Canadian Centre for Management Development
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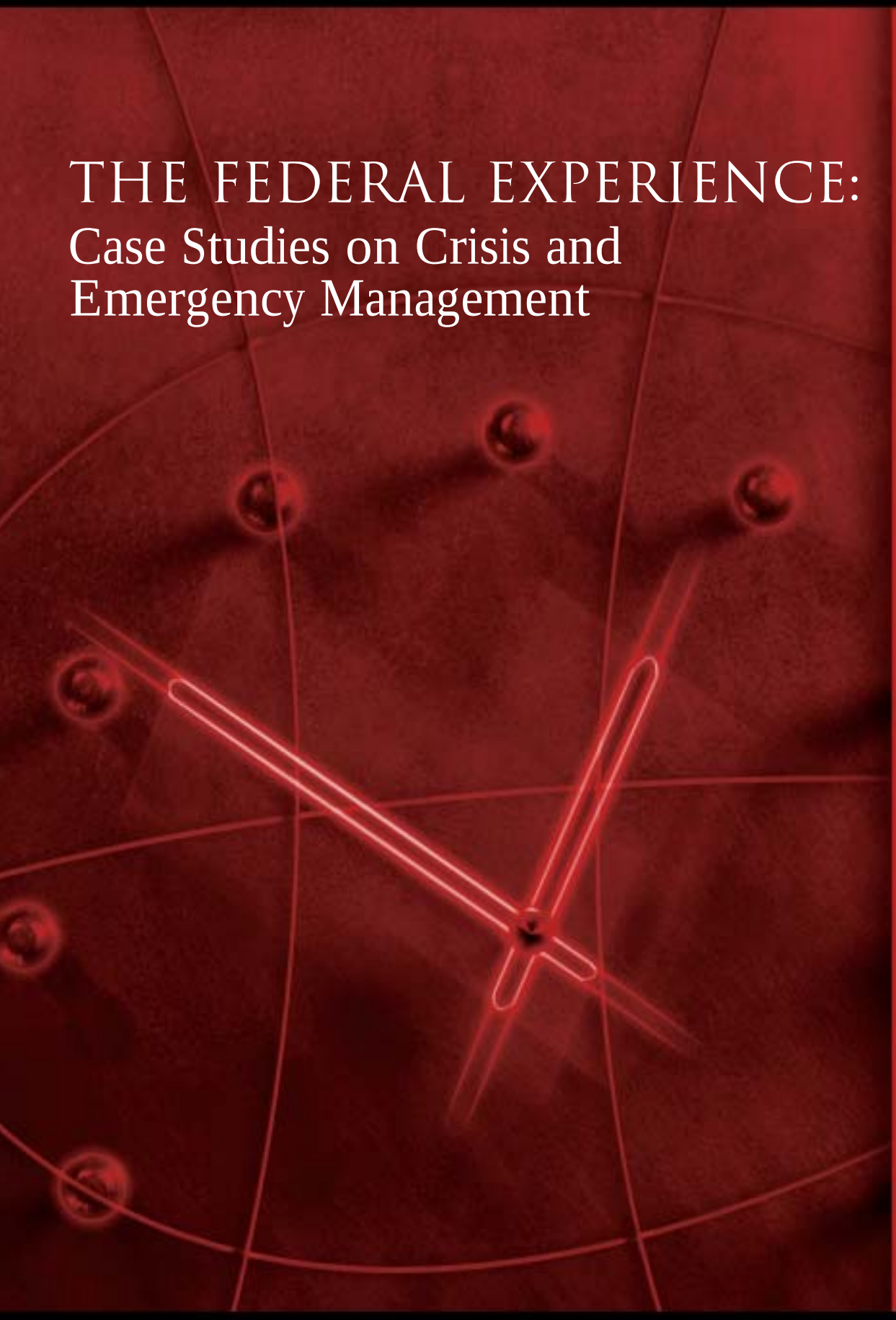
THE FEDERAL EXPERIENCE:
Case Studies on Crisis and Emergency Management



CCMD Action-Research Roundtable on **Crisis Management**

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Prepared with the collaboration of:

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GRANTS AND CONTRIBUTIONS
HUMAN RESOURCES DEVELOPMENT CANADA (2000)

BACKGROUND

Human Resources Development Canada (HRDC) delivers its programs through a network of 320 offices, 21 telecentres and 25,000 staff across the country. Operations are organized into ten regions and HRDC is a highly decentralized department. The department was created from a variety of programs and cultures in 1993. Many programs were governed by very specific legislation, rules and procedures, but service quality was a common departmental theme. A major downsizing as a result of program review (1995) and devolution of services to the provinces reduced staff by over seven thousand.

HRDC has an overall annual budget of more than $60 billion. About 95% of that spending goes to statutory programs such as Employment Insurance, Old Age Security and Canada Pension Plan payments to Canadians. The other 5% go to a range of other programs and services. This leaves $3 billion that is administered through the Labor Market Development Agreements. Of this, some $2 billion is transferred to provincial governments or co-managed with them.

It was the remaining $1 billion generally earmarked for employment programs, expenditures with community organizations, aboriginal programs, training for the disabled, sectoral agreements with business and labour and experimental programs that suddenly attracted so much attention in the winter of 2000.

Within the job creation programs, the Transitional Jobs Fund was an easy target. It had been quickly designed: there were not enough clear funding criteria and it was not to be delivered through existing NGOs but local entrepreneurs. The program allowed for consultation with local Members of Parliament as a feature of the program design. In March of 1998 the department had initiated an internal audit of selected grants and contributions. Staff had been cut by 20% and senior officials were concerned about the impact on program management.

In January 2000 the Minister publicly released the internal audit report. It showed significant administrative shortcomings in the grants and contribution programs. A political firestorm followed and was exacerbated by the public media.

The Transitional Jobs Fund became the focus of Opposition and media attention. More than 800 questions were directed to the Minister in Question Period. 100,000 pages of documentation were released to opposition parties under access-to-information legislation. The press attention was fierce and persisted relentlessly for almost seven months.

That extensive criticism was further fuelled in December 2000 when the Auditor General released his report on HRDC noting the same shortcomings as well as corrective actions underway.

The controversy over HRDC grants and contributions program was one of the longest running press and parliamentary controversies ever. Was it a real or imaginary crisis? Because of the fishbowl that government managers work in, myth can become reality at the drop of a headline.

A department and its employees under attack: a crisis had to be managed. Serious staff morale problems had to be addressed and HRDC's credibility with clients was at risk. Moreover, attention was diverted from the quality work that the department was doing.

M**ANAGEMENT APPROACHES**

Before the internal audit report had been made public, senior officials within HRDC had begun to address the identified problems. The department had recognized through earlier internal audits that the grants and contributions programs had been undermanaged. This reality was recognized by the Auditor General's report released in December 2000 that showed significant administrative shortcomings and deficiencies in program administration. It did not suggest that money was missing or wasted.

The department had an improvement plan underway. With the release of the auditor's report the Minister was also able to launch a "Six Point Action Plan to Strengthen Grants and Contributions" to bring management of these projects up to expected levels.

The Six Point Action Plan was based on input from an outside consulting firm and the Treasury Board Comptrollership Standards Advisory Board. The Board is an independent committee set up to provide advice to the Secretary of the Treasury Board on the government's choice of standards and frameworks and their application. It was also endorsed by Canada's Auditor General.

