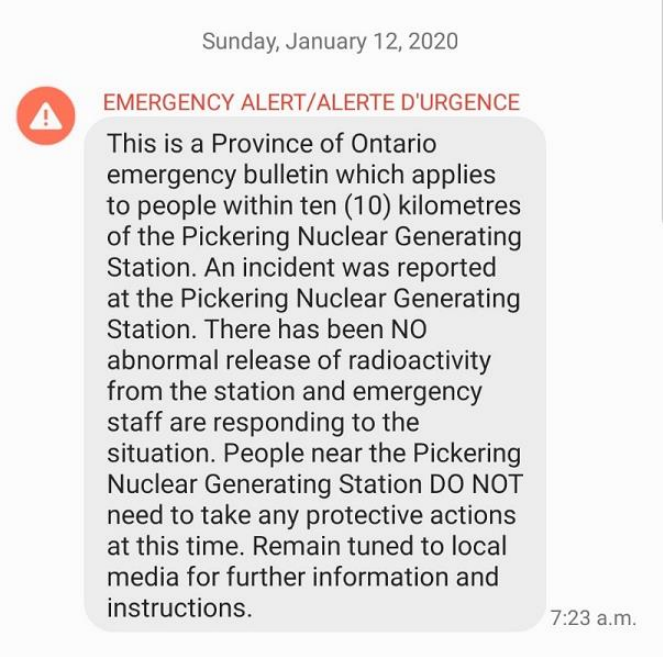
Executive Summary

Early in the morning on January 12, 2020, many Ontario residents awoke to an alert from the Province of Ontario's emergency notification system.



Key stakeholders quickly determined this was a false alarm, but the first public notification confirming the false alert was not issued until 43 minutes later via Twitter, from the plant operator, Ontario Power Generation (OPG). Most senior staff at the Canadian Nuclear Safety Commission (CNSC) realized there had not been an incident at the facility within minutes of the original notification. However, a public message from the CNSC was not issued until 08h46, 1 hour 23 minutes after the initial alert.

The Province of Ontario subsequently issued a correction via the original notification system 1 hour and 48 minutes after the initial notification was released, and 1 hour and 5 minutes after the operator tweet.

The delay in correcting the error contributed to confusion within the community near the facility and fostered public mistrust in the emergency alert system. The event became the lead story for many news outlets and led to a significant increase in social media dialogue directed at the Province and OPG. Media coverage focused on the false alert and why it took the Province so long to issue a correction.

The subsequent investigation led by the Province revealed that the first alert was issued in error during a routine internal test of the emergency notification system. Internal reporting also revealed that provincial staff lacked the authority to recall the message. Once granted permission, the staff struggled to develop a plan for issuing a correction, causing further delays.

Following the event, the CNSC conducted an internal review and commissioned Global Public Affairs to conduct a third-party review of the CNSC response. This review aimed to identify flaws or gaps in processes and provide recommendations to improve the CNSC's performance in an emergency or a crisis, whether due to operational or reputation factors. For the review, the CNSC provided the research team with a transparent look into their operations, including internal reports, logs and emergency procedures. The CNSC also allowed complete access to staff for confidential interviews.

In terms of research methodology, interviewee selection criteria were identified jointly by the researchers and the CNSC. Based on the three internal incident reports completed by CNSC, there was a base understanding of the key players with a line of sight into how the day's events unfolded. Participants were selected based on their proximity to the incident. All participants played an active role at some point in the decision-making process on January 12.

The interviews followed a semi-structured process. Each interview followed a set of base questions (see Appendix B), and an additional set of unique questions for each functional group (communications, operations). Interviewees had time to provide any final thoughts before the interview close.

In assessing the findings, there are two methodological considerations to bear in mind. First, there was nearly a two-month gap from the date of the event and the first interviews. During that time, CNSC staff completed three internal reports on the January 12 incident. Those reports were available to most of the interview participants so, internal CNSC findings had been shared and reinforced for two months before the independent review began. The two factors combined create a possibility that conclusions had been drawn even before the first interview began. However, the research team judges this as a low risk to the research's integrity since most participants kept detailed notes of the day's events. During the interviews, some participants also referenced outstanding questions or concerns that they hoped to see addressed through the independent review.

Secondly, towards the end of the interview process, CNSC became understandably consumed with the COVID-19 situation. Four interviews happened during the early stages of CNSC's COVID-19 response. While some of those four participants made comparisons between January 12 and COVID-19, the research team decided to omit those comparisons from the analysis as not every interviewee was able to use this context. Further, the COVID-19 response limited our ability to interview external stakeholders, and our use of external inputs was limited.

Our review identified several areas that, on their own, may not have created significant issues. But, as is typical in emergencies, combined to create a situation that caused delays in the CNSC's response and, if not addressed, can produce similar delays in the event of a real emergency.

Key areas of focus in this report include:

- A need for greater clarity regarding the CNSC's sequencing with licensees and the Province in communicating about nuclear events and how they will respond to non-operational, reputational events, as occurred on January 12, 2020,
- Reinforcing a culture that allows for the flexibility and immediacy that emergency communications require
- A training regime focused on large scale events without enough focus on reputational events, like the one that occurred on January 12, 2020, and
- The connection between the goals and priorities of senior leadership and their staff.

Throughout the interviews, we observed a strong sense of pride among staff and a desire and commitment to learn from this event and improve.

Background

About the Incident

Canada's National Public Alerting System (NPAS), otherwise known as Alert Ready, is a public-private

partnership between federal, provincial and territorial governments, Canada's broadcasting and telecommunications players, and the Pelmorex Corporation. The Province of Ontario can determine when an alert is issued, the content of the alert and the geographical area receiving the alert. The Province of Ontario's Emergency Operations Centre (PEOC) tests the NPAS system during each Duty Officer (DO) shift change and has a series of template messages in the case of emergency. According to the investigation conducted by the Government of Ontario, the alert on the morning of January 12 was a pre-scripted message accidentally sent by a DO, believed to be logged into the training system. The DO immediately communicated the error to the supervising staff. In the absence of a pre-scripted cancellation message, combined with a need to communicate with multiple stakeholders, created a delay in message retraction. There was confusion on the part of the Province and the operator. This confusion extended to communications with external stakeholders, including the CNSC.

In addition to the communication challenges that the Strategic Communications Directorate (SCD) faced with the Province and operator, a second major challenge on January 12 was the that CNSC website outage caused delays in relaying information until approximately 13h00 that day, with internal briefing notes highlighting that media outlets could not reach the website at 10h30 that day. According to an internal briefing note summarizing the website performance issues, total page views on January 12, 2020, compared to November 6, 2019, increased by 204 per cent. Total users increased by 357 per cent, and users in Ontario increased by 503 per cent.

To address these issues, SCD staff liaised with the Information Management and Technology Directorate (IMTD) and Public Safety Canada to explore alternate options to communicate updates while the CNSC website was not operational. Given the pressures to communicate extensively and immediately, SCD decided to communicate public messaging over social media until the website became available since any of the other options considered would not have "improved timing on Sunday to post information before 1300h." (CNSC Internal Review, p. 5).

Verified Timeline of Events

The following timeline has been pieced together from the CNSC internal reviews and the Province of Ontario's public investigation into the emergency alerts. The timeline is not intended to be exhaustive but instead aims to provide a summary of the key activities that took place.

Sunday, January 12, 2020

07h23 PEOC issues an emergency alert to 10 million Ontarians via Alert Ready regarding an incident at the Pickering Nuclear Generating Station

07h46 and 07h51: CNSC IMTD confirms to the CNSC SCD that the website server cannot handle traffic and contact had been made with Rogers to address website issues

08h03 CNSC Duty Officer (DO) confirms the false alert to SCD and other CNSC staff

08h06 Operator issues a tweet confirming the false alert

08h33 CNSC receives first media inquiry through social media (The New York Times)

08h40 CNSC Media relations replies, via email, to media inquiry with media lines

08h42 CNSC Emergency Operations Centre (EOC) is partially activated

08h46 CNSC posted a tweet via Hootsuite in both official languages confirming the false alert

08h59 CNSC posts on Facebook and LinkedIn in both official languages confirming the false alert

09h11 PEOC issues a second emergency alert via Alert Ready stating that the previous alert had been sent in error

09h45 First EOC meeting takes place at CNSC HQ

09h57 Luc Sigouin is confirmed as CNSC spokesperson

10h31 CNSC issues a tweet containing the media relations phone line as information was not otherwise accessible via the website

12h11 Province of Ontario, via the Solicitor General, issues a statement regarding the false alert

12h22 SCD records a message recorded to CNSC employee information line about partial EOC activation, alert error and Pickering safety

12h51 CNSC tweets statement from Solicitor General about the alert error (there was no authorized tweet available to retweet)

13h14 CNSC shares a statement from Solicitor General about the alert error on Facebook and LinkedIn

13h37 CNSC website content goes live including the latest news, a Pickering facility update, alert error and a link to the Ontario statement

15h30 CNSC EOC disbands

18h03 Internal message sent to all CNSC staff containing information regarding the day's events

Monday, January 13, 2020

13h52 CNSC issues a tweet reiterating the alert error and linking to a thread "explaining who does what during a nuclear emergency."

Wednesday, January 15, 2020

The Government of Ontario's Deputy Solicitor General – Community Safety directs the Provincial Security Advisor to investigate the January 12 incident.

- Government of Ontario Solicitor General announces a full investigation into the alerts.

Reviews Completed to Date

Internal CNSC Review

Below is a summary of the key findings that came out of the CNSC's SCD internal review.

