

**OFFSHORE HELICOPTER SAFETY INQUIRY**

*February 17, 2010*

*Tara Place, Suite 213, 31 Peet Street*

*St. John's, NL*

February 17, 2010

**PRESENT:**

**John F. Roil, Q.C./**

**Anne Fagan.....Inquiry Counsel**

**John Andrews/Amy Crosbie. .... Canada-Newfoundland and Labrador Offshore  
..... Petroleum Board (C-NLOPB)**

**Cecily Strickland/Ian Wallace..... Hibernia Management and  
..... Development Company (HMDC)**

**D. Blair Pritchett/Stephanie Hillier ..... Suncor (Petro-Canada)**

**Stephanie Hickman.. ..... Husky Oil Operations Ltd.**

**Lewis Manning/ ..... Canadian Association of Petroleum Producers (CAPP)  
Neil Schultz**

**Jennifer Berlin ..... Government of Newfoundland and Labrador**

**Norman J. Whalen, Q.C./Michael Cohen ..... Cougar Helicopters Inc.**

**Jamie Martin.....Families of Deceased Passengers**

**Kate O'Brien.....Davis Estate (Pilot) and  
..... agent on behalf of Douglas A. Latto for Lanouette Estate (Co-pilot)**

**V. Randell J. Earle, Q.C. .... Communications, Energy and Paperworkers Union  
..... Local 2121**

**David F. Hurley, Q.C. .... Offshore Safety and Survival Centre, Marine Institute**

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1 February 17, 2010  
 2 COMMISSIONER:  
 3 Q. Good morning, ladies and gentlemen. Good  
 4 morning, Mr. Pike. Ready, Mr. Roil?  
 5 ROIL, Q.C.:  
 6 Q. Thank you, Commissioner, yes. Good morning,  
 7 we're ready to proceed. Just by way of a  
 8 brief opening comment, we, of course, had Mr.  
 9 Pike here once before on the first day of the  
 10 public hearings in Phase 1, and he is now here  
 11 perhaps appropriately to close this part of  
 12 the proceedings, not by any means all of our  
 13 proceedings, but the initial public hearing.  
 14 COMMISSIONER:  
 15 Q. Alpha and Omega.  
 16 ROIL, Q.C.:  
 17 Q. The Alpha and the Omega, indeed. The first  
 18 time around, I think the information that the  
 19 C-NLOPB brought to us was perhaps at a higher  
 20 level of what they're enabled to do, what  
 21 they're entitled to do, and this time around  
 22 we're going to go back down into some more  
 23 details as to how they do some of those  
 24 things. There are a significant number of  
 25 exhibits that have been posted to the parties.

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1 The exhibits respond to some of the questions  
 2 that came up initially and requests from  
 3 parties, and some of them are exhibits that we  
 4 have brought up as a matter of completing the  
 5 entire piece. So I would ask that Exhibits  
 6 187 to 194, and then 196 to 206, be made as  
 7 exhibits within our hearings. The only public  
 8 exhibit is the presentation itself. The other  
 9 exhibits are considered as confidential  
 10 exhibits, but are available to the parties.  
 11 COMMISSIONER:  
 12 Q. Okay, thank you.  
 13 ROIL, Q.C.:  
 14 Q. Mr. Pike, good morning.  
 15 MR. PIKE:  
 16 A. Good morning.  
 17 ROIL, Q.C.:  
 18 Q. We meet again, and we understand that you have  
 19 already been sworn with respect to evidence  
 20 before this Inquiry and that oath, of course,  
 21 continues for today.  
 22 MR. PIKE:  
 23 A. Okay.  
 24 MR. HOWARD PIKE (RECALLED) EXAMINATION BY JOHN ROIL,  
 25 Q.C.:

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1 ROIL, Q.C.:  
 2 Q. Okay.  
 3 MR. PIKE:  
 4 A. I'm going to start this morning with a little  
 5 bit of a confession, for the first time in  
 6 many years I didn't attend the Memorial  
 7 Service the Ocean Ranger on Monday. I usually  
 8 make a point of attending that. I take the  
 9 time to reflect on what I do and why I do it.  
 10 It's a very emotional time and it brings home  
 11 the point that it's about the people. We  
 12 can't bring back those people, the 84 people  
 13 that were lost on the Ocean Ranger, the three  
 14 divers that were lost in the recovery  
 15 operations, and now we have 17 lives lost on  
 16 Cougar 491, but what we can do is work to make  
 17 the offshore a safer place. When I do that, I  
 18 ask some difficult questions and it takes a  
 19 very difficult perspective, and I know that  
 20 over the years when I've met with some of the  
 21 families of the people lost in the Ocean  
 22 Ranger, my exuberance for looking for those  
 23 answers to make for a safer workplace  
 24 sometimes upset those family members, and I  
 25 have to be conscious of being sympathetic with

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1 them and temper some of those, so I do have to  
 2 ask tough questions, and if I say something  
 3 today that upsets the families, I apologize in  
 4 advance, but it's part of my job to ask some  
 5 of those tough questions. Our sympathies are  
 6 with them and our prayers are with them.  
 7 While I'm on confessions, as we go through  
 8 this piece, you'll notice that we use  
 9 extensive use of databases. The official file  
 10 system of the Board has been paper for many  
 11 years. We're in a transition now towards more  
 12 electronic, and when I was trying to retrieve  
 13 some of these files, it took me a little bit  
 14 longer than I had anticipated, but I think as  
 15 we go through we'll see how that piece works.  
 16 ROIL, Q.C.:  
 17 Q. And there was, I gather, a significant amount  
 18 of paper that had to be reviewed just to  
 19 extract the information that we have here?  
 20 MR. PIKE:  
 21 A. That's correct, helicopter operations are one  
 22 part of a very larger piece that we do.  
 23 ROIL, Q.C.:  
 24 Q. Okay. We recall that you are the Chief Safety  
 25 Officer on behalf of the C-NLOPB, and in that

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1 capacity, I understand that you are  
 2 responsible for a number of activities.  
 3 You've talked about some of them, and now  
 4 you're going to set out an agenda for us for  
 5 the next number of hours?  
 6 MR. PIKE:  
 7 A. Yes. We're going to start and talk about some  
 8 of the incidents, talk about complaints, and  
 9 by doing that we will see how some of those  
 10 can feed into the safety audits that we do,  
 11 safety audits and inspections, we'll talk a  
 12 little about the communications, the different  
 13 groups that we communicate with, we'll talk a  
 14 little bit about our compliance and  
 15 enforcement policy, and then we'll end off  
 16 with emergency response.  
 17 ROIL, Q.C.:  
 18 Q. Okay, that's fine. I think you have control  
 19 of the slide presentation, so you take it at a  
 20 pace that you're comfortable with, and we'll  
 21 stop you when we need to ask questions from  
 22 time to time.  
 23 MR. PIKE:  
 24 A. Recommendation 89 of the Ocean Ranger  
 25 Commission Report talked in terms of incidents

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1 and the collection, correlation, and analysis  
 2 of that information. So we've taken that  
 3 piece very seriously and do collect those.  
 4 I refer to Exhibit 48, if we could.  
 5 ROIL, Q.C.:  
 6 Q. This is an exhibit that was up in your first  
 7 round, hence the rather low number.  
 8 MR. PIKE:  
 9 A. Correct.  
 10 ROIL, Q.C.:  
 11 Q. Just give us a moment to get that up on the  
 12 screen for those present because it's probably  
 13 not one that people have brought their paper  
 14 copies with them.  
 15 MR. PIKE:  
 16 A. That's the latest guideline we have published.  
 17 It was done in June of last year and it refers  
 18 to the reporting. The full name is "The  
 19 guideline for reporting and investigation of  
 20 incidents", and I think we're going to start  
 21 maybe by talking a little bit about what we  
 22 define as an incident. We've heard different  
 23 people define those. In 1984, international  
 24 regulators formed -- developed a working group  
 25 to take a look at the measurement of some of

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1 these things and their goals were exchange of  
 2 information regarding health and safety  
 3 trends, industry health and safety performance  
 4 measure, and measuring the effectiveness of  
 5 regulatory activities. Those were the goals  
 6 of that committee. Some of that work also  
 7 helped us in forming and trying to develop the  
 8 definitions of incidents.  
 9 ROIL, Q.C.:  
 10 Q. So you, I take it, don't necessarily have the  
 11 same definition of incidents that Transport  
 12 Canada or other parties may have?  
 13 MR. PIKE:  
 14 A. No, no, it -- it was an interesting piece as  
 15 we went through that internationally.  
 16 Everybody had slightly different definitions  
 17 for these pieces, and even within Canada, the  
 18 definitions between, and the one most commonly  
 19 used between jurisdictions in Canada is  
 20 Workers Compensation incidents. They're  
 21 different. The definitions are different. So  
 22 it's a difficult comparison to do between  
 23 provinces because there are differences in  
 24 those definitions, but what we attempted to do  
 25 with that piece and what we've rolled into

Page 8

1 here is to try to get some standardized  
 2 definitions. If I can move -- okay, try to  
 3 get us up to page 11 here.  
 4 REGISTRAR:  
 5 Q. Page 11.  
 6 MR. PIKE:  
 7 A. I can move it up. You'll see that we just go  
 8 through a lot of definitions in here.  
 9 ROIL, Q.C.:  
 10 Q. Yeah.  
 11 MR. PIKE:  
 12 A. Of note, when we first started, it was a form  
 13 where you reported the incident and the back  
 14 side of that form was information to fill it  
 15 out. We've now got a larger document to help  
 16 define those. Too quick on the finger. At  
 17 this point here, page 11, it talks about  
 18 reporting an incident and we provided further  
 19 clarification, support craft in this regard,  
 20 "For support craft, an incident shall be  
 21 reported if the support craft is in the  
 22 offshore area conducting any worker activity  
 23 related to an authorization. An incident shall  
 24 be reported at the time when the support craft  
 25 is engaged in transporting personnel via air

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1 or sea to or from an installation or a  
 2 vessel". This guidance actually started long  
 3 before March 12th, but it came into force in  
 4 June.  
 5 ROIL, Q.C.:  
 6 Q. And the definition of support craft here would  
 7 include helicopters?  
 8 MR. PIKE:  
 9 A. That's correct.  
 10 ROIL, Q.C.:  
 11 Q. Okay.  
 12 MR. PIKE:  
 13 A. So this again was another point we provided to  
 14 improve the reporting that we were getting.  
 15 Just moving down to page 15, we start getting  
 16 into -- we can sort of quickly get some of  
 17 those. Incident classifications, fatality, it  
 18 seems fairly obvious, but there were some  
 19 questions as to how you would -- you know, is  
 20 it occupational, is it natural causes. There  
 21 are a number of those things that come into  
 22 play as to whether you would define the death  
 23 as a fatality or not when it comes to the  
 24 workplace.  
 25 ROIL, Q.C.:

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1 Q. But a fatality is clearly an incident?  
 2 MR. PIKE:  
 3 A. Yes, very clearly so. Missing persons --  
 4 major injury, we've now started to break out  
 5 what we define as a major injury. So there's  
 6 amputation, skeletal injuries, burns, injuries  
 7 to internal organs, you know, the eyes, and  
 8 again more clearly defining what we would have  
 9 as an incident.  
 10 ROIL, Q.C.:  
 11 Q. So if one hurts one's finger or something like  
 12 that, would that be considered an incident?  
 13 MR. PIKE:  
 14 A. It's reportable, but it's not reportable as a  
 15 major injury.  
 16 ROIL, Q.C.:  
 17 Q. Okay.  
 18 MR. PIKE:  
 19 A. It's breaking down the categories.  
 20 ROIL, Q.C.:  
 21 Q. Thank you.  
 22 MR. PIKE:  
 23 A. A loss or restricted workday. So if an  
 24 employee injures a finger and is not able to  
 25 go back and perform all their duties the

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1 following day, that's a loss time, that's a  
 2 reportable injury, but we've classified it a  
 3 little bit differently than the major injury.  
 4 Occupational illnesses, medical treatment, and  
 5 first aid. So we're distinguishing here as to  
 6 whether -- let's say somebody cuts their  
 7 finger, they get some stitches, but they're  
 8 able to go back and perform their duty, that  
 9 wouldn't be considered sort of a loss time,  
 10 but it is reported as a medical treatment  
 11 injury. Then there are first aids, so they  
 12 would be more minor trips to the offshore  
 13 platform nurse. Medical evacuations, we get  
 14 reports on those. Fires and explosions,  
 15 collisions, loss of well control, again we  
 16 have some fairly detailed ways to define what  
 17 is meant by a loss control. Hydrocarbon  
 18 releases, that's a relatively new one.  
 19 They've been doing this in the North Sea for a  
 20 number of years. It's a way of measuring  
 21 process safety. It's not -- it's one of the  
 22 ways to sort of measure where we are on  
 23 process safety. At least that's the way it's  
 24 used in the North Sea, so we've started to  
 25 introduce that and start collecting some data

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1 on that. Spills, and this guideline is  
 2 actually combined with environmental  
 3 protection. So we define spills, and we get  
 4 spills reported coming in through the same  
 5 system. The unauthorized discharge, some  
 6 adverse weather conditions, security issues,  
 7 damage to the actual equipment. So we have a  
 8 fairly extensive definition for incident.  
 9 ROIL, Q.C.:  
 10 Q. Okay, well, perhaps as we go through the  
 11 piece, we can reflect back on this definition  
 12 and see where incidents are being reported in  
 13 accordance with this kind of -- definition is  
 14 not the right word, but this kind of context.  
 15 MR. PIKE:  
 16 A. We can probably go back to the presentation,  
 17 if you like.  
 18 ROIL, Q.C.:  
 19 Q. Back to the presentation, yeah, we can do  
 20 that.  
 21 MR. PIKE:  
 22 A. Okay. So incident reports, three basic steps;  
 23 we receive notification of the incident, then  
 24 there's an incident report required, and then  
 25 we would go through the formal process to

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1 close the incident.  
 2 ROIL, Q.C.:  
 3 Q. So this is just a summary slide to tell us  
 4 what our next slides --  
 5 MR. PIKE:  
 6 A. That's the three basic steps we go through for  
 7 incident reporting.  
 8 ROIL, Q.C.:  
 9 Q. Right.  
 10 MR. PIKE:  
 11 A. So the operator notifies the Board of an  
 12 incident as soon as reasonably practicable, in  
 13 no terms later than 24 hours after the  
 14 incident. It comes into a duty officer. So  
 15 we do -- our safety officers and environmental  
 16 protection officers are on a rotation. They  
 17 take what we refer to as the duty phone. It's  
 18 24 hour, 7 day a week, 52 weeks of the year,  
 19 there's somebody on that duty phone. They do  
 20 it on a two week rotation. So the incident is  
 21 called in regardless of whether it's a working  
 22 day or not on that duty phone. Once they get  
 23 notification of an incident, they will let --  
 24 internally they notify us. So I would be  
 25 notified of any incident, and as we go down

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1 through there, there's a decision then made as  
 2 to whether we would initiate the emergency  
 3 response plan.  
 4 ROIL, Q.C.:  
 5 Q. That's a decision point that comes early on,  
 6 is it?  
 7 MR. PIKE:  
 8 A. That's correct. When I get a notification of  
 9 an incident, you know, it's a decision made.  
 10 The example here is that on March 12th, when  
 11 we received notification of Cougar 491, I made  
 12 the decision that the emergency response plan  
 13 would be initiated.  
 14 ROIL, Q.C.:  
 15 Q. Right.  
 16 MR. PIKE:  
 17 A. If we get notification of a spill of five  
 18 litres, that's really within the domain of the  
 19 Manager of Environmental Affairs, but we would  
 20 not trigger our response plan for that piece.  
 21 So it depends on the incident that's reported,  
 22 so it's a decision made. In this case, it  
 23 would be the Chief Safety Officer, but if you  
 24 can't get a hold to me, the duty officer can  
 25 also make that decision as well. So it's part

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1 of our emergency response plan.  
 2 ROIL, Q.C.:  
 3 Q. When the emergency response plan -- sorry,  
 4 when the emergency response plan is activated,  
 5 does that take it all to a different way, or  
 6 does the incident still have a life of its  
 7 own?  
 8 MR. PIKE:  
 9 A. It still has a life of its own, yes.  
 10 ROIL, Q.C.:  
 11 Q. Okay, yeah.  
 12 MR. PIKE:  
 13 A. So we'll talk a little bit more about the --  
 14 ROIL, Q.C.:  
 15 Q. So the process we're following now would be  
 16 followed in any event?  
 17 MR. PIKE:  
 18 A. Yes.  
 19 ROIL, Q.C.:  
 20 Q. Okay.  
 21 MR. PIKE:  
 22 A. Correct, and indeed we did do that on the  
 23 March 12th incident. This next decision point  
 24 is whether we will formally investigate and I  
 25 refer to that as the big "I", investigate.

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1 The safety officers have two sets of powers.  
 2 One is to inspect and the other one is to  
 3 investigate, and the simplest way to describe  
 4 what's going on and the difference in there is  
 5 when we are inspecting, it is actually an  
 6 offense not to answer our questions, but if we  
 7 are investigating, you have a right not to  
 8 answer our question. That's the easiest way I  
 9 have of describing what the difference is  
 10 here, and we try to distinguish what we're  
 11 doing. So we have a very formal process when  
 12 we start engaging in the investigation  
 13 process. The investigation would be if we are  
 14 looking at a prosecution, that's a formal  
 15 investigation. We would then proceed to get a  
 16 warrant before we start our investigation. We  
 17 do that because of the remoteness of our work  
 18 sites, and to start that process sooner. So  
 19 we would probably start the formal warrant  
 20 process sooner than you may see in the onshore  
 21 instance, but that's because of the remoteness  
 22 of our work sites and that's the way we  
 23 trigger, so we sometimes do a review, we call  
 24 it a review, that's a small "I" investigate  
 25 versus the large "I" formal, we're looking at

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1 prosecution type investigation.  
 2 ROIL, Q.C.:  
 3 Q. So a large "I" investigation is a formal  
 4 process. Are you telling us that there are  
 5 informal investigations, but you don't call  
 6 them that, you call them some other name, or  
 7 are they also called investigations?  
 8 MR. PIKE:  
 9 A. Well, we would refer to them as a review.  
 10 ROIL, Q.C.:  
 11 Q. As a review, okay.  
 12 MR. PIKE:  
 13 A. To distinguish between the two.  
 14 ROIL, Q.C.:  
 15 Q. Yes, indeed.  
 16 MR. PIKE:  
 17 A. We would notify governments, and I think we  
 18 had a presentation here from the -- or a piece  
 19 from the Provincial Government, they noticed  
 20 MOUs, and we would notify them. Indeed on  
 21 March 12th, we did notify the government when  
 22 we received that thing, so I would have  
 23 notified both the Departments of Energy and  
 24 the Occupational Health and Safety program  
 25 with the province.

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1 ROIL, Q.C.:  
 2 Q. Right.  
 3 MR. PIKE:  
 4 A. And we would initiate an entry in your  
 5 database. Again we're starting to see the use  
 6 of the databases.  
 7 ROIL, Q.C.:  
 8 Q. And this is a database that is your database?  
 9 MR. PIKE:  
 10 A. This is our database that we established to  
 11 track incidents. The incident report, the  
 12 operator is required to provide an incident  
 13 report within 21 days of the notification.  
 14 The report would be reviewed for completeness,  
 15 including a root cause analysis and corrective  
 16 actions, and we would also review it for  
 17 accuracy. The requirement is 21 days, but  
 18 obviously some incidents may be very complex  
 19 and may require additional analysis. A  
 20 potential example there would be we did have  
 21 an incident several years ago with a  
 22 helicopter and the engine. I think it's been  
 23 mentioned in other -- other people have  
 24 mentioned that particular piece. Well, it  
 25 took some six months to get the report back on

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1 the analysis of what went wrong with that  
 2 engine. So that report wasn't done in 21  
 3 days. We would have gotten some notification  
 4 of where they were, and when the final report  
 5 came in with that more detailed technical  
 6 analysis, we would have received the final  
 7 report.  
 8 ROIL, Q.C.:  
 9 Q. How many, in a ball park way, would be  
 10 responded to fully in 21 days as opposed to  
 11 requiring some extension?  
 12 MR. PIKE:  
 13 A. Most of them would be reported within 21 days.  
 14 It's more the exception that they would go  
 15 beyond the 21 days.  
 16 ROIL, Q.C.:  
 17 Q. Okay.  
 18 MR. PIKE:  
 19 A. We would identify then any follow-up required.  
 20 We'll see some of that as we take a look at a  
 21 couple of the incidents, whether we want to  
 22 follow-up during one of our safety audits or  
 23 inspections, whether there needs to be a  
 24 dedicated inspection associated with this  
 25 piece. The other one is, is there something

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1 about this incident that we should be sharing  
 2 with the entire industry, so we may do a  
 3 safety notice. So we would review it to see  
 4 if there's a safety notice required at this  
 5 point, and then as -- with that report or the  
 6 information for that report, we would enter  
 7 that into the database.  
 8 ROIL, Q.C.:  
 9 Q. So there's a tracking mechanism to follow what  
 10 the steps are and whether they've been  
 11 followed?  
 12 MR. PIKE:  
 13 A. Yes.  
 14 ROIL, Q.C.:  
 15 Q. Who's responsible to monitor that, to see that  
 16 it is being followed?  
 17 MR. PIKE:  
 18 A. We have a safety officer assigned to  
 19 coordinate the database for the incident  
 20 reports.  
 21 ROIL, Q.C.:  
 22 Q. Okay.  
 23 MR. PIKE:  
 24 A. Generally there would be a safety officer  
 25 assigned for an incident, so they would be the



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1 one following through on that. Closure of the  
 2 incident; the safety officer prepares a  
 3 recommendation for the Chief Safety Officer.  
 4 So they would come in and review with me where  
 5 we are in the incident, ensure that all the  
 6 pieces are complete, and it's only when we've  
 7 completed everything, we're satisfied that  
 8 they've done a complete root cause analysis  
 9 and identified the corrective actions, that we  
 10 would look to close out. We can probably now  
 11 take a quick look at that -- look at the  
 12 spreadsheet. I think there are 31 incidents  
 13 related to helicopter operations, and I think  
 14 it's Exhibit 196.  
 15 ROIL, Q.C.:  
 16 Q. Okay, can we go to Exhibit 196, and again just  
 17 give the Registrar a moment to get there.  
 18 MR. PIKE:  
 19 A. I think there are 31 incidents noted on this.  
 20 We've added a couple since I was here last  
 21 fall that are not actually closed in our  
 22 database yet, we're still following up with  
 23 some of the root cause and corrective actions.  
 24 ROIL, Q.C.:  
 25 Q. So these are all of the incidents relating to

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1 helicopter?  
 2 MR. PIKE:  
 3 A. Yes.  
 4 ROIL, Q.C.:  
 5 Q. That have happened between what period of  
 6 time?  
 7 MR. PIKE:  
 8 A. I believe the first one in there shows up as  
 9 1988.  
 10 ROIL, Q.C.:  
 11 Q. And how many of these would be closed at this  
 12 point in time?  
 13 MR. PIKE:  
 14 A. Most of these would be closed. It's really a  
 15 number of them that have been -- we received  
 16 in the last four months that are still open.  
 17 I'm not sure of the exact number. We can  
 18 check it here. There are four incident files  
 19 we've provided for you.  
 20 ROIL, Q.C.:  
 21 Q. Yeah, we've extracted four --  
 22 MR. PIKE:  
 23 A. We've extracted four.  
 24 ROIL, Q.C.:  
 25 Q. They're out of this list, are they?

Page 23

1 MR. PIKE:  
 2 A. They are out of this list.  
 3 ROIL, Q.C.:  
 4 Q. Okay.  
 5 MR. PIKE:  
 6 A. The first one is an April 5th, 2001 incident.  
 7 ROIL, Q.C.:  
 8 Q. Okay, take a moment now to --  
 9 MR. PIKE:  
 10 A. At the top of page two, the one that we have  
 11 up here now.  
 12 ROIL, Q.C.:  
 13 Q. Okay, so you're staying with the same exhibit?  
 14 MR. PIKE:  
 15 A. I'm just identifying the ones that we've done.  
 16 We'll get to the detailed ones in a moment.  
 17 ROIL, Q.C.:  
 18 Q. Okay.  
 19 MR. PIKE:  
 20 A. You'll notice that this was an engine shutdown  
 21 on over speed. It was on a Super Puma  
 22 aircraft in April of 2001, April 5th. That  
 23 aircraft actually landed on the Hibernia  
 24 Platform and they effected some repairs before  
 25 they brought it back. The next one that we've

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1 supplied is December 16th. We're going to  
 2 take a look at that one a little more closely.  
 3 ROIL, Q.C.:  
 4 Q. Yes.  
 5 MR. PIKE:  
 6 A. That would identifies a worker was transported  
 7 within the field without a flight suit.  
 8 ROIL, Q.C.:  
 9 Q. Sorry, which number -- which date is this now?  
 10 MR. PIKE:  
 11 A. That's December 16th, 2001, and we've got that  
 12 one up and we'll take a look at that one in a  
 13 little more --  
 14 ROIL, Q.C.:  
 15 Q. Yeah, we have the actual detail of that one,  
 16 okay.  
 17 MR. PIKE:  
 18 A. We do, and we'll take a look at that in a  
 19 moment. The other one is a January 18th,  
 20 2006, January 18th, and I think we may have  
 21 heard mention of this one. A chip light came  
 22 on, the pilot elected to return to base, and  
 23 in that process, it deteriorated further and  
 24 they ended up shutting down an engine. So we  
 25 have that report there as well. We'll take a

Page 25

1 look at that one in a little more detail. The  
 2 other one is a more recent one which is still  
 3 open, and I think we've heard some comment  
 4 about that here at the Inquiry, and that's the  
 5 October 11th. I refer to it as a weight  
 6 distribution. It's still open. That's the  
 7 heavy equipment in the cargo.  
 8 ROIL, Q.C.:  
 9 Q. That's the one that required the passengers to  
 10 move forward?  
 11 MR. PIKE:  
 12 A. The passengers to be shifted, correct.  
 13 ROIL, Q.C.:  
 14 Q. Yes.  
 15 MR. PIKE:  
 16 A. So we have that one in there as well. That's  
 17 still open. We have some questions as to --  
 18 we wanted a little more closer look at the  
 19 root cause piece on that, so it's still being  
 20 discussed.  
 21 ROIL, Q.C.:  
 22 Q. Okay, but we're going to take two that are  
 23 closed, and again our purpose here,  
 24 Commissioner, is to show the processes of the  
 25 Board, rather than to determine or judge

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1 whether the things were closed properly or  
 2 whether they were not closed properly. We're  
 3 more interested in the steps that you go  
 4 through, just so we can understand it.  
 5 MR. PIKE:  
 6 A. Okay. Again some of these are from an earlier  
 7 period, so some of the processes now have --  
 8 you know, with constant improvement, we've  
 9 made some changes to it, so some of these are  
 10 actually from an early process. So if we  
 11 could call up Exhibit 202. That's the  
 12 December 16th, 2001 incident. What you see  
 13 here is a printout from our database. So the  
 14 type of information that we could collect, the  
 15 operator, if we have a time, the date, when it  
 16 was reported to us. In this case, we didn't  
 17 actually get the report until January, and  
 18 we'll talk a little bit about that as we go  
 19 through it, the type of installation, et  
 20 cetera. So this is the type of information we  
 21 put into our database, description of the  
 22 event, a passenger travelled from the  
 23 Kommander 2000, that was a diving support  
 24 vessel that was in the field doing  
 25 construction work, it was the commissioning of

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1 the Terra Nova field, to the Henry Goodrich,  
 2 which was the mobile offshore drilling unit,  
 3 without wearing a helicopter transit suit or a  
 4 transportation suit.  
 5 ROIL, Q.C.:  
 6 Q. Yes.  
 7 MR. PIKE:  
 8 A. The individual was wearing regular work  
 9 clothes and a red jacket. It was reported  
 10 that the flight was conducted in five minutes.  
 11 The flight crew was aware that the individual  
 12 was not suitably attired for the helicopter  
 13 flight over open water, the pilot made a  
 14 judgment call that the risk of flying the  
 15 passenger to the Henry Goodrich was less than  
 16 the risk of landing back on the Kommander, and  
 17 you'll see as we go through some of the detail  
 18 there. In hindsight, this was not the  
 19 decision that should have been made, and the  
 20 individual -- and our premise as we went  
 21 through this, the pilot should never have been  
 22 put in that position in the first instance.  
 23 ROIL, Q.C.:  
 24 Q. Yeah, the impression I would take from that is  
 25 that the pilot wasn't aware until he was

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1 already taken off.  
 2 MR. PIKE:  
 3 A. He was put in a very difficult position and he  
 4 shouldn't have been put in that position is  
 5 our contention as we went through and did the  
 6 analysis on this particular incident.  
 7 ROIL, Q.C.:  
 8 Q. Okay.  
 9 MR. PIKE:  
 10 A. You know, there was contributing factors here.  
 11 There was changes made to the -- what do they  
 12 refer to it as?  
 13 ROIL, Q.C.:  
 14 Q. The manifest?  
 15 MR. PIKE:  
 16 A. The manifest, exactly, thank you. Again this  
 17 is the type of information we've captured in  
 18 the database, some of the corrective actions  
 19 that were taken. There's now a very clear  
 20 directive from Petro-Canada that no passengers  
 21 shall be transmitted without wearing a  
 22 transportation suit. They had that policy,  
 23 but it just wasn't as clear prior to this  
 24 incident.  
 25 ROIL, Q.C.:

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1 Q. Okay, just to go back a bit, my impression  
 2 from initially reading it was that the pilot  
 3 had already taken off and he was making the  
 4 judgment to keep going instead of coming back,  
 5 but I take it here it appears that he was  
 6 confronted with the problem that there wasn't  
 7 enough flight suits for this gentleman to have  
 8 one?  
 9 MR. PIKE:  
 10 A. That's correct.  
 11 ROIL, Q.C.:  
 12 Q. Okay.  
 13 MR. PIKE:  
 14 A. This was also at the end of the construction  
 15 piece. They were finishing up their  
 16 construction work, so people were coming off,  
 17 and I believe the vessel would have left soon  
 18 after this. It would have concluded its work.  
 19 Diving in December is never a good thing. It  
 20 would have been heading back to the North Sea.  
 21 We would there note who the investigator was  
 22 and the operator. In this case, the safety  
 23 officer that did the review is no longer with  
 24 us, so we've redacted that person's name.  
 25 ROIL, Q.C.:

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1 Q. Right.  
 2 MR. PIKE:  
 3 A. And it would have been closed -- the senior  
 4 safety officer would have reviewed it and  
 5 closed it at that time. There is a process to  
 6 go through to close it. It doesn't show up  
 7 here, but should, there was a follow-up, we  
 8 actually did an audit of Petro-Canada in 2002  
 9 and we'll look at that when we do the audits.  
 10 So this particular incident --  
 11 ROIL, Q.C.:  
 12 Q. So this was tracked into the audit, was it?  
 13 MR. PIKE:  
 14 A. Correct. What we did is we did a focused  
 15 audit on helicopter operations associated with  
 16 Petro-Canada in -- we'll take a look at it  
 17 when we hit the audits, I guess.  
 18 ROIL, Q.C.:  
 19 Q. So we should see this incident being reviewed  
 20 in the course of the audit?  
 21 MR. PIKE:  
 22 A. You will see it as part of the documentation  
 23 associated with that audit.  
 24 ROIL, Q.C.:  
 25 Q. Okay.

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1 MR. PIKE:  
 2 A. If we can just sort of quickly go through it,  
 3 this is actually taken off the file, the same  
 4 sort of information. You'll note that the  
 5 safety officer, and this is where I'm coming  
 6 back, we received a report, we felt that they  
 7 didn't get down to the root, that the pilot  
 8 shouldn't have been -- so we went back to the  
 9 operator in this case and said, you know, we  
 10 didn't feel that the pilot should have been  
 11 put in that position in the first instance.  
 12 What we have here is the letter that was  
 13 transmitted. We received notification of this  
 14 incident on January 11th. They acknowledged  
 15 that they had not reported it in time. The  
 16 other note in here, it was actually a worker  
 17 on the Henry Goodrich mobile offshore drilling  
 18 unit that identified this piece. So again  
 19 we've had a worker here reporting an incident  
 20 and it was further investigated. So there as  
 21 no coverup here. The worker identified that  
 22 he saw something wrong and there was an  
 23 investigation that took place.  
 24 ROIL, Q.C.:  
 25 Q. But there was a delay between the incident and

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1 when it came to your attention?  
 2 MR. PIKE:  
 3 A. Yes, there was.  
 4 ROIL, Q.C.:  
 5 Q. Did the worker report it to you or report it  
 6 to his employer?  
 7 MR. PIKE:  
 8 A. There is an internal system, and the internal  
 9 system worked. The worker reported it within  
 10 their internal reporting system.  
 11 ROIL, Q.C.:  
 12 Q. Okay.  
 13 MR. PIKE:  
 14 A. So again this is just indicating, and then we  
 15 get into the information in the report. As I  
 16 indicated, it was reported by a drilling  
 17 contractor employee that on the afternoon of  
 18 December 16th, a helicopter arrived at that  
 19 drilling unit with a passenger from the diving  
 20 support vessel that was not wearing a  
 21 transportation suit.  
 22 ROIL, Q.C.:  
 23 Q. I take it that this was a very, very short  
 24 flight? I think there was a reference to five  
 25 minutes?

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1 MR. PIKE:  
 2 A. Five minutes or less, yes. What they had  
 3 done, and if you go down through it, you'll  
 4 see what they've done is they've brought this  
 5 vessel in the lee of the FPSO, thinking that  
 6 that would make it -- they do that a lot with  
 7 marine operations, they bring the support  
 8 vessel on the lee of the vessel, it reduces  
 9 the motions, so it makes it for a safer  
 10 operation when you're doing transfers that  
 11 way. Unfortunately, in this case it didn't  
 12 quite work out the same for helicopter  
 13 operations. When you're in the lee of the  
 14 FPSO, there's a lot of turbulence that comes  
 15 off the actual FPSO, so it wasn't quite as  
 16 smooth an operation as they had hoped.  
 17 ROIL, Q.C.:  
 18 Q. So they were trying to make the flight as  
 19 short a period of time as possible?  
 20 MR. PIKE:  
 21 A. Short, and to give -- because again the dive  
 22 vessel is also a floating vessel, it has  
 23 motions. You bring it into the lee, the seas  
 24 are calmer, so there should be less motions  
 25 associated with it. So they're trying to

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1 bring down the motions on the helideck to make  
 2 the whole operation safer, but part of the  
 3 piece in this is that they also create -- some  
 4 turbulence comes off the FPSO when you do  
 5 that, and it shows up as you go through. We  
 6 won't go through the detail here, but that's  
 7 some of the things that were happening at that  
 8 time. You'll also note as you go through that  
 9 there's a lot of correspondence in here. The  
 10 manifest was set before it went out, they put  
 11 the transportation suits on board, but while  
 12 that flight was in transit offshore, they were  
 13 adding people to the list. So there was some  
 14 confusion on the manifest. So when it  
 15 actually arrived on that vessel, they didn't  
 16 have sufficient suits for the number of people  
 17 that they were proposing to transfer. So  
 18 again this is all -- it just explains the  
 19 sequence of events that happened.  
 20 ROIL, Q.C.:  
 21 Q. Yes, we won't take the time to read all of  
 22 this. If you can paraphrase it and summarize  
 23 it for us.  
 24 MR. PIKE:  
 25 A. There was some confusion between the FPSO and

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1 the drilling unit, and the shore, as to  
 2 exactly who knew what at what point in time,  
 3 but it's - there were two people essentially  
 4 from this diving vessel being transferred to  
 5 the drilling unit. Again they were associated  
 6 with some of the subsea completions, and they  
 7 would have had additional work to do on the  
 8 diving vessel. So that's, in part, what they  
 9 were doing.  
 10 ROIL, Q.C.:  
 11 Q. So what happened at the end of the day to  
 12 close this incident reporting? I think you've  
 13 told us that it goes off to an audit and we'll  
 14 follow that later, but is there any other step  
 15 that was taken?  
 16 MR. PIKE:  
 17 A. We had certain questions for them, but in the  
 18 end Petro-Canada, while they had a policy,  
 19 they made it abundantly clear with Cougar and  
 20 to the pilots that they are not to transport  
 21 anybody. So that was essentially the way they  
 22 closed it. When you've done that, then that  
 23 piece sort of closed it. We did a follow-up  
 24 audit, so when we were finished that audit, we  
 25 were able to close this incident.

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1 ROIL, Q.C.:  
 2 Q. So for your purposes, it didn't become closed  
 3 until after the audit?  
 4 MR. PIKE:  
 5 A. It did not become closed until after the  
 6 audit.  
 7 ROIL, Q.C.:  
 8 Q. Okay.  
 9 MR. PIKE:  
 10 A. It just goes through some of the background.  
 11 We can possibly move on to the --  
 12 ROIL, Q.C.:  
 13 Q. Yes, perhaps we'll have a look at -- there was  
 14 another one you wanted to look at.  
 15 MR. PIKE:  
 16 A. Unless you have any questions on that one, we  
 17 can move on to the January 18th, 2006, and  
 18 that's Exhibit 203.  
 19 ROIL, Q.C.:  
 20 Q. 203?  
 21 MR. PIKE:  
 22 A. Yes.  
 23 ROIL, Q.C.:  
 24 Q. Okay.  
 25 MR. PIKE:

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1 A. This incident took place on January 18th,  
 2 2006. The report was a little delayed coming  
 3 in, February 3rd, 2006. Again another reason  
 4 why when we updated the guidance note, that we  
 5 included that caveat on support craft. It  
 6 hasn't been always clear that we are looking  
 7 for incidents on support crafts as well, so  
 8 part of the reason why in that new guidance we  
 9 make explicit reference to the support craft  
 10 in our expectations and the reporting of those  
 11 incidents.

12 ROIL, Q.C.:

13 Q. What would support craft be in addition to  
 14 helicopters? What other types of vehicles or  
 15 vessels would be included?