HRDC's Six Point Action Plan

1. Ensure payments meet financial and program requirements
2. Check and correct problem files
3. Equip and support staff
4. Ensure accountability
5. Get the best advice available
6. Report progress to the public

Working the plan was essential. Progress was being made and reported regularly through the winter and spring of 2000, but the criticism continued. The department had been prepared for a strong public response to the release of the audit but they were not prepared for the intensity or the duration of it. In particular, they had not anticipated that critics would focus almost exclusively on whether money was lost. Nor were they ready for the way the debate would widen to the efficiency of the programs, the competence of staff and the role of the federal government in the Canadian economy.

The department initiated many structural and procedural changes to address the problems. As an example, a rigorous monitoring of performance through a quality assurance process was established to detect and correct errors at the earliest possible time. The Performance Tracking Directorate's mandate was to give senior officials an ongoing measure of performance in the management of grants and contributions.

But staff at HRDC suffered a hard year. They continued to support and implement the change mandate but did so under trying conditions. They had to deal with very strong public criticism while many of them worked extraordinarily hard to put the administrative reforms into practice.

Senior officials and the Minister herself devoted great attention to internal communications – keeping employees informed of the progress being made and of the support they continued to receive in communities across Canada. At the height of the "crisis period" daily conference calls were held that involved the regions and headquarters. The Minister and Deputy Minister participated in regular videoconferences with employees involved in grants and contributions across the country. The Minister also made a point of meeting with groups of employees as she traveled across Canada to visit HRDC projects.

This communication was deemed necessary for morale and for reporting progress. The Minister also became a rallying point for staff as she defended their actions consistently when pressured in the House.

Management approaches therefore needed two separate and distinct thrusts: First, *fix* the identified problems with program administration through the Six Point Plan. Secondly, *communicate* progress to the staff that had to implement the changes and more importantly support their emotional well being.

LESSONS

What went wrong?

There is no doubt that this crisis took senior management by surprise. Internal audit reports had pointed to weaknesses in the past, but these were not considered "crisis priorities".

Departments leaders did not recognize the politically explosive nature of the crisis—and the ferocity of the attacks. In the firestorm that erupted around HRDC, myths soon become a reality at the drop of a headline and the department had real trouble keeping ahead of the media.

What went right?

HRDC resolved the crisis in a number of ways. One of the early turning points came with the termination of the Transitional Jobs Fund. The Deputy Minister likened that decision to the famous action of Johnson and Johnson in "Taking the Tylenol off the shelves." It took the highly controversial program out of play. Admitting weaknesses or failures; articulating clearly and rapidly what corrective actions are being taken; having the "Six Point Plan" ready

in bold and concrete terms – were all essential aspects of the recovery. The first lesson, therefore, was: fix the bone of contention.

The second lesson: never underestimate the potential for criticism and be prepared for it. In releasing the results of the internal audit HRDC expected strong criticism but they never expected the virulence of the attack from the Opposition and media. While most accusations eventually proved untrue, myth did become reality in the blink of an eye. The power of outside influences to misinterpret actions (whether intentionally or not) and to set the agenda should never be underestimated.

The third lesson: Respond Clearly. The department set up a rapid response team immediately to coordinate communications. It was essential that question period briefings, media responses, all public and internal communications were consistent and accurate.

The fourth lesson: Think of the staff. Marking progress (HRDC reported to staff often and reported publicly regularly about progress on the plan), and celebrating success (staff need to have a sense of progress and understand that their work extra effort is recognized) were absolutely essential.

THE MUSSEL CRISIS
FISHERIES AND OCEANS (1987)

BACKGROUND

In November 1987, three Canadians died and over 100 became ill from food poisoning originating from an unknown source. A search for the cause began in earnest by the federal Center for Disease Control (CDC), and its provincial counterparts. The Minister of Health and Welfare was immediately accused in the House of Commons of failing in his primary mission of protecting the health of Canadians.

These attacks dominated Question Period each day and the issue became a major headline in the newspapers but, particularly, in the electronic media.

The CDC soon determined that the common denominator in the deaths and illnesses was the consumption of mollusk shellfish, even though the product on the market had been inspected under internationally established protocols. (Bivalve mollusks feed themselves by filtering surrounding water and ingesting as a consequence any toxin present in the water.) At the time, these inspection tests detected mainly Paralytic Shellfish Poisoning (PSP). Regulatory agencies in both the Health Protection Branch (HPB) of National Health and Welfare (NHW) and the Fish Inspection Branch (FIB) of the Department of Fisheries and Oceans (DFO) were dealing with food poisoning from an unknown toxin.

Divergences of views emerged quickly between the two agencies as to the extent of the regulatory action required. These were raised at the ministerial level. Because of the high profile of the issue, this potentially damaging conflict was identified by the PCO and the PMO. These agencies immediately determined that for the purposes of resolving this extremely serious public health issue, both the Fish Inspection Branch and the Health Protection Branch would report directly and be accountable to the NHW minister.

This “machinery of government” decision ensured that there was a single focus for resolving the crisis. An Operations Center reporting to the NHW Minister, co-chaired by the responsible ADMs in the two operational departments, was immediately set up to manage all aspects of the issue. The technical staff of both departments worked as a single team. The DFO minister and Cabinet were kept abreast of all developments for the duration of the crisis.

The mussel, oyster, clam and quahog industry was shut down Canada-wide and the market cleared of all such products. Then, the specific cause of the illness and the responsible vector, mussels, was identified by federal scientists from both departments and the National Research Council, working in tandem with universities. An improved inspection test was developed to assure product safety. Within two months, before Christmas of 1987, the industry was gradually allowed to resume commercial operations as all safe harvesting areas were reopened.

In the final analysis, Canada’s fish inspection (the Canadian test protocol has since been adopted internationally) was improved as a result of the crisis.

MANAGEMENT APPROACHES

The mussel crisis had four distinct phases:

Phase 1: Shutting down the supply and clearing the market

When the CDC narrowed down the cause of food poisonings to mussels, Health Protection and Fish Inspection worked together as they had over the years but not in an integrated way. The first internal communication problem between the two agencies emerged at the very beginning.

Considering the extreme pressure to which the minister (NHW) had been subjected for many days - with incessant calls for his resignation for failing to protect the health of Canadians - HPB issued a press release calling for the removal of all shellfish from sales outlets, as soon as the food poisoning source—mussels—was known. The text of the release had not been cleared with senior management in FIB, let alone DFO, which prompted a barrage of calls to FIB as to whether lobster and crab, which are also shellfish, fell under the HPB definition. As lobster and crustaceans were clearly not implicated in the food poisoning event, the answer was negative and required the issuance of a clarification. Since lobster is a highly lucrative industry ($200M+) and the Christmas period the peak of the market, the issue was immediately brought to the DFO minister's attention. Communications to his Health colleague, as well as with the PMO, ensued forthwith.

Seizing quickly on the potential for market and public confusion, which would further compound the problems related to the ongoing attacks directed to the NHW minister on the health protection front, the PMO—on the basis of a PCO recommendation—directed that FIB and HPB be integrated for the purpose of managing this particular crisis. Both agencies were to report directly and be accountable to the NHW minister.

An Operations Center, physically regrouping key senior staff from both agencies, as well as regional operations in both departments through telephone conferences, was established. Co-Chaired by the Senior ADM of DFO and the ADM of HPB, the Operations Center coordinated and vetted all vertical, lateral and external communications on all crisis-related issues. Central agencies monitored its activities on an ongoing basis.

The Operations Center quickly and concurrently:

- Closed all mussel, clam, oyster and quahog harvesting areas in Canada until the source of the poisoning was found and areas could be reopened safely. This generated significant industry pressure.

