AMALGAMATED TRANSIT UNION LOCAL 113
812 WILSON AVENUE, DOWNSVIEW, ONTARIO M3K 1E5 • TEL.: (416) 398-5113 FAX: (416) 398-4978

CARLOS SANTOS
President/Business Agent

RICHARD FOX
Executive Vice-President

FRANK MALTA
Assistant Business Agent
Transportation

SCOTT GORDON
Assistant Business Agent
Maintenance

KEVIN MORTON
Secretary-Treasurer

All correspondence should be addressed to the Secretary-Treasurer

EXECUTIVE SUMMARY

Letter from Carlos Santos, ATU Local 113 President to Mayor John Tory et al
July 7, 2021

Following is a summary of major key points in a letter from ATU Local 113 President, Mr. Carlos Santos to Toronto Mayor John Tory regarding the extraordinarily complex Osgoode Pocket incident. We understand that the full letter is relatively long, which is the reason for this summary. We appreciate your interest and value your time. You have many public service responsibilities. But the issues arising from this unprecedented incident are of a "life and death" nature. They are of great importance to not only those who use the TTC subway system but to all Toronto residents and taxpayers.

Just after midnight on Friday, June 12, 2020, south of Osgoode Station, near Queen and University, a catastrophic collision of two moving TTC subway trains was averted by the instantaneous response of the two-person crew on one of those trains – the "pocket" train. The Subway Guard at the rear of the pocket train saw that they were about to crash into a passenger train going northbound on the mainline track at regulation speed. He urgently alerted the Operator (the "Driver") in the front car to "STOP!" their train, which had been unclearly (according to an external investigation commissioned by the TTC) directed by TTC Transit Control to merge onto the mainline track. By immediately hitting the emergency brake, the Driver stopped the pocket train about five feet – a split second – before his train would have slammed into the passenger-occupied mainline track train. How many people would have been killed or seriously injured cannot be known because it did not happen. A single subway car can carry well over 100 passengers. On a weekend night in downtown Toronto, two blocks from City Hall, some of the six cars on that train would have been, or nearly been, standing room only.

Subsequent to this incident:

- TTC management did not report the incident to the Ministry of Labour, the TTC Board, City Council, the TTC Joint Health and Safety Committee ("JHSC"), which is legislated under provincial law with the authority to investigate any real or potential workplace health or safety hazard, or to Local 113, the legal representative of the subway workers. It is not known if or when the incident was reported to Mayor John Tory.

- An internal TTC investigative report on the incident was presented to a small TTC executive group on July 8, 2020, four weeks after the incident. It confirmed the closeness of the near-disaster. The TTC Board of Commissioners did not, to our knowledge, see this report.

- When the incident became public knowledge in early 2021, the Commission publicly blamed "human error," and penalized (time off without pay). ATU Local 113 filed grievances against the discipline, which are in the early stages of the grievance procedure.

- The Ministry of Labour tangentially learned of the incident from a written complaint about several subway safety concerns. The MOL conducted an investigation by telephone and no orders of any kind were issued to the TTC.

- The TTC JHSC began conducting its own investigation soon after the incident. The TTC, which has the statutory duty to cooperate with a JHSC investigation, has not responded to most of the JHSC's multiple requests, over the course of a year, for specifically relevant information, documentation and access to potential witnesses in TTC employ.

- Sometime in late 2020, the TTC retained an external transit consulting firm: California-based Transit Systems Engineering/Rail Transport Engineering ("TSE/RTE") to conduct an investigation of the incident, determine insofar as possible its causes, and make recommendations it deemed prudent to prevent future such incidents.

- The eight-page TSE/RTE report is dated February 3, 2021. It was distributed to the Board at its regular meeting on June 16, 2021, more than four months later. There has been no public explanation of why the report was not given to the Board for more than 140 days.

- In his letter to the union, TTC Commissioners, the Mayor and City Councillors, TTC CEO Richard Leary, a former Chief Operating Officer of Boston's Metropolitan Bay Transportation Authority, selectively quoted segments of the TSE/RTE report that, he construed, casts the blame for the incident onto the pocket train crew. Leary's letter, however, does not quote, even indirectly, two key findings of the report that tell a markedly different story. These findings are:

- The TTC's "ongoing and rapidly changing operation to support the Automatic Train Control (ATC) project implementation, along with putting the new signal system into operation, may be placing difficult burdens and challenges on the TTC operating staff. ***Conducting service delivery tasks under such additional burdens and challenges could result in hazards to normal operation. The identification of these hazards is difficult due to the ongoing significant physical and operational changes to the signal system*** (emphasis added).

