OFFSHORE HELICOPTER SAFETY INQUIRY
February 17, 2010
Tara Place, Suite 213, 31 Peet Street
St. John's, NL

February 17, 2010

PRESENT:

John F. Roil, Q.C./
Anne Fagan.....Inquiry Counsel

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

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

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

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

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

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

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

Jamie Martin.....Families of Deceased Passengers

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

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

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

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COMMISSIONER:

Q. Good morning, ladies and gentlemen. Good morning, Mr. Pike. Ready, Mr. Roil?

ROIL, Q.C.:

Q. Thank you, Commissioner, yes. Good morning, we're ready to proceed. Just by way of a brief opening comment, we, of course, had Mr. Pike here once before on the first day of the public hearings in Phase 1, and he is now here perhaps appropriately to close this part of the proceedings, not by any means all of our proceedings, but the initial public hearing.

COMMISSIONER:

Q. Alpha and Omega.

ROIL, Q.C.:

Q. The Alpha and the Omega, indeed. The first time around, I think the information that the C-NLOPB brought to us was perhaps at a higher level of what they're enabled to do, what they're entitled to do, and this time around we're going to go back down into some more details as to how they do some of those things. There are a significant number of exhibits that have been posted to the parties.

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The exhibits respond to some of the questions that came up initially and requests from parties, and some of them are exhibits that we have brought up as a matter of completing the entire piece. So I would ask that Exhibits 187 to 194, and then 196 to 206, be made as exhibits within our hearings. The only public exhibit is the presentation itself. The other exhibits are considered as confidential exhibits, but are available to the parties.

COMMISSIONER:

Q. Okay, thank you.

ROIL, Q.C.:

Q. Mr. Pike, good morning.

MR. PIKE:

A. Good morning.

ROIL, Q.C.:

Q. We meet again, and we understand that you have already been sworn with respect to evidence before this Inquiry and that oath, of course, continues for today.

MR. PIKE:

A. Okay.

MR. HOWARD PIKE (RECALLED) EXAMINATION BY JOHN ROIL, Q.C.:

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ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. I'm going to start this morning with a little bit of a confession, for the first time in many years I didn't attend the Memorial Service the Ocean Ranger on Monday. I usually make a point of attending that. I take the time to reflect on what I do and why I do it. It's a very emotional time and it brings home the point that it's about the people. We can't bring back those people, the 84 people that were lost on the Ocean Ranger, the three divers that were lost in the recovery operations, and now we have 17 lives lost on Cougar 491, but what we can do is work to make the offshore a safer place. When I do that, I ask some difficult questions and it takes a very difficult perspective, and I know that over the years when I've met with some of the families of the people lost in the Ocean Ranger, my exuberance for looking for those answers to make for a safer workplace sometimes upset those family members, and I have to be conscious of being sympathetic with

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them and temper some of those, so I do have to ask tough questions, and if I say something today that upsets the families, I apologize in advance, but it's part of my job to ask some of those tough questions. Our sympathies are with them and our prayers are with them. While I'm on confessions, as we go through this piece, you'll notice that we use extensive use of databases. The official file system of the Board has been paper for many years. We're in a transition now towards more electronic, and when I was trying to retrieve some of these files, it took me a little bit longer than I had anticipated, but I think as we go through we'll see how that piece works.

ROIL, Q.C.:

Q. And there was, I gather, a significant amount of paper that had to be reviewed just to extract the information that we have here?

MR. PIKE:

A. That's correct, helicopter operations are one part of a very larger piece that we do.

ROIL, Q.C.:

Q. Okay. We recall that you are the Chief Safety Officer on behalf of the C-NLOPB, and in that

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capacity, I understand that you are responsible for a number of activities. You've talked about some of them, and now you're going to set out an agenda for us for the next number of hours?

MR. PIKE:

A. Yes. We're going to start and talk about some of the incidents, talk about complaints, and by doing that we will see how some of those can feed into the safety audits that we do, safety audits and inspections, we'll talk a little about the communications, the different groups that we communicate with, we'll talk a little bit about our compliance and enforcement policy, and then we'll end off with emergency response.

ROIL, Q.C.:

Q. Okay, that's fine. I think you have control of the slide presentation, so you take it at a pace that you're comfortable with, and we'll stop you when we need to ask questions from time to time.

MR. PIKE:

A. Recommendation 89 of the Ocean Ranger Commission Report talked in terms of incidents

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and the collection, correlation, and analysis of that information. So we've taken that piece very seriously and do collect those. I refer to Exhibit 48, if we could.

ROIL, Q.C.:

Q. This is an exhibit that was up in your first round, hence the rather low number.

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Just give us a moment to get that up on the screen for those present because it's probably not one that people have brought their paper copies with them.

MR. PIKE:

A. That's the latest guideline we have published. It was done in June of last year and it refers to the reporting. The full name is "The guideline for reporting and investigation of incidents", and I think we're going to start maybe by talking a little bit about what we define as an incident. We've heard different people define those. In 1984, international regulators formed -- developed a working group to take a look at the measurement of some of

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these things and their goals were exchange of information regarding health and safety trends, industry health and safety performance measure, and measuring the effectiveness of regulatory activities. Those were the goals of that committee. Some of that work also helped us in forming and trying to develop the definitions of incidents.

ROIL, Q.C.:

Q. So you, I take it, don't necessarily have the same definition of incidents that Transport Canada or other parties may have?

MR. PIKE:

A. No, no, it -- it was an interesting piece as we went through that internationally. Everybody had slightly different definitions for these pieces, and even within Canada, the definitions between, and the one most commonly used between jurisdictions in Canada is Workers Compensation incidents. They're different. The definitions are different. So it's a difficult comparison to do between provinces because there are differences in those definitions, but what we attempted to do with that piece and what we've rolled into

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here is to try to get some standardized definitions. If I can move -- okay, try to get us up to page 11 here.

REGISTRAR:

Q. Page 11.

MR. PIKE:

A. I can move it up. You'll see that we just go through a lot of definitions in here.

ROIL, Q.C.:

Q. Yeah.

MR. PIKE:

A. Of note, when we first started, it was a form where you reported the incident and the back side of that form was information to fill it out. We've now got a larger document to help define those. Too quick on the finger. At this point here, page 11, it talks about reporting an incident and we provided further clarification, support craft in this regard, "For support craft, an incident shall be reported if the support craft is in the offshore area conducting any worker activity related to an authorization. An incident shall be reported at the time when the support craft is engaged in transporting personnel via air

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or sea to or from an installation or a vessel". This guidance actually started long before March 12th, but it came into force in June.

