CRISIS, WHAT CRISIS?
RESPONDING TO EHS DISASTERS

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OVERVIEW:
1. Examples of poor responses to EHS events
2. Examples of good responses to EHS events
3. The dos and don’ts of EHS event response
Poor Responses to EHS Events
BP’s Response to the Deepwater Horizon Oil Spill

• Explosion and sinking of the Deepwater Horizon oil rig on April 20, 2010, followed by an oil spill in the Gulf of Mexico.
• Eleven people killed.
• Oil discharge continued for 84 days, resulting in the largest oil spill in U.S. waters; estimated at approximately 206 million gallons (4.9 million barrels).
BP’s Response to the Deepwater Horizon Oil Spill

• Pointing the finger at others.
  – BP chief executive, Tony Hayward, tried shifting the blame to the US owner of the sunken rig, Transocean in an interview with the BBC in May, 2010:
    “This was not our accident … This was not our drilling rig ... This was Transocean's rig. Their systems. Their people. Their equipment.”
  – Investigations into the cause of the incident had barely started at this time.
  – Weeks later, Hayward confessed: "A number of companies are involved, including BP, and it is simply too early – and not up to us – to say who is at fault."
BP’s Response to the Deepwater Horizon Oil Spill

• Downplaying the damage

  – In an interview with the Guardian, Hayward called the Deepwater Horizon oil spill “relatively tiny.”

  – He further stated: “The Gulf of Mexico is a very big ocean. The amount of volume of oil and dispersant we are putting into it is tiny in relation to the total water volume.”
BP’s Response to the Deepwater Horizon Oil Spill

• Suggesting that the company, or that individuals within the company, deserve sympathy.
  – In an interview with NBC, Hayward stated: “I'm sorry. We're sorry for the massive disruption it's caused their lives. There's no one who wants this over more than I do. I'd like my life back.”
Montreal Maine and Atlantic Railway’s Response to the Lac-Mégantic Derailment

- Incident occurred on July 6, 2013.
- Unattended 73-car freight train carrying crude oil ran away and derailed, causing the explosion of multiple tank cars in the center of a small Quebec town.
- At least 47 people killed.
- Company has now filed for bankruptcy protection in Canada and the U.S.
Montreal Maine and Atlantic Railway’s Response to the Lac-Mégantic Derailment

• Delayed response and inappropriate joking.
  – No company statement until 36 hours after the derailment.
  – Ed Burkhardt, the president and CEO of Rail World, Inc., Montreal Maine’s parent company, did not arrive on the scene until five days after the incident.
  – Burkhardt commented to a television reporter: “I hope that I don't get shot at. I won't have a bullet proof vest on.”
Montreal Maine and Atlantic Railway’s Response to the Lac-Mégantic Derailment

• Speculating about the cause of the event before information is available.
  – Two days after the event, Burkhardt commented that he was certain the train had been tampered with.
  – He stated: “We have evidence of this [tampering].” But added, “This is an item that needs further investigation. We need to talk to some people we believe to have knowledge of this.”
  – Days later, Burkhardt suggested that the engineer did not adequately apply the hand brakes when he parked the train for the night.
Good Responses to EHS Events
Canadian Red Cross Tainted Blood Scandal

• From the late 1970s to the mid-1980s, about 2000 Canadians were infected with HIV and more than 160,000 were infected with Hepatitis C through contaminated blood products.
• One of the worst public health disasters in the Canada’s history, resulting in loss of public trust in the Canadian blood system and in those responsible for its management.
Canadian Red Cross Tainted Blood Scandal

- As a response to the crisis, Canada established a special commission to examine what factors contributed to these contaminations.
- The inquiry was led by Justice Horace Krever. It reviewed all activities of the blood system, including the events that surrounded the contamination.
Canadian Red Cross Tainted Blood Scandal

- Responsibility for running the Canadian blood system was transferred from the Canadian Red Cross to Canadian Blood Services (CBS) in 1998.
- Public concerns about the safety of blood products persisted after the transfer.
Canadian Red Cross Tainted Blood Scandal

- In survey commissioned by CBS in November 1998, only 51% of Canadians indicated that “setting up a new organization will help convince me that the blood system is now safe.”
- Only 64% agreed that “the problems that led to the blood supply being tainted have now been fixed.

15

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Canadian Red Cross Tainted Blood Scandal

How did CBS rebuild trust?

Public Engagement:

- Established a Consumer Advisory Committee (CAC), designed to gather the opinions of key consumers of blood products (e.g. hemophilia and cancer patients) and other members of the public. (Later, the CAC re-launched a new forum, National Liaison Committee.)

