

**OFFSHORE HELICOPTER SAFETY INQUIRY**

*September 9, 2010  
Tara Place, Suite 213, 31 Peet Street  
St. John's, NL*

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CERTIFICATE

September 9, 2010

**PRESENT:**

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

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

**John Andrews/..... Canada-Newfoundland and Labrador Offshore**

**Amy Crosbie ..... Petroleum Board (C-NLOPB)**

**Stacey O’Dea/ ..... Hibernia Management and**

**Cecily Strickland ..... Development Company (HMDC)**

**D. Blair Pritchett/Denis Mahoney/**

**Stephanie Hillier.....Suncor (Petro-Canada)**

**Alexander C. MacDonald, Q.C./**

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

**Lewis Manning/**

**Nick Schultz ..... Canadian Association of Petroleum Producers (CAPP)**

**Geoffrey Spencer..... Helly Hansen Canada Ltd.**

**Rolf Pritchard/**

**Laura Brown Laengle .....Government of Newfoundland and Labrador**

**Jack Harris, Q.C. .... Member of Parliament**

**Kevin Stamp, Q.C. .... 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)**

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

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

**..... Local 2121**

**Jonathan Tarlton.....Department of Transport Canada**

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1 September 9, 2010  
 2 COMMISSIONER:  
 3 Q. Good morning, ladies and gentlemen. I think,  
 4 Mr. Roil, you have something to say before Mr.  
 5 Earle starts.  
 6 ROIL, Q.C.:  
 7 Q. Yes, Commissioner, thank you. Yesterday  
 8 morning when Mr. Spencer was presenting on  
 9 behalf of Helly Hansen Canada Limited, he made  
 10 reference, and I think in your question there  
 11 was reference to whether or not the HTS-1 suit  
 12 had a second approval, that being the marine  
 13 one, and he has since provided me with a  
 14 document that I'd like him to speak briefly to  
 15 and then we can make it an exhibit as part of  
 16 our records.  
 17 COMMISSIONER:  
 18 Q. Okay.  
 19 SUBMISSIONS BY MR. SPENCER:  
 20 Q. Good morning, Mr. Commissioner. Following my  
 21 submissions yesterday, it was brought to my  
 22 attention that just two months ago, in fact,  
 23 on July 6th, 2010, the HTS-1 suits did receive  
 24 a certificate approval from Transport Canada  
 25 for the Marine Abandonment Standard. Now you

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1 will recall yesterday my thought was that it  
 2 would be difficult to do that because of the  
 3 donning requirements and the minimum buoyancy  
 4 requirements, and I've been advised that in  
 5 order to obtain the certificate, Transport  
 6 Canada waived the donning requirements and it  
 7 waived some of the minimum buoyancy  
 8 requirements. In issuing the certificates,  
 9 it's restricted to those working in the  
 10 offshore industry. So there was a process of  
 11 several months because you'll recall that the  
 12 suits, in fact, were authorized to be put into  
 13 service in November of 2009, so it took a fair  
 14 bit of time to get the Certificate of  
 15 Approval, and even then you had to get several  
 16 exemptions and restrictions to have the  
 17 certificate issued. So it really goes back to  
 18 our comments yesterday, we think it's  
 19 preferable for the suits only to have to be  
 20 certified to the Aviation Standard rather than  
 21 having to go through this process of getting  
 22 this Marine Abandonment Certificate with all  
 23 of the exemptions and the restrictions that go  
 24 through that.  
 25 COMMISSIONER:

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1 Q. So from what you were saying yesterday, what  
 2 was in the brief, I take it your client is  
 3 really recommending the Aviation Standard?  
 4 MR. SPENCER:  
 5 Q. Yes.  
 6 COMMISSIONER:  
 7 Q. Rather than the dual standard.  
 8 MR. SPENCER:  
 9 Q. Yes, exactly, and in speaking with my client  
 10 yesterday, I'm advised that at the CGSB  
 11 meetings that are ongoing now and the review  
 12 process, they're looking at, in fact, creating  
 13 perhaps a whole separate standard just for the  
 14 offshore and maybe that's the way to go, but  
 15 this idea of having to get dual certification  
 16 and the processes that are inherent in that is  
 17 really cumbersome and it's restricting in  
 18 terms of trying to design these things. So we  
 19 do have the Certificate of Approval for the  
 20 Marine Abandonment Standard, and perhaps - and  
 21 I think it has been entered as an exhibit now.  
 22 COMMISSIONER:  
 23 Q. If not, it's going to be in a moment, is it?  
 24 ROIL, Q.C.:  
 25 Q. Yes, a copy has been provided to all the

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1 parties in the room and the Registrar has a  
 2 copy. I understand it will bear #P-00241.  
 3 REGISTRAR:  
 4 Q. That's correct.  
 5 ROIL, Q.C.:  
 6 Q. And the appropriate title of it we'll  
 7 determine briefly to make sure that it fits  
 8 within our record keeping appropriately.  
 9 COMMISSIONER:  
 10 Q. Thank you, Mr. Spencer.  
 11 MR. SPENCER:  
 12 Q. Thank you, sir.  
 13 ROIL, Q.C.:  
 14 Q. Now I think, Commissioner, Mr. Earle is ready  
 15 to proceed.  
 16 SUBMISSIONS BY RANDELL EARLE, Q.C.:  
 17 Q. Good morning, Commissioner. Initially, I  
 18 would like to thank the Inquiry staff and  
 19 counsel and yourself, Mr. Commissioner, for  
 20 the courtesies, assistances, and from time to  
 21 time indulgences that we have been granted  
 22 over the course of the Inquiry. In  
 23 particular, on behalf of the members of CEP  
 24 2121, thank you for the courage to make the  
 25 interim recommendation for a move to a SAR

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1 response time of 15 to 20 minutes wheels up,  
 2 and a ceasing of night flights.  
 3 When CEP 2121 undertook this exercise,  
 4 the highest priority was to make the point  
 5 that Search and Rescue response time had to be  
 6 improved and night flights were a hazard which  
 7 could not be tolerated. The fact that you  
 8 made an interim recommendation, I think has  
 9 underlined the importance of this particular  
 10 recommendation, and I think it has really set  
 11 a new tone for safety in offshore Newfoundland  
 12 and Labrador.  
 13 When you get an Inquiry like this,  
 14 there's almost a Stockholm Syndrome where the  
 15 prisoners and the guards gradually come to get  
 16 comfortable with each other. I think we  
 17 should remind ourselves at this point that the  
 18 Aerosafe Survey found after all the activity,  
 19 even after the interim order, that 27 percent  
 20 of offshore workers indicate that they have  
 21 confidence issues vis a vis offshore  
 22 helicopter travel, 37 percent have expressed a  
 23 desire for travel to the offshore  
 24 installations by a means other than  
 25 helicopter. Safety of helicopter travel weighs

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1 heavily on the minds of too many of the people  
 2 that CEP 2121 represents.  
 3 We haven't come to this Inquiry to defend  
 4 a position. Nor have we come here to make  
 5 points by beating up on people. We've come  
 6 here to participate in a rigorous examination  
 7 of the status quo and what has gone on in the  
 8 past in the hope that we can find in that a  
 9 route to improved safety for offshore workers  
 10 in Newfoundland and Labrador. CEP 2121 has  
 11 identified the why of the failures respecting  
 12 the helicopter transportation suit, the  
 13 emergency underwater breathing device, SAR  
 14 response time, as key issues for this Inquiry.  
 15 Now it makes good press to have a few shots at  
 16 an organization because they made mistakes.  
 17 Let me assure you that's not what we're here  
 18 about, we're here about the "why" because -  
 19 and I have to say to you the "why" of the  
 20 failures is important because it tells us if  
 21 there is an underlying cause, is there a  
 22 systemic problem. Everyone makes mistakes.  
 23 That's why in safety we look to redundancy.  
 24 We accept that there will be mistakes, so we  
 25 look to have - to use the analogy that so many

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1 of the safety experts use, we look to have  
 2 enough slices of swiss cheese, so even though  
 3 each slice has a hole in it, a weakness that  
 4 something can get through, we've got enough  
 5 slices that disaster cannot make its way all  
 6 the way through.  
 7 Now if there is an underlying cause, if  
 8 there is a systemic problem, just adding  
 9 another barrier will not be enough. If there  
 10 is a systemic problem, major change is  
 11 necessary because if it's a systemic problem,  
 12 we will see that the level of redundancy is  
 13 insufficient, the attention to the necessity  
 14 of redundancy is insufficient. It is the job  
 15 of the operators in the scheme in the  
 16 Newfoundland and Labrador offshore. It's  
 17 their job to ensure redundancy. They produce  
 18 the safety plan, they come up with the  
 19 mechanisms to this ALARP principle to ensure  
 20 that the risk is as low as reasonably  
 21 practicable.  
 22 On the other hand, it is the job of the  
 23 regulator to validate that sufficient  
 24 redundancy is in place, and to take action if  
 25 it isn't. They don't develop the safety

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1 plans, they don't decide on the mechanisms,  
 2 they validate them, but if the ALARP principle  
 3 is not being honoured, then the regulator must  
 4 take action. If sufficient redundancy is not  
 5 there, they must take action.  
 6 Our conclusion is that a history that we  
 7 have seen here indicates that C-NLOPB has  
 8 failed in its role as a regulator. Now that's  
 9 a very severe statement and we don't make it  
 10 lightly, but we can find no other conclusion.  
 11 We all went through the history of things with  
 12 the emergency underwater breathing device. It  
 13 was a new piece of redundancy, it was a  
 14 critical piece of redundancy because if you  
 15 recall Dr. Coleshaw's evidence and the report  
 16 on breathing hold time, the fact of the matter  
 17 is that the probability of being able to make  
 18 it to the surface without taking in water into  
 19 the lungs and drowning from a submerging  
 20 helicopter is extremely low, there just wasn't  
 21 enough time in a held breath to get you to the  
 22 surface. So this is a critical piece of  
 23 redundancy standing between the individual and  
 24 death. This exercise started in 2000. An  
 25 emergency breathing device was in use in the

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<p>1 North Sea. By 2003, everybody was using it.                  2 The military was using the compressed air                  3 device. Recreational scuba divers had been                  4 using a similar device for years. Rather than                  5 demand that the operators adopt a schedule,                  6 develop a plan of attack, move the device                  7 forward, a device that was in play in the rest                  8 of the world, C-NLOPB displayed what I can                  9 only describe as an institutional lethargy                  10 that's absolutely mind boggling. You know,                  11 you can look at the little pieces of that and                  12 you can say, yes, we had to be sure that we                  13 could do the training safe, or, yes, we wanted                  14 to pick the best device, but somebody has to                  15 look at the big picture, and the big picture                  16 was without an emergency breathing device                  17 people weren't going to be able to hold their                  18 breath long enough to come to the surface from                  19 a sinking helicopter. The big picture was                  20 that other people had found a solution, so why                  21 are we taking nine years to bring this advance                  22 to workers in the Newfoundland and Labrador                  23 offshore.                  24 Now CAPP, I suspect, prompted by this                  25 process, has engaged in a lessons learned</p>	<p>1 stairways from helicopters, walking across                  2 helidecks. There was just - just an ordinary                  3 everyday safety risk posed by the ill-fitting                  4 suit. Someone could have injured themselves.                  5 There was a risk to mobility posed by these                  6 ill-fitting suits in the circumstances of the                  7 suit having to be relied upon during escape.                  8 We're talking about people, you know - I mean,                  9 the visual image is practically someone trying                  10 to get out of a helicopter while suited up in                  11 a sack. We heard from the people at Marine                  12 Institute about how people have to get out of                  13 this. You need a properly fitting suit to be                  14 agile and able to get out of these                  15 helicopters.                  16 C-NLOPB was aware of the risk of ill-                  17 fitting, leading to water ingress, and we know                  18 what that meant for Robert Decker, and I'll                  19 deal with the Helly Hansen remarks of                  20 yesterday a little later on. C-NLOPB knew                  21 that these suits fitted so poorly that there                  22 was a significant risk for individuals that                  23 excess water would come from the ocean into                  24 the suit. They also knew, and it is                  25 interesting this was - because this was a risk</p>
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<p>1 exercise on this, and I will say that they                  2 brought forward some fairly sound ideas. We                  3 have some problems with them, but they're on a                  4 different level and I'll address that later,                  5 but they have found, you know, things we                  6 should have done. They're strong on that.                  7 They are weak on how it was an industry in                  8 which project management is the modus operandi                  9 for any significant change got so mired in                  10 moving forward with this process, but, you                  11 know, CAPP and - are really just the operators                  12 in another forum, they have responsibility,                  13 but C-NLOPB has a greater responsibility.                  14 They're the organization with the power to                  15 enforce, they're the organization that had the                  16 ability to say you have to get this done, and                  17 they declined to do it.                  18 Let's just take a moment to look at the                  19 suits, the helicopter transportation suits.                  20 The C-NLOPB became aware in June of 2008 of                  21 four serious safety issues with the E-452                  22 suit. Those issues were ill-fit, posing a                  23 risk to wearers during movement on land. I                  24 mean, people were coming up out of the boots                  25 of these things and walking down ladders</p>	<p>1 that actually came out here first identified                  2 through C-NLOPB, the experts later confirmed,                  3 that there was a risk with these suits because                  4 with excessive material and excessive size,                  5 there would be excessive buoyancy, the                  6 individual could be driven against the frame                  7 of the helicopter by the excessive buoyancy                  8 and restricted in their ability to get out.                  9 Now did they investigate the dimensions                  10 of the problem; no. They called in the                  11 operators and said what are you doing about                  12 it, and accepted we're working with the                  13 manufacturer and we're working with                  14 government. Did they consider alternatives to                  15 the continued use of defective safety                  16 equipment; no, we'll continue using this and                  17 we'll work on it, we'll try and fix it. Yeah,                  18 you know - Mr. Pike agreed that those risks                  19 were real and known to them in his evidence.                  20 This is not safe, we've got to figure out                  21 another way people to the platforms; no. This                  22 is a classic example of a failure to recognize                  23 what their job is. I mean, the idea that an                  24 occupational health and safety inspector from                  25 the Provincial Department of Labour would</p>

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1 accept for an employer, well, we can't get  
 2 safety gear for this individual that fits, so  
 3 they'll continue working with safety gear that  
 4 doesn't fit that poses a risk. I mean, it's  
 5 so far fetched as to be ludicrous, yet that's  
 6 exactly what C-NLOPB did here. They ignored  
 7 their mandate which was to ensure that the  
 8 redundancy put forward by the operators,  
 9 helicopter transportation suits - functioning  
 10 helicopter transportation suits was part of  
 11 the operators safety plan, and C-NLOPB ignored  
 12 that this part of the safety plan was missing.  
 13 We need to remind ourselves of the dimensions  
 14 of this problem. After a professional fitting  
 15 exercise, that is someone who trained in  
 16 ensuring that the fit was appropriate, after a  
 17 professional fitting exercise, 180 people were  
 18 found to not have a suit that fit properly.  
 19 That's at least 180. The way the evidence  
 20 came out, it could have been more, 180 people.  
 21 What has C-NLOPB told us that they've  
 22 learned from this; nothing. What have they  
 23 told us they've tried to do to find out how  
 24 they got themselves in this position; nothing.