16 MR. PIKE:

17 A. The multi-function vessels they use. The  
 18 supply vessels that we see in the harbour, we  
 19 refer to them as multi-function. Not only do  
 20 they do supply, they're capable most of them,  
 21 anchor handling and standby duty. So they  
 22 would be a multi-function. We can take a  
 23 moment maybe -- in 1986 when the Hibernia  
 24 decision report initially came in, they talked  
 25 in terms of having a dedicated standby vessel,

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1 but it quickly became apparent or in the  
 2 intervening time that with one single standby  
 3 vessel, you did not have coverage seven days a  
 4 week -- 24 hours a day, seven days a week, 52  
 5 weeks. It's a mechanical system, it needs to  
 6 have maintenance. When you're maintaining it,  
 7 it's no longer available. So the option we've  
 8 taken here is have multi-function vessels. So  
 9 most of the supply vessels you see in the  
 10 harbour are referred to as multi-function, so  
 11 they carry an ability to do standby on all the  
 12 installations. So the have the FRCs, most of  
 13 them will have fire fighting capability,  
 14 there's the Dacron Scoop, which is used in  
 15 instances where they can't launch the FRC.  
 16 They call it the full suite of response  
 17 capability from a marine perspective. There  
 18 will be potentially other type -- it's an all  
 19 encompassing definition, but those would be  
 20 the two major pieces that we would know as the  
 21 helicopters and the supply vessels in the  
 22 harbour. In order to provide that standby  
 23 vessel coverage 24 hours a day, seven days a  
 24 week, 52 weeks of the year, year end, year  
 25 out, we have multiple vessels capable of doing

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1 that. So that's the way we are able to  
 2 achieve that coverage.

3 ROIL, Q.C.:

4 Q. I think we heard the evidence from DND about  
 5 the fact they have three helicopters to  
 6 provide --

7 MR. PIKE:

8 A. They need three Cormorant helicopters in  
 9 Gander in order to provide one helicopter on a  
 10 24 hour, seven day a week basis, that's right.

11 ROIL, Q.C.:

12 Q. Okay, thank you. Let's get back to this  
 13 incident and take a few moments to look --

14 MR. PIKE:

15 A. I think you may have heard about this, I'm not  
 16 100 percent sure. We will note that on the  
 17 18th, there was a flight experienced a  
 18 technical issue. The number two engine chip  
 19 light -- chip light on number two engine on  
 20 the outbound leg to the Terra Nova FPSO.  
 21 There was 16 passengers and two pilots on  
 22 board. Due to the technical issue, the pilot  
 23 elected to return to the -- the helicopter to  
 24 the base rather than try to land on board  
 25 offshore. So that was a decision of the

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1 pilot. The aircraft then proceeded to St.  
 2 John's on two engines. It's important to note  
 3 that for the aircraft to land and takeoff  
 4 offshore, it requires a great deal more power,  
 5 and I believe we heard that comment made when  
 6 workers related to what the pilot had told  
 7 them.

8 ROIL, Q.C.:

9 Q. Yes, we heard evidence about how a number of  
 10 passengers were on board when with only one  
 11 engine running the helicopter would make a  
 12 airplane type landing rather than a vertical  
 13 descent.

14 MR. PIKE:

15 A. That's correct. Well, on that trip back when  
 16 the initial chip light came on, they had  
 17 additional signals came up on that engine and  
 18 they eventually shut down that engine before  
 19 they came in to land. The passengers were  
 20 briefed, and I believe it indicates here that  
 21 two passengers elected not to return offshore  
 22 and came out on a later flight. It just  
 23 indicates the actions that were taken by the  
 24 operator in that case. This is a case where  
 25 we did not get the final report in the

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1 required 21 days. It was actually some time  
 2 later in August of that year when the final  
 3 report from the engine manufacturer was  
 4 available to identify what the issue was in  
 5 that case.  
 6 ROIL, Q.C.:  
 7 Q. So I take it, your interest is not simply in  
 8 the steps that they take, but also in what  
 9 happened to that particular piece of  
 10 equipment?  
 11 MR. PIKE:  
 12 A. We're looking for the root causes and the  
 13 corrective actions. So have they dug down to  
 14 find out the root cause of this incident, and  
 15 what are they doing to correct it so it  
 16 doesn't happen again. You can see the  
 17 immediate cause, some of the basic causes, and  
 18 the corrective actions that were taken. We've  
 19 identified here -- the investigator in this  
 20 case was one of our safety officers, and then  
 21 we've entered comments. You'll note as we've  
 22 gone through this and when we've closed it.  
 23 It didn't actually get closed until October,  
 24 2007, when we got the complete package  
 25 together.

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1 ROIL, Q.C.:  
 2 Q. So this event, unlike -- this incident, unlike  
 3 the other incident, didn't get tracked off on  
 4 another path, it had its own path, did it?  
 5 MR. PIKE:  
 6 A. Yes.  
 7 ROIL, Q.C.:  
 8 Q. That's the impression I'm taking from your  
 9 evidence. I want to make sure I'm  
 10 understanding it correctly.  
 11 MR. PIKE:  
 12 A. Yeah.  
 13 ROIL, Q.C.:  
 14 Q. Good, and all of these incidents come to your  
 15 attention before they're closed off?  
 16 MR. PIKE:  
 17 A. Yes.  
 18 ROIL, Q.C.:  
 19 Q. And you have to accept responsibility that  
 20 they're --  
 21 MR. PIKE:  
 22 A. I'm the one that signs off before we close  
 23 them, yes. At the time of this one, Mr. Noel  
 24 was the senior safety officer, and safety  
 25 officers would report to him. Our current

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1 arrangement is Mr. Noel is now a senior safety  
 2 advisor, the safety officers report to me and  
 3 I'd be the one that signs off those.  
 4 ROIL, Q.C.:  
 5 Q. Okay, before we -- I think you're probably  
 6 finished with that one. Before we close off  
 7 on the issue of incidents, there is an exhibit  
 8 in there, and I'm not going to take you to it  
 9 because I don't want to spend a lot of time on  
 10 it, others may, but I do want you to comment  
 11 on it, and that is we have learned -- after  
 12 you were a witness, I believe, we learned that  
 13 Transport Canada has a system called CADORS,  
 14 and it is an "incident" reporting system as  
 15 well, and that helicopter incidents do get  
 16 reported to them. What can you tell us about  
 17 your knowledge of that and your view as to the  
 18 importance of that or the relative value of  
 19 that in terms of your reporting systems?  
 20 MR. PIKE:  
 21 A. As indicated, we weren't aware of it before.  
 22 We haven't done an extensive analysis to do  
 23 comparison because again some of their  
 24 reporting criteria is different than ours.  
 25 It's interesting that they do do that publicly

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1 because in Norway there is no public register  
 2 of aviation incidents. They are captured by  
 3 the aviation authority, but they're only in  
 4 paper file system. So there is no captures  
 5 equivalent in Norway, which I found rather  
 6 interesting. The Norwegian authorities there  
 7 thought that that was a useful piece that we  
 8 had in having this database. It would afford  
 9 us an opportunity to cross-reference, but  
 10 again given that they're using a different  
 11 reporting criteria, the comparisons can be a  
 12 little more difficult. So it is a bit of a  
 13 check for us if we go check there to make sure  
 14 that we're capturing the incidents.  
 15 ROIL, Q.C.:  
 16 Q. Where there be any value in lining your  
 17 incident reporting criteria for helicopter  
 18 transport up with theirs as opposed to  
 19 maintaining your own in relation to support  
 20 craft and your own definitions? Is there  
 21 value there or would it simply confuse you?  
 22 MR. PIKE:  
 23 A. There may be, but as I indicated, any time  
 24 you're starting to line up two very different  
 25 systems, there's a lot of effort involved in

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1 it. It currently is useful for us as a check,  
 2 but to try to get a detailed line up, there's  
 3 a large amount of effort, I would think, that  
 4 is going to be required for it. That's a  
 5 system that Transport Canada has across all  
 6 commercial aviation. So it is not just, you  
 7 know, the offshore helicopters. It's the  
 8 commercial flights that we all get on. So  
 9 it's a much broader system than we would be  
 10 looking at. There is some value in looking at  
 11 it, but getting a complete alignment may be a  
 12 very difficult task.

13 ROIL, Q.C.:

14 Q. Do you now monitor that service as well?

15 MR. PIKE:

16 A. We do -- I won't say we do it regularly, but  
 17 we do do a check with that system.

18 ROIL, Q.C.:

19 Q. Okay. If you found an incident reported there  
 20 but not reported to you -

21 MR. PIKE:

22 A. We would follow up with the operator to -- try  
 23 to determine which flight it was and follow up  
 24 with the operator.

25 ROIL, Q.C.:

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1 Q. Even though it didn't necessarily perhaps fit  
 2 your definition of an incident?

3 MR. PIKE:

4 A. Well, if it didn't fit our definition, we may  
 5 try to get some additional information on it,  
 6 but we wouldn't necessarily include it in our  
 7 incident database.

8 ROIL, Q.C.:

9 Q. Okay. Okay, I think we can now move on to the  
 10 next issue, which was the issue of complaints,  
 11 and I think this arose out of your initial  
 12 evidence back in October when you, I think,  
 13 testified that there were some complaints that  
 14 you had received over the years about  
 15 helicopter transit or helicopter related  
 16 issues.

17 MR. PIKE:

18 A. Yes. Again, a fairly simple course, three-  
 19 step process. The actual formal procedure for  
 20 this was established in 2004. It was during  
 21 that time we had a safety officer seconded  
 22 from Labour Canada and he was helping us out.  
 23 He had had some experience working offshore  
 24 many years ago and he was helping us out. He  
 25 identified the need for a more formal process

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1 for a complaint processing procedure and  
 2 indeed, he helped us write that and drew very,  
 3 very heavily on the Labour Canada process for  
 4 registering complaints. We had complaints  
 5 prior to that, but they were not handled in a  
 6 more formal process. They were a little bit  
 7 more informal.

8 So if we receive a complaint, the  
 9 information that would be collected is the  
 10 name, address of the complainant. That's a  
 11 way of identifying who it is and how we get  
 12 back to them. The operator's or employer's  
 13 name and address. The time and date the  
 14 complaint was received. Is a collective  
 15 agreement in place? Sometimes the collective  
 16 agreements will have provisions for complaints  
 17 as well, so that's a piece of information that  
 18 we would need, and he highlighted it from the  
 19 Labour Canada experience that that was a piece  
 20 we needed to look at. The statement of the  
 21 complaint, and the other piece that we would  
 22 ask, has this sort of -- within the internal  
 23 responsibility system, has it been dealt with  
 24 internally. So has the supervisor -- has it  
 25 been discussed with the supervisor, what the

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1 name of the supervisor, what action was or  
 2 wasn't taken in that regard.

3 All or part of this may come out because  
 4 some of the complaints we get are anonymous so  
 5 obviously we wouldn't have the name and  
 6 address and sometimes they -- so this is the  
 7 information we look for. We don't always get  
 8 it all, depending on whether it's an anonymous  
 9 complaint.

10 ROIL, Q.C.:

11 Q. In what manner are you using, what technology  
 12 or means do complaints come into you?

13 MR. PIKE:

14 A. We've either gotten them by e-mail, and we'll  
 15 see some of that as we move forward. I think  
 16 there's two we've taken a look at. And the  
 17 other one would be in person or by phone. So  
 18 we would get those by any convention.

19 ROIL, Q.C.:

20 Q. What about old-fashioned writing out "I  
 21 complain about" type letter? Would that  
 22 trigger a complaint?

23 MR. PIKE:

24 A. It would. Any of those would trigger it, and  
 25 at this point, we would fill out the complaint

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1 registration form in the database. It's  
 2 another one of our databases where we would  
 3 track those things.  
 4 Once the complaint is received, the  
 5 person who has received it would consult with  
 6 the chief safety officer, consult with me. We  
 7 would decide on what level of review was  
 8 required and again, a decision point is, you  
 9 know, does this complaint warrant a capital I  
 10 investigation, one of those formal ones or is  
 11 it more of just a review, a more formal  
 12 review. It will depend also on how much the  
 13 person who complained wants us to disclose to  
 14 the operator as well. In some cases, it's  
 15 going to take that in order to correct the  
 16 one, and we'll see that in one of the examples  
 17 we have a little bit later on. We may assign  
 18 a different safety officer to the actual  
 19 review than the one that actually received the  
 20 complaint, but normally the person that  
 21 receives the complaint would be the one to do  
 22 the review, but we go through that step as  
 23 well. It's just sometimes if one safety  
 24 officer receives it, but it's associated with  
 25 an installation they're not familiar with, we

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1 assign the safety officer who's familiar with  
 2 that installation.  
 3 ROIL, Q.C.:  
 4 Q. So these decisions are made on a case-by-case  
 5 basis?  
 6 MR. PIKE:  
 7 A. They are.  
 8 ROIL, Q.C.:  
 9 Q. Okay.  
 10 MR. PIKE:  
 11 A. The safety officer would then prepare a report  
 12 to the chief safety officer and would review  
 13 that report with me. We would decide on what  
 14 follow-up actions are required. So again,  
 15 does this trigger a piece in one of our safety  
 16 audits? Does it -- will it trigger its own  
 17 safety inspection in its own right? And that  
 18 information would then be entered in the  
 19 database to update the data.  
 20 So the safety officer would complete a  
 21 complaint report. So we look to make sure  
 22 that it is complete and accurate. If we've  
 23 done any sort of formal investigation or  
 24 formal review, we would ensure that that's  
 25 complete before we close off the complaint.

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1 Once they've got all those pieces complete,  
 2 they'll meet with me and we'll review the  
 3 complete complaint package and once we've  
 4 decided that it is complete, we'll advise the  
 5 complainant, if we've got that information and  
 6 the disposition of that complaint and we would  
 7 close the database. So the information is now  
 8 in the database.  
 9 I think we've identified we've had four  
 10 complaints since we've had our formal process  
 11 up to last fall. I think there's been one  
 12 received since the last time I was here, and  
 13 it was in November I actually received it. It  
 14 was with regard to seating arrangement and  
 15 training. It was an anonymous complaint and  
 16 it has since been closed. It was investigated  
 17 as -- some of the information from our work  
 18 refusals was also used to close that  
 19 complaint.  
 20 ROIL, Q.C.:  
 21 Q. I think the exhibits that you have put forward  
 22 here are those that were requested by one of  
 23 the parties?  
 24 MR. PIKE:  
 25 A. Correct, and those were the ones that would

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1 have been known to us when we testified in  
 2 October.  
 3 ROIL, Q.C.:  
 4 Q. Right, and I think your evidence was that  
 5 there was four, and so we have four here.  
 6 MR. PIKE:  
 7 A. Yes, correct.  
 8 ROIL, Q.C.:  
 9 Q. Okay.  
 10 MR. PIKE:  
 11 A. Those are the four you have and that's exhibit  
 12 -- if we could sort of pull up those exhibits?  
 13 In January of -  
 14 ROIL, Q.C.:  
 15 Q. Sorry, one second now. It's Exhibit 188.  
 16 MR. PIKE:  
 17 A. I'm sorry, yes.  
 18 ROIL, Q.C.:  
 19 Q. Give us a moment to -  
 20 MR. PIKE:  
 21 A. Getting ahead of myself.  
 22 ROIL, Q.C.:  
 23 Q. I'll slow you down, if necessary.  
 24 MR. PIKE:  
 25 A. We'll just talk a little bit about the four.



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1 In January of 2004, a former Cougar pilot, he  
 2 actually came in to our industrial benefits  
 3 folks, was talking about an employment issue  
 4 and first consideration to Newfoundlanders for  
 5 employment. While he was in, he identified  
 6 some concerns he had with safety and as soon  
 7 as the safety was raised, our industrial  
 8 benefits folks advised him to come and speak  
 9 to a safety officer and he did that. So we'll  
 10 take a look at that one.  
 11 ROIL, Q.C.:  
 12 Q. So he was in to see the industrial relations  
 13 people?  
 14 MR. PIKE:  
 15 A. Correct.  
 16 ROIL, Q.C.:  
 17 Q. And they said we would call a safety incident-  
 18 MR. PIKE:  
 19 A. As soon as he identified a safety issue, stop,  
 20 let's go to the safety people.  
 21 ROIL, Q.C.:  
 22 Q. Okay.  
 23 MR. PIKE:  
 24 A. So the safety part of that took precedence  
 25 over the industrial benefits piece. The next

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1 one was in January 2007 and it was an  
 2 anonymous complaint about weather conditions  
 3 for flying.  
 4 ROIL, Q.C.:  
 5 Q. Sorry, is this one of the -  
 6 MR. PIKE:  
 7 A. I just quickly -  
 8 ROIL, Q.C.:  
 9 Q. - one of the ones we're going to detail?  
 10 MR. PIKE:  
 11 A. Yeah, we'll detail this one and I'll just sort  
 12 of highlight the other four and then we'll  
 13 come back to this one.  
 14 ROIL, Q.C.:  
 15 Q. Okay, that's fine.  
 16 MR. PIKE:  
 17 A. In April 2009 -  
 18 ROIL, Q.C.:  
 19 Q. Okay, that's page 15, just to give the  
 20 Registrar a moment to pull that up, just so we  
 21 can see it, page 15.  
 22 MR. PIKE:  
 23 A. Oh, okay.  
 24 ROIL, Q.C.:  
 25 Q. Do it the old-fashioned way. It's not

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1 responding, is it?  
 2 REGISTRAR:  
 3 Q. No.  
 4 ROIL, Q.C.:  
 5 Q. Oh. There we go, okay. So the first one, I  
 6 think, was a person who visited in person.  
 7 MR. PIKE:  
 8 A. Yes.  
 9 ROIL, Q.C.:  
 10 Q. This one -  
 11 MR. PIKE:  
 12 A. The second one was a call, which was -- which  
 13 we'll take a look at in more detail. That was  
 14 the weather conditions of flying. Then in  
 15 April 2009, it was an e-mail.  
 16 ROIL, Q.C.:  
 17 Q. Yes.  
 18 MR. PIKE:  
 19 A. Received from an offshore worker, and again,  
 20 we filled out the form in our database,  
 21 identifying that she did not have -- or they  
 22 did not have a flight suit that fit. We  
 23 followed up with the operator in this case.  
 24 They had identified that they would like us to  
 25 do that, and -

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1 ROIL, Q.C.:  
 2 Q. That is a post-incident complaint?  
 3 MR. PIKE:  
 4 A. Correct.  
 5 ROIL, Q.C.:  
 6 Q. Yes.  
 7 MR. PIKE:  
 8 A. So when we became -- you may have seen this in  
 9 some of the JOHS minutes previous, which we  
 10 thought was being worked by the operator, but  
 11 when the individual identified a problem to  
 12 us, we went back to the operator and it was  
 13 corrected and they were transported with a  
 14 marine abandonment suit that fit. The last  
 15 one was simply somebody complaining that the  
 16 Board hadn't taken a firm enough position with  
 17 regard to the return to flight.  
 18 But if we want to go back now to January,  
 19 so it's back at the beginning.  
 20 ROIL, Q.C.:  
 21 Q. January of '04, page one on this exhibit?  
 22 MR. PIKE:  
 23 A. Yes. This is an older form. We were still in  
 24 draft with our procedures, so that's -- we  
 25 were still working with how the form would

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1 come out. This individual was concerned what  
 2 he felt the general focus on production over  
 3 safety. He further felt Cougar might be  
 4 pushed -- pushing the limits a little bit too  
 5 much. He did not feel that there was an  
 6 immediate or significant problem, but the  
 7 situation needed to be looked at. He also  
 8 cited two specific examples, an S-61 control  
 9 problem that was illegally fixed by the pilot  
 10 and a case where the flights travelling  
 11 offshore without a standby helicopter.  
 12 We did further investigate the S-61 piece  
 13 and actually checked Transport Canada's  
 14 website and they did identify that a Cougar  
 15 pilot was indeed fined for illegally fixing  
 16 the S-61 and I believe had not actually told  
 17 Cougar that he had fixed the flight.  
 18 ROIL, Q.C.:  
 19 Q. But that finding and action by Transport  
 20 Canada did not come as a result of any action  
 21 by you?  
 22 MR. PIKE:  
 23 A. No.  
 24 ROIL, Q.C.:  
 25 Q. Okay.

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1 MR. PIKE:  
 2 A. No.  
 3 ROIL, Q.C.:  
 4 Q. Do you know how that -- you know, do you know  
 5 who reported that? Did he self-report or did  
 6 Cougar report or do you know?  
 7 MR. PIKE:  
 8 A. I'm not -  
 9 ROIL, Q.C.:  
 10 Q. At this point you don't know?  
 11 MR. PIKE:  
 12 A. I don't know.  
 13 ROIL, Q.C.:  
 14 Q. Okay, that's fine.  
 15 MR. PIKE:  
 16 A. We just know that before we looked at it, it  
 17 had been captured. It had been identified and  
 18 the individual in question was indeed fined  
 19 for having done that. There is some detail in  
 20 what the actual incident -- how the incident  
 21 played out. This particular complaint also  
 22 triggered a -- as we note, as I indicated, we  
 23 did find that there was a -- they fined the  
 24 pilot in that particular one.  
 25 We also did an audit in April of 2004

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1 that included Cougar. So in this case, this  
 2 one also triggered, when we were doing an  
 3 audit of Hibernia in this case, where we were  
 4 looking at some of their contractors, we chose  
 5 to look at Cougar. We wouldn't have at this  
 6 point have told either Cougar or HMDC that we  
 7 had had this complaint and we went in and did  
 8 our audit and we were looking for specific  
 9 things that we saw from this complaint.  
 10 ROIL, Q.C.:  
 11 Q. So a complaint -  
 12 MR. PIKE:  
 13 A. We could go to that audit. You'll see that  
 14 this particular complaint was one of the  
 15 pieces that they took a look at when they  
 16 prepared to do that audit.  
 17 ROIL, Q.C.:  
 18 Q. So I take the message to be that like an  
 19 incident, a complaint can have a life of its  
 20 own and be dealt with on its own or it can  
 21 trigger some activity in an audit or it can  
 22 actually trigger an audit itself? Is that -  
 23 MR. PIKE:  
 24 A. It can, yes.  
 25 ROIL, Q.C.:

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1 Q. Okay.  
 2 MR. PIKE:  
 3 A. And we have here just some of the notes that  
 4 were taken by the safety officer during the  
 5 interview with the individual.  
 6 ROIL, Q.C.:  
 7 Q. So using this old form, is there any way we  
 8 can tell whether or not the complaint was  
 9 responded back to the complainant? Is there -  
 10 - I don't know if there's a place where that -  
 11 MR. PIKE:  
 12 A. In that form, there is not unfortunately.  
 13 ROIL, Q.C.:  
 14 Q. Okay.  
 15 MR. PIKE:  
 16 A. But I believe we did respond back. The note  
 17 here as well, I guess, is that he was looking  
 18 to get employed back with Cougar. So he did  
 19 have some concerns, but -  
 20 ROIL, Q.C.:  
 21 Q. And this was some of the material that the  
 22 safety officer accumulated?  
 23 MR. PIKE:  
 24 A. This is the material to the thing and this is  
 25 actually, I think -- here we go. This is

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1 actually from Transport Canada's website. It  
 2 identifies -  
 3 ROIL, Q.C.:  
 4 Q. The last one down, Atlantic March 27th '03?  
 5 MR. PIKE:  
 6 A. Correct. On March 27th, a commercial  
 7 helicopter pilot operating an S-61 noticed on  
 8 two separate occasions that the collective,  
 9 which I assume is a piece of equipment on the  
 10 helicopter, was jamming during the final  
 11 approach. He did not inform the company  
 12 before undertaking two more flights with  
 13 passengers. The pilot was fined for not  
 14 complying with the procedure specified in the  
 15 company's operations manual. So yes, it  
 16 happened, and yes, there was a process and  
 17 yes, it did get covered. So again, something  
 18 else that Transport does, they list all the -  
 19 ROIL, Q.C.:  
 20 Q. Okay. The other one you were going to look at  
 21 in detail, I think, was January of '07 which  
 22 is on page 24.  
 23 MR. PIKE:  
 24 A. Okay.  
 25 ROIL, Q.C.:

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1 Q. Let's just see if we can scan to that before  
 2 we go there. Okay.  
 3 MR. PIKE:  
 4 A. Okay. This was in the nature of an anonymous  
 5 complaint. It was taken by phone. So an  
 6 individual phoned. I will speculate and say  
 7 they were waiting for a flight to come home  
 8 and felt that -- received a call from an  
 9 offshore worker who did not wish to give his  
 10 name. However, he did mention that he had  
 11 been working offshore for some years. He  
 12 stated that Cougar had not flown yesterday,  
 13 there was a snowstorm that day, and was  
 14 attempting flights today and may not be able  
 15 to fly tomorrow, given the forecast storm.  
 16 The scan on this one is a little difficult to  
 17 read, but we'll -- based on the scenario, he  
 18 had concerns that Cougar may be pressured by  
 19 the operators to fly in the current  
 20 conditions, minus one to zero degrees, with  
 21 what appears to be freezing rain. It was his  
 22 understanding Cougar did not fly in freezing  
 23 rain and yet the company was attempting to fly  
 24 in the current conditions. He and a number of  
 25 other people were concerned about this and

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1 therefore decided to call the Board to raise  
 2 the question with us.  
 3 If we go through this, the safety officer  
 4 took this piece, identified the safety officer  
 5 -- he did not leave his name, so we had no way  
 6 of contacting him. We did indicate we would  
 7 do the investigation and he could call us  
 8 back. We proceeded then to find out from  
 9 Cougar exactly what their operating procedures  
 10 were in these conditions. So again, we  
 11 received that information back from Cougar.  
 12 We did a full investigation on this piece or a  
 13 review, if you will. There were certain  
 14 questions we wanted as well to answer, vis-a-  
 15 vis what the conditions were for flight. So  
 16 we had that information and the individual did  
 17 not return the call to find out what we had  
 18 found, but we did go ahead and do that  
 19 investigation and you can see we collected  
 20 from Cougar what their operations manual said  
 21 about flying in icing and snowing conditions.  
 22 So they have a very clear protocol that is  
 23 being followed with regard to flying in icing  
 24 or snow conditions.  
 25 ROIL, Q.C.:

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1 Q. Okay. So I take it the complaint was non-  
 2 specific? It was a fear that they would fly?  
 3 MR. PIKE:  
 4 A. Yes.  
 5 ROIL, Q.C.:  
 6 Q. And what were you looking for? The policy?  
 7 MR. PIKE:  
 8 A. We wanted to make sure indeed there was a  
 9 policy.  
 10 ROIL, Q.C.:  
 11 Q. Um-hm.  
 12 MR. PIKE:  
 13 A. And that indeed it was being followed, so we  
 14 confirmed those two pieces before we closed  
 15 that incident and now we have that information  
 16 on file as to what that -  
 17 ROIL, Q.C.:  
 18 Q. Would this -  
 19 MR. PIKE:  
 20 A. Some idea of what that, those parameters would  
 21 be.  
 22 ROIL, Q.C.:  
 23 Q. Would this complaint have triggered any  
 24 additional activity or was it closed within  
 25 itself?

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1 MR. PIKE:  
 2 A. It was closed within itself.  
 3 ROIL, Q.C.:  
 4 Q. These are four complaints, and these, I think  
 5 you testified earlier, were the only four in  
 6 relation to helicopter activity. Just to give  
 7 us an overview or an understanding in context,  
 8 what would the number be if you were looking  
 9 at all complaints with respect to workers and  
 10 the offshore? Is it 4 out of 20 or 4 out of  
 11 200?  
 12 MR. PIKE:  
 13 A. I don't have that number with me  
 14 unfortunately.  
 15 ROIL, Q.C.:  
 16 Q. Okay.  
 17 MR. PIKE:  
 18 A. I was focused on the helicopter piece.  
 19 ROIL, Q.C.:  
 20 Q. Yeah. Intuitively would it be a much larger  
 21 number?  
 22 MR. PIKE:  
 23 A. It is a much larger number.  
 24 ROIL, Q.C.:  
 25 Q. Yeah.

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1 MR. PIKE:  
 2 A. We don't or hadn't, prior to March 12th,  
 3 gotten a lot of complaints with regard to  
 4 helicopter flights. There were other  
 5 complaints. There have been a number since  
 6 March the 12th.  
 7 ROIL, Q.C.:  
 8 Q. Okay. But prior to March 12th, it was not a  
 9 significant workload investigating complaints  
 10 about helicopters?  
 11 MR. PIKE:  
 12 A. No.  
 13 ROIL, Q.C.:  
 14 Q. Just, yeah, I wanted to know was it four in  
 15 the total of all were six or was it four and  
 16 the total of all was much larger.  
 17 MR. PIKE:  
 18 A. It was a much larger number.  
 19 ROIL, Q.C.:  
 20 Q. Okay.  
 21 MR. PIKE:  
 22 A. We can certainly get you that larger number,  
 23 but I don't have it.  
 24 ROIL, Q.C.:  
 25 Q. No, and that's fine. I don't think we need

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1 it. I just needed to know order of magnitude.  
 2 MR. PIKE:  
 3 A. It was not a significant issue among our  
 4 complaints piece. It wouldn't have triggered  
 5 -- you know, we had so many complaints about  
 6 helicopters, it wouldn't trigger additional  
 7 action from that regard.  
 8 ROIL, Q.C.:  
 9 Q. Thank you. Okay, perhaps we'll now move from  
 10 complaints into the issue of audits, and so  
 11 we'll go back -- close that out and we'll go  
 12 back to the PowerPoint and then you can  
 13 control it.  
 14 MR. PIKE:  
 15 A. Okay.  
 16 ROIL, Q.C.:  
 17 Q. And again, I think you have a summary slide  
 18 and I have some questions to ask once you get  
 19 to this.  
 20 MR. PIKE:  
 21 A. Three-step process, the pre-audit procedures,  
 22 the audit procedures and then post-audit. The  
 23 Ocean Ranger Commission report on  
 24 recommendation 91 talked in terms of safety  
 25 audits and safety assessments. So it was from

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1 that report we started looking at safety  
 2 audits of the management systems. So in 1988,  
 3 not long after the Board was formed, we  
 4 engaged the International Loss Control  
 5 Institute. It was an organization in Georgia  
 6 that had what they referred to as a safety  
 7 rating system for safety management systems.  
 8 So we engaged them to help us develop an audit  
 9 process for safety management systems.  
 10 Principally, they designed it for operators,  
 11 but we were trying to adapt it for a  
 12 regulator. Take a look at those things.  
 13 Over the intervening years, we've adapted  
 14 to it. It had its limitations. It was based  
 15 on their management model and not all  
 16 management models were the same, so it -- you  
 17 didn't necessarily get an objective view of  
 18 the thing. So over the years, we've developed  
 19 it and the current procedure that we use was  
 20 established in 1999 and we're currently on  
 21 revision 17. So we're constantly looking at  
 22 ways to improve this process. Indeed, we also  
 23 have a draft integrated audit procedure. I  
 24 think we talked a little bit about that. We  
 25 were working together with our environmental

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1 affairs folks to do a more fulsome look at the  
 2 management system of the operator and we're  
 3 still working on that process.  
 4 We also then identified and developed an  
 5 inspection procedure. The process is  
 6 different but very, very similar between the  
 7 two. So we'll talk about the safety audit  
 8 process. We started in this process where we  
 9 -- the safety officers would take ownership of  
 10 an element within the safety management system  
 11 and they would go to each installation taking  
 12 a look at that element. So they were focused  
 13 audits against a particular element in the  
 14 safety management system.  
 15 ROIL, Q.C.:  
 16 Q. By the expression "element" what do you mean?  
 17 What would an element be, by way of example?  
 18 MR. PIKE:  
 19 A. Some of the hazard pieces like, you know, they  
 20 may focus on the control of work system, the  
 21 job safety analysis parts of those. So the  
 22 control of work piece and a number of those  
 23 would be covered under one element.  
 24 ROIL, Q.C.:  
 25 Q. Okay.

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1 MR. PIKE:  
 2 A. So the safety officer would be going to each  
 3 of the installations looking at their control  
 4 of work system.  
 5 ROIL, Q.C.:  
 6 Q. Okay.  
 7 MR. PIKE:  
 8 A. The idea being that with -- once you get all  
 9 the elements, you get the complete picture.  
 10 We were finding that we weren't -- as I  
 11 identified back in October, we weren't  
 12 completing it. What we now do is assign the  
 13 safety officer to an installation or an  
 14 authorization. That does a couple of things  
 15 for us. They have a better appreciation of  
 16 what's going on on that installation. The  
 17 other thing that's happened, and it's a  
 18 positive piece, is there's a rapport built  
 19 with the workforce. So the workers are much  
 20 more prone now to call the safety officer if  
 21 they have an issue because they know who the  
 22 individual is and they know how to get a hold  
 23 of them. So we do get now, with this system,  
 24 workers phoning the safety officer saying "did  
 25 you know" and there's a dialogue that has

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1 developed with the workers on those  
 2 installations.  
 3 The second piece we do is we don't leave  
 4 a safety officer there indefinitely. We do  
 5 move them around to different installations.  
 6 You don't want to become too familiar, as it  
 7 were.  
 8 ROIL, Q.C.:  
 9 Q. So familiarity is a benefit until it becomes  
 10 over familiar?  
 11 MR. PIKE:  
 12 A. That's correct. So there's a balancing act to  
 13 be done in there.  
 14 ROIL, Q.C.:  
 15 Q. Yes.  
 16 MR. PIKE:  
 17 A. And we do develop an annual audit plan and I  
 18 think if we take a look at Exhibit 206, we can  
 19 take a look at a clean version of an audit  
 20 plan. As with any plan, at the beginning of  
 21 the year, and our year runs April 1st to March  
 22 31st, we would develop a plan as to how and  
 23 what we would audit.  
 24 ROIL, Q.C.:  
 25 Q. So is this the plan or is this the reality and

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1 is there any relationship between them? Do  
 2 they -- do plans change much?  
 3 MR. PIKE:  
 4 A. Plans change.  
 5 ROIL, Q.C.:  
 6 Q. Yeah.  
 7 MR. PIKE:  
 8 A. At the beginning of the year, you'll notice  
 9 there's quite a number of geophysical programs  
 10 in here. We are guessing as to how many  
 11 geophysical programs are going to take place.  
 12 We try to identify when they're going to take  
 13 place so we can get resources available to  
 14 take a look and do the safety assessment and  
 15 indeed if it's required, a pre-audit of that  
 16 piece. So we need to put those in. Is there  
 17 a construction activity? We see in here a  
 18 diving program. So that would require a  
 19 safety assessment as well, usually done during  
 20 the summer months when the weather conditions  
 21 are conducive to that. And in between these  
 22 pieces, we'll try to fit in the regular visits  
 23 we have to the production facilities. So it's  
 24 a way of balancing our workload and as we  
 25 indicated, it is a plan. So things change and

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1 some audits get moved or inspections get  
 2 moved. But this is an indication of between -  
 3 - I think it goes from April 2007 up until  
 4 October 2009 of the type audits that we did in  
 5 that period.  
 6 ROIL, Q.C.:  
 7 Q. So yeah, these are safety assessments I think  
 8 is the heading of it.  
 9 MR. PIKE:  
 10 A. Yes, safety assessments, I'm sorry, and  
 11 there's a second page -  
 12 ROIL, Q.C.:  
 13 Q. Are they pre -- sorry, just go back. Try to  
 14 remember our jargon.  
 15 MR. PIKE:  
 16 A. Yeah, sorry.  
 17 ROIL, Q.C.:  
 18 Q. Is a safety assessment performed before an  
 19 activity takes place?  
 20 MR. PIKE:  
 21 A. Yes.  
 22 ROIL, Q.C.:  
 23 Q. Okay.  
 24 MR. PIKE:  
 25 A. This would be the activity -- that's the

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1 operation we would be doing when we have an  
 2 application for an authorization.  
 3 ROIL, Q.C.:  
 4 Q. So if I can corrupt the language and internal  
 5 auditors will kill me, is this like an audit  
 6 of the plan or the approach?  
 7 MR. PIKE:  
 8 A. Yes.  
 9 ROIL, Q.C.:  
 10 Q. An audit of the paper trail, if you will?  
 11 MR. PIKE:  
 12 A. Yeah.  
 13 ROIL, Q.C.:  
 14 Q. Okay.  
 15 MR. PIKE:  
 16 A. That's the application.  
 17 ROIL, Q.C.:  
 18 Q. Yeah.  
 19 MR. PIKE:  
 20 A. They made an application and this is the  
 21 audit, if you will, of the application.  
 22 ROIL, Q.C.:  
 23 Q. Right, okay.  
 24 MR. PIKE:  
 25 A. Sometimes in these, we would also have an

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1 actual on board audit associated with it and  
 2 so in certain cases, for a geophysical  
 3 program, we actually may go on board before as  
 4 part of the safety assessment.  
 5 ROIL, Q.C.:  
 6 Q. If the vessel -  
 7 MR. PIKE:  
 8 A. Just to complicate things.  
 9 ROIL, Q.C.:  
 10 Q. If the vessel or vehicle is not in  
 11 Newfoundland, do you actually send people to  
 12 other parts of the world?  
 13 MR. PIKE:  
 14 A. We have. We would tend to do that more for  
 15 say a diving support vessel. We would want to  
 16 look at those and indeed we encourage to take  
 17 a look at those and we usually do that some  
 18 months in advance, just in case we identify  
 19 something that needs to be corrected. It'll  
 20 give them time to correct it before it arrives  
 21 here. Instead of having one of these vessels  
 22 tied up down in the harbour while they make  
 23 the correction, they can do it in the  
 24 intervening period. So we will sometimes take  
 25 a look at these vessels some months in

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1 advance, more particularly with things like  
 2 diving programs, you know. There's a fair  
 3 level of hazard associated with diving  
 4 operations and we want to make sure we get  
 5 those right.  
 6 ROIL, Q.C.:  
 7 Q. Okay. So this page is the safety assessments.  
 8 I think, do we have another -  
 9 MR. PIKE:  
 10 A. And that would be an indication of the number  
 11 of applications that we have for  
 12 authorization. The next page -  
 13 ROIL, Q.C.:  
 14 Q. The font is getting smaller, but I think it  
 15 says audits and inspections.  
 16 MR. PIKE:  
 17 A. Correct.  
 18 ROIL, Q.C.:  
 19 Q. Okay.  
 20 MR. PIKE:  
 21 A. And again, that goes from the April 2007 up to  
 22 October 2009.  
 23 ROIL, Q.C.:  
 24 Q. Now what resources do you have available to  
 25 you to carry out this work? Who are the

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1 personnel and what resources do they have to  
 2 carry on these safety assessments, audits and  
 3 inspections?  
 4 MR. PIKE:  
 5 A. We have a number of safety officers. We  
 6 currently have four safety officers and a  
 7 senior safety advisor. We have a well  
 8 operations engineer who was one of our safety  
 9 officers. We had some personnel changes in  
 10 the fall. Our previous senior drilling  
 11 engineer became the manager industrial  
 12 benefits, which left a vacancy and one of our  
 13 safety officers was moved into the well  
 14 operations engineer piece, which left us with  
 15 two vacancies for safety officers. We are  
 16 currently recruiting for those. We've hired  
 17 one. He started on Monday and we are still  
 18 recruiting for a second position.  
 19 ROIL, Q.C.:  
 20 Q. Do you have a lot of turnover of your safety  
 21 officers or do they tend to stay for a  
 22 relatively long period of time?  
 23 MR. PIKE:  
 24 A. My department have -- they tend to stay for a  
 25 longer period of time. There is some

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1 turnover, but not a high turnover.  
 2 ROIL, Q.C.:  
 3 Q. Okay.  
 4 MR. PIKE:  
 5 A. Luckily.  
 6 ROIL, Q.C.:  
 7 Q. And what sort of -- I think we talked about  
 8 this before, but I'll focus the discussion.  
 9 What sort of skill sets and backgrounds do  
 10 these people have, not individuals, but  
 11 generally what kind of backgrounds do they  
 12 have when they come to you as a safety  
 13 officer?  
 14 MR. PIKE:  
 15 A. All of them have post-secondary degrees. Some  
 16 of them have graduate degrees. There are --  
 17 I'm trying to remember. A number of us are  
 18 professional engineers as well. All the  
 19 safety officers are registered, Canadian  
 20 registered safety professionals, so CRSP  
 21 designation and they've done extensive  
 22 training. Normally when we hire a safety  
 23 officer, it takes us a full year to fully  
 24 implement a training program and to bring them  
 25 up to be fully recognized as a safety officer.