- CNSC training exercises are not focused on preparing the organization "for a very sudden event where the media and public are fully engaged before the operator, Province or CNSC."
- Communication with all CNSC staff should be prioritized.
- CNSC SCD should implement a digital-first communications approach, meaning that SCD will retweet other official sources within the first 30 minutes of the event.
- The creation of social media lines should be prioritized over traditional media lines.

- Hootsuite and social media training should be prioritized for CNSC's Head of Communication and key SCD staff.
- Establish best practices for social media monitoring. This could potentially mean active social media monitoring by one person with monitoring capabilities but also to potentially provide advice on content and engagement. In this instance, two SCD social media staff monitored for the first 12 hours.
- After-hours IT support should be available to ensure, among other things, that "SCD staff have stable access to website content, ability to connect from offsite, and urgent responsive action from IMTD when there is a website or remote connectivity problems."
- Increased preparation and protocols are required to deal with a remote-staff response. The SCD response would have been more efficient if staff were already in the office, but CNSC should be prepared if an emergency scenario happens after hours.
- Ultimately, it was determined that staff relied on their training and connections with the Province and operator to "ensure consistent messaging and awareness."

Ontario Government Investigation into the Emergency Alerts Sent on January 12, 2020

As Emergency Management Ontario (EMO) is responsible for administering and implementing the Provincial Nuclear Emergency Response Plan (PNERP), the Office of the Provincial Security Advisor conducted an in-depth analysis of the events surrounding the false alarm. In addition to determining the sequence of events, the investigation focused on understanding the protocols for issues, sending alerts via Alert Ready, cancelling alerts, Alert Ready training and a review of EMO's communications protocol with critical audiences.

The PEOC is activated in the event of a provincial or large municipal emergency to coordinate the provincial response.

Findings from the Investigation:

Sequence of events

- The false alert was issued due to human error on the part of a PEOC Duty Officer (DO).
- Standard protocol requires the DO, at the beginning of each shift change, to test both the live and training Alert Ready systems. In this instance, the DO signed into the live Alert Ready system, believing it was the training system.
- The DO "immediately recognized the error and proceeded to seek guidance on corrective action from EMO supervisors."
- On-duty, on-call and off-duty EMO supervisors, ranging in seniority, were consulted by the DO, who allegedly did not receive clear instructions on corrective next steps.
- EMO supervisors were uncertain of how to deal with issuing a correction and were concerned that a follow-up alert via Alert Ready would be "broadcast intrusive."

Protocols and Procedures for Issuing an Alert via Alert Ready

- EMO maintains an Alert Ready policy to detail how an alert is created and issued. However, the policy does not cover the chain of internal approvals for issuing an alert, although there was a "common understanding" among staff regarding the approval chain.
- The PNERP includes a notification protocol in the event of a nuclear emergency, which was not activated in this instance.

Protocols and Procedures for Cancelling an Alert

- EMO maintains an "End Alert" procedure. However, the investigation did not find any record of this procedure being enacted.

Review of Pre-Scripted Messages in the Alert Ready System

- PEOC only had message templates related to nuclear alerts as required by the Provincial Nuclear Emergency Response Plan and no templates related to the “End Alert” procedure.
- Further, the PEOC issued messages were initially done in English only as PEOC did not have templates translated into French.
- Pre-written messages in the Alert Ready training system do not begin with a training exercise notification – the training messages are the same on the training and live site.

EMO Training on Alert Ready

- PEOC requires DOs to pass a four-week “entry training program that includes Alert Ready training.” The most recent training in November 2019 was shorter than usual “due to PEOC activation to coordinate a provincial response for an emergency flood evacuation.” This training is targeted for DOs, and EMO supervisors are not required to complete similar training.
- A review of the Alert Ready training system logs found that training alerts were not always sent according to the shift change protocol.

Lines of Communication with Government and Stakeholders

- Per the PNERP, government officials and key stakeholders must be given advanced notice in the event of a nuclear emergency.
- The investigation determined that communications with government and stakeholders “were handled on a case-by-case basis using inconsistent messaging.”

CNSC Emergency Protocol

The CNSC conducts training exercises to support communications training for nuclear/radiological emergencies and business continuity planning (BCP) exercises. According to CNSC, these exercises serve “to test protocols, improve collaboration and response time of message development and communications" (CNSC Internal Review, p. 4). The most recent exercise, Exercise Huron Resilience, held in fall 2019, found that a lack of after-hours technical support was a gap to be addressed. However, the critical gap identified by CNSC in its internal review is due to a lack of protocol, after-hours IMTD technical support or on-call and after-hours staff to respond in a non-nuclear, non-BCP incident. Instead, the CNSC describes SCD management and senior staff monitoring emails and media outside of working hours and dealing with after-hour requests individually based on priority. At the time of the interviews, SCD executives were informally on-call after hours and on weekends.

CNSC's protocol for radiological or BCP situations includes template public communications content, but no existing template content was deemed suitable for this non-radiological, non-BCP situation.

As outlined in CNSC’s protocol for nuclear-related incidents, SCD holds off communication until the Province or operator communicates publicly, after which SCD amplifies messages and redirects inquiries to the Province. During this incident, SCD did not wait for the Province before issuing a response, although the operator had sent a tweet confirming the false alert.

CNSC Emergency and Crisis Communications Framework

The CNSC's emergency and crisis communications framework (ECCF) outlines the role of the federal regulator in an emergency or crisis response scenario. More significantly, the Framework outlines the role of the SCD in a scenario. "The Strategic Communications Directorate (SCD) is responsible for communications with the public and employees and media relations during any emergency or crisis. SCD ensures that appropriate communication practices and resources are available in the event of an emergency or crisis" (Emergency and Crisis Communications Framework, 1).

The CNSC defines a nuclear emergency as "any abnormal situation that may increase the risk of harm to the health and safety of persons, the environment, or national security, and that requires the immediate attention of the CNSC." It is an abnormal situation that requires action beyond the scope of standard procedures, and additional resources and coordination are required to minimize the impact effectively. Whereas, a crisis is defined as a situation that challenges the public's sense of appropriateness, traditions, values or security, or the integrity of the government. Under these definitions, the event on January 12 falls within the CNSC's definition of a crisis communications scenario.

According to the ECCF, the communications strategy to be undertaken by the CNSC is decided at the time of an event and "may include information updates, social media updates, news conferences, technical briefings and activation of the CNSC's crisis website" (ECCF, 2). The ECCF provides a simple guide for the strategy.

The DG SCD is ultimately responsible for identifying communications personnel for crisis communications. The DG reviews and signs off on the communications strategy and messaging developed by the Communications Section during a stand up of the EOC and has responsibility for all communications staff and messaging during a crisis scenario. Within the Government of Canada, the DG keeps in contact with the DG Communications from other departments, including Natural Resources Canada, Public Safety and the US Nuclear Regulatory Commission (USNRC).

Research Methodology

Participant Description

Participant selection criteria were identified jointly by the research team and CNSC. Based on the three internal incident reports completed by CNSC, there was a base understanding of the key players with a line of sight into how the day's events unfolded. Participants were selected based on their proximity to the incident – all participants were directly involved at some point in the decision-making process on January 12.

There were two groups of participants interviewed, CNSC staff (n=12) and non-CNSC staff (n=2). Of the CNSC staff invited to participate in the study, all agreed to participate and signed consent forms (See Appendix A). Participating CNSC staff were surveyed at the beginning of each interview to create a profile of the group. Most of the interviewees were senior members of the organization, with 10 of the 12 respondents holding a Director-level position or higher. While this ratio is not representative of the organizational structure, most respondents involved in the January 12 response were senior-level staff who were required to be "on-call" or, at the very least, monitoring their work phone and email during off-hours.

While interviewees were generally more senior, their length of time working at the CNSC varied significantly, and there was a minimal correlation between organizational seniority and length of time at

the CNSC. Three interviewees held the position of either President or Vice-President, four interviewees are Director General-level, three are Director-level, one serves as a Team Lead, and finally, one serves as an advisor.

An early decision was taken to include non-CNSC staff in the interview process to understand better how external stakeholders perceived the CNSC's actions on January 12. Invitations to participate in the research were sent to CNSC stakeholder groups across media (n=2), provincial response staff (n =1), Ontario Power Generation (n =1) and municipal leaders (n=2).

A low response rate was observed across the external stakeholders invited to participate due to several factors, including illness and scheduling conflicts resulting from the evolving COVID-19 situation. Ultimately, one official from OPG and one municipal leader participated in the interview process. Given the small sample group, these participants' comments were used to provide additional context to the CNSC group's findings. No direct findings or recommendations were drawn solely based on comments made by the external stakeholders.

Interview Design

The interviews followed a semi-structured process. A set of base questions was used for each interviewee (see Appendix B), and an additional set of questions was developed for each functional group (communications, operations, IT). Finally, time at the end of each interview was set aside for an unstructured question-and-answer period when the researchers posed different questions to each interviewee. Interviewees were also provided time to put any final thoughts on the record that they had not already had the chance to discuss.

Each interview had a scheduled duration of 60 minutes, and the majority took place on-site at the CNSC between March 4-11. Due to events outside the control of both the researchers and the CNSC, three interviews with staff were completed via phone call. Both interviews with the external stakeholders were completed via phone call.

Coordinated Review Disclosure

As agreed in advance by the research team and the CNSC, senior CNSC staff had an opportunity to review a draft version of this report to verify the report's accuracy. Ultimately, the research team had full independence with respect to writing and analysis.

Findings

Please note that quotes have been edited for clarity and to ensure anonymity.