ROIL, Q.C.:

Q. And the definition of support craft here would include helicopters?

MR. PIKE:

A. That's correct.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. So this again was another point we provided to improve the reporting that we were getting. Just moving down to page 15, we start getting into -- we can sort of quickly get some of those. Incident classifications, fatality, it seems fairly obvious, but there were some questions as to how you would -- you know, is it occupational, is it natural causes. There are a number of those things that come into play as to whether you would define the death as a fatality or not when it comes to the workplace.

ROIL, Q.C.:

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Q. But a fatality is clearly an incident?

MR. PIKE:

A. Yes, very clearly so. Missing persons -- major injury, we've now started to break out what we define as a major injury. So there's amputation, skeletal injuries, burns, injuries to internal organs, you know, the eyes, and again more clearly defining what we would have as an incident.

ROIL, Q.C.:

Q. So if one hurts one's finger or something like that, would that be considered an incident?

MR. PIKE:

A. It's reportable, but it's not reportable as a major injury.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. It's breaking down the categories.

ROIL, Q.C.:

Q. Thank you.

MR. PIKE:

A. A loss or restricted workday. So if an employee injures a finger and is not able to go back and perform all their duties the

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

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on that. Spills, and this guideline is actually combined with environmental protection. So we define spills, and we get spills reported coming in through the same system. The unauthorized discharge, some adverse weather conditions, security issues, damage to the actual equipment. So we have a fairly extensive definition for incident.

ROIL, Q.C.:

Q. Okay, well, perhaps as we go through the piece, we can reflect back on this definition and see where incidents are being reported in accordance with this kind of -- definition is not the right word, but this kind of context.

MR. PIKE:

A. We can probably go back to the presentation, if you like.

ROIL, Q.C.:

Q. Back to the presentation, yeah, we can do that.

MR. PIKE:

A. Okay. So incident reports, three basic steps; we receive notification of the incident, then there's an incident report required, and then we would go through the formal process to

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

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

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of our emergency response plan.
ROIL, Q.C.:
Q. When the emergency response plan -- sorry, when the emergency response plan is activated, does that take it all to a different way, or does the incident still have a life of its own?
MR. PIKE:
A. It still has a life of its own, yes.
ROIL, Q.C.:
Q. Okay, yeah.
MR. PIKE:
A. So we'll talk a little bit more about the --
ROIL, Q.C.:
Q. So the process we're following now would be followed in any event?
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. Correct, and indeed we did do that on the March 12th incident. This next decision point is whether we will formally investigate and I refer to that as the big "I", investigate.

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The safety officers have two sets of powers. One is to inspect and the other one is to investigate, and the simplest way to describe what's going on and the difference in there is when we are inspecting, it is actually an offense not to answer our questions, but if we are investigating, you have a right not to answer our question. That's the easiest way I have of describing what the difference is here, and we try to distinguish what we're doing. So we have a very formal process when we start engaging in the investigation process. The investigation would be if we are looking at a prosecution, that's a formal investigation. We would then proceed to get a warrant before we start our investigation. We do that because of the remoteness of our work sites, and to start that process sooner. So we would probably start the formal warrant process sooner than you may see in the onshore instance, but that's because of the remoteness of our work sites and that's the way we trigger, so we sometimes do a review, we call it a review, that's a small "I" investigate versus the large "I" formal, we're looking at

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prosecution type investigation.

ROIL, Q.C.:

Q. So a large "I" investigation is a formal process. Are you telling us that there are informal investigations, but you don't call them that, you call them some other name, or are they also called investigations?

MR. PIKE:

A. Well, we would refer to them as a review.

ROIL, Q.C.:

Q. As a review, okay.

MR. PIKE:

A. To distinguish between the two.

ROIL, Q.C.:

Q. Yes, indeed.

MR. PIKE:

A. We would notify governments, and I think we had a presentation here from the -- or a piece from the Provincial Government, they noticed MOUs, and we would notify them. Indeed on March 12th, we did notify the government when we received that thing, so I would have notified both the Departments of Energy and the Occupational Health and Safety program with the province.

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ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. And we would initiate an entry in your database. Again we're starting to see the use of the databases.

ROIL, Q.C.:

Q. And this is a database that is your database?

MR. PIKE:

A. This is our database that we established to track incidents. The incident report, the operator is required to provide an incident report within 21 days of the notification. The report would be reviewed for completeness, including a root cause analysis and corrective actions, and we would also review it for accuracy. The requirement is 21 days, but obviously some incidents may be very complex and may require additional analysis. A potential example there would be we did have an incident several years ago with a helicopter and the engine. I think it's been mentioned in other -- other people have mentioned that particular piece. Well, it took some six months to get the report back on

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the analysis of what went wrong with that engine. So that report wasn't done in 21 days. We would have gotten some notification of where they were, and when the final report came in with that more detailed technical analysis, we would have received the final report.

ROIL, Q.C.:

Q. How many, in a ball park way, would be responded to fully in 21 days as opposed to requiring some extension?

MR. PIKE:

A. Most of them would be reported within 21 days. It's more the exception that they would go beyond the 21 days.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. We would identify then any follow-up required. We'll see some of that as we take a look at a couple of the incidents, whether we want to follow-up during one of our safety audits or inspections, whether there needs to be a dedicated inspection associated with this piece. The other one is, is there something

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about this incident that we should be sharing with the entire industry, so we may do a safety notice. So we would review it to see if there's a safety notice required at this point, and then as -- with that report or the information for that report, we would enter that into the database.

ROIL, Q.C.:

Q. So there's a tracking mechanism to follow what the steps are and whether they've been followed?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. Who's responsible to monitor that, to see that it is being followed?

MR. PIKE:

A. We have a safety officer assigned to coordinate the database for the incident reports.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. Generally there would be a safety officer assigned for an incident, so they would be the

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one following through on that. Closure of the incident; the safety officer prepares a recommendation for the Chief Safety Officer. So they would come in and review with me where we are in the incident, ensure that all the pieces are complete, and it's only when we've completed everything, we're satisfied that they've done a complete root cause analysis and identified the corrective actions, that we would look to close out. We can probably now take a quick look at that -- look at the spreadsheet. I think there are 31 incidents related to helicopter operations, and I think it's Exhibit 196.