- The instruction given to that [pocket] train by TTC transit control "was not sufficiently clear or adequate to this situation."

- The report recommends that the TTC conduct a "Phase II" additional study in order to assess whether implementation of the ATC system has complied with the "Minimum Performance Requirements," i.e., that the new ATC system is *as safe or safer* than the previous signal installation. We do not know the status of a Phase II study.

ATU Local 113 asserts in the strongest possible terms that the TSE/RTE report clearly points to TTC operational decisions as the principal factors that led to the incident. **The Guard and the Operator did not cause the incident. They prevented it from becoming a catastrophe that would have been seared into Toronto's civic memory for generations.**

We offer the following points that are highly relevant to the Osgoode Pocket incident and what lessons have been learned by the Commission, which, as of now, intends to OPTO-ize Line 2.

- Local 113 has warned the Commission since 2016, when One Person Train Operation ("OPTO") was first introduced on the Sheppard Line, that eliminating the Guards and burdening Operators with their duties, in addition to their responsibilities to safely drive the train, is hazardous to passengers and staff. This issue has been in arbitration for nearly five years. We believe the TTC's haste in implementing the new ATC system is, in part, motivated by the Commission's effort to get ahead of an arbitration decision that may find that OPTO is *not as safe or safer than* the traditional two-crew system.
- The union has also, continuously and urgently, warned the Commission that OPTO creates, by its very nature, an environment of "distracted driving" as the Operator must perform several safety-critical functions simultaneously. Mayor Tory has publicly blamed "distracted driving" for an alarming rise in auto-related accidents and fatalities. We hope he will consider the OPTO system as creating distracted driving, but with potentially far greater consequences.
- TTC management's defence that numerous transit systems around the world have adopted, or plan to adopt, OPTO systems – and therefore Toronto should as well. This defence has only been tested in Toronto once, in 2016, in the curiously-named "Black Panther" project, a staged, rehearsed, simulation of what might happen if an evacuation of a stopped subway car in a tunnel was urgently needed and there was only one TTC employee – the Operator – to organize and lead that evacuation. No Guard. OPTO failed that test. A Person Requiring Assistance (PRA) was left behind. The report on Black Panther is difficult to find.
- Is One Person Train Operation as safe or safer than what we have now? That question is now in litigation and a decision is expected sometime next year. In the interim, there is significant evidence, including dramatic videos, available online that would give reasonable people reason to pause before a high dive into the OPTO world.

We ask that the Commission and, if necessary, City Council **stop the OPTO plan** until meaningful public consultation can be conducted. In a February 2021 poll of 2715 randomly-selected Torontonians, 84 percent said public consultation was "important" and 43 per cent said they would be "much less likely" to vote for a Councillor who does not support public consultation on important TTC safety decisions. **Seventy-one per cent of the poll's respondents "do not approve" of the OPTO plan.**

The TTC is one of the safest subway systems in the world. Huge, costly changes will determine the future of that system for many decades to come. What will be the consequences? Surely Torontonians, who own the system, deserve a voice. What's the rush?

Carlos Santos
President
ATU Local 113

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July 7, 2021

Mayor John Tory
Office of the Mayor
City Hall, 2nd Floor
100 Queen St. W.
Toronto, ON M5H 2N2

Dear Mayor Tory:

I write further to the Osgoode Pocket near-collision incident of June 12, 2020 and the recent correspondence from Chief Executive Officer Richard Leary to myself and copied to you. Specifically, I write to:

1. correct material omissions made by Mr. Leary regarding the June 12, 2020 near catastrophe near Osgoode Station;
2. alert you to the role of changes to signalling systems, Automatic Train Control and the presence of the Guard to the near-collision and;
3. ask you to direct TTC to halt the ongoing and reckless push to remove safety critical Guards from the subway system.

Mr. Leary's correspondence is extremely distressing on two counts. On the first count, it continues to seek to blame the near-collision on the train crew who actually prevented a disaster. Strikingly, it fails to focus on the subsequently-identified systemic issues within the TTC that led to what would almost certainly have been, were it not for this crew, a human catastrophe that would have been seared into Toronto's civic memory for generations.