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1 SAR response time - let's start at the  
 2 beginning. C-NLOPB chose to accept a standard  
 3 for SAR response which was massively lower  
 4 than that which was recommended by the Ocean  
 5 Ranger Inquiry. That in and of itself says  
 6 volumes about their attitude to safety. The  
 7 Ocean Ranger Inquiry, for those who have been  
 8 around long enough to remember it, had masses  
 9 of experts. They didn't have to function in  
 10 the kind of restricted fashion that this  
 11 Inquiry has had to function where we've had  
 12 real problems in terms of overlapping  
 13 jurisdictions and things of that nature. The  
 14 Ocean Ranger Inquiry was a full scale Inquiry  
 15 on the level of a Royal Commission. Great  
 16 expertise. The C-NLOPB from the outset chose  
 17 to ignore that recommendation. Leaving that  
 18 aside, they sat on the sidelines for 13 years,  
 19 but the rest of the world moved into response  
 20 times like the 15 to 20 minutes, and did  
 21 nothing. I don't think they can say they  
 22 didn't know about it. They just did nothing.  
 23 This is - they approved the safety plan, there  
 24 it is, but don't revisit it. Their mandate is  
 25 to ensure that the operators are operating in

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1 accordance with the ALARP principle, a risk is  
 2 as low as reasonably possible. How can you  
 3 say that you've carried out that mandate when  
 4 you have sat for 13 years with the rest of the  
 5 world improving the situation. You sat for 13  
 6 years with the people of this province  
 7 regularly raising a fuss in the airwaves and  
 8 in the press about the response time of DND.  
 9 So the issue was very much - response time was  
 10 very much a public and current issue, and you  
 11 sit by for 13 years, and have the offered any  
 12 explanation as to how they, as an  
 13 organization, got themselves in this  
 14 situation; have they offered any insight to  
 15 us, have they even indicated that they're  
 16 looking at it. Their submission is an eight  
 17 page recitation of their jurisdiction.  
 18 Mr. Commissioner, one of the issues that  
 19 has been identified by you is whether or not  
 20 the safety management risk systems of the  
 21 operators is sufficiently robust to ensure  
 22 passenger safety. Well, we now know as a  
 23 matter of public record what Cougar  
 24 Helicopters position is on the causes of the  
 25 crash of Flight 491. They've issued a

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1 Statement of Claim in which they have said  
 2 that Sikorsky represented to them, amongst  
 3 other things, that the S92 was equipped with a  
 4 high durability main gear box which had a 30  
 5 minute run dry capability. That is, it could  
 6 operate safely for 30 minutes following total  
 7 loss of lubrication. Cougar says that  
 8 Sikorsky made those representations with the  
 9 intention that they would be relied upon by  
 10 potential customers of the S92, of which they  
 11 were one. Cougar says they did not know that  
 12 the representations were false, and, in fact,  
 13 relied upon them in selecting the S92 for  
 14 offshore operations, and that their pilots  
 15 reasonably relied upon the representations in  
 16 calculating the dry run capability of the  
 17 helicopter. They go on to say these were  
 18 intentionally false representations. Now in  
 19 plain everyday language, what Cougar is saying  
 20 is Sikorsky lied to us. Well, the question is  
 21 what about the due diligence of the people  
 22 involved here in terms of selecting the S92,  
 23 which goes to the issue that you're talking  
 24 about, and that you have identified, what  
 25 about their due diligence. This wasn't a 737

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1 or a twin Otter that Cougar was buying.  
 2 Cougar, in fact, in some of the publications  
 3 is described as the launch customer for the  
 4 S92. They were buying a new helicopter  
 5 design. The question I think has to be asked  
 6 now is why were there not sufficient  
 7 mechanisms in place to discover this lie  
 8 before it resulted in such a tragedy. Why did  
 9 the operators audit systems not identify such  
 10 a horrendous and basic flaw in the due  
 11 diligence. Why did C-NLOPB not have ascertain  
 12 -- did it not ascertain that the processes of  
 13 the operators were insufficient? We've  
 14 offered the Inquiry a view as to why C-NLOPB  
 15 has failed. The inherent conflict in the  
 16 mandate of C-NLOPB creates a subtle and even  
 17 unconscious pressure not to be negative  
 18 towards the operators. The reality is that  
 19 what's good for the operators is good for C-  
 20 NLOPB. In the same report of C-NLOPB where  
 21 they recorded the tragedy of the Flight 491's  
 22 crash, C-NLOPB stated, with some pleasure,  
 23 that that year had seen the billionth barrel  
 24 of oil produced in the Newfoundland offshore.  
 25 That, I think, starkly underlines the

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1 conflict. It is a very difficult place in  
 2 which to rain upon the operators' parade.  
 3 Mr. Andrews, in his evidence, talked  
 4 about the fact that the chief safety officer  
 5 has independent action, but of course, you  
 6 know, we're a collegial operation, I don't  
 7 think that was the word he used, but this was  
 8 the message, so we talk to each other about  
 9 what we're doing. The reality is in an  
 10 organization that has this split mandate, this  
 11 inherently conflicting mandate, when the chief  
 12 safety officer says to the chair "I'm going to  
 13 have to shut down this operator," which is the  
 14 crude remedy that they have, whether his voice  
 15 says it, his face will say "do you really have  
 16 to?" That's human nature. We express these  
 17 things in phrases like "don't shoot the  
 18 messenger." Just think about that. Where  
 19 does that come from? Nobody wants to hear bad  
 20 news, but it is the job of a safety officer to  
 21 deliver bad news and a safety officer should  
 22 not be working in an organization where the  
 23 largest part of the organization, the mandate  
 24 of the organization, does not want to hear bad  
 25 news.

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1 It is unfortunate that we have not been  
 2 able to hear from some experts in behavioural  
 3 organization. We really haven't had time and  
 4 I want to say at this point that I have to say  
 5 the Inquiry is to be complimented on doing as  
 6 much as reasonably practicable within a very  
 7 tight time frame and a difficult mandate, in  
 8 terms of the jurisdictions of others. But  
 9 there are people out there. There's some very  
 10 interesting work being done by some of the  
 11 people, the Kellogg School of Management, on  
 12 organizational behaviour and just how the  
 13 messenger is treated and most importantly, the  
 14 impact of those subtle cues back on the  
 15 messenger and how it causes the messengers to  
 16 filter their behaviour.  
 17 If we're right, C-NLOPB is not the  
 18 organization to regulate safety in the  
 19 Newfoundland and Labrador offshore. If we're  
 20 not right, Mr. Commissioner, we are left with  
 21 an organization that has demonstrated  
 22 institutional lethargy, dereliction of duty,  
 23 and which, most disturbingly, has not offered  
 24 you an iota of insight as to why they have  
 25 failed so dismally. Such an organization

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1 cannot be left with the responsibility to  
 2 regulate safety.  
 3 We're saying to you, Mr. Commissioner, to  
 4 make a recommendation that goes against the  
 5 mainstream. The mainstream of Canada contains  
 6 or is largely made up of combined safety and,  
 7 for want of a better word, development  
 8 promotion regulators. But we know that the UK  
 9 has adopted a different system and we know  
 10 that a small jurisdiction, like New Zealand,  
 11 has a system where the regulation of safety is  
 12 separated from the economic natural resource  
 13 type regulation. So it's not impossible to  
 14 do, and if safety, worker safety is truly the  
 15 top priority then we cannot let the fact that  
 16 everybody else is doing it a certain way in  
 17 Canada stand as an impediment to remedying  
 18 this problem.  
 19 Mr. Commissioner, the system in  
 20 Newfoundland and Labrador offshore is already  
 21 essentially a goal system, goal based system,  
 22 and we'd have a lot of talk around that issue.  
 23 In my respectful submission, not enough expert  
 24 evidence to come down on it. But you know, it  
 25 is essentially one of your mandate, operators,



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1 is to provide a safe operation, a safe  
 2 workplace. Tell us how you'll do it and we  
 3 will validate it. That's the essence of the  
 4 current system, so that's not you must have,  
 5 you know, 110 suits of a certain type. You  
 6 must have a pair of safety goggles for every  
 7 worker, et cetera. It's a goal based system,  
 8 and these three areas that I've talked about  
 9 in terms of the failures of C-NLOPB equally  
 10 reflect failures on the part of the companies,  
 11 and I know before I finished, everybody'll be  
 12 looking at their watch, but why should things  
 13 change in how people have reacted to me  
 14 throughout this thing, so -  
 15 COMMISSIONER:  
 16 Q. Now, Mr. Earle, quite seriously, everybody in  
 17 the room is going to be able to say, in these  
 18 next two days, you know, what they feel. So  
 19 don't feel constrained.  
 20 EARLE, Q.C.:  
 21 Q. Well, we were advised that we had an hour.  
 22 COMMISSIONER:  
 23 Q. Well, that's true, but -  
 24 EARLE, Q.C.:  
 25 Q. Yeah, and I'll be probably 59 minutes and 59

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1 seconds. But all these three issues, you can  
 2 look at it, look at them and ask about the  
 3 operators' role. I mean, the operators are  
 4 CAPP. With the underwater breathing device,  
 5 they have to wear responsibility, and to their  
 6 credit, they have accepted responsibility for  
 7 the nine-year delay.  
 8 You know, the suit problems, I mean, they  
 9 had all the information that C-NLOPB had.  
 10 They knew those problems were there. They had  
 11 a survey done and the survey showed, if you  
 12 looked at it carefully, that eight percent of  
 13 the people surveyed said they had no trouble  
 14 getting the zipper up, but they had a problem  
 15 making the seal, and then they just went on.  
 16 Eight percent of the offshore workforce is a  
 17 lot of people who had problems making the seal  
 18 in those suits.  
 19 Now the question I have is were they  
 20 blinded by their desire to save money and  
 21 remove a logistics problem by combining the  
 22 two suits? Because when you look at the  
 23 evidence of Suncor, in particular, it seemed  
 24 to be the focus was, you know, we're trying to  
 25 deal with Transport Canada. We're trying to

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1 get the suits approved. Well, they had a goal  
 2 with Transport Canada when they started out  
 3 with the new suit. It had to be a suit that  
 4 was an abandonment suit and a helicopter  
 5 transportation suit, both, and they fixated,  
 6 it seems to me, on this and ignored the fact  
 7 that the people were going back and forth to  
 8 the offshore installations with unsafe gear  
 9 on. Nothing changed with the suit as a result  
 10 of the crash of 491. Nothing changed with the  
 11 suits, the same suit, E-452. What changed was  
 12 the profile of the issue. Robert Decker's  
 13 body temperature when he was rescued simply  
 14 underlined the consequences of the poor seal.  
 15 For an organization that is to be allowed  
 16 to lead on safety, which is this is a system,  
 17 that's what a goal system, we say here's the  
 18 goal. Lead, go for it. An organization that  
 19 is to be allowed to lead on safety must be  
 20 sufficiently robust and rigorous in its  
 21 approach to safety that it can see the greater  
 22 risk when the signs are reported. They must  
 23 not need to be hit over the head by the stark  
 24 evidence provided by Robert Decker's body  
 25 temperature on rescue. They must be able to

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1 see these things are not watertight.  
 2 Watertight equals safety. Not watertight  
 3 equals hyperthermia. We can't have people  
 4 using them. They must be able to see  
 5 somebody's going to be walking down the steps  
 6 from one of these helicopters in one of these  
 7 suits that fit so badly that they're going to  
 8 fall and break a bone or worse. We can't use  
 9 those suits.  
 10 On SAR response time, this, in my  
 11 respectful submission, in our respectful  
 12 submission, is a condemnation of the ability  
 13 of these operators to lead. They all operate  
 14 in jurisdictions where the response time is  
 15 the standard you've ordered. They knew about  
 16 the availability of that response time. They  
 17 operate in jurisdictions where the operator  
 18 has full responsibility for SAR. There is no  
 19 other explanation for their failure to move  
 20 that forward, other than they weren't going to  
 21 do it until they were told to do it. That's  
 22 not how you lead on safety.  
 23 I am disturbed by the operators'  
 24 submission. Everything is okay. Everything  
 25 is okay. Well, we can have a conference a

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1 couple times a year, but other than that,  
 2 everything's okay. 180 people going around in  
 3 suits that don't fit. Safety suits that don't  
 4 fit is not everything is okay. Nine years to  
 5 put a HUEBA in place is not everything is  
 6 okay. A substandard SAR response is not  
 7 everything is okay. 17 families who have lost  
 8 husbands, fathers, sons and a daughter in a  
 9 crash that didn't have to happen is not  
 10 everything is okay. It is disturbing when you  
 11 said to the participants in this matter at the  
 12 outset in this Inquiry, "this is not about  
 13 finger pointing. We want this to be a  
 14 collaborative exercise," that the posture of  
 15 the operators throughout this Inquiry has been  
 16 so utterly defence oriented and that they have  
 17 failed to look at the problems and identify  
 18 the underlying causes that have led to these  
 19 things so that we can have confidence in their  
 20 ability to lead on safety issues.  
 21 The lessons learned in this Inquiry is  
 22 that Newfoundland and Labrador needs a strong  
 23 and effective safety regulator. We can't  
 24 leave it to the operators and we can't have a  
 25 safety regulator that sits on its hands.