In assessing the findings, there are two methodological considerations to bear in mind. First off, between the date of the incident and the date of the first interview, there was nearly a two-month gap. During that time, CNSC staff completed three internal reports on the January 12 incident. One report focused on the communications team’s response, another on social media engagement and the final report on the IMITD response. Both reports were available to most CNSC interview participants, so internal findings had been shared and reinforced for two months before the independent investigation. Given the two- month gap, participants may not have had the same recollection capacity as they would have had the day or week after the incident. The two factors combined create a possibility that conclusions and next steps had been drawn even before the first interview began. However, the research team judges this as a low risk to the research’s integrity since most participants kept detailed notes of the day’s events. During the interviews, some participants also referenced outstanding questions or concerns that they hoped to see addressed through

the independent investigation.

Secondly, towards the end of the interview process, CNSC became understandably consumed with the COVID-19 situation. Four interviews happened during the early stages of CNSC's COVID-19 response. While some of those four participants made comparisons between January 12 and COVID-19, the research team decided to omit those comparisons from the analysis as not every interviewee was able to use this context.

As a result of the different functional groups participating in the interview process, some findings are specific to those groups (e.g. findings specific to communications versus emergency management versus IT). However, some findings were agnostic of those groupings.

Verifying the False Alert

All CNSC respondents stated that they knew the mobile alert was false either right away or within minutes of being contacted by a colleague. Certain respondents highlighted that the text of the Ontario emergency alert was not in line with the text that would usually be sent for a situation of this nature as it resembled wording seen in drills and tests. Others noted that if this had been an emergency, the CNSC would have received a warning before the public alert. However, even for those that knew this was a false alert, there was a feeling of obligation to verify with the duty officer. Respondent 3 noted: "there had been a little issue overnight at Pickering, which the organization want[ed] to make absolutely fundamentally sure [that there was no link]."

Respondent 4 stated: "We didn't have any notification that there was an event until the public and the media already knew about it, and normally there would be some kind of notification to the CNSC, there would be some standing up of somebody somewhere, and there was none of that. So, it was catching up, and it was already all over social."

Despite the high degree of certainty that most respondents reported, the need to follow the nuclear emergency procedure in confirming the false alert took precedence.

Holding CNSC Public Communications

Respondent 3 reported a common sentiment shared by his colleagues: "we know by let's say a quarter to eight absolutely that it's not an issue, there is no safety issue at Pickering. I still really wanted the utility, and the operator or the Province [to] correct their mistake first as opposed to having us step into it."

Out of all the procedures followed that day, the established procedure to not get ahead of the operator or Province on public communications was the most enduring and firmly held procedure across the interviewees. The principle behind this procedure was generally understood as a need to protect the discrete responsibilities of the involved parties. Respondent 13 said: "[In a radiological event or emergency] we don't step over and say, "We hear the province is going to call an evacuation," because that transfers responsibility to us."

Respondent 8 described the historical context behind this procedure: "that has been an issue as we went through exercises starting around 2014 moving forward to the Darlington exercise in 2014. We used to have issues with people stepping on each other's toes, which is why we developed this MOU with the Province to develop a better relationship because I don't think anybody in the early 2000s was clear on who was in charge of what." According to Respondent 8, on the MOU referenced in the above quote: "we do have a memorandum of understanding with the Province with the OFMEM and the CNSC…But within that, the memorandum of understanding is about meeting regularly, communicating with each other,

understanding roles and responsibilities, and having a level playing ground between the two of us. We understand who belongs in which sandbox and things we can do for improvements." While these were principles cited across the respondents, Respondent 8 was the only one to reference the MOU explicitly. This is in line with another general finding related to an inconsistent application and understanding of existing and relevant procedures and policies, especially in this case of a non-nuclear emergency.

Emergency and Crisis Communications Plan

Most staff explained that the January 12 incident tested the CNSC because there was no existing communications protocol for non-nuclear emergencies and that no previous training or exercise had focused on what to do in the event of a false alert. Respondent 1 said: "I was told in no uncertain terms we did not have a protocol to responding in a situation like this; that's why we didn't." Respondent 2 echoed, "[I] don't think there is one. I'm not aware of one, but at the same time, leadership in the case of a crisis does not need a protocol." Despite this widely shared belief, there is an existing CNSC document directly related to this situation, the CNSC Emergency and Crisis Communications Framework. The evergreen document was last updated in April 2019 and was not referenced directly by any interviewee. The Framework defines both emergency and crises, outlines procedures and approval authorities. The Framework does not explicitly outline the process for dealing with a false alarm, but it does provide a structure to follow in crises.

Training

Similarly, there was a wide variety of responses when participants were asked about CNSC-delivered training or exercises related to crisis communications. Most were able to speak about emergency operations training and exercises.

Respondent 10 said, "we exercise our crisis comms at least once a year, if not twice."

Respondent 3 said, "[the] training manuals and protocols are primarily geared to a major nuclear emergency at a nuclear power plant."

Respondent 12 said, "there are the basic video and training that everyone has to undergo when they join the organization. There was one formal training, a full day, of exercise simulation with a power plant regarding how to simulate a real crisis."

Many respondents felt that a training session developed explicitly to simulate a false alert would be useful. Respondent 1 described the potential training: "you simulate a false alert; you simulate panic in public, and then it's only later you find out it's a false alert to see how do you mobilize and what are your capabilities."

Emergency Operations Centre

While there was a consensus that a lack of procedure and training on the topic of false alerts handicapped the team, efficiency and speed of response were also hampered by mixed messages regarding EOC activation. Respondent 7 noted that any lag time that may have been experienced when deciding to stand up the EOC was in part since the false alert did not constitute an actual emergency, so there was uncertainty whether or not an EOC-level response was required or appropriate. The thought process behind the decision to partially activate the EOC is described by Respondent 8: "once I knew that there had been a false alert. It may have taken me three or four minutes to click in, but we had an alert from the Province of Ontario saying there's a nuclear emergency, nothing's been retracted officially, and one of our key roles in the CNSC is to communicate to the public. I knew that we were going to have to get everybody into the same room to coordinate our efforts... activating the EOC is normally dependent on the facility that's having the accident, but there was no facility having the accident. In this case, we defaulted to [the DG]

providing the authorization to activate." While this decision was confirmed a little after an hour past the false alert, it was not until later that morning that the EOC Director arrived in the EOC, and by that point, communications and social media staff had already arrived.

Part of the confusion around when the EOC was officially activated that morning was due to different staff finding out at different times. Respondent 8 says: "[they] should have told the duty officer to send out [a] MIR3 notification at that time. But what had happened was people had naturally migrated to the EOC already. Staff said, "let's draw a line in the sand here and send out a MIR3 just to activate this EOC officially." The executive committee members were not included in the MIR3 message. We target people we want in the EOC [with MIR3]. If we're going to hold an executive briefing, I know we call the emergency executive team briefing, the EET. We use the MIR3 to bring them to that meeting."

Even once the EOC was activated, the Communications Chief deviated from regular EOC procedures as previously agreed to. Respondent 13 said, "We kind of wrote in our DG into [the EOC procedure]...so when she came in, she brought a different set of expectations for what her involvement would be with the EOC because she is connected to PCO, PMO, NRCan... And so, she needed a loop in. We practiced that once with an exercise, and then once with this. It's a little bumpy still, I will admit it, but it feels a little bumpy because the authority had to go outside the room briefly, and then come back in. But it makes sense. She does need to be engaged on that because she's also bringing us information from the center that we wouldn't otherwise have."

Including a DG outside of the EOC decision-making authority for communications-specific approval seemed to be an accepted and justified move. However, other actors external to the EOC also attempted to interject into the process without warning or approval from the EOC Director. Respondent 13 said: "The whole point of activating your EOC is that you reduce your decision making into the room. And there's a functionality to reporting to the senior executive... but the EET wasn't stood up as part of this partial activation. So, each senior exec was tapping in and wanting to know what was happening, instead of waiting for a briefing. [It] very much hindered our ability to focus on what we needed to do because we were managing up, rather than out."

Approval Authorities

As documented earlier, three members of CNSC's executive team were out of the country on CNSC business. While two of the three had colleagues in Ottawa acting on their behalf that Sunday, the executives abroad were described as still being involved to varying degrees in the CNSC response. Respondent 8 said: "I left the room, and I got involved in that communication [with executive staff abroad]…[the communications staff] were getting direction from there… it was going directly to the government relations team and the communications team." By their own account, one senior executive, within the first hour of receiving notice of the false alert, made between "10 to 24" calls. While admitting that they "knew every time I was calling them either asking for an update or giving them direction, I was also distracting them from getting the job done, which was in that initial communication." This is despite accounting that they had received a call from the CNSC DO "at about 8h06 that morning" to confirm the false alert. Many staff cited communications with executive staff abroad resulted in a slowdown of activities taking place in Ottawa. The social media post, website updates and staff email were the most cited activities that were not executed as quickly as would have been preferred.

Social Media Post

That morning, after the first social media contact could not be reached, a second or alternate social media contact was asked to assist with editing and posting social media. Some response time that morning was lost to identifying a social media lead due to the absence of a formal SCD on-call program. However, even once a social media contact was reached and confirmed, they experienced technical difficulties logging into Citrix. The decision was made to have the social media lead come into the EOC to avoid dealing with any further technical problems.

That morning, before the first tweet was issued, there were two tweets under consideration. The first was a tweet drafted by the VP for Regulatory Affairs and sent by text message to the staff member acting for him. Respondent 7 stated: "I understood from a conversation on Monday that there was a tweet ready to go from CNSC, 30 minutes before the actual release of that tweet. But it was deemed between the VP and the DG on the RAB side not to release that tweet until it was better." The second tweet was the planned "holding tweet" that the CNSC was aware of the situation and would update when it had further information to share.