- Clarified the definition of product at risk (bivalve mollusks) and communicated the information to the trade and to the general public.

- Cleared the shelves of potentially tainted product across the country. A mammoth task requiring the combined efforts of the two agencies, working as a single unit with provincial and local food safety authorities.

- Established a 1-800 public information line.

Because of the technical nature of the issues, all media inquiries and communications were handled by the DFO Co-Chair and a number of designated spokespersons from both departments. This procedure was operative until the conclusion of the crisis.

Phase 2: Fixing the problem

The two ingredients required to fix the problem were finding the cause of the food poisonings and developing a test that would consistently identify the presence of the/any toxin to assure product safety.

The first task was carried out by CDC scientists, with the help of DFO, the NRC and academics. The active agent was identified as Domoic Acid.

HPB also led the development of a bioassay test to track toxins. Simply put, the technique required injecting mice with product fluids from a given production area; survival of the mice beyond 48 hours enabled to certify growing area waters as safe and, consequently, product safety. This test tracked any toxin and was an improvement over testing procedures heretofore used internationally. Developing and implementing a regional capability to conduct the testing reliably in all production areas was a significant management challenge, which was met in a very short period of time.

This critical phase could be qualified as "the eye of the storm" from a crisis management perspective. The health risk had been removed. The only public pressure came from the industry and was principally directed to the regulatory agencies. There was no national media attention of any significance during that phase.

During that period, the Operations Center was focused on developing a strategic plan - for the NHW minister's approval — to ensure the gradual reopening of production areas to supply the market once remedies were found.

Phase 3: Reopening production and market supply

The impact of the crisis on fish and seafood markets during the crisis and its aftermath were extremely significant. Fish and seafood consumption dropped by as much as 60% from historical levels. Perhaps this was the most critical phase of the crisis, as it was imperative to assure the minister that the measures put in place to ultimately resupply the market would be consistently reliable from a food safety perspective. Furthermore, the plan to reopen the individual areas was technically complex.

Daily ministerial briefings were held on the issue, where the plan and its components were reviewed during the course of their development. The opposition criticism—while always targeting health—gradually shifted to include reference to the damage inflicted to the mollusk industry as a result of the government's inability to fix the problem.

The mussel crisis was a standing item of daily Cabinet committee meetings to prepare for Question Period.

The minister eventually committed to table a plan by the end of the week before Christmas. The night before tabling day, the description of the plan had to be simplified to ensure it would be readily understood by all concerned (the House, the general public, the industry and the media) and result in a positive conclusion without further damaging controversy to either the fish inspection system or the industry. This was done overnight, with the final plan approved and tabled on the day previously committed to by the minister.

There was no press conference as the release tabled in the House was self-contained. Media enquiries (which carried on for 3 to 4 days after tabling of the plan) were handled by officials. The public dimension of the crisis finally came to an end.

Phase 4: Rebuilding the fish and seafood markets

The impact of the crisis on the mussel, clam and oyster markets—regionally important industries—was obviously devastating at the time. On the other hand, the measures taken to deal with public health in the short term and to find a permanent solution to the problem were absolutely necessary to the long term viability of the industry. This indeed happened with permanent resourcing of the improved inspection procedures by the government. From a $3.3 million shipment value in 1987, the value of the Atlantic Canada mussel industry exceeded $26 million in 2000.

Even though DFO had put an end to its ongoing market assistance programs in the first of many waves of program cuts, the government allocated special funds to assist the industry in a one shot campaign to rebuild consumer confidence in fish and seafood products.

LESSONS

What went wrong?

The mussel crisis surprised many departments. They had not anticipated this event, and in the scramble to respond, there were lapses in communication between various departments and regional offices. To their credit, players in Ottawa quickly recognized the problem areas and stepped up their coordination.

What went right?

The integration of all aspects of the management of a given crisis under a single source of authority and accountability proved critical to the successful outcome. Interference by other players in the system must be avoided to prevent the emergence of conflicts and contradictions which usually fuel and prolong damaging Parliamentary / media “stories”. Other players in the system with a stake in the issue (central agencies, departments or agencies with a related or peripheral interest in the crisis), must be included in the management process from the outset, under a single accountability structure.

Operations Centers such as the one established to deal with this crisis may not be necessary all the time, but some components may be essential:

1. A “war” room - with teleconferencing and logistical support facilities - where all major players actually met every day, sometimes all day.

2. Single source decision making, informed by extensive real time deliberation with all interested parties (technical, operational, as well as central agency and political representatives in the same room), to ensure the development of the soundest possible strategies and programs, as well as evolving party lines, consistent across the operational, interdepartmental and political spectrum.

3. Vetting of all communications (press releases, QP cards, spokespersons lines, messaging, etc.) on a daily basis, with scrupulous attention to every detail. In this particular case, the inadvertent use of the word “shellfish” and the prudent use of the expression “bioassay test” illustrate the latter point.

4. Systematic involvement of key regional staff. On operational issues, the real action is on the front lines. An error in the field can be devastating and a regional media blip can reverberate nationally on the evening national news...

5. Round the clock administrative support, without which, in this particular instance, timely production, printing, delivery and tabling of the plan on a Friday - when QP is in the morning - would have literally been impossible. In some cases, delay can make things spin out of control.

The pro-active management of allies in media relations is a key to success. It goes without saying that the media does not limit interviews to government representatives. Industry participants, affected parties and potential supporters of the government position(s) should be briefed on an ongoing basis to ensure they are supportive or at the very least properly informed, when interviewed or solicited for advice by the media. In this instance, industry leaders were fully informed and reacted responsibly in interviews even though they were personally faced with severe short term financial hardship. In at least one case towards the conclusion of the crisis, this avoided providing the national media with the opportunity of transforming the event into an “industry versus public health” issue...creating a brand new crisis in a slow news period of the year.

Longer term operational implications of solutions must be factored in to avoid re-emergence of the crisis situation. In this particular instance, a joint Treasury Board submission by DFO and NHW to secure the additional financial and human resources required to implement the new testing and verification procedures was approved and funded from the TB Operational Reserve, which fortunately existed at the time.. As a result, a lasting and effective solution was put in place.

TAINTED BLOOD CRISIS
CANADIAN RED CROSS (1998)

BACKGROUND

The Red Cross has a history in Canada almost as old as the country itself. It can be traced back to 1885, to the battlefield of Louis Riel's North West Rebellion, where a surgeon general made a Red Cross flag out of white cloth and two torn strips of red artillery cotton so he could distinguish a horse-drawn wagon being used to transport the wounded.

Eleven years after the rebellion, Dr. George Sterling Ryerson, the same man who flew the makeshift flag, won approval from Britain to form a Canadian Branch of the Red Cross in Toronto. The organization grew quickly and in 1909 the federal government adopted the Canadian Red Cross Society Act. In 1927, the International Committee of the Red Cross recognized the society as an autonomous group. It went on to become the preeminent not-for-profit organization in the country.

On February 3, 1947, the Canadian Red Cross opened its first civilian blood donor clinic in Vancouver with the goal of providing free blood to anyone who needed it. Before that, patients had to pay for or replace the blood they were given in hospitals.

In the late 1970s and early 1980s, Canada's blood system infected approximately 1,200 people with the HIV virus and it has been estimated that another 12,000 people were infected with Hepatitis C. Many of the victims were hemophiliacs and people who had received blood during routine operations. At that time we had less knowledge than we do now about these viruses. Many of those who had been infected did not know they had received contaminated blood. Some people unknowingly passed on the viruses to their spouses and family members. As a result by the 1990s it was estimated that the number of infected people had increased substantially and exponentially. The staggering number of victims illustrated that the blood system had failed the very people it was supposed to protect. In response many people began calling for a judicial inquiry into Canada's blood system.