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1 Now I'd like to touch for a few moments  
 2 on some of the other issues and obviously we  
 3 have addressed most of them in our brief, but  
 4 the comments by Helly Hansen yesterday, such a  
 5 blatant and classic example of blame the  
 6 victim I've never heard. The fact of the  
 7 matter is Robert Decker had a suit that didn't  
 8 fit him and it was a suit that was supplied by  
 9 his employer through Helly Hansen. Nobody had  
 10 the job of seeing that the suit fit. Nobody  
 11 instructed the workers on checking the fit,  
 12 but Helly Hansen said "well, you know, maybe  
 13 Robert" -- implicitly, "maybe Robert Decker  
 14 took the wrong suit." There were 180 people  
 15 who were found to have no suit that could fit  
 16 them.  
 17 This brings us to the issue of personal  
 18 accountability, because that's where Helly  
 19 Hansen touched, you know, personal  
 20 accountability. Look, the occupational health  
 21 and safety committee on the Terra Nova  
 22 platform kept the suit issue on the table for  
 23 11 months. How much more worker  
 24 accountability do we need? Accountability on  
 25 the part of workers is very important, but it

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1 requires knowledge. You have to know what a  
 2 suit is supposed to achieve before you can go  
 3 to somebody and say "it doesn't achieve what  
 4 it's supposed to. I need another one." It  
 5 requires a vehicle to raise the issues, a  
 6 means, and we've heard about ProAct and we've  
 7 heard about occupational health and safety  
 8 committees. But most of all, it requires a  
 9 receptive ear, because there is nothing that  
 10 dampens accountability on the part of workers,  
 11 initiative upon the part of workers, like a  
 12 deaf ear when they raise the issues, and I ask  
 13 you to reflect upon the response that the  
 14 Terra Nova occupational health and safety  
 15 committee got, the "oh, meets government  
 16 standards. We're working on it" and is that  
 17 the kind of thing that promotes personal  
 18 accountability on the part of workers.  
 19 Yes, there is a big role for it, but  
 20 there is a set of conditions that have to be  
 21 in place before they -- and note, you know,  
 22 when the workers were given the opportunity to  
 23 express their views on the suit, they did,  
 24 they survey, but was the effect of the survey  
 25 taken on board by the operators? Did they

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1 listen to the results? Did they pick up the  
 2 fact that there were people who were -- eight  
 3 percent of the people were saying clearly "my  
 4 suit doesn't seal"?  
 5 Worker participation and representation,  
 6 we've outlined to you in our brief, the many  
 7 instances where the right of workers to be  
 8 heard, to participate, and supposedly  
 9 enshrined in the Occupational Health and  
 10 Safety legislation, was ignored. The HUEBA  
 11 experience is classic.  
 12 We have a brief from the operators. One  
 13 of them is not unionized. Two of them are.  
 14 The organization which appears before you now,  
 15 CEP 2121, is granted, under the legislation of  
 16 this province, the legal right to demand that  
 17 the employer deal with them on terms of  
 18 conditions of employment, including safety.  
 19 Indeed, the role of the union in occupational  
 20 health and safety is identified in the  
 21 legislation. We find it disturbing that,  
 22 notwithstanding the public policy role that is  
 23 given to unions, that in all of their  
 24 discussion of worker participation, and no  
 25 doubt they'll say "well, there's three of us,

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1 you know, and we had to use common language."  
 2 In all their discussion of worker  
 3 participation, the words "union", "CEP",  
 4 "bargaining agent", "Local 2121", don't  
 5 appear. They're trying to pretend we don't  
 6 exist. It belies an attempt to deny reality  
 7 and it doesn't honour the workers' right to  
 8 have an organization that speaks for them in  
 9 these matters.  
 10 Now I want to touch for a brief moment on  
 11 the interaction between regulators and  
 12 industry associations. CAPP has presented  
 13 some fairly sound proposals in terms of how  
 14 they would see things, clear terms of  
 15 reference, a project champion, essentially a  
 16 project management approach, and these ideas,  
 17 I think, are sound so far as they go. But  
 18 there is a problem with them. They lack  
 19 enforceability. If they don't work, the  
 20 answer for the regulator in the current scheme  
 21 is go back to the operator and basically start  
 22 from the beginning, all over again, and say  
 23 "okay, operator, you have to do this, and  
 24 operator B, you have to do this, and operator  
 25 C, you have to do this."

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1 It is our submission that any involvement  
 2 with industry associations on behalf of the  
 3 industry, and we accept the notion of a single  
 4 -- the benefits of a single point of contact,  
 5 should include enforceability so that the  
 6 arrangement should be contractual, and there  
 7 should be clearly articulated authority on the  
 8 part of the industry association to act on  
 9 behalf and bind the operators.  
 10 In respect of SAR response time, we  
 11 concur with Mr. Harris' remarks about the need  
 12 for this Inquiry to consider the role of the  
 13 second responder, and we think this is  
 14 particularly important in the area of night  
 15 flights, because the second responder in night  
 16 -- and this is one of the reasons we feel  
 17 night flights cannot be allowed. The second  
 18 responder for night flights is two hours plus  
 19 travelling time away. It is a great pity that  
 20 only the three operators who we have here have  
 21 participated. There are other operators in  
 22 the Newfoundland and Labrador offshore. In  
 23 respect of SAR response time, we are very  
 24 concerned about the importance of the role of  
 25 the second responder when you have distant

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1 drilling, such as the Stena Carron has been  
 2 conducting for ConocoPhillips, where the  
 3 helicopter that transports people out there,  
 4 in order to be able to make the distance, must  
 5 have two auxiliary fuel tanks and we  
 6 understand a reduced payload, and that gives  
 7 us real concern as to the ability of SAR  
 8 aircraft to be on the scene for the length of  
 9 time necessary to effect a rescue.  
 10 Mr. Commissioner, nothing can redress the  
 11 loss which the families have suffered. In  
 12 closing, we would like to commend to you the  
 13 very eloquent words of Lori Chynn when she  
 14 said "I just hope and pray that he did not  
 15 suffer and that his death, along with the  
 16 deaths of his friends and colleagues, will not  
 17 be in vain. I hope that the legacy of those  
 18 lives lost on March 12th, 2009 will be  
 19 significant improvements in helicopter safety.  
 20 Such a tragedy must not happen again. That  
 21 must be your guiding principle." Thank you.  
 22 COMMISSIONER:  
 23 Q. Okay, thank you, Mr. Earle. We'll take our  
 24 break now.  
 25 (BREAK)

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1 ROIL, Q.C.:  
 2 Q. I don't need any -- I don't know that I need  
 3 to do it, but the next presenter is Alexander  
 4 MacDonald, Q.C. on behalf of the operators.  
 5 COMMISSIONER:  
 6 Q. Okay, thank you. Good morning, Mr. MacDonald.  
 7 SUBMISSIONS BY ALEXANDER D. MACDONALD, Q.C.  
 8 MACDONALD, Q.C.:  
 9 Q. Good morning, Commissioner. Thank you, Mr.  
 10 Roil. Commissioner, the tragic events of  
 11 March 12th have forever changed the lives of  
 12 everyone who's been involved. Everyone in  
 13 Newfoundland has lost friends, neighbours,  
 14 loved ones, colleagues. We'd like to express  
 15 our severe -- our sincere and profound thanks  
 16 to the families of the deceased, to our  
 17 workforce, to Robert Decker, to you,  
 18 Commissioner, to the Commission staff who have  
 19 been fantastic throughout this process and  
 20 everyone else who has participated in this  
 21 Inquiry.  
 22 As you've pointed out yourself,  
 23 Commissioner, in human events we can't  
 24 guarantee that accidents will not occur, but  
 25 what we do have is an obligation to learn from

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1 this accident and to improve the safety of all  
 2 workers travelling offshore. Safety and  
 3 nourishing a mature safety culture is our  
 4 biggest concern. However, as your own  
 5 consultant, Aerosafe, has told us, the true  
 6 test of a safety culture is in the aftermath  
 7 of a serious accident, and I think it's worth  
 8 describing what the operators did after this  
 9 accident.

10 After the tragic events, we formed the  
 11 Helicopter Task Force and this task force had  
 12 the mandate to examine all areas, all aspects  
 13 of the safety of helicopter transportation of  
 14 personnel. Travel did not restart until after  
 15 the HOTF task force had submitted its report,  
 16 which was long after the FAA directives on the  
 17 gear box were implemented. Nowhere else in  
 18 the world did this occur. Everywhere else in  
 19 the world, travel resumed within a few days of  
 20 the FAA compliance order being followed. Our  
 21 actions were extraordinary.

22 It's important to know that no  
 23 restrictions at all were placed on the work of  
 24 the task force, including its lines of  
 25 authority, the resources or expertise it

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1 needed to do its work, its timetable, its time  
 2 line or the conclusions they were to reach.  
 3 It looked at all aspects of helicopter  
 4 transportation. It hired and looked and  
 5 consulted with experts, technical experts,  
 6 safety experts, aviation experts. It  
 7 solicited opinions from everyone in the  
 8 workforce. In addition to assessing our  
 9 readiness to return to flight, it made 18  
 10 recommendations. All of these have been  
 11 submitted to the Commission. Some of these  
 12 recommendations touch directly on issues that  
 13 we've all been discussing here.

14 Today we want to describe many of the  
 15 initiatives we've undertaken since the  
 16 accident, all in the spirit of continuous  
 17 improvement, which is a life blood of any  
 18 safety plan. We also want to discuss further  
 19 recommendations for initiatives we think which  
 20 might be able to be made to assist  
 21 communication between regulators, industry  
 22 associations, occupational health and safety  
 23 committees and the workforce.

24 We have already begun implementing safety  
 25 improvements to the suit sizing and the

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1 fitting of suits. We have already begun  
 2 improvements to response search and rescue,  
 3 first response search and rescue. We're also  
 4 in the process of making improvements to  
 5 offshore safety training programs and  
 6 facilities and we're working with the Canada -  
 7 - the appropriate authorities on a revised  
 8 helicopter transportation suit standard. We  
 9 want to describe to you today all of these  
 10 improvements and safeguards we're undertaking.

11 Our presentation today will also deal  
 12 with some of the specific issues you've asked  
 13 about in Phase 1A, all of which have been  
 14 discussed in great detail in our brief. It's  
 15 important to note though our approach is not  
 16 retrospective. We're not trying to assess  
 17 blame. We're looking forward. Our  
 18 presentation is fact based and we know that  
 19 you, too, Commissioner, when you make your  
 20 recommendations will rely on the facts and the  
 21 evidence before you.

22 We are committed, the operators are  
 23 committed to safe helicopter transportation.  
 24 This is demonstrated through our continuous  
 25 improvement activities contained in our safety

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1 management plans and our participation on this  
 2 Inquiry. This Inquiry, this collaborative  
 3 effort, as you've called it. We're looking  
 4 forward to working with you, to use your  
 5 words, "to find sensible and achievable  
 6 solutions which can work in the real world,"  
 7 all of which are designed to improve  
 8 transportation safety by helicopters in the  
 9 offshore.

10 We'd like to talk a little bit about  
 11 issue one and issue one you've identified is  
 12 should there be a degree of separation between  
 13 the Canada Newfoundland Offshore Petroleum  
 14 Board, and I'm going to call them the Board,  
 15 and on regulation of helicopter transportation  
 16 generally and other offshore industry  
 17 regulation.

18 Commissioner, we don't see how a  
 19 separation of the safety functions out of the  
 20 other functions of the Board is going to help  
 21 the situation or improve safety. This is not  
 22 the situation that we have in the United  
 23 States where the regulators also deal with  
 24 royalty, royalty being the financial  
 25 arrangements surrounding the offshore. In

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1 that recent reform in the United States, the  
 2 royalty function was stripped from the US  
 3 offshore regulator. This has never been the  
 4 case in Canada. The offshore regulator is not  
 5 mandated to promote the offshore in  
 6 Newfoundland. That's government policy.  
 7 They're mandated to regulate in accordance  
 8 with government policy. So we don't think,  
 9 although it sounds like it might be an obvious  
 10 solution, it will make any difference, that it  
 11 will in fact enhance safety at all.

12 The province also highlighted this  
 13 fundamental difference in its brief when it  
 14 talked about the royalty collector in  
 15 Newfoundland Labrador is the Government of  
 16 Newfoundland. It is not the Offshore  
 17 Petroleum Board. They have no interest  
 18 whatsoever in royalty, so we don't think there  
 19 is a conflict. The Board itself in its  
 20 testimony has testified that safety is its  
 21 primary obligation, its first obligation among  
 22 many.

23 What we do think would be useful is a  
 24 clarification of the roles between the two  
 25 primary regulators in the offshore relating to

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1 helicopter transportation, that being  
 2 Transport Canada and the Canada Newfoundland  
 3 Offshore Petroleum Board. We think you should  
 4 give consideration to recommending a  
 5 memorandum of understanding be executed  
 6 between the Board and Transport Canada.  
 7 Similar memorandums of understanding have been  
 8 executed in the UK, Australia and the United  
 9 States. We've included in our brief a summary  
 10 of the terms and conditions you might consider  
 11 making a recommendation on, and they're  
 12 highlighted there in great detail.

13 Finally, when you consider this issue,  
 14 there's of course, the Offshore Health and  
 15 Safety amendments to the Accord Act, which  
 16 you've heard about yesterday, and there's the  
 17 FORRI initiative, the Frontier and Offshore  
 18 Regulatory Renewal Initiative, undertaken  
 19 between various regulators in Canada. You  
 20 should be cognizant of their work and make  
 21 sure that you take that into account in any  
 22 recommendations you make.