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1 ROIL, Q.C.:  
 2 Q. Is there another industry that you can steal  
 3 from to get resources or do you have to tend  
 4 to train them a bit from within?  
 5 MR. PIKE:  
 6 A. The quickest we've ever done in the training  
 7 of a safety officer was the secondee we had  
 8 from Labour Canada, and I think that was a  
 9 matter of months, given the skill set that he  
 10 came in with. We had to reacquaint him with  
 11 the industry. It had been some time since he  
 12 worked in the industry, so it was the  
 13 technical side that we were working with him  
 14 on that, but he brought the skill sets from  
 15 the regulator. He already had those. If we  
 16 hire an individual from the industry, he has  
 17 the technical skill sets, but he doesn't have  
 18 the regulatory skill sets. So it'll take us  
 19 some time to invest in training on the  
 20 regulatory skill sets. So again, ordinarily  
 21 it'll take us a year to complete at least the  
 22 entry level training for a safety officer.  
 23 ROIL, Q.C.:  
 24 Q. Okay now, just before we go to break, to focus  
 25 it down a little more on the areas that we

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1 have immediate concern for. What skill sets  
 2 do they have or in your view are necessary or  
 3 what resources do they have available to them  
 4 to assist them in aviation type audits, in  
 5 fact audits and inspections of processes and  
 6 workplaces that are dealing with flying  
 7 helicopters?  
 8 MR. PIKE:  
 9 A. Well, the engineers have a technical  
 10 background, so they understand some of these  
 11 elements, but they're not aviation people. We  
 12 have, on a regular basis, I'll talk to that,  
 13 communications with Transport Canada Aviation  
 14 in Moncton. Indeed, when we were doing the  
 15 work refusals, we had extensive discussions  
 16 with the aviation specialist with Transport  
 17 Canada in Moncton. In addition to that,  
 18 during that period, we also had discussions  
 19 with the Transportation Safety Board to  
 20 identify -- you know, we gave them an -- told  
 21 them what we were dealing with and what  
 22 elements were there. We went to some of our  
 23 international colleagues and attempted to get  
 24 some additional information there. So they  
 25 were assembling it from different sources. We

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1 don't actually possess the technical piece,  
 2 but we talked to the technical experts and  
 3 they have been very forthcoming.  
 4 ROIL, Q.C.:  
 5 Q. If you look at a safety plan or a safety -- an  
 6 operations manual or a safety management  
 7 system, does the fact that it is an aviation  
 8 piece, as opposed to some other industrial  
 9 piece, does that change things entirely or are  
 10 there similarities in the approach?  
 11 MR. PIKE:  
 12 A. Similarities in the approach. We would use --  
 13 our focus when we look at some of the  
 14 helicopter operations would be the helideck.  
 15 There are some standards that we look at. If  
 16 there are any questions, more detailed  
 17 questions that we have or something doesn't  
 18 quite look right, we'll have discussions then  
 19 with Transport Canada Aviation. We'll say  
 20 "we've seen this. Is this right? What are we  
 21 looking for?" They've been looking now --  
 22 most of the safety officers, a number of them  
 23 have been there since the beginning of the  
 24 Board, have seen a number of helidecks so they  
 25 understand those elements. We've also

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1 attended the helicopter landing officer  
 2 training courses out at the Marine Institute.  
 3 So they have some familiarity with it and when  
 4 they start seeing things that don't look quite  
 5 right and they want additional information, we  
 6 will contact the experts at Transport Canada.  
 7 ROIL, Q.C.:  
 8 Q. And is it clear to them that they have the  
 9 authority to do that, to go wherever they  
 10 need?  
 11 MR. PIKE:  
 12 A. Yes, no question.  
 13 ROIL, Q.C.:  
 14 Q. Okay. This might be a good place,  
 15 Commissioner, to take our morning break.  
 16 Thank you.  
 17 (BREAK)  
 18 MR. PIKE:  
 19 A. If we could take a moment, Mr. Roil, I got  
 20 some information for you during the break on  
 21 the number of complaints. We get an average  
 22 of seven to eight complaints per year. In  
 23 2006, we had 13. 2007, we had nine. 2008, we  
 24 had three. 2009, we had 11 and so far we've  
 25 had one this year.

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1 ROIL, Q.C.:  
 2 Q. And in terms of that total number, we have  
 3 four or five overall?  
 4 MR. PIKE:  
 5 A. For helicopter operations?  
 6 ROIL, Q.C.:  
 7 Q. For helicopter operations.  
 8 MR. PIKE:  
 9 A. Yes.  
 10 ROIL, Q.C.:  
 11 Q. Okay, that's useful. Thank you. Okay, I  
 12 think we can go back to the PowerPoint now and  
 13 to the audits slides and you can take us  
 14 through, as we discussed, we'll go back and  
 15 look at a couple of audits in some degree of  
 16 detail, not intense, but you can take us  
 17 through the explanation of the audit processes  
 18 first.  
 19 MR. PIKE:  
 20 A. Pre-audit process procedure set the focus and  
 21 scope of the audit. Obviously in earlier days  
 22 when we had a focused piece, this became more  
 23 relevant, but it kicks in also from our audit  
 24 plan as to what it is we're going to be  
 25 looking at. Is it an inspection? Is it a

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1 full-blown audit? Is it a focus piece?  
 2 Sometimes we'll go out and take a look at the  
 3 lifting operations. That's another one of the  
 4 projects that the International Regulators  
 5 Forum has engaged in. They identified  
 6 internationally that there were problems  
 7 associated with the lifting operations. So  
 8 that's moving -- logistically moving cargo off  
 9 the supply boats onto the installations and  
 10 the operation of the cranes. So we've done  
 11 some of those focused audits in that regard.  
 12 ROIL, Q.C.:  
 13 Q. So an audit can be an audit of the entire  
 14 operation or a segmental piece?  
 15 MR. PIKE:  
 16 A. Yes, or down to just the inspection, and  
 17 inspections tend to be more of a follow up.  
 18 There's been a previous audit. There's some  
 19 open observations we want to take a look at  
 20 it. It's opportunity to sit down with the  
 21 Joint Occupational Health and Safety committee  
 22 and to see what's going on. So the  
 23 inspections are a much narrower piece usually.  
 24 So in that process, they know what it is  
 25 they're looking for. They'll sit down and



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1 start collecting some of the information and  
 2 reviewing it.  
 3 The safety assessment of the  
 4 authorization, we'll take a look at that as we  
 5 look at a more detailed piece or certainly in  
 6 some of the audits we supplied. You will see  
 7 in there the safety assessment process is  
 8 looked at. It helps us also to quickly  
 9 identify where those specific elements are  
 10 covered by the operator, what manual or  
 11 document they've used to cover those elements  
 12 and where we would go to look for it.  
 13 The previous safety audit file. So we  
 14 would take a look at the file or more  
 15 particularly these days, the database, to see  
 16 what was happening previously.  
 17 We would look at the daily reports.  
 18 We'll talk a little bit more about those a bit  
 19 later. So to see what the current operational  
 20 activities are. So what's going on? What  
 21 equipment is shut down? What equipment is  
 22 operating? In the case of a drilling  
 23 operation, where are they in the well? What  
 24 type activities are taking place? That might  
 25 also help us frame the focus of the audit as

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1 to what's happening on board.  
 2 We have the regulatory equivalencies. We  
 3 talked a little bit about those back in  
 4 October. There may be some conditions  
 5 associated with those equivalencies where the  
 6 operator has come in to make an application to  
 7 use a procedure or a standard other than the  
 8 one that's listed in the regulation. There  
 9 may be certain conditions associated with  
 10 that. So we'll follow up on those conditions  
 11 to see if they're being followed up.  
 12 COMMISSIONER:  
 13 Q. So you always monitor what's going on then on  
 14 the platforms?  
 15 MR. PIKE:  
 16 A. Yes, through the daily reports.  
 17 COMMISSIONER:  
 18 Q. Yes.  
 19 MR. PIKE:  
 20 A. I won't say we do it every day, but regularly  
 21 the safety officer assigned to that  
 22 installation will take a look at the daily  
 23 reports.  
 24 ROIL, Q.C.:  
 25 Q. And later in the presentation, Commissioner,

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1 we'll deal with a little more detail on what  
 2 is involved there.  
 3 COMMISSIONER:  
 4 Q. Okay.  
 5 MR. PIKE:  
 6 A. Yeah. The certificate of fitness, we've  
 7 talked a little bit about that previously as  
 8 well. Certificate of fitness may have  
 9 limitations associated with it.  
 10 ROIL, Q.C.:  
 11 Q. That's the one issued by the certifying  
 12 authority, like Lloyd's Register?  
 13 MR. PIKE:  
 14 A. The independent third party verification.  
 15 ROIL, Q.C.:  
 16 Q. Right.  
 17 MR. PIKE:  
 18 A. They may have certain limitations associated  
 19 with that certificate. So we'll take a look  
 20 at those limitations and we'll frequently have  
 21 some discussion with the certifying authority  
 22 as to what the status is there. And sometimes  
 23 what we're doing as well in there is actually  
 24 verifying what the certifying authority is  
 25 doing. So again, we're following up on the

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1 activities of the certifying authority. So  
 2 sometimes it's associated with the operator.  
 3 Sometimes it's associated with what the third  
 4 party verifier is doing, verifying the  
 5 verifier, if you will.  
 6 The incident notifications. We've gone  
 7 through incidents, so we will take a look at  
 8 those associated with the installation and if  
 9 there's any follow up to be done in those  
 10 reports.  
 11 ROIL, Q.C.:  
 12 Q. And what about the complaints?  
 13 MR. PIKE:  
 14 A. Complaints would be looked at as well,  
 15 correct. The monthly statistical report,  
 16 that's the occupational safety type issues,  
 17 the lost times, et cetera. Monthly the  
 18 operator -- we'll talk actually about those a  
 19 little bit later. We'll take a look at that  
 20 to see if there's some trends in there that we  
 21 need to take a look at.  
 22 We'll take a look at the joint  
 23 occupational health and safety committee  
 24 minutes. Is there some items in there that,  
 25 you know, seem to have been on there for a

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1 long time or, you know, is there something  
 2 going on there? So we'll take a look at those  
 3 as well.  
 4 And any conditions of the approval or the  
 5 authorization, we'll take a look at those and  
 6 there may be some things we need to follow up.  
 7 So we may do all or part of that, but that's  
 8 part of the background piece that the safety  
 9 officer will do as they prepare for that  
 10 audit.  
 11 ROIL, Q.C.:  
 12 Q. And so the dedicated safety officer to this  
 13 audit will actually go through this kind of  
 14 process?  
 15 MR. PIKE:  
 16 A. Yes, and normally these days, we actually use  
 17 two safety officers for the audit. When we  
 18 first started, in the audit we have here from  
 19 1999, it would have been a single safety  
 20 officer. Talk about it here or later on in  
 21 the process. What we did then was sent out a  
 22 single safety officer. They prepared a non-  
 23 compliance report, the table that we'll see,  
 24 and they prepared it before they left. In  
 25 hindsight, that was probably a bit much to ask

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1 of an individual on a single trip, so what  
 2 they do now is we usually send out two, if  
 3 it's a safety audit, and while they'll give a  
 4 preliminary report on some of the observations  
 5 they've seen on board before they leave, they  
 6 actually prepare the report when they return  
 7 to the beach, and we'll talk a little bit more  
 8 about that.  
 9 ROIL, Q.C.:  
 10 Q. Okay.  
 11 MR. PIKE:  
 12 A. So they'll develop some checklists, and again,  
 13 checklist is a tool. It's not the -- it's  
 14 more a prompt for the safety officer to make  
 15 sure they cover off all the elements, as  
 16 opposed to tick the box and everything is  
 17 right. It's really a prompt about the things  
 18 that they need to be looking at. So they take  
 19 those checklists for the relevant legislation  
 20 and the guidance from the operator's own  
 21 policies and procedures, what they've  
 22 committed to do, and we do have a database,  
 23 another database, not surprising, of  
 24 questions. So they can pull from a rather  
 25 extensive database of questions to ask for

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1 particular elements.  
 2 Review the outstanding items from the  
 3 previous audit with the initiating safety  
 4 officer. Again, this is a legacy from the  
 5 time when we were doing it by element.  
 6 Although sometimes if that safety officer  
 7 wasn't the one that was on the last time, they  
 8 will talk to them. So it's to make sure they  
 9 understood what the observations were that  
 10 were being carried forward that they need to  
 11 look at. So they would talk to the safety  
 12 officer who had done it previously.  
 13 We would then notify the operator and  
 14 make arrangements for the audit. So generally  
 15 we would notify the safety officer some two  
 16 weeks in advance and then work out what the  
 17 logistics are for getting offshore.  
 18 ROIL, Q.C.:  
 19 Q. What about the wisdom or ability of a snap  
 20 audit, of an unannounced audit? Is that  
 21 something that you can do in the world that  
 22 you work in?  
 23 MR. PIKE:  
 24 A. It's virtually impossible in the offshore  
 25 area. Even if we had our own helicopters, as

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1 soon as we show up at the heliport somebody  
 2 knows we're going out and they'll know --  
 3 they'll have an hour and a half warning  
 4 anyway. So what we've tended to do is do more  
 5 extensive audits, dig deeper and look for the  
 6 things that you can't simply -- we lift up the  
 7 rug, as it were.  
 8 ROIL, Q.C.:  
 9 Q. Not suggesting that anybody would sweep dust  
 10 under the rug, but you're saying if they do -  
 11 MR. PIKE:  
 12 A. If you dig deep enough in your audits, then  
 13 you're looking for those things and that's the  
 14 process we've taken. We have not actually  
 15 shared our annual audit plan with the  
 16 operators. We would generally -- they would  
 17 generally know that we would be looking at  
 18 their facility once sometime during the  
 19 quarter and we would give them advance notice  
 20 to the make the logistical arrangements for  
 21 that.  
 22 COMMISSIONER:  
 23 Q. This may not be a fair question, and tell me  
 24 if it isn't, but the standard of -- I mean,  
 25 we've heard of lots of audits of all kinds, of

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1 Cougar, of the rigs, a lot of audits. In your  
 2 view, are the standards high of these audits  
 3 that various entities conduct or would you  
 4 know anything about that?  
 5 MR. PIKE:  
 6 A. As with any audits, there's varying qualities  
 7 of those. It depends on what the purpose and  
 8 the scope of the audit is. So they vary.  
 9 Some of them have been good, but it depends on  
 10 what it is you're seeking to do. It's the  
 11 goal of that audit that really needs to be  
 12 clearly articulated.  
 13 COMMISSIONER:  
 14 Q. I see, yes, yes.  
 15 MR. PIKE:  
 16 A. So in most cases, they meet the goal, but  
 17 whether the goal is high enough is the  
 18 question probably to be asked. We've  
 19 certainly -- with regard to Cougar, we've been  
 20 impressed with the audits we've seen that have  
 21 taken place of Cougar from the operators and  
 22 from others, if that answers your question.  
 23 COMMISSIONER:  
 24 Q. Thank you.  
 25 MR. PIKE:

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1 A. They're fairly extensive and I think in some  
 2 of our safety audits, you'll see that we  
 3 actually took a look at some of the checklists  
 4 that are used by the operators when they go  
 5 and take a look at Cougar's operations, and  
 6 they're fairly extensive.  
 7 We would identify that -- there's opening  
 8 and closing meetings and we would identify  
 9 that we would like to see the OIM, the person  
 10 in charge offshore and the senior operator  
 11 representative. Those are busy people  
 12 offshore and we want to make sure that they're  
 13 present during our opening and closing  
 14 meetings, and we would also ask that a worker  
 15 representative from the Joint Occupational  
 16 Health and Safety Committee be present at  
 17 those meetings as well. So we identify those  
 18 parameters upfront before we arrive offshore.  
 19 ROIL, Q.C.:  
 20 Q. Okay. Do you have any evidence, anecdotal or  
 21 otherwise, as to the amount of participation?  
 22 Do generally the worker representatives get  
 23 engaged with this process?  
 24 MR. PIKE:  
 25 A. Yes, they do. I'm not aware of an opening

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1 meeting that hasn't taken place without a  
 2 worker representative present. That said, in  
 3 the offshore. The onshore component is a  
 4 little more difficult, but offshore, no  
 5 opening meeting has taken place without a  
 6 worker representative present.  
 7 So the audit procedure. Once we arrive  
 8 offshore, we would hold an opening meeting.  
 9 So we would explain the focus and the timing  
 10 of the audit, finalize the agenda. We would  
 11 have established an agenda. We may have  
 12 shared it with the operator beforehand, again  
 13 to try to line up some of the people we may  
 14 want to see. It's a very busy operation  
 15 offshore and you don't want to be too  
 16 disruptive when you're out there, so we give  
 17 them some advance warning as to some of the  
 18 people we may want to see. So we line up and  
 19 make sure we've got that done. We do make an  
 20 offer to the worker representative, an  
 21 opportunity to observe the audit, if they so  
 22 choose.  
 23 ROIL, Q.C.:  
 24 Q. And again, do you know anything about the take  
 25 up on that? Is that something that you have

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1 seen or heard reported?  
 2 MR. PIKE:  
 3 A. No, they have not. It's -- the other thing  
 4 offshore, it's like any small community.  
 5 Everybody knows what that stranger on board is  
 6 doing anyway. So they have a very good idea  
 7 of where we are, what we're doing and they can  
 8 certainly approach us at any time during that  
 9 period or at some point.  
 10 ROIL, Q.C.:  
 11 Q. So a safety officer from the C-NLOPB is a  
 12 known commodity when he or she is doing an  
 13 audit?  
 14 MR. PIKE:  
 15 A. Anybody new offshore is recognized as somebody  
 16 new, but yes, we are known. And more  
 17 recently, we have -- our offshore clothing has  
 18 actually identified us as C-NLOPB as well. So  
 19 we'll discuss the closure of items from the  
 20 previous audit. So we'll review some of the  
 21 items that were opened and how they've closed  
 22 them and that we'll be taking a look at those.  
 23 We'll offer to meet with the full Joint  
 24 Occupational Health and Safety Committee and  
 25 we also arrange a private meeting with the

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1 worker representatives of the Joint  
 2 Occupational Health and Safety Committee, and  
 3 again, that's always taken place for each of  
 4 the audits and inspections that we do  
 5 offshore, and then we will schedule the  
 6 closing meeting.  
 7 ROIL, Q.C.:  
 8 Q. I don't know if this is the right place to  
 9 ask, but is there any period of time that it  
 10 takes to do an audit or does the time tie to  
 11 the size of the mandate? Are we talking an  
 12 audit takes a day or a week or a month, or the  
 13 inspection, this offshore inspection process?  
 14 MR. PIKE:  
 15 A. When we're doing a fully integrated audit,  
 16 actually four officers go offshore, so we can  
 17 cover a fair amount of ground in a three to  
 18 four-day period. So one of those audits would  
 19 probably last three to four days offshore.  
 20 ROIL, Q.C.:  
 21 Q. Um-hm.  
 22 MR. PIKE:  
 23 A. A more focused audit may take us two days  
 24 offshore. An inspection might be a day or  
 25 two. So depending on how much material they

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1 have to review will dictate how long we stay  
 2 offshore. But generally it'll be two days.  
 3 So one of the things we do when we're  
 4 offshore is verify the completion items from  
 5 the previous audit. You'll see as we go  
 6 through and look at some of the detailed  
 7 audits, the audit -- the operator may consider  
 8 an item closed but we won't close it sometimes  
 9 until we actually go offshore and verify it.  
 10 So they will have done their work. We'll go  
 11 out and just verify that what they've said  
 12 they've done, they've actually done. So  
 13 that's what's happening in this phase. And  
 14 any of the items that are not closed will be  
 15 brought forward in the current audit. So that  
 16 way we're able to close the previous audit and  
 17 we carry that observation forward.  
 18 We meet with the medical advisor or the  
 19 platform nurse. I was corrected at that at  
 20 one of our annual JOHS sessions. Indeed that  
 21 individual said that they had some information  
 22 that would be valuable to us and since that  
 23 time, we've actually made a point of meeting  
 24 with the platform nurse to talk about the  
 25 occupational health issues. The occupational

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1 health is frequently one of the forgotten  
 2 things in the occupational health and safety  
 3 system. So that's an opportunity to have that  
 4 discussion with the platform nurse as to the  
 5 health issues that are going on on the  
 6 installation. So we make a point of meeting  
 7 with the platform nurse.  
 8 Then we would conduct the audit against  
 9 the agenda and the checklist. So we would go  
 10 through and we would have identified that,  
 11 when we were going to visit, where and that  
 12 would be followed through.  
 13 All non-conformances are to be documented  
 14 and we have -- currently we have a two-part  
 15 system. An observation is an objective  
 16 statement of the fact and the finding would be  
 17 more of a conclusion. We're actually  
 18 reviewing that piece to see if we can do --  
 19 maybe break it down a little bit more. The  
 20 statement of fact might be if we're looking at  
 21 the control of work system, for example, and  
 22 we go out, we take a look at some of the  
 23 permits that have been issued as part of the  
 24 control of work system. We note that the  
 25 signatures aren't complete or they didn't, you

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1 know, fill in the job safety analysis. That  
 2 would be an observation. If we've gone  
 3 through and seen that there are numerous ones  
 4 in numerous permits, that could be a finding  
 5 to say that you've got a problem with your  
 6 permit to work system. If we look at a number  
 7 of permits and see a number of issues raising  
 8 is the permit to work system actually working  
 9 well.  
 10 ROIL, Q.C.:  
 11 Q. Okay. So a series of observations could give  
 12 rise to a finding?  
 13 MR. PIKE:  
 14 A. Correct, or you may have a finding in and of  
 15 itself. If we come across something that is  
 16 significant enough that this is a problem,  
 17 we'll raise it as a finding in and of itself.  
 18 But for the most -  
 19 ROIL, Q.C.:  
 20 Q. So a single event can trigger a finding?  
 21 MR. PIKE:  
 22 A. It can. But for the most case, it's usually a  
 23 series of observations will lead you to a  
 24 conclusion about whether something is  
 25 functioning or not. So if we go out, and

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1 let's say in one of those permits, we'll  
 2 looking a job site and we have a problem with  
 3 a confined space entry and they aren't  
 4 following the full procedure, that could be a  
 5 finding in and of itself or it may actually  
 6 result in an order to stop what you're doing.  
 7 We'll talk about the enforcement provisions  
 8 further on or if we're looking at a  
 9 scaffolding operation and we have a certain  
 10 concern with how it's going on, there could be  
 11 a finding related to it or a stop order  
 12 issued. And then we would hold a closing  
 13 meeting where the OIM is present, again the  
 14 senior operator representative. Some of the  
 15 installations, that's one and the same person.  
 16 In others, where you have a drilling unit, the  
 17 OIM is more than likely the drilling  
 18 contractor's employee, and we would have a  
 19 senior operator representative. Again, the  
 20 worker representative would be present and we  
 21 would review -- currently we would review some  
 22 of the observations we've seen in a more draft  
 23 way, sort of a preliminary piece without  
 24 coming to some of the conclusions.  
 25 But in earlier days, we would have

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1 presented the table of non-compliances --  
 2 would have been presented at that time and  
 3 would have been signed off by the parties.  
 4 ROIL, Q.C.:  
 5 Q. Yeah. I think you told us earlier that there  
 6 was a time when the officer or officers had to  
 7 do that before they left the facility.  
 8 MR. PIKE:  
 9 A. Correct.  
 10 ROIL, Q.C.:  
 11 Q. Now you're saying they have the meeting, but  
 12 they reserve the sign off until after they get  
 13 back?  
 14 MR. PIKE:  
 15 A. After they get back, yeah. And that gets us  
 16 into the post-audit procedures. Even in the  
 17 earlier days, we would prepare a report or a  
 18 memo on what happened. If you look at the one  
 19 we have here from 1999, the focus there is on  
 20 the things we saw wrong as opposed to the full  
 21 scope, but they would do a memo up  
 22 highlighting some of the areas that were  
 23 included in the plan. They'd note -- and it  
 24 was done as an internal memo -- note if any  
 25 conditions of approval were verified, note on

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1 the follow up incidents.  
 2 Today what we do is we actually produce  
 3 that summary and it is given to the operator  
 4 as well and as an attachment to that piece,  
 5 that non-compliance table is attached to that  
 6 report. So it's a more complete picture of  
 7 what it is we've looked at. So they would  
 8 also note the things that we didn't find  
 9 anything, any non-compliances with.  
 10 ROIL, Q.C.:  
 11 Q. Okay. So in the evolving piece of audits,  
 12 there was a time you'd only notice the --  
 13 you'd only record the problems?  
 14 MR. PIKE:  
 15 A. Yes.  
 16 ROIL, Q.C.:  
 17 Q. And then what, the ones that weren't problems  
 18 were assumed to be okay?  
 19 MR. PIKE:  
 20 A. And if you go back to those, it's a little  
 21 more difficult to see what the full gamete of  
 22 what they looked at were because we were  
 23 really only recording the problems, as it  
 24 were, as opposed to the full scope of what we  
 25 were looking at. So today, we're trying to

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1 give the full scope and then say these are the  
 2 problem areas we found within that full scope.  
 3 So it gives you a more complete picture,  
 4 particularly when you're going back to look at  
 5 an audit, a previous audit.  
 6 ROIL, Q.C.:  
 7 Q. Right.  
 8 MR. PIKE:  
 9 A. After they've prepared that report, they'll  
 10 meet with the chief safety officer to discuss  
 11 the audit. So they'll go through what they  
 12 saw, what their impressions were and we'll  
 13 discuss that audit report before it's actually  
 14 transmitted to the operator. So they'll enter  
 15 the observations and findings into the audit  
 16 summary database, again another database. So  
 17 we keep all our observations and findings in a  
 18 database and we'll take a look at one of those  
 19 when it comes up in a moment.  
 20 So we now arrange -- and certainly, in  
 21 earlier days, when they did it before they  
 22 left, it was in that closing meeting. Now we  
 23 arrange for a meeting onshore with the  
 24 operator. Sometimes the offshore will tele-  
 25 conference in. So in that meeting, we provide

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1 and review a copy of the safety audit report,  
 2 including the non-compliance report. So  
 3 that's the table that appears in it, and so  
 4 it's provided to the operator. We request  
 5 that a copy be sent offshore to the OIM and  
 6 the Joint Occupational Health and Safety  
 7 Committee.  
 8 I will try to attend these meetings, but  
 9 I don't always get that opportunity. I  
 10 certainly will attend any meeting that  
 11 involves a finding. So if we have a finding,  
 12 I make a special effort to make sure I attend  
 13 those meetings. Again, we will file the audit  
 14 and supporting documentation.  
 15 Initial and close any items from the  
 16 previous audit. So that audit non-compliance  
 17 table will be either -- will be filled out,  
 18 noted as being closed. We verified it or  
 19 we're carrying it forward into the next audit.  
 20 Those notes would appear in the audit file.  
 21 ROIL, Q.C.:  
 22 Q. So I take it from your evidence, and again,  
 23 correct me if I'm wrong, that if there's an  
 24 outstanding item from a previous audit, it  
 25 gets (tape error) one, if it's not closed?

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1 MR. PIKE:  
 2 A. And that gives us -- afford us an opportunity  
 3 to close the previous audit and not lose the  
 4 item.  
 5 ROIL, Q.C.:  
 6 Q. That's my -- my point is the closure entry of  
 7 the previous audit is that it is moved to the  
 8 newer audit?  
 9 MR. PIKE:  
 10 A. Correct.  
 11 ROIL, Q.C.:  
 12 Q. Okay.  
 13 MR. PIKE:  
 14 A. We may have to refer to it later on for the  
 15 detail, but we carry that item forward. It  
 16 allows us to close some of those files, so we  
 17 don't have too many files open.  
 18 ROIL, Q.C.:  
 19 Q. And would you record in the audit that it was  
 20 something carried from an earlier audit? In  
 21 other words -  
 22 MR. PIKE:  
 23 A. Yes.  
 24 ROIL, Q.C.:  
 25 Q. - that it's been outstanding for some time?

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1 MR. PIKE:  
 2 A. Yes, yes. As we go through the table, you'll  
 3 see that we'll note this is from an audit of  
 4 such and such a date and this is the  
 5 observation and the observation number from  
 6 that audit.  
 7 The operator would then respond to those  
 8 non-compliance items identifying corrective  
 9 actions and completion dates. That  
 10 information would also be entered into our  
 11 database and then we would monitor those  
 12 corrective actions and completion, and we can  
 13 take a look at the table, which I think is  
 14 Exhibit 190.  
 15 ROIL, Q.C.:  
 16 Q. Okay, Exhibit 190 we'll call up.  
 17 MR. PIKE:  
 18 A. We were asked to provide the observations that  
 19 have been raised against helicopter  
 20 operations.  
 21 ROIL, Q.C.:  
 22 Q. Okay. So this was the document that you  
 23 prepared in response to a request from one of  
 24 the parties arising out of your earlier  
 25 evidence?

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1 MR. PIKE:  
 2 A. Yeah.  
 3 ROIL, Q.C.:  
 4 Q. Okay.  
 5 MR. PIKE:  
 6 A. Okay, yes. That's just a bit of a summary,  
 7 some of the things we've done. We've tried to  
 8 break down some of those observations.  
 9 ROIL, Q.C.:  
 10 Q. I think that paragraph that starts "since  
 11 1997" I think is worthy of our focusing on for  
 12 a moment.  
 13 MR. PIKE:  
 14 A. Okay. "Since 1997, we've had 178 observations  
 15 and zero findings having been raised against  
 16 helicopters, helicopter transport, helicopter  
 17 operations or helideck and associated  
 18 equipment. The breakdown of the observations  
 19 are as follows." So what we've done there is  
 20 tried to break it out, and again, it becomes  
 21 part of our classification system in the  
 22 observations.  
 23 Under helicopters, there was one instance  
 24 noticed where a helicopter -- when helicopters  
 25 were not fully compliant. That related to the

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1 use of the -- when they brought in an S-61, it  
 2 did not have the high back seats. We normally  
 3 look to have the life rafts deployable  
 4 externally. S-61s have an internal life raft.  
 5 In the end, we accepted the notion that the  
 6 life raft is located next to the exit. Our  
 7 preference is that the life rafts be located  
 8 outside. And there was a note there on the  
 9 auxiliary fuel tank.  
 10 ROIL, Q.C.:  
 11 Q. Again, I don't want us to go down through all  
 12 178 here, but I think this was -  
 13 MR. PIKE:  
 14 A. And then, we've just broken them down again  
 15 and where for helicopter transport, there were  
 16 issues with the public address system. That  
 17 was the previous system, the entertainment  
 18 system, I think Cougar referred to it as.  
 19 There were just -- there were some problems  
 20 with that system that not everybody could hear  
 21 the announcements. Some of the orientations,  
 22 we saw from Cougar's presentation that at the  
 23 heliport there is the video presentation.  
 24 Well, on occasions, the video doesn't match if  
 25 you're using -- if the videos are geared to

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1 the Super Puma and we've now introduced an S-  
 2 61, you might miss it on the first couple. So  
 3 there's sometimes those pieces need to be  
 4 updated in those videos.  
 5 ROIL, Q.C.:  
 6 Q. To accumulate this exhibit that you've  
 7 prepared for us, was there a particular  
 8 databank you could go to or did you have to -  
 9 MR. PIKE:  
 10 A. As I indicated, we enter all our observations  
 11 and findings into a database and there's some  
 12 sorting done on that database. We would have  
 13 tagged those observations against some of  
 14 these particular items.  
 15 ROIL, Q.C.:  
 16 Q. But the observations themselves, they come  
 17 from where?  
 18 MR. PIKE:  
 19 A. From the audits.  
 20 ROIL, Q.C.:  
 21 Q. From inspections done by your -  
 22 MR. PIKE:  
 23 A. From the audits and inspections.  
 24 ROIL, Q.C.:  
 25 Q. - employees when they're flying to an audit?

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1 MR. PIKE:  
 2 A. Correct.  
 3 ROIL, Q.C.:  
 4 Q. Okay, so it's a -  
 5 MR. PIKE:  
 6 A. From that non-compliance report, that table.  
 7 ROIL, Q.C.:  
 8 Q. Yes.  
 9 MR. PIKE:  
 10 A. That will highlight the observation. That  
 11 observation is entered into a database. So  
 12 the things that would tag it are when the  
 13 audit was done, what the focus of the audit  
 14 was, who the operator was, what the  
 15 authorization was, and there would be some  
 16 particular information associated with the  
 17 installation that it's done against and then  
 18 we would break down some of the observations  
 19 into this type category, the helideck or some  
 20 of those.  
 21 ROIL, Q.C.:  
 22 Q. So can we take it as a fact that with each of  
 23 these 178 observations, somebody would have  
 24 gone forward to see whether or not remedial  
 25 action was taken? Or I mean, I'm just

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1 wondering what happens.  
 2 MR. PIKE:  
 3 A. Yes. We would verify each of the ones --  
 4 through the audit process, we are verifying  
 5 the closure of these observations.  
 6 ROIL, Q.C.:  
 7 Q. Okay. So these are all taken from audits or  
 8 inspections and if we -  
 9 MR. PIKE:  
 10 A. Yes, some of them would have been closed, have  
 11 been closed.  
 12 ROIL, Q.C.:  
 13 Q. Yes.  
 14 MR. PIKE:  
 15 A. But this is an example of the observations  
 16 that we'd take.  
 17 ROIL, Q.C.:  
 18 Q. Okay.  
 19 MR. PIKE:  
 20 A. And just some statistics on the type of  
 21 installation, et cetera. These totals and  
 22 then from this we have identified that part of  
 23 our audits, we actually did four visits, if  
 24 you will, or four of our audits involved  
 25 actually going to Cougar's facilities and it's

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1 those four that we've presented to the  
 2 Inquiry.  
 3 ROIL, Q.C.:  
 4 Q. Right.  
 5 MR. PIKE:  
 6 A. And this is just the table, which is  
 7 orientated -  
 8 ROIL, Q.C.:  
 9 Q. Yeah. Unless you wanted to deal with it now,  
 10 we won't bother to orient it properly. This  
 11 is a table of what, of all these complaints?  
 12 MR. PIKE:  
 13 A. Those are the observations.  
 14 ROIL, Q.C.:  
 15 Q. Sorry, not complaints, all these observations.  
 16 Okay.  
 17 MR. PIKE:  
 18 A. I think if we just -  
 19 ROIL, Q.C.:  
 20 Q. I think we initially indicated to the parties  
 21 that we would not provide all, but it appeared  
 22 that in the process of trying to extract some,  
 23 it was better to provide a summary of  
 24 everything.  
 25 MR. PIKE:

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1 A. We provided the table of all of them. So I  
 2 think -- page four, page five. We will  
 3 actually be looking at I think the May -  
 4 ROIL, Q.C.:  
 5 Q. Rotate view is there if you wanted to try it.  
 6 Just go up a couple of more. There we go.  
 7 Had a 50/50 chance of being right. Okay.  
 8 MR. PIKE:  
 9 A. May, I think we have here the May 14th, 2002.  
 10 We've identified it as a focused audit on  
 11 helicopter operations. The operator in this  
 12 case was Petro-Canada. The facility was  
 13 Cougar Helicopters.  
 14 ROIL, Q.C.:  
 15 Q. Right.  
 16 MR. PIKE:  
 17 A. This was the observation.  
 18 ROIL, Q.C.:  
 19 Q. Okay, can you read that for us? Because I  
 20 don't think we can all perhaps read it, or  
 21 we're going to have some trouble.  
 22 MR. PIKE:  
 23 A. Maybe we'll wait until we actually get to the  
 24 audit, because this is one of the ones we'll  
 25 pull up.