In 1993 Justice Horace Krever was appointed to head a Commission of Inquiry with the mandate to investigate the management and operation and contamination of the blood system in Canada. After nearly four years of a public judicial inquiry, Justice Krever issued his much-awaited final report on November 26, 1997.

Krever's report stopped short of finding the Canadian government liable for the contaminated blood or singling out individuals for blame. But he criticized federal and local authorities for their roles in distributing the tainted blood. The report also criticized the Canadian Red Cross for failing to put into place an adequate screening program for high-risk blood donors. After the report was issued the Red Cross (through Gene Durnin) apologized. "While we cannot know your suffering, we will weep with you. While we cannot feel your loss we grieve with you. We are very sorry."

Krever also recommended that the thousands of people infected with Hepatitis C should be entitled to automatic compensation. He did not set an amount. The 1,200 people infected with HIV through tainted blood products had already been compensated by the federal government. Further, the Red Cross and its insurers together with the provinces contributed to a second compensation program for HIV victims – the Multi-Provincial/Territorial Assistance Program. There had been no requirement for court proceedings or legal negotiations in an overwhelming numbers of these cases.

But federal and provincial health ministers decided not to compensate hepatitis C victims at all, leaving the Red Cross with billions of dollars in claims. This led to massive complications. By the time the issue had been sorted out the Canadian Red Cross had been forced to seek bankruptcy protection under the Companies' Creditors Arrangement Act. It shook the organization to its foundation and nearly brought it tumbling down.

MANAGEMENT APPROACHES

In September of 1998 following agreement reached with the provinces and territories, the Red Cross handed over all of its blood operations to two new agencies – Canadian Blood Services and Hema-Quebec. Under the deal the Red Cross got $133 million in exchange for its assets – money to be used to pay off debts and set up a fund for victims of tainted blood. Buildings, vehicles, donor lists and 3,100 employees of the Red Cross were transferred to the two new non-profit organizations. This arrangement changed the nature of the Red Cross substantially.

There were approximately $8 billion unsubstantiated claims against the Red Cross related to tainted blood. They did not have nearly enough money to settle even a small percentage of those claims. They also had accumulated substantial debt as a result of these operational changes. The Society's overreaching objective under CCAA was to settle its claims so the organization could get on with its work.

The organization had two objectives – to avoid bankruptcy and to put forward a plan to compensate victims.

Holding itself together, maintaining its substantial volunteer base, managing its other lines of business, and redrafting its business plan all had to be done under extreme duress.

The Red Cross had a disaster planning process and it was followed:

1. Experienced communications competence was extremely important.
2. The public received positive messages about the future of the organization in the face of devastating effects of recent actions.
3. The organization apologized for the suffering and hardship that resulted for so many.
4. There was also a system of crisis management that they were able to use to their advantage.

The Red Cross also recognized that it was important to maintain excellent internal communications with the remaining staff and volunteers. They needed to be kept up to date.

They needed to be proud volunteers who would speak well of the Red Cross. This was a hard task in the environment the organization faced but the future of the organization depended on it. The loss of marquee programs – Blood Donor Recruitment and Blood Transfusion Services – was devastating from a morale point of view. Volunteers felt that the organization's contribution to Canada was overlooked and marginalized.

The organization shrunk: from 165,000 volunteers to 68,000. Three hundred branches were closed. But the Red Cross tried to keep volunteers focused on their overall mission – "Helping people deal with situations that threaten their survival, their security and well being and their human dignity in Canada and around the world." The Red Cross has a continuing and important role to play. It needed a committed volunteer force to enable it to function. They worked aggressively to keep volunteers onside and informed. They would be called on to help support the Government of Canada as it worked on the resettlement of refugees from war-torn Kosovo.

The organization developed a plan of arrangement while under court protection. That plan set up the compensation program for transfusion claimants and a schedule for creditors. When it was approved it extinguished all claims against the Red Cross. An excellent negotiating team headed by Mr. Bob Rae, former Premier of Ontario worked on that plan and the quality of their work and their leadership gave the plan added credibility.

The Red Cross management team stayed committed to the organization's mission. There was quality information sharing within the team. Team consensus decision-making was a norm. Open information sharing with volunteers was key.

LESSONS

What went wrong?

Many procedures were to blame for this painful crisis, but surely the most troubling was the extended duration of the crisis. Leaders of he Red Cross, a compassionate agency, were frustrated by their inability to show compassion. Public statements were controlled by insurers, and the communications effort as a result seemed uncaring.

Reputation is a very fragile thing that must never be taken for granted. Other organizations may not have withstood the pressure as well as the Red Cross. With 105 years of dedicated community service behind them the Red Cross had established a high degree of credibility with the Canadian public. That credibility has allowed the organization to survive and continue to serve. But public opinion can swing--and swing quickly.

Risk analysis must be an integral part of an organization's management approach. It must be done constantly and consistently. Better planning can minimize the impact of crises.

Non-Governmental Organizations must carefully consider how they engage the government. The government needs the voluntary sector as a partner. When things go well the partners should celebrate together. But the reverse is also true. When things go off the rails the partners should suffer together. The NGOs should not be cut loose when problems arise. The relationship works best when it is one of mutual care and respect and operates from a

stance that recognizes that agencies are inevitably facing crises together – from the beginning to the end.

Keep communications with the front line people in the organization accurate, frequent and complete. This is even more crucial when the organization is under stress.

YEAR 2000 PREPAREDNESS
TREASURY BOARD SECRETARIAT (1998-2000)

BACKGROUND

In the second half of the twentieth century information technology made possible advances ranging from the ability to bank and invest electronically in markets around the world to satellite tracking of approaching weather systems to ground-breaking research to find cures for the most complex diseases. Technology had ushered in an age of astonishing possibility.

The Year 2000 problem (Y2K) posed a threat to that progress. It stemmed from the use in many computer systems of a two-digit dating method that assumed 1 and 9 were the first two digits of the year. Without programming changes, the systems would recognize 00 not as 2000 but as 1900, which could have caused computers either to shut down or malfunction on January 01, 2000.

The Year 2000 transition was a unique event that posed a series of challenges to the traditional work of government. What was initially perceived simply as a problem of technology was soon understood to have implications for every government agency, every university, every hospital, every business and organization--large and small. At stake were Canada's industrial competitiveness, supply chain integrity, the continuous delivery of government services and programs, and the health, safety, security, and economic well being.

The situation encouraged the development of a broad, horizontal approach to management that involved all levels of governance and their non-governmental partners and left a lasting legacy in the operations of government.

MANAGEMENT APPROACHES

Governance

The hard work began in 1998 with broad recognition and acceptance of the challenge. The Government of Canada assigned the effort high priority, made additional financial resources available and clearly assigned accountability for readiness and preparedness. It also supported a governance structure for the issue and assigned four key ministerial level leadership roles to play.

Because the millenium bug was a global concern that cut across jurisdictions and sectors a horizontal approach was required using a matrix management structure.

All ministers were responsible for Year 2000 preparedness in their portfolios, which included departments, agencies and Crown corporations, and for liaison with their respective stakeholders. While it was desirable to manage many of the issues horizontally it was also important to assign clear responsibility for leadership on any given issue in order to avoid duplication and to allow for rapid decision making.