23 We'd like to talk a little as well about  
 24 issue number two. Are the risk management  
 25 systems of oil operators and helicopter

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1 operators sufficient and adequate to ensure  
 2 the risks of helicopter transport are as low  
 3 as reasonably practicable in the Newfoundland  
 4 offshore area?

5 I think it's important to know, remind  
 6 ourselves, Commissioner, the operators are  
 7 subject to extensive and comprehensive  
 8 regulatory oversight, which is detailed in our  
 9 brief. We have comprehensive, dynamic and  
 10 effective integrated management systems for  
 11 the management of risk, including that  
 12 helicopter transportation. Effective risk  
 13 management requires the persistent application  
 14 and enhancement of safety management systems  
 15 to reduce risk to as low as reasonably  
 16 practical. The operator systems are applied  
 17 to all of their operations worldwide and in  
 18 our view represent best industry practice.  
 19 They're all structured to identify, assess and  
 20 eliminate or mitigate risks and to manage  
 21 change. The operators consistent and  
 22 effective application of these systems, in our  
 23 view, ensures the risk of helicopter transport  
 24 is as low as is reasonably practicable.  
 25 So what are these management systems? As

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1 explained by Aerosafe in Phase 1 of this  
 2 Inquiry, an effective management system must  
 3 be systematic, comprehensive and integrated  
 4 into all aspects of the operation. So safety  
 5 management is, in fact, embedded within the  
 6 operator's general management systems. This  
 7 integrated approach is also required by the  
 8 Offshore Petroleum Board as part of its work  
 9 authorization process. You cannot get a work  
 10 authorization to do anything in the offshore  
 11 without demonstrating to the Board that you  
 12 have an integrated operator management system.  
 13 They're not identical. The three operator  
 14 systems are not identical or called by the  
 15 same name, but they have all of the same  
 16 common key elements. They're all outlined in  
 17 our brief in great detail.

18 Workers play an essential role in these  
 19 systems and we're proud of their efforts to  
 20 make safety the way we do business around  
 21 here, and that truly is the attitude of the  
 22 operators, and I think, Commissioner, you had  
 23 firsthand experience to this when you were on  
 24 the Hibernia platform.  
 25 So we must have an integrated management

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1 system which includes a safety management  
 2 system embedded in all aspects of it, but that  
 3 doesn't end there. We must also have a safety  
 4 plan and each operator must submit a safety  
 5 plan acceptable to the Board, and this plan is  
 6 just not a generic statement. It includes  
 7 summary of all studies undertaken to identify  
 8 hazards and to evaluate safety risks, a  
 9 description of the hazards identified and the  
 10 results of the risk evaluation, and a summary  
 11 of the measures to avoid, prevent and reduce  
 12 and manage safety risk. By law, we are  
 13 required to ensure that everyone working under  
 14 us, our contractors, also comply with these  
 15 safety plans. The legislation, in fact,  
 16 explicitly requires offshore installations to  
 17 be operated in a safe manner and I just draw  
 18 your attention to Section 119 of the drilling  
 19 and production regulations which are on the  
 20 Board's website. Safety is an explicit  
 21 requirement in the operation of facilities.  
 22 In Phase 1A, Aerospace (sic.) and the  
 23 operators described the swiss cheese model  
 24 which really is a simple way to describe  
 25 preventative safeguards. In other words,

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1 preventative safeguards are safeguards  
 2 undertaken to prevent a particular accident  
 3 from occurring, to block the holes in the  
 4 swiss cheese, if you like.  
 5 Our brief highlights many preventative  
 6 safeguards which we have in place relating to  
 7 helicopter operations. I'll give you some  
 8 examples: the health and usage monitoring  
 9 system, the so called HUMS on the aircraft;  
 10 the development of weather monitoring; and the  
 11 provision of simulated training for pilots,  
 12 flight training, things of this sort. So  
 13 these are examples of many contained in our  
 14 brief of the so called preventative  
 15 safeguards.  
 16 However, we also then put in place  
 17 mitigating safeguards which reduce the  
 18 consequences of an accident if they do occur.  
 19 If the swiss cheese lines up and the  
 20 preventative safeguards do not prevent an  
 21 accident, then there have to be mitigating  
 22 safeguards and these safeguards include many  
 23 of the things before you. They include the  
 24 requirement to wear helicopter passenger  
 25 transportation suits, to do the offshore

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1 training, the BST and the BST-R, and the use  
 2 of a four-point harness on a helicopter seat.  
 3 So these are examples of mitigating  
 4 safeguards.  
 5 It's through all of these efforts we  
 6 strive to create a safe workplace and to  
 7 ensure that risks are reasonable. One thing  
 8 is certain though, while there's always going  
 9 to be risk in helicopter travel, offshore  
 10 workers are never, never subject to  
 11 unnecessary risks.  
 12 Issue number three. What is the role of  
 13 organizational safety culture in offshore  
 14 helicopter transportation? You've heard a lot  
 15 of testimony on this. Aerosafe and others  
 16 have written there are five levels of safety  
 17 culture, from bad to best, pathological,  
 18 reactive, calculative, proactive and  
 19 generative, and generative, as Aerospace has  
 20 said is summarized in the statement HSE is how  
 21 we do business around here.  
 22 We believe the operators' safety  
 23 management systems contains practices,  
 24 procedures and tools that establish a mature  
 25 or generative safety culture. These systems

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1 instill the attitudes, values and beliefs that  
 2 permeate all levels of the operator, from the  
 3 very top, the CEO, to throughout the entire  
 4 organization. Key elements of our safety  
 5 management system have been outlined in our  
 6 brief, but we'd like to talk a little bit  
 7 about some of them now, just to remind us all  
 8 what they contain.  
 9 There's an integrated system and process  
 10 for the identification and reduction of risk.  
 11 There's an endorsement and commitment to  
 12 safety at all levels, from the top to the  
 13 bottom or across the organization. A  
 14 philosophy that safety practices extend  
 15 through every aspect of the business. A sense  
 16 of tools and processes, some of which you  
 17 heard about in this hearing: new worker  
 18 orientations; pre-job meetings; hazard  
 19 identification cards, these STOP cards you've  
 20 seen; and incident investigation and  
 21 reporting. There's audits, inspections  
 22 throughout the system to ensure compliance  
 23 verification and continual learning, and I  
 24 think many of the things we talked about in  
 25 our brief will highlight that point, continual

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1 learning and improvement. And finally,  
 2 there's a root cause analysis of incidents and  
 3 hazards, what caused the accident, what caused  
 4 the incident.  
 5 I think everyone on this Inquiry who's  
 6 testified, the operators and the worker  
 7 representatives who testified, have  
 8 acknowledged that hazard awareness and  
 9 reporting expectations permeate every aspect  
 10 of the operation. I don't think there's any  
 11 doubt about this. Investigations focus on  
 12 root causes rather than blaming individuals.  
 13 Effective communication and continual learning  
 14 are key to this system, continuous  
 15 improvement. We've heard this over and over  
 16 again. We really have to take exception to  
 17 any suggestion that it's been historically  
 18 unwise for anyone to report a safety issue.  
 19 We don't think this is correct and we think  
 20 the evidence of the opposite is true, and I  
 21 think you've seen that yourself on the  
 22 offshore platforms and I think some of the  
 23 witnesses who talked here talked about that.  
 24 I don't think there's any suggestion that that  
 25 is at all a factor in these situations.

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1 All of this being said, actions speak  
 2 louder than words, and the actions that we  
 3 took after the loss of 491 illustrate that we  
 4 have a mature safety culture. There's been  
 5 continuous learning since that date.  
 6 Issue four, we'd like to talk about that  
 7 a little bit, which is "what are the most  
 8 appropriate practices, standards and forums of  
 9 interaction between the Board and the  
 10 following" and we'd like to talk about the  
 11 industry, including suppliers and contractors,  
 12 industry associations, which in this context  
 13 is CAPP, and other worker representation.  
 14 I think we have to remember the Board has  
 15 broad, enforceable regulatory authority over  
 16 our operations. The operators, in turn, have  
 17 to ensure that everyone in the contractual  
 18 chain has the appropriate safety practices in  
 19 place, including Cougar, including our  
 20 drilling contractors, including everyone else.  
 21 The buck stops with the operators, with us.  
 22 We hold the production authorizations and we  
 23 are responsible for the conduct of everyone  
 24 that works for us. It's the operators who are  
 25 accountable to the Board. The Board doesn't

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1 change subcontractor number 12. They deal  
 2 with the operator. You have the  
 3 responsibility to ensure safety in the  
 4 offshore.  
 5 The Board then verifies these processes  
 6 and they have a wide range of enforcement  
 7 powers which haven't been talked about in  
 8 great detail, but they can do safety audits.  
 9 They can issue warnings and orders to cease.  
 10 They can order -- issue an order to comply.  
 11 They can suspend or revoke a work  
 12 authorization, an extremely powerful tool.  
 13 They can cancel your interest. They can  
 14 cancel your production license. They can  
 15 cancel your interest in the offshore, and they  
 16 can prosecute you under the legislation for an  
 17 offence, and they can establish an inquiry,  
 18 which they've done in this case. So the Board  
 19 has very broad powers. So the operator is  
 20 responsible for its operations of everyone in  
 21 the chain. The Board is responsible to  
 22 monitor that through these broad powers.  
 23 We really believe that the current  
 24 interaction, the current legislative  
 25 framework, does not require changes. It is

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1 the most appropriate way to legislate in the  
 2 offshore. The buck stops with the operators.  
 3 We're responsible to the Board. The Board has  
 4 great powers to enforce its obligations.  
 5 Talk about industry organizations. In  
 6 this case, we're talking about CAPP. There's  
 7 been a great deal of testimony about CAPP. We  
 8 believe CAPP is an effective organization to  
 9 facilitate discussions between the Board and  
 10 operators when an industry wide initiative is  
 11 required, not one involving one operator or  
 12 another. We also think it would be imprudent  
 13 to judge the effectiveness of CAPP solely on  
 14 the timing of the HUEBA initiative. CAPP has  
 15 done many good things in the offshore. They  
 16 successfully developed and updated the CAPP  
 17 standard practice for training and  
 18 qualifications of personnel. It's done the  
 19 same with respect to the CAPP east coast  
 20 medical assessment for fitness to work, and  
 21 also with respect to something called a safe  
 22 lifting practices. Lifting merely being when  
 23 you take the crude out of the facility, the  
 24 offshore facility, into a tanker. So CAPP has  
 25 done extremely good work.

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1 CAPP, in the spirit of continuous  
 2 improvement which permeates the operator  
 3 safety plans, and its members, because CAPP is  
 4 a vehicle of its members, have issued a  
 5 lessons learned document. What have we  
 6 learned from this incident? These  
 7 improvements were highlighted by counsel for  
 8 CAPP yesterday and they have been implemented.  
 9 So this is another demonstration of a mature  
 10 safety culture. We learn from our mistakes on  
 11 this issue and have made changes.

12 Finally, what is the appropriate  
 13 interaction between the Board, the Offshore  
 14 Petroleum Board, and workers? To put this in  
 15 context, we believe that there's already  
 16 significant effective interaction between the  
 17 Board and workers through the OHS committees.  
 18 They have a lot of interaction. It includes  
 19 attending opening and closing audits, opening  
 20 and closing inspection meetings, meeting with  
 21 the Board safety officers during their  
 22 offshore quarterly visits, attending the  
 23 annual Board OHS meetings, which I think,  
 24 Commissioner, you actually attended this year.  
 25 They have the ability to contact the Board

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1 directly at any time and they are engaged by  
 2 the Board in any investigation and resolution  
 3 of any refusal to work, undertake work  
 4 believed to be unsafe. So these are extensive  
 5 interactions already between the Board and the  
 6 workforce.

7 However, we think some improvements can  
 8 be made, especially with respect to the annual  
 9 meeting, the one you attended. We believe you  
 10 could establish a formal terms of reference  
 11 setting out the goals and expectations of this  
 12 meeting. A survey of the workforce could be  
 13 undertaken to determine what matters are of  
 14 interest to the workforce, and we could expand  
 15 this meeting to include safety learnings and  
 16 initiatives from other jurisdictions, what's  
 17 happening around the world, how can we learn  
 18 from those. And finally, we believe the Board  
 19 should develop an enhanced training for the  
 20 OHS committees specific to the oil and gas  
 21 industry. So with these improvements, we  
 22 think the communication between the Board and  
 23 the workforce is more than adequate and it's  
 24 excellent actually.

25 Issue six, which has had a lot of

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1 discussion at this hearing, is what is the  
 2 appropriate standard first response search and  
 3 rescue that the Board should require of all  
 4 operators in the Newfoundland offshore area.  
 5 We believe the standard of first response for  
 6 search and rescue required by the Board  
 7 pursuant to your interim order is the  
 8 appropriate one. We are continuing to work  
 9 with Cougar to meet this standard and to  
 10 identify and implement additional  
 11 improvements. As you know, Commissioner, in  
 12 February of this year, the Board issued a  
 13 directive requiring the operators to enhance  
 14 their first response search and rescue, as a  
 15 result of your interim order. We began this  
 16 process immediately by sourcing equipment and  
 17 contracting for an S-92, an additional S-92.

18 I want to give you some update now of  
 19 where we are on our efforts. The operators  
 20 now have four S-92s and an S-61 in the  
 21 airframe pool. The fourth, the new S-92, was  
 22 delivered in July. It's been modified to  
 23 include Blue Sky, the tracking system, the  
 24 FLR, the forward looking radar, Night Sun, and  
 25 it has an auxiliary fuel tank. This has been

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1 put into regular service as of today. It's  
 2 been put into regular service and the S-91  
 3 continues to act as our search and rescue  
 4 aircraft while we upgrade the other aircraft.  
 5 They're all getting new floatation. One of  
 6 the aircraft is getting sort of a mirror  
 7 installation of the Blue Sky, FLR, Night Sun  
 8 and auxiliary fuel tank. We're continuing to  
 9 work with Cougar to enhance this first  
 10 response capability. So as soon as the  
 11 aircraft upgrades are completed, which it'll  
 12 be about October, the S-91 -- S-61 will be  
 13 released and the S-92, fully modified with  
 14 Blue Sky, FLR and Night Sun, will become the  
 15 dedicated search and rescue aircraft.