Respondent 9 said: "[we] received direction from senior management to get communications out ASAP." However, the direction to communicate publicly as soon as possible did not consider a variety of factors as experienced by Respondent 9 that were preventing swift action. "For me, it was telling the staff that we needed to put something out. I knew that an employee was already working with the duty officer to try to get the right language because the canned message that we had ready for an emergency did not apply to that. Did we just have to say that it was a false alert, or did we have to say that CNSC confirms that DO officer in the language that the DO officer would have put in? That's the piece that we were trying to clarify that we needed to go out. Then, after that, it was a question of going to translation..."

When asked whether procedures caused unnecessary delays that day, SCD staff acknowledged that they would have preferred to send the initial public communication sooner than 8h46. However, multiple factors caused a delay. Respondent 4 said: "understanding that minutes matter and with social media, its actual minutes. It's not; I'll get back to you in 10 minutes or 20 minutes, you're already too late if you have to wait. We had information early enough that morning that we could have, if our protocol supported it, gone out earlier than we did with [a] social media message, but we were being asked to wait. Wait until... "I'm attending this meeting; I'll get back to you." I think that the organization and its protocols outside of communications need to understand the impact of minutes."

The tweet that was issued was from the VP RAB, and based on the OPG tweet that had been sent at 8h06. The CNSC tweet was ultimately sent at 8h46.

One respondent characterized the above-cited tension between senior management's expectations and the reality unfolding in Ottawa as a lack of understanding of how social media works, how quickly the SCD team could respond and the role of social media in communications. When asked to comment on their level of familiarity and comfort with CNSC's social media channels, two of the participating senior executives acknowledged social media as a blind spot.

Website

Early in the morning, the CNSC website went down due to the high traffic surge. Respondent 4 described what it meant to have the website down that day. "We prioritized because we were battling for a few hours over the challenge around the lack of access to the web. The SCD team, beyond the basic information available in emergency preparedness documents, were having trouble accessing materials. They also couldn't post anything on the web and were spending effort trying to come up with other solutions at the

time and trying to find ways to work around the fact that there was no web, so the team was doing things like posting tweets about if you need to reach our media relations person, here's her phone number. Those are things that we've never practised."

Moreover, Respondent 4 noted how unprepared the team was to deal with an IT issue during a crisis. "IMTD has not been integrated into our major exercises...IMTD is our IT folks, and when it comes to being agile to post on the web, or if we run into any web challenges, they don't have any on-call or after hours protocol that fits within a crisis timeline."

Not only had IMTD been excluded from previous major exercises, but according to one respondent, there were broader organizational concerns. Respondent 6 stated that the CNSC needed "a better awareness of where we were vulnerable...we knew the infrastructure was older [but] didn't appreciate the vulnerability of it."

Echoing this lack of organizational understanding, Respondent 7 noted that senior management was unaware of the extent to which web server limitations could impact website capacity, reliability and security. "It was due to an old server, and so [senior management] was not pleased that [they] did not know about this." Regarding the capacity issue, Respondent 3 explained: "[the]server upgrade was previously scheduled for mid-February. This event just happened to happen on January 12, and that server upgrade has [now] been done."

Staff Email

Some respondents also raised timing concerns regarding communications to CNSC staff. Respondent 9 commented that "one of the criticisms is that we focused a lot on digital and trying to put a message out; we only got to the employees at the end of the day."

Respondent 4 describes from a personal perspective why the staff email was not prioritized that morning. "We were focused on dealing with social media and traditional media … if there was an issue that [staff] needed to know about, we updated the employee info line in the morning, as one of our early internal comms actions. But because there was no risk to the environment or people, we knew it was already all-over social media ... We decided to wait until we had the actual energy and focus on issuing a message to staff, so we issued that later in the day. It wasn't a priority because it was Sunday and it was going to be a message to staff by email, and knowing that a lot of staff don't check their emails, or don't have work devices, we didn't think that it was a priority earlier in the day. And we didn't have the resources to do it, or the capacity to do it earlier in the day."

Despite not sending out an all-staff email earlier in the day, the employee phone line was updated with the current situation. As described by Respondent 13: "As part of the initial conversations, we were talking about updating the employee information line. This is a line that employees can call into, it's a 1-800 line, and that would give people updates. So that got done, and it went through."

External Perspectives

As mentioned in the methodology, given the small sample size of external interviewees, no conclusions or recommendations were drawn from these interviews. However, a few noteworthy points were raised by the two interviewees. These points are intended to help the CNSC understand how external stakeholders assessed the CNSC's performance on January 12.

Firstly, like CNSC staff, the two external interviewees knew soon after receiving the mobile alert that it was

a false alert. The OPG interviewee noted that relevant OPG staff who would be involved in responding to the false alert quickly organized an early morning phone call. Respondent 14 said, "we were able to mobilize staff and have everybody into their proper positions and supporting that effort. That was a positive finding from us." While many CNSC interviewees reported a high number of emails and calls that day, no CNSC interviewee reported that a cross-division CNSC phone call was convened early in the morning.

However, both respondents echoed the challenge faced due to the Province's delayed retraction of the false alert. Respondent 14 said: "in hindsight, for OPG and I also expect for the CNSC, we were respecting the due process there, that the Provinces Emergency Operations had triggered the alert and that they were retracting it and that they owned that action... And I think in hindsight, we all recognize now that, given it took them two hours to do so, we should have all come out with something immediately. But hindsight is 20/20, and we were operating constantly on the information and assumption that something was coming out imminently that would clear up the situation, and then we would provide any backup communication to that retraction."

Both external interviewees reported an understanding of the CNSC's role as a regulator and oversight body and did not expect CNSC to have communicated in the Province or operator's place that morning. When asked about the municipal impact of the delay in publicly confirming the false alert, respondent 11 stated, "we had no role to play at that point in time until PEOC recalled. Again, coming back, there's got to be one source of information. It was rather frustrating...we knew it was a false alert. We would have been delighted to get information out that it was a false alert, but that was not our information to share."

When asked if they felt the CNSC should take a more active role in public communications, not just in a crisis but generally, neither external stakeholder thought it would be necessary. Respondent 14 said, "I haven't seen any evidence that would say it's required... part of my job is trying to encourage members of the public to become informed about nuclear energy, and I know the CNSC is doing more and more of those kinds of informative pieces for the general public. But I wouldn't say that there's a dire need for them to increase what they are doing already.

However, respondents did identify ways that relationships could be strengthened between the CNSC and its external stakeholders. Respondent 14 noted that discussions on this topic have already begun. "I have had conversations and meetings with my counterparts at the CNSC since the alert. We're looking at different ways of strengthening ties between us from a communications perspective, and also looking at whether we can put any additional processes in place, or procedures, to ensure that we're not left waiting for the Province to issue something before we come out with information next time." Meanwhile, Respondent 11 stated that in the event of an emergency, dealings with CNSC staff would primarily happen via specific municipal staff and that he wouldn't personally know whom to contact at CNSC. "I'd be dealing through our fire chief and FEMO. But in terms of someone's name with a cell number, not a number on a website, I don't, and that is problematic."

Analysis

While there is never "a perfect day" for a crisis or emergency, Sunday, January 12, was a particularly bad day. The initial notification was sent during off-hours for staff in the Eastern time zone. Because the alert had been sent in error, the CNSC had not received any advanced warning about the alert, as would usually happen. Three key executive staff members were abroad and separated by an eight-hour or more time difference." Finally, a previously scheduled web server upgrade, which reportedly could have handled the surge in web traffic, was scheduled to happen the following month.

As Respondent 4 describes, “we weren't in the office at our desks able to multitask through our desktops and our telephones and stuff. We were all offsite in the early part of the day, managing mostly through mobile devices. It’s very difficult to direct multiple staff, review messaging, and get phone calls, and call people, and do it via a mobile device. There was an impact on timeliness just from that. I think it's a reality that we experienced through the incident that was very instructive. This is maybe 10 per cent of what it would be like if it had been a serious incident, so I think it was good to go through it, but it was extremely intense, and there was not a lot of time to think.”

There are no doubt opportunities for improvement at the CNSC to ensure any future false alerts are handled as seamlessly as possible. However, on balance, while many CNSC staff recognized that there were many factors including the weather working against them that morning, despite all of that, CNSC staff were proud of the work they accomplished together.

Ultimately, organizational efforts to build more flexibility and autonomy are bound to fail in the absence of an organizational culture that supports flexibility and autonomy. Members of CNSC’s SCD were quick to highlight a feeling of frequently wrestling with high expectations while also dealing with a consistent level of criticism.

Unclear and inconsistent expectations were cited as a challenge facing SCD staff. Respondent 9 said: “for me, it's clarifying what the expectations are moving forward because this is not something that was expected. The CNSC was not the target on social media, nor was it in the media. From the media, [the CNSC] was viewed as a source of expertise…there was no criticism for not having done the right work at the right time.”

Among respondents, there was a stark difference between how staff and senior management portrayed the day's events. Senior management respondents felt that on January 12, staff should have been more prepared to step out of procedures to meet more critical objectives. The below-unattributed quote comes from a senior management respondent:

“That's why we have procedures, that's we have drills. You've got to follow procedures and so on. But in a scenario that's not covered, one has to exercise judgment and get back to first principles. Not only was the ability not there, but I think the chain of command was not respected.”

Staff followed the nuclear emergency procedure as closely as possible when it came to matters of shared responsibility with partners (Province, facility). While the team expressed a willingness and ability to exercise judgement to step outside of protocol, if that would have happened in this situation, CNSC SCD staff wouldn't have simply taken an organizational risk. They would have risked the reputation and relationship of the Province and facility had they responded first, because of a codified procedure among the three partners of the chain of command regarding public communications. Some respondents acknowledged this risk. Respondent 3 stated: “there's a recognition that the faster you ask staff to move, the more risk. There's risk associated with moving quickly.”