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1 ROIL, Q.C.:  
 2 Q. Okay.  
 3 MR. PIKE:  
 4 A. And it was related to helidecks and  
 5 maintenance and I think in this regard, it was  
 6 related to inspection of the helideck. Petro-  
 7 Canada, in this case, had identified semi-  
 8 annual checks and in actual fact, they were  
 9 only doing annuals, which is the norm here.  
 10 They had actually gone above the norm by  
 11 saying they were going to do semi-annual and  
 12 they indicated that no, were only doing  
 13 annuals, and they would be done by Cougar. So  
 14 we've identified that as their documentation,  
 15 their process didn't match up with what they  
 16 were doing and that needed to be corrected.  
 17 ROIL, Q.C.:  
 18 Q. So either had to, what, correct the work or  
 19 correct the rule?  
 20 MR. PIKE:  
 21 A. They either had to start doing it semi-  
 22 annually or they had to change their document  
 23 to agree with what they were doing, which was  
 24 the annual, and the annual was an acceptable  
 25 standard and they indicated that that's what

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1 they were going to do. We just said okay, you  
 2 need to update your documentation.  
 3 ROIL, Q.C.:  
 4 Q. Okay.  
 5 MR. PIKE:  
 6 A. And page 16 should have the October 2006.  
 7 ROIL, Q.C.:  
 8 Q. There, it's the bottom. At the bottom there.  
 9 MR. PIKE:  
 10 A. Yes, yeah. It's actually Chevron is the  
 11 operator on this one, and it was helicopter  
 12 operations (unintelligible) drilling. Chevron  
 13 was drilling an exploratory well in the Orphan  
 14 basin with the Eirik Raude. So the  
 15 installation was the Eirik Raude and we have  
 16 identified and we'll actually take a look at  
 17 that audit as well.  
 18 ROIL, Q.C.:  
 19 Q. Okay.  
 20 MR. PIKE:  
 21 A. Without trying to read this right now, we'll  
 22 take a look at it when we actually look at the  
 23 audit.  
 24 ROIL, Q.C.:  
 25 Q. Yeah.



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1 MR. PIKE:  
 2 A. The other two -  
 3 ROIL, Q.C.:  
 4 Q. It'll be in larger font when we see it again,  
 5 I take it.  
 6 MR. PIKE:  
 7 A. Yes.  
 8 ROIL, Q.C.:  
 9 Q. Okay.  
 10 MR. PIKE:  
 11 A. The other two audits we have is a May 1999  
 12 audit. It was an audit of HMDC focused on  
 13 training, and again, at that time we were  
 14 doing focused audits. And we would look at  
 15 what they had done with regard to their  
 16 contractors and we took a look at how they  
 17 were monitoring Cougar's training in that  
 18 piece and it was a three volume audit, so the  
 19 audit actually had three volumes of material  
 20 that were reviewed and -  
 21 ROIL, Q.C.:  
 22 Q. So the exhibit that I have has about a quarter  
 23 of an inch. I take it that this is not  
 24 everything that was in the audit?  
 25 MR. PIKE:

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1 A. No, it was not because the audit -- the  
 2 training audit covered people that were  
 3 actually working on board the installation and  
 4 some of their contractors. So it was a full  
 5 training audit and then one of the components  
 6 in that piece was to look at their contractors  
 7 and one of the contractors we chose to look at  
 8 was Cougar.  
 9 ROIL, Q.C.:  
 10 Q. Right.  
 11 MR. PIKE:  
 12 A. We've identified the May 2002 audit. That was  
 13 a focused audit on helicopter operations and  
 14 as it turns out, that's only one volume. In  
 15 April of 2004, this is after we had the  
 16 complaint, we did an audit of Hibernia and  
 17 again we didn't identify to Hibernia or Cougar  
 18 that we'd had a complaint.  
 19 ROIL, Q.C.:  
 20 Q. Which complaint are we talking about here?  
 21 MR. PIKE:  
 22 A. That was from the former pilot.  
 23 ROIL, Q.C.:  
 24 Q. Okay.  
 25 MR. PIKE:

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1 A. We were doing leadership, administration and  
 2 coordination audit of Hibernia which would  
 3 include their oversight of their contractors,  
 4 and as a result of that complaint, one of the  
 5 contractors we identified was Cougar. That  
 6 particular audit is a seven-volume set and  
 7 there are really only two volumes that have  
 8 any relevance to the helicopter operations.  
 9 So there's an extensive volume in there that  
 10 covers a lot of the Cougar procedures and  
 11 we'll see that -- you could see that in there,  
 12 but some of those procedures we've actually  
 13 redacted, but -  
 14 ROIL, Q.C.:  
 15 Q. That's actually not a -  
 16 MR. PIKE:  
 17 A. It's not one we're going to actually look at  
 18 in any detail.  
 19 ROIL, Q.C.:  
 20 Q. It's not one we're going to look at. No, but  
 21 -  
 22 MR. PIKE:  
 23 A. But it's there. It was seven volumes. Two  
 24 were associated with helicopter operations out  
 25 of those seven. I did review the full seven

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1 volumes though to make sure that's all was  
 2 there. And then the October 2006, which was  
 3 the Chevron audit, that's actually two volumes  
 4 and we will be taking a look at that one. So  
 5 maybe if we can pull up the first of those  
 6 audits, which is the May 2002, which is  
 7 Exhibit 192.  
 8 So we had two safety officers conducting  
 9 this one. At this stage, one of the safety  
 10 officers was fairly new, so this was actually  
 11 a team approach in part of the training  
 12 component. So the lead auditor in this one  
 13 was actually being trained, although they were  
 14 conducting the audit.  
 15 ROIL, Q.C.:  
 16 Q. Okay. So this audit was specifically focused  
 17 on helicopter operations?  
 18 MR. PIKE:  
 19 A. It was.  
 20 ROIL, Q.C.:  
 21 Q. As they were being undertaken by Petro-Canada?  
 22 MR. PIKE:  
 23 A. And recall we had that incident where a worker  
 24 was transported without the flight suit within  
 25 the field. This audit followed that

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1 particular incident. That memo would normally  
 2 have been prepared at the end of the audit,  
 3 but we've put it upfront as sort of an  
 4 executive summary, as you will, to highlight -  
 5 - to give you some sense of flow of the audit.  
 6 So it was conducted at Cougar's facilities on  
 7 May the 14th, 2002 by two of the Board's  
 8 safety officers and we were auditing Petro-  
 9 Canada's helicopter operations as it  
 10 interfaces with the helicopter contractor and  
 11 the audit resulted in one observation and no  
 12 findings.  
 13 ROIL, Q.C.:  
 14 Q. Okay. So the one observation is what?  
 15 MR. PIKE:  
 16 A. We can take a look at that, but that's the one  
 17 with regard to the semi-annual or the annual  
 18 inspection of helidecks.  
 19 ROIL, Q.C.:  
 20 Q. Okay.  
 21 MR. PIKE:  
 22 A. So it just identify -  
 23 ROIL, Q.C.:  
 24 Q. So other than that particular observation,  
 25 there were no other observations or findings?

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1 MR. PIKE:  
 2 A. There were no other observations associated  
 3 with that. During the audit, we've identified  
 4 who was present from the operator. There were  
 5 two incidents that we actually used as  
 6 background when we did this audit, the  
 7 December one with the flight suit, and the  
 8 other one we did was the April 2001 where the  
 9 engine shutdown on over speed. By this point  
 10 in time, we actually had the TSB report on  
 11 that particular incident. There was actually  
 12 a TSB investigation. So we had that report as  
 13 well and we would have looked at the  
 14 recommendations from that report and were  
 15 verifying whether indeed they were being  
 16 implemented.  
 17 Then a bit of a summary as to what they  
 18 would have seen from the helicopter  
 19 operations. We also took a look at -- because  
 20 Cougar does some training with regard to  
 21 helicopter landing officers. So we took a  
 22 look at that component as well. And the  
 23 movements, MAPS they call it, movement and  
 24 personnel system. I think we've heard Cougar  
 25 refer to that as well in their presentation.

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1 The note in here, Cougar had identified  
 2 to us some concern with what's referred to as  
 3 ad hoc workers or contract workers offshore  
 4 spending three weeks at one installation,  
 5 coming ashore and going out within a few days  
 6 to another installation. That was a concern  
 7 at that time. So we took a look at the MAP  
 8 system to try to identify instances where that  
 9 was taking place. So part of this audit was  
 10 also a bit of an investigation of an issue  
 11 that had been raised. It had been raised by  
 12 workers previously, but again, we have to  
 13 confine ourselves to facts. I mean, we've  
 14 heard that anecdotally from workers, but I'm a  
 15 regulator. I have to deal in facts. So we  
 16 went through the MAP system to try to identify  
 17 who indeed was doing this and we do follow up  
 18 in that regard. So that was identified during  
 19 this piece and there was a follow up with  
 20 regard to that, and how big an issue we had  
 21 going with regard to what is referred to as ad  
 22 hoc workers or contract workers. They would  
 23 have specific tasks on board for an activity  
 24 and they would move between installations.  
 25 ROIL, Q.C.:

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1 Q. What was the safety issue with respect to ad  
 2 hoc workers?  
 3 MR. PIKE:  
 4 A. Fatigue.  
 5 ROIL, Q.C.:  
 6 Q. Okay. So the safety angle that you were  
 7 looking at -  
 8 MR. PIKE:  
 9 A. We wanted to make sure that, you know, the  
 10 individuals weren't fatigued when they're  
 11 doing their work.  
 12 ROIL, Q.C.:  
 13 Q. Right, okay.  
 14 MR. PIKE:  
 15 A. And we have occasionally gotten complaints  
 16 from the contract workers that they feel  
 17 they're working too much and we've tried to  
 18 deal with those complaints. So over the years  
 19 there's been a combination where we've seen it  
 20 and then we've actually had complaints from  
 21 workers.  
 22 Then the attachment is the audit report.  
 23 In this case, we're referring to the table  
 24 that's prepared. We'll take a look at it, the  
 25 audit schedule, attendance at the opening and

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1 closing meeting, the checklist that was used  
 2 as part of this and the follow-up incident  
 3 reports and the pre-audit correspondence. And  
 4 we took a look at Petro-Canada's field. The  
 5 helicopter operations manual was one of the  
 6 documents from the operator that we would have  
 7 used as a base for this audit.  
 8 ROIL, Q.C.:  
 9 Q. Okay. So I think you've told us this really  
 10 is a document that should naturally fit at the  
 11 back of the list of documents we have.  
 12 MR. PIKE:  
 13 A. Yes.  
 14 ROIL, Q.C.:  
 15 Q. But you brought it forward -  
 16 MR. PIKE:  
 17 A. In this case, it gives us a good executive  
 18 summary of what this audit is doing.  
 19 ROIL, Q.C.:  
 20 Q. Right, okay.  
 21 MR. PIKE:  
 22 A. This was the agenda, the schedule that they  
 23 had developed for review when they were with  
 24 Cougar, and I think the next one will actually  
 25 list the opening meeting, who attended. So

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1 you can see from that, the two safety officers  
 2 are there. There were representatives from  
 3 Petro-Canada and quite a number of  
 4 representatives from Cougar. And in the  
 5 closing meeting, there weren't quite as many  
 6 people present, but representatives from  
 7 Cougar and Petro-Canada and the two safety  
 8 officers.  
 9 ROIL, Q.C.:  
 10 Q. Okay. Now if I look at the dates of these,  
 11 they're both on the same date.  
 12 MR. PIKE:  
 13 A. That's correct.  
 14 ROIL, Q.C.:  
 15 Q. Does that mean that this audit was a one-day?  
 16 MR. PIKE:  
 17 A. It was a one-day audit.  
 18 ROIL, Q.C.:  
 19 Q. Yeah, okay.  
 20 MR. PIKE:  
 21 A. What we're looking at now is the checklist  
 22 that the safety officer would have prepared  
 23 prior to doing the audit, and here we go. As  
 24 you can see, the safety officer has done  
 25 extensive notes on it. So from these notes,

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1 they would then prepare their non-compliance  
 2 report.  
 3 ROIL, Q.C.:  
 4 Q. So this is the actual piece of paper that the  
 5 -  
 6 MR. PIKE:  
 7 A. Safety officer would be using -  
 8 ROIL, Q.C.:  
 9 Q. - the officer takes with them?  
 10 MR. PIKE:  
 11 A. - as they go through their audit and they  
 12 would be making their notes on it as to what's  
 13 happening.  
 14 ROIL, Q.C.:  
 15 Q. Again, I'm not going to draw your attention or  
 16 ask you to comment on any one of these things.  
 17 Again, we're trying to understand what your  
 18 processes are.  
 19 MR. PIKE:  
 20 A. And the piece that we've redacted in here are  
 21 people's names. They would have referred in  
 22 some cases to individuals and we've just  
 23 redacted their names. And a discussion of the  
 24 different -- the training that we've looked  
 25 at, the MAP system. Transit tanks, those are

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1 the tanks that are offshore that carry the  
 2 helifuel. We've heard some mention of those  
 3 by Cougar and the checks that are made, so  
 4 we're verifying those. The inspections, again  
 5 those are the helideck inspections that Cougar  
 6 would do on behalf of the operator. And then  
 7 we took a look at some of the maintenance  
 8 issues associated with the helicopter. Our  
 9 focus here is less on the actual operational  
 10 safety of Cougar as opposed to the  
 11 occupational safety of the passengers.  
 12 So we were focusing a little bit more in  
 13 the areas of the transportation suits and how  
 14 they were being maintained, although we did  
 15 take a look at Cougar's maintenance operation.  
 16 We aren't aviation experts, so it was a -- you  
 17 know, it was more a high level type review as  
 18 to what processes they had in place. You  
 19 know, verifying that they had the HUMS system,  
 20 the HUMS system is being checked. So we would  
 21 have done some of those verifications, taken  
 22 the recommendations out of the TSB report. So  
 23 the TSB report would be fairly detailed and we  
 24 would have taken that and looked at it to see  
 25 that indeed those things were being -

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1 Just the checklist that Cougar has for  
 2 the helifuel that's transported offshore. So  
 3 that's what we're seeing in the next few pages  
 4 is indeed Cougar does have a process and  
 5 checklists. I'm not sure we need to actually  
 6 rotate it.  
 7 ROIL, Q.C.:  
 8 Q. No, I don't think for that page we need to  
 9 bother to rotate it. Now we got to go back  
 10 perhaps because this looks like a familiar  
 11 document.  
 12 MR. PIKE:  
 13 A. Yes, we would have looked at this.  
 14 ROIL, Q.C.:  
 15 Q. One more up, up, there you go.  
 16 MR. PIKE:  
 17 A. Rotate view. I should have left it to the --  
 18 let's go back.  
 19 ROIL, Q.C.:  
 20 Q. You're going to have to do it twice, no matter  
 21 what way you go.  
 22 MR. PIKE:  
 23 A. Yeah. So you recall this was one that we --  
 24 it's in actually the package. We didn't  
 25 actually review it in detail. This is the one

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1 on the engine. So it was the April 5th 2001.  
 2 I made reference that it was carried forward.  
 3 So as part of the documentation package that  
 4 was reviewed for this audit, the safety  
 5 officer reviewed this incident and understood  
 6 what was going on. I think the thing to note  
 7 is the corrective actions, immediate  
 8 corrective actions, helicopter landed -- there  
 9 was some correctives down here with regard to  
 10 monitoring program and you'll notice what the  
 11 safety officer has done is checked these as  
 12 yes, I verified and saw that Cougar was  
 13 actually doing these things that was  
 14 recommended as part of this piece. And this  
 15 is the one with regard to the flight suit, so  
 16 again they would have had this one.  
 17 ROIL, Q.C.:  
 18 Q. Okay. So here we have two incidents that find  
 19 their way into the audit process?  
 20 MR. PIKE:  
 21 A. Correct.  
 22 ROIL, Q.C.:  
 23 Q. Yeah.  
 24 MR. PIKE:  
 25 A. And if there were recommendations or

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1 corrective actions, the safety officer would  
 2 verify that those corrective actions have  
 3 actually taken place.  
 4 This is actually the passenger manifest  
 5 for the flight that -- where the individual  
 6 wasn't wearing the flight suit. So we checked  
 7 those out.  
 8 These are the training dispensations that  
 9 were issued. So I think there was some talk  
 10 of that previously. The requirement is to  
 11 have the basic training. On occasions,  
 12 there's a dispensation issued and in this  
 13 case, we're taking a look at the number of  
 14 dispensations that have been issued.  
 15 ROIL, Q.C.:  
 16 Q. These are people who've gotten training  
 17 elsewhere in the world? Is that the issue?  
 18 MR. PIKE:  
 19 A. Either that or in some cases, if you're  
 20 dealing with a Secunda person, they have the  
 21 marine component, but they don't have the  
 22 helicopter component possibly. So they may be  
 23 given -- because it's a one-time trip, they  
 24 may be given a dispensation, but what we're  
 25 doing here is checking to make sure that the

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1 same individual isn't showing up multiple  
 2 times.  
 3 ROIL, Q.C.:  
 4 Q. Okay.  
 5 MR. PIKE:  
 6 A. And if they need a specialist mechanic for a  
 7 particular item, they may bring him out to do  
 8 that item and they put other special  
 9 procedures in place for that individual, but  
 10 what we're doing here is checking to make sure  
 11 that individual isn't showing up multiple  
 12 times.  
 13 ROIL, Q.C.:  
 14 Q. Right.  
 15 MR. PIKE:  
 16 A. And what you're seeing in here, the Secunda  
 17 piece. What they're obviously doing in here  
 18 is doing a crew change for that supply boat  
 19 offshore. So they're transporting the crew  
 20 and that's what you're tending to see when  
 21 those things happen. But again, we're seeing  
 22 that that doesn't happen very often or that  
 23 they start giving the HUET training to those  
 24 marine personnel. So we would have reviewed  
 25 that list. We look for similarities and

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1 that's a piece that was going on. You see  
 2 notes that the safety officer has put on that  
 3 piece.  
 4 This is actually an individual and the  
 5 number of times he's travelled offshore in the  
 6 previous year say. So what we're trying to  
 7 identify then, and you can see the notes that  
 8 the safety officer has taken from the MAP  
 9 system that's tracking people offshore.  
 10 They're able to identify an individual and the  
 11 number of times and when he's travelled  
 12 onshore or offshore, or she has travelled  
 13 onshore or offshore. So what we did there was  
 14 just a little bit of analysis. They've  
 15 travelled 28 times offshore in the last 12  
 16 months, when they arrived, when they departed,  
 17 how much time between their next piece  
 18 offshore. So again the norm, and particularly  
 19 for Petro-Canada, is there's at least seven  
 20 days between the time you were last offshore  
 21 and you go offshore again and we're just  
 22 verifying, in this case, that indeed people  
 23 aren't travelling offshore before they get  
 24 their seven days off.  
 25 ROIL, Q.C.:

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1 Q. So travelling 28 times in a one-year period  
 2 would be a higher than normal number?  
 3 MR. PIKE:  
 4 A. It would tend to be, yes.  
 5 ROIL, Q.C.:  
 6 Q. Yes, okay. So now you're looking to see  
 7 whether or not the person is stressed by  
 8 overwork? Is that -  
 9 MR. PIKE:  
 10 A. Correct.  
 11 ROIL, Q.C.:  
 12 Q. You've mentioned that in your earlier  
 13 evidence, okay.  
 14 MR. PIKE:  
 15 A. Yeah. So that's the piece we were looking at  
 16 when we looked at that and we were using the  
 17 MAP system. This is the training for the  
 18 helideck officers, in this case the instructor  
 19 is a Cougar employee. We've just redacted the  
 20 name and the other -- we've identified who the  
 21 companies are, but these would be the names of  
 22 individuals who've received that  
 23 certification. I think Cougar testified that  
 24 they want to familiarize these people with  
 25 their machines when it comes to the refuelling

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1 operation. So they want to make sure that  
 2 they're familiar with that. So we're  
 3 verifying that that training did indeed take  
 4 place.  
 5 And this would be a report on the  
 6 training of the pilots, and I think from -- we  
 7 would just review the training of the pilots  
 8 and I think there's the full gamete. One of  
 9 the lists would actually include the survival  
 10 training as well.  
 11 COMMISSIONER:  
 12 Q. So you do both the training of the pilots and  
 13 their survival training comes under your -  
 14 MR. PIKE:  
 15 A. We would verify that that's part of the  
 16 training regime that would take place.  
 17 COMMISSIONER:  
 18 Q. Yes, I see.  
 19 MR. PIKE:  
 20 A. This is probably a -- I'm not getting it right  
 21 at all this morning.  
 22 ROIL, Q.C.:  
 23 Q. No, that's okay. We'll let the Registrar -  
 24 MR. PIKE:  
 25 A. I'll let the Registrar do it.

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1 ROIL, Q.C.:  
 2 Q. Yeah.  
 3 MR. PIKE:  
 4 A. She seems to be much more adept at it.  
 5 ROIL, Q.C.:  
 6 Q. Just more familiar. We can all learn it if we  
 7 do it a few times, but I wouldn't even attempt  
 8 it. There you go.  
 9 MR. PIKE:  
 10 A. Again, this would be the pilots and, you know,  
 11 some of the specialized training. I'm not  
 12 sure if this -- BST, I believe is this one.  
 13 So indeed, we've verified that they do indeed  
 14 get that training or that would have been one  
 15 of the processes we would have done. And I  
 16 think -- I'm not sure if it's this one or  
 17 another one. We would have identified a  
 18 medical -- one of the medicals was outstanding  
 19 and as it turns out, it was a database  
 20 problem. The pilot actually had an invalid --  
 21 or had a valid medical. It just hadn't been  
 22 entered in the database in one of our audits.  
 23 This is just an excerpt from Cougar's  
 24 manual. Talks about -- and I think we've  
 25 talked about cargo in the passenger

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1 compartment. That's not occurring currently  
 2 with the S-92s. They aren't configured to  
 3 carry cargo in the passenger compartment but  
 4 the Super Pumas could carry cargo and on the  
 5 rare occasions, they did carry some cargo in  
 6 the passenger compartment.  
 7 ROIL, Q.C.:  
 8 Q. I think for the Commissioner to understand,  
 9 this was a much bigger document that I decided  
 10 rather than cut down trees, we simply show the  
 11 front page to show the document they went  
 12 through -  
 13 MR. PIKE:  
 14 A. Basically we're showing the -  
 15 ROIL, Q.C.:  
 16 Q. - went to rather than to attempt to put in the  
 17 whole document and try to analyze.  
 18 MR. PIKE:  
 19 A. This has been a question raised. We verified  
 20 that there was indeed a process in place as to  
 21 how they would do these things to make sure  
 22 that this cargo was not impeding any of the  
 23 egress routes and exactly that they fastened  
 24 it down appropriately, et cetera. So we were  
 25 checking Cougar's procedures to ensure that,

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1 number one, it was rare, but when they did do  
 2 it, they had proper process in place for doing  
 3 it. So that's what we were verifying in this  
 4 case.  
 5 And this is some of the correspondence  
 6 before we did the audit. So just identifying  
 7 when we want to do it. So in this case, the  
 8 audit took place on the 14th. We identified  
 9 to the operator on the 3rd of May that we  
 10 wanted to do that audit, and this is just some  
 11 of the correspondence as to how we set the  
 12 audit up and what we wanted and didn't.  
 13 ROIL, Q.C.:  
 14 Q. Right, I don't think we need to spend any time  
 15 on that.  
 16 MR. PIKE:  
 17 A. No, and again some more of the correspondence  
 18 before we went. They actually changed out one  
 19 of the safety officers from the original.  
 20 What we've done here as part of our review,  
 21 helicopter landing officer training piece, and  
 22 this is from the joint contractor. In this  
 23 case, it would be the Henry Goodrich. So they  
 24 have identified who has the training and when  
 25 they completed it. It identified who will be

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1 doing some additional work and some of the  
 2 people that they have actually trained as  
 3 helideck officers, and you'll notice, as was  
 4 talked about before, it's not uncommon that  
 5 they helideck landing officer is the crane  
 6 operator.  
 7 ROIL, Q.C.:  
 8 Q. Yes.  
 9 MR. PIKE:  
 10 A. That makes sure that the crane is not in  
 11 motion while the helicopter is landing. He  
 12 can't be two places at once, and again we're  
 13 tracking the training of the helicopter  
 14 landing officers and this is just some of the  
 15 correspondence. After the audit, we would  
 16 have written -- this is the letter  
 17 transmitting that table of non-compliances, or  
 18 as we referred to it at that time, the audit  
 19 report. In this case, the senior safety  
 20 officer signed it. The norm particularly now  
 21 would be for the safety officer who actually  
 22 does the audit to sign the transmittal.  
 23 ROIL, Q.C.:  
 24 Q. So this is transmitting his findings to the  
 25 operator?

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1 MR. PIKE:  
 2 A. Correct.  
 3 ROIL, Q.C.:  
 4 Q. To the operator.  
 5 MR. PIKE:  
 6 A. And we'll see here this is the actual -- I'll  
 7 leave it to the Registrar. It may take me a  
 8 while, but I do learn. There we go. You'll  
 9 see in this case, in actual fact this one  
 10 contains the operator's response, but we would  
 11 have identified, you know, that Petro-Canada  
 12 Helicopter Operations Manual states that  
 13 Cougar Helicopters inspector will inspect the  
 14 heli-fuel facility, the helideck on a semi  
 15 annual basis. It was noted these inspections  
 16 are being conducted on an annual basis,  
 17 statement of fact, it's an observation. It's  
 18 not that we're saying one or the other is  
 19 better. The norm is for an annual. This was  
 20 -- and they've written back saying was an  
 21 oversight in the rewrite of their manual last  
 22 year, the operations manual will be amended to  
 23 reflect the current practice, which is one  
 24 helideck inspection per year.  
 25 ROIL, Q.C.:

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1 Q. And I think your earlier evidence indicated  
 2 that if there's similar things to be done  
 3 today, it would be much longer than a one page  
 4 audit report.  
 5 MR. PIKE:  
 6 A. Yes.  
 7 ROIL, Q.C.:  
 8 Q. It would have all the different things.  
 9 MR. PIKE:  
 10 A. You would tend to see that summary report that  
 11 we saw at the beginning.  
 12 ROIL, Q.C.:  
 13 Q. Yes.  
 14 MR. PIKE:  
 15 A. That would show up as well, and this would be  
 16 attached to it.  
 17 ROIL, Q.C.:  
 18 Q. Okay, and we'll perhaps see that in another  
 19 example.  
 20 MR. PIKE:  
 21 A. I'm not sure we've actually -- that's more in  
 22 the last few years. Even the 2006 one we  
 23 didn't actually transmit the memo.  
 24 ROIL, Q.C.:  
 25 Q. Okay.

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1 MR. PIKE:  
 2 A. That's only something we've been doing in the  
 3 last number of years, and again you're just  
 4 seeing some of the correspondence back and  
 5 forth where we would have transmitted  
 6 electronically that audit report to the  
 7 operator.  
 8 ROIL, Q.C.:  
 9 Q. So when the operator says --  
 10 MR. PIKE:  
 11 A. A couple days later we would have submitted  
 12 the electronic, so that then affords the  
 13 operator the opportunity to actually enter  
 14 within an electronic one their response to our  
 15 audit observation.  
 16 ROIL, Q.C.:  
 17 Q. So this response, which was back on page 41,  
 18 and you don't need to go back there, where the  
 19 operator said our operations manual will be  
 20 amended, do you close your audit then?  
 21 MR. PIKE:  
 22 A. No.  
 23 ROIL, Q.C.:  
 24 Q. Okay. Well, take us forward to how and when  
 25 that gets closed?

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1 MR. PIKE:  
 2 A. We'll see as we go forward, it actually took  
 3 Petro-Canada a little longer than we had  
 4 anticipated to actually run -- you've got to  
 5 appreciate as well that the operator has a  
 6 very formal process when they change one of  
 7 these procedures of review and sign off. So  
 8 again just correspondence on some of the  
 9 issues and some that related to some of the  
 10 training and you go through -- so that's the  
 11 28th, so we're identifying that. Again we're  
 12 back to the helicopter landing officers and  
 13 verifying some of that training. Again status  
 14 of the helicopter landing officers. So again  
 15 we're following these things out to make sure  
 16 that we get closure on them. We're into July.  
 17 Again the landing officers, and this is just  
 18 some of the correspondence that's going back  
 19 and forth, closing some of these items.  
 20 ROIL, Q.C.:  
 21 Q. I think page 55 is the next one where I'd ask  
 22 you to slow up a bit.  
 23 MR. PIKE:  
 24 A. Okay. So we're now almost a year later, and  
 25 we haven't actually seen that updated manual,

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1 and in addition there are a number of other  
 2 observations we have outstanding with Petro-  
 3 Canada, so we've written them a letter  
 4 indicating they should have a number of  
 5 observations open, and 22 of them have  
 6 exceeded our agreed completion date.  
 7 ROIL, Q.C.:  
 8 Q. Now the 115 observations that are referred to  
 9 there, they were not garnered from this  
 10 particular audit?  
 11 MR. PIKE:  
 12 A. No, they would be from various audits that  
 13 were done. They may have been from the FPSO,  
 14 they may have also included some of the  
 15 observations from the drilling rig as well.  
 16 ROIL, Q.C.:  
 17 Q. Okay, now --  
 18 MR. PIKE:  
 19 A. And they were not -- there was only one  
 20 related to helicopter operations, which is the  
 21 one we're following. So again we would have  
 22 sent them a table indicating what some of  
 23 those observations were.  
 24 ROIL, Q.C.:  
 25 Q. Can we take a moment here now to -- we won't

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<p>1 take any other audit and go through with this</p> <p>2 amount of detail, but just so that we all</p> <p>3 understand what it is you do and how you do</p> <p>4 it, I think we need to take this one a little</p> <p>5 bit more detail.</p> <p>6 MR. PIKE:</p> <p>7 A. I don't feel as bad any more. What you're</p> <p>8 seeing there, this is the one that we had</p> <p>9 identified. This is the audit we're going</p> <p>10 through right now is the May 14th, 2002.</p> <p>11 There had been an audit done in April of 2002</p> <p>12 on the Henry Goodrich and we'd identified some</p> <p>13 issues with the Helicopter Operations Manual</p> <p>14 there. So again we were following through</p> <p>15 with those and they aren't closed until we</p> <p>16 actually see the updated manual.</p> <p>17 ROIL, Q.C.:</p> <p>18 Q. Okay, so again tying back to your earlier</p> <p>19 evidence, so this is where items that were in</p> <p>20 an earlier audit that were unclosed are now</p> <p>21 becoming part of this audit?</p> <p>22 MR. PIKE:</p> <p>23 A. Correct.</p> <p>24 ROIL, Q.C.:</p> <p>25 Q. Okay.</p>	<p>1 observation from May 14th on the procedure.</p> <p>2 So we're following it, and again this is July</p> <p>3 of 2003, and then just the correspondence back</p> <p>4 and forth until we actually get the --</p> <p>5 ROIL, Q.C.:</p> <p>6 Q. Page 72, I think, is where --</p> <p>7 MR. PIKE:</p> <p>8 A. Okay.</p> <p>9 ROIL, Q.C.:</p> <p>10 Q. Perhaps we'll reorient the page when we get</p> <p>11 there. I guess that we should do that</p> <p>12 counterclockwise.</p> <p>13 MR. PIKE:</p> <p>14 A. Okay. So again they will be responding to</p> <p>15 some of our observations.</p> <p>16 ROIL, Q.C.:</p> <p>17 Q. And again the redacted ones have nothing to do</p> <p>18 with helicopters.</p> <p>19 MR. PIKE:</p> <p>20 A. Nothing to do with helicopter operations, and</p> <p>21 what they've done with this particular letter</p> <p>22 is attached the relevant sections of their</p> <p>23 revised Helicopter Operations Manual. Now</p> <p>24 that we've actually seen the revised manual,</p> <p>25 we can close this observation.</p>
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<p>1 MR. PIKE:</p> <p>2 A. And we have that database and we're tracking</p> <p>3 the open observations, and this is just a list</p> <p>4 of the observations.</p> <p>5 ROIL, Q.C.:</p> <p>6 Q. Again those redacted out have nothing to do</p> <p>7 with helicopter operations.</p> <p>8 MR. PIKE:</p> <p>9 A. In December of '02, this one has to do with</p> <p>10 the sampling line on the heli-fuel system. We</p> <p>11 identified an observation, "the connecting</p> <p>12 line has been installed from the heli-fuel</p> <p>13 sampling canister to the drain line on the</p> <p>14 heli-fuel dispensing cabinet. The current</p> <p>15 arrangement does not provide for the drainage</p> <p>16 potential of leaks for the filters". So we're</p> <p>17 just identifying an observation in that</p> <p>18 regard.</p> <p>19 ROIL, Q.C.:</p> <p>20 Q. Uh-hm.</p> <p>21 MR. PIKE:</p> <p>22 A. Again more correspondence. We don't need to</p> <p>23 rotate that one, I don't think, and</p> <p>24 identifying the observations in which -- and</p> <p>25 the one that we're looking at is this</p>	<p>1 ROIL, Q.C.:</p> <p>2 Q. Okay.</p> <p>3 MR. PIKE:</p> <p>4 A. And this is just -- we did indeed get a copy</p> <p>5 of this document. It was signed off, August,</p> <p>6 2003, so we did get a copy of it. This is the</p> <p>7 Table of Contents from that manual, and indeed</p> <p>8 the section we were looking for was -- we just</p> <p>9 redacted the document. This would also be</p> <p>10 attached to the original file.</p> <p>11 ROIL, Q.C.:</p> <p>12 Q. Just give us a moment to rotate this one</p> <p>13 clockwise.</p> <p>14 MR. PIKE:</p> <p>15 A. Okay, you'll note in here, you can just barely</p> <p>16 make it out, but the safety officer in this</p> <p>17 case has signed off this observation as</p> <p>18 closed.</p> <p>19 ROIL, Q.C.:</p> <p>20 Q. So he's saying I've seen the change that they</p> <p>21 said they're going to make is complete.</p> <p>22 MR. PIKE:</p> <p>23 A. She's saying.</p> <p>24 ROIL, Q.C.:</p> <p>25 Q. Sorry, she said.</p>



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1 MR. PIKE:  
 2 A. So that's now essentially closed that  
 3 particular audit file.  
 4 ROIL, Q.C.:  
 5 Q. Right.  
 6 MR. PIKE:  
 7 A. There could have been an instance where we  
 8 carried that one forward, but in this case it  
 9 wasn't, and it was closed in the original  
 10 file.  
 11 ROIL, Q.C.:  
 12 Q. Right.  
 13 MR. PIKE:  
 14 A. The other one we were going to look at was the  
 15 audit of Chevron's exploratory drilling  
 16 program, and that's Exhibit 194.  
 17 ROIL, Q.C.:  
 18 Q. Okay. Give us a moment to get that one up.  
 19 While that's coming up, do I take it that --  
 20 can you tell me that the general process that  
 21 you've gone through there, obviously with  
 22 changes as a result of evolution, that that  
 23 process is still generally the process?  
 24 MR. PIKE:  
 25 A. Yes.

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1 ROIL, Q.C.:  
 2 Q. We would follow here, with the meetings up  
 3 front, and then the work being looked at, and  
 4 the follow up, and the documentation trail and  
 5 so on?  
 6 MR. PIKE:  
 7 A. Yes.  
 8 ROIL, Q.C.:  
 9 Q. Okay. Again for that reason, I don't think  
 10 we'll take the same amount of diligence in  
 11 going through this one, but we'll take some  
 12 pages and --  
 13 MR. PIKE:  
 14 A. Okay, it might be useful to use -- again this  
 15 was an internal memo. As I indicated today,  
 16 we would generate that as a report to the  
 17 operator. So it's a summary, you know,  
 18 between October 16th and 20th, 2006, a safety  
 19 audit targeting the helicopter, marine, and  
 20 drilling operation was conducted on board the  
 21 drilling rig, Eirik Raude, operated by Ocean  
 22 Rig under contract to Chevron Canada. Earlier  
 23 in September 28th, an onshore portion of the  
 24 audit targeting helicopter search and rescue  
 25 operations was conducted at Chevron's offices

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1 and Cougar's facilities. At the time of the  
 2 audit, the Eirik Raude was drilling the Great  
 3 Barasway F-66 well in the Orphan Basin. The  
 4 audit included a review of the documentation,  
 5 interviews at the Ocean Rig, and Chevron  
 6 personnel verification on board the  
 7 installation and at Cougar Helicopters. The  
 8 audit resulted in five observations being  
 9 brought forward from a pre-approval audit.  
 10 Again I made reference that we would sometimes  
 11 look at these rigs before they come.  
 12 ROIL, Q.C.:  
 13 Q. Uh-hm.  
 14 MR. PIKE:  
 15 A. And 15 new observations were raised during  
 16 this audit. All observations were discussed.  
 17 At the closing meeting, again at this time we  
 18 were still doing some of this on board before  
 19 we left, attended by representatives of Ocean  
 20 Rig, Chevron Canada, and a worker  
 21 representative from the Joint Occupational  
 22 Health and Safety Committee. Overall we were  
 23 satisfied with how safety of helicopter,  
 24 marine, and drilling operations is managed.  
 25 Again just a summary of what was happening.