ROIL, Q.C.:

Q. Okay, can we go to Exhibit 196, and again just give the Registrar a moment to get there.

MR. PIKE:

A. I think there are 31 incidents noted on this. We've added a couple since I was here last fall that are not actually closed in our database yet, we're still following up with some of the root cause and corrective actions.

ROIL, Q.C.:

Q. So these are all of the incidents relating to

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helicopter?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. That have happened between what period of time?

MR. PIKE:

A. I believe the first one in there shows up as 1988.

ROIL, Q.C.:

Q. And how many of these would be closed at this point in time?

MR. PIKE:

A. Most of these would be closed. It's really a number of them that have been -- we received in the last four months that are still open. I'm not sure of the exact number. We can check it here. There are four incident files we've provided for you.

ROIL, Q.C.:

Q. Yeah, we've extracted four --

MR. PIKE:

A. We've extracted four.

ROIL, Q.C.:

Q. They're out of this list, are they?

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MR. PIKE:

A. They are out of this list.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. The first one is an April 5th, 2001 incident.

ROIL, Q.C.:

Q. Okay, take a moment now to --

MR. PIKE:

A. At the top of page two, the one that we have up here now.

ROIL, Q.C.:

Q. Okay, so you're staying with the same exhibit?

MR. PIKE:

A. I'm just identifying the ones that we've done. We'll get to the detailed ones in a moment.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. You'll notice that this was an engine shutdown on over speed. It was on a Super Puma aircraft in April of 2001, April 5th. That aircraft actually landed on the Hibernia Platform and they effected some repairs before they brought it back. The next one that we've

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supplied is December 16th. We're going to take a look at that one a little more closely.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. That would identifies a worker was transported within the field without a flight suit.

ROIL, Q.C.:

Q. Sorry, which number -- which date is this now?

MR. PIKE:

A. That's December 16th, 2001, and we've got that one up and we'll take a look at that one in a little more --

ROIL, Q.C.:

Q. Yeah, we have the actual detail of that one, okay.

MR. PIKE:

A. We do, and we'll take a look at that in a moment. The other one is a January 18th, 2006, January 18th, and I think we may have heard mention of this one. A chip light came on, the pilot elected to return to base, and in that process, it deteriorated further and they ended up shutting down an engine. So we have that report there as well. We'll take a

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look at that one in a little more detail. The other one is a more recent one which is still open, and I think we've heard some comment about that here at the Inquiry, and that's the October 11th. I refer to it as a weight distribution. It's still open. That's the heavy equipment in the cargo.

ROIL, Q.C.:

Q. That's the one that required the passengers to move forward?

MR. PIKE:

A. The passengers to be shifted, correct.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. So we have that one in there as well. That's still open. We have some questions as to -- we wanted a little more closer look at the root cause piece on that, so it's still being discussed.

ROIL, Q.C.:

Q. Okay, but we're going to take two that are closed, and again our purpose here, Commissioner, is to show the processes of the Board, rather than to determine or judge

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whether the things were closed properly or whether they were not closed properly. We're more interested in the steps that you go through, just so we can understand it.

MR. PIKE:

A. Okay. Again some of these are from an earlier period, so some of the processes now have -- you know, with constant improvement, we've made some changes to it, so some of these are actually from an early process. So if we could call up Exhibit 202. That's the December 16th, 2001 incident. What you see here is a printout from our database. So the type of information that we could collect, the operator, if we have a time, the date, when it was reported to us. In this case, we didn't actually get the report until January, and we'll talk a little bit about that as we go through it, the type of installation, et cetera. So this is the type of information we put into our database, description of the event, a passenger travelled from the Kommander 2000, that was a diving support vessel that was in the field doing construction work, it was the commissioning of

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the Terra Nova field, to the Henry Goodrich, which was the mobile offshore drilling unit, without wearing a helicopter transit suit or a transportation suit.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. The individual was wearing regular work clothes and a red jacket. It was reported that the flight was conducted in five minutes. The flight crew was aware that the individual was not suitably attired for the helicopter flight over open water, the pilot made a judgment call that the risk of flying the passenger to the Henry Goodrich was less than the risk of landing back on the Kommander, and you'll see as we go through some of the detail there. In hindsight, this was not the decision that should have been made, and the individual -- and our premise as we went through this, the pilot should never have been put in that position in the first instance.

ROIL, Q.C.:

Q. Yeah, the impression I would take from that is that the pilot wasn't aware until he was

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already taken off.

MR. PIKE:

A. He was put in a very difficult position and he shouldn't have been put in that position is our contention as we went through and did the analysis on this particular incident.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. You know, there was contributing factors here. There was changes made to the -- what do they refer to it as?

ROIL, Q.C.:

Q. The manifest?

MR. PIKE:

A. The manifest, exactly, thank you. Again this is the type of information we've captured in the database, some of the corrective actions that were taken. There's now a very clear directive from Petro-Canada that no passengers shall be transmitted without wearing a transportation suit. They had that policy, but it just wasn't as clear prior to this incident.

ROIL, Q.C.:

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Q. Okay, just to go back a bit, my impression from initially reading it was that the pilot had already taken off and he was making the judgment to keep going instead of coming back, but I take it here it appears that he was confronted with the problem that there wasn't enough flight suits for this gentleman to have one?

MR. PIKE:

A. That's correct.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. This was also at the end of the construction piece. They were finishing up their construction work, so people were coming off, and I believe the vessel would have left soon after this. It would have concluded its work. Diving in December is never a good thing. It would have been heading back to the North Sea. We would there note who the investigator was and the operator. In this case, the safety officer that did the review is no longer with us, so we've redacted that person's name.

ROIL, Q.C.:

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Q. Right.

MR. PIKE:

A. And it would have been closed -- the senior safety officer would have reviewed it and closed it at that time. There is a process to go through to close it. It doesn't show up here, but should, there was a follow-up, we actually did an audit of Petro-Canada in 2002 and we'll look at that when we do the audits. So this particular incident --

ROIL, Q.C.:

Q. So this was tracked into the audit, was it?

MR. PIKE:

A. Correct. What we did is we did a focused audit on helicopter operations associated with Petro-Canada in -- we'll take a look at it when we hit the audits, I guess.