In this situation, SCD staff acknowledged a desire and preference to have communicated earlier than they did that morning. However, unrealistic expectations, a lack of appreciation for the work that needed to get done (i.e. translation, working on multiple platforms) and competing pressures were cited as issues encountered that day.

Respondent 4 stated: “there's a bit of a culture here of aggressive conversation to communications, but there's a lot at stake. It’s very difficult on staff from a psychological perspective. They’re the experts in communication and understand about reach and the importance of communicating at certain levels and

often have to battle with colleagues in operations over what is the right kind of communications. It can be a very challenging place to work."

Respondent 13 said: "[SCD] is among the busiest groups. I think the other groups are dealing with bigger questions, but they deal with one or two at a time, whereas [SCD] deals with 100 at a time…this team came together very quickly and worked hard. I think honestly, overall, I think [SCD] did a very good job of managing that day. I'm a little startled by how much the senior management don't agree."

Respondent 9 stated: "we in communications can be on-call, [but] we have to make sure that we have the controls, or we have the tools or the support from the rest of the organization to be able to do that."

If senior management is keen on providing employees with discretionary decision-making autonomy when required, a directive alone is not likely to stick. Staff need an organizational culture that supports those priorities. When staff were asked if they felt that recommendations for improvement would be implemented, not all staff felt that would be easy. Some staff noted patterns exhibited January 12 were similar to those experienced in drills. One example cited was a consistent tendency to "micromanage," which led to delays in relating materials to the public.

In terms of more procedurally focused improvements, there was a split between respondents who felt that in a similar situation in the future CNSC should go ahead with public communications if there is a demonstrated inexplicable delay from the Province or operator, and respondents who felt the currently in-place protocol should be followed.

However, there is a range of options between not communicating at all versus going ahead with a CNSC message in advance of others. One of those middle options is the option to retweet or share a message from the operator or Province. In this instance, OPG went out with their first tweet at 8h06, and CNSC staff were made aware in advance of the tweet being posted. In the interest of having a quick confirmation of the false alert on the CNSC's Twitter account, a retweet of the OPG tweet could have been instantaneous, while allowing CNSC time to continue preparing their public message for social media. However, it is essential to highlight that this would not be a full solution as the OPG tweet was only posted in English. Therefore, a translation would have to be completed if the CNSC were to retweet.

When asked why a retweet of OPG's 8h06 tweet wasn't done, Respondent 3 stated that "I think that the view of the team was that we should have our own independent statement…There's no process I don't think that says you must or you cannot do that. That would have been permissible." The objectives to have a CNSC-crafted message and the requirement to communicate about the false alert publicly did not have to be at odds that morning.

Finally, most respondents who were eventually involved in the partial EOC activation agreed that the EOC should have come together faster than it did that morning. Respondent 4 said: "We were hampered because we didn't really have support. We were spending effort trying to manually get ourselves organized without the support of the organization." Indeed, much of the organization seemed unaware that one section of the CNSC was operating under the emergency procedures of the EOC. This created confusion on proper approval authorities. Clarity around activation and notification of staff of activation for all participants and responders is needed to improve the efficiency and effectiveness for any future event.

Conclusion

This review was commissioned to provide an independent assessment of the CNSC's response to the false

emergency alert issued by the Ontario PEOC on that day to support continuous improvement.

The review focused on the internal organizational structures, protocols and culture that influenced the CNSC's response on January 12. Some additional context was provided by two external stakeholder interviews.

It must be noted that the International Atomic Energy Association's *Peer Appraisal of the Arrangements in Canada Regarding Preparedness and Response for a Nuclear or Radiological Emergency* found Canada's emergency response program was in accordance with international standards.

In our review of CNSC documentation and subsequent interviews, we noted a great sense of pride within the organization. However, this was generally coupled with a feeling that CNSC performance did not meet its performance expectations on January 12.

The following recommendations are based on collective experience in crisis communications and organizational management. This review included the CNSC's *REG DOC-3.2.1, Public Information and Disclosur*e and a report of the IAEA outlining findings of an *International Symposium on Communicating Nuclear and Radiological Emergencies*.

Our review uncovered several cascading factors that prevented a swifter initial response as well as other key communications activities that would improve the CNSC's crisis communications. If not corrected, these could delay the CNSC's response should there be a real emergency at one of Canada's nuclear facilities.

Key areas of focus/consideration include:

- Resolving the tension between senior executives' expectation that staff display flexibility and autonomy and the sentiment held by senior and mid-level staff who do not always feel enabled to step beyond protocols and procedures without executive-level approval.
- Clarification around senior staff on travel status and delegation of authority during an incident should be clarified for incident reporting.
- Resolve the inconsistent understanding around the CNSC's role in terms of sequencing of public communications as per the MOU with provincial authorities and plant operators.
- Some respondents, but not all, felt the EOC Director had the authority to approve all materials. This was exacerbated by partial activation of the EOC, which did not seem to be fully understood by those not directly involved in its operation. As a result, one group was working under a procedure separate from the rest of the organization.
- A lack of details around process for communicating with key stakeholders and what stakeholders the CNSC should engage with outside the federal government. We identified at least three individuals who felt they had accountability for contacting officials within the federal government.
- The need for additional training that anticipates different scenarios including events that were communications or reputation-based
- While a focus on external communications is understandable, and although the employee phone line was updated in case staff were concerned that the false alert was real, the agency missed a significant opportunity to reach a key audience by not issuing an immediate email notice to its employees.
- The CNSCs "digital-first" communications strategy has merit, but there was a lack of awareness of its existence and its implementation, particularly concerning potential time limits for external communications. The CNSC website issues exacerbated this on January 12.
- There is also a risk that too much focus on digital response may miss critical segments of the population and lead to a lack of focus on traditional media, which, as was evident January 12, still

plays a crucial role in emergencies.

While staff agreed that January 12 served as an important learning opportunity, serious concerns were raised regarding staff resources, noting that CNSC would be hard-pressed to fully staff a 24/7 emergency communications group for a sustained period.

Recommendations

Recommendation 1

There was an expectation at the executive level that staff should display flexibility and autonomy in the absence of procedure or precedence, but the senior and mid-level staff did not feel enabled to do this.

CNSC management should ensure they foster a corporate culture where staff have a better understanding of their boundaries and are encouraged to use their expertise to make decisions and take actions with the understanding that there will be no risk of recrimination.

To do this, procedures and protocols used during emergencies must give clear direction on the latitude allowed for team members to make informed decisions needed to respond to events without securing multiple layers of approval.

This should be tested and trained during exercises and other training and must be supported by senior management.

Recommendation 2

Senior executives who were overseas created confusion by overriding delegated authorities. In some cases, senior staff called their direct reports multiple times, which prevented staff from carrying out a prompt response.

While natural for executives to want to become involved in this type of event, CNSC training, culture and protocols should stress the importance of delegated authorities being the sole contact with their reporting staff. Executive team members who are absent should restrict their contact to delegates and not bypass these reporting lines. This should be clearly outlined in emergency procedures and protocols and written into exercise scenarios.

Recommendation 3

The CNSC training regime does not appear to anticipate events that are communications or reputation-based. This training regime is also focused on high impact, low probability events, which leaves staff unprepared for a low impact but higher probability events.

Nuclear training exercises are typically focused on large loss of coolant accidents with potential public impacts taking place over several days or weeks. Events that may happen more frequently and start and end more rapidly than a large-scale nuclear emergency are not typically practiced. The CNSC should exercise these scenarios more often, and train for events that require more creative and flexible communications. This would also help identify scenarios outside of large-scale nuclear accidents where the EOC might activate.

The CNSC should adopt a crisis communications plan that would be controlled by the SCD team and would operate outside of the EOC. This would allow the CNSC to better respond to events that are not operational in nature and do not require activation of the EOC.

Recommendation 4

There was a lack of agreement on the sequencing of the CNSC's communications with provincial authorities and plant operators during an emergency. Senior executives indicated a desire to be leaders in getting communications out rapidly, while staff felt adherence to protocols between the Province and the plant operator was a priority over rapid communications. This led to some staff thinking they were operating under existing protocols related to the CNSC's role, while senior leadership was prepared to override protocol.

The CNSC needs to establish a set of "first principles" on emergency communications. Senior leaders should ensure all staff fully understand first principles but with a focus on communications staff and staff within the CNSC emergency response organization. These principles should include: what the CNSC's role is during an emergency (are they leaders or authenticators?) which methods will be used to communicate, who will be communicated with and the expected tone of messages. To aid in the design of these principles, the CNSC should consider public opinion research on what the public sees as the desired role for the CNSC during emergencies.

Once in place, these principles should be communicated to all CNSC staff and practised during drills.

Until the CNSC can establish these "first principles," we recommend the CNSC pause its work on its digital-first strategy as the creation of first principles should ultimately guide any further work on digital-first.

Recommendation 5

There was an inconsistent understanding of existing protocols between the CNSC, plant operators and provincial authorities and, in some cases, a lack of awareness that protocols even existed.

Once the CNSC has completed this review of the first principles, it should review existing communications protocols to determine if they still meet the expectations of the CNSC. If they don't, a process should be launched to revise them to ensure they reflect current CNSC communications' first principles. CNSC must ensure all personnel involved in communications and at the executive level are aware of the protocols and how they govern communications during emergencies.

This review should examine the role of the plant operators, the provincial emergency authorities and create a new set of guidelines of roles and responsibilities based on current organizational expectations, public expectations and evolving communications practices.