There was also a compelling need to facilitate clear, coordinated and effective communications with provinces and territories, with stakeholder partners across the country

and internationally and with the Canadian public. All levels of government had to be committed to managing the challenge.

An *ad hoc* Committee of Ministers on Year 2000 was established to ensure consistency and provide oversight. It was created by expanding Treasury Board to include the Ministers of Industry and Foreign Affairs and International Trade (DFAIT). Each month this Committee received a report on Year 2000 progress. This committee drove the horizontality, provided continuing legitimacy and urgency to the effort and sustained accountability. Senior management and staff were appointed to coordinate the effort from within the Treasury Board Secretariat.

Four ministers were assigned broader responsibility for Year 2000. The Minister of Industry was responsible for promoting and reporting on industry readiness. DFAIT would work with international partners and governments in priority countries and collect and assess readiness information. The Department of National Defense would coordinate emergency preparedness and national contingency planning. Treasury Board Secretariat coordinated the overall government readiness effort.

The commitment from the Government, the governance structure, the clear lines of responsibility and accountability and continual clear, effective communications with stakeholders, government partners and the Canadian public were essential elements of the management approach.

Partnering

The departments also had to partner with critical stakeholders in win-win collaboration. This networking allowed the government to establish key relationships with the provinces and territories, industry and trade associations, the telecommunications industry, the banking sector and Canada's key trading partners. These were critical working relationships that demanded good communications, regular meetings all to share information and to produce an agreed upon outcome. Those relationships have lasted well past the critical Year 2000 problem and continue today.

Communications

There were several key communications objectives:

- Convince target audiences to fix systems and prepare contingency plans
- Show government of Canada progress through regular public reports
- Keep public concern under control
- Ally with partners showing progress
- Proactive and transparent communications with the media
- Coordinated federal government communications
- Designated spokespersons for a coordinated voice
- Keep Ministers abreast of progress

LESSONS

What went wrong?

In light of what turned out to be a success story, the only weakness proved to be in not anticipating early on the communication imperatives of this emergency. In late 1998 the press began to speculate on doomsday scenarios: "The sky will fall" kind of messages. The government was in a reactive mode of responding to press coverage at the time. A rigorous plan was in place, it had been tested, the preparedness of departments and stakeholders was high, and the exercise was on track towards a final plan yet the media created a worried public. People were stocking upon food and taking out large amounts of cash. The Government decided to move to a more proactive communications stance to head off the negative media. This openness about the state of readiness disarmed the negativity. Polling data suggested that the government's message was being believed. So the lesson was to be proactive in communications.

What went right?

There was a strong political will to address this challenge: A team with the required competencies was made available; the financial resources were made available. Those factors provided a good basis for success.

Whether the crisis is large or relatively small, some governance/management structure must be considered. In this case, the sheer size and scope of the problem necessitated clear responsibilities and accountability. That should also be true for less wide ranging issues.

Crisis management leaders will have to make communications a top priority. Managers will also have to commit to continued communications – they will have to repeat messages over and over again. Consistency is crucial and variation is the fodder for press speculation and pressure.

Getting the right leadership and the right people is always critical but in this kind of time bounded emergency it was essential. Leadership must continually communicate the vision of success to all parties involved. Because partnering and networking were essential to success the leadership must demonstrate these values day to day. Leadership must continually engage in open, two-way communications with staff.

Crisis management is part of the nature of governing. There is no one else to do it. There is a need to move crisis management competence from personal knowledge to institutional knowledge. We should not need to reinvent processes each time. An action plan that guides managers through the typical stages and appropriate responses – structures - approaches – key messages would be most useful.

Stakeholders buy in when they see both need and benefit. This process became a win-win for all concerned. The relationships that were established with partners both within government and without were open, honest and based on trust. All parties to the enterprise benefited.

LOVE BUG HACKER INCIDENT
TREASURY BOARD SECRETARIAT (2002)

BACKGROUND

On Thursday morning May 4, 2002 many government managers arrived at work to find an unwanted guest had invaded their offices. More specifically, it had invaded their computers.

Fresh in from the Philippines, the Love Bug virus had circumvented existing virus scanners and instantly started to degrade the systems that it had invaded. The virus swept across the world with alarming speed and had a major impact across Canada, affecting the both the private and broad public sectors.

The virus was in many ways more damaging than any previous ones. It spread very quickly, propagating itself via email. It also searched across all computer files to replace certain types of files with the virus.

Twenty federal departments reported being affected to greater or lesser degrees. Six reported extensive infection. Examples included:

- Cheque production at Public Works and Government Services. The Department responded quickly and implemented contingency plans. The problem was fixed within a few hours.
- Some mapping files at Natural Resources were infected but there were back-ups to replace them.
- The government's X400 gateway – the system that allows departments to talk to each other did not close. PWGSC put a script in place that checked extensions of emails every two minutes. It flushed out 90,000 infected emails.

Managers were perplexed but systems professionals were scared. Government has become increasingly dependent upon excellent computer systems and programs. An unknown virus with unknown consequences prompted furious action to forestall damage.

For the next nine days systems professionals and senior managers worked out a process to ensure that essential services were protected. It was also vital that the private information that the government has on each citizen was secure.

MANAGEMENT ISSUES

The potential damage was great. Some systems had been hit but the extent and impact of the damage was unknown. The extent of the damage had to be determined. And systems had to be secured.

At the time there was no central agency or department set up to manage a crisis like this. The locus of responsibility was unclear and no agency appeared to have the designated lead.

Communications became difficult because email systems could not be used. No formal interdepartmental links had been established for emergencies of this kind, although efforts to build such a system were already underway involving Treasury Board Secretariat, OCIPEP, CSE and the RCMP.

The technical dimensions of the problem were of little interest to senior non-technical managers and politicians. They were concerned that essential services were delivered and that the personal and confidential information held by the government on Canadians was secure.

Once it became known that the virus had infiltrated the government the public needed to be reassured that no personal information had been compromised. Media reports, briefing notes and speaking notes had to be prepared – for the most part by Treasury Board Secretariat. The message had to get out that the government was in control.

So the task became:

- Contain the virus and asses impact
- Eliminate it
- Re-establish a "new" secure system with adequate virus screening and the installation of "patches"
- Communicate with IT departments and IT security staff
- Communicate with senior managers and politicians
- Communicate with Canadians about the security of personal information
- Communicate with all of the above regarding what was being done to remedy the problem.

MANAGEMENT APPROACHES

The initial triage required disconnecting all government systems from the outside. The sources of the virus appeared to be email and the Internet. The virus was detected in government systems at 8:00 am – the RCMP, because of their responsibility for computer crime were notified of the problem at 10:25 am and a warning was issued to all stakeholders at 11:00 am.

The triage system was focused on tasks such as:

- ensuring the disconnect from the outside
- determining how to scrub the virus from the systems
- identifying vulnerable sites
- identifying the extent of the damage
- determining a process for identifying affected files
- getting a new scanner before any reconnect occurs
- Communicating this within the technical community.

Chief Information Officers from across the country were already linked into a conference call process for a broad range of technical purposes. That system, managed by a private sector contractor proved its worth in this crisis. The system linked the CIOs from across the country in the federal, provincial and municipal sectors. Treasury Board Secretariat and the RCMP were able to conduct thorough briefings and get feedback from across the country to lessen the impact of the virus.

It should be emphasized that there was no formal system in place for doing any of this. Staff at Treasury Board (CIOB and GOS) took the initiative and played an operational role for which them is unusual. The RCMP operations centre carried some of the load – but the crisis demanded action and it got it. By the end of day one, staff felt they were beginning to understand the scope of the problem.