To make his case that "The workers are completely to blame," Mr. Leary makes highly selective reference to the report of the external investigation of the incident: *Osgoode Interlocking Incident Report by Transit Systems Engineering/Rail Transport Engineering* (*"*TSE/RTE*")* dated February 3, 2021. That report, despite being heavily redacted, clearly indicates significant systemic issues related to the Commission's subway system and its procedures that led to this incident.

Mr. Leary's correspondence, however, is void of any real, meaningful acknowledgement of these systemic issues in order, we strongly assert, to scapegoat the train crew and thereby deflect attention away from the Commission's failure to ensure the safety of the public and Commission employees during the subway system's transition to the use of Automatic Train Control ("ATC").

A review of the redacted report of the TSE/RTE investigation into this incident discloses:

1) Serious systemic failures did not allow for a system of "protection" of trains against possible collisions at the Osgoode pocket track. There was no system in place to ensure a "fail safe" response in the event a train moved out of the Osgoode pocket and into the path of an oncoming revenue service train on the mainline;
2) That major risks were passed on from the manufacturer, Alstom, to the Commission, which accepted these risks. We have seen no evidence that the Commission created any test procedures to certify that train movement in or out of the Osgoode pocket track was safe; and
3) That the ATC project itself has unduly burdened TTC operators, and that hazards could result. From the report:

   "It is understood that the ATC project is placing a significant burden on [TTC] staff and that assistance in performing their assigned duties is a factor in the undertaking…There is evidence from interviews conducted by the TTC that ongoing and rapidly changing operation to support the ATC project implementation, along with putting the new signal system into operation, may be placing difficult burdens and challenges on the TTC operating staff. ***Conducting service delivery tasks under such additional burdens and challenges could result in hazards to normal operation. The identification of these hazards is difficult due to the ongoing significant physical and operational changes to the signal system*** (emphasis added). The new ATC system is technically sophisticated and has different architecture and supporting infrastructure***. However, some of the traditional safety functions were not provided by the ATC system and were handled as exported hazards to TTC*** (emphasis added)."

Mr. Leary's correspondence makes no direct or indirect reference to these above critical points. Further, it did not cite the report's conclusion that the instruction given to that [pocket] train by TTC transit control "was not sufficiently clear or adequate to this situation."

A reader of Mr. Leary's correspondence who had not read the TSE/RTE report could be forgiven for concluding, as Mr. Leary clearly intended, that this incident was the fault of the pocket train crew.

The TSE/RTE report further recommends that additional study be done in order to assess whether implementation of the ATC system has complied with the "Minimum Performance Requirements," i.e., that the new ATC system is as safe or safer than the previous wayside, fixed block signal installation.

We are surprised and concerned to learn that the Commission has spent significant time and resources implementing a new system for which it has failed to conduct even the most fundamental assessment to ensure that it is at least <u>as safe</u> as the original system.

With regard to the Osgoode near-collision, ATC was clearly less safe than its predecessor, with none of the fail-safe protections of the old signal system. The near-collision was, in fact, caused by forcing operators to work in a needlessly complex environment in which the Commission contemporaneously operated two signalling systems on a single line in the midst of an ongoing construction project and without having proven the safety of its system.

In fact, it was only the presence of the Guard that averted the collision. The presence of a guard has been a crucial safety feature in the Commission's system since the subway first opened, in 1954. It is Mr. Leary's plan to begin removing the guards from Line 1 in August. He is planning to do so even though a collision at Osgoode was avoided only due to the presence of a guard on the train.

I wish to outline for you the manner in which recent TTC alterations to subway safety systems have caused risk to increase:

CHANGE FROM BLOCK SIGNALLING SYSTEM TO AUTOMATIC TRAIN CONTROL

Lines 1 and 2 were originally designed and operated utilizing a block signalling system. This system relies on drivers observing and obeying signals. The signals are timed so that trains remain a certain distance, or number of blocks, away from one another. The block signalling system relies on a large number of signals located throughout the system that can be read by an operator.