Recommendation 6

There is an internal disconnect as to whom the approval authority for external communications is during an emergency. For example, some respondents felt the EOC Director had the authority to approve all materials. This was not the understanding of the EOC Director, who himself believed SCD had final authority for communications and instead viewed his role as approving for technical accuracy.

The CNSC should introduce a consistent "natural path" approval process. Using a landscaping example, organizations can build pathways, force people on them, or observe how they behave naturally and build pathways based on this. Transferred to emergency communications, this can result in situations where approvals are required from people who don't understand communications. And this often means dealing with people who are unfamiliar with each other. Therefore, it is recommended that the CNSC's emergency communications approval process mirror daily processes and operations.

Recommendation 7

The partial activation of the EOC was not clearly understood by those not directly involved in its operation.

As a result, one group was working under an emergency procedure while the rest of the organization did not appear to be. This appeared to be one reason for a delay in the release of materials as some staff felt they needed to get sign off via emergency procedures, while also being pressed by line management to act quickly.

The CNSC needs to clarify partial and full activation of the EOC and notify implicated staff via the MIR3 system at the onset and completion of EOC activation. A partial activation can take place to monitor situations, but it must be clear that the procedures and processes associated with full activation are not applicable.

In this scenario, a challenge was created because the executive team did not receive the MIR3 system notification and may not have been aware that the EOC was in action. In the future, all Director-level and up staff should be made aware of the EOC's activation, even if they are not notified to report into the EOC.

Recommendation 8

There was a reported lack of process for communicating with external stakeholders. At least three people interviewed felt they had sole accountability for providing verbal information to officials within the federal government, and there was not a coordinated process to manage this.

We recommend that the CNSC broaden the definition of the key stakeholders and create an outreach strategy to be implemented during crises. This detailed stakeholder map would allow a more thorough outreach and ensure the consistency of messages.

The CNSC should also consider regular stakeholder audits, like those conducted by licensees, to provide regular input as to how key stakeholders perceive the CNSC. This is something licensees often do, and it is an invaluable tool.

Recommendation 9

CNSC missed an opportunity to reach a key audience by not issuing an immediate email message to its employees. The employee information line was updated in the morning, but a staff email was not issued until late the day. This meant CNSC staff who were not part of the response were left unprepared for questions they received from friends, neighbours and families.

Employee communications must be part of the “first principles” as staff are key ambassadors during an emergency. They can deliver messages and assure a concerned public. Conversely, their lack of knowledge of a public event could be taken by some to indicate an attempt to hide the truth, fostering mistrust.

This will require a cultural shift and requires that the CNSC build prompt employee communications into procedures and training exercises until it becomes a natural part of the emergency communications process.

Recommendation 10

While these two events are not directly comparable, there are similarities as to how the PEOC, OPG and the CNSC opted to communicate on January 12 and the recent tragedy in Nova Scotia. Specifically, in that case, the RCMP decided to only communicate via Twitter. In the January 12 event, early notifications were sent via Twitter. In both cases, reliance on Twitter meant large sections of the population were not informed of these events. This was compounded by the failure of the CNSC website.

To ensure it is reaching the widest possible audience, the CNSC should review emergency communications

using the expectations for licensees set under REG DOC-3.2.1, Public Information and Disclosure. While this document applies to regular communications, many of the principles can be applied to emergency communications to ensure information reaches as many sectors as possible. Reg Doc 3.2.1 requires licensees to consider a wide range of tools and outlets for communications. This is particularly key when most people don't use twitter, and agencies, like the CNSC, don't typically have a large follower base. In a real emergency, the CNSC will be required to staff all communications channels and respond quickly.

To enable a prompt response, we recommend that bilingual CNSC staff be authorized to translate or prepare materials in both official languages if it is determined that having an official translator complete the work will cause significant or unnecessary delay.

Further, we recommend that the CNSC immediately have spokespeople in place and mechanisms to deal with mainstream media.

Recommendation 11

The CNSC communications contact at the operator was the Director of Community and Stakeholder Relations for nuclear operations. While this person is part of the broader communications team, they do not have authority over communications strategy or tactics. It was also noted there is no backup contact listed should this person be unavailable.

Neither the CNSC, provincial, or OPG plans and procedures appear to call for a coordinated communications approach.

It is recommended that the CNSC work with the provinces and facility operators in Canada to ensure contact lists are up to date and have sufficient backup support listed. Further, the CNSC should work with provincial authorities and plant operators to convene meetings to prepare a coordinated response.

Recommendation 12

The events of January 12 were relatively short-lived and non-operational. A major nuclear emergency would unfold over weeks. If this occurs, several respondents suggested that the CNSC will be hard-pressed to fully staff a 24/7 emergency communications group for a sustained period. While some staff management issues can be addressed via scheduling, staff burnout would likely occur quickly without adequate support.

It is also not unusual for these events to take place after-hours, and we found the lack of a formal "on-call" communications response team created unnecessary delays.

Explore inter-agency co-operation agreements whereby communications staff from other government agencies or Ministries be provided to support during emergencies. Further, the CNSC should have contracted crisis communications professionals available to provide short term relief roles. These initiatives would feed a formal on-call emergency communications process with a clear designation of authority.

Appendix A – Interview Participant Consent Form

PROTECTED – SOLICITOR-CLIENT PRIVILEGE

Interview Participant Consent Form

Study Title: Independent Review of the Canadian Nuclear Safety Commission's Response to the January 12, 2020, Pickering False Alarm

I _____choose to participate in the study entitled "Independent Review of the Canadian Nuclear Safety Commission's (CNSC) Response to the January 12, 2020, Pickering False Alarm", which aims to understand the roles and responsibilities of CNSC staff during emergency situations and how these both support and prevent effective internal and external crisis communications.

I understand that this study will be organized and executed by Global Public Affairs, and that the primary researchers of the study include Ted Gruetzner, Vice President, Global Public Affairs, Nancy Cruz, Consultant, Global Public Affairs and Catherine Lansley, Research Analyst, Global Public Affairs.

I understand that my participation in this study will be in the form of one 60-minute one-on-one, in- person interview. I acknowledge that the in-person interview will be audio-recorded, and I hereby consent to be audio recorded for this purpose, on the understanding that once the recording has been transcribed, the audio-recording will be securely destroyed. I understand that throughout the in-person interview, I will be asked a series of questions; that I may decline to answer any of these questions; and that I will not be subject to work-related consequences, disciplinary or otherwise, for such refusal to answer.

I understand that in order to ensure my privacy and anonymity, the researchers will take precautions to protect my identity by keeping all responses anonymous in the interview transcripts. I understand that all responses in the transcripts will be non-attributable and any direct quotes used in the final report will be non-attributable as well.

I acknowledge that I may end my participation in the study for any reason by way of written notice of my withdrawal from the study sent to one of the primary researchers before April 28, 2020. If I choose to withdraw, I understand and expect that all the information I provided throughout the duration of the research project will be securely destroyed.

I understand that all research data, including audio recordings and notes will be encrypted; that any hard copies of data (including any handwritten notes or USB keys) will be kept in a secure storage facility at Global Public Affairs; and that research data will only be accessible by the primary researchers.

I acknowledge that I may direct any questions or concerns related to my involvement in this research to:

Ted Gruetzner
Vice-President/National Practice Lead Energy, Environment and Resources
Global Public Affairs
416-597-3485
tgruetzner@globalpublic.com

Signature of Participant: _____

Printed Name:_____

Date:_____

Appendix B.1 –CNSC Operations Team Member Interview Guide

Please note that this guide only represents the main themes discussed with the participants and as such does not include the various prompts that may also have been used. Non-leading and general prompts were also used, such as "Can you please tell me a little bit more about that?"

Introduction

Hello,

Thank you for agreeing to participate in this interview. We are interviewing you to better understand what CNSC staff think about the CNSC's response to the January 12, 2020 Pickering false alert and what lessons can be learned from the situation. There are no right or wrong answers to any of our questions, we are simply interested in understanding the situation from your point of view.

Participation in this study is voluntary. The interview should take approximately one hour. All responses will be kept confidential. This means that your un-identifiable interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time, for any reason.

Finally, I would like to request your consent to audio record this interview to ensure we don't miss any of your comments. May I turn on the digital recorder?

Identifying Questions

- Can you please state your name and job title?
- How many years have you worked at the CNSC?
- Could you please describe your primary responsibilities at CNSC?

Now, we'll turn to questions specifically focused on the incident that occurred on January 12, 2020. We'll ask you to do your best to recall the events on January 12 and your perception and understanding of said events. However, if any point during the questioning you feel that your recollection is not strong enough to answer a particular question, please let us know and we'll move on to the next question.

Role Specific Questions

- Did you receive the mobile alert?
    - IF YES = Was there a particular protocol or protocols that you were prepared to follow in response to the mobile alert?
- At what point during the day, did it become clear to you that the mobile alert was sent in error
- Who, within the CNSC, or elsewhere notified you that it was indeed a false alert?
- Upon learning that the alert was sent in error, and therefore did not constitute a nuclear emergency, was it clear to you what role you would play in CNSC's efforts to rectify the situation?
- How did your role on January 12, 2020 differ from your daily role?

Emergency/Crisis Scenario Questions

- Have you ever received formal training in crisis or emergency communications while at CNSC?
- To the best of your memory, could you please describe how the emergency and crisis

communications plan was executed on January 12?

- Do you feel the adherence to strict protocols limited the CNSC's ability to release timely and appropriate communications?
- Overall, how would you describe the CNSC's role during an emergency situation? How does it differ from the role of provincial or regional emergency teams?