ROIL, Q.C.:

Q. So we should see this incident being reviewed in the course of the audit?

MR. PIKE:

A. You will see it as part of the documentation associated with that audit.

ROIL, Q.C.:

Q. Okay.

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MR. PIKE:

A. If we can just sort of quickly go through it, this is actually taken off the file, the same sort of information. You'll note that the safety officer, and this is where I'm coming back, we received a report, we felt that they didn't get down to the root, that the pilot shouldn't have been -- so we went back to the operator in this case and said, you know, we didn't feel that the pilot should have been put in that position in the first instance. What we have here is the letter that was transmitted. We received notification of this incident on January 11th. They acknowledged that they had not reported it in time. The other note in here, it was actually a worker on the Henry Goodrich mobile offshore drilling unit that identified this piece. So again we've had a worker here reporting an incident and it was further investigated. So there as no coverup here. The worker identified that he saw something wrong and there was an investigation that took place.

ROIL, Q.C.:

Q. But there was a delay between the incident and

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when it came to your attention?

MR. PIKE:

A. Yes, there was.

ROIL, Q.C.:

Q. Did the worker report it to you or report it to his employer?

MR. PIKE:

A. There is an internal system, and the internal system worked. The worker reported it within their internal reporting system.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. So again this is just indicating, and then we get into the information in the report. As I indicated, it was reported by a drilling contractor employee that on the afternoon of December 16th, a helicopter arrived at that drilling unit with a passenger from the diving support vessel that was not wearing a transportation suit.

ROIL, Q.C.:

Q. I take it that this was a very, very short flight? I think there was a reference to five minutes?

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

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

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

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ROIL, Q.C.:
Q. So for your purposes, it didn't become closed until after the audit?
MR. PIKE:
A. It did not become closed until after the audit.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. It just goes through some of the background. We can possibly move on to the --
ROIL, Q.C.:
Q. Yes, perhaps we'll have a look at -- there was another one you wanted to look at.
MR. PIKE:
A. Unless you have any questions on that one, we can move on to the January 18th, 2006, and that's Exhibit 203.
ROIL, Q.C.:
Q. 203?
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

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

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

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

ROIL, Q.C.:

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

MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

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

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

ROIL, Q.C.:

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

MR. PIKE:

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

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required 21 days. It was actually some time later in August of that year when the final report from the engine manufacturer was available to identify what the issue was in that case.

ROIL, Q.C.:

Q. So I take it, your interest is not simply in the steps that they take, but also in what happened to that particular piece of equipment?

MR. PIKE:

A. We're looking for the root causes and the corrective actions. So have they dug down to find out the root cause of this incident, and what are they doing to correct it so it doesn't happen again. You can see the immediate cause, some of the basic causes, and the corrective actions that were taken. We've identified here -- the investigator in this case was one of our safety officers, and then we've entered comments. You'll note as we've gone through this and when we've closed it. It didn't actually get closed until October, 2007, when we got the complete package together.

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ROIL, Q.C.:

Q. So this event, unlike -- this incident, unlike the other incident, didn't get tracked off on another path, it had its own path, did it?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. That's the impression I'm taking from your evidence. I want to make sure I'm understanding it correctly.

MR. PIKE:

A. Yeah.

ROIL, Q.C.:

Q. Good, and all of these incidents come to your attention before they're closed off?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. And you have to accept responsibility that they're --

MR. PIKE:

A. I'm the one that signs off before we close them, yes. At the time of this one, Mr. Noel was the senior safety officer, and safety officers would report to him. Our current

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arrangement is Mr. Noel is now a senior safety advisor, the safety officers report to me and I'd be the one that signs off those.

ROIL, Q.C.:

Q. Okay, before we -- I think you're probably finished with that one. Before we close off on the issue of incidents, there is an exhibit in there, and I'm not going to take you to it because I don't want to spend a lot of time on it, others may, but I do want you to comment on it, and that is we have learned -- after you were a witness, I believe, we learned that Transport Canada has a system called CADORS, and it is an "incident" reporting system as well, and that helicopter incidents do get reported to them. What can you tell us about your knowledge of that and your view as to the importance of that or the relative value of that in terms of your reporting systems?

MR. PIKE:

A. As indicated, we weren't aware of it before. We haven't done an extensive analysis to do comparison because again some of their reporting criteria is different than ours. It's interesting that they do do that publicly

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because in Norway there is no public register of aviation incidents. They are captured by the aviation authority, but they're only in paper file system. So there is no captures equivalent in Norway, which I found rather interesting. The Norwegian authorities there thought that that was a useful piece that we had in having this database. It would afford us an opportunity to cross-reference, but again given that they're using a different reporting criteria, the comparisons can be a little more difficult. So it is a bit of a check for us if we go check there to make sure that we're capturing the incidents.

ROIL, Q.C.:

Q. Where there be any value in lining your incident reporting criteria for helicopter transport up with theirs as opposed to maintaining your own in relation to support craft and your own definitions? Is there value there or would it simply confuse you?

MR. PIKE:

A. There may be, but as I indicated, any time you're starting to line up two very different systems, there's a lot of effort involved in

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

ROIL, Q.C.:

Q. Do you now monitor that service as well?

MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

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

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

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

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

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

ROIL, Q.C.:

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

MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

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

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registration form in the database. It's another one of our databases where we would track those things.

Once the complaint is received, the person who has received it would consult with the chief safety officer, consult with me. We would decide on what level of review was required and again, a decision point is, you know, does this complaint warrant a capital I investigation, one of those formal ones or is it more of just a review, a more formal review. It will depend also on how much the person who complained wants us to disclose to the operator as well. In some cases, it's going to take that in order to correct the one, and we'll see that in one of the examples we have a little bit later on. We may assign a different safety officer to the actual review than the one that actually received the complaint, but normally the person that receives the complaint would be the one to do the review, but we go through that step as well. It's just sometimes if one safety officer receives it, but it's associated with an installation they're not familiar with, we

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assign the safety officer who's familiar with that installation.

ROIL, Q.C.:

Q. So these decisions are made on a case-by-case basis?

MR. PIKE:

A. They are.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. The safety officer would then prepare a report to the chief safety officer and would review that report with me. We would decide on what follow-up actions are required. So again, does this trigger a piece in one of our safety audits? Does it -- will it trigger its own safety inspection in its own right? And that information would then be entered in the database to update the data.

So the safety officer would complete a complaint report. So we look to make sure that it is complete and accurate. If we've done any sort of formal investigation or formal review, we would ensure that that's complete before we close off the complaint.

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Once they've got all those pieces complete, they'll meet with me and we'll review the complete complaint package and once we've decided that it is complete, we'll advise the complainant, if we've got that information and the disposition of that complaint and we would close the database. So the information is now in the database.