The block signalling system has a built-in fail safe in case of error: the presence of electro-mechanical "trip arms." Trip arms are designed to engage a train's brakes if a train is moved for any reason past a signal when it is not safe to do so. Such train movements are commonly referred to as a Signal Passed at Danger ("SPAD"). Such movements can occur for a variety of reasons including human error or malfunctions in the signalling system.

Human errors do occur. When they do and the trip arms are engaged, it identifies that an error has occurred and the issue of what led to the error can be investigated and resolved. Thus, a SPAD resulting in a trip arm engagement serves as a warning that there may be some sort of problem causing the Operator to misread a signal or that the system itself is malfunctioning.

AUTOMATIC TRAIN CONTROL

ATC is a system through which computers monitor the location of subway trains and control train speed, stopping the trains where required. The computerized system is responsible for maintaining a safe separation between subway trains. The system being installed by the TTC is designed to allow subway trains to operate closer to one another on a given track and run faster than under the predecessor block signalling system. In theory, when working correctly, ATC should allow more trains per hour to run on the line.

ATC uses some visual signals, but far fewer signals than the block signalling system. There is no use of trip arms in the ATC system.

ADDED SAFETY THROUGH A SECOND CREW MEMBER

The presence of two crew members on each train constitutes an additional safety protection to the train and its occupants. These crew members alternate performing driving and guard duties. One important function this alternation of duties serves is that it reduces fatigue. No one person is required to engage in the highly focussed activity of constantly monitoring the track ahead, etc. for an entire day, typically eight hours or more. While ATC uses fewer signals, it is still vital that the track ahead be monitored for unexpected conditions such as the presence of a train where there should not be one, unexpected persons or other obstacles at track level, or unfavourable signals.

Whether in motion or stopped, train operators have a better opportunity to detect and react to an unexpected unsafe condition because they experience less fatigue when deployed as part of a two-person crew. Academic literature on the subject makes clear that unexpected conditions are the most likely to be missed.

The second crew member also serves as a second set of eyes and ears and may detect errors or unsafe conditions not detected by the first crew member. As made evident in the Osgoode pocket near-collision, which was avoided only due to the presence of the Guard – since it was impossible for the drivers of the two trains to have seen one another until tragedy had already struck.

NEEDLESSLY COMPLEX WORKING ENVIRONMENT

The Commission is engaged in a multiyear construction project involving the replacement of the existing block signalling system with ATC. This replacement has been happening piecemeal. Line 1 is littered with signal trees that have been "covered up" as they are not in use, while in some instances, a second set of signals is being installed.

In most cases, there is no new signal installed where the old signal has been removed. However, due to the manner in which the Commission has been implementing its ATC system, there is no consistent way for an operator to predict if a new signal will be present where an old signal has been removed. Operators do not know what to expect.

Operators are presently being asked to drive a 450-foot-long, six-car train in a "dual" environment where two highly complex signalling systems are being used simultaneously and where the point of transition from one signalling system to another is changing. Operators are being required to do so in circumstances where the driving workload is reduced on the ATC sections of the line as the computer controls train separation and speed. "Attentional underload" is a recognized cognitive issue, where the reduction in workload reduces an individual's ability to detect unusual or unexpected conditions when they occur.

Thus, at the same time that drivers are being exposed to the risks associated with attentional underload, they are being required to do so in an often chaotic and confused environment where they are being required to:

1) Deal with two signalling systems on one line;

2) "Guestimate" as to on what portions of the line they are on have new, functioning signals and/or whether existing safety equipment is still operational or not;

3) Determine which of two separate sets of operating procedures apply, depending on whether the train is ATC or not on a given section of track;

4) Drive trains in two different manners, one where the Operators control speed, separation and stopping and one where they do not; and

5) On OPTO trains, divide their attention between performing operator and guard duties, which is the central purpose of One Person Train Operation (OPTO), sometimes when the train is in motion

Further, in this confusing dual environment, trip arms are also being tied down so they cannot function. That longstanding key safety feature is gone. Why?

DISTRACTED DRIVING

Mayor Tory, in view of the above Point 5, we remind you of your stance on distracted driving. Does the following quote sound familiar? "There are still far too many people engaged in distracted driving of one kind or another."

Or this? "Distracted driving continues to be a major contributor to deaths and injuries and collisions….It must become a thing of the past."