16 We're continuing to work with Cougar to  
 17 enhance our first response capabilities. We  
 18 have tripled the number of rescue specialists.  
 19 We have an additional search and rescue first  
 20 response crew. We have increased the training  
 21 time for all of our crews. We're working to  
 22 enhance the wheels up time even further. A  
 23 key element to this is having a dedicated  
 24 aircraft facility for the first response  
 25 activities. You need the crew on site all the



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1 time and Cougar is now in discussions with the  
 2 St. John's Airport Authority and Nav Canada to  
 3 acquire the necessary approvals to build a new  
 4 facility at the airport. So that's well under  
 5 way.  
 6 With respect to auto hover, the aircrafts  
 7 are equipped with auto hover, but they're not  
 8 yet certified by the FAA and Transport Canada.  
 9 We expect that soon, but we can't predict  
 10 exactly when that will occur. We will provide  
 11 a further update on the auto hover  
 12 certification as soon as we have more details  
 13 on it.  
 14 It has been suggested that the S-61, I  
 15 think in one of the briefs, would be a  
 16 suitable year round search and rescue aircraft  
 17 because it has auto hover. Yes, it has auto  
 18 hover, as does the S-92, but it's not  
 19 certified, so it cannot be used. But more  
 20 important, the S-61 does not have de-icing  
 21 capability. So that would not be suitable for  
 22 year round aircraft in Newfoundland.  
 23 Issue seven. Are there circumstances  
 24 other than declared emergencies when the  
 25 rescue helicopter should be dispatched to

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1 assist a transport helicopter, so called  
 2 proactive dispatch? We're fully supportive of  
 3 this concept and believe Cougar should do this  
 4 in relation to incidents which have the  
 5 potential to escalate an emergency. If Cougar  
 6 deems it prudent and reasonable, they should  
 7 do it and we fully support that concept.  
 8 Issue nine and ten, Commissioner, are  
 9 really the guts of many of the things we've  
 10 talked about here, other than search and  
 11 rescue, and I'll break them down into two  
 12 parts.  
 13 The first part of the question is "are  
 14 operational limitations on helicopter  
 15 transport, in addition to those dictated by  
 16 Transport Canada, required to ensure the  
 17 standard of first response search and rescue  
 18 is able to be maintained at all times" and  
 19 then we had in brackets, to remind ourselves  
 20 what the issues were, "operational sea states,  
 21 night flights and low visibility."  
 22 Our primary goal is to do all that is  
 23 reasonably practicable to keep the helicopter  
 24 incidents to a minimum. However, as Robert  
 25 Decker stated in his testimony, the best way

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1 to keep offshore workers safe is to keep the  
 2 helicopter in the air where it belongs. So no  
 3 discussion of this issue is possible without  
 4 that in the back of our mind. To achieve this  
 5 goal, the operators, in conjunction with  
 6 Cougar, have put in place numerous  
 7 preventative safeguards and I described that  
 8 just a few minutes ago. These are the things  
 9 to prevent an accident. These preventative  
 10 safeguards are such that no additional  
 11 operational limitations need to be imposed by  
 12 the Board. A key point is first response  
 13 search and rescue can be conducted under the  
 14 current operational limits relating to  
 15 visibility and sea states and, once auto hover  
 16 is approved by the FAA, at night.  
 17 Talk a little bit about these  
 18 preventative safeguards. So there's  
 19 preventative safeguards in place. We believe  
 20 these are sufficient to -- that no additional  
 21 limitations need to be imposed and search and  
 22 rescue can be conducted under the current  
 23 operational limits. So what are the  
 24 preventative safeguards?  
 25 The S-92 aircraft itself is certified to

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1 the latest regulations of the FAA, the  
 2 European Aviation Safety Agency and Transport  
 3 Canada. The advanced features of this are set  
 4 out in great detail in our brief. They're  
 5 certified by the experts in the field as being  
 6 a suitable aircraft.  
 7 Cougar has a satellite based flight  
 8 following system which automatically provides  
 9 updates of the aircraft position every three  
 10 or five minutes, depending on the altitude,  
 11 and after an accident, every 15 seconds or  
 12 after a declared emergency. It also has what  
 13 is called a formal GUI dispatch system.  
 14 Essentially, this is a 24/7 operational  
 15 control centre located in St. John's. It's a  
 16 requirement that the pilot in command and the  
 17 dispatcher agree that conditions are  
 18 acceptable for flight. They both must agree  
 19 or a flight does not occur.  
 20 Cougar uses a pre-flight risk assessment  
 21 to assist in the identification of risk  
 22 factors. These include many factors including  
 23 crew experience, environment, time of day,  
 24 fatigue and complexity. Pilots are obliged to  
 25 report to the chief pilot or the director of

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1 flight operations changes in risks that could  
 2 affect that matrix.

3 There are effective and integrated safety  
 4 management systems, as outlined in our brief  
 5 and I described briefly a few minutes ago, and  
 6 also outlined in the Cougar brief, and as  
 7 Cougar counsel indicated, Aerospace commented  
 8 favourably on the safety management systems  
 9 and culture of Cougar.

10 It's important that the ultimate  
 11 responsibility for making the decision to fly  
 12 rests with Cougar. The pilot in command and  
 13 the dispatcher, they must agree that it's  
 14 suitable to fly. The OIM, or the offshore  
 15 installation manager, has authority to cancel  
 16 or prevent a flight from landing if he thinks  
 17 conditions are unsafe on the facility. He  
 18 can't direct the flight to proceed, but he can  
 19 prevent the flight from proceeding.

20 Finally, an important preventative  
 21 measure is the environmental criteria to  
 22 ensure the safe helicopter operations. So  
 23 what are these environmental criteria? The  
 24 operators, in conjunction with Cougar, have  
 25 established criteria for flight operations

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1 which comply with all regulatory and  
 2 manufacturer requirements, to Transport Canada  
 3 and the Sikorsky requirements. Beyond that,  
 4 they also have requirements for heave, pitch  
 5 and roll on facilities, wind speeds,  
 6 visibility and sea states. So let's talk  
 7 about those in general.

8 First of all, in a broad term, we believe  
 9 that there are no additional operational  
 10 limitations should be imposed by the Board,  
 11 other than the ones already in place. We  
 12 believe the operational criteria for  
 13 helicopter transportation in the offshore are  
 14 consistent with those in other offshore  
 15 jurisdictions, and ultimately, only when  
 16 Cougar is satisfied a flight -- conditions are  
 17 suitable for flight will they make the  
 18 determination to fly.

19 So let's talk a little bit about the  
 20 operational criteria. First, let's deal with  
 21 sea states. The overriding message here is  
 22 search and rescue operations can be initiated  
 23 whenever passenger flights are operating, as  
 24 it relates to sea states. We had some  
 25 discussion on sea states. Sea states apply to

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1 some facilities. Some they don't. The  
 2 floating platforms move at sea state, so they  
 3 have operational limitations on sea state.  
 4 Terra Nova doesn't have a sea state  
 5 limitation, but it factors in heave, pitch and  
 6 roll, all of which relate to sea state. Terra  
 7 Nova, of course, has no movement of its --  
 8 Hibernia doesn't have the movement of its  
 9 platform, so it's not as relevant, but they  
 10 still have sea state limitations.

11 So each manual, each operator maintains  
 12 an operations manual that deals exactly with  
 13 the criteria to ensure the safety of flight  
 14 operations to the particular facility. Search  
 15 and rescue can be initiated any time when  
 16 passenger flights are operating. While  
 17 increases in wind, speed and wave height make  
 18 helicopter rescue more difficult, there is no  
 19 defined limit on wind speed and wave height  
 20 for successful helicopter rescues of  
 21 personnel, either in the sea or in a life  
 22 raft. As well, fast rescue craft and the  
 23 Dacon scoop can be conducted -- rescue can be  
 24 conducted by these facilities in emergency  
 25 situations up to wave heights of 5.5 metres

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1 and 7 metres respectively. 5.5 metres for the  
 2 fast rescue craft and 7 metres for the Dacon  
 3 scoop. All well within the current flight  
 4 limitations for the facilities. So both  
 5 aircraft search and rescue and fast rescue  
 6 craft search and rescue can be conducted under  
 7 the current sea state limitations. There's no  
 8 evidence to the contrary. So the answer on  
 9 sea states is no additional criteria need to  
 10 be imposed.

11 Visibility, the second example referred  
 12 to in the issue. Again, any time that flights  
 13 are actually taking off and flying, a first  
 14 response search and rescue aircraft can be  
 15 launched. With use of various tracking  
 16 devices, locator tools such as emergency  
 17 locator transmitters, real time flight  
 18 tracking systems so called Blue Sky, and  
 19 personal locator beacons, both aircraft and  
 20 passengers can be located with precision. The  
 21 introduction of additional visibility  
 22 limitations, above those imposed by Transport  
 23 Canada and those imposed by the operators in  
 24 their operating manual, would make flight  
 25 operations virtually impossible to conduct

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1 with any consistency.  
 2 Cougar operates in accordance with  
 3 Transport Canada regulations, the experts in  
 4 the field, with respect to low visibility  
 5 flying. Cougar's flight planning includes a  
 6 series of considerations, which are outlined  
 7 in great detail in our brief, but they include  
 8 aircraft status, forecast and reported  
 9 conditions throughout the flight path,  
 10 precipitation, surface winds at take off and  
 11 landing and at alternate landing sites, wind  
 12 aloft speeds and directions, freezing  
 13 precipitation, installation movement,  
 14 alternate offshore landing site information.  
 15 Prior to any flight, the dispatcher and  
 16 the pilot, not the OIM or not the operators,  
 17 will determine if it is suitable to conduct an  
 18 entire flight, including a return to base.  
 19 Cougar's dispatch operation ensures consistent  
 20 monitoring of all weather and flight related  
 21 conditions and adjust flights accordingly. So  
 22 it's important when you answer this question  
 23 that at any time we take off and fly to a  
 24 facility, we can also launch a first response  
 25 aircraft. A first response aircraft can find

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1 passengers and aircrafts with precision with  
 2 their current technology, and, therefore,  
 3 first response search and rescue by aircraft  
 4 can occur under the current flight limitations  
 5 relating to visibility. No additional  
 6 requirements are necessary.  
 7 Night flights, the third operational  
 8 criteria. There's a lot of discussion about  
 9 this and we have to remember, of course, that  
 10 night flights involve a flight that any of the  
 11 flight, even if it's five minutes, occurs in  
 12 the dark or after daytime. We believe the  
 13 passenger night flights are both safe and  
 14 sometimes necessary. Restrictions on night  
 15 flights present a significant challenge for  
 16 completing flight operations on a prudent  
 17 schedule, and I'll describe why. With the  
 18 first response search and rescue enhancements  
 19 required by the Board on your recommendation,  
 20 first response search and rescue can be  
 21 conducted at night. As soon as the auto-hover  
 22 is certified for use, search and rescue can be  
 23 conducted at night. So the question was are  
 24 there additional restrictions necessary to  
 25 maintain the standard of first response and

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1 the answer to that is no. There are many  
 2 jurisdictions as well where flights are  
 3 routinely carried out at night. For example,  
 4 as you would know, Commissioner, in regions of  
 5 the North Sea in Norway the hours of darkness  
 6 can extend 18 hours a day. The Jean D'Arc,  
 7 where we operate, it's up to 16 hours a day of  
 8 darkness during the winter. What this would  
 9 mean practically if there was an absolute ban  
 10 on night flights is we could not launch a  
 11 flight before 7 a.m. or after 1 p.m., a five  
 12 hour window. You also should consider,  
 13 Commissioner, what a recommendation in this  
 14 area could mean to exploration offshore  
 15 Labrador, the Flemish Cap, the far reaches of  
 16 the Laurentian Basin. This is an important  
 17 issue for the offshore.  
 18 It's important to know, though, even  
 19 though we've made this presentation, that  
 20 Newfoundland flight operations generally occur  
 21 during the daylight hours as the general rule.  
 22 However, the offshore is subject to adverse  
 23 weather conditions as we all know, rain,  
 24 drizzle, and fog, and delays to scheduled  
 25 flights often occur. As a matter of fact, 66

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1 percent of flights depart on time; 70 percent  
 2 of the delays, 70 percent of the 34 percent  
 3 that don't depart on time relate to weather,  
 4 and this is no surprise to any of us who have  
 5 lived here in the spring. If the operators  
 6 cannot conduct necessary flights that occur,  
 7 at least in part in darkness, the offshore  
 8 workforce rotations are going to be affected  
 9 and workers will be required to work beyond  
 10 their regular rotation and everything that  
 11 entails. So it's not a simple answer,  
 12 Commissioner, to say there can't be night  
 13 flights. There's operational and safety  
 14 issues associated with that, and more  
 15 important than that, Commissioner, there's no  
 16 evidence whatsoever that search and rescue  
 17 cannot be conducted at night. As a matter of  
 18 fact, we suggest to you the evidence is the  
 19 opposite. So in summary, there is no  
 20 additional restriction on night flights  
 21 required to maintain search and rescue  
 22 standard that you have helped to establish.  
 23 I'll come back then to the second part of  
 24 that question which was should the board  
 25 impose additional operation requirements on

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1 the operators to ensure that the risk of  
 2 helicopter travel in the Newfoundland and  
 3 Labrador offshore is as low as reasonable  
 4 practicable, and then you gave examples,  
 5 including auxiliary fuel tanks and location on  
 6 seating, restrictions on seating locations.  
 7 I'd like to talk a little bit about the  
 8 auxiliary fuel tank. It's important to know  
 9 that without the use of an auxiliary fuel  
 10 tank, flights to many of the offshore  
 11 installations would simply not occur. We also  
 12 believe that limiting the use of certain seats  
 13 on the S92 would necessitate - would require  
 14 increasing the number of flights, and the  
 15 overall risk of helicopter transportation  
 16 would actually increase. So a layperson's  
 17 interpretation, well, if we restrict the  
 18 seats, we'll make flights safer is not  
 19 necessarily true. You would have to increase  
 20 the number of flights and the overall risk to  
 21 workers generally could actually increase. To  
 22 come back to the auxiliary fuel tanks, these  
 23 are well built, well designed, well maintained  
 24 and they require - they comply with all  
 25 regulatory requirements. Now what do all