Lessons Learned

- How do you think the Commission could have improved their response on January 12, 2020?
- Are you confident that the CNSC will identify areas of improvement and improve crisis communications approach?
- How would you change the training protocols or exercises to better prepare for an emergency scenario?
- Do you think the CNSC is well-prepared to respond in an emergency? Why or why not?

Individual Questions/ Unstructured Portion

Conclusion

- Do you have any final thoughts or comments that you haven't yet had the chance to share?

Appendix B.2 –CNSC Communications Team Member Interview Guide

Please note that this guide only represents the main themes discussed with the participants and as such does not include the various prompts that may also have been used. Non-leading and general prompts were also used, such as "Can you please tell me a little bit more about that?"

Introduction

Hello,

Thank you for agreeing to participate in this interview. We are interviewing you to better understand what CNSC staff think about the CNSC's response to the January 12, 2020 Pickering false alert and what lessons can be learned from the situation. There are no right or wrong answers to any of our questions, we are simply interested in understanding the situation from your point of view.

Participation in this study is voluntary. The interview should take approximately one hour. All responses will be kept confidential. This means that your un-identifiable interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time, for any reason.

Finally, I would like to request your consent to audio record this interview to ensure we don't miss any of your comments. May I turn on the digital recorder?

Identifying Questions

- Can you please state your name and job title?
- How many years have you worked at the CNSC?
- Could you please describe your primary responsibilities at CNSC?

Now, we'll turn to questions specifically focused on the incident that occurred on January 12, 2020. We'll ask you to do your best to recall the events on January 12 and your perception and understanding of said events. However, if any point during the questioning you feel that your recollection is not strong enough to answer a particular question, please let us know and we'll move on to the next question.

Role Specific Questions

- Did you receive the mobile alert?
    - IF YES = Was there a particular protocol or protocols that you were prepared to follow in response to the mobile alert?
- Are you automatically part of the Emergency response call out?
- If so, does your role differ from your daily role? If not, do you think you should be?

Emergency/Crisis Scenario Questions

- Have you ever received formal training in crisis or emergency communications while at CNSC?
- To the best of your memory, could you please describe how the emergency and crisis communications plan was executed on January 12?

- Do you feel the adherence to strict protocols limited the CNSC's ability to release timely and appropriate communications?
- Overall, how would you describe the CNSC's role during an emergency situation? How does it differ from the role of provincial or regional emergency teams?

Strategic and Crisis Communications Questions

- Have you ever received formal training in crisis or emergency communications while at CNSC?
- Can you outline your actions on January 12?
- How much extra web traffic did the CNSC site experience that day?
- Did this surge surprise you?
- What steps are in place to prepare for future events?

Lessons Learned

- How do you think the Commission could have improved their response on January 12, 2020?
- Are you confident that the CNSC will identify areas of improvement and improve crisis communications approach?
- How would you change the training protocols or exercises to better prepare for an emergency scenario?
- Do you think the CNSC is well-prepared to respond in an emergency? Why or why not?

Individual Questions/ Unstructured Portion

Conclusion

- Do you have any final thoughts or comments that you haven't yet had the chance to share?

Appendix B.3 – Municipal Leader Interview Guide

Please note that this guide only represents the main themes discussed with the participants and as such does not include the various prompts that may also have been used. Non-leading and general prompts were also used, such as "Can you please tell me a little bit more about that?"

Introduction

Hello,

Thank you for agreeing to participate in this interview. We are interviewing you to better understand what CNSC staff think about the CNSC's response to the January 12, 2020 Pickering false alert and what lessons can be learned from the situation. There are no right or wrong answers to any of our questions, we are simply interested in understanding the situation from your point of view.

Participation in this study is voluntary. The interview should take approximately one hour. All responses will be kept confidential. This means that your un-identifiable interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time, for any reason.

Finally, I would like to request your consent to audio record this interview to ensure we don't miss any of your comments. May I turn on the digital recorder?

Identifying Questions

- Can you please state your name and job title?
- How many years have you served in your role?

Now, we'll turn to questions specifically focused on the incident that occurred on January 12, 2020. We'll ask you to do your best to recall the events on January 12 and your perception and understanding of said events. However, if any point during the questioning you feel that your recollection is not strong enough to answer a particular question, please let us know and we'll move on to the next question.

Event Specific Questions

- Did you receive the mobile alert?
    - IF YES = Was there a particular protocol or protocols that you were prepared to follow in response to the mobile alert?
- At what point during the day, did it become clear to you that the mobile alert was sent in error
- Who, within the CNSC, or elsewhere notified you that it was indeed a false alert?
- Upon learning that the alert was sent in error, and therefore did not constitute a nuclear emergency, was it clear to you what role you would play in the coordinated efforts to rectify the situation?
- Once the alert went out, did you try to contact the Province, the operator or the CNSC? If so, please describe your experience with this.

Community Specific Questions

- How quickly did you, and your city staff start to hear from constituents?
- On a scale of 1 – 10, with 1 being no interest at all and 10 being high interest from most of the community, how would you rate the level the public interest?
- Were you satisfied with how quickly the correction notices went out?
- At any time throughout the day did you consider issuing something from the city and if not, why didn't you?

Lessons Learned

- How do you think the Commission could have improved their response on January 12, 2020?
- Do you think the CNSC is well-prepared to respond in an emergency? Why or why not?
- What role do you see the CNSC playing in emergencies, or events such as the one that occurred on January 12?

Individual Questions/ Unstructured Portion

Conclusion

- Do you have any final thoughts or comments that you haven't yet had the chance to share?

Appendix B.4 – Ontario Power Generation Team Member Interview Guide

Please note that this guide only represents the main themes discussed with the participants and as such does not include the various prompts that may also have been used. Non-leading and general prompts were also used, such as "Can you please tell me a little bit more about that?"

Introduction

Hello,

Thank you for agreeing to participate in this interview. We are interviewing you to better understand what CNSC staff think about the CNSC's response to the January 12, 2020 Pickering false alert and what lessons can be learned from the situation. There are no right or wrong answers to any of our questions, we are simply interested in understanding the situation from your point of view.

Participation in this study is voluntary. The interview should take approximately one hour. All responses will be kept confidential. This means that your un-identifiable interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time, for any reason.

Finally, I would like to request your consent to audio record this interview to ensure we don't miss any of your comments. May I turn on the digital recorder?

Identifying Questions

- Can you please state your name and job title?
- How many years have you been in this role?
- Could you please describe your primary responsibilities?

Now, we'll turn to questions specifically focused on the incident that occurred on January 12, 2020.

Event Specific Questions

- Could you describe how interactions unfolded between the Province, OPG and the CNSC to coordinate efforts?
- Do you deal directly with CNSC communications staff in emergencies or events like this?
- Are your internal procedures for nuclear and non-nuclear emergencies different?

Strategic and Crisis Communications Questions

- Do you participate in nuclear emergency drills?
    - And if yes, how often to do you interact with the CSNC staff in training?
- Further to that, what is your role in terms of interaction with the CNSC and nuclear operators during emergencies?
- Do you understand who has accountability for what during emergency communications?
- Do you know if there a formal agreement as to who does what during nuclear emergencies?

Lessons Learned

- How aware were you of CNSC communications efforts on January 12?
- Does the Province have any time goals on the release of emergency information? And would it create issues if the CNSC adopted a more rapid response process?
- How would you change the training protocols or exercises to better prepare for an emergency scenario?
- What role do you see the CNSC playing during emergencies?

Individual Questions/ Unstructured Portion

Conclusion

- Do you have any final thoughts or comments that you haven't yet had the chance to share?

Management Response to the Global Public Affairs Independent Review of the Canadian Nuclear Safety Commission's Response to the January 12, 2020 Pickering False Alarm

Recommendation 1

There was an expectation at the executive level that staff should display flexibility and autonomy in the absence of procedure or precedence, but the senior and mid-level staff did not feel enabled to do this.

CNSC management should ensure they foster a corporate culture where staff have a better understanding of their boundaries and are encouraged to use their expertise to make decisions and take actions with the understanding that there will be no risk of recrimination.

To do this, procedures and protocols used during emergencies must give clear direction on the latitude allowed for team members to make informed decisions needed to respond to events without securing multiple layers of approval.

This should be tested and trained during exercises and other training and must be supported by senior management.

CNSC response

Agree. Communications procedures and protocols will be updated with direction on latitude. These updated documents will be used in Communications Section training and exercises.

Recommendation 2

Senior executives who were overseas created confusion by overriding delegated authorities. In some cases, senior staff called their direct reports multiple times, which prevented staff from carrying out a prompt response.

While natural for executives to want to become involved in this type of event, CNSC training, culture and protocols should stress the importance of delegated authorities being the sole contact with their reporting staff. Executive team members who are absent should restrict their contact to delegates and not bypass these reporting lines. This should be clearly outlined in emergency procedures and protocols and written into exercise scenarios.

CNSC response

Agree. CNSC protocols and training will reinforce reporting lines through the EOC and continue to be practiced in exercises.

Recommendation 3

The CNSC training regime does not appear to anticipate events that are communications or reputation-based. This training regime is also focused on high impact, low probability events, which leaves staff unprepared for a low impact but higher probability events.

Nuclear training exercises are typically focused on large loss of coolant accidents with potential public impacts taking place over several days or weeks. Events that may happen more frequently and start and end more rapidly than a large-scale nuclear emergency are not typically practiced. The CNSC should exercise these scenarios more often, and train for events that require more creative and flexible communications. This would also help identify scenarios outside of large-scale nuclear accidents where the EOC might activate.