We applaud your forceful views on the dangers of distracted driving. You may mistakenly believe, as do most Torontonians, that the Guard is only there to open and close subway car doors, something that TTC management says can be safely done by the drivers. The same drivers who will now have to respond to many unpredictable situations, such as onboard medical emergencies, disruptive drunks, lost/separated children, passenger sexual harassment and more. The same drivers who will have to organize and lead tunnel evacuations in the event of power outages or fire and smoke incidents like the one that occurred at Dundas West Station in December, 2019.

INCREASED CONFUSION AND COMPLEXITY TO COME

The Commission has recently decided to increase confusion and complexity to the operation of subway trains on Line 1.

In its report, TSE/RTE warned that the Commission might be placing undue burdens and challenges on TTC operating staff as a result of ongoing and new rapidly changing operations to support the ATC project while bringing the new ATC signal system into operation.

We are advised that the Commission has elected to add to those burdens by requiring that, in addition to complexities identified by TSE/RTE, they will also be required to operate *without* a guard for part of their workweek and *with* a guard for the remainder of the week. That this will increase operational confusion should be blindingly obvious. The reason for this change remains unexplained by the Commission. Will it make Line 1 safer? How?

The Commission's proposed course of action is irresponsible and dangerous. We are asking you to intervene to halt these changes before a near collision becomes an actual collision.

OSGOODE POCKET NEAR-COLLISION

Many of the issues identified above were at play in the Osgoode Pocket near-collision. Mr. Leary has brought virtually none of them to your attention.

The near-collision occurred close to the transition point between the use of the block signalling system and ATC. The old signal tree was covered up as it was not in use. A new signal was installed. However, it was placed in a location that made it nearly impossible for the train operator to see.

In addition, and unannounced to the Operator, the trip arm was tied down so it could not function. Why? Does *that* make Line 1 safer?

ATC "protection" was turned off such that there was no automatic protection that would prevent a train from moving from the Osgoode pocket track to the mainline. **The decision to turn off that protection was a Commission decision; it was a not a decision of the crew.**

There was no ATC automatic protection for the train running on the mainline. The computer would not detect that another train was heading onto the mainline. **This is an astonishing oversight**. Without this protection, the computer kept driving the mainline train, with passengers on board, even as the "invisible" Osgoode pocket train was heading toward it on a collision course.

The drivers of the two trains could not see one another.

With no automatic protection for the Osgoode pocket train, no automatic protection for the mainline train, and no ability for the drivers of the trains to see one another, how was a collision averted? There is only one answer: the two-crew team.

The Guard at the back of the train monitored and observed what was happening behind the train and could see the train on the mainline operating at speed and on a collision course with his vehicle. The Guard was already on the internal phone with the Operator. He alerted the Operator to stop the train, which he did, with five feet to spare – a split-second. Catastrophe averted.

REPORT BY TRAIN SYSTEMS ENGINEERING/RAIL TRANSPORT ENGINEERING

The Commission retained, on its own initiative, TSE/RTE to investigate the incident. Local 113 was not invited to participate in this investigation and has only been able to obtain a heavily redacted copy of this report.

Mr. Leary's letter exclusively cast blame at the train crew who **averted the collision by a margin of less than a heartbeat**. In sharp contrast, the TSE/RTE report focusses on the real, systemic issues that contributed to the near-collision. Essentially, in its haste to deploy ATC, the Commission "imposed difficult burdens on operating staff." The Commission accepted the burden of risks passed on by the manufacturer, Alstom. We have seen no evidence that the Commission tested the system to ensure that those risks were mitigated. It would be important to know if – and when – Alstom advised the Commission of these risks.

The Commission required operators to work in an environment where there were no fail-safe systems to ensure trains in the pocket track could not collide with those on the mainline and, moreover, to work without clarity about whether safety and signalling equipment was, or was not, functioning. The Commission again failed to demonstrate that ATC and its operating procedures are *as safe or safer* than the block signalling system.

LACK OF TRANSPARENCY

Contrary to the assertions in Mr. Leary's recent correspondence, the TTC has **not** been transparent in its handling of this matter. Their actions have raised a number of questions as yet unanswered:

- Why was the Ministry of Labour not notified by the Commission after the video of the near-collision was viewed by Commission staff?

- Why were the Commissioners not informed of the incident?