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1 regulatory requirements mean? Well, obviously  
 2 there's airworthiness issues that the FAA has  
 3 certified, but there's also egress or exit  
 4 requirements of the FAA and Transport Canada.  
 5 This auxiliary fuel tank meets all of those  
 6 regulatory requirements. It does not intrude  
 7 into the centre aisle or impede any of the  
 8 exits. It is safe. We would not use it if it  
 9 was not safe. This actually has been  
 10 confirmed by the Board when they dealt with a  
 11 refusal to work by an offshore worker claiming  
 12 that the auxiliary fuel tank made the aircraft  
 13 unsafe, and the Board just didn't do a rubber  
 14 stamp investigation, they consulted experts  
 15 and concluded it does not increase - does not  
 16 result in an unacceptable increase in risk. So  
 17 it's just not the operator saying so. These  
 18 auxiliary fuel tanks are necessary for  
 19 offshore travel in Newfoundland. They've been  
 20 used on many aircrafts, including the AS332L,  
 21 and some may have flown on these, the Super  
 22 Puma, the S-61, and, of course, the S-92. We  
 23 need these to get to our locations, and as  
 24 important to get to alternate locations in the  
 25 case of bad weather. So these are safe and

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1 that's the overriding message. They're  
 2 necessary, but that's not enough; they are  
 3 safe, these are safe.  
 4 Finally, if there are any changes to the  
 5 auxiliary fuel tank, this isn't a simple  
 6 matter. It requires the approval of the FAA  
 7 and Transport Canada. The Transportation  
 8 Safety Board may have something to say about  
 9 fuel tanks, we don't know. So in any event,  
 10 it's premature to make any recommendation on  
 11 changes to a fuel tank without getting all of  
 12 the information, including the Transport  
 13 Safety Board report.  
 14 In summary, Commission, on issue 9 and  
 15 10, at any time when flight operations are  
 16 underway, first response search and rescue by  
 17 aircraft can be maintained - the standard that  
 18 can be maintained under current operational  
 19 limits. The only exception to that is at  
 20 night, and that will be true once auto-hover  
 21 is certified we hope very soon, certainly this  
 22 fall. Therefore, no additional flight  
 23 limitations are required to improve safety,  
 24 they're just not. The fuel tanks are  
 25 absolutely necessary to fly in the offshore,

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1 but far more important than that, they are  
 2 safe and certified to the highest standard.  
 3 The limitation of the use of particular seats  
 4 will not necessarily at all increase safety of  
 5 passengers. It may actually have the opposite  
 6 effect, but there's also no evidence to  
 7 suggest that the current configuration of the  
 8 aircraft in any way would require you to  
 9 restrict particular seats from being used.  
 10 Issue 11 is, "Can helicopter safety be  
 11 affected by the capacity of the helicopter  
 12 transportation fleet, and if so, what role  
 13 should the Board play in the determination of  
 14 fleet capacity". Like everything else,  
 15 Commissioner, safety is our primary concern.  
 16 The helicopter transportation fleet must  
 17 operate safely, but beyond that, it's a  
 18 commercial issue. We believe the capacity with  
 19 the existing pool to manage - is there to  
 20 manage both the offshore transportation  
 21 workers and our fleet requirements. So we  
 22 don't think there's any role at all for the  
 23 board in this area. Their role is to ensure  
 24 helicopter transportation is safe. They're  
 25 not going to get into how many aircraft that

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1 will take or get into the commercial  
 2 arrangements surrounding that. It's important  
 3 to know that about 90 percent - we're  
 4 operating now at less than 90 percent  
 5 capacity, and 60 percent for the so-called ad-  
 6 hoc or unscheduled flights. There's lots of  
 7 capacity in the fleet and if there isn't  
 8 capacity, the operators will require more  
 9 aircraft. It is not a safety issue.

10 Issue 12, "What are the appropriate  
 11 standards of offshore helicopter safety  
 12 training to ensure that the risk to passengers  
 13 is as low as reasonably practicable, both  
 14 during training and helicopter transport?".  
 15 The operators endorse the continued  
 16 utilization of CAPP's Training and  
 17 Qualifications Committee training practice,  
 18 and the CAPP East Coast Medical Assessment for  
 19 work. It's important to know, though, that  
 20 CAPP is currently reviewing the training  
 21 standards, and I think the Marine Institute  
 22 talked about this in their summation. Any  
 23 action by the Board, in any event, would wait  
 24 that review to see what the conclusions would  
 25 be. We are currently pursuing upgrading the

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1 actual training, equipment, and facilities,  
 2 and we're exploring other survival training  
 3 enhancements.

4 So let's talk a little bit about the CAPP  
 5 training and qualifications standard. This  
 6 standard was first issued in March of 2001.  
 7 It's been regularly updated by the industry.  
 8 The industry through CAPP has initiated what  
 9 is called "The Survival Course Review  
 10 Project", and this was done in March of 2010  
 11 to review the offshore survival courses, and  
 12 the Marine Institute talked about this  
 13 yesterday. The purpose of this project is to;  
 14 one, define performance standards; two, to  
 15 define and identify core competencies for  
 16 offshore survival training. The third  
 17 objective is to have consistent training  
 18 throughout Atlantic Canada. In the review,  
 19 the project team will consider both the BST  
 20 and the BSTR, and will solicit regulatory  
 21 industry and worker OHS input. The review is  
 22 expected to be completed by the end of this  
 23 year, the end of 2010. The offshore training  
 24 requirements in the offshore area are quite  
 25 rigorous, but we do identify - do recognize,

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1 as you did yesterday, Commissioner, that  
 2 training itself can involve risk. The benefit  
 3 that can be achieved by training has to be  
 4 balanced with the risk of that training. Far  
 5 more people do training than will ever be  
 6 involved in an accident, so a small increase  
 7 in risk in training can have devastating  
 8 impacts on the entire safety of the offshore.

9 The offshore - with respect to  
 10 facilities, as you know, the safety training  
 11 takes place at the Marine Institute's facility  
 12 in Foxtrap, I believe it is. There are  
 13 currently negotiations with the Marine  
 14 Institute to procure a newly designed HUET,  
 15 which can be configured to represent multiple  
 16 aircrafts, including the S-92. It will be  
 17 fitted with a four point harness, high back  
 18 stroking seats, and an auxiliary fuel tank.  
 19 They are also negotiating with the Marine  
 20 Institute to procure new facilities equipment  
 21 to simulate wind and wave conditions to create  
 22 a more realistic training environment. We  
 23 agree with Michael Taber when he testified  
 24 before this group that the repetition,  
 25 flipping the aircraft, getting out, repetition

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1 improves survival skills. However, this  
 2 increase in repetition involves training risk.  
 3 So we caution you that any increase in the  
 4 number and complexity of egress exercises from  
 5 an inverted HUET, including using the HUEBA  
 6 while you do it, should not be recommended  
 7 without consideration of any increased risk  
 8 associated with that training. We think that  
 9 is critical. So if there's a move towards  
 10 more realistic training, particularly more  
 11 frequent repetition of that training, it must  
 12 be properly assessed to ensure that, in fact,  
 13 we are making transportation safer as opposed  
 14 to less safe.

15 Issue 13, "What personal protective  
 16 equipment and clothing is necessary for  
 17 helicopter passengers and pilots, and what are  
 18 the standards; should the Board require  
 19 guidelines to ensure such equipment is  
 20 properly fitted?". The current structure is  
 21 the Board requires operators to have  
 22 helicopter transportation suits approved by  
 23 the Canadian General Standards Board. We  
 24 believe that is appropriate. Any further  
 25 consideration of the appropriate standards for

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1 personal protective equipment and clothing  
 2 necessary for helicopter passengers should be  
 3 done in consultation with the CGSB working  
 4 group, which I'll describe in a few minutes.  
 5 The correct role of the Board, after they  
 6 stipulate a standard, is to audit the  
 7 operators safety management systems, are to  
 8 ensure that passengers are equipped with the  
 9 most appropriate protective PPES, personal  
 10 protective equipment, and that the operators  
 11 management of change processes are used when  
 12 changes are made to the PPE. That's the  
 13 Board's role. The Board stipulates a standard  
 14 and ensure we comply with processes to ensure  
 15 that that standard is being properly applied.  
 16 With respect to suit fitting standards,  
 17 in particular, we don't think any further  
 18 action is necessary. This is not because the  
 19 old system was correct, because in the system  
 20 - in the process of continuous improvement  
 21 since the accident, the operators believe that  
 22 the protocols developed by Helly Hansen and  
 23 the operators are best industry practice and  
 24 this practice will be applied to all future  
 25 suits. So in the continuous improvement,

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1 operators and Helly Hansen have improved this  
 2 fitting standard and we believe now it's  
 3 appropriate. With respect to pilots, we  
 4 understand the issue raised by pilots counsel.  
 5 We believe for the purpose of this Commission,  
 6 they are clearly workers for your purposes;  
 7 however, we do believe that the jurisdiction  
 8 over pilots must remain with Transport Canada  
 9 where the expertise is. So we really have to  
 10 defer to Transport Canada and Cougar in these  
 11 issues.  
 12 To talk about the new suit standard, the  
 13 CGSB through a working group of stakeholders,  
 14 which includes many people, including workers,  
 15 management, unions, are currently conducting  
 16 an extensive review of the standard, including  
 17 water egress standards, under garment  
 18 requirements, and glove design. In our brief,  
 19 as an appendix, we have a list of the research  
 20 topics they are actually considering and they  
 21 are quite extensive. We also agree with Helly  
 22 Hansen when they made the reference to the  
 23 National Research Council gap in the  
 24 difference between calm weather testing and  
 25 real life testing about thermal protection of

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1 subjects. This knowledge gap or testing gap  
 2 is also being addressed by the working group.  
 3 To come to the issue that was discussed today  
 4 and yesterday, there had been suggestions the  
 5 operators were focused on ensuring the suits  
 6 had been certified to both marine and aircraft  
 7 standards. This isn't true. The focus was to  
 8 acquire a safe suit. The secondary goal was a  
 9 dual certification. The HTS-1 has met all  
 10 aviation standards. The primary goal is a  
 11 safe suit, it has met the Board's standards.  
 12 A second goal, it has also been certified as a  
 13 marine abandonment suit. There's nothing  
 14 wrong with that, Commissioner, and it did not  
 15 impact the safety of the suit. The first  
 16 goal, the aircraft standard, has been met.  
 17 Helly Hansen testified that's how they  
 18 designed the suit. They didn't have in mind  
 19 the marine transport certification. Helly  
 20 Hansen's suggestion it's more difficult to  
 21 manufacture a suit to meet this requirement;  
 22 this may be so, but difficult or not, the suit  
 23 has been certified, and if you follow the  
 24 process here, it was certified to aircraft  
 25 standard. Helly Hansen then convinced the

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1 regulator that it was suitable for marine  
 2 abandonment purposes as well and got some  
 3 exemptions particularly to the suit. This is  
 4 exactly how regulation should work. It's  
 5 redundancy. The operators in the Newfoundland  
 6 offshore don't use them as abandonment suits,  
 7 in any event. So it's a redundancy, it's  
 8 exactly an example of how regulation should  
 9 work. It met the primary goal, it also is a  
 10 secondary goal, there's nothing wrong with  
 11 that. As a matter of fact, it would only make  
 12 the suit more flexible, and, therefore,  
 13 workers more safe.  
 14 The suit fitting protocol. Helly Hansen  
 15 and the operators began to address this issue  
 16 as you've heard great testimony about - a  
 17 great deal of testimony about. The formalized  
 18 suit fitting assessment was ultimately  
 19 implemented in 2009, again in the spirit of  
 20 continuous improvement. The suit fitting  
 21 protocol has been recognized by the Transport  
 22 Safety Board, you've seen the letter, who  
 23 recommended that Transport Canada inform  
 24 others about importance of the suit sizing.  
 25 Your own expert, Susan Coleshaw, observed that

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1 suit fitting is not done anywhere else in the  
 2 world. So we all, everyone in this room, we  
 3 all should be proud of this achievement. This  
 4 suit fitting assessment process was the first  
 5 of its kind and is now a standard component of  
 6 any suit system management change process used  
 7 by the operators. In 2010, when the operators  
 8 finally converted entirely to the HTS-1, all  
 9 offshore workers were required to go through  
 10 this process. So in the spirit of continuous  
 11 improvement and a mature safety culture,  
 12 changes have been made, and I believe now we  
 13 have a world class first in the world  
 14 standard.

15 Also we acknowledge the testing gap that  
 16 the National Research Council identified. So  
 17 the operators have arranged to perform, and  
 18 counsel for Helly Hansen talked about this  
 19 yesterday, perform this real life scenario  
 20 testing, and members of the offshore  
 21 committees observed this testing and the  
 22 positive results from this testing were shared  
 23 with the offshore workforce prior to the  
 24 introduction of the HTS-1. So in the spirit of  
 25 continuous improvement we've actually pushed

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1 the limits beyond that currently required by  
 2 regulation, even while the Standards Board is  
 3 actually considering this entire issue. So  
 4 this is a positive development and we believe  
 5 reflects a mature safety culture that you  
 6 learn from incidents that have occurred.

7 Thermal undergarment requirements. This  
 8 is an interesting issue. Right now current  
 9 regulations and the Canada General Standards  
 10 Board standards do not specify any clothing be  
 11 worn under a helicopter suit. However,  
 12 they're actually studying this issue, and we  
 13 believe any recommendation on that should  
 14 await the results of this work. We just don't  
 15 know, we have a knowledge gap, we don't know  
 16 if they're appropriate or not.