I think we've identified we've had four complaints since we've had our formal process up to last fall. I think there's been one received since the last time I was here, and it was in November I actually received it. It was with regard to seating arrangement and training. It was an anonymous complaint and it has since been closed. It was investigated as -- some of the information from our work refusals was also used to close that complaint.

ROIL, Q.C.:

Q. I think the exhibits that you have put forward here are those that were requested by one of the parties?

MR. PIKE:

A. Correct, and those were the ones that would

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have been known to us when we testified in October.

ROIL, Q.C.:

Q. Right, and I think your evidence was that there was four, and so we have four here.

MR. PIKE:

A. Yes, correct.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. Those are the four you have and that's exhibit -- if we could sort of pull up those exhibits? In January of -

ROIL, Q.C.:

Q. Sorry, one second now. It's Exhibit 188.

MR. PIKE:

A. I'm sorry, yes.

ROIL, Q.C.:

Q. Give us a moment to -

MR. PIKE:

A. Getting ahead of myself.

ROIL, Q.C.:

Q. I'll slow you down, if necessary.

MR. PIKE:

A. We'll just talk a little bit about the four.

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In January of 2004, a former Cougar pilot, he actually came in to our industrial benefits folks, was talking about an employment issue and first consideration to Newfoundlanders for employment. While he was in, he identified some concerns he had with safety and as soon as the safety was raised, our industrial benefits folks advised him to come and speak to a safety officer and he did that. So we'll take a look at that one.

ROIL, Q.C.:

Q. So he was in to see the industrial relations people?

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. And they said we would call a safety incident-

MR. PIKE:

A. As soon as he identified a safety issue, stop, let's go to the safety people.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. So the safety part of that took precedence over the industrial benefits piece. The next

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one was in January 2007 and it was an anonymous complaint about weather conditions for flying.

ROIL, Q.C.:

Q. Sorry, is this one of the -

MR. PIKE:

A. I just quickly -

ROIL, Q.C.:

Q. - one of the ones we're going to detail?

MR. PIKE:

A. Yeah, we'll detail this one and I'll just sort of highlight the other four and then we'll come back to this one.

ROIL, Q.C.:

Q. Okay, that's fine.

MR. PIKE:

A. In April 2009 -

ROIL, Q.C.:

Q. Okay, that's page 15, just to give the Registrar a moment to pull that up, just so we can see it, page 15.

MR. PIKE:

A. Oh, okay.

ROIL, Q.C.:

Q. Do it the old-fashioned way. It's not

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responding, is it?

REGISTRAR:

Q. No.

ROIL, Q.C.:

Q. Oh. There we go, okay. So the first one, I think, was a person who visited in person.

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. This one -

MR. PIKE:

A. The second one was a call, which was -- which we'll take a look at in more detail. That was the weather conditions of flying. Then in April 2009, it was an e-mail.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. Received from an offshore worker, and again, we filled out the form in our database, identifying that she did not have -- or they did not have a flight suit that fit. We followed up with the operator in this case. They had identified that they would like us to do that, and -

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ROIL, Q.C.:

Q. That is a post-incident complaint?

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. So when we became -- you may have seen this in some of the JOHS minutes previous, which we thought was being worked by the operator, but when the individual identified a problem to us, we went back to the operator and it was corrected and they were transported with a marine abandonment suit that fit. The last one was simply somebody complaining that the Board hadn't taken a firm enough position with regard to the return to flight.

But if we want to go back now to January, so it's back at the beginning.

ROIL, Q.C.:

Q. January of '04, page one on this exhibit?

MR. PIKE:

A. Yes. This is an older form. We were still in draft with our procedures, so that's -- we were still working with how the form would

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come out. This individual was concerned what he felt the general focus on production over safety. He further felt Cougar might be pushed -- pushing the limits a little bit too much. He did not feel that there was an immediate or significant problem, but the situation needed to be looked at. He also cited two specific examples, an S-61 control problem that was illegally fixed by the pilot and a case where the flights travelling offshore without a standby helicopter.

We did further investigate the S-61 piece and actually checked Transport Canada's website and they did identify that a Cougar pilot was indeed fined for illegally fixing the S-61 and I believe had not actually told Cougar that he had fixed the flight.

ROIL, Q.C.:

Q. But that finding and action by Transport Canada did not come as a result of any action by you?

MR. PIKE:

A. No.

ROIL, Q.C.:

Q. Okay.

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MR. PIKE:

A. No.

ROIL, Q.C.:

Q. Do you know how that -- you know, do you know who reported that? Did he self-report or did Cougar report or do you know?

MR. PIKE:

A. I'm not -

ROIL, Q.C.:

Q. At this point you don't know?

MR. PIKE:

A. I don't know.

ROIL, Q.C.:

Q. Okay, that's fine.

MR. PIKE:

A. We just know that before we looked at it, it had been captured. It had been identified and the individual in question was indeed fined for having done that. There is some detail in what the actual incident -- how the incident played out. This particular complaint also triggered a -- as we note, as I indicated, we did find that there was a -- they fined the pilot in that particular one.

We also did an audit in April of 2004

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that included Cougar. So in this case, this one also triggered, when we were doing an audit of Hibernia in this case, where we were looking at some of their contractors, we chose to look at Cougar. We wouldn't have at this point have told either Cougar or HMDC that we had had this complaint and we went in and did our audit and we were looking for specific things that we saw from this complaint.

ROIL, Q.C.:

Q. So a complaint -

MR. PIKE:

A. We could go to that audit. You'll see that this particular complaint was one of the pieces that they took a look at when they prepared to do that audit.

ROIL, Q.C.:

Q. So I take the message to be that like an incident, a complaint can have a life of its own and be dealt with on its own or it can trigger some activity in an audit or it can actually trigger an audit itself? Is that -

MR. PIKE:

A. It can, yes.

ROIL, Q.C.:

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Q. Okay.

MR. PIKE:

A. And we have here just some of the notes that were taken by the safety officer during the interview with the individual.