The CNSC should adopt a crisis communications plan that would be controlled by the SCD team and would operate outside of the EOC. This would allow the CNSC to better respond to events that are not operational in nature and do not require activation of the EOC.

CNSC response

Agree. The Strategic Communications Directorate (SCD) will update its emergency and crisis communications framework to include non-radiological communications crisis scenarios that may be handled outside of the CNSC's Emergency Operations Centre (EOC) and the Duty Officer Program.

Recommendation 4

There was a lack of agreement on the sequencing of the CNSC's communications with provincial authorities and plant operators during an emergency. Senior executives indicated a desire to be leaders in getting communications out rapidly, while staff felt adherence to protocols between the Province and the plant operator was a priority over rapid communications. This led to some staff thinking they were operating under existing protocols related to the CNSC's role, while senior leadership was prepared to override protocol.

The CNSC needs to establish a set of "first principles" on emergency communications. Senior leaders should ensure all staff fully understand first principles but with a focus on communications staff and staff within the CNSC emergency response organization. These principles should include: what the CNSC's role is during an emergency (are they leaders or authenticators?) which methods will be used to communicate, who will be communicated with and the expected tone of messages. To aid in the design of these principles, the CNSC should consider public opinion research on what the public sees as the desired role for the CNSC during emergencies.

Once in place, these principles should be communicated to all CNSC staff and practised during drills.

Until the CNSC can establish these "first principles," we recommend the CNSC pause its work on its digital-first strategy as the creation of first principles should ultimately guide any further work on digital-first.

CNSC response

Agree. Clarity on first principles of crisis communications exists for nuclear emergencies. The CNSC (SCD) needs to expand this to all types of potential crises in its emergency and crisis communications framework. The CNSC will engage with provinces and operators to establish a protocol to ensure a rapid communications response.

Recommendation 5

There was an inconsistent understanding of existing protocols between the CNSC, plant operators and provincial authorities and, in some cases, a lack of awareness that protocols even existed.

Once the CNSC has completed this review of the first principles, it should review existing communications protocols to determine if they still meet the expectations of the CNSC. If they don't, a process should be launched to revise them to ensure they reflect current CNSC communications' first principles. CNSC must ensure all personnel involved in communications and at the executive level are aware of the protocols and how they govern communications during emergencies.

This review should examine the role of the plant operators, the provincial emergency authorities and create a new set of guidelines of roles and responsibilities based on current organizational expectations, public expectations and evolving communications practices.

CNSC response

Agree. The emergency and crisis communications framework will be updated to address non-radiological events. Tabletop exercises will be designed to test this type of scenario and staff trained.

Recommendation 6

There is an internal disconnect as to whom the approval authority for external communications is during an emergency. For example, some respondents felt the EOC Director had the authority to approve all materials. This was not the understanding of the EOC Director, who himself believed SCD had final authority for communications and instead viewed his role as approving for technical accuracy.

The CNSC should introduce a consistent "natural path" approval process. Using a landscaping example, organizations can build pathways, force people on them, or observe how they behave naturally and build pathways based on this. Transferred to emergency communications, this can result in situations where approvals are required from people who don't understand communications. And this often means dealing with people who are unfamiliar with each other. Therefore, it is recommended that the CNSC's emergency communications approval process mirror daily processes and operations.

CNSC response

Agree. In a nuclear emergency or non-nuclear, non-radiological crisis, CNSC approvals follow our natural approval path. If the EOC is activated, the EOC director has final approval on the messaging that has been proposed by the Communications Section Chief and approved by the DG, Strategic Communications. If the EOC is not stood up, the Head of Communications or delegate will authorize the messaging. This will be reinforced in our procedures and training.

Recommendation 7

The partial activation of the EOC was not clearly understood by those not directly involved in its operation. As a result, one group was working under an emergency procedure while the rest of the organization did not appear to be. This appeared to be one reason for a delay in the release of materials as some staff felt they needed to get sign off via emergency procedures, while also being pressed by line management to act quickly.

The CNSC needs to clarify partial and full activation of the EOC and notify implicated staff via the MIR3 system at the onset and completion of EOC activation. A partial activation can take place to monitor situations, but it must be clear that the procedures and processes associated with full activation are not applicable.

In this scenario, a challenge was created because the executive team did not receive the MIR3 system notification and may not have been aware that the EOC was in action. In the future, all Director-level and up staff should be made aware of the EOC's activation, even if they are not notified to report into the EOC.

CNSC response

Agree. This is the first time that the EOC has been partially activated since 2011. The CNSC will evaluate the definition of a partial activation, and include the need to fully activate SCD for all events.

Recommendation 8

There was a reported lack of process for communicating with external stakeholders. At least three people interviewed felt they had sole accountability for providing verbal information to officials within the federal government, and there was not a coordinated process to manage this.

We recommend that the CNSC broaden the definition of the key stakeholders and create an outreach strategy to be implemented during crises. This detailed stakeholder map would allow a more thorough outreach and ensure the consistency of messages.

The CNSC should also consider regular stakeholder audits, like those conducted by licensees, to provide regular input as to how key stakeholders perceive the CNSC. This is something licensees often do, and it is an invaluable tool.

CNSC response
Agree. There are several complementary protocols in place to alert appropriate federal partners, stakeholders and international stakeholders. While specific protocols exist within individual EOC section's procedures, it would be useful to develop one overarching outreach strategy to map out who is responsible for contacting which agency at which level. This could then be added to each EOC section document to ensure consistency.

Recommendation 9

CNSC missed an opportunity to reach a key audience by not issuing an immediate email message to its employees. The employee information line was updated in the morning, but a staff email was not issued until late the day. This meant CNSC staff who were not part of the response were left unprepared for questions they received from friends, neighbours and families.

Employee communications must be part of the "first principles" as staff are key ambassadors during an emergency. They can deliver messages and assure a concerned public. Conversely, their lack of knowledge of a public event could be taken by some to indicate an attempt to hide the truth, fostering mistrust.

This will require a cultural shift and requires that the CNSC build prompt employee communications into procedures and training exercises until it becomes a natural part of the emergency communications process.

CNSC response
Agree. This finding is consistent with our internal review. Internal communications need to be prioritized.

Recommendation 10

While these two events are not directly comparable, there are similarities as to how the PEOC, OPG and the CNSC opted to communicate on January 12 and the recent tragedy in Nova Scotia. Specifically, in that case, the RCMP decided to only communicate via Twitter. In the January 12 event, early notifications were sent via Twitter. In both cases, reliance on Twitter meant large sections of the population were not informed of these events. This was compounded by the failure of the CNSC website.

To ensure it is reaching the widest possible audience, the CNSC should review emergency communications using the expectations for licensees set under REG DOC-3.2.1, Public Information and Disclosure. While this document applies to regular communications, many of the principles can be applied to emergency communications to ensure information reaches as many sectors as possible. Reg Doc 3.2.1 requires licensees to consider a wide range of tools and outlets for communications. This is particularly key when most people don't use twitter, and agencies, like the CNSC, don't typically have a large follower base. In a real emergency, the CNSC will be required to staff all communications channels and respond quickly.

To enable a prompt response, we recommend that bilingual CNSC staff be authorized to translate or prepare materials in both official languages if it is determined that having an official translator complete the work will cause significant or unnecessary delay.

Further, we recommend that the CNSC immediately have spokespeople in place and mechanisms to deal with mainstream media.

CNSC response

Partially agree. The CNSC has identified and trained spokespeople for emergency situations. On January 12, the spokesperson was identified and provided media lines early and responded to media interviews. That said, there is room for improvement in having established media contact lists to strengthen mechanisms to deal with mainstream media.

Recommendation 11

The CNSC communications contact at the operator was the Director of Community and Stakeholder Relations for nuclear operations. While this person is part of the broader communications team, they do not have authority over communications strategy or tactics. It was also noted there is no backup contact listed should this person be unavailable.

Neither the CNSC, provincial, or OPG plans and procedures appear to call for a coordinated communications approach.

It is recommended that the CNSC work with the provinces and facility operators in Canada to ensure contact lists are up to date and have sufficient backup support listed. Further, the CNSC should work with provincial authorities and plant operators to convene meetings to prepare a coordinated response.

CNSC response

Disagree. The province and the licensee were contacted by SCD on the morning of January 12 to ensure a coordinated approach. In addition, contact lists are kept up to date. The CNSC's communications procedures were updated in April 2019 with communications contacts at the province and the licensee confirmed. There is regular contact with the licensee communications point of contact. Backups may be added.

Recommendation 12

The events of January 12 were relatively short-lived and non-operational. A major nuclear emergency would unfold over weeks. If this occurs, several respondents suggested that the CNSC will be hard-pressed to fully staff a 24/7 emergency communications group for a sustained period. While some staff management issues can be addressed via scheduling, staff burnout would likely occur quickly without adequate support.

It is also not unusual for these events to take place after-hours, and we found the lack of a formal "on-call" communications response team created unnecessary delays.

Explore inter-agency co-operation agreements whereby communications staff from other government agencies or Ministries be provided to support during emergencies. Further, the CNSC should have contracted crisis communications professionals available to provide short term relief roles. These initiatives would feed a formal on-call emergency communications process with a clear designation of authority.

CNSC response

Agree. The Government of Canada Operation Centre managed by Public Safety Canada is staffed 24/7. In the event of a crisis, CNSC communications would be able to draw on their staff for support. Public Safety and CNSC communications were in contact minutes after the false alert was issued and Public Safety was prepared to support as needed. In addition, the CNSC's SCD has established an interim on-call roster using existing staff to ensure after-hours coverage. Development of a formal on-call system that is integrated in the duty officer procedures is underway and will be complete by Q3.