17 The operators are continuing to monitor  
 18 additional improvements in other areas of PPE,  
 19 including goggles, and PLBs. We're also  
 20 anxiously awaiting the anticipated UK  
 21 Emergency Breathing System Standards that  
 22 Susan Coleshaw talked about in her testimony  
 23 at the Inquiry. If there's any continuous  
 24 improvement opportunities we can find in that  
 25 report, we'll of course implement them.

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1 We also just to - a technical matter, the  
 2 MI, Marine Institute in its brief refers to  
 3 dive goggles. In our brief, we refer to those  
 4 - dive masks, and we refer to them as goggles,  
 5 same issue, and that's also being looked at by  
 6 the Canada Safety Board - Standards Board.

7 I'll just draw your attention to Appendix  
 8 C of our brief. It's a full list of the areas  
 9 being considered for review by the CGSB, and  
 10 it's quite a comprehensive list. Issue #14,  
 11 "Are changes needed to maximize worker and  
 12 pilot participation in the development,  
 13 implementation, and monitoring of helicopter  
 14 safety initiatives and activities?". We're  
 15 always looking for ways to improve  
 16 communication opportunities for the workforce.  
 17 We've also already begun significant - made  
 18 significant initiatives since March 12th of  
 19 2009, and we describe them in our brief.  
 20 During the return to work process, we provided  
 21 regular updates to our workers and more  
 22 comprehensive and frequent updates to the OHS  
 23 committees. The committees in the offshore  
 24 workforce are engaged in this task force.  
 25 They submitted over 350 questions to the

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1 operators. These were all answered and  
 2 responded to, all of which has been filed with  
 3 you, Commissioner, in the report of the HOTEF.  
 4 However, we would suggest that we establish -  
 5 or you recommend we establish a forum to  
 6 facilitate worker OHS Committee engagement in  
 7 identification, development, and  
 8 implementation of - and monitoring of  
 9 helicopter safety initiatives. We would call  
 10 this the Helicopter Operations Safety Forum,  
 11 or whatever other appropriate name could be  
 12 used, should be held twice a year, and it  
 13 should facilitate worker engagement in  
 14 helicopter safety initiatives, which would be  
 15 attended by all key stakeholders, workforce,  
 16 regulator, all key stakeholders. We've  
 17 actually suggested an agenda for your  
 18 consideration, Commissioner, in Appendix D,  
 19 and this would be a full day comprehensive  
 20 session.

21 Issue 15, "Should offshore workers have a  
 22 level of personal accountability for their own  
 23 safety in helicopter transport?". Safety is  
 24 everyone's business. When the operators  
 25 testified with Trevor Pritchett, Gary Vokey,

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<p>1 and Paul Sacuta, their workers, they were                  2 talking about their own safety. This isn't                  3 some nebulous concept of someone else, this is                  4 everyone's business. These three gentlemen                  5 travel to the offshore, they're talking about                  6 their safety, they're not talking about                  7 someone else's safety. Workers, all of them,                  8 play a key role in ensuring that health,                  9 safety, and environmental objectives are                  10 established by the operators are achieved                  11 through the consistent application of                  12 policies, procedures, and safe work practices.                  13 So it's our expectation that our workforce and                  14 it's the legislative requirement as well, be                  15 accountable for their own safety at workplace,                  16 including during helicopter transport. It                  17 doesn't take away from anyone else's                  18 responsibility, but all of us who travel to                  19 the offshore - I've never done it, but people                  20 in this room who travel to the offshore, and I                  21 see many in the room, we all have                  22 responsibility to ensure each other's safety.                  23 Issue 17, "Should the Board and oil                  24 operators safety aviation audits include</p>	<p>1 families that workers have the right to be                  2 provided with pertinent information so they,                  3 themselves, can assess the risks and make                  4 informed decisions on managing their own risk.                  5 That's a quote out of their brief. So we all                  6 agree on that, I think. The key issue is what                  7 is the pertinent information. To answer that,                  8 I think you first need to start, what do we                  9 actually provide now, what do the operators                  10 provide now. These include information and                  11 updates on the following things; the HOTF                  12 recommendations, there's 18 of them, many of                  13 which relate directly to the aircraft; TSB                  14 investigation regular updates; Cougar                  15 litigation against Sikorsky, we briefed our                  16 workforce a couple of months ago when we                  17 discovered that the litigation had been                  18 commenced; all worker rights to refuse                  19 relating to helicopter transport; search and                  20 rescue updates; shutdown of helicopters due to                  21 mechanical issues when passengers have already                  22 boarded; in flight and in taxi turnarounds;                  23 unplanned shutdowns of aircraft offshore due                  24 to mechanical issues; significant maintenance                  25 and inspection activities and manufacturer's</p>
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<p>1 reviews of past responses to declared                  2 emergencies and emergency preparedness                  3 exercises". This already exists with respect                  4 to the operators. The operators do audit                  5 these exercises, and each of the operators who                  6 have testified before you have done so. Cougar                  7 also engages in operator emergency response                  8 exercises and drills, and any learnings as a                  9 result of that drill are immediately applied                  10 to helicopter response and they're identified                  11 for following up.                  12 Issue 18, "What information from the                  13 helicopter operator about flight operations                  14 should the Board require oil operators to                  15 provide to offshore workers", and you give                  16 examples, alert service bulletins,                  17 airworthiness directives, and so on. This is                  18 a complex issue and the simple answer                  19 sometimes is not the correct answer, we'd                  20 submit. We believe each operator already                  21 provides an appropriate level of                  22 communications about Cougar flight operations,                  23 and we don't think it would be appropriate for                  24 the Board to stipulate additional information.                  25 We agree, though, with the statement by the</p>	<p>1 continuous improvement activities.                  2 So let's talk a little bit about other                  3 issues which are the alert service bulletin                  4 and the airworthiness directives. We've                  5 included one in our brief, Commissioner, as                  6 Schedule E, just to show the nature of these                  7 documents. These are written for aircraft                  8 owners and helicopter service providers, and                  9 are very technical and include technical                  10 information in relation to the required action                  11 to be taken. They are not written for a                  12 general audience. I would just encourage                  13 people to read it and see how much we can all                  14 understand as users of air transport, all of                  15 us. ASBs, in particular, are not even                  16 authorized for distribution without the                  17 expressed consent of the manufacturer. ADs, or                  18 airworthiness directives, are public documents                  19 and are published on Transport Canada's                  20 website. Read Appendix E, and see how useful                  21 that would be to circulate generally. So what                  22 we do is when the operators are alerted to an                  23 ASB or an AD considered relevant to the                  24 workforce, the operators work with Cougar and                  25 the manufacturer to develop an information</p>



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1 package to assist in the understanding of this  
 2 AD and ASB. We did this with respect to the  
 3 recent ASBs dealing with maintenance of  
 4 filters and gear box mounting feed inspection  
 5 requirements to put it into something that  
 6 people can understand. We can improve in some  
 7 areas ongoing aircraft maintenance activities  
 8 which are all based on prescriptive  
 9 maintenance requirements, Transport Canada  
 10 tell you what has to be done and when, are  
 11 generally conducted during outside normal  
 12 flight hours. The operators believe, though,  
 13 it would be beneficial to improve the  
 14 awareness of what is done, when, and how, and  
 15 we propose that we would work with Cougar,  
 16 develop a DVD or a video to be disseminated to  
 17 the workforce so people can understand what  
 18 Cougar does, when they do it, and why they do  
 19 it. We must remember that 66 percent of  
 20 aircraft depart on time, so 34 percent don't.  
 21 70 percent of those delays relate to weather.  
 22 Delays can also be caused by unplanned  
 23 maintenance, as well as late passengers, or  
 24 some particular cargo requirements. So while  
 25 we can give general updates on Cougar's

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1 information flight line, to give detailed  
 2 updates of every delay and the reasons for  
 3 every delay would, in our view, not be  
 4 feasible, practical, or increase worker  
 5 safety, or another way to put it, it's not  
 6 pertinent information. So we believe the  
 7 information is complex and sufficient enough,  
 8 and no additional changes should be made.  
 9 Issue 21, Commissioner, which is the  
 10 final issue, "Should there be safety  
 11 conferences for all parties involved in  
 12 offshore helicopter transport; if so, how  
 13 often should they be held?". We agree fully  
 14 with the concept for continuous improvement in  
 15 communication engagement relating to  
 16 helicopter transportation, and are committed  
 17 to any goal that can make that happen.  
 18 However, we got to remember the east coast  
 19 does not have the volume and scope of  
 20 helicopter operations. For example, in the UK,  
 21 they've announced a new helicopter safety  
 22 steering group. We don't think that would be  
 23 appropriate in Canada. We have three  
 24 operators and four aircraft - five now with  
 25 the S-91 still in place. They have hundreds

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1 of facilities in the UK, as you know, in the  
 2 North Sea, and hundreds of aircraft. However,  
 3 we want to learn from this process and we  
 4 demonstrated that already when CAPP has  
 5 participated in a UK helicopter task force  
 6 group. So we propose to monitor this group,  
 7 but something of that magnitude would not be  
 8 suitable for the east coast, we don't have the  
 9 volume. We believe the operators should focus  
 10 and the industry generally on safety related  
 11 forums which focus on best practice and shared  
 12 learnings. We believe this helicopter  
 13 operation safety forum which we talked about  
 14 before in Issue 14, and highlighted in  
 15 Appendix D of our brief, would be an ideal  
 16 area to deal with these issues; what are  
 17 people doing elsewhere, how can we learn from  
 18 them. As the industry develops and becomes  
 19 more comprehensive and more intensive, perhaps  
 20 this is an idea that could be revisited then.  
 21 So that's our submission on your issues.  
 22 I'd like to conclude by quoting a statement  
 23 from Aerosafe, I think they quoted it from  
 24 someone else, "That achieving a positive and  
 25 sustaining a positive health, safety, and

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1 environmental culture is not a discreet event,  
 2 it's a journey", and I think you've  
 3 acknowledge that yourself, Commissioner. A  
 4 very important part of this journey has been  
 5 our participation in this Helicopter Safety  
 6 Inquiry. We are committed to do what is  
 7 necessary to ensure the safety of our  
 8 workforce. It is our number one priority.  
 9 Accordingly, we support your work,  
 10 Commissioner, and very much appreciate the  
 11 opportunity you have given us to participate  
 12 in this process. We hope that our response to  
 13 this tragedy and the improvements that will  
 14 result from the work of this Inquiry will in  
 15 some very small way honour those lives that  
 16 have been lost, and those whose lives have  
 17 been very profoundly affected. Thank you,  
 18 Commissioner, for your time.  
 19 COMMISSIONER:  
 20 Q. Okay, thank you, Mr. MacDonald.  
 21 ROIL, Q.C.:  
 22 Q. Commissioner, the next presenter is the C-  
 23 NLOPB. In view of the lateness of this hour, I  
 24 wonder would it be more prudent for us to take  
 25 a break now for our lunch break rather than

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1 break them up midstream, and have them begin  
 2 at 2 o'clock.  
 3 COMMISSIONER:  
 4 Q. Would you like a break a little longer than  
 5 normal, Ms. Crosbie.  
 6 MS. CROSBIE:  
 7 Q. I think that would make sense.  
 8 COMMISSIONER:  
 9 Q. Yes, all right then that's what we'll do, and  
 10 we'll come back at 2 o'clock.  
 11 (RECESS)  
 12 ROIL, Q.C.:  
 13 Q. Commissioner, the next presenter is Amy  
 14 Crosbie, on behalf of the C-NLOPB, and Mr.  
 15 Andrews is seated with her, but she will be  
 16 making the presentation.  
 17 COMMISSIONER:  
 18 Q. Okay, thank you. Good afternoon, Ms. Crosbie.  
 19 SUBMISSION BY MS. AMY CROSBIE:  
 20 Q. Good afternoon. Our comments will be  
 21 relatively brief, and I know we've dragged you  
 22 all back here after lunch, but I figure we  
 23 won't be that long this afternoon.  
 24 The Canada Newfoundland and Labrador  
 25 Offshore Petroleum Board would first like to

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1 express their condolences to the families of  
 2 the passengers and the pilots of Cougar Flight  
 3 491. This tragedy has deeply affected the  
 4 Board and its staff. The C-NLOPB are  
 5 themselves offshore workers and they travel to  
 6 and from the installations regularly. The  
 7 victims of the crash were people who they knew  
 8 and they worked with.  
 9 The Board called this inquiry to examine  
 10 the existing regime in relation to helicopter  
 11 transport of workers to the offshore, and to  
 12 determine what if any improvements are  
 13 necessary to ensure that the risks associated  
 14 with such travel are as low as reasonably  
 15 practicable.  
 16 We have throughout this matter supported  
 17 the Inquiry to ensure that the Commission can  
 18 provide it with recommendations that are  
 19 meaningful. We have willingly provided all  
 20 requirement and requested information and have  
 21 provided testimony to explore our role in a  
 22 broad sense, and specifically with respect to  
 23 safety. Mr. Andrews and Mr. Pike testified  
 24 and were cross-examined and they answered  
 25 thoughtfully and honestly. We have

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1 intentionally taken this limited role to  
 2 ensure that the pertinent information was  
 3 disclosed without interference. The Board is  
 4 a body which will receive the recommendations,  
 5 and as such, the Board did not provide any  
 6 written submission with respect to the  
 7 specific issues identified. We felt that this  
 8 would be inappropriate and perceived to be  
 9 interference with the process that we  
 10 established.  
 11 The mandate includes the phrase, "As low  
 12 as reasonably practicable". This was  
 13 described by Mr. Earle as wiggle words in his  
 14 submission on behalf of CEP Local 2121. The  
 15 mandate states that the risk should be as low  
 16 as reasonably practicable, which is a well  
 17 known term and is utilized in industry  
 18 worldwide. Mr. Earle's submission on behalf  
 19 of the CEP has applied this term to the  
 20 remedy, and implies that the mandate is to  
 21 assess whether remedies are reasonably  
 22 practicable or affordable. He has, in fact,  
 23 wiggled the words to convey a completely  
 24 different meaning. This Inquiry is looking at  
 25 the risk and examining whether the risks

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1 associated with helicopter transport to and  
 2 from the Newfoundland offshore are as low as  
 3 reasonably practicable. The Inquiry is not  
 4 looking at whether any particular operator can  
 5 afford to minimize the risk, and, in fact,  
 6 absolutely no evidence was led to suggest that  
 7 there were no remedies that a party did not  
 8 implement due to costs.  
 9 The Board has taken criticism during this  
 10 Inquiry primarily from counsel for CEP Local  
 11 2121. This was somewhat surprising, given the  
 12 level of criticism, which was not expressed by  
 13 any other party or the representatives who  
 14 testified on behalf of CEP, nor was it  
 15 reflected in the comments of the offshore  
 16 workforce in the Aerosafe survey. There are  
 17 several areas in which the evidence of the  
 18 Board, we feel, has been misrepresented to  
 19 skewed to such an extent that the Board feels  
 20 it's appropriate to provide some correction.  
 21 At page three of Mr. Earle's brief, he  
 22 stated that the legislation does not in and of  
 23 itself require the operation of an offshore  
 24 installation be carried on in a safe manner.  
 25 It must be remembered that the Board does not

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1 draft or enact the legislation under which it  
 2 operates. This is the job of both the  
 3 Provincial and the Federal Governments, and  
 4 the evidence has established that it can  
 5 sometimes be a long process. However, the  
 6 evidence also established that the Board has  
 7 wide ranging authority on any or all  
 8 authorizations issued to operators in the  
 9 offshore.