- Why did the Commission conceal the TSE/RTE report for 4 months? Why was this report not immediately disclosed to the Commission, the riding public, and the workers who operate the system? Was it because the report identified systemic failings at the Commission? Was it because the Commission was worried it would interfere with its plans to remove the Guards?

- Are you aware of the findings from the TTC's 2016 "Black Panther Functional Exercise" report (Yes, that was its actual name: "Black Panther"). This report clearly shows that **OPTO is not as safe** as the current two-crew system. Evacuation of the tunnel using an OPTO system resulted in a Person Requiring Assistance (PRA) being "forgotten" and left on the train. OPTO failed, even though Black Panther was planned, rehearsed and staged with actors hired to pose as passengers. Had this been a real-life situation, such as a smoke-filled subway car and not a drill, **what would have happened to the PRA left behind?** Would they have survived? This problem is easily resolved: have two crew members on the train so one can lead passengers out and the other can sweep the train to ensure everyone gets off safely. Was the Board shown the Black Panther Report? A search of ttc.ca for "Black Panther" shows no results.

- Finally, the TTC has refused to make many relevant documents and persons employed by TTC who may have knowledge of the incident available to the Joint Health and Safety Committee, despite multiple requests by the JHSC. Mr. Leary's letter lists a few documents that had been provided to the JHSC, but those documents are a fraction of what was requested. If the Commission has been withholding important information about the near-collision from the Commissioners, the Ministry and the legislatively-empowered JHSC, how can its employees, the Board, the public and *you*, Mayor Tory, have any confidence that it is being forthcoming and transparent?

THE ATTACK ON THE TRAIN CREW

Mr. Leary's attack on the train crew is misguided and, we contend, deliberately so. Local 113 unequivocally challenges the Commission's characterization of the crew's conduct on the date in question. These claims will be tested in arbitration.

However, from a safety perspective, the central question that all interested parties must address is this: "Should an error occur, *irrespective of its cause*, how do we prevent the error from becoming a tragedy? Clearly, the presence of a Guard plays a key role in mitigating any errors – be they errors of an Operator, Transit Control (The instruction given to that pocket train by TTC Transit Control **"was not sufficiently clear or adequate to this situation"** – TSE report. *Emphasis added*) or errors fuelled by the confusing and complicated operating environment mandated by the Commission.

NEXT STEPS

For Local 113, ATC and the removal of the subway Guard are two very different issues. Nothing prevents the Commission from implementing ATC while at the same time keeping the Guard. In fact, that's how most of Line 1 is running now.

However, ATC must be implemented safely. That includes identifying and mitigating all risks that have been "exported" from the manufacturer of the system to the Commission, its employees and the public. That also includes not overburdening operating staff with complex or confusing situations where two systems are running on one line. It also includes meaningful assessments to confirm the new system is as safe or safer than the system it is replacing. Where is the evidence that such assessments were conducted? Finally, it should also include not blaming train crews for Commission failures.

A transit authority that evades responsibility for its failings is a dangerous entity. Its evasions will prevent it from learning from its mistakes. TTC management's repetitive defence that transit systems around the world have adopted, or plan to adopt, OPTO systems – and therefore Toronto should as well – has not been put to the only test that matters: "Is it at least as safe, or safer, than what we now have?" That question is now in litigation, and a decision is expected sometime next year. In the interim, there is significant evidence available online, including dramatic videos, that would give reasonable people reason to pause before a high dive into the OPTO world.

Safe implementation of ATC requires the continued presence of a key safety-critical element - Guards on subway trains. In an already complex environment, in the aftermath of a near collision, it is almost inexpressively irresponsible to eliminate the crew member that stood between a slow news day and a catastrophe on June 12, 2020.

We seek your assistance, and that of Council and the Commissioners, to direct TTC to maintain the presence of Guards on subway trains - for the sake of the safety of our members and of the women, men and children who entrust their lives to us.

Respectfully,

Carlos Santos
President/Business Agent

CC:
Richard Leary, TTC Chief Executive Officer

TTC Commissioners
Councillor Jaye Robinson, Joanne De Laurentiis (Citizen), Councillor Brad Bradford, Councillor Shelley Carroll, Fenton Jagdeo (Citizen), Councillor Cynthia Lai, Ron Lalonde (Citizen), Councillor Jennifer McKelvie, Julie Osborne (Citizen), Councillor Denzil Minnan-Wong

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