ROIL, Q.C.:

Q. So using this old form, is there any way we can tell whether or not the complaint was responded back to the complainant? Is there -- I don't know if there's a place where that -

MR. PIKE:

A. In that form, there is not unfortunately.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. But I believe we did respond back. The note here as well, I guess, is that he was looking to get employed back with Cougar. So he did have some concerns, but -

ROIL, Q.C.:

Q. And this was some of the material that the safety officer accumulated?

MR. PIKE:

A. This is the material to the thing and this is actually, I think -- here we go. This is

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actually from Transport Canada's website. It identifies -

ROIL, Q.C.:

Q. The last one down, Atlantic March 27th '03?

MR. PIKE:

A. Correct. On March 27th, a commercial helicopter pilot operating an S-61 noticed on two separate occasions that the collective, which I assume is a piece of equipment on the helicopter, was jamming during the final approach. He did not inform the company before undertaking two more flights with passengers. The pilot was fined for not complying with the procedure specified in the company's operations manual. So yes, it happened, and yes, there was a process and yes, it did get covered. So again, something else that Transport does, they list all the -

ROIL, Q.C.:

Q. Okay. The other one you were going to look at in detail, I think, was January of '07 which is on page 24.

MR. PIKE:

A. Okay.

ROIL, Q.C.:

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Q. Let's just see if we can scan to that before we go there. Okay.

MR. PIKE:

A. Okay. This was in the nature of an anonymous complaint. It was taken by phone. So an individual phoned. I will speculate and say they were waiting for a flight to come home and felt that -- received a call from an offshore worker who did not wish to give his name. However, he did mention that he had been working offshore for some years. He stated that Cougar had not flown yesterday, there was a snowstorm that day, and was attempting flights today and may not be able to fly tomorrow, given the forecast storm. The scan on this one is a little difficult to read, but we'll -- based on the scenario, he had concerns that Cougar may be pressured by the operators to fly in the current conditions, minus one to zero degrees, with what appears to be freezing rain. It was his understanding Cougar did not fly in freezing rain and yet the company was attempting to fly in the current conditions. He and a number of other people were concerned about this and

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therefore decided to call the Board to raise the question with us.

If we go through this, the safety officer took this piece, identified the safety officer -- he did not leave his name, so we had no way of contacting him. We did indicate we would do the investigation and he could call us back. We proceeded then to find out from Cougar exactly what their operating procedures were in these conditions. So again, we received that information back from Cougar. We did a full investigation on this piece or a review, if you will. There were certain questions we wanted as well to answer, vis-a-vis what the conditions were for flight. So we had that information and the individual did not return the call to find out what we had found, but we did go ahead and do that investigation and you can see we collected from Cougar what their operations manual said about flying in icing and snowing conditions. So they have a very clear protocol that is being followed with regard to flying in icing or snow conditions.

ROIL, Q.C.:

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Q. Okay. So I take it the complaint was non-specific? It was a fear that they would fly?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. And what were you looking for? The policy?

MR. PIKE:

A. We wanted to make sure indeed there was a policy.

ROIL, Q.C.:

Q. Um-hm.

MR. PIKE:

A. And that indeed it was being followed, so we confirmed those two pieces before we closed that incident and now we have that information on file as to what that -

ROIL, Q.C.:

Q. Would this -

MR. PIKE:

A. Some idea of what that, those parameters would be.

ROIL, Q.C.:

Q. Would this complaint have triggered any additional activity or was it closed within itself?

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MR. PIKE:
A. It was closed within itself.
ROIL, Q.C.:
Q. These are four complaints, and these, I think you testified earlier, were the only four in relation to helicopter activity. Just to give us an overview or an understanding in context, what would the number be if you were looking at all complaints with respect to workers and the offshore? Is it 4 out of 20 or 4 out of 200?
MR. PIKE:
A. I don't have that number with me unfortunately.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. I was focused on the helicopter piece.
ROIL, Q.C.:
Q. Yeah. Intuitively would it be a much larger number?
MR. PIKE:
A. It is a much larger number.
ROIL, Q.C.:
Q. Yeah.

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MR. PIKE:
A. We don't or hadn't, prior to March 12th, gotten a lot of complaints with regard to helicopter flights. There were other complaints. There have been a number since March the 12th.
ROIL, Q.C.:
Q. Okay. But prior to March 12th, it was not a significant workload investigating complaints about helicopters?
MR. PIKE:
A. No.
ROIL, Q.C.:
Q. Just, yeah, I wanted to know was it four in the total of all were six or was it four and the total of all was much larger.
MR. PIKE:
A. It was a much larger number.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. We can certainly get you that larger number, but I don't have it.
ROIL, Q.C.:
Q. No, and that's fine. I don't think we need

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it. I just needed to know order of magnitude.
MR. PIKE:
A. It was not a significant issue among our complaints piece. It wouldn't have triggered -- you know, we had so many complaints about helicopters, it wouldn't trigger additional action from that regard.
ROIL, Q.C.:
Q. Thank you. Okay, perhaps we'll now move from complaints into the issue of audits, and so we'll go back -- close that out and we'll go back to the PowerPoint and then you can control it.
MR. PIKE:
A. Okay.
ROIL, Q.C.:
Q. And again, I think you have a summary slide and I have some questions to ask once you get to this.
MR. PIKE:
A. Three-step process, the pre-audit procedures, the audit procedures and then post-audit. The Ocean Ranger Commission report on recommendation 91 talked in terms of safety audits and safety assessments. So it was from

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that report we started looking at safety audits of the management systems. So in 1988, not long after the Board was formed, we engaged the International Loss Control Institute. It was an organization in Georgia that had what they referred to as a safety rating system for safety management systems. So we engaged them to help us develop an audit process for safety management systems. Principally, they designed it for operators, but we were trying to adapt it for a regulator. Take a look at those things.

Over the intervening years, we've adapted to it. It had its limitations. It was based on their management model and not all management models were the same, so it -- you didn't necessarily get an objective view of the thing. So over the years, we've developed it and the current procedure that we use was established in 1999 and we're currently on revision 17. So we're constantly looking at ways to improve this process. Indeed, we also have a draft integrated audit procedure. I think we talked a little bit about that. We were working together with our environmental

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affairs folks to do a more fulsome look at the management system of the operator and we're still working on that process.

We also then identified and developed an inspection procedure. The process is different but very, very similar between the two. So we'll talk about the safety audit process. We started in this process where we -- the safety officers would take ownership of an element within the safety management system and they would go to each installation taking a look at that element. So they were focused audits against a particular element in the safety management system.

ROIL, Q.C.:

Q. By the expression "element" what do you mean? What would an element be, by way of example?

MR. PIKE:

A. Some of the hazard pieces like, you know, they may focus on the control of work system, the job safety analysis parts of those. So the control of work piece and a number of those would be covered under one element.