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1 These are some of the -- when we looked at the  
 2 helicopter operations, including witnessing a  
 3 helicopter landing, we were looking at the  
 4 helideck issues, the heli-fuel storage area,  
 5 fire fighting stations, the refuelling area.  
 6 For marine operations, we looked at the radio  
 7 room, the bridge, the port -- we actually went  
 8 down into the port pontoon, the thruster rooms  
 9 in the port pontoon, the ballast control  
 10 centre, the DP. This rig was a dynamically  
 11 positioned rig, so it had no anchors. It  
 12 maintained station by dynamic positioning, so  
 13 we reviewed the control system there. We  
 14 looked at the pump rooms when we were down in  
 15 the pontoon. So this is --  
 16 ROIL, Q.C.:  
 17 Q. Again I don't think we need to go through the  
 18 details. This was other than helicopter  
 19 issues that were part of the more --  
 20 MR. PIKE:  
 21 A. Correct, this is a more fulsome audit and  
 22 that's why some of these audit files are much  
 23 larger, and again the drilling operations, we  
 24 took a look at what was happening on the drill  
 25 floor. So those are some of the items. There

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1 were several regulatory equivalencies issues  
 2 on this rig, so we did some follow-up on those  
 3 regulatory equivalencies that weren't  
 4 associated with helicopter operations, so  
 5 we've redacted those. There were no open  
 6 incident reports when we were on board, so we  
 7 didn't -- so we weren't reviewing any of  
 8 those. We did hold a meeting with the worker  
 9 representatives of the Joint Occupational  
 10 Health and Safety Committee. There is a note  
 11 on those. They didn't raise any issues. No  
 12 issues were brought forward from that meeting.  
 13 ROIL, Q.C.:  
 14 Q. Uh-hm.  
 15 MR. PIKE:  
 16 A. And here's a note on the Cougar -- Chevron  
 17 Cougar helicopter search and rescue operations  
 18 audit. As part of the audit, we did the  
 19 onshore portion targeting the search and  
 20 rescue operations. That's conducted on  
 21 September 28th in Chevron's offices and at  
 22 Cougar facilities. Key points of interest  
 23 reveal Chevron retains a standby helicopter  
 24 dedicated to search and rescue on a 24 hour  
 25 basis by means of contractual arrangement for

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1 access to -- a SAR compliant helicopter is  
 2 always available. Four out of the six  
 3 helicopters are SAR compliant. Of those four,  
 4 one is always within 30 minutes. At this  
 5 time, the 30 minute piece still allowed them  
 6 the one hour wheels up.  
 7 ROIL, Q.C.:  
 8 Q. Okay, and what equipment were they operating  
 9 at that time?  
 10 MR. PIKE:  
 11 A. There was a combination -- I think in this  
 12 case the S-61 was there, but it was not SAR  
 13 compliant.  
 14 ROIL, Q.C.:  
 15 Q. It speaks of six Cougar helicopters, yet we  
 16 know there's only four there now, so -- would  
 17 that tell you anything about what the airframe  
 18 might have been?  
 19 MR. PIKE:  
 20 A. I think in 2006 we were also in the transition  
 21 phase between the S-92s and the Super Pumas.  
 22 ROIL, Q.C.:  
 23 Q. Uh-hm.  
 24 MR. PIKE:  
 25 A. So some of those would have been Super Pumas.

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1 The S-92 would have been operating at that  
 2 time as well, and there was the S-61 brought  
 3 in for some of those operations as well, I  
 4 believe. Again this summarized --  
 5 ROIL, Q.C.:  
 6 Q. The detail of their findings.  
 7 MR. PIKE:  
 8 A. The detail of their findings and what they  
 9 observed. So again what we're getting here is  
 10 a more fulsome description of what it was they  
 11 observed. If you looked at the earlier audit,  
 12 all we were really nothing were the  
 13 deficiencies. In this case, they're telling  
 14 the more fulsome story that this is some of  
 15 the things and the notes we took from that  
 16 particular audit. So it gives us a more  
 17 complete picture.  
 18 ROIL, Q.C.:  
 19 Q. And perhaps would you just go down to the very  
 20 last paragraphs, again the overall findings?  
 21 MR. PIKE:  
 22 A. We identified no issues that would lead to a  
 23 finding or observation for this component of  
 24 the audit. We gained a positive impression  
 25 about how Cougar conducts its activities with

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1 respect to search and rescue operations, and  
 2 cooperation and coordination between Chevron  
 3 and Cougar for the Eirik Raude drilling  
 4 project. Again we had two safety officers on  
 5 that one. This would have been the  
 6 noncompliance report, the table that would  
 7 have been shared with the operator at that  
 8 time.  
 9 ROIL, Q.C.:  
 10 Q. Again I don't think that we need to or want to  
 11 take the time to go through this one in the  
 12 same way that we did with the other one.  
 13 MR. PIKE:  
 14 A. The only issue that we had there was with  
 15 regard to use of the flight suits. At this  
 16 time for this program they were actually using  
 17 the Helly Hansen suits, where the norm for the  
 18 other operators would have been the Mustang  
 19 suits. These Helly Hansen suits, I believe,  
 20 had dual approval. We verified that with  
 21 Transport Canada, and you'll see further that  
 22 we actually had correspondence with Transport  
 23 Canada Marine Safety folks to verify that  
 24 these suits did indeed have immersion suit  
 25 certification. So we were following up on the

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1 notion of the 200 percent marine abandonment  
2 suits. They were using some of the heli suits  
3 as part of fulfilling that requirement on  
4 marine abandonment suits. In that case, we  
5 were following up to verify that they indeed  
6 did have 200 percent marine abandonment suits.  
7 In this case, they were using the helicopter  
8 suits as part of that, and we verified that  
9 they did indeed have the marine abandonment  
10 certification.

11 ROIL, Q.C.:

12 Q. The 200 percent requirement is not a  
13 helicopter aspect, it is an operational  
14 aspect?

15 MR. PIKE:

16 A. It is an operational aspect on the drilling  
17 rig itself.

18 ROIL, Q.C.:

19 Q. But here they were using the helicopter dual  
20 suit as a way of satisfying that compliance?

21 MR. PIKE:

22 A. Correct. What would normally happen in this  
23 case, 100 percent of the suits would be  
24 located in the muster areas, and these --  
25 because you're carrying your transportation

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1 suit anyway. Those would be stored in the  
2 accommodations. So what would normally  
3 happen, if you have a muster, if you're in  
4 your accommodations room, you'd take the suit  
5 from your room; if you're not, you go to the  
6 muster area and you take of the suits from the  
7 pool. That's generally how that piece works.

8 ROIL, Q.C.:

9 Q. And is that the reason that the 100 percent  
10 solution is found because you can be in  
11 different places per incident or when a  
12 difficulty is encountered?

13 MR. PIKE:

14 A. Yes.

15 ROIL, Q.C.:

16 Q. Yeah.

17 MR. PIKE:

18 A. And again 200 percent is another  
19 recommendation from the Ocean Ranger  
20 Commission. The one observation against the  
21 actual helicopter operations really related to  
22 the bunting around the heli-fuel tanks. They  
23 did not have plugs, so if there was any leak,  
24 it could leak into the environment. So that's  
25 more an environmental issue associated with

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1 the actual refuelling operation. The other  
2 thing we noted while we were there, and has  
3 come up before, we've talked about, measuring  
4 wave heights. In this case, the Waverider  
5 equipment for monitoring the oceanographic  
6 environment wasn't working at that time, so we  
7 identified that as an item that needed to be  
8 corrected.

9 ROIL, Q.C.:

10 Q. Would you have any way of knowing whether that  
11 was a longstanding problem or whether it was  
12 an incident relating to that day, or can you  
13 tell at this point in time?

14 MR. PIKE:

15 A. I can't tell from this particular --

16 ROIL, Q.C.:

17 Q. Presumably, the -- would the safety officer  
18 have asked that kind of question?

19 MR. PIKE:

20 A. They would have, yes.

21 ROIL, Q.C.:

22 Q. That would be the natural course of his  
23 questions, would it, to be --

24 MR. PIKE:

25 A. Yes.

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1 ROIL, Q.C.:

2 Q. Is this just today or --

3 MR. PIKE:

4 A. They would have identified in this case that  
5 it wasn't working and they would have normally  
6 dug down to find out how long it hasn't been  
7 working, what's the problem, when are you  
8 going to get it corrected. It would be  
9 identified as an observation. If they weren't  
10 satisfied with the answers they were getting,  
11 they'd raise that as a finding.

12 ROIL, Q.C.:

13 Q. Okay.

14 MR. PIKE:

15 A. And these are just some of the other  
16 observation they had, and they got good  
17 cooperation on board, so they thanked them for  
18 the cooperation. That's the meeting that was  
19 held at Cougar on the 28th. A number of  
20 Cougar employees, and actually I don't see a  
21 Chevron, so -- that actually took place out at  
22 Cougar's facilities.

23 ROIL, Q.C.:

24 Q. Yes.

25 MR. PIKE:

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1 A. And it was the same day meeting, and in this  
 2 case they didn't actually log the closing  
 3 meeting. They would have talked to Cougar  
 4 before they left in the closing meeting. This  
 5 would have been the checklist, as it were,  
 6 that they would have used when they went to  
 7 the Cougar facility. So again there's a  
 8 number of questions that they would have  
 9 raised, and these are the answers that they --  
 10 ROIL, Q.C.:  
 11 Q. So these questions are a part of their pre-  
 12 audit requirements, is it, to develop a list  
 13 of questions?  
 14 MR. PIKE:  
 15 A. And I think you asked the question as to what  
 16 the balance was, and I think it appear at this  
 17 time there were three Super Pumas, one S-92,  
 18 which was SAR complaint, one S-92 that was not  
 19 SAR compliant because it didn't have a wench,  
 20 and one S-61 that did not have a wench. So  
 21 that's the breakdown of helicopters that you  
 22 were asking. There were six there, what were  
 23 they, and that's where that piece came from,  
 24 and they would have witnessed them in the  
 25 hangars as to how they have those arrangements

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1 and how they have it ready to go. Again just  
 2 the observations. They would have questions  
 3 and then they would have the answers. The  
 4 reserve heli-fuel on board, that's a question  
 5 we ask to make sure there's sufficient heli-  
 6 fuel for all their operations, and indeed they  
 7 sometimes carry a little extra just in case  
 8 the federal search and rescue folks dropped by  
 9 on a search and rescue --  
 10 ROIL, Q.C.:  
 11 Q. We heard some evidence about that, yeah.  
 12 MR. PIKE:  
 13 A. And they have used the offshore facilities to  
 14 extend their reach further out into the  
 15 Atlantic. Again these are just notes that --  
 16 this the other safety officer's notes. So  
 17 both sets of notes are in this file, and then  
 18 just sort of handwritten notes.  
 19 ROIL, Q.C.:  
 20 Q. I think page 24 is the one I asked you to stop  
 21 at as we scanned through.  
 22 MR. PIKE:  
 23 A. Prior to the Eirik Raude arriving in  
 24 Newfoundland, one of the employees raised some  
 25 questions with us. We did indeed answer their

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1 questions prior to the arrival of the rig, but  
 2 we used their questions as also a prompt in  
 3 our audit just to verify that some of the  
 4 things -- it was a flag, was there a problem,  
 5 why was the individual asking some of these  
 6 questions. Some of them were related to  
 7 differences of operation between here and  
 8 Norway because the rig had been operating in  
 9 Norway before it came, and other cases it was  
 10 just a flag, let's verify what's happening on  
 11 board to make sure that they are doing as they  
 12 said they'd do. So we used the questions that  
 13 he'd raised as part of our audit piece.  
 14 ROIL, Q.C.:  
 15 Q. So in addition to incidents, complaints,  
 16 observations, your policies, how do they allow  
 17 you to track things like a question from an  
 18 employee, which is clearly not a complaint?  
 19 How do you -- do you have a database for that  
 20 kind of stuff?  
 21 MR. PIKE:  
 22 A. Luckily we're a small office, so we were aware  
 23 that those questions were raised, and we don't  
 24 actually have a formal process for it, but  
 25 we're small enough to know somebody had raised

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1 the questions, we were preparing the  
 2 responses, so we were aware that there were  
 3 questions raised. As safety officer would be -  
 4 I was aware that these questions had been  
 5 raised, so when the safety officer was  
 6 preparing for the audit, I would have made him  
 7 aware of the fact that there had been  
 8 questions raised and that we should include  
 9 those in the audit, or at least verify some of  
 10 the things in there, just as a -- it's not  
 11 really a complaint or anything, but let's --  
 12 you know, there's some questions been raised,  
 13 let's answer them, let's make sure that the  
 14 answers are there. We did answer the  
 15 questions, but -- just to do some  
 16 verification. So again this is the questions  
 17 that were asked by that individual. I believe  
 18 in actual fact, it was a Newfoundlander  
 19 working on board the rig while it was in  
 20 Norway, so --  
 21 ROIL, Q.C.:  
 22 Q. They had personal knowledge. Perhaps I could  
 23 ask you to move over to page 52, in the  
 24 interest of finding some efficiencies here.  
 25 MR. PIKE:

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1 A. Okay.  
 2 ROIL, Q.C.:  
 3 Q. Because I think there's only a couple places  
 4 where some of it pops up.  
 5 MR. PIKE:  
 6 A. And again we're reviewing some of the Cougar  
 7 documentation. You can see that that's there.  
 8 So we would have verified -- and some of the  
 9 training that was taking place with their SAR  
 10 technicians, we verified that in their  
 11 records. It was 50 --  
 12 MR. PIKE:  
 13 A. 52, please.  
 14 MR. PIKE:  
 15 A. Again some of the correspondence back and  
 16 forth from the training, Cougar's training  
 17 plan.  
 18 ROIL, Q.C.:  
 19 Q. Again we've redacted some detail of that  
 20 document out, but --  
 21 MR. PIKE:  
 22 A. We have the entire document, we reviewed it.  
 23 ROIL, Q.C.:  
 24 Q. In your files you have it, page 52.  
 25 MR. PIKE:

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1 A. Okay.  
 2 ROIL, Q.C.:  
 3 Q. I see something new happening here. There's a  
 4 document that I haven't seen in the first one  
 5 we looked at.  
 6 MR. PIKE:  
 7 A. The others you saw were (unintelligible), but  
 8 we were onshore. When the safety officers  
 9 travel offshore, they try to have a more  
 10 pocket sized question list, so that this is  
 11 actually a pocket sized questions that they  
 12 keep in their pocket. So they prepared this  
 13 one, and this one is specific to helicopter  
 14 operations. When they were offshore, they  
 15 would have had another little pocket one for  
 16 the drilling operations and another pocket one  
 17 for the marine operations.  
 18 ROIL, Q.C.:  
 19 Q. So this what, just enables them to carry it in  
 20 their coveralls?  
 21 MR. PIKE:  
 22 A. Carry it while they're out in the field.  
 23 ROIL, Q.C.:  
 24 Q. Okay.  
 25 MR. PIKE:

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1 A. Again they would have done this up, so this  
 2 document is just sort of that pocket sized.  
 3 The questions are here, and you'll see that  
 4 he's either ticked them off or made some notes  
 5 in the margins on it. In this case, we're  
 6 checking some of the rescue equipment on the  
 7 helideck, so there's a list of the equipment  
 8 that should be there, and you'll notice that  
 9 he's ticked off each of those items, so he's  
 10 found those, the grab hooks, the crowbars,  
 11 bolt cutters, the rescue axe. So a number of  
 12 those items we would verify are in the actual  
 13 kit on the helideck.  
 14 ROIL, Q.C.:  
 15 Q. Okay, now I'm going to move you right over to  
 16 page 74 where we get back into the kind of  
 17 reporting that begins the paper trail towards  
 18 the end.  
 19 MR. PIKE:  
 20 A. The other thing this safety officer did in  
 21 addition to the questions, this was actually  
 22 also attached to his audit piece as well. So  
 23 now he has Ocean Rigs Policy Manual that  
 24 outlines the stuff they were supposed to be  
 25 doing. So this was also an aid for him when

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1 he was doing his audit. So this was actually  
 2 attached in that booklet, folded up in the  
 3 back, so that he had some verification. Just  
 4 a note on what the standards were that they  
 5 used and we've heard some of those before, the  
 6 UK Civil Aviation Authority, CAPP 437, and the  
 7 Transport Canada.  
 8 ROIL, Q.C.:  
 9 Q. And we've redacted a significant amount of  
 10 that out because it's proprietary to that  
 11 particular facility.  
 12 MR. PIKE:  
 13 A. Yes.  
 14 ROIL, Q.C.:  
 15 Q. Again Minutes of -- you've established that,  
 16 so I want to keep going. I'm going to push  
 17 you a little bit to get --  
 18 MR. PIKE:  
 19 A. That's the agenda.  
 20 ROIL, Q.C.:  
 21 Q. To get to page 74.  
 22 MR. PIKE:  
 23 A. What's the page again?  
 24 ROIL, Q.C.:  
 25 Q. 73, I guess, is the one.

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1 MR. PIKE:  
 2 A. Okay.  
 3 ROIL, Q.C.:  
 4 Q. This looks like a format that we've seen  
 5 before.  
 6 MR. PIKE:  
 7 A. Okay, this audit was taking place in October.  
 8 We would have carried forward observations  
 9 from a May audit, and what you're seeing here  
 10 is that the safety officer has indicated  
 11 closure on those items.  
 12 ROIL, Q.C.:  
 13 Q. Okay. I think we're coming to a couple that  
 14 are --  
 15 MR. PIKE:  
 16 A. Again this is an observation taken from May.  
 17 ROIL, Q.C.:  
 18 Q. Yes.  
 19 MR. PIKE:  
 20 A. Again it's back to the heli-fuel -- the suits  
 21 and the 200 percent immersion suit piece. So  
 22 there's some notes taken here as to what --  
 23 and we're using Helly Hansen E-350 suits.  
 24 ROIL, Q.C.:  
 25 Q. Again this is not closed off, this is just

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1 continuing to keep the paper trail alive?  
 2 MR. PIKE:  
 3 A. Yeah.  
 4 ROIL, Q.C.:  
 5 Q. Okay.  
 6 MR. PIKE:  
 7 A. Some issues around the compressed air system.  
 8 There would be self-contained breathing  
 9 apparatus that would be needed, and they'd  
 10 need to refill those.  
 11 ROIL, Q.C.:  
 12 Q. That's not in relation to the HUEBA that we've  
 13 heard about?  
 14 MR. PIKE:  
 15 A. No. By way of example, you'll see firemen  
 16 wearing the hoods, etc. It's the same type  
 17 gear as the backpack, the large tank on their  
 18 back, with the mask for breathing. So  
 19 offshore when they're fire fighting, they have  
 20 essentially the same equipment as you would  
 21 see a fire fighter carry.  
 22 ROIL, Q.C.:  
 23 Q. And that fire fighting equipment could be used  
 24 in fighting a fire involving a helicopter  
 25 landing?

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1 MR. PIKE:  
 2 A. Correct, and those tanks are offshore and you  
 3 need a way to fill them. From that previous  
 4 audit, it was noted that when they looked at  
 5 the rescue kit previously, there was something  
 6 missing, so they verified that indeed it is  
 7 there on this subsequent audit.  
 8 ROIL, Q.C.:  
 9 Q. And again at this point in time I'm going to  
 10 move you right to the end, right up to page  
 11 114.  
 12 MR. PIKE:  
 13 A. This is just some of the certificates  
 14 verifying the helicopter landing officer has  
 15 all the training. Those are some of the  
 16 meetings that took place, one of which was  
 17 with the work reps from the Joint Occupational  
 18 Health and Safety Committee.  
 19 ROIL, Q.C.:  
 20 Q. That's the same list coming back again, is it?  
 21 MR. PIKE:  
 22 A. Yes, what you're seeing there is the  
 23 operator's commitment as to when it was  
 24 closed, and this would be our -- we wouldn't  
 25 necessarily -- they call it closed. We might

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1 not sign off until we've actually verified it.  
 2 ROIL, Q.C.:  
 3 Q. Yes, okay, and I think --  
 4 MR. PIKE:  
 5 A. It explains what the operator is indicating in  
 6 this case is they consider it closed.  
 7 ROIL, Q.C.:  
 8 Q. But you don't until there's an entry in the  
 9 last column?  
 10 MR. PIKE:  
 11 A. Yes, that the safety officer is satisfied and  
 12 that's usually by verification. I'm not sure  
 13 if there's -- there would be correspondence  
 14 going back and forth on some of these  
 15 observations.  
 16 ROIL, Q.C.:  
 17 Q. I think now we're beginning to see some items  
 18 closed here, are we?  
 19 MR. PIKE:  
 20 A. Yes, you're seeing now that the safety officer  
 21 is concurring with the operator that they're  
 22 closed and the date that they closed them.  
 23 ROIL, Q.C.:  
 24 Q. Uh-hm.  
 25 MR. PIKE:

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1 A. This is November 7th, so it's after they've  
 2 come back from offshore. In some instances,  
 3 it may not actually require a verification  
 4 offshore. If it's documentation that needs to  
 5 be verified, that can be done onshore with the  
 6 operator.  
 7 ROIL, Q.C.:  
 8 Q. Right.  
 9 MR. PIKE:  
 10 A. And then correspondence tracking the  
 11 completion of some of these audits.  
 12 ROIL, Q.C.:  
 13 Q. Yeah, I think 114 then takes us to the end of  
 14 the piece which is where I'd like to get  
 15 before we break.  
 16 MR. PIKE:  
 17 A. Which page were you --  
 18 ROIL, Q.C.:  
 19 Q. 114, I think. We start seeing that the report  
 20 now again -- is this the last of the reports  
 21 in this file?  
 22 MR. PIKE:  
 23 A. This version of the report is actually stapled  
 24 to the inside of the file folder that holds  
 25 it. You have to actually dig until the actual

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1 file folder to find the ones where you have  
 2 responses from the operator. So what happens  
 3 is on the inside cover -- so you can open it  
 4 up, and it's readily available to you, you can  
 5 check to see that the safety officer signed  
 6 off and closed it. I believe in this case  
 7 we're seeing that they're all closed, although  
 8 you can't read some of the --  
 9 ROIL, Q.C.:  
 10 Q. You've actually seen the original of this, I  
 11 take it?  
 12 MR. PIKE:  
 13 A. Yes.  
 14 ROIL, Q.C.:  
 15 Q. And you can tell us that they are closed?  
 16 MR. PIKE:  
 17 A. Yeah. In this case, you see it's not, but  
 18 what you're seeing here it's been deferred, so  
 19 that means it's carried forward.  
 20 ROIL, Q.C.:  
 21 Q. Okay, and that's a non-helicopter related  
 22 item, I take it?  
 23 MR. PIKE:  
 24 A. Yes. So if we've carried it forward, that  
 25 would also be noted on this form as well that,

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1 yes, they've closed it for this particular  
 2 file and we're keeping the file open in a new  
 3 audit. What we're seeing here again, this  
 4 report would have been the one shared before  
 5 we left the rig. So the safety officers have  
 6 signed it, a worker representative from the  
 7 Joint Occupational Health and Safety Committee  
 8 has signed it, they have seen it, the operator  
 9 representative has signed it and accepted  
 10 those observations, and the owner, in this  
 11 case the OIM would have signed it, and  
 12 indicated that, yes, they're acknowledging  
 13 those observations.  
 14 ROIL, Q.C.:  
 15 Q. Just to bring us by way of sort of closing the  
 16 evidence on audits, are there any remarkable  
 17 changes in the audit process from the ones  
 18 that we've looked at to what is happening  
 19 today at C-NLOPB, or is there a continuing  
 20 evolution of small changes?  
 21 MR. PIKE:  
 22 A. As I indicated, we continue to try to improve  
 23 that process. We have instituted the  
 24 integrated audit, which is a much broader  
 25 piece. That's creating somewhat of a

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1 challenge for us, but we are working through  
 2 it because we are trying to look at the entire  
 3 system and that's a fair piece of work. So  
 4 that's still an evolving piece, but the basic  
 5 process is similar, but there are variances as  
 6 to how we do that.  
 7 ROIL, Q.C.:  
 8 Q. Okay. These are the only recent year audits  
 9 of helicopter operations that have been  
 10 conducted by C-NLOPB?  
 11 MR. PIKE:  
 12 A. Yes.  
 13 ROIL, Q.C.:  
 14 Q. Commissioner, I think that's probably a good  
 15 place for us to break for lunch.  
 16 COMMISSIONER:  
 17 Q. Yes.  
 18 (RECESS)  
 19 ROIL, Q.C.:  
 20 Q. Commissioner. Welcome back, Mr. Pike. Unless  
 21 you have some other item that arose during  
 22 lunch time that you wanted to address on the  
 23 issue of audits, we'll move on to the next --  
 24 actually there is one that I -- it's not in  
 25 your piece, but it is something that we spoke

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1 of and I asked you to reflect on and give some  
 2 comment on, and that is the issue of work  
 3 refusals. We had some evidence from one of  
 4 the workers, one of the representatives of  
 5 CEP, to the effect that he, and perhaps two  
 6 other workers, had exercised their legitimate  
 7 right to indicate that they believed the work  
 8 was unsafe, and the work in this case being  
 9 helicopter transportation, and that he  
 10 explained the process, and I just want to make  
 11 sure that we have that process understood from  
 12 your perspective as to what happened, and  
 13 perhaps the best one to focus on would be Mr.  
 14 Peddle, who was the witness who gave that  
 15 evidence. Rather than speak of the other two,  
 16 let's address his, and I don't need  
 17 documentation, I simply need -- did you get an  
 18 opportunity to see or hear his evidence or to  
 19 review it in any way.  
 20 MR. PIKE:  
 21 A. I don't recall his full evidence, but I  
 22 understood he did speak to it.  
 23 ROIL, Q.C.:  
 24 Q. Can you speak to the issue of how the C-NLOPB  
 25 deals with work refusals in the context of --

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1 MR. PIKE:  
 2 A. We have an exhibit that was prepared before.  
 3 52, can we bring that one up?  
 4 ROIL, Q.C.:  
 5 Q. Okay, we'll take a moment to bring that up.  
 6 REGISTRAR:  
 7 Q. On October 20th?  
 8 ROIL, Q.C.:  
 9 Q. That would probably be the day indeed. It was  
 10 our first day of hearings.  
 11 MR. PIKE:  
 12 A. It's the other requirements respecting  
 13 occupational health and safety --  
 14 ROIL, Q.C.:  
 15 Q. 52, that's the one. Okay, can you control it  
 16 from there?  
 17 MR. PIKE:  
 18 A. I can. These mirror the provisions in the  
 19 Provincial Occupational Health and Safety Act.  
 20 ROIL, Q.C.:  
 21 Q. Indeed. That's right, this right to refuse  
 22 work is a right that is consistently applied,  
 23 I think, throughout Canada in Occupational  
 24 Health and Safety --  
 25 MR. PIKE:

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1 A. It's one of the three basic rights of the  
 2 worker.  
 3 ROIL, Q.C.:  
 4 Q. Yes.  
 5 MR. PIKE:  
 6 A. Right to know, right to participate, and right  
 7 to refuse.  
 8 ROIL, Q.C.:  
 9 Q. Right, and we did have a fair bit of evidence  
 10 on those three rights.  
 11 MR. PIKE:  
 12 A. Right to refuse, a worker may refuse to do  
 13 work that the worker has reasonable grounds to  
 14 believe is dangerous to his or her health or  
 15 safety, or the health or safety of another  
 16 person at work, until remedial action has been  
 17 taken by the employer to the worker's  
 18 satisfaction. That generally takes place when  
 19 the worker has identified it to their  
 20 supervisor, and indeed the situation has been  
 21 remedied. If they're not satisfied at that  
 22 point, they can bring it to the next stage, to  
 23 the committee, and in this case we're  
 24 referring to the Joint Occupational Health and  
 25 Safety Committee.

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1 ROIL, Q.C.:  
 2 Q. Indeed.  
 3 MR. PIKE:  
 4 A. Or the worker health and safety  
 5 representative, that's for a smaller workplace  
 6 that would not have a committee, has  
 7 investigated the matter and advised the worker  
 8 to return to work. If they're not satisfied  
 9 at that stage, they can bring it forward, in  
 10 this case to the Board until an officer, in  
 11 this case we're talking about a safety officer  
 12 for the Offshore Petroleum Board, has  
 13 investigated the matter and advised the worker  
 14 to return to work. Then it goes on to  
 15 explain. So that's the basic process.  
 16 ROIL, Q.C.:  
 17 Q. Yeah.  
 18 MR. PIKE:  
 19 A. The first stage is that the worker would  
 20 identify to his supervisor or within the  
 21 workplace. The next stage is then it goes to  
 22 the committee. If he's not satisfied with  
 23 that piece from the committee, he would go to  
 24 the Board.  
 25 ROIL, Q.C.:



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1 Q. Right. I believe the evidence of Mr. Peddle  
 2 was that he went to the committee, the  
 3 committee was deadlocked, I believe, or it in  
 4 any event was unable to resolve it in his  
 5 favour, it was sent up to the Board and then  
 6 he explained that it was sent back to the  
 7 committee, and he was troubled by that  
 8 process. Do you understand what might have  
 9 happened there that would have caused it to be  
 10 sent back?  
 11 MR. PIKE:  
 12 A. In our discussion with the Board after the  
 13 first time they took it, we didn't believe at  
 14 that point that -- as you go on further, I  
 15 think the committee's obligation is to  
 16 investigate, and we didn't feel at that point  
 17 that they had done an investigation, while  
 18 albeit they did not have the expertise within  
 19 that committee, they could have availed or  
 20 expertise from the employer, and indeed that  
 21 has happened in other refusal cases offshore.  
 22 We haven't received it, but it has gone to the  
 23 committee level for other instances offshore,  
 24 in which case the committee engaged the  
 25 expertise they needed to take a look at the

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1 situation. In that case, it was resolved to  
 2 the employee's satisfaction. In this case, we  
 3 hadn't seen that investigation component of  
 4 the committee. We asked that the committee go  
 5 back and do their due diligence in this case,  
 6 their investigation. Once they had done the  
 7 reasonable investigation and still could not  
 8 come to a conclusion, then the piece was  
 9 brought to us.  
 10 ROIL, Q.C.:  
 11 Q. Okay, so you're simply saying to the  
 12 committee, you have to follow through the  
 13 steps that are available to you.  
 14 MR. PIKE:  
 15 A. There is a process, and they have a duty in  
 16 this piece as well.  
 17 ROIL, Q.C.:  
 18 Q. Okay, and --  
 19 MR. PIKE:  
 20 A. And throughout this whole process, we were in  
 21 consultation with the Provincial Health and  
 22 Safety Program, so those folks -- we were in  
 23 discussion with them to make sure that the  
 24 process that we were following was correct.  
 25 ROIL, Q.C.:

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1 Q. Okay, and again the purpose of my questioning  
 2 is not to test whether you came up with the  
 3 right answer, but what sort of resources did  
 4 you call upon to answer the question? You've  
 5 already indicated that there was not a  
 6 specific expertise within the Board's staff.  
 7 What kind of resources would you have had  
 8 access to, and did you have access to, in  
 9 order to answer the question about whether  
 10 helicopter safety was safe in the context of  
 11 one of these auxiliary tanks? I think it was  
 12 the auxiliary fuel tank that was the issue.  
 13 MR. PIKE:  
 14 A. In the first instance, we assigned two safety  
 15 officers.  
 16 ROIL, Q.C.:  
 17 Q. Yes.  
 18 MR. PIKE:  
 19 A. The first step in that process was to sit down  
 20 with the complainant to make sure we  
 21 understood exactly what was -- what his  
 22 concern was, and from that we proceeded and  
 23 got some additional information. I believe we  
 24 talked to in that case the helicopter  
 25 manufacturer, we talked to Transport Canada

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1 Aviation, we talked to the Transportation  
 2 Safety Board, we got some additional  
 3 information from our colleagues in the North  
 4 Sea, some expertise there. We had the  
 5 evidence from the Marine Institute, the  
 6 Offshore Safety and Survival Centre, and in  
 7 addition to that we did have discussions with  
 8 Survival Systems in Halifax. We didn't note  
 9 that in our response back, but we did have  
 10 those discussions with Survival Systems at  
 11 that time. So they did a fairly extensive  
 12 search for the facts in this situation.  
 13 ROIL, Q.C.:  
 14 Q. And at the end of the day, I take it the C-  
 15 NLOPB did make a decision?  
 16 MR. PIKE:  
 17 A. We did.  
 18 ROIL, Q.C.:  
 19 Q. And you decided that the worker should --  
 20 MR. PIKE:  
 21 A. Return to work.  
 22 ROIL, Q.C.:  
 23 Q. That it was not unsafe?  
 24 MR. PIKE:  
 25 A. Yes.

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1 ROIL, Q.C.:

2 Q. Again I'm not -- I understand that the worker

3 was not happy with that conclusion, but I

4 wanted to know what processes you went through

5 to come to a conclusion. Would that be a

6 similar -- would you amount of diligence

7 normally be associated with a work refusal

8 that comes up to the Board?

9 MR. PIKE:

10 A. Yes.

11 ROIL, Q.C.:

12 Q. So you would normally look outside and look

13 for special expertise?

14 MR. PIKE:

15 A. We would, depending on what it was we were

16 looking at, yes. If we needed that outside

17 expertise, we would look for it, yes.

18 ROIL, Q.C.:

19 Q. I think that's all I wanted to ask you. I

20 wanted to give you an opportunity to explain

21 what happened from the Board's perspective, so

22 that we have both sides of the explanation, as

23 I say, not to test whether the right answer

24 was gotten, but just to see that there was a

25 diligence process.

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1 MR. PIKE:

2 A. And we took what time was necessary to get

3 that information.

4 ROIL, Q.C.:

5 Q. How long did it take, ball park?

6 MR. PIKE:

7 A. Approximately a week.

8 ROIL, Q.C.:

9 Q. Would that be a longer than normal period of

10 time?

11 MR. PIKE:

12 A. This is the first three work refusals we've

13 had to investigate were the three that have

14 been mentioned here, and they occurred in the

15 November time frame.

16 ROIL, Q.C.:

17 Q. So in relation to the offshore, there have not

18 been other work refusals?

19 MR. PIKE:

20 A. Not that it reached the stage of a Board

21 investigation, no.

22 ROIL, Q.C.:

23 Q. Okay. We wanted to move on this afternoon to

24 the issue of communication and some other

25 points. So if your mouse will work, you can

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1 control the --

2 MR. PIKE:

3 A. Again this is an outline. I'll talk a little

4 bit about the daily reports that we receive,

5 the monthly statistics, the quarterly meetings

6 that are held with the producing operators,

7 the operators and the producing facilities,

8 the installation or workplace Joint

9 Occupational Health and Safety Committee, we

10 receive their Minutes, the annual Joint

11 Occupational Health and Safety Committee

12 sessions that we hold, and you're familiar

13 with those.

14 ROIL, Q.C.:

15 Q. Indeed.

16 MR. PIKE:

17 A. An annual meeting that the Chief Safety

18 Officers of both the Newfoundland and the Nova

19 Scotia Board hold with the CAPP Safety

20 Committee, and I'll deal now very briefly with

21 the other regulatory agencies that we would

22 have communications with. I just indicated as

23 we talked about the refusals, that we had

24 extensive discussions with the Provincial

25 Occupational Health and Safety Program over

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1 the OHS -- the refusals, and to get some

2 understanding from them as to the processes

3 involved and some advice in that regard. So

4 we talk extensively with the Provincial OHS

5 Program and they provide us some advice. The

6 Energy Departments, obviously we have an

7 ongoing dialogue with them. Transport Canada

8 Marine Safety, we've had a longstanding

9 working relationship with them, a very good

10 working relationship. They issue letters of

11 compliance for the drilling units on our

12 behalf, and in addition to that, the two FPSOs

13 are actually also Canadian flagged vessels, so

14 there are certain Canada Shipping Act pieces

15 that apply as well, so we work very closely

16 with them on the FPSOs and discuss issues

17 continuously on that piece. So we are in

18 constant dialogue. If they see something

19 that's coming up, they talk to us; as we see

20 something, we'll talk to them, particularly

21 with regards to the FPSOs. Again when they're

22 on the drilling units which are foreign

23 flagged, they're working on our behalf. As I

24 indicated as well while we were going through

25 work refusals, and any time we come up with an

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1 aviation issue, we have discussions with  
 2 Transport Canada Aviation out of their Moncton  
 3 office. So we have several contacts there  
 4 that we -- while we don't have a formal  
 5 agreement and we are working towards a formal  
 6 agreement on that, and indeed Transport Canada  
 7 Marine Safety, we're updating our MOU with  
 8 them. We do have one and I think the  
 9 provincial -- when they presented here, they  
 10 did note that we do have an MOU with the  
 11 Provincial OHS Program, what we notify and  
 12 what help they provide us. We do have a  
 13 current MOU with the Transportation Safety  
 14 Board. We are updating that one as well.  
 15 They provide some training that we're hoping  
 16 to avail of from those folks, and again during  
 17 the work refusals, we did have some  
 18 discussions with them. We're developing an  
 19 MOU with Transport Canada Marine Security  
 20 folks. Under Public Safety Canada, there is a  
 21 Regional Emergency Management Coordinating  
 22 Committee, and that essentially is most of  
 23 what would be referred to as the first  
 24 response government agencies within this  
 25 region. So that's your Coast Guard, your

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1 RCMP, DND. There's a full gamut of those  
 2 agencies that would have some piece within the  
 3 emergency management component.  
 4 ROIL, Q.C.:  
 5 Q. I'll just ask you, Public Safety Canada is not  
 6 a name that many people would be familiar  
 7 with. Is that the new name?  
 8 MR. PIKE:  
 9 A. That's the new name of what might have been  
 10 referred to as Emergency Preparedness Canada.  
 11 They have gone through several different names  
 12 in the last number of years, and that's the  
 13 one they currently sit, and they chair  
 14 essentially or coordinate that meeting.  
 15 Indeed there was one last fall where we did  
 16 review the government response to the March  
 17 12th incident. That was reviewed at that  
 18 meeting. It's also used for onshore  
 19 emergencies as well. You know, they would  
 20 have been involved in things like the flooding  
 21 that occurred several years ago in Badger. So  
 22 that same group would have been dealing with  
 23 that, and we're part of that committee. It  
 24 also helps to meet some of those folks so that  
 25 when you're in an emergency, you know who it

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1 is at the other end of the phone when you call  
 2 them. There's also a security sub-committee  
 3 of that one. In addition, on a federal and  
 4 national level, there is an energy  
 5 infrastructure protection working group. So  
 6 it's really the energy agencies, and they meet  
 7 twice a year. So we're involved with that one  
 8 as well. It really is focused more in the  
 9 security area, so it's more of the security  
 10 folks that would be there, and it's usually  
 11 hosted at CSIS Headquarters in Ottawa. So we  
 12 meet there twice a year. So that's  
 13 essentially some of the other agencies that we  
 14 do have and can avail of their expertise.  
 15 ROIL, Q.C.:  
 16 Q. So this is all under the auspices of that  
 17 heading, "Other regulatory agencies"?  
 18 MR. PIKE:  
 19 A. Other regulatory agencies.  
 20 ROIL, Q.C.:  
 21 Q. And we don't have a specific slide dealing  
 22 with that?  
 23 MR. PIKE:  
 24 A. We don't.  
 25 ROIL, Q.C.:

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1 Q. Okay. Now daily reports, I think you  
 2 indicated when you were going through your  
 3 evidence this morning that daily reports can  
 4 sometimes find their way into the audit piece?  
 5 MR. PIKE:  
 6 A. We would review those to see what's happening  
 7 on the installation before we actually go  
 8 offshore. There are several different types.  
 9 The ones we receive and have the most  
 10 background on are drilling reports. They call  
 11 them tour sheets. You go out on any drilling  
 12 rig anywhere in the world and ask for the tour  
 13 sheet and they'll know exactly what it is  
 14 you're talking about. The standard format for  
 15 those are set by the International Association  
 16 of Drilling Contractors, and that covers the  
 17 full gamut of what I referred to as  
 18 operational safety issues, so precisely from a  
 19 technical standpoint what they're doing in the  
 20 drilling of the well. It also covers some of  
 21 the occupational safety issues and some of the  
 22 logistics issues. So you'll know who's on  
 23 board, what the POB is, when they did their  
 24 last safety drills. It would even include  
 25 when the helicopter flights -- what

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1 helicopters flights have taken place.  
 2 ROIL, Q.C.:  
 3 Q. I was about to ask, there would be some  
 4 indication of helicopter activity on them?  
 5 MR. PIKE:  
 6 A. Yes, and supply boat activity.  
 7 ROIL, Q.C.:  
 8 Q. Right.  
 9 MR. PIKE:  
 10 A. In addition to those, I haven't listed it  
 11 there, we would also receive the geological  
 12 reports. That gives us some sense of what's  
 13 happening down-hole so that it becomes an  
 14 issue if you're dealing -- you know, to keep  
 15 on top of things like well blowouts and what  
 16 not. That's a useful piece of information.  
 17 We don't tend to look at them very often, we  
 18 rely on our geoscientists to brief us on what  
 19 they see, vis a vis the geology. The daily  
 20 production reports have got a similar content,  
 21 but they're all individually styled to the  
 22 operators. The would contain the production  
 23 information by well in total. That's  
 24 information that our resource management folks  
 25 are looking at more particularly. We have

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1 occasionally looked at it, but it's really a  
 2 resource management issue there. The process  
 3 summary, they would highlight in there what  
 4 pieces of process equipment are up and running  
 5 and which pieces are down, so that gives us  
 6 some idea of how things are going, and a  
 7 logistics summary, and again they will note  
 8 there whether there's been helicopter --  
 9 whether a helicopter had to be cancelled, the  
 10 POB numbers, they will sometimes list the  
 11 drills, emergency safety equipment, or any  
 12 safety incidents, they will note those in a  
 13 very brief form in that particular report.  
 14 Then construction reports, if we had a diving  
 15 operation ongoing offshore, they would supply  
 16 daily reports including what the dive activity  
 17 is and again there will be some logistical  
 18 components to that. Reports -- if there's a  
 19 flow line, a vessel installing flow lines,  
 20 they would provide us with daily reports as  
 21 well. There is also geophysical reports, so  
 22 the seismic programs that are run offshore,  
 23 they will provide us reports generally on a  
 24 weekly basis, but occasionally we will get  
 25 them daily depending on what works for them,

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1 but we would generally expect those on a  
 2 weekly basis and they would provide us a  
 3 summary. Principally it's the geoscientists  
 4 want to know what's going on, but we would  
 5 also get some information and they would give  
 6 us -- some of the health safety and  
 7 environment summary would show up in that  
 8 piece as well. It's checked regularly, these  
 9 daily reports, but I wouldn't necessarily say  
 10 they're checked daily.  
 11 ROIL, Q.C.:  
 12 Q. If there was an incident about helicopter  
 13 safety that happened on a facility, would you  
 14 expect to see it here or is it more likely to  
 15 have a different type of reporting?  
 16 MR. PIKE:  
 17 A. We would expect to see it as an incident  
 18 report, but you may see something noted here  
 19 as well.  
 20 ROIL, Q.C.:  
 21 Q. Okay.  
 22 MR. PIKE:  
 23 A. If it didn't occur there, I wouldn't be  
 24 surprised, but occasionally you will see them  
 25 listed there as well.