10 Specifically with respect to safety, all  
 11 authorizations contain the condition that  
 12 compliance with the draft occupational health  
 13 and safety regulations be adhered to. It  
 14 should be noted that these draft regulations  
 15 are substantially the same as the Provincial  
 16 occupational health and safety regime, and  
 17 they include the right to know, the right to  
 18 participate, and the right to refuse. The  
 19 Board also incorporates specific and relevant  
 20 requirements to authorizations dealing with  
 21 helicopter transport that the operators must  
 22 include in their contract with helicopter  
 23 providers. These include, among other things,  
 24 high back stroking seats, additional flotation  
 25 on the helicopters, and the four point harness

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1 restraints. Conditions to an authorization  
 2 must be complied with. In the event that they  
 3 are not, the operator can face harsh penalties  
 4 or revocation of the authorization, which  
 5 would shut down all their operations conducted  
 6 in the offshore. The inclusion of the draft  
 7 occupational health and safety guidelines as a  
 8 condition - sorry, the draft regulations as a  
 9 condition has provided the Board with the same  
 10 powers it would have had if these draft  
 11 regulations were enacted, and we did hear from  
 12 the Government yesterday that regulations are  
 13 hopefully to be enacted in due course.

14 In Paragraph 38 of Mr. Earle's brief,  
 15 when he was talking about search and rescue  
 16 and what was provided in the safety plans, he  
 17 stated that, "It appears from the evidence of  
 18 Mr. Pike that the C-NLOPB simply saw itself as  
 19 verifying that what was presented in a safety  
 20 plan was, in fact, available". We believe  
 21 this has been misquoted. The testimony that  
 22 Mr. Earle relies on to substantiate this  
 23 statement was Mr. Pike's testimony regarding  
 24 the audit of Cougar, it did not in any way  
 25 relate to the process of approving safety

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1 plans. Mr. Pike testified that the  
 2 requirements of the safety plan are discussed  
 3 extensively with the operator in advance of  
 4 any formal submission. They are thoroughly  
 5 reviewed and risk assessed. On occasion,  
 6 sections are rejected and they require  
 7 modification, and then they are finally  
 8 approved by the Board. The C-NLOPB does not  
 9 simply verify; what is presented in a safety  
 10 plan by an operator is available.

11 With respect to the C-NLOPB as a  
 12 regulator, Mr. Earle this morning proposed a  
 13 theory. His theory is that the Board is a  
 14 promoter of the offshore, that they piggyback  
 15 on the successes of the operators, and that it  
 16 has an organizational behaviour that tends  
 17 toward industry success. His recommendations  
 18 are contingent on his being right, and indeed  
 19 his morning himself, he said, if I am right.  
 20 The Board's position is that he's wrong, his  
 21 theory has no foundation in the facts or the  
 22 evidence presented before this Inquiry. When  
 23 he testified today about the organizational  
 24 behaviour at the Board, he based his  
 25 assumption on the evidence of Mr. Andrews, who

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1 testified that the Chief Safety Officer has  
 2 authority to act independently of the Board,  
 3 which is correct, he does, and Mr. Andrews  
 4 testified to that. He then points to the fact  
 5 that Mr. Andrews also said that the Chief  
 6 Safety Officer may discuss with others before  
 7 he makes such a decision. From this, Mr. Earle  
 8 assumes that the Chief Safety Officer doesn't  
 9 do his job. He went so far as to put himself  
 10 in the room between the Chief Safety Officer  
 11 and the Chair of the Board, and he stated that  
 12 there must be some communication, subtle or  
 13 perhaps unconscious, from the Chair which  
 14 would stop the Chief Safety Officer from  
 15 acting. Interestingly, Mr. Earle does not  
 16 refer to the testimony of Mr. Pike when he  
 17 makes this assumption. Mr. Pike's testimony  
 18 was that he has the authority to shut down an  
 19 operation, and that he has done so in the  
 20 past. He did not testify that there was any  
 21 form of pressure on him from anyone who would  
 22 influence such a decision. There is no  
 23 evidence that would lead anyone, other than  
 24 Mr. Earle, to conclude that the Board or the  
 25 Chief Safety Officer ever acts so as to favour

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1 the operators. Some of these points were also  
 2 made in Mr. Earle's brief. At Paragraph 49, he  
 3 said, "The successes of oil industry are the  
 4 successes of the C-NLOPB". The Board takes  
 5 great exception to this statement. There is  
 6 no evidence that establishes that the Board  
 7 members, their executive or their staff  
 8 measure their performance in relation to the  
 9 performance of oil industry.

10 Mr. Earle also, throughout his  
 11 submission, states that the C-NLOPB  
 12 facilitates and promotes offshore oil  
 13 exploration and production. He quotes Mr.  
 14 Andrews when he makes this statement, and he  
 15 actually quotes Mr. Andrews accurately.  
 16 However, he completely misinterprets this  
 17 statement. Mr. Andrews said that the role of  
 18 the C-NLOPB is to facilitate the exploration  
 19 for and the production of offshore petroleum  
 20 resources. By this, he meant that the C-NLOPB  
 21 -- by this, Mr. Earle assumes that it means  
 22 they promote these activities. He then goes  
 23 on to conclude that this promotional activity  
 24 erodes the Board's focus on and its commitment  
 25 to safety. This misinterpretation, wilful or

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1 otherwise, is wrong and the conclusion he  
 2 comes to is wrong.

3 Governments create regulatory bodies to  
 4 facilitate the performance of an activity  
 5 which society wants performed in a particular  
 6 manner. It is the obligation of every  
 7 activity regulator in Canada to facilitate the  
 8 performance of the activity it was created to  
 9 regulate. In the case of the C-NLOPB, the  
 10 activity which governments created it to  
 11 facilitate is the exploration for and  
 12 development of offshore petroleum resources,  
 13 which is exactly what Mr. Andrews indicated in  
 14 his testimony. It does not follow that  
 15 because the C-NLOPB facilitates that activity  
 16 that it promotes it or the companies that  
 17 pursue it.

18 The Canadian Food Inspection Agency was  
 19 created to facilitate the production of safe  
 20 food for Canadians. This does not mean that  
 21 the CFIA promotes food production or food  
 22 producers. The Canadian Radio and  
 23 Telecommunications Commission was created to  
 24 facilitate the orderly provision of  
 25 telecommunication services in Canada. That

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1 does not mean that the CRTC promotes any  
 2 particular service or service provider.

3 When Mr. Andrews stated that the C-NLOPB  
 4 facilitates the exploration for and the  
 5 development of offshore petroleum resources,  
 6 he is merely stating the purpose for which  
 7 governments created the C-NLOPB. The claim  
 8 that this amounts to the promotion of the  
 9 industry and an erosion of the focus on safety  
 10 is simply wrong.

11 In order to determine what improvements  
 12 can be added to the current regime, the  
 13 Inquiry had to look back. It's now time to  
 14 look forward and to be positive about the  
 15 Newfoundland and Labrador offshore industry.  
 16 Our oil and gas industry is one of the most  
 17 highly regulated in the world and has one of  
 18 the highest safety records. The C-NLOPB is  
 19 mandated to regulate and enforce safety in the  
 20 offshore and does this effectively.

21 The Board is a proactive regulator which  
 22 has been demonstrated by their increased  
 23 oversight program on deep water drilling  
 24 operations. This was more progressive than  
 25 that implemented by any other oil and gas

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1 regulator. The Board has also shown itself to  
 2 be reactive in its regulation, as shown by its  
 3 immediate implementation of the interim  
 4 recommendations from the Commissioner in  
 5 February. This is also shown by the immediate  
 6 call for this inquiry to make recommendations  
 7 for improvements following the disastrous  
 8 events of March 12th.

9 The Board would once again like to  
 10 express its thanks to the Commissioner,  
 11 Inquiry counsel and all of the parties who  
 12 have participated throughout this Inquiry.  
 13 The Board established this Inquiry to examine  
 14 the important safety questions that have  
 15 arisen following the tragic events of March  
 16 12th, 2009. It is, and always has been, the  
 17 Board's hope that this Inquiry will result in  
 18 recommendations and changes that will make  
 19 travelling to and from the offshore safer and  
 20 that will ease the mind of the offshore  
 21 workforce and their families. Thank you.

22 COMMISSIONER:  
 23 Q. Okay, thank you, Ms. Crosbie. Well, I think I  
 24 mentioned earlier, ladies and gentlemen, that  
 25 I didn't want anybody to leave here this

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1 afternoon feeling that they didn't have a  
 2 chance to make a point that was raised perhaps  
 3 after they spoke. By that, I don't mean that  
 4 I would invite anybody to get up and make a  
 5 lengthy speech, but if it's a matter of a  
 6 point or two that anyone would like to make,  
 7 then this is the opportunity to do it.

8 ROIL, Q.C.:

9 Q. Commissioner, might it be appropriate to take  
 10 a break for a moment or two, perhaps to give  
 11 parties an opportunity to formulate what their  
 12 thoughts might be and perhaps we could go  
 13 through the list the way we did before, and  
 14 that would give these parties an opportunity  
 15 to -

16 COMMISSIONER:

17 Q. I think that that might be a good idea. I  
 18 think that's a good idea. Okay then, thank  
 19 you.

20 (BREAK)

21 COMMISSIONER:

22 Q. Ladies and gentlemen, one or two things, I  
 23 guess I will say to clue up, and that won't  
 24 take long. Firstly, I intended to say and I  
 25 gather one or two of you have asked Inquiry

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1 counsel if they are going to speak and counsel  
 2 and I have discussed that. It would be  
 3 inappropriate. What would they be speaking  
 4 for? Would they be trying to persuade me?  
 5 Not likely. We are discussing things all the  
 6 time. That's the role of the three of us. So  
 7 no, they won't be speaking, and I think, quite  
 8 properly so.

9 To the group here, I would say this, that  
 10 it seems a long time ago now that I made some  
 11 opening remarks and I guess it is. I suspect  
 12 not everyone in the room, not people working  
 13 for the industry perhaps, but the rest of us  
 14 have all had a learning curve and it has been  
 15 steep, but well worthwhile, and I want to  
 16 thank everybody for the effort they've put  
 17 into this, for the preparation of the original  
 18 material that was filed back last fall and in  
 19 the winter. I want to say that the experts'  
 20 reports and the discussions with the experts,  
 21 I have found very valuable. I found it very  
 22 valuable, particularly in learning about  
 23 things like goal based or performance based  
 24 regulation, to go to the UK and Norway and  
 25 talk to the people who are administering that

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1 and who are working in it. That was very  
 2 valuable. And of course, the presentations  
 3 made in writing which really gave me the basis  
 4 of everybody's positions at the end of July  
 5 and that enabled me to get to work in a very  
 6 serious way in preparation of the report, but  
 7 I deliberately refrained from putting anything  
 8 even in the slightest way of a draft vis-a-vis  
 9 recommendations until after I heard from you  
 10 yesterday and today.

11 So I will let this settle down in my mind  
 12 for a day -- I know what all of you think and  
 13 I'll let it settle down and probably by  
 14 Monday, I'll ask myself, "well, what do you  
 15 think?" and I will get to work hard because I  
 16 don't want the report to be delayed any more  
 17 than it must be, and it won't be delayed in  
 18 any significant way. In fact, I say this for  
 19 Mr. Andrews, Ms. Crosbie, I'm still hoping for  
 20 the 30th of September.

21 Anyway, thank you once again, and thank  
 22 you for the very calm and reasonable way  
 23 throughout that arguments and discussion and  
 24 information has been presented and I shall  
 25 always remember this as an excellent

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1 experience. I hope it's been a good and  
 2 learning experience for most of the people in  
 3 the room also and most of all, and everybody  
 4 has mentioned the families, and of course, the  
 5 families have been uppermost in my mind all  
 6 the time, right from the time I was appointed,  
 7 and I'm glad to see that people today  
 8 expressed themselves in sympathy and regard  
 9 for the families who suffered the loss. So  
 10 that's in my mind very much also.

11 In any event, I will get down to work and  
 12 you will have -- or the C-NLOPB will have, and  
 13 in due course you will have -- well, the  
 14 expression nowadays is you will have my best  
 15 shot. Okay, so thank you again, and we'll  
 16 adjourn.

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 9th day of September, 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 9th day of September, 2010

11 Cindy Sooley  
12 Discoveries Unlimited Inc.  
13 Judy Moss  
14 Discoveries Unlimited Inc.

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