- CBS bylaws required two out of twelve directors to represent consumers of blood products.
Canadian Red Cross Tainted Blood Scandal

Critical Stakeholder Engagement:

- In 1999, as concerns mounted about the potential for Variant Creutzfeldt-Jakob Disease (the human variant of “mad cow disease”) to contaminate the blood system, CBS created an ad hoc committee of consumers to advice it on how to deal with the threat.

- In 2000, CBS conducted weekly conference calls with hemophilia patients, doctors, nurses, scientists, the Canadian Hemophilia Society and others regarding shortages of Factor VIII (blood component used to treat hemophilia).
Canadian Red Cross Tainted Blood Scandal

Active Steps to Address Public Concerns:
- CBS invested heavily in donor recruitment and retention to address the issue of inadequate supply,
- Created a national blood inventory and management system, integrating collections, testing, production, labeling and distribution.
- Heavy investment in blood testing.
- Creation of scientific and research committees to advise the CEO.
Maple Leaf Foods Listeria Outbreak

• Widespread outbreak of listeriosis in Canada linked to cold cuts from a Maple Leaf Foods Plant in Toronto, Ontario.
• Twenty-two deaths and fifty-seven confirmed cases.
Maple Leaf Foods Listeria Outbreak

High level response to the event:

- Maple Leaf’s CEO, Michael McCain, held press conferences and posted an apology on its web site.
- McCain stated: "Tragically, our products have been linked to illness and loss of life. To those people who are ill, and to the families who have lost loved ones, I offer my deepest and sincerest sympathies. Words cannot begin to express our sadness for their pain."
- Company praised for using McCain prominently in its communications with the public.
Maple Leaf Foods Listeria Outbreak

- Maintaining presence in the media throughout the crisis
  - In addition to McCain’s press conferences and apology, a Maple Leaf spokeswoman did interviews in a wide range of media.
  - The firm also ran TV spots and took out advertisements in newspapers.
Maple Leaf Foods Listeria Outbreak

• Taking all precautions to protect against further harm.
  – On August 12, 2008, the Canadian Food Inspection Agency (CFIA) informed Maple Leaf that a formal investigation has been launched into their products.
  – The next day, Maple Leaf sent a letter to distributors to inform them of the investigation and ask them to put products on hold pending test results from CFIA.
  – Maple Leaf Foods launched a voluntary recall before the outbreak was linked to its plant.
Maple Leaf Foods Listeria Outbreak

• Communicating response efforts to the public
  – McCain announced that all products had been removed from its facility and all equipment was disassembled to allow for internal sanitation – a step beyond usual standards in the industry.
  – McCain said these steps were necessary because no immediate cause of the contamination was apparent.
Johnson & Johnson Tylenol Crisis

- In 1982, seven people died after taking cyanide-laced capsules of Extra-Strength Tylenol.
- Marketers predicted that the brand, which accounted for 17 percent of the company's net income in 1981, would never recover from the sabotage.
- A year later, its share of the $1.2 billion pain-relief market, which had plunged to 7 percent from 37 percent following the poisoning, had climbed back to 30 percent.
- Described as the “gold standard” of corporate crisis-control.
Johnson & Johnson Tylenol Crisis

• What made this response so effective?
  – The company recalled 31 million bottles of Tylenol at a time when recalls were not common, and stopped advertising the product.
  – Company chairman, James Burke, gave a news conference one month after the crisis, and gave a complete chronology of what the company had done.
  – Burke appeared on the news program “60 Minutes” and allowed cameras into strategy sessions.
Johnson & Johnson Tylenol Crisis

• Tylenol products were re-introduced containing a triple-seal tamper resistant packaging.
The Dos and Don’ts of EHS Event Response

• Do:
  – Ensure that a company response plan and internal line of crisis communication is in place
  – Evaluate and re-evaluate each crisis as events unfold and more information is obtained
  – Ensure that the correct person delivers the message and becomes the face of the company
  – Ensure that all crises are treated in a serious manner
  – Consider hiring a client relations firm and a law firm to provide guidance during a crisis, especially if the crisis is a “bet the company” event
  – Ensure timely and ongoing communication with the public
  – Consider issuing an apology
  – Ensure that the public knows “you care”
The Dos and Don’ts of EHS Event Response

• Don’t
  – Be a slave to precedent. Previous ways of dealing with a crisis may no longer be appropriate (especially when it comes to public perception)
  – Deliver mixed messages depending on which company employee is asked a question (ensure that one spokesperson is appointed).
  – Have a junior employee continue to be the spokesperson when the crisis is or becomes significant
  – Make light of a crisis or make any attempts at humour (especially if injuries or deaths are involved)
  – Assume that the public is not interested or unaware
  – Describe an EHS event as “routine”
  – Allocate blame or responsibility before all of the facts are known
  – Ignore a series of minor repeating events or consider them all to be isolated events (the public may not agree)
  – Be seen as a company that “does not care”
Questions?

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