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1 ROIL, Q.C.:  
 2 Q. Okay, so these daily reports are not designed  
 3 specifically with a safety focus, but they can  
 4 engage you in the safety piece?  
 5 MR. PIKE:  
 6 A. It gives us that operational overview of  
 7 what's happening and they do note some of the  
 8 safety things that are happening.  
 9 ROIL, Q.C.:  
 10 Q. Okay.  
 11 MR. PIKE:  
 12 A. The monthly statistics reports, they give us  
 13 the number of hours worked by the operator in  
 14 that month. Any reportable injuries, and for  
 15 us a reportable injury is where the worker is  
 16 not able to return for the next shift for  
 17 their full duties. So if any way they aren't  
 18 able to do their full duties, that's  
 19 considered a reportable injury. Traditionally  
 20 you'll hear them referred to as lost time  
 21 injuries and potentially restricted work  
 22 injuries. Those two would be lumped together  
 23 when they report those to us. As I mentioned,  
 24 I think earlier this morning, medical aid  
 25 injuries, there were something beyond first

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1 aid that was rendered, but the individual was  
 2 able to return to work the next shift for  
 3 their full -- and be able to do their full  
 4 duties, and then a note on the first aids.  
 5 ROIL, Q.C.:  
 6 Q. Which again is a lower triaging of the  
 7 seriousness of the medical event?  
 8 MR. PIKE:  
 9 A. Yeah.  
 10 ROIL, Q.C.:  
 11 Q. Okay.  
 12 MR. PIKE:  
 13 A. We put these statistics in our annual report  
 14 and we also publish those on our web, and the  
 15 other note in this, it's only part of the  
 16 story for safety in the offshore. I mean,  
 17 we're talking here about the occupational  
 18 safety. It really doesn't deal anything with  
 19 the operational safety. The operational  
 20 safety would be the safety of the actual plant  
 21 itself, and are not really covered in these  
 22 statistics. So relying solely on this piece,  
 23 will give -- could give a false sense of  
 24 what's happening on the installation. There's  
 25 been several major incidents that have pointed

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1 that out, I think.  
 2 ROIL, Q.C.:  
 3 Q. Where would -- in your environment, where  
 4 would the operational safety piece get  
 5 reported?  
 6 MR. PIKE:  
 7 A. We pick those up in the -- we pick those  
 8 pieces up in the incident reporting.  
 9 ROIL, Q.C.:  
 10 Q. Yes.  
 11 MR. PIKE:  
 12 A. That's why we've expanded some of our incident  
 13 reporting to cover off that. The operational  
 14 or process safety component, that's a  
 15 relatively newer area, highlighted extensively  
 16 when you look at the refinery accident in  
 17 Texas, the BP Texas City Refinery explosion.  
 18 They had an exemplary occupational safety  
 19 record, yet there was an underlying  
 20 occupational -- operational safety issues were  
 21 there and weren't being displayed when you  
 22 look at only the occupational safety  
 23 statistics. So a costly example of you can  
 24 get misled if you only look at one set of  
 25 statistics. You need to be looking at it all.

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1 Quarterly meetings, we meet on a quarterly  
 2 basis with each of the operators of the  
 3 producing facilities. We review the  
 4 activities of the previous quarter, and the  
 5 first item on the agenda is the safety  
 6 performance. We also forecast activities over  
 7 the next quarter and beyond. So it's an  
 8 opportunity for us to discuss what's coming up  
 9 and what we need to prepare for, and discuss  
 10 any issues of concern. With regard to that,  
 11 we did see, and I think we made mention of  
 12 issues with the transportation suits in our  
 13 monitoring of the Joint Occupational Health  
 14 and Safety Committee Minutes. We'll see that  
 15 in a minute. We were seeing that as a  
 16 increasing concern, so during our July, 2008  
 17 quarterly meetings, I did raise the issue of  
 18 transportation suits, and indeed I think  
 19 you've seen a presentation that Suncor gave us  
 20 in July of 2008.  
 21 ROIL, Q.C.:  
 22 Q. Yes.  
 23 MR. PIKE:  
 24 A. I can quickly go over some of the issues as we  
 25 understood them in July of 2008.

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1 ROIL, Q.C.:  
 2 Q. Do you want to do that? Is this as good a  
 3 time as any to talk about suits?  
 4 MR. PIKE:  
 5 A. We can do it. It was one of the key things  
 6 that we did in that quarterly meeting and we  
 7 identified it.  
 8 ROIL, Q.C.:  
 9 Q. Everybody else has offered some commentary on  
 10 it, so it might be appropriate for the Board  
 11 to give its view on --  
 12 MR. PIKE:  
 13 A. I can give you what we understood from it that  
 14 week in July, and then we can talk a little  
 15 bit about some of the others. So problems  
 16 being able to completely zip up the suits,  
 17 most operators have implemented a process to  
 18 have people do this at the heliport before  
 19 they leave, although one of our safety  
 20 officers noted that on this last trip, it  
 21 wasn't done, so we did follow up with the  
 22 operators on that piece. Problems with false  
 23 activation of the life vests, the toggle used  
 24 to activate the life vest was more prone to  
 25 accidental release in the older suits, albeit

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1 they did note that that normally was occurring  
 2 when they were actually donning the suit in  
 3 the heliport or offshore. The one that was  
 4 somewhat troubling was buoyancy issues. These  
 5 suits were more buoyant than the old suits and  
 6 it has caused issues with the egress in the  
 7 HUET trainer. One of our own environmental  
 8 affairs officer can attest to that problem.  
 9 At I note, the suits do meet the new standard,  
 10 as well the C-NSOPB has noted, and that's the  
 11 Nova Scotia Offshore Petroleum Board, has  
 12 noted issues with the suit buoyancy has  
 13 indicated, and I've got some notes from Nova  
 14 Scotia. So we were hearing some things from  
 15 Nova Scotia as well. Sizing issues for people  
 16 who were outside the normal size, and we did  
 17 note in here the issue from the Terra Nova  
 18 Joint Occupational Health and Safety Minutes  
 19 about a petite individual. The boots have a  
 20 very aggressive sole resulting in problems  
 21 walking without stumbling, and goggles for  
 22 helicopter escape no longer useful because of  
 23 the current style of goggles with the seal,  
 24 with the face seal. There was some issues  
 25 with getting a proper seal on the goggles. Of

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1 note, goggles are not actually used in the  
 2 Nova Scotia offshore. They've had the Helly  
 3 Hansen suit with the face shield for some  
 4 years, and I think they identified that  
 5 problem very early on and actually eliminated  
 6 goggles, so goggles are not actually carried  
 7 in the Nova Scotia --  
 8 ROIL, Q.C.:  
 9 Q. You say in Nova Scotia, the face seal, is that  
 10 the HTS-1 that we've heard about?  
 11 MR. PIKE:  
 12 A. No, they're using essentially the same suit as  
 13 we're using here, but the suit they replaced  
 14 with the current suit was a Helly Hansen suit  
 15 -- sorry, was the model --  
 16 ROIL, Q.C.:  
 17 Q. The 352, I think.  
 18 MR. PIKE:  
 19 A. Yes, the 352 suit versus the one, so they  
 20 identified very early on that there was an  
 21 issue with goggles and they eliminated  
 22 goggles. We retain goggles in this  
 23 jurisdiction, feeling that they are a benefit.  
 24 ROIL, Q.C.:  
 25 Q. But your transition wasn't from a 352, it was

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1 from a different manufacturer?  
 2 MR. PIKE:  
 3 A. Different manufacturer, yes.  
 4 ROIL, Q.C.:  
 5 Q. Okay.  
 6 MR. PIKE:  
 7 A. And we've been working some of those issues on  
 8 the goggles, and from the Nova Scotia side,  
 9 they identified sizing, and in this case  
 10 they're identifying larger people. They also  
 11 did identify some leakage during training  
 12 exercise. The buoyancy issue was raised.  
 13 Thermal rating, the standards now requires  
 14 thermal testing in agitated water which has  
 15 increased the amount of insulation, and hence  
 16 buoyancy in there. They had an additional  
 17 problem where on the Sable Project crews are  
 18 moved on a daily basis, and in the warmer  
 19 temperatures they were finding heat exhaustion  
 20 was an issue for the workers. So they were  
 21 overheating with these suits. In particular,  
 22 the Super Pumas didn't have, or don't have air  
 23 conditioning, so as a result the cabin would  
 24 heat up. With these warmer suits, the workers  
 25 were finding a problem. They identified the

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1 zippers being difficult and they were working  
 2 with those. They identified the testing issue  
 3 with regard to how the suit standard as it  
 4 currently exists involved the testing, and  
 5 they also identified some issues coming out of  
 6 the training institutes and what they were  
 7 noting vis a vis the students having a little  
 8 more difficulty performing some of the  
 9 functions. So that's the information we had  
 10 then. We raised some of these issues with the  
 11 operators in July. We had a meeting, and I  
 12 think it'll show up in a few minutes, our  
 13 annual meeting was held in November of 2008,  
 14 the issues came up again. So we did raise it  
 15 again with the operators in January, 2009.  
 16 There were some discussions on that. We were  
 17 still looking at what the issues were at that  
 18 point when we had the incident on March 12th.  
 19 I think if we refer to a letter that I wrote  
 20 in June of 2009, Exhibit 205, at this point we  
 21 were aware that the operators were aware of  
 22 these issues and we were working them, we knew  
 23 as well that the committees had them as items  
 24 on their list, and -- probably just look at  
 25 the one.

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1 ROIL, Q.C.:

2 Q. We just need to look at one, and I think the

3 second paragraph is the one that I'd like to

4 draw your attention to and speak about a

5 little bit.

6 MR. PIKE:

7 A. And again as a regulator, we're looking at

8 performance to the regulation, and in this

9 case, notwithstanding the helicopter suits are

10 certified to the CSGB standard, and that's the

11 standard that's called up in the regulations

12 and that indeed everybody is wearing them,

13 which are the two criteria in the prescriptive

14 regulations, so they are essentially meeting

15 the regulatory requirement here, the

16 prescriptive regulatory requirement, we still

17 had an issue. So what I have done here is

18 identified another section stating that -- I

19 think it's -- I thought it might help, but it

20 doesn't.

21 ROIL, Q.C.:

22 Q. Yeah, no, you --

23 MR. PIKE:

24 A. Notwithstanding the helicopter suits meet that

25 standard, I have called up Section 12 of the

Page 206

1 regulations requires all protective equipment

2 be designed to protect the person from the

3 hazard for which it is provided, and shall not

4 in itself create a hazard, which is a more

5 goal oriented piece as opposed to the

6 prescriptive piece that calls up the standard,

7 and that you shall wear it. We are aware of

8 comments from the previous year on the actual

9 standard because the committee was

10 reactivating to take a look at the standard.

11 The helicopter suit standard, there was

12 questions of adequacy of the leak testing. We

13 required the operators to immediately begin

14 the process to demonstrate that helicopter

15 transport suits provide adequate protection

16 from the hazard of hypothermia. The operator

17 should provide the results of the assessments

18 to the C-NLOPB and also to the CSGB Committee

19 to help inform action on the standard. As a

20 result of that, some testing was done in July,

21 I believe, of last year at the Core Group, or

22 Survival Systems, one of the companies that

23 fall under the umbrella of Survival Systems,

24 did they some testing in their facilities in

25 Halifax on the leakage.

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1 ROIL, Q.C.:

2 Q. I think the point I want to ask you to comment

3 on here is not so much the suits because I

4 think they're getting a fair bit of diligence

5 at this point in time, but you had mentioned

6 the so-called prescriptive test versus the

7 goal oriented one, so I'm -- I just want to

8 make sure we understand. If all you had in

9 your toolbox was a prescriptive set of "thou

10 shalt wear a CGSB approved and thou shalt wear

11 it at all times", you're saying the test is

12 met?

13 MR. PIKE:

14 A. The test is met and there's very little else I

15 could do as a regulator.

16 ROIL, Q.C.:

17 Q. Okay.

18 MR. PIKE:

19 A. They have met the test of the requirement of

20 the prescriptive regulation. Notwithstanding

21 there's a problem, they have met the

22 prescriptive test of the regulations.

23 ROIL, Q.C.:

24 Q. So how did you link yourself into the goal

25 performance?

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1 MR. PIKE:

2 A. We were able to link it back as a piece of

3 protective equipment.

4 ROIL, Q.C.:

5 Q. Yes.

6 MR. PIKE:

7 A. And that the goal of it actually providing the

8 protection from the hazard that it was

9 designed to. So we're linking it back in this

10 regard, notwithstanding they're meeting the

11 standard, and in fairness to the operator,

12 they were identifying at this point as well

13 there were some issues and this was a follow

14 up to make sure that we did take a look at --

15 that we are getting adequate protection from

16 these suits.

17 ROIL, Q.C.:

18 Q. Right. I don't want to oversimplify what

19 might be in your world a very complex item.

20 Is it that we are now learning that the goal

21 oriented measurement is the better tool, or is

22 it a blend of prescriptive and goal, depending

23 on what the issue is, or what the wording is?

24 MR. PIKE:

25 A. The newer regulations that we've come out

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1 with, the Drilling and Production Regulations,  
 2 are what I would refer to as goal oriented.  
 3 So in many parts they have goals, but they are  
 4 also some prescriptive parts in it as well,  
 5 but the leaning is towards the goal. The both  
 6 have their strengths and weaknesses. Certainly  
 7 the prescriptive piece is very easy to say,  
 8 yes, you're complying or, no, you're not, so  
 9 it's a very tick box type thing, and provided  
 10 the rule has been set and it's robust enough,  
 11 you're in good shape, but if it's not, and I  
 12 think the Ocean Ranger certainly identified  
 13 that prescriptive regulation is not  
 14 necessarily the right way to go, and it was a  
 15 very clear statement in the report, Chapter 2,  
 16 that they felt that there are limitations in  
 17 the goal oriented world, that's not to say I  
 18 don't believe in standards, I think they're a  
 19 helpful piece to us, but if it's just tagged  
 20 to the standard or the prescriptive piece, it  
 21 makes it very difficult when you do run into  
 22 problems because there is compliance in that  
 23 case.  
 24 ROIL, Q.C.:  
 25 Q. So the --

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1 MR. PIKE:  
 2 A. The goal then becomes -- and it's a little  
 3 more difficult one sometimes to enforce, but  
 4 it does provide you that avenue to take a look  
 5 at the broader picture of what's happening.  
 6 ROIL, Q.C.:  
 7 Q. So to oversimplify, the prescriptive one is  
 8 does it meet the test; the goal one is, does  
 9 it do the job?  
 10 MR. PIKE:  
 11 A. Does it do the job, exactly, and the it's --  
 12 the operator then has to demonstrate how the  
 13 device that they have used meets that goal.  
 14 ROIL, Q.C.:  
 15 Q. Okay, I think that explanation is very helpful  
 16 to us. Thank you.  
 17 MR. PIKE:  
 18 A. Okay.  
 19 ROIL, Q.C.:  
 20 Q. Okay, we need to go back to our slide.  
 21 MR. PIKE:  
 22 A. Go back to the presentation, unless you've got  
 23 any other questions on --  
 24 ROIL, Q.C.:  
 25 Q. No, I think that's all I have for the suit

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1 issue. I think we've -- we've talked a lot  
 2 about it, but I wanted to get a little  
 3 commentary from you on that prescriptive and  
 4 goal objective because I think that's a thing  
 5 we need to understand fully.  
 6 MR. PIKE:  
 7 A. Yeah.  
 8 ROIL, Q.C.:  
 9 Q. Okay.  
 10 MR. PIKE:  
 11 A. The Joint Occupational Health and Safety  
 12 Committee Minutes. Each workplace must have a  
 13 Joint Occupational Health and Safety  
 14 Committee, and I think I talked a little bit  
 15 about that the last time I was here.  
 16 ROIL, Q.C.:  
 17 Q. And we've heard a lot about that from the  
 18 operators as well, so --  
 19 MR. PIKE:  
 20 A. Again in the offshore, we've got it workplace  
 21 based as opposed to employer based.  
 22 ROIL, Q.C.:  
 23 Q. Right.  
 24 MR. PIKE:  
 25 A. You'll see that the legislation onshore refers

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1 to, "The employer shall have a Joint  
 2 Occupational Health and Safety Committee", and  
 3 what we've applied in the offshore is the  
 4 workplace because there are many employers on  
 5 these installations, and the way that this has  
 6 worked and certainly the model that we've  
 7 taken from the North Sea is a single committee  
 8 for the entire installation, or a workplace  
 9 based committee with constituencies  
 10 representing different parts of the committee.  
 11 We expect them to meet once each rotation, so  
 12 that's every three weeks. The actual minimum  
 13 requirement within the legislation is once  
 14 every three months, and we feel that that's  
 15 not adequate given the workplace that we have  
 16 offshore. It's a very dynamic workplace, as  
 17 highlighted in the Ocean Ranger Commission, it  
 18 changes quite quickly, so having it once  
 19 rotation we felt was an important piece.  
 20 ROIL, Q.C.:  
 21 Q. So that's really twice in every six weeks, but  
 22 each time with a different group of the three  
 23 week cycle?  
 24 MR. PIKE:  
 25 A. Yes. So the Minutes of their meetings must be



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1 submitted, the operators are required to  
 2 respond in a timely manner, normally about 30  
 3 days if there's an issue raised by the  
 4 committee, the Minutes are reviewed by two  
 5 safety officers. I think -- I have one safety  
 6 officer who coordinates all the Minutes, so he  
 7 tracks them all and enters them in the  
 8 database, and the other safety officer that  
 9 would look at it is the safety officer  
 10 associated with that installation or that work  
 11 authorization. So there's two safety officers  
 12 doing it. The database is entered so that we  
 13 can track to make sure that the meetings are  
 14 taking place and that we do receive the  
 15 Minutes. In addition to that, they may  
 16 identify issues that we might want to follow  
 17 up on, and I won't say that that's more  
 18 subjective for them, but there's some things  
 19 that they may want to track to make sure  
 20 things are getting closed, and of note in  
 21 there, in 2008, we had 20 entries on  
 22 transportation suits in the database on Joint  
 23 Occupational Health and Safety Committees, and  
 24 since June of 2009, there are 27 entries in  
 25 the database on Joint Occupational Health and

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1 Safety Committee Minutes. So we are tracking  
 2 some of those items and we've identified those  
 3 as something to be tracked in the database.  
 4 ROIL, Q.C.:  
 5 Q. Okay, before you go to the next slide and the  
 6 next issue, I would ask you to give a comment  
 7 to the Commissioner on the concern, if you  
 8 will, that was expressed by the workers who  
 9 gave evidence who were, and forgive me if I  
 10 don't express this quite right, they were  
 11 acknowledging that in the activity that goes  
 12 on on board the vessel or the facility, that  
 13 they have the expertise and the knowledge and  
 14 the understanding, or they have immediate  
 15 access to that so that they can understand the  
 16 issues, but that with respect to helicopter  
 17 transportation, they felt that the resources  
 18 weren't available to them to be able to  
 19 understand and monitor helicopter safety in  
 20 this kind of environment. Has that opinion  
 21 ever been expressed to you before, and is it  
 22 something that you have any commentary on?  
 23 MR. PIKE:  
 24 A. That's been a more recent comment from the  
 25 committees, and I would say with our new

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1 guidance document that actually covers support  
 2 craft, it would be along the list of incidents  
 3 that would be available from the operator, so  
 4 it would then be a matter of the committee  
 5 actually requesting the list of incidents from  
 6 the operator, and that should include the  
 7 incidents involving helicopters.  
 8 ROIL, Q.C.:  
 9 Q. Okay, but if they get the incidents -- you  
 10 know, the explanation was if I get something  
 11 about a valve that is leaky on a facility,  
 12 then either me or one of my buddies, we work  
 13 on these valves. If I get a report on a  
 14 helicopter incident, I don't have and my  
 15 coworkers don't have the ability to understand  
 16 or ask the right questions about those, and I  
 17 think their plea was for there to be some  
 18 resource or some information available to them  
 19 to assist them in that -- in getting  
 20 ownership, to use that word, of the helicopter  
 21 issues when they come to the Occupational  
 22 Health and Safety Committees?  
 23 MR. PIKE:  
 24 A. If they frame that question appropriately in  
 25 the Minutes as an issue, the operator is

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1 required to respond. So the operator should  
 2 be providing, when they are phrased that way,  
 3 the report or the information back to the  
 4 committee. So if they frame the question  
 5 correctly, and we've had discussion over the  
 6 years at our annual sessions as to how they  
 7 may do some of these things, not necessarily  
 8 associated with helicopters, but other areas,  
 9 if you frame your question correctly, the  
 10 operator is required to respond. So if it is  
 11 an issue related to transport of helicopters,  
 12 and you framed it correctly in your Minutes,  
 13 there is a requirement on the operator to  
 14 respond with the information that you need to  
 15 form that opinion.  
 16 ROIL, Q.C.:  
 17 Q. I'm not sure that this issue ever came as  
 18 clear to anybody as it did during our  
 19 hearings, but certainly the issue is before us  
 20 now.  
 21 MR. PIKE:  
 22 A. We haven't had that sort of discussion with  
 23 helicopters, but we have had it for other  
 24 issues in the past at the annual JOHS  
 25 sessions.

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1 ROIL, Q.C.:

2 Q. And I think we're going to get on to the

3 annual JOHS sessions right now.

4 MR. PIKE:

5 A. Back, and I think around 2000, we identified a

6 need to be able to meet with workers, to get

7 worker input in what we did, and after some

8 discussion, we finally sort of settled --

9 because at that point, there was no organized

10 offshore workplace, so getting workers

11 together was a bit of a challenge. So we

12 identified the Joint Occupational Health and

13 Safety Committee as being a vehicle to meet

14 with workers. So in 2002, we convened a

15 meeting of the worker representatives only to

16 meet and discuss some of the issues about the

17 offshore. Those meetings tended to be a

18 little bit more informal. We kept holding

19 those on an annual basis. They progressed

20 from a worker representative only to the

21 committee, the Joint Occupational Health and

22 Safety Committee. Supervisors rightly pointed

23 out it was a committee, there were two sides

24 to it, so they wanted to be present, so we did

25 that. They're held as two sessions over a two

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1 day period, three weeks apart.

2 ROIL, Q.C.:

3 Q. So they're two two-day sessions three weeks

4 apart?

5 MR. PIKE:

6 A. Two two-day sessions three weeks apart. At

7 one stage we would hold the first day with the

8 entire committee, and the second day with the

9 worker reps. More recently, in the meeting

10 that you would have been present for, what we

11 did was a little different format and again,

12 this is an evolving piece, trying to improve

13 it, get the most out of this period. We held

14 it with the entire committee over the two days

15 and we held breakout sessions, and I think

16 that went fairly well and most people were

17 very receptive to it. It's only been in more

18 recent years that we've actually done formal

19 minutes and we have some of those and we'll

20 refer to those coming up. I think it really

21 started in about 2006 where we actually got

22 formal minutes.

23 It's an opportunity to discuss issues in

24 a multi-workplace forum. So they aren't

25 focused necessarily on one installation.

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1 Those are offshore industry wide sort of

2 discussions that we can get into, and while

3 the safety officers do meet with worker reps

4 and are on the offshore installations, it was

5 another opportunity to have that discussion

6 with the offshore workers, and indeed

7 supervisors are also offshore workers, so it's

8 an opportunity to meet and have that

9 discussion with them and I think they've been

10 very successful.

11 ROIL, Q.C.:

12 Q. Do I understand that you've also brought in

13 some additional resources from outside your

14 organization to help you focus?

15 MR. PIKE:

16 A. I was just going to say. The initial set of

17 minutes in February/March, we got the minutes

18 out in June. So we got a bit of a lag. We're

19 having trouble there. In the November 2006

20 meeting, we were March before we got the

21 minutes out. So we're struggling to get the

22 minutes out. So we got some help and Safety-

23 Net, which is the centre for occupational

24 health and safety at Memorial University has

25 acted as our secretariat. In addition to

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1 being the policeman and getting our minutes

2 out in good time and taking some of the notes,

3 they're fresh ears listening to the workforce

4 to make sure that we are hearing the right

5 issues. So they're listening as well and

6 hearing what the workers are saying. So they

7 helped us, starting in October 2009 -- or

8 2007, I should say, I'm sorry, and again,

9 they've been helping us out since then with

10 organizing the meetings and acting as a

11 secretariat and you would have noted in the

12 last session they actually were the

13 facilitators were some of the breakout

14 sessions. So they've been very helpful for us

15 in that regard and we can probably take a look

16 at a set of those minutes. The first set

17 would be October 2007, and they are Exhibit

18 199.

19 ROIL, Q.C.:

20 Q. 199.

21 MR. PIKE:

22 A. And you'll notice a vast improvement in the

23 minutes once we had some help in putting them

24 out.

25 ROIL, Q.C.:

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1 Q. It's good to recognize that other people have  
 2 skills that we can draw upon. Actually 198, I  
 3 think, takes us back even earlier, does it  
 4 not, to the 2006? So if you want to see the  
 5 full evolution of your minutes?  
 6 MR. PIKE:  
 7 A. Okay.  
 8 ROIL, Q.C.:  
 9 Q. Or even 197. Let's just take 198. This is  
 10 earlier enough for my purposes, just to see  
 11 and show an evolution.  
 12 MR. PIKE:  
 13 A. 197 is again a more table format as opposed to  
 14 a text format. We were just trying to  
 15 capture. And again, what we would do is  
 16 highlight what we heard as the issue. We  
 17 would send those out to the workforce. Have  
 18 we heard the issue correctly? They're busy  
 19 folks. We haven't necessarily received too  
 20 much feedback when we've sent some of those  
 21 out, but we would raise the issue and then we  
 22 would give some response to it if they had  
 23 raised an issue during the sessions. So  
 24 that's the format that these were done and  
 25 we've -

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1 ROIL, Q.C.:  
 2 Q. Okay. Now I think we can perhaps move on to  
 3 the one, Exhibit 199.  
 4 MR. PIKE:  
 5 A. Yes.  
 6 ROIL, Q.C.:  
 7 Q. Because that gives us another iteration at a  
 8 further stage of development, and then we can  
 9 look finally at the next ones.  
 10 MR. PIKE:  
 11 A. So one of the things we would do is review the  
 12 issues and what progress we've made from the  
 13 previous meeting. I'm not sure if I clicked  
 14 this too quickly. Okay. So again, these  
 15 other issues were not related to helicopter  
 16 transport, so we've redacted those. So we  
 17 would indicate what the issue was and what our  
 18 response is. There were some communications  
 19 issues, so we took on board to try to see what  
 20 we could do to facilitate communications among  
 21 committees. We did highlight to them some of  
 22 the incident reporting guidelines and we had  
 23 some discussion on incidents during our most  
 24 recent session.  
 25 In October of -- or November of 2006,

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1 there had been issues raised about the  
 2 helicopters and the S-92s, so at this point,  
 3 we invited Cougar in to give us a special  
 4 presentation on their fleet and they gave us -  
 5 - came in and did give us a rather complete  
 6 presentation as to what was happening with  
 7 regard to helicopters and to answer some of  
 8 the questions that the workforce had with  
 9 regard to helicopters, and if memory serves  
 10 me, it was well received and they answered a  
 11 lot of the questions that the workforce had  
 12 with regard to what was happening with  
 13 helicopters.  
 14 ROIL, Q.C.:  
 15 Q. I see as early as 2007, we were looking at the  
 16 incoming HUEBA breathing device.  
 17 MR. PIKE:  
 18 A. We were. It was raised in previous sessions  
 19 as well. The expectations were that it was  
 20 eminent and we understand that that -  
 21 ROIL, Q.C.:  
 22 Q. Well, we have a specific slide, Commissioner,  
 23 to deal with that issue in some more detail,  
 24 so I just note it here.  
 25 MR. PIKE:

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1 A. And I think as the Province noted, the OSH  
 2 amendments have been ongoing and we did give  
 3 an update to the offshore workforce as to  
 4 where the OSH amendment piece was.  
 5 ROIL, Q.C.:  
 6 Q. I don't think we need to go into a lot of  
 7 detail here. I'd rather move to the Exhibit  
 8 200, just to show again the evolution of your  
 9 process now where you have -  
 10 MR. PIKE:  
 11 A. Yeah. There are training issues raised during  
 12 those sessions as well. There were people  
 13 questioning the amount of training. Over the  
 14 years there have been questions on the sea  
 15 day, "do we really need it?" We've heard that  
 16 that opinion has changed significantly since  
 17 some of those earlier days.  
 18 ROIL, Q.C.:  
 19 Q. So again, can we conclude that there's no  
 20 reluctance on the part of workers to bring up  
 21 helicopter transportation issues in these  
 22 joint sessions that you're having?  
 23 MR. PIKE:  
 24 A. No.  
 25 ROIL, Q.C.:

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1 Q. They're clearly within the bounds of those  
 2 meetings?  
 3 MR. PIKE:  
 4 A. Yes.  
 5 ROIL, Q.C.:  
 6 Q. And that's the opportunity they're taking.  
 7 MR. PIKE:  
 8 A. Yes.  
 9 ROIL, Q.C.:  
 10 Q. Okay. Exhibit 200, please? Yeah.  
 11 MR. PIKE:  
 12 A. Again, we reviewed the issues that were raised  
 13 in 2007. What we tried to do or what we  
 14 started to do is identify the ones that we  
 15 were going to give priority to, not that we  
 16 were necessarily losing the other ones, but  
 17 the list was growing long and with limited  
 18 resources, you try to prioritize which ones  
 19 you're going to look at. You know, there was  
 20 issues there on the training, refresher  
 21 training, implementation of the HUEBA,  
 22 question on overlap. Again, what we're  
 23 dealing with there is the FPSOs. They're  
 24 offshore installations, therefore they come  
 25 under our regulation.