ROIL, Q.C.:

Q. Okay.

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MR. PIKE:

A. So the safety officer would be going to each of the installations looking at their control of work system.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. The idea being that with -- once you get all the elements, you get the complete picture. We were finding that we weren't -- as I identified back in October, we weren't completing it. What we now do is assign the safety officer to an installation or an authorization. That does a couple of things for us. They have a better appreciation of what's going on on that installation. The other thing that's happened, and it's a positive piece, is there's a rapport built with the workforce. So the workers are much more prone now to call the safety officer if they have an issue because they know who the individual is and they know how to get a hold of them. So we do get now, with this system, workers phoning the safety officer saying "did you know" and there's a dialogue that has

Page 71

developed with the workers on those installations.

The second piece we do is we don't leave a safety officer there indefinitely. We do move them around to different installations. You don't want to become too familiar, as it were.

ROIL, Q.C.:

Q. So familiarity is a benefit until it becomes over familiar?

MR. PIKE:

A. That's correct. So there's a balancing act to be done in there.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. And we do develop an annual audit plan and I think if we take a look at Exhibit 206, we can take a look at a clean version of an audit plan. As with any plan, at the beginning of the year, and our year runs April 1st to March 31st, we would develop a plan as to how and what we would audit.

ROIL, Q.C.:

Q. So is this the plan or is this the reality and

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is there any relationship between them? Do they -- do plans change much?

MR. PIKE:

A. Plans change.

ROIL, Q.C.:

Q. Yeah.

MR. PIKE:

A. At the beginning of the year, you'll notice there's quite a number of geophysical programs in here. We are guessing as to how many geophysical programs are going to take place. We try to identify when they're going to take place so we can get resources available to take a look and do the safety assessment and indeed if it's required, a pre-audit of that piece. So we need to put those in. Is there a construction activity? We see in here a diving program. So that would require a safety assessment as well, usually done during the summer months when the weather conditions are conducive to that. And in between these pieces, we'll try to fit in the regular visits we have to the production facilities. So it's a way of balancing our workload and as we indicated, it is a plan. So things change and

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some audits get moved or inspections get moved. But this is an indication of between -- I think it goes from April 2007 up until October 2009 of the type audits that we did in that period.

ROIL, Q.C.:

Q. So yeah, these are safety assessments I think is the heading of it.

MR. PIKE:

A. Yes, safety assessments, I'm sorry, and there's a second page -

ROIL, Q.C.:

Q. Are they pre -- sorry, just go back. Try to remember our jargon.

MR. PIKE:

A. Yeah, sorry.

ROIL, Q.C.:

Q. Is a safety assessment performed before an activity takes place?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. This would be the activity -- that's the

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operation we would be doing when we have an application for an authorization.

ROIL, Q.C.:

Q. So if I can corrupt the language and internal auditors will kill me, is this like an audit of the plan or the approach?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. An audit of the paper trail, if you will?

MR. PIKE:

A. Yeah.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. That's the application.

ROIL, Q.C.:

Q. Yeah.

MR. PIKE:

A. They made an application and this is the audit, if you will, of the application.

ROIL, Q.C.:

Q. Right, okay.

MR. PIKE:

A. Sometimes in these, we would also have an

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actual on board audit associated with it and so in certain cases, for a geophysical program, we actually may go on board before as part of the safety assessment.

ROIL, Q.C.:

Q. If the vessel -

MR. PIKE:

A. Just to complicate things.

ROIL, Q.C.:

Q. If the vessel or vehicle is not in Newfoundland, do you actually send people to other parts of the world?

MR. PIKE:

A. We have. We would tend to do that more for say a diving support vessel. We would want to look at those and indeed we encourage to take a look at those and we usually do that some months in advance, just in case we identify something that needs to be corrected. It'll give them time to correct it before it arrives here. Instead of having one of these vessels tied up down in the harbour while they make the correction, they can do it in the intervening period. So we will sometimes take a look at these vessels some months in

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advance, more particularly with things like diving programs, you know. There's a fair level of hazard associated with diving operations and we want to make sure we get those right.

ROIL, Q.C.:

Q. Okay. So this page is the safety assessments. I think, do we have another -

MR. PIKE:

A. And that would be an indication of the number of applications that we have for authorization. The next page -

ROIL, Q.C.:

Q. The font is getting smaller, but I think it says audits and inspections.

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. And again, that goes from the April 2007 up to October 2009.

ROIL, Q.C.:

Q. Now what resources do you have available to you to carry out this work? Who are the

Page 77

personnel and what resources do they have to carry on these safety assessments, audits and inspections?

MR. PIKE:

A. We have a number of safety officers. We currently have four safety officers and a senior safety advisor. We have a well operations engineer who was one of our safety officers. We had some personnel changes in the fall. Our previous senior drilling engineer became the manager industrial benefits, which left a vacancy and one of our safety officers was moved into the well operations engineer piece, which left us with two vacancies for safety officers. We are currently recruiting for those. We've hired one. He started on Monday and we are still recruiting for a second position.

ROIL, Q.C.:

Q. Do you have a lot of turnover of your safety officers or do they tend to stay for a relatively long period of time?

MR. PIKE:

A. My department have -- they tend to stay for a longer period of time. There is some

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turnover, but not a high turnover.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. Luckily.

ROIL, Q.C.:

Q. And what sort of -- I think we talked about this before, but I'll focus the discussion. What sort of skill sets and backgrounds do these people have, not individuals, but generally what kind of backgrounds do they have when they come to you as a safety officer?

MR. PIKE:

A. All of them have post-secondary degrees. Some of them have graduate degrees. There are -- I'm trying to remember. A number of us are professional engineers as well. All the safety officers are registered, Canadian registered safety professionals, so CRSP designation and they've done extensive training. Normally when we hire a safety officer, it takes us a full year to fully implement a training program and to bring them up to be fully recognized as a safety officer.

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ROIL, Q.C.:

Q. Is there another industry that you can steal from to get resources or do you have to tend to train them a bit from within?

MR. PIKE:

A. The quickest we've ever done in the training of a safety officer was the secondee we had from Labour Canada, and I think that was a matter of months, given the skill set that he came in with. We had to reacquaint him with the industry. It had been some time since he worked in the industry, so it was the technical side that we were working with him on that, but he brought the skill sets from the regulator. He already had those. If we hire an individual from the industry, he has the technical skill sets, but he doesn't have the regulatory skill sets. So it'll take us some time to invest in training on the regulatory skill sets. So again, ordinarily it'll take us a year to complete at least the entry level training for a safety officer.