Of course the Deputy Ministers and Ministers wanted to know how this was affecting Canadians and extensive briefing notes and media releases were prepared and issued. The Privy Council Office got involved in getting the key messages out to Canadians.

LESSONS

What went wrong?

As with all crises, there was an initial scramble to sort out roles. There was no clear locus of responsibility as to who would take the lead in resolving this issue and first efforts were ad hoc. There was a recognition, however, that there was a clear need for a "centre" of balance.

During a major crisis there is a need to brief senior federal government decision-makers on the delivery of critical and essential services and the impact on overall government operations. It was not clear initially which department/agency would take the lead in polling departments/agencies during the event and in preparing ongoing status reports of this nature to senior managers.

What went right?

Because no essential services to Canadians were unduly affected and no personal information was compromised, the existing IT security processes and firewalls worked. The *ad hoc* approach worked as well. Staff commented that they used the existing Treasury Board Secretariat structure because it made sense. There was no other place to turn. But *ad hoc* probably will not work next time. The government needs to prepare a range of contingency plans and practice responses to them and then document those emergency procedures.

A new governance structure is in place for the next crisis. The government is better prepared now with regular virus scanning updates, alerts, and more money has been allocated to IT security.

The Office of Critical Information and Emergency Preparedness Canada in the Department of National Defense is in place. Its mandate includes advising departments on critical infrastructure security matters (e.g. future "Love Bugs"), issuing alerts, and helping mitigate

risk, finding fixes for problems and repairing damage. But departments also need to have internal procedures in place to manage these kinds of intrusions.

The management and technical sides of a crisis like this are different. The issues they deal with are different, their interests are different and their competencies are different. It needs to be recognized that both points of view are valid and need to be addressed.

Communications is critical. Assess all stakeholders and find a communications tools that fit their needs accurately. The extensive use of conference calls became important here because the email systems were down. The networks that had been established for a variety of purposes worked in this crisis. Optional uses in times of emergency should be considered.

CANADA-UNITED STATES BORDER SECURITY RESPONSE TO SEPTEMBER 11, 2001 TERRORIST ATTACKS
CANADA CUSTOMS AND REVENUE AGENCY

BACKGROUND

The terrorist attacks in the United States of September 11, 2001 carried diverse and far-reaching ramifications for Canada. The events emphasized Canada's interdependence with the U.S. and our shared vulnerability from a security and economic perspective. The 5000-mile border – the world's longest undefended border boasted about – finally needed to be defended.

The Canadian Customs and Revenue Agency (CCRA) is responsible for enforcing compliance with Canada's border legislation and regulations along that border at three hundred border crossings, airports and harbours.

It is a busy border. 300,000 people and 40,000 commercial truck shipments per business day cross that border. Canada is the greatest export market for the United States, receiving about 25% of all American exported goods. Canadians and Americans have a daily bilateral trade in goods and services of C$1.9 billion.

With the security issues front and centre, and trade between the countries at record levels the border needed to be tightened – not shut down. Both the Canadian Prime Minister and the President of the United States stated publicly that the border must remain open. To do otherwise would be to submit to terrorism.

However, as border security tightened, the border began to contribute to an economic crisis with 18-hour line-ups for trucks wanting to cross. 38 jets carrying 6,500 passengers and crew were diverted to Gander, Newfoundland after U.S. airspace was closed amid a wave of terrorist attacks. Gander, a small town of 9,600 people rallied to help so many reluctant visitors. Those 6,500 passengers presented a logistical nightmare for the small Customs staff normally at Gander. Document processing and passenger screening were essential even though the extent of the threat and the "who" of the search were unknown.

The task for Canada and the United States was to increase security while not damaging the economy of both countries.

MANAGEMENT ISSUES

Tightening the border meant more careful screening of those leaving and entering Canada. Last year some 14,000 criminals were stopped from entering the United States from Canada and some 21,000 were stopped from entering Canada from the United States. But the main enemy became uncertainty. Who and what was the border staff looking for?

Most of the people and goods that cross the border are legitimate. The focus of screening needed to be on the high-risk travelers and not on legitimate low risk individuals. Of the

300,000 people who cross the border daily, 50% are Canadian. They pass judgment on the service they encounter. Staff still had to provide competent and secure service in this new environment. Once the identity of those high-risk individuals who were being sought had been defined all border staff were immediately informed and kept up-to-date about those who would seek to cross illegitimately.

In order to address these threats to the security of Canadians and their economy the following concurrent operations were put into place:

- liaise operationally with affected government departments
- liaise operationally with all of our border points
- communicate constantly with the Canadian public to reassure them they were secure and that the government was doing the right things to protect our collective security
- determine the long term business case to change the management of border points in the future
- keep the economy moving in the short term by taking immediate action
- implement the highest state of alert to ensure the security of Canada and North America.

MANAGEMENT APPROACHES

Within two to three hours of the devastation in New York City all of our ports of entry were at high alert.

A 24-hour command centre was immediately operational within the CCRA. The CCRA also had a representative at the RCMP command centre. In addition representatives of Canada Customs and Revenue Agency, Citizenship and Immigration, Finance, Foreign Affairs and International Trade, Industry Canada, the RCMP and Transport met often at the call of the Department of the Solicitor General to focus on the security needs of the country.

A committee of Deputy Ministers was established to coordinate efforts and to keep the Government informed.

The command team and staff from PCO met two to three times daily. PCO managed the communications track and all statements to the media, the public and the politicians were centralized in that office.

Departments with operational responsibilities in border matters managed their own application in full coordination with others present at those meetings. CCRA asked their U.S. counterparts if there was anything that could be done on our side to assist their enforcement concerns. Instead of two line-ups could we help them with their screening? This help was accepted and resulted in reduced wait times.

Staff was willing to commit the extra time needed to clear backlogs and keep vehicles and people moving. Additional funding was found to pay for the extra hours needed.

A "wait time " procedure was also established to monitor the status of the backlog at all major ports of entry into Canada. All ports of entry advised our central office every two hours about the "wait time" both entering and leaving Canada. This was posted on our web site. Truckers could then pick their border crossing point based on their shortest wait.

As part of a longer term strategy dialogue with the Americans was begun in reference to the future of the border. This resulted in a Canada-U.S. Smart Border Declaration in December that contained an Action Plan for Creating a Secure and Smart Border

In addition, an interdepartmental group was put together by DFAIT comprised of members from CCRA, CIC, Transport Canada, Finance, Treasury Board, PCO, Industry Canada, CFIA and others to develop and monitor the evolving strategy for engaging the US on security and streamlining initiatives at the perimeter and shared land border.

LESSONS

What went wrong?

Truth is often a first victim of crisis. Efforts to overcome the concern among American people and decision-making (fuelled by specific media reports) about the perceived threat from Canada have not been successful and the notion that Canada had become a launching ground for terrorists persists unfairly. It was perhaps the single failure in the communications approach.

What went right?

Public servants communicated constantly throughout. They were in large command centre meetings all the time and this strategy worked well. The regions and the border points were kept in the loop consistently and constantly. This was centre out communication. They maintained constant and consistent communications with our stakeholders. They kept the Government well informed. They decided that the unknown is the enemy. They adopted the maxim that to share is better than not sharing,

They also kept informed constantly by the field. They learned from their experience and that helped shape our reactions. That worked superbly. They learned to trust people to do the right thing at the regional and local level. They could not control everything from the centre.

They were able to reassure the Canadian public that the government was competently handling the situation. The public needed to have confidence that we were reacting in sufficient reasonable ways and that they had the right balance between reacting and overreacting.