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1 ROIL, Q.C.:  
 2 Q. Yes.  
 3 MR. PIKE:  
 4 A. And that would be the Petroleum Occupational  
 5 Health and Safety Regulations. They are also  
 6 Canadian flagged vessels. Canadian flagged  
 7 vessels come under the Canada Labour Code and  
 8 under the Marine Occupational Health and  
 9 Safety Regulations. While those Marine  
 10 Occupational Health and Safety Regulations are  
 11 enforced by Transport Canada Marine Safety,  
 12 they are set by Labour Canada and Transport  
 13 Canada can't amend or waive them. That's the  
 14 objective of Labour Canada. I have identified  
 15 that issue to Labour Canada on several  
 16 instances that we need to decide one or the  
 17 other set of these occupational health and  
 18 safety regulations need to apply. Trying to  
 19 apply both is a bit problematic. But again,  
 20 it comes from the fact that they are, in  
 21 addition to being a Canadian flagged vessel,  
 22 they are also an installation.  
 23 We had a presentation from an industrial  
 24 hygienist. Some information from the  
 25 Workplace Health Safety Compensation

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1 Commission. Where we were going through some  
 2 changes ourselves, so again after the  
 3 Norwegian review, so identified for the  
 4 offshore workers some of the things that we  
 5 were changing, and I gave an update on the OSH  
 6 amendments. The other thing we try to do at  
 7 these sessions is identify some success  
 8 stories, what things were working well for  
 9 offshore workers, start sharing some of those  
 10 success stories.  
 11 ROIL, Q.C.:  
 12 Q. So they're not just bad news events?  
 13 MR. PIKE:  
 14 A. No.  
 15 ROIL, Q.C.:  
 16 Q. Good news events are welcome as well.  
 17 MR. PIKE:  
 18 A. "This worked well. This thing is working well  
 19 for us. We're having" -- so it's very much an  
 20 ability, a dialogue, somebody is having a  
 21 problem. Somebody else may have a solution.  
 22 So we try to foster that sort of dialogue as  
 23 well. And then there was some discussion on  
 24 training, too many courses, again the question  
 25 on the sea day indicating the UK has

Page 228

1 eliminated it.  
 2 ROIL, Q.C.:  
 3 Q. I think actually on page ten, the issue of  
 4 flight suits comes up again. So we'll take a  
 5 moment to reflect on what was being discussed  
 6 there.  
 7 MR. PIKE:  
 8 A. Some discussions on the heliport facilities.  
 9 Again, so they're raising concerns about  
 10 what's happening at the heliport.  
 11 Flight suits. Somebody noted here that  
 12 there was a proper way to hang these suits and  
 13 that's that tab that I think we identified  
 14 earlier on in the session as opposed to some  
 15 people were using the hood to hang it by, and  
 16 that was not an appropriate way to hang it,  
 17 and the workers felt that that was something  
 18 that we should identify and we did.  
 19 So the things that were noted from those  
 20 sessions, as the concerns with the suits. The  
 21 zippers again were raised as an issue. The  
 22 sizing for bigger workers in this case they  
 23 were identifying. One of the things they were  
 24 talking in terms of the Mustang suits had  
 25 multiple more sizes than the newer Helly

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1 Hansen suits, so there was some suggestion  
 2 that maybe we needed more of those. The  
 3 zippers again, this -- when they refer to the  
 4 closure, it's the zipper issue and how the  
 5 suits are zippered up and the pressure it puts  
 6 on the neck.  
 7 ROIL, Q.C.:  
 8 Q. Just as a question of the impression that was  
 9 in Howard Pike's mind at this time. Now this  
 10 is becoming the fall of 2008 and it's not long  
 11 before we had the tragic incident of March  
 12 2009. With all of this accumulating  
 13 complaining going on and troublesome noise  
 14 about suits, was there ever any impression in  
 15 the mind of you or anybody at C-NLOPB that  
 16 there was a large number of people whose suits  
 17 didn't fit them because the face seals weren't  
 18 working? Was that issue ever squarely in your  
 19 mind?  
 20 MR. PIKE:  
 21 A. The face seal piece issue didn't come up until  
 22 much later. We weren't identifying that at  
 23 that stage. Indeed, you know, in  
 24 conversations with our Nova Scotian colleagues  
 25 who were familiar with these suits had not

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1 identified the face seals as an issue. So at  
 2 that stage, while, you know, in my own mind I  
 3 was really questioning as to whether we were  
 4 getting down to the root issues with these  
 5 suits because they were carrying on for so  
 6 long, you know, the flip side is, I'll go back  
 7 to that prescriptive piece, they met the  
 8 standard and that people were wearing them.  
 9 There was nothing in the standard that talked  
 10 in terms of fit or how they fit or that you  
 11 should be doing fit testing. That's not in  
 12 the standard. But given that this was going  
 13 on for so long, my own thought process was  
 14 that there's more to this than we're seeing.  
 15 We're not getting to the root would be my  
 16 thought, and then the question becomes, as the  
 17 regulator, how do I raise that with the  
 18 operators because they do meet the  
 19 prescriptive regulatory requirement. So  
 20 again, we started to raise those issues in  
 21 January of 2009.  
 22 ROIL, Q.C.:  
 23 Q. I don't think there's anything else in that  
 24 particular series of JOHS minutes that I want  
 25 to take your attention to, unless you wish to,

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1 in which case we can move on.  
 2 MR. PIKE:  
 3 A. No, I think as you can just see from that,  
 4 there's a wide gamete of things that we  
 5 discuss at those sessions -  
 6 ROIL, Q.C.:  
 7 Q. Indeed.  
 8 MR. PIKE:  
 9 A. - and it's really a forum for them, for the  
 10 workers. Again, what we did here was try to  
 11 summarize some of the issues going back to  
 12 them. We would have shared this with them and  
 13 asked for feedback. Was there something we  
 14 missed? Is there something we need to follow  
 15 up on?  
 16 ROIL, Q.C.:  
 17 Q. Okay, I think we can move on to the next  
 18 subject matter which is at slide 25.  
 19 MR. PIKE:  
 20 A. And to be quite honest with you, I don't  
 21 remember when these meetings started, but  
 22 they've been going on for some time, that on  
 23 an annual basis, the chief safety officers for  
 24 the Newfoundland Board and the Nova Scotia  
 25 Board sit with CAPP safety committee. They've

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1 been informal meetings to discuss safety  
 2 issues. Essentially taking a look at what  
 3 CAPP has as its priority items and what we  
 4 would have, as chief safety officers, as our  
 5 priority items, and that's to try to get some  
 6 alignment and make sure there's no surprises  
 7 in that, and quite obviously, the HUEBA would  
 8 have been discussed at those meetings as to  
 9 what progress was or wasn't being made. That  
 10 would have been a priority item for us as we  
 11 met with the CAPP safety committee.  
 12 ROIL, Q.C.:  
 13 Q. Putting aside the HUEBA issue, which we'll  
 14 deal with separately, and which I think  
 15 there's going to be an intensive piece of work  
 16 done by CAPP and others, perhaps us, to see  
 17 what lessons we can learn from that, what can  
 18 you tell us about the relationship between  
 19 you, as a safety officer for C-NLOPB, and the  
 20 whole piece involving CAPP and it setting  
 21 standards and training and whatnot? Does that  
 22 work for the C-NLOPB?  
 23 MR. PIKE:  
 24 A. We certainly have some examples where that's  
 25 worked very well. The training and

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1 qualifications standard practice is a really  
 2 good example where working with CAPP, CAPP  
 3 acts as the secretariat in that regard. The  
 4 terms of reference dictate that they won't  
 5 make changes unless we concur with those  
 6 changes. So that's a model that has worked  
 7 quite well with regard to that. We've also  
 8 developed with CAPP a lifting practice  
 9 standard practice as well. That essentially  
 10 came more particularly for issues that were in  
 11 Nova Scotia. There was some real concern with  
 12 the logistics and lifting practices in Nova  
 13 Scotia and also from the IRF, the  
 14 International Regulators Forum. They were  
 15 identifying worldwide issues associated with  
 16 logistics and lifting operations. There had  
 17 been a number of fatalities. Indeed Norway  
 18 had had a couple of fatalities associated with  
 19 the operations of cranes, the first in several  
 20 years. Australia had had several. Again, so  
 21 they were highlighting potential issues around  
 22 lifting practice that we wanted to take a look  
 23 at and CAPP indeed agreed to work on that and  
 24 we have a standard practice. So it talks in  
 25 terms of, you know, the training that we want

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1 to have for the crane operators. You know,  
 2 what happens on board, the issues associated  
 3 with containers. We already had with CAPP a  
 4 standard that was being used for offshore  
 5 containers to make sure they were built to a  
 6 high standard and maintained at a high  
 7 standard and that the lifting kit that's put  
 8 on it, the slings that are put on it are kept  
 9 in good repair and that they're certified and  
 10 that certification continues. So there's a  
 11 number of examples where it works quite well.  
 12 ROIL, Q.C.:  
 13 Q. Right. Can I ask you, in your relationship  
 14 with regulators in other places, such as in,  
 15 you know, the Norwegian, the North Sea  
 16 experience, in the United States, in Brazil,  
 17 Australia, wherever you have relationships  
 18 with other regulators, are there similar  
 19 relationships between the regulators and an  
 20 industry sponsored organization with respect  
 21 to training and the definition of how work  
 22 gets performed in the offshore?  
 23 MR. PIKE:  
 24 A. Yes.  
 25 ROIL, Q.C.:

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1 Q. This isn't just a Canadian model, I take it,  
 2 is it?  
 3 MR. PIKE:  
 4 A. No. It would be -- I think it takes place in  
 5 most of those other jurisdictions, certainly  
 6 the ones that we meet with regularly and the  
 7 International Regulators Forum. That would  
 8 include Norway, UK and the Netherlands. They  
 9 all meet with their industry associations on a  
 10 regular basis and there's some things handled  
 11 at that level and some things handled at the  
 12 operator level. In the US, the Mineral  
 13 Management Service meets regularly with their  
 14 industry associations and in some cases, it  
 15 would include both -- as well as the  
 16 contractors as well, the IAD, International  
 17 Association of Drilling Contractors.  
 18 ROIL, Q.C.:  
 19 Q. Yes, we heard something about that.  
 20 MR. PIKE:  
 21 A. They would meet with them as well. And I  
 22 believe in Australia, they do meet regularly  
 23 with the Australian operators association. So  
 24 it's not an uncommon piece.  
 25 ROIL, Q.C.:

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1 Q. Okay. Meeting is not the issue, I think.  
 2 It's giving to the industry associations the  
 3 ability to be engaged in the definition of  
 4 training and the definition of standards.  
 5 That is not uniquely Canadian?  
 6 MR. PIKE:  
 7 A. No. If you go to the UK model, there's a  
 8 group referred to as OPEDO.  
 9 ROIL, Q.C.:  
 10 Q. Yes, we've heard of them.  
 11 MR. PIKE:  
 12 A. They set the standard. There are  
 13 representatives there from the operators. I  
 14 believe the regulator is represented, but the  
 15 regulator does not control that committee.  
 16 That is a -- I think OPEDO is actually, if  
 17 memory serves me, a not for profit type  
 18 organization. I can't recall the exact makeup  
 19 of it, but it is essentially an industry piece  
 20 that set the standards for training in the  
 21 offshore for the UK.  
 22 ROIL, Q.C.:  
 23 Q. Okay. So this relationship with CAPP goes on  
 24 with these meetings and how often do you meet?  
 25 Is it just annually?

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<p>1 MR. PIKE:</p> <p>2 A. Just once a year.</p> <p>3 ROIL, Q.C.:</p> <p>4 Q. Just annually, okay, and what about the</p> <p>5 committees, do you ever meet with their safety</p> <p>6 committee or is that a piece that is done</p> <p>7 separately, if there's a safety committee of</p> <p>8 CAPP?</p> <p>9 MR. PIKE:</p> <p>10 A. They occasionally will call us in, if there's</p> <p>11 a particular issue that they want to apprise</p> <p>12 us of. They may call us into a meeting that</p> <p>13 they're holding, but by and large, it's just</p> <p>14 this annual meeting, unless there's a specific</p> <p>15 issue.</p> <p>16 ROIL, Q.C.:</p> <p>17 Q. Okay.</p> <p>18 MR. PIKE:</p> <p>19 A. Maybe just to talk a little bit more about the</p> <p>20 training aspect. In 2001, we did raise with</p> <p>21 the other regulators the issue of training and</p> <p>22 the ability to recognize training among other</p> <p>23 international jurisdictions, a large issue for</p> <p>24 the mobile offshore drilling units, less so</p> <p>25 for the producing facilities. But they did --</p>	<p>1 the time seems inordinately long and that</p> <p>2 there was a piece of diligence being put into</p> <p>3 investigating it. What can you tell us about</p> <p>4 -</p> <p>5 MR. PIKE:</p> <p>6 A. And they'd certainly get no argument from me.</p> <p>7 It took far too long.</p> <p>8 ROIL, Q.C.:</p> <p>9 Q. Okay.</p> <p>10 MR. PIKE:</p> <p>11 A. By way of note, I have summarized in one slide</p> <p>12 what is a ten-volume file in our system. We</p> <p>13 have an extensive file on this piece.</p> <p>14 ROIL, Q.C.:</p> <p>15 Q. So we saw, through CAPP's evidence, four</p> <p>16 letters that have been written by either the</p> <p>17 CEO or a safety officer at the C-NLOPB.</p> <p>18 MR. PIKE:</p> <p>19 A. There were many more e-mails associated with</p> <p>20 keeping track of where this was going and what</p> <p>21 the problems were, what the issues were. So</p> <p>22 there's an extensive trail of us following up</p> <p>23 with CAPP to see where this issue was.</p> <p>24 Just by way of summary, we raised the</p> <p>25 issue in 2000. So in 2000-2001, I refer to it</p>
<p>Page 238</p> <p>1 we talked about that and in each instance,</p> <p>2 they identified that the training standards</p> <p>3 are really set by industry and that the</p> <p>4 regulators would have a limited role in the</p> <p>5 ability to get some recognition of standards</p> <p>6 between jurisdictions.</p> <p>7 ROIL, Q.C.:</p> <p>8 Q. So if standards were to be standardized</p> <p>9 internationally, it would engage more than</p> <p>10 just the regulators?</p> <p>11 MR. PIKE:</p> <p>12 A. That's correct.</p> <p>13 ROIL, Q.C.:</p> <p>14 Q. Okay.</p> <p>15 MR. PIKE:</p> <p>16 A. And that was identified when we first raised</p> <p>17 that issue in 2001 forum. So maybe we'll talk</p> <p>18 a little bit about the -</p> <p>19 ROIL, Q.C.:</p> <p>20 Q. The breathing device. Indeed, I think you're</p> <p>21 aware of the fact that there was evidence</p> <p>22 brought by CAPP and there's been a lot of</p> <p>23 questions about it since then, the period of</p> <p>24 time, and I think you may be aware that the</p> <p>25 oil company executives have acknowledged that</p>	<p>Page 240</p> <p>1 as a gathering of information. There was a</p> <p>2 study being done by the CORD Group, Dr. Chris</p> <p>3 Brooks. So they wanted to get some</p> <p>4 information when that piece was published. In</p> <p>5 addition to that, they were gathering some</p> <p>6 information out of the North Sea. So I refer</p> <p>7 to that as a gathering the background piece.</p> <p>8 So that was what was going on in that time</p> <p>9 frame, waiting for some of the research to</p> <p>10 come out.</p> <p>11 In 2002, there was a discussion paper</p> <p>12 issued that recommended the hybrid device, and</p> <p>13 in 2003, they formed the first implementation</p> <p>14 committee.</p> <p>15 ROIL, Q.C.:</p> <p>16 Q. And just on that word "implementation" did you</p> <p>17 understand back then, again I'm asking you to</p> <p>18 cast your mind back, that the implementation</p> <p>19 committee were going to implement a specific</p> <p>20 device?</p> <p>21 MR. PIKE:</p> <p>22 A. Yes.</p> <p>23 ROIL, Q.C.:</p> <p>24 Q. Within a period of time, and that device was</p> <p>25 what?</p>

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1 MR. PIKE:  
 2 A. That would have been the hybrid device that  
 3 came out of -- that's what I was understanding  
 4 they were doing at that time.  
 5 ROIL, Q.C.:  
 6 Q. Right, okay.  
 7 MR. PIKE:  
 8 A. It's apparent at some point in late 2003 or  
 9 2004 something changed and that there was a  
 10 debate on the type of system to be used.  
 11 ROIL, Q.C.:  
 12 Q. And so this is getting us away from the hybrid  
 13 device, was it?  
 14 MR. PIKE:  
 15 A. No, that -- yes, that's correct, and that's  
 16 when we first started hearing the use of the  
 17 compressed air system, the system that we  
 18 currently have, and I think they, at that  
 19 point, changed the recommendation to the  
 20 compressed air system, but felt because the  
 21 compressed air system, at that point, had only  
 22 been used for military purposes, that we  
 23 needed to take a look at and assess the  
 24 training and implementation risk associated  
 25 with it. So in 2005, they started identifying

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1 where the issues were with training and  
 2 implementation.  
 3 And again, I think as we noted in 2006,  
 4 early, they held a workshop. That was an  
 5 international workshop. They brought in some  
 6 experts from the UK to talk. In addition to  
 7 that, in that same year, they identified that  
 8 if they were using the compressed air system,  
 9 they were going to need new suits. They  
 10 couldn't retrofit the existing suits to fit  
 11 this device, and I think we've also seen  
 12 testimony that they were seeing that those  
 13 suits were coming to the end of their useful  
 14 life in any event. So it was an opportunity  
 15 to upgrade the suits and they would include  
 16 the provision for the new rebreathing device.  
 17 2007, there was liability and medical  
 18 issues raised and that's with the training,  
 19 and it comes back to, and we've heard a lot of  
 20 talk about fidelity of training. The proposal  
 21 at this point was that they would use the  
 22 compressed air system in the HUET trainer.  
 23 What was being identified here from the  
 24 medical professionals, and there was a divided  
 25 opinion among the medical professionals in

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1 this regard, specialists in the area of  
 2 hyperbaric medicine. There was not a  
 3 definitive view on this, but they were  
 4 identifying concerns and risks associated with  
 5 training or using that level of fidelity with  
 6 the compressed air system, which in turn  
 7 invoked a certain level of liability back to  
 8 the operators that if you were indeed  
 9 imparting that risk this is something that  
 10 every worker would have to go through every  
 11 year -- every three years. So you're talking  
 12 about something in the training component  
 13 where it was believed that there was a level  
 14 of risk associated that needed to be  
 15 mitigated. So that's where you're starting to  
 16 see those issues and they actually started  
 17 surfacing a little bit before that, but they  
 18 came to a head during 2007.  
 19 Then in 2008, there was a second  
 20 implementation committee, and I think previous  
 21 testimony has talked about when it was the  
 22 operators versus CAPP doing some of these  
 23 things. We were part of both implementation  
 24 committees, I should say. We had a  
 25 representative present. The second

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1 implementation committee also included -- they  
 2 went to the North Sea to further investigate  
 3 the devices that were used there and some of  
 4 the reasons that they chose those devices.  
 5 That committee came back and made their  
 6 recommendation at the end of 2008-2009 that  
 7 the compressed air system would be used. What  
 8 they agreed to was the training, while it  
 9 would take place in water, it would not be in  
 10 the HUET, taking away some of that risk. So  
 11 we're mitigating the risk in this regard, and  
 12 that the training would take place in water  
 13 but in less than one metre. What we're  
 14 mitigating against is the barotrauma type risk  
 15 associated with the use of compressed air  
 16 systems.  
 17 ROIL, Q.C.:  
 18 Q. In the explanation you just gave us, you  
 19 indicated, and we have the evidence that the  
 20 issue moved back and forth between CAPP and  
 21 some of its resident members, in other words  
 22 the oil companies took it back and had a look  
 23 at it for some time, and it has been expressed  
 24 to us by some in the room that the ability of  
 25 the oil companies, the operators, to take it



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1 back from CAPP is something that is troubling  
 2 for them. Did that create any concerns for  
 3 you, the fact that you -- you know, one moment  
 4 you're dealing with the oil companies  
 5 individually and another time you're dealing  
 6 with CAPP as a corporate entity or as a  
 7 separate entity?  
 8 MR. PIKE:  
 9 A. Ultimately, we hold the operators accountable  
 10 and they were the ones we would ultimately be  
 11 talking to for the implementation. If they  
 12 choose to use CAPP as the vehicle for a  
 13 coordinated effort, then that's their -- and  
 14 they would like us to deal with CAPP on that  
 15 basis, but ultimately we would hold the  
 16 operators accountable. So in this case, if  
 17 they wanted to use CAPP as the coordinator, we  
 18 will facilitate that request. I think what  
 19 you were looking at in certain regards is on  
 20 the liability side, it was something that the  
 21 operators themselves needed to come to terms  
 22 with, versus something that CAPP could assume  
 23 on their part. That would be sort of my  
 24 understanding of that piece.  
 25 ROIL, Q.C.:

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1 Q. Um-hm.  
 2 MR. PIKE:  
 3 A. But again, we would ultimately hold -- there's  
 4 some of the other issues that were going on at  
 5 this stage as well, would have been the  
 6 medical screening. What additional screening  
 7 would be required for the medical to travel  
 8 offshore? Again, you're now talking if you  
 9 did the high fidelity training in the HUET,  
 10 you know, it could be considered diving in  
 11 that regard and you would need some increased  
 12 medical surveillance of folks travelling  
 13 offshore. So there was some issues there as  
 14 well.  
 15 A side note for you. I've mentioned  
 16 Safety-Net before, and I've been involved with  
 17 Safety-Net since its inception. I sat on --  
 18 initially it was actually a project as opposed  
 19 to a centre. I sat on one of their  
 20 committees, the cold working committee and  
 21 actually discussed the HUEBA with some of  
 22 their researchers and we talked about  
 23 different elements and we talked about breath  
 24 holding and you know, what effect does cold  
 25 water have on it, and they took that away and

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1 indeed, in 2004, a young Masters student,  
 2 Jonathan Power, actually did his thesis on  
 3 just that, the effects of water temperature,  
 4 gender and exercise on breath holding  
 5 following sudden face immersion, and it  
 6 certainly highlighted some of the concerns I  
 7 had and the need we had for a HUEBA system.  
 8 Indeed, Jonathan is actually now doing  
 9 his PhD and is involved in research at the  
 10 Institute of Ocean Technology on the thermal  
 11 properties of immersion suits. While  
 12 immersion suits aren't transportation suits,  
 13 they are very similar. So what he is studying  
 14 in that regard is what effect wind and waves  
 15 have on the thermal properties of suits and  
 16 that's a three-year project. They've been  
 17 doing it over the last three years. This is  
 18 the third year in that piece. They're using  
 19 the wave basin at IOT. They do it in the  
 20 winter because that's when they can get the  
 21 coldest water. They have no chilling facility  
 22 for their wave basin so they drain it and put  
 23 cold -- or the water in during this time of  
 24 year. It's a bit colder than if they were  
 25 doing it in the summer, and they've been doing

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1 that testing. They certainly raise some  
 2 questions as to survival times. So I became  
 3 aware of that piece of work after March the  
 4 12th last year and actually had an opportunity  
 5 last year to sit and talk to Jonathan and take  
 6 a look at the research that was going on  
 7 there, and that certainly raised additional  
 8 questions in my mind on survival times,  
 9 something that hadn't been raised previously.  
 10 ROIL, Q.C.:  
 11 Q. Looking back over those ten files and those  
 12 ten years and your knowledge of what has  
 13 happened and acknowledging, as we all have,  
 14 that this seemed to be an inordinately long  
 15 length of time, was it ever your impression  
 16 that somebody was dropping the ball or that  
 17 there was no real desire to bring within the  
 18 Newfoundland offshore a breathing assist  
 19 device? Did you ever get the impression that  
 20 somebody was, to use a vernacular, ragging the  
 21 puck?  
 22 MR. PIKE:  
 23 A. No, I don't think that it was that, but  
 24 equally, I think it needed a lot more focus  
 25 than it was potentially getting. I don't

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1 think anybody was consciously doing that. But  
 2 obviously this period of time, when you sit  
 3 back in hindsight looking at it, it took a  
 4 very long time, and it, in hindsight, needed a  
 5 little more focus than it was potentially  
 6 getting. And again, we wait and see what the  
 7 industry has when they do their lessons  
 8 learned from this piece.  
 9 ROIL, Q.C.:  
 10 Q. Was it ever a consideration of C-NLOPB to  
 11 force the issue and say "do it now"?  
 12 MR. PIKE:  
 13 A. Yes.  
 14 ROIL, Q.C.:  
 15 Q. Some of the letters seem to suggest that there  
 16 was that kind of clout behind the messaging.  
 17 MR. PIKE:  
 18 A. Certainly when we approached our Chair and  
 19 indicated we had concerns with the  
 20 implementation in this and he wrote the  
 21 letter, that's an indication that we were  
 22 escalating this issue -  
 23 ROIL, Q.C.:  
 24 Q. Right.  
 25 MR. PIKE:

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1 A. - to that level and that we were prepared to  
 2 move on if the industry had not started moving  
 3 again. So by bringing it to our Chair, our  
 4 Chair agreed with us and actually wrote that  
 5 letter. So yes, we did raise it.  
 6 ROIL, Q.C.:  
 7 Q. Okay. The next piece takes us into compliance  
 8 and enforcement which is pretty much the last  
 9 piece that we have. So this might be a good  
 10 time to take our break a little bit earlier  
 11 and we'll perhaps come back a little bit  
 12 earlier as well.  
 13 COMMISSIONER:  
 14 Q. Yes, all right then.  
 15 (BREAK)  
 16 ROIL, Q.C.  
 17 Q. Thank you, Commissioner. It's been pointed  
 18 out to me on the break that I used an  
 19 expression "ragging the puck" and not  
 20 everybody knows what that expression means.  
 21 As a true hockey Canadian, I would have  
 22 thought that we all knew what it mean, but to  
 23 rag the puck is to -  
 24 THE COMMISSIONER:  
 25 Q. I would have thought so.

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1 ROIL, Q.C.  
 2 Q. - is to take something, but intentionally not  
 3 try to advance it too far, as you would do in  
 4 hockey. So I apologize if that analogy went  
 5 over the heads of some in the room and perhaps  
 6 some out of the room as well. Okay, Mr. Pike,  
 7 we are now moving on to compliance and  
 8 enforcement and you have another summary slide  
 9 for me?  
 10 MR. PIKE:  
 11 A. Yes, we're just going to review the policy  
 12 that the Board has established, vis-a-vis  
 13 compliance and enforcement, so we'll talk a  
 14 little bit about the guiding principles. The  
 15 protocol for non-compliance, we've seen the  
 16 non-compliance table in the audits, so that's  
 17 really what that's referring to, although the-  
 18 -and then warnings, order, suspending or  
 19 revoking an authorization, cancellation of  
 20 interest and prosecutions.  
 21 ROIL, Q.C.  
 22 Q. So this is your tool box of compliance items?  
 23 MR. PIKE:  
 24 A. Yes. So the guiding principles, all operators  
 25 must comply with the legislation, fairly

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1 straight forward. Compliance will be  
 2 encouraged through effective communications.  
 3 Indeed if you look at, in the Atlantic Accord  
 4 Implementation Act, Part III, the purpose of  
 5 that part is the promotion of safety and  
 6 environmental protection. So indeed if you  
 7 are doing that, you have to encourage  
 8 effective communication if you're going to  
 9 promote safety and environmental protection,  
 10 and that's the only promotion that the Board  
 11 has a mandate to do. "All non-compliances  
 12 must be treated appropriated and rectified.  
 13 The Board is committed to enforcing all  
 14 legislative requirements. Enforcement action  
 15 will be carried out in a fair and consistent  
 16 manner." I would define that as sort of a  
 17 natural justice type provision. "Operators  
 18 will be notified of non-compliance issues  
 19 within a reasonable time and deadlines will be  
 20 reasonable." So these are the guiding  
 21 principles we have for our compliance and  
 22 enforcement policy.  
 23 ROIL, Q.C.  
 24 Q. Just before you go on to the protocols, some  
 25 have come before us and said that they believe

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1 that the industry or the workers would be  
 2 better served if there was a separate, a  
 3 separation between the regulatory function or  
 4 the license granting function and the safety  
 5 function. My question to you, Mr. Pike, is in  
 6 your experience and your role as chief safety  
 7 officer, has it ever occurred to you that  
 8 there is a difficulty or have you ever had a  
 9 problem with advancing safety items within the  
 10 Newfoundland Offshore?  
 11 MR. PIKE:  
 12 A. I never have, it's never been an occasion  
 13 where we've compromised safety in any way in  
 14 the dealings with the Board. I've had a  
 15 hundred percent support from each of the Board  
 16 and there have been various boards over the  
 17 years.  
 18 ROIL, Q.C.  
 19 Q. Thank you.  
 20 COMMISSIONER:  
 21 Q. If I may just interject, one of the things--  
 22 I've been thinking about that, you know, since  
 23 it's been raised here in the hearings and I  
 24 know that Norway has done it and the UK has  
 25 done it, but then their oil fields, in terms

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1 of numbers of platforms are gigantic, compared  
 2 with our small number by comparison. It  
 3 strikes me that it may make a lot more sense  
 4 when you're as big in oil production as they  
 5 are, compared with the small number of  
 6 platforms and installations we have, do you  
 7 have any thoughts on that?  
 8 MR. PIKE:  
 9 A. That's part of it certainly, the other one  
 10 I'll point out, I was going to talk about a  
 11 little later under emergency preparedness,  
 12 there's a recent incident in Australia, the  
 13 Montara blow out. The Australian National  
 14 Safety Authority only has responsibility up to  
 15 the wellhead. There's a bunch of things going  
 16 on below the wellhead and essentially that's  
 17 where the blow out has occurred, so without  
 18 having access to that geoscience information  
 19 that we would have in an integrated  
 20 organization, you do run into a problem with  
 21 regard to that and we would have some  
 22 responsibility for the integrity of the well.  
 23 So you'd have to be very careful when you  
 24 start carving it out as to how you set up the  
 25 boundaries. There have indeed been three

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1 inquiries in Australia, the current one is  
 2 ongoing about the Montara blow out, but there  
 3 have been others which have bumped up against  
 4 the boundaries that they established for that  
 5 single safety authority, that when you get  
 6 into some of those boundaries, you can run  
 7 into issues where the regulatory piece gets  
 8 missed between regulatory authorities. And  
 9 indeed it is actually difficult to define  
 10 exactly who had responsibility for the  
 11 integrity of the well in the Montara blow out.  
 12 In Norway's case, to my knowledge there was no  
 13 issue, working issue that drove them to that.  
 14 That was a policy issue established at the  
 15 highest levels within their government. The  
 16 other sort of note in that regard is that when  
 17 they did that, the Petroleum Safety Authority  
 18 has actually assumed a larger responsibility  
 19 for onshore refineries and petroleum storage  
 20 pieces and I will speculate and I probably  
 21 shouldn't be doing that, but that was probably  
 22 something they could only do with a separate  
 23 agency, as opposed to an agency that  
 24 incorporated the resource management side.  
 25 But in Norway the MPD operated quite

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1 successfully for a number of years as a single  
 2 agency with a resource management and with  
 3 safety operating under the same organization.  
 4 So it can work either way, there are pluses  
 5 and minuses to both of it, it depends on how--  
 6 what the oversight piece is on that regulator  
 7 as to how well that will work.  
 8 COMMISSIONER:  
 9 Q. It's interesting that you say the Norwegian  
 10 government simply came up with it as a matter  
 11 of policy. I was told or I read or I can't  
 12 remember now, but anyway, fairly recently in  
 13 the UK it came up as a matter of policy  
 14 without even prior consultation and bang,  
 15 suddenly legislation was introduced, which is  
 16 an interesting -  
 17 MR. PIKE:  
 18 A. I'm not sure if that's quite--it came out of  
 19 the Piper Alpha Inquiry. It was after that  
 20 that they did the separation.  
 21 COMMISSIONER:  
 22 Q. There was some separation, but Piper Alpha was  
 23 1989, wasn't it?  
 24 MR. PIKE:  
 25 A. '88.

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1 COMMISSIONER:  
 2 Q. '88, yes and then the report took a little  
 3 while.  
 4 MR. PIKE:  
 5 A. Couple of years after that that they made the  
 6 change.  
 7 COMMISSIONER:  
 8 Q. But this was done--what was done in the UK  
 9 recently, I think was 2003 and that  
 10 legislation, I was told, came out of the blue,  
 11 which - I could check that out perhaps -  
 12 MR. PIKE:  
 13 A. The only thing I'm aware that they did was  
 14 they updated their safety case legislation in  
 15 about that timeframe.  
 16 COMMISSIONER:  
 17 Q. Maybe that's what it was that I was told  
 18 about, you know. Yeah, okay, thank you.  
 19 ROIL, Q.C.  
 20 Q. Okay, Mr. Pike, I think we'll go back to slide  
 21 29 which I interrupted you before you were  
 22 ready to go there.  
 23 MR. PIKE:  
 24 A. We saw the reference to non-compliances in the  
 25 report from the safety audit, so there's the

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1 tie-in to our policy and what we're doing here  
 2 with safety audits. So some of the criteria  
 3 that we've established for those non-  
 4 compliances are the seriousness of personal  
 5 injury or damage, whether or not non-  
 6 compliance is a repeat offence, attempts to  
 7 circumvent the Acts, so that sort of speaks  
 8 for itself, but it would be an intentional  
 9 circumvention of the Act. The history of  
 10 compliance to the alleged violator, the  
 11 willingness to co-operate with the safety  
 12 officers, and I think you've seen in most of  
 13 the reports there that we've always gotten  
 14 great co-operation from the operators in that  
 15 regard. Existence of other enforcement  
 16 actions and consistency in approach with other  
 17 boards, so that's a dialogue we would have, in  
 18 particular Nova Scotia Board, but also the  
 19 National Energy Board who has responsibilities  
 20 for offshore jurisdictions in the Arctic, so  
 21 we have a dialogue with those people as well.  
 22 ROIL, Q.C.  
 23 Q. So these are the kind of factors you consider  
 24 in determining what of the toolbox you use?  
 25 MR. PIKE:

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1 A. Yes. And the other sort of note in that, they  
 2 make reference in there to requirement for  
 3 preliminary report and indeed we do do the  
 4 memos associated with our safety audits, so  
 5 that's sort of a linkage back into that policy  
 6 piece. The warnings would be the next level  
 7 of tool in our toolbox. As is stated here,  
 8 reasonable grounds to believe the person is  
 9 not complying with the Act or regulations or a  
 10 condition of the authorization and suspected  
 11 non-compliance is not likely to cause serious  
 12 threat to the safety of workers or serious  
 13 damage to the environment. We're  
 14 distinguishing there between an immediate  
 15 threat, which would require an order verses a  
 16 warning that something needs to be corrected.  
 17 The warning can be issued by any officer  
 18 without prerequisite of a preliminary report,  
 19 that ties back into the non-compliance, the  
 20 expectation there is that we do a report or  
 21 the memo that we saw previously. The warning  
 22 is usually in writing, but we could issue a  
 23 warning verbally and then follow it up in  
 24 writing.  
 25 ROIL, Q.C.

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1 Q. In your experience has there ever been a  
 2 warning issued with respect to helicopter  
 3 operations in offshore Newfoundland and  
 4 Labrador?  
 5 MR. PIKE:  
 6 A. The closest thing I would say we did to that  
 7 was the letter I wrote last June.  
 8 ROIL, Q.C.  
 9 Q. Which -  
 10 MR. PIKE:  
 11 A. I didn't characterize it as a warning, but it  
 12 could be seen as a warning.  
 13 ROIL, Q.C.  
 14 Q. Which letter, is that the one you referred to  
 15 earlier?  
 16 MR. PIKE:  
 17 A. Yes, June of 2009, the one that we referred to  
 18 on the helicopter suits.  
 19 ROIL, Q.C.  
 20 Q. On the suits, okay.  
 21 MR. PIKE:  
 22 A. But that's as close to a warning as I've come.  
 23 ROIL, Q.C.  
 24 Q. Okay, so you were being pointed in letter.  
 25 MR. PIKE:

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1 A. Yes.  
 2 ROIL, Q.C.  
 3 Q. Okay, next thing.  
 4 MR. PIKE:  
 5 A. Orders. We basically have two kinds of  
 6 orders. The first one is sort of a cease or  
 7 continue activity and that's specific, I made  
 8 reference to that, if the safety officer  
 9 there, they see that something is not going  
 10 right with a, say a confined space entry, they  
 11 could issue an order to stop the confined  
 12 space entry or indeed the activity could  
 13 continue, but under certain conditions. So  
 14 it's where the safety officer is of the  
 15 opinion that the continuation of an activity  
 16 is likely to result in serious injury,  
 17 regardless of whether or not a non-compliance  
 18 is believed to exist.  
 19 ROIL, Q.C.  
 20 Q. So that's something any safety officer of the  
 21 Board can do or only you?  
 22 MR. PIKE:  
 23 A. Yes. No, any safety of the Board can issue  
 24 that order. And the other type of order we  
 25 have is an order to comply and the two sort of

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1 criterion in that one is when it appears a  
 2 person or an operator is not--or is ignoring a  
 3 warning, an order could be issued and to  
 4 document a remedial action that has already  
 5 been proposed, so there's an agreed course of  
 6 action and in order to document it, we could  
 7 issue an order in that regard. And of note,  
 8 failure to comply with an order is an offence  
 9 under the Accord Act.  
 10 ROIL, Q.C.  
 11 Q. And again my question to drive it towards  
 12 helicopter transportation, has there ever been  
 13 an order issued to your knowledge with respect  
 14 to helicopter transportation related issues?  
 15 MR. PIKE:  
 16 A. No.  
 17 ROIL, Q.C.  
 18 Q. Thank you.  
 19 MR. PIKE:  
 20 A. Suspending or revoking an authorization or an  
 21 operating license, revoke, revocation or  
 22 suspension of an authorization or a license is  
 23 a decision of the Board. Indeed, the Board is  
 24 the one that issues those authorizations, so  
 25 they would be the one to suspend it. Where

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1 there is a failure to comply, a contravention  
 2 of or a default in the requirement approval  
 3 fee or deposit associated with that  
 4 authorization or license, requirement  
 5 undertaken in a declaration, the operators  
 6 provide a declaration of fitness, so if the  
 7 requirement under that declaration isn't being  
 8 met, they could be withdrawn. Notification of  
 9 a change on the original declaration, so if  
 10 the original declaration was associated with a  
 11 particular drilling rig, for example, and the  
 12 operator changed it out, not likely to happen,  
 13 but by way of example -  
 14 ROIL, Q.C.  
 15 Q. Yes.  
 16 MR. PIKE:  
 17 A. Without telling us and changing their  
 18 declaration, that would be enough to cancel  
 19 the authorization. They're required to have a  
 20 valid certificate of fitness, ie. that it  
 21 continues to remain valid, so if it either  
 22 runs out or the certifying authority cancels  
 23 out, then that's enough to cancel the  
 24 authorization. Financial responsibility  
 25 remains in force. We identified one of the

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1 requirements on an authorization is financial  
 2 responsibility. We'll talk a little bit about  
 3 it in our emergency response planning, but  
 4 that affords the Board the funds that if we  
 5 have to intervene in a particular situation,  
 6 that the funds are available for us to  
 7 intervene. We'll talk a little bit more about  
 8 that later. And any applicable regulation,  
 9 those would be the criteria that the Board  
 10 would use and we would potentially be the ones  
 11 to bring it forward to the Board to identify  
 12 that there's either a suspension or revocation  
 13 of the authorization.  
 14 ROIL, Q.C.  
 15 Q. Would you have to go through the warning and  
 16 order step first to get to this or -  
 17 MR. PIKE:  
 18 A. No.  
 19 ROIL, Q.C.  
 20 Q. You could get to this as a first remedial  
 21 action?  
 22 MR. PIKE:  
 23 A. Yes. Cancellation of interest, this is what I  
 24 affectionately referred to as our "dangerous  
 25 offender" provision. This is where you have

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1 an actor that's being a continual problem, so  
 2 where the chief safety officer is of the  
 3 opinion that there exists non-compliance in  
 4 relation to safety, the chief safety officer  
 5 may recommend to the chairman--and again, this  
 6 is to the Board, that the operator's interest  
 7 be revoked or suspended. Before effecting any  
 8 such revocation or suspension, the Board shall  
 9 facilitate a show cause process allowing the  
 10 operator to demonstrate why such revocation or  
 11 suspension should not occur at a hearing  
 12 conducted by the oil and gas committee. Any  
 13 action taken by the Board in this regard,  
 14 however, is a fundamental decision. So there  
 15 is a process involved where we could cancel an  
 16 operator's interest because of non-compliance  
 17 to safety. It is a rather long process, but  
 18 it is a process available to us.  
 19 Prosecution. The criteria we would use  
 20 proceed with a prosecution would be the  
 21 gravity of the offence, whether other remedies  
 22 would be available and preferred, whether an  
 23 offence can be clearly identified the grounds  
 24 upon which the offence is believed to have  
 25 occurred, whether the burden of proof on the

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1 Board is likely to be met, where it is in the  
 2 public interest to proceed with the  
 3 prosecution, the consequences in terms of  
 4 time, cost, benefits and harm of prosecuting  
 5 and the likelihood of success having  
 6 considered all the relevant factors. We get  
 7 great assistance from legal on writing this  
 8 criteria.  
 9 ROIL, Q.C.  
 10 Q. Okay, again, I would ask you has there ever  
 11 been a prosecution in relation to helicopter  
 12 operators in the Newfoundland offshore?  
 13 MR. PIKE:  
 14 A. No, there has not.  
 15 ROIL, Q.C.  
 16 Q. I didn't ask you about the cancellation or the  
 17 suspension or revocation, I just assumed that  
 18 that was not the case.  
 19 MR. PIKE:  
 20 A. No. So the next piece I was going to talk  
 21 about is our emergency response plan. I'll  
 22 talk a little bit about the roles of the  
 23 different officers during that piece. We run-  
 24 -and you will see that ours is a very  
 25 different response plan to what you will get

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1 from the operators, we have what we refer to  
 2 as a category one, category two and category  
 3 three response and we'll go through each of  
 4 those.  
 5 ROIL, Q.C.  
 6 Q. Okay.  
 7 MR. PIKE:  
 8 A. We talked a little bit back when we had the  
 9 incident, when we get our incident  
 10 notification, the role of the chief safety  
 11 officer, in the case--normally in a category  
 12 one, it would be the chief safety officer that  
 13 would initiate the emergency response plan.  
 14 Indeed the chief conservation officer would  
 15 have responsibilities with regard to an  
 16 environmental event or a resource conservation  
 17 issue, not likely to see a resource  
 18 conservation issue as an immediate issue to  
 19 invoke your emergency response plan, but  
 20 that's sort of where it sits. The duty  
 21 office, and again, the duty officer is the one  
 22 that gets the initial notification and they  
 23 would take some of the notes associated with  
 24 the meeting or engaging the emergency response  
 25 plan.