In announcing the Canada-U.S. Smart Border Declaration the Department of Foreign Affairs noted:

"Our countries have a long history of cooperative border management. This tradition facilitated both countries' immediate responses to the attacks of September 11. It is the foundation on which we continue to base our cooperation, recognizing that our current and future prosperity and security depend on a border that operates efficiently and effectively under all circumstances."

CLOSING THE SKIES AND RESPONDING TO TERROR ON SEPTEMBER 11, 2001
TRANSPORT CANADA

BACKGROUND

At 8:45 American Airlines Flight 11 struck the north tower of the World Trade Center in New York. The plane carried 81 passengers and a crew of eleven. Air transport officials wondered how it could happen.

At 9:03 United Airlines Flight 175 struck the south tower of the World Trade Center. There were 56 passengers and 9 crewmembers aboard. It was now clear that these were acts of terrorism. Transport Canada officials realized that there were bound to be important implications for Canada and the department would be expected to play a lead role in any response.

At 9:21 Transport Canada activates its Situation Centre (SitCen) in Ottawa. The SitCen instantly became a nerve centre and focal point for all decisions and actions to be taken by Transport Canada and its partners as they respond to the crisis. Across Canada, regional Transport Canada SitCens activate their emergency response measures.

At 9:37 American Airlines Flight 77 crashes into the Pentagon with 58 passengers and 6 crewmembers aboard. At 9:45 the federal Aviation Administration (FAA) prohibits all aircraft from taking off, orders all aircraft to land at the nearest airport and closes American airspace to incoming international flights. Transport Canada began working on the formal order to halt all departures.

The FAA order poses enormous logistical implications for Canadian decision-makers. Approximately 500 trans-Atlantic and trans-Pacific flights are in the air bound for destinations that are now closed to them. They enter Canadian airspace at an average rate of one plane every 45 seconds. Transport Canada must decide within minutes what to do with these planes.

Transport Canada instructed NAV CANADA to order all flights with enough fuel to head back to Europe. Two hundred and seventy planes turn around in mid air. The remainder are diverted to airports across Canada. Airports had to be identified for those flights past the halfway point, and the Department of National Defense was alerted to the diversion. Customs and Immigration were advised to position staff handle the massive influx of passengers.

The first planes land at Goose Bay. Others follow at 16 airports from coast to coast.

In a short time 224 passenger flights carrying more than 33,000 passengers as well as 10 cargo flights are stacked up on runways from one end of the country to the other. This marks the beginning of Transport Canada's "Operation Yellow Ribbon."

At 10:24 United Airlines Flight 93 slams into a farm field in southern Pennsylvania carrying 38 passengers and 7 crew.

Once the planes were out of the sky and the potential for additional "planes as bombs" scenario had been controlled the logistical and managerial tasks became top priority. The lunatic fringe also got involved and officials had to deal with over 20 additional bomb threats at airports across Canada.

From the afternoon of September 11 and into early September 12, thousands of passengers aboard the diverted flights are screened again, cargo is taken off all aircraft and re-searched. Additional Customs and Immigration staff are brought in to clear all passengers at airports across Canada.

On September 12 the logistical problems and looking after the stranded passengers become priority activities. Communities across Canada responded wonderfully. Transport Canada officials began to draft and revise security requirements so that aircraft could safely return to the skies. At 14:25 that day the Minister cleared all diverted domestic flights for resumption of travel to points other than the USA. By 18:00 the Minister authorized the operation of most domestic passenger flights.

September 13 saw the re-opening of US airspace under enhanced security and by 18:30 the Minister authorized operation of passenger flights to the U.S. The 14th of September saw a return to flight normalcy but with enhanced security in place throughout the continent. All domestic restrictions were removed by 21:47

The departure of the last diverted flight on September 17 did not end the work at the SitCen. The emergency response team drafts, processes and implements new security measures to ensure Canada's skies remain safe. Around the clock operations continue for 21 days after which the SitCen goes back into a monitoring mode and the officials return to a more normal state of operations.

MANAGEMENT APPROACHES

The SitCen is a state-of-the-art facility designed specifically for emergency response. Since opening in 1994, it has been activated a number of times including during the ice storm in Ontario and Quebec and the Swissair disaster near Peggy's Cove.

The centre quickly filled with key Transport Canada personnel. In addition several other critical organizations assigned staff. These include NAV CANADA, National Defense, RCMP, CSIS, Citizenship and Immigration and Canada Customs and Revenue Agency. In this case the SitCen established contact with other key members of the Canadian aviation community, the American regulator, the FAA and international civil aviation authorities.

The SitCen was the centre of problem solving, logistical decisions, development of new security measures and guidelines, the development of answers for the government and the public and the communications hub for project management.

Many of the practical logistical problems had to be solved locally: Getting passengers off planes and into accommodations, organizing communications for them, keeping them in touch with progress on going home, searching baggage and checking documentation. None of this could be directed from the centre. Certainly communications kept staff at the local level informed but they had to act with minimal direction. They performed superbly.

Consistent and accurate communications with the media, the public, the Government, and Ministers and deputy Ministers was a priority. This was managed through the SitCen.

LESSONS

What went wrong?

In the early moments decisions had to be taken. There was no time for in depth consultation. The management approach was cool headed, informed, instantaneous decision-making. Staff wondered to each other under what specific authorities they were issuing orders. They determined that unlike normal times where it would be "all-stop" until the exact authority was found, they had the moral imperative to act. The authorities would be confirmed later. Effectiveness became the operational standard.

What went right?

It is often said, but rarely are the results seen so clearly – trust your people. There were no precedents to fall back on. For example, a plane touched down carrying a shipment of exotic animals. With no previous experience like this, Transport Canada advised local staff to sort it out. There were many other issues that they sorted out. The decision was made to "turn good people loose". Officials at Transport Canada felt they had no choice: they simply could not micromanage an event of this magnitude. With new empowerment, staff performed extremely well. Everything they did was done well. It was a lot of people doing it together.

What really counted was experience. Transport Canada knew which staff had crisis management experience. The SitCen worked as it was intended to. Even with its excellent access to modern communications tools, telephone lines into the SitCen were overwhelmed. Transport Canada made extreme use of the multifax machine to distribute one message to many locations at the same time.

A process for ensuring consistent and accurate communications proved essential. All key actors delivered a unified message. Perhaps the most important communications link Transport Canada had to maintain and actively support was with local field offices. As one observer put it: "They were flying by the seats of their collective pants as well and unique situations were the norm. We empowered them to decide, kept them informed of decisions being made centrally or by their colleagues in another region, and kept quality information flowing to them."

Finally, interdepartmental links were very important. The staff at the SitCen used their departmental contacts rather than any chain of command to get information, policy advice or decisions. Getting quick and friendly access into other departments proved to be critical.

OPERATION PARASOL – REFUGEES FROM KOSOVO
CITIZENSHIP AND IMMIGRATION CANADA (1999)

BACKGROUND

In late winter of 1999, NATO forces were waging war with the forces of Slobodan Milosevic in Kosovo. With war raging in their homeland, hundreds of thousands of Kosovars were fleeing into Macedonia and Albania. The UN had established refugee camps in these two neighboring countries but they soon became horribly overcrowded.

On Easter weekend 1999, Canada responded to an appeal from the United Nations High Commissioner for Refugees (UNHCR) by agreeing to accept 5,000 Kosovar refugees.

The request, initially, was to provide temporary protection for 3 to 6 months. This changed to one where temporary housing would be provided for a period of 6 to 8 weeks until longer term support could be found in communities across Canada. Soon after, Canada offered these refugees the option to stay in Canada for up to two years during which time they could decide to apply for Landed Immigrant Status or return home after the war was over.

This type of response fell under the mandate of the Department of Citizenship and Immigration (CIC), which became the lead department for the project. Due to the magnitude of the project and the complexities of the situation several other Federal Departments played key roles: Department of National Defence (DND), Department of Foreign Affairs and International Trade (DFAIT), Health Canada, Canada Customs and Revenue Agency and the Canadian Food Inspection agency. CIC has also had a long history of working with partners and this project proved the benefits of these relationships. Critical partnerships and support were provided by the Canadian Red Cross, the UNHCR, the International Organization for Migration, Private Sponsorship organizations (mostly church groups), Immigrant and Refugee Service Provider organizations, the Salvation Army, community groups as well as Provincial and Municipal governments.

Preparations immediately began for this project, dubbed Operation Parasol, based on the need to be operational within 7 days (arrival of the first flight).

However the refugee crisis eased and on April 9 the UNHCR decided to temporarily suspend their appeal. All of the preparations continued on the basis of being ready to "become operational within 24 hours notice". A week later, this changed to "72 hours".

On April 30 the request from UNHCR shifted back into high gear and the "stand by" order was lifted and 7 Canadian Forces Bases became operational. Immigration Visa Officers who had been deployed into Macedonia and Albania began the selection, initial screening and transportation arrangements to move the refugees to Canada via chartered flights. All transportation, both to and in Canada, was contracted through the International Organization for Migration.

On May 4, 1999 the first of 22 chartered flights began to arrive at the two reception centres CFB Trenton (Ont.) and CFB Greenwood (NS). Essentially, Trenton and Greenwood operated as Ports of Entry with the required Customs, Immigration and Canadian Food Inspection Agency processing. Medical services were also provided. The Canadian Red Cross was active in providing staff and volunteers as greeters, providing refreshments during basic orientation, providing comfort kits, clothing and Zeddy Bears for the children.

Approximately 260 refugees arrived daily on an alternate basis in Trenton and Greenwood. From the reception centres where they were housed temporarily the refugees were bused to sustainment sites at CF bases at Trenton, Borden, Kingston, Gagetown, Halifax, Greenwood and Aldershot where more permanent accommodation was provided.

Most of the Immigration processes took place in those sustainment sites. Basic things such as registration of individuals and families, undertaking a needs assessment, documentation, meeting basic clothing and food needs, medical needs, dealing with language difficulties and translation services were also provided at the sustainment sites.

The process of resettlement came next. The refugees had to be settled into communities where support and sponsorship was possible. There was remarkable interest from Canadians and from Canadian business to support the resettlement. Community response was impressive and the last group of refugees to leave a sustainment occurred on August 11, 1999.

During May and June, 1999 all signs were indicating that the war in Kosovo would soon come to an end. In view of Canada's commitment, Kosovar refugees in the sustainment camps began asking when they could return to Kosovo. This element added to the complexity of the project. On July 9 the UNHCR ended its appeal for temporary protection. The war was over. Now for the first time in CIC's history, the Department had to arrange charter flights home for large-scale repatriation of refugees. Again, thanks to the cooperation and support of key partners such as the Canadian Red Cross and IOM this process was successful. Overall, approximately 23% decided to return home. This was a unique challenge for everyone involved.

The crisis was over. The four phases – logistics for leaving Macedonia – reception in Canada – temporary sustainment in Canada – and finally resettlement/repatriation had been accomplished well.

MANAGEMENT APPROACHES

On Easter Monday April 5, the Associate Deputy Minister called together a task force to manage the expected influx of refugees. Lead roles were assigned. Key partners were identified and invited to subsequent meetings. Within CIC, the Director of the European Desk was charged with managing logistics in theatre and the Director of Refugee Resettlement was to be in charge of logistics In Canada. Both of these directors would need strong liaison and good working relationships with DND and DFAIT staff who were critical partners in this process. The entire CIC management team was involved in one way or another in responding to this crisis. Regional Directors from across Canada were all involved to help determine where the refugees would be temporarily settled.

From the outset, the Task Force met every morning to address issues, receive updates and to prepare for the day's events. Needless to say there were also a plethora of other meetings, conference calls and e-mails.

It became necessary to set up a field office in Macedonia to do initial screening. This was left to the European desk of the International region at CIC. They handle situations like this, on a smaller scale, often. Their systems worked well in the field.

Communications with the media were very important. DND and DFAIT, because of the war, already had a process of daily press conferences. These were utilized to report on daily happenings regarding the refugees including sustainment and resettlement activities.

Regular conference calls were held with the field offices as well as with all of the Partners to keep them in touch with what was going on.

Local media interest around the sustainment sites overwhelmed CIC staff. Cooperation from the main partners (DND and the Red Cross) helped to alleviate the pressures.

The CIC link with the Canadian Red Cross was very important. They coordinated the efforts of all NGOs (and there were many) regarding the reception, sustainment and resettlement activities. They brought an international symbol easily recognized into play. They have a trained capacity in crisis. They have experience in family reunification and family messaging that was needed. They also had expertise in corporate fund raising – something the government needed. It was a beneficial partnership.

DND is used to working in emergencies. They have processes in place that were useful to the overall project. They are used to dealing with the media. All of the partners brought great strengths to the table.

MANAGEMENT LESSONS

What went wrong?

When UNHCR called on Easter weekend, 1999 no formal system was in place for handling a crisis. The department had handled massive refugee resettlement from Vietnam (50,000 refugees) in 1979 but much had changed since then and those approaches had not been documented. They had to bring in those with corporate memory. This was not always very satisfactory. There was no contingency plan for handling emergencies. Nevertheless, there is a plan that is now being worked on.

The initial response was reactive. Roles and responsibilities were partially defined and sorting them out resulted in uncertainty, duplication and at times frustration. While each situation is unique, a structured response plan with the roles and responsibilities of partners would have contributed more certainty in the crisis management process.

What went right?

The most important dimension of effective crisis management was the quality work of people. In comparing the Vietnamese movement of 1979 with the Kosovo movement, one can note some interesting observations. As an example, in 1979, the level of technology was the telex machine. In 1999, the latest computer technology was utilized. In summary, there was little incremental gain in efficiency because of technology. Even in this light, it would be wrong to assume that technology will alleviate the problems. Emails are not always the best tool for communication. During this crisis some managers received 200 to 300 email messages a day. Role clarity would have focused the broadcast email and allow people to target their communications to appropriate recipients.

Because technology is available, the expectations of communication may be set too high. It would be wrong to expect excellent reports and accurate detail. It is worth remembering that in emergencies the reporting and paperwork will get sloppy.

When working with other departments or NGOs a sound teamwork ethic is vital. Role clarity and trust are important dimensions of keeping those relationships strong. Experienced crisis management partners like the Red Cross and DND may outrun other departments on some issues. As team members they deserve to be trusted and efforts should be made to reinforce each other. Petty criticisms can destroy good working relationships: in this light it is important to keep a positive perspective.

It is vital for the department to be prepared practically and psychologically for dealing with the media who should not be seen as an intrusion into the management process. Even when they make a negative out of positively intended actions, it is important to recognize their role and to respect it. Public servants should expect negative criticism and focus on doing good work.

Finally, staff needs to be aware that long hours are the norm in crisis management situations. Working together on a project like this can create interest and a sense of pride. It must be understood that this is part of public service life.