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1 ROIL, Q.C.  
 2 Q. Is that the person who carries the 24 hour,  
 3 seven day contact information from time to  
 4 time?  
 5 MR. PIKE:  
 6 A. Yes. Onshore liaison officer, indeed on March  
 7 12th we did invoke this provision. This is  
 8 something optional for us. We put two safety  
 9 officers over in Husky's Emergency Response  
 10 Centre, so they were monitoring and observing  
 11 what was going on in Husky's Emergency  
 12 Response Centre, so in addition to hearing  
 13 from the operator, we were also hearing from  
 14 our own safety officer who was sitting there.  
 15 So depending on the situation, we actually may  
 16 have a safety officer, in this case two,  
 17 sitting in the operator's emergency response  
 18 room monitoring what is going on.  
 19 ROIL, Q.C.  
 20 Q. So is their role monitoring or assisting?  
 21 It's more monitoring, is it?  
 22 MR. PIKE:  
 23 A. It's more monitoring.  
 24 ROIL, Q.C.  
 25 Q. Yes.

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1 MR. PIKE:  
 2 A. They would certainly respond to any questions  
 3 that are posed to them, but it's meant as more  
 4 of a monitoring piece.  
 5 ROIL, Q.C.  
 6 Q. Yes.  
 7 MR. PIKE:  
 8 A. The managerial--public relations would also be  
 9 included in this piece when we call or invoke  
 10 our emergency response plan. Manager  
 11 environmental affairs, he tends to take the  
 12 lead when we're dealing with environmental  
 13 events, spills. And an environmental officer  
 14 would be brought in, again more for the spill  
 15 events. And I made reference to the  
 16 geoscience, again if we're dealing with a well  
 17 issue, it's very valuable to have access to  
 18 the geologists and geophysicists and reservoir  
 19 engineers to give us that information about  
 20 what's happening within the well. So it's a  
 21 very critical piece with regard to blow outs.  
 22 The manager of support services, and obviously  
 23 they're providing us support, administration,  
 24 and IT should we require some other  
 25 secretarial type work, secretarial, they would

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1 provide that and we would engage our manager  
 2 of legal and land, as well. And I think I  
 3 talked a little bit about the Montara blow out  
 4 and how some of those geoscience pieces are  
 5 very critical as you go forward. And we would  
 6 have responsibility for the integrity of a  
 7 well, which is not the case for the NPOSA.  
 8 National Petroleum Offshore Safety Authority  
 9 of Australia.  
 10 ROIL, Q.C.  
 11 Q. The Australian authority, yes.  
 12 MR. PIKE:  
 13 A. Category one, most of our emergency responses  
 14 and virtually--well all of them--well no -  
 15 ROIL, Q.C.  
 16 Q. Start again.  
 17 MR. PIKE:  
 18 A. Start again. The vast majority are category  
 19 one which is a monitoring function. What  
 20 we're doing there is we're monitoring the  
 21 operator's response to an emergency situation.  
 22 It does not involve intervention by the Board.  
 23 It's intended to ensure that the chief  
 24 conservation officer and the chief safety  
 25 officer and other government departments are

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1 apprised of the developments. The chief  
 2 safety officer takes the lead during a  
 3 category one emergency situation. There is a  
 4 slight exception to that, if we're dealing  
 5 with an environmental event that's in category  
 6 one, the chief conservation officer would be  
 7 taking the lead in that particular case. So  
 8 in this case, for March 12th, we were in a  
 9 category one situation. We were monitoring  
 10 and we were keeping the governments apprised  
 11 of what was happening.  
 12 ROIL, Q.C.  
 13 Q. Okay. And so by monitoring, what contact did  
 14 you have other than, for example, the two  
 15 liaison officers that were situated in the  
 16 Husky Emergency Response Centre?  
 17 MR. PIKE:  
 18 A. I would have made contact with the assisted  
 19 deputy minister of OSH program in the province  
 20 and had discussions with her, I would have  
 21 touched base with the Department of Energy,  
 22 the assistant deputy minister there and the  
 23 director of Frontier Lands in Ottawa, we would  
 24 have talked to them. I also made contact with  
 25 the Marine Rescue Subcentre folks there, the

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1 assisting commissioner of Coastguard, so I  
 2 made several calls to make sure that things  
 3 were happening the way they were supposed to  
 4 be happening that morning. The other piece  
 5 that happened that morning that we haven't  
 6 really talked about, we actually had four  
 7 officers offshore that day returning. They  
 8 were on the Terra Nova FPSO scheduled to come  
 9 in that morning, they were actually in the  
 10 air. So we needed to determine exactly where  
 11 they were and what was happening with them.  
 12 So that was another piece of the plan that we  
 13 had to initiate as well, and to notify their  
 14 spouses of what was happening.  
 15 ROIL, Q.C.  
 16 Q. So on the first report of the helicopter being  
 17 in difficulty, you didn't know who was on that  
 18 helicopter?  
 19 MR. PIKE:  
 20 A. We did not know and we knew we had four people  
 21 coming in.  
 22 ROIL, Q.C.  
 23 Q. As you look back, did anything--did you learn  
 24 any lessons from March 12th that would make  
 25 you do things differently or did your category

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1 one response work well in that kind of -  
 2 MR. PIKE:  
 3 A. It worked reasonable well, we will change some  
 4 things. We want to make sure that we get the  
 5 appropriate contact information for the  
 6 spouses at work. We had some problems there,  
 7 but other than there, there were a number of  
 8 lessons that we learned from that piece.  
 9 ROIL, Q.C.  
 10 Q. But generally, category one worked the way you  
 11 expected it to?  
 12 MR. PIKE:  
 13 A. Yes. Category two responses really deal with  
 14 environmental emergency situations. Where the  
 15 intervention of the Board is necessary  
 16 partially or completely to manage the  
 17 operators, environmental protection or  
 18 restoration activities during an emergency  
 19 situation. If the operator's response is  
 20 deemed to be adequate, category one applies.  
 21 So the CSO takes the lead--and this is not  
 22 correct, I should have corrected this, the CCO  
 23 takes the lead in a category two emergency  
 24 situation. The last final figures comes under  
 25 conservation officer and the chief

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1 conservation officer, it doesn't come under  
 2 safety.  
 3 ROIL, Q.C.  
 4 Q. Yes, so we'll take that as a typo in the last  
 5 sentence, the CCO takes the lead in category  
 6 two.  
 7 MR. PIKE:  
 8 A. Yes.  
 9 ROIL, Q.C.  
 10 Q. Okay, and I take the hallmark of that is  
 11 intervention, as opposed to monitoring.  
 12 MR. PIKE:  
 13 A. Yes, and we're talking there not necessarily  
 14 partial, so we could sometimes bounce between  
 15 the two. If we're not quite happy with what  
 16 the operator is doing, we may issue the order.  
 17 If they comply with the order, we'll drop back  
 18 to a category one where we're monitoring, so  
 19 that sort of could be happening.  
 20 ROIL, Q.C.  
 21 Q. Could you start off with a category one  
 22 response and realize that things aren't  
 23 happening the way it should be and then have  
 24 to go to a monitoring--to a two?  
 25 MR. PIKE:

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1 A. Yes.  
 2 ROIL, Q.C.  
 3 Q. So these are not cast in stone, it's a  
 4 moveable feast.  
 5 MR. PIKE:  
 6 A. No. They are. The category three response is  
 7 associated with safety and other matters on  
 8 their own or in addition to environmental  
 9 matters where intervention by the Board is  
 10 necessary to provide direction to the operator  
 11 during an emergency situation. If no  
 12 direction to the operator is necessary, a  
 13 category one applies. The CSO takes the lead  
 14 in a category three emergency situation and  
 15 this could also be a case where the Board  
 16 takes over a particular operation of we aren't  
 17 satisfied with what the operator is doing and  
 18 I'll go back to the Australian example, if  
 19 there was an extended blow out, we weren't  
 20 happy with what the operator was doing, we  
 21 could take over the operation and arrange for  
 22 a well control piece to have taken place. A  
 23 rather remote piece and if you've done your  
 24 homework right in the first instance when you  
 25 issue the authorizations, you aren't going to

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1 have to go here, but it is a provision that  
 2 you keep in your toolbox just in case, but if  
 3 you've done the right work up front and got  
 4 the right provisions with your operator up  
 5 front, you aren't necessarily going to find  
 6 yourself in this position.  
 7 ROIL, Q.C.  
 8 Q. Okay, well I think that takes us through all  
 9 of the evidence that I intended to lead you  
 10 on. I don't know if you have any closing  
 11 statement that you want to make, Mr. Pike,  
 12 before we get into the next issue of other  
 13 counsel having questions.  
 14 CLOSING STATEMENT BY MR. HOWARD PIKE  
 15 MR. PIKE:  
 16 A. Maybe just a quick--a safety regulator never  
 17 takes any joy in getting his picture in the  
 18 paper. It's usually a measure of failure and  
 19 unfortunately in the safety business, we tend  
 20 to measure failure, as opposed to success.  
 21 And I think one of the challenges we should  
 22 look forward to is how can we measure success  
 23 in safety. And I think it's through that  
 24 measure of safety that we can build confidence  
 25 in both the workers and in the public in what



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1 we're doing. And I think you've seen today a  
 2 lot more than we would normally show, and I'm  
 3 not sure if transparency or more transparency  
 4 is a way to do that or not, but as you talk to  
 5 the different regulators, it'll be interesting  
 6 to see what they do. We're making efforts to  
 7 be a little more transparent, but we do have  
 8 constraints of the legislation. There is the  
 9 Section 199 provisions. But I think there is  
 10 potentially a way to go forward and I think we  
 11 need to be looking at success versus the  
 12 measurement in failure.

13 ROIL, Q.C.:

14 Q. So while we are borne out of an incident of  
 15 failure, you think that we should look also at  
 16 the opportunities for successes?

17 MR. PIKE:

18 A. That's correct. Thank you.

19 ROIL, Q.C.:

20 Q. Thank you very much, Mr. Pike. Commissioner,  
 21 as I indicated to you during the break, there  
 22 is one counsel who is constrained with her  
 23 ability to be here tomorrow and by saying her,  
 24 I think I've indicated -- at least I've  
 25 narrowed the body of people, but it has been

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1 indicated that Ms. O'Brien would, with the  
 2 concurrence of you and other counsel, would  
 3 like to ask questions first because of her  
 4 inability to be here tomorrow morning.

5 COMMISSIONER:

6 Q. Thank you. Yes, I presume nobody has any  
 7 objection, have they, if Ms. O'Brien were to  
 8 ask her questions now? If not then, okay, Ms.  
 9 O'Brien.

10 MR. HOWARD PIKE, EXAMINATION BY MS. KATE O'BRIEN

11 MS. O'BRIEN:

12 Q. Thank you very much, Commissioner, and thank  
 13 you to my colleagues here in the room for  
 14 allowing me this opportunity because I do  
 15 appreciate it. Mr. Pike, I'm going to go --  
 16 ask the Registrar to go right to Exhibit C-188  
 17 and that is the four complaints that you  
 18 discussed earlier today that you had received  
 19 in the area of helicopter transport, and it's  
 20 really the first of those complaints, the one  
 21 there that's currently up on the screen as  
 22 being put forward by an ex-Cougar employee  
 23 that I want to talk about.

24 So I'm going to just go through, just hit  
 25 on a couple of things that are brought forward

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1 in that complaint. I know that in your -- in  
 2 the complaint registration form filled out by  
 3 the C-NLOPB, and I understand this is the old  
 4 form, it does have a section here at the front  
 5 where it does a statement of complaints, sort  
 6 of summarizes the complaint, and then it has a  
 7 little section on the next page, action taken,  
 8 and then what follows, I understand, is a  
 9 series of handwritten notes that were taken by  
 10 your safety officer. Am I correct on that?

11 MR. PIKE:

12 A. That's correct.

13 MS. O'BRIEN:

14 Q. Okay. So in your summary of the statement of  
 15 complaint, it says that you cite two specific  
 16 examples of safety concerns that were cited by  
 17 this individual. One was a S-61 control  
 18 problem that was illegally fixed by a pilot,  
 19 and another was a case where flights travelled  
 20 offshore without a standby helicopter. I'm  
 21 going to just -- I want to highlight --  
 22 because more comes out -- when I read those  
 23 notes of that safety officer attached to that  
 24 complaint, sort of more comes out. I'm not  
 25 saying that's inaccurate but I'm just saying

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1 there's more there, and I just want to, as  
 2 best I can, quote from the somewhat messy  
 3 handwriting of the safety officer involved.  
 4 So if I misquote, please forgive me.

5 But what we're getting here is a picture  
 6 of not a safety culture at Cougar. This  
 7 particular former employee doesn't see a  
 8 safety culture at Cougar. He is reporting  
 9 quite the opposite. "There may be some  
 10 attitude problems with management who are old  
 11 school and they feel they know better than the  
 12 regs." I think that's regs, maybe regulators.  
 13 He also uses the quote, and it's in quotes  
 14 here, "it's an old guys network" and in there,  
 15 I think in particular talking about the  
 16 relationship with Transport Canada. Again,  
 17 old boys network. There's a concern raised,  
 18 and I'm at page three of the notes, that  
 19 there's nowhere to go for safety issues, and  
 20 at this point, it seems the employee was  
 21 concerned about the relationship between the  
 22 base manager, the reporting relationship with  
 23 the base manager and the chief pilot and their  
 24 chain of command there, and says "so nowhere  
 25 to go for safety issues."

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1 There's concern raised that the C-NLOPB  
 2 and the oil companies should be more informed  
 3 of violations. That the C-NLOPB should get  
 4 copies of the JOHS committee minutes and  
 5 report of all incidents, and I would assume  
 6 there they mean at Cougar as opposed to with  
 7 the operators, this having been a Cougar  
 8 employee.  
 9 "The pilot complained" and I'm on page  
 10 five here, "the pilot complained about flying  
 11 without MEL," which I understand is the  
 12 minimum equipment list, "and was told to fly  
 13 or go home." Fly something or go home. So  
 14 really, this employee was raising some  
 15 concerns certainly about the safety culture in  
 16 place and I know we had some of the operators  
 17 who spoke to us earlier who are long time  
 18 offshore oil workers, you know, having started  
 19 in jobs where they were offshore, and they  
 20 said that of course, you know, offshore it  
 21 started as a very male, rough and tumble kind  
 22 of culture and imposing a safety culture on a  
 23 body that's historically been quite -- you  
 24 know, had sort of a very different culture  
 25 than that, is a difficult thing to do and they

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1 have seen big improvements over the years, and  
 2 I would think when we're looking at particular  
 3 work groups where it may be a little more  
 4 difficult to impose safety cultures or there  
 5 may be a bit more of a culture of bravado,  
 6 pilots and flying may be another one of those  
 7 types of cultures. So I certainly see some  
 8 concern here.  
 9 So my question, with a very long preamble  
 10 I realize, to you is to ask when you got this  
 11 -- I know you followed up in your next audit,  
 12 your next August or April 2004 audit. You did  
 13 a specific look at Cougar, and I know you were  
 14 looking at in particular the fix that the  
 15 pilot -- the unauthorized fix on the S-61 and  
 16 a couple of the other issues, but what, if  
 17 anything, did you do to look and see and delve  
 18 a little bit deeper on this issue, this red  
 19 flag that was being raised about the safety  
 20 culture or the lack of safety culture at  
 21 Cougar?  
 22 MR. PIKE:  
 23 A. Part of our standard sort of questioning tries  
 24 to get at those elements. So to go back to  
 25 some of the -- we didn't actually look at that

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1 detailed audit, but part of our standard sort  
 2 of questioning is trying to delve at what is  
 3 happening there, so the way they respond to  
 4 some of those things. We took that on board  
 5 and this individual, I have no doubt, believed  
 6 these things and we had to go back and try to  
 7 find out whether there was any background to  
 8 it. So in a lot of cases, the way we have  
 9 structured some of our questions will get us  
 10 some sense as to what's happening there. But  
 11 this is a highly sort of structured and  
 12 regulated industry. There is also a saying  
 13 that goes, and I learnt it not on the east  
 14 coast but in Alberta when I worked out there,  
 15 there are old pilots and bold pilots, but no  
 16 old, bold pilots. So you know, as we went  
 17 through and we did our questioning, we're  
 18 really -- and again, our focus was on the  
 19 safety or the occupational safety of the  
 20 passengers, as opposed to the pilots. The  
 21 pilots come under Labour Canada. They are a  
 22 federal jurisdiction, so when those issues are  
 23 raised, that would be the correct avenue to  
 24 raise it, and I understand that Transport  
 25 Canada Aviation has the avenue.

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1 We went in to see if we could see any  
 2 evidence of some of the things that he was  
 3 raising, a difficult thing to try to nail  
 4 down. We've continued to evolve our processes  
 5 to try to pick up on those things, but we  
 6 didn't get that sense when we went in and did  
 7 our audit. I'm not saying that this  
 8 individual didn't believe what was going on,  
 9 but we couldn't verify it in any way when we  
 10 went in and took a look at our audit, and the  
 11 way we structured our questions would have  
 12 been around can we get any sense that these  
 13 things are happening? Can we document it? So  
 14 we would have structured our questions around  
 15 some of these issues.  
 16 MS. O'BRIEN:  
 17 Q. Can you give me a bit more? I agree with you  
 18 that it is going to something that's difficult  
 19 to get at, but yet it's something that is very  
 20 important to get at. So can you give me a bit  
 21 of an example of what you would have done to  
 22 try to uncover whether this was something real  
 23 or this was just an opinion that really wasn't  
 24 based on fact?  
 25 MR. PIKE:

1 A. We would have to go back to the audit and take  
 2 a closer look at the questioning and the  
 3 questions that were raised at that time, but  
 4 that's -- it would be in the format of those  
 5 questions that we would have done it. I'm  
 6 trying to recall which two safety officers we  
 7 sent, and occasionally there are different --  
 8 safety officers have different strengths, so  
 9 if I know what I'm looking for, I may choose  
 10 one safety officer over another for a  
 11 particular -- or the right team to get these  
 12 things. So it's a combination of the  
 13 questions that were asked, the people that are  
 14 sent to ask the questions.

15 MS. O'BRIEN:

16 Q. Who are they asking the questions of or who  
 17 were they in this case asking the questions  
 18 of?

19 MR. PIKE:

20 A. I'm not sure. Which one are they on? The  
 21 exhibits would have that, but we would have  
 22 listed who the questions were being asked of.

23 MS. O'BRIEN:

24 Q. Would it have been pilots? I mean, I did -- I  
 25 have to be honest, I did review the April 2004

1 in, they asked a series of questions. Were  
 2 they the right ones? We might have asked a  
 3 different set of questions had we gone in now  
 4 because we have taken benefit. There is a  
 5 researcher at St. Mary's University who does a  
 6 lot of work on safety culture. Indeed, we've  
 7 had him in our office and given us training  
 8 and he has more recently developed an audit  
 9 tool associated with safety culture. So we've  
 10 tried to integrate some of those things more  
 11 recently into our auditing process. 2004, we  
 12 wouldn't have been there. We would have done  
 13 the best we could with the tools that we had  
 14 at the time to ask the right questions to  
 15 ascertain where they were.

16 MS. O'BRIEN:

17 Q. Okay.

18 MR. PIKE:

19 A. And the only answer I can give you is because  
 20 the safety officers didn't note it, and at  
 21 that time the focus was on the idea of noting  
 22 what was wrong, as opposed to what was right,  
 23 I can only assume that those questions were  
 24 asked.

25 MS. O'BRIEN:

1 audit. Nothing jumped out at me as really  
 2 addressing this. That doesn't mean it's not  
 3 there. I mean, it's a big document and it's  
 4 not a document I'm familiar with navigating,  
 5 so I easily could have missed something, but I  
 6 didn't see anything.

7 MR. PIKE:

8 A. The focus again, and that is one of the  
 9 problems we run into, is the focus when we  
 10 were auditing, particularly in 2004, was on  
 11 the non-compliances. What the safety officers  
 12 weren't quoting at that point were some of the  
 13 positive elements that they were seeing. So  
 14 if it was -- met their question or had met the  
 15 positive piece, they weren't recording it.  
 16 That was one of the deficiencies we had  
 17 identified in our system, that we needed to be  
 18 able to tell a more complete picture, not only  
 19 the things that we were finding that were  
 20 wrong, but the things that we were finding  
 21 that were right. So in 2004, we weren't  
 22 recording those things, so I don't really have  
 23 a good record of what they did or didn't find  
 24 in that regard.

25 It's my understanding that when they went

1 Q. Okay. On February 2nd, 3rd and 4th of this  
 2 year, we had Cougar employees here testifying  
 3 before us and one of the issues that came up  
 4 at that time, I was questioning Mr. Burt about  
 5 the use of helmet, say for pilots, okay, and  
 6 we had just sat through -- by the time I  
 7 questioned him, we had sat through two days of  
 8 testimony from Cougar where they took us  
 9 through how, you know, they have a good safety  
 10 culture. They have safety management systems.  
 11 They're all about risk assessment, you know,  
 12 pages and pages of detail on the strength of  
 13 their risk assessment and safety systems, at  
 14 least on paper we had that. But then when I  
 15 put the question to him whether anyone had  
 16 actually done an assessment on the use of a --  
 17 a risk assessment on whether a helmet, which  
 18 he agreed was, you know, a good piece of  
 19 safety equipment and would keep someone safer,  
 20 had they ever done an actual risk assessment  
 21 on what seems to me a pretty standard piece of  
 22 safety equipment for pilots, his answer was  
 23 no, that they hadn't, but he felt actually  
 24 that would be a very good idea to do that.

25 Were you -- when you, you know, heard

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1 that testimony from Mr. Burt were you  
 2 surprised that Cougar had, to this date, not  
 3 done a risk assessment on sort of a  
 4 fundamental piece of safety equipment?  
 5 MR. PIKE:  
 6 A. That's, again, I think if you go back through  
 7 some of these audits, you'll notice that that  
 8 safety management and culture has been  
 9 evolving at Cougar. In one of the audits, we  
 10 actually identify that they didn't have a  
 11 fully developed safety management system.  
 12 They were essentially relying on the  
 13 regulatory structure within which they were.  
 14 So it is in some regards somewhat surprising,  
 15 yes, because they seem to be an innovative  
 16 company. When people were raising some of  
 17 these things that would increase the safety of  
 18 how they operated, they seemed to be embracing  
 19 them. So it was somewhat surprising that they  
 20 hadn't taken the initiative to take a look at  
 21 helmets. So in some respects, it seemed a  
 22 little bit out of the character that I  
 23 understood Cougar to be operating under. They  
 24 seem to be a very innovative company,  
 25 embracing some of the initiatives to improve

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1 safety. So the fact that they hadn't done  
 2 that, yeah, that was somewhat surprising.  
 3 MS. O'BRIEN:  
 4 Q. Okay. You know, I agree and certainly after  
 5 hearing their presentation, they really  
 6 describe themselves as not just a -- certainly  
 7 not a reactive company, but a proactive  
 8 company or even a generative company, which I  
 9 guess is the new word for even better than  
 10 proactive. So that's how they put themselves  
 11 forward in their presentation. But yet, when  
 12 the breathing apparatuses came up, something  
 13 for pilots, something that had been around for  
 14 pilots for many years, they first started  
 15 looking at that, I think they said only two  
 16 years ago, so 2008, which is of course eight  
 17 years after it was starting to be looked at at  
 18 this industry for passengers on the system.  
 19 So again, did that surprise you, that they  
 20 again were -- I mean, that seems to me more  
 21 reactive than proactive truly. I'd like to  
 22 know what -- you're a safety officer. What's  
 23 your opinion on it?  
 24 MR. PIKE:  
 25 A. I have to be honest and say that I had thought

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1 some of their pilots did have it. My  
 2 understanding was that some of their ex-  
 3 military pilots had asked and were permitted  
 4 to use it. It came as a surprise to me when  
 5 they announced that that wasn't the case.  
 6 MS. O'BRIEN:  
 7 Q. Okay.  
 8 MR. PIKE:  
 9 A. So I didn't pursue it. It was -- and I don't  
 10 -- can't tell you where I heard it, but when  
 11 some of this HUEBA stuff first came up and it  
 12 was raised, I had honestly understood that  
 13 some of the pilots carried it. The pilots  
 14 that had military training that had been  
 15 trained in it had asked to be able to use it,  
 16 I understood were -- had it. Now I'm  
 17 obviously mistaken, but that was my  
 18 understanding.  
 19 MS. O'BRIEN:  
 20 Q. Okay.  
 21 MR. PIKE:  
 22 A. I didn't pursue it. You know, the pilots and  
 23 Cougar is not directly what we regulate.  
 24 That's a Transport Canada Aviation piece, but  
 25 when we asked the question, I had sort of

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1 understood that piece.  
 2 MS. O'BRIEN:  
 3 Q. And this is really, you know, you're really  
 4 coming to what my main -- putting your finger  
 5 on my main concern here is that certainly, the  
 6 C-NLOPB is doing certainly some auditing of  
 7 Cougar, because you've just told us that you  
 8 do do auditing of Cougar, and your -- so at  
 9 least on paper, it looks like we have a  
 10 company here who has all these systems in  
 11 place and someone is going to do the auditing.  
 12 But I guess we're all aware that sometimes the  
 13 paperwork and, you know, the boxes that are  
 14 being checked and that someone's checking the  
 15 boxes can sometimes not really give you the  
 16 full picture of what's going on and you don't  
 17 always get the -- at the end of the day,  
 18 what's happening is really still not good  
 19 enough, despite all these audit procedures  
 20 that you have, at least on paper. And I'm  
 21 wondering, you know, do you feel that it's not  
 22 your responsibility to make sure that Cougar  
 23 is being as safe as it possibly can with its  
 24 employees? Do you feel that's someone else's  
 25 responsibility? Do you feel you're doing

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1 enough? Do you feel you're limited in what  
 2 you can do?  
 3 MR. PIKE:  
 4 A. The lead regulatory agency for Cougar and its  
 5 employees is Transport Canada Aviation. Their  
 6 occupational health and safety  
 7 responsibilities fit within Labour Canada.  
 8 It's a federal jurisdiction. I'd be stepping  
 9 outside my bounds if I started moving in  
 10 there. Now do I occasionally push that way?  
 11 Yes. But it is outside, strictly speaking, my  
 12 regulatory bounds to be dealing with Cougar  
 13 pilots. They are covered by a regime within  
 14 Canada under Transport Canada Aviation and  
 15 Labour Canada.  
 16 MS. O'BRIEN:  
 17 Q. Okay. And yet their safety, the safety of  
 18 Cougar pilots, is inextricably linked to the  
 19 safety of the workers who you are regulating,  
 20 right?  
 21 MR. PIKE:  
 22 A. Yes, that's one of the reasons we do go take a  
 23 look and you're right, systems aren't perfect.  
 24 We try to take a look at it to see where the  
 25 system is and that's what the audit is trying

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1 to do. It doesn't look at the entire piece.  
 2 We try to take some samples to see if what  
 3 they presented to us is reflected in reality  
 4 and the samples we've taken at Cougar have  
 5 demonstrated that they do reflect and there  
 6 may be things that we're missing, but the  
 7 audits are not -- we don't look at everything.  
 8 We take those sample slices down through it  
 9 and you look at it and were there any  
 10 abnormalities in it and the answer is no.  
 11 MS. O'BRIEN:  
 12 Q. But yet some things are obviously being missed  
 13 or you wouldn't have been surprised here on  
 14 February 4th, right?  
 15 MR. PIKE:  
 16 A. Yeah, certainly.  
 17 MS. O'BRIEN:  
 18 Q. Yeah, okay. I know that this -- and this is  
 19 really my last area of questioning. You have  
 20 described that we know that we have -- for  
 21 example, let's take the helicopter passenger  
 22 transport suits. We know that there is a  
 23 regulation in place that these suits must  
 24 meet, a standard that these suits must meet,  
 25 and we know that the C-NLOPB has taken the

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1 view that perhaps something a little bit over  
 2 the standard is required. Am I stating that  
 3 fairly?  
 4 MR. PIKE:  
 5 A. Yes.  
 6 MS. O'BRIEN:  
 7 Q. Yes. So you have gone and actually, you know  
 8 -- I think we looked at Exhibit 255 or  
 9 something today. Anyway, it was a letter  
 10 where you put forward and you said to the  
 11 operators "we want you to demonstrate the  
 12 water ingress and egress testing. We want you  
 13 to demonstrate to us that these suits do  
 14 adequately protect against hypothermia." Now  
 15 I'm going to take that, so where we have a  
 16 regulator here who has a standard and yet is  
 17 saying, you know, we have a really dangerous  
 18 environment out there in the North Atlantic.  
 19 We need to do better than the standard. We're  
 20 going to force you to do better than the  
 21 standard. To what we have for the pilots and  
 22 their suits, which we don't have a standard  
 23 for the pilot suits. All we have is that they  
 24 have to adequately protect from hypothermia.  
 25 So unlike the passenger suits where reams of

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1 numbers and water egress and ingress and  
 2 temperature gradings that we have to meet, we  
 3 don't have anything like that for the pilot  
 4 suits and my concern is maybe what the pilots  
 5 are wearing is not good enough. I mean, at  
 6 the end of the day, that's my concern.  
 7 What body would be responsible for taking  
 8 a look at pilots flying in the North Atlantic  
 9 where the water is frigid and looking and  
 10 saying "those suits are good enough. We need  
 11 to go above the stated standard. We need to  
 12 have some numbers involved here. We need to  
 13 have some testing done to have someone show us  
 14 that these suits work"? Who would that be?  
 15 MR. PIKE:  
 16 A. For the pilots, I would see that as being  
 17 Transport Canada Aviation. Indeed, Transport  
 18 Canada Aviation also has the requirement for  
 19 the passengers. They cite the passenger suit  
 20 standard in their regulations as well. I said  
 21 at the beginning what I do sometimes, it's  
 22 very important to take a different  
 23 perspective. We have to look at things from  
 24 different ways. Your premise here is that the  
 25 helicopter pilots aren't protected as well as

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1 the passengers. Let's take a different  
 2 premise. Maybe they're better protected than  
 3 the passengers.  
 4 MS. O'BRIEN:  
 5 Q. Sure.  
 6 MR. PIKE:  
 7 A. The suits they've got may provide better  
 8 waterproofing or water ingress than the  
 9 passenger suits. What happens if I was  
 10 involved in an outdoor activity, snowshoeing,  
 11 cross country skiing, go to a sporting goods  
 12 store somewhere, Outfitters, whoever, how  
 13 would they outfit me for it? They would put  
 14 me in layers. I'd have one of those Miranda  
 15 wool maybe underneath and then some additional  
 16 layers that are for protection even when it  
 17 gets wet and it wicks away your -- sort of  
 18 keeps you cooler. So they'd give me a bunch  
 19 of layers and then on top of that, you'd put a  
 20 waterproof layer, and that's, in essence, what  
 21 the pilots have. The passengers, on the other  
 22 hand, are put into an all encompassing suit.  
 23 In addition to that, the pilots are able to  
 24 wear their own boots. We've already seen that  
 25 in the passenger suits, the boots were an

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1 issue, are an issue, continue to be an issue.  
 2 So sometimes you need to take a different  
 3 perspective on some of these things. We've  
 4 assumed here that the pilots weren't as well  
 5 protected, but maybe they were better  
 6 protected. I don't know, but certainly we  
 7 need to look at those things and look at --  
 8 and ask those kinds of questions.  
 9 MS. O'BRIEN:  
 10 Q. That's right, and really to be -- I am not  
 11 assuming. I don't know.  
 12 MR. PIKE:  
 13 A. Okay.  
 14 MS. O'BRIEN:  
 15 Q. I don't know. I haven't seen any data on  
 16 those suits whatsoever and I've asked the  
 17 questions and I still -- I don't have any  
 18 data. No one's provided us with any  
 19 information that there's been any testing.  
 20 You might be -- you know, that they're better  
 21 is just as possible at this point than that  
 22 they're worse. I'm -  
 23 MR. PIKE:  
 24 A. I don't know either and it would be  
 25 interesting to take a look at that, certainly.

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1 MS. O'BRIEN:  
 2 Q. Do you feel that the C-NLOPB in that you can  
 3 require the operators to do some testings of  
 4 the passenger suit, which as you said is also  
 5 a Transport Canada standard, do you feel the  
 6 C-NLOPB could say to the operators "by the  
 7 way, we want you to ensure that the pilots who  
 8 are flying also can demonstrate to us that  
 9 their suits adequately prevent against  
 10 hypothermia in this environment"?  
 11 MR. PIKE:  
 12 A. That would certainly be pushing our boundary,  
 13 and what I see as our jurisdiction, so I'd  
 14 have to review that one with my counsel in  
 15 order to see whether we could do anything, but  
 16 on the surface, I'd have to say no. I think  
 17 we would be pushing beyond some of the bounds  
 18 of what would be reasonable.  
 19 MS. O'BRIEN:  
 20 Q. Okay. I mean, I certainly would like -  
 21 MR. PIKE:  
 22 A. I appreciate that this is a difficult problem  
 23 and we can certainly look at it, but I can't -  
 24 - I can see some problems in that regard.  
 25 MS. O'BRIEN:

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1 Q. You know, and I certainly am going to be  
 2 urging, when we get to discussing issues  
 3 coming out of this phase, that you know, I  
 4 think somebody should be requiring Cougar to  
 5 demonstrate that their suits do work and that  
 6 it's not just for the safety of the pilots,  
 7 though I think that's very important too.  
 8 They're offshore workers too. They're people  
 9 who are in those helicopters flying back and  
 10 forth over that water on a daily basis.  
 11 They're in there more than anybody else. But  
 12 it's also important for the rest of the  
 13 workers because, you know, when you're in a  
 14 situation like that, the safety of one is  
 15 important to the safety of all.  
 16 MR. PIKE:  
 17 A. The only way I could see potentially doing it  
 18 is to contrast it. Asking whether that form  
 19 of protection is better than the form of  
 20 protection we are currently using. That would  
 21 be the only avenue that I would see that would  
 22 fit in within our -  
 23 MS. O'BRIEN:  
 24 Q. But what about the requirement for testing,  
 25 just to find out?

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1 MR. PIKE:  
 2 A. Pardon?  
 3 MS. O'BRIEN:  
 4 Q. What about the requirement for some testing?  
 5 MR. PIKE:  
 6 A. We would have to take a look at that. Again,  
 7 it's pushing our boundary.  
 8 MS. O'BRIEN:  
 9 Q. Okay. Those are my questions. Thank you.  
 10 COMMISSIONER:  
 11 Q. Before you go, the question of the pilots, I  
 12 and Inquiry counsel have talked about the  
 13 pilots. My own impression was, like Mr.  
 14 Pike's, that they were governed by Transport  
 15 Canada. But of course, I'm going to discuss  
 16 with all the people, counsel for people with  
 17 standing, the issues and we will endeavour to  
 18 find out for sure about that and so I'll bring  
 19 it up and you'll be there anyway and that's  
 20 something we'll have to discuss and find out  
 21 for sure if I have any jurisdiction to enter  
 22 into that.  
 23 MS. O'BRIEN:  
 24 Q. All right. Thank you very much. I appreciate  
 25 it, and I appreciate the opportunity to ask

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1 questions today. Thank you very much, Mr.  
 2 Pike.  
 3 COMMISSIONER:  
 4 Q. Okay then. Probably Mr. Roil, 20 past 4 is  
 5 too late to have -- to start other questions.  
 6 ROIL, Q.C.:  
 7 Q. I think, unless some other counsel can  
 8 indicate that he or she would be finished in  
 9 ten minutes. It's probably -- I'm sure Mr.  
 10 Earle will take a considerably longer, and so  
 11 -  
 12 COMMISSIONER:  
 13 Q. He hasn't said now whether he's going to ask  
 14 any.  
 15 EARLE, Q.C.:  
 16 Q. Commissioner, the world is not about to change  
 17 on the last day.  
 18 COMMISSIONER:  
 19 Q. So all right then. Well, in the  
 20 circumstances, unless anybody wants to stand  
 21 up and ask one or two or three questions,  
 22 we'll adjourn until tomorrow morning at 9:30.  
 23 (UPON CONCLUSION AT 4:20 P.M.)

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1 CERTIFICATE  
 2 We, the undersigned, do hereby certify that  
 3 the foregoing is a true and correct transcript of a  
 4 hearing heard on the 17th day of February, 2010 at  
 5 Tara Place, 31 Peet Street, Suite 213, St. John's  
 6 Newfoundland and Labrador and was transcribed by us  
 7 to the best of our ability by means of a sound  
 8 apparatus.  
 9 Dated at St. John's, NL this  
 10 17th day of February, 2010  
 11 Cindy Sooley  
 12 Discoveries Unlimited Inc.  
 13 Judy Moss  
 14 Discoveries Unlimited Inc.

<p style="text-align: center;">-?-</p> <p>'02 [1] 146:9</p> <p>'03 [1] 61:4</p> <p>'04 [1] 56:21</p> <p>'07 [1] 61:21</p> <p>'88 [2] 256:25 257:2</p> <hr/> <p style="text-align: center;">---</p> <p>-and [2] 251:18 266:24</p> <hr/> <p style="text-align: center;">-1-</p> <p>1 [1] 1:10</p> <p>100 [3] 39:16 157:23 158:9</p> <p>11 [4] 8:3,5,17 82:24</p> <p>114 [3] 171:11 173:13,19</p> <p>115 [1] 144:8</p> <p>11th [2] 25:5 31:14</p> <p>12 [2] 133:15 205:25</p> <p>12th [13] 9:3 14:10 15:23 17:21 66:2,6,8 190:17 204:18 248:4 268:7 271:8 272:24</p> <p>13 [1] 82:23</p> <p>14th [5] 114:9 121:7 138:8 145:10 147:1</p> <p>15 [4] 9:15 54:19,21 151:15</p> <p>16 [2] 39:21 116:6</p> <p>16th [5] 24:1,11 26:12 32:18 150:18</p> <p>17 [3] 1:1 3:15 68:21</p> <p>178 [3] 108:14 109:12 111:23</p> <p>17th [2] 303:4,10</p> <p>187 [1] 2:6</p> <p>188 [1] 52:15</p> <p>18th [5] 24:19,20 36:17 37:1 39:17</p> <p>190 [2] 107:14,16</p> <p>192 [1] 120:7</p> <p>194 [2] 2:6 149:16</p> <p>196 [3] 2:6 21:14,16</p> <p>197 [2] 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