ROIL, Q.C.:

Q. Okay now, just before we go to break, to focus it down a little more on the areas that we

Page 80

have immediate concern for. What skill sets do they have or in your view are necessary or what resources do they have available to them to assist them in aviation type audits, in fact audits and inspections of processes and workplaces that are dealing with flying helicopters?

MR. PIKE:

A. Well, the engineers have a technical background, so they understand some of these elements, but they're not aviation people. We have, on a regular basis, I'll talk to that, communications with Transport Canada Aviation in Moncton. Indeed, when we were doing the work refusals, we had extensive discussions with the aviation specialist with Transport Canada in Moncton. In addition to that, during that period, we also had discussions with the Transportation Safety Board to identify -- you know, we gave them an -- told them what we were dealing with and what elements were there. We went to some of our international colleagues and attempted to get some additional information there. So they were assembling it from different sources. We

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don't actually possess the technical piece, but we talked to the technical experts and they have been very forthcoming.

ROIL, Q.C.:

Q. If you look at a safety plan or a safety -- an operations manual or a safety management system, does the fact that it is an aviation piece, as opposed to some other industrial piece, does that change things entirely or are there similarities in the approach?

MR. PIKE:

A. Similarities in the approach. We would use -- our focus when we look at some of the helicopter operations would be the helideck. There are some standards that we look at. If there are any questions, more detailed questions that we have or something doesn't quite look right, we'll have discussions then with Transport Canada Aviation. We'll say "we've seen this. Is this right? What are we looking for?" They've been looking now -- most of the safety officers, a number of them have been there since the beginning of the Board, have seen a number of helidecks so they understand those elements. We've also

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attended the helicopter landing officer training courses out at the Marine Institute. So they have some familiarity with it and when they start seeing things that don't look quite right and they want additional information, we will contact the experts at Transport Canada.

ROIL, Q.C.:

Q. And is it clear to them that they have the authority to do that, to go wherever they need?

MR. PIKE:

A. Yes, no question.

ROIL, Q.C.:

Q. Okay. This might be a good place, Commissioner, to take our morning break. Thank you.

(BREAK)

MR. PIKE:

A. If we could take a moment, Mr. Roil, I got some information for you during the break on the number of complaints. We get an average of seven to eight complaints per year. In 2006, we had 13. 2007, we had nine. 2008, we had three. 2009, we had 11 and so far we've had one this year.

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ROIL, Q.C.:

Q. And in terms of that total number, we have four or five overall?

MR. PIKE:

A. For helicopter operations?

ROIL, Q.C.:

Q. For helicopter operations.

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. Okay, that's useful. Thank you. Okay, I think we can go back to the PowerPoint now and to the audits slides and you can take us through, as we discussed, we'll go back and look at a couple of audits in some degree of detail, not intense, but you can take us through the explanation of the audit processes first.

MR. PIKE:

A. Pre-audit process procedure set the focus and scope of the audit. Obviously in earlier days when we had a focused piece, this became more relevant, but it kicks in also from our audit plan as to what it is we're going to be looking at. Is it an inspection? Is it a

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full-blown audit? Is it a focus piece? Sometimes we'll go out and take a look at the lifting operations. That's another one of the projects that the International Regulators Forum has engaged in. They identified internationally that there were problems associated with the lifting operations. So that's moving -- logistically moving cargo off the supply boats onto the installations and the operation of the cranes. So we've done some of those focused audits in that regard.

ROIL, Q.C.:

Q. So an audit can be an audit of the entire operation or a segmental piece?

MR. PIKE:

A. Yes, or down to just the inspection, and inspections tend to be more of a follow up. There's been a previous audit. There's some open observations we want to take a look at it. It's opportunity to sit down with the Joint Occupational Health and Safety committee and to see what's going on. So the inspections are a much narrower piece usually. So in that process, they know what it is they're looking for. They'll sit down and

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start collecting some of the information and reviewing it.

The safety assessment of the authorization, we'll take a look at that as we look at a more detailed piece or certainly in some of the audits we supplied. You will see in there the safety assessment process is looked at. It helps us also to quickly identify where those specific elements are covered by the operator, what manual or document they've used to cover those elements and where we would go to look for it.

The previous safety audit file. So we would take a look at the file or more particularly these days, the database, to see what was happening previously.

We would look at the daily reports. We'll talk a little bit more about those a bit later. So to see what the current operational activities are. So what's going on? What equipment is shut down? What equipment is operating? In the case of a drilling operation, where are they in the well? What type activities are taking place? That might also help us frame the focus of the audit as

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to what's happening on board.

We have the regulatory equivalencies. We talked a little bit about those back in October. There may be some conditions associated with those equivalencies where the operator has come in to make an application to use a procedure or a standard other than the one that's listed in the regulation. There may be certain conditions associated with that. So we'll follow up on those conditions to see if they're being followed up.

COMMISSIONER:

Q. So you always monitor what's going on then on the platforms?

MR. PIKE:

A. Yes, through the daily reports.

COMMISSIONER:

Q. Yes.

MR. PIKE:

A. I won't say we do it every day, but regularly the safety officer assigned to that installation will take a look at the daily reports.

ROIL, Q.C.:

Q. And later in the presentation, Commissioner,

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we'll deal with a little more detail on what is involved there.

COMMISSIONER:

Q. Okay.

MR. PIKE:

A. Yeah. The certificate of fitness, we've talked a little bit about that previously as well. Certificate of fitness may have limitations associated with it.

ROIL, Q.C.:

Q. That's the one issued by the certifying authority, like Lloyd's Register?

MR. PIKE:

A. The independent third party verification.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. They may have certain limitations associated with that certificate. So we'll take a look at those limitations and we'll frequently have some discussion with the certifying authority as to what the status is there. And sometimes what we're doing as well in there is actually verifying what the certifying authority is doing. So again, we're following up on the

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activities of the certifying authority. So sometimes it's associated with the operator. Sometimes it's associated with what the third party verifier is doing, verifying the verifier, if you will.

The incident notifications. We've gone through incidents, so we will take a look at those associated with the installation and if there's any follow up to be done in those reports.

ROIL, Q.C.:

Q. And what about the complaints?

MR. PIKE:

A. Complaints would be looked at as well, correct. The monthly statistical report, that's the occupational safety type issues, the lost times, et cetera. Monthly the operator -- we'll talk actually about those a little bit later. We'll take a look at that to see if there's some trends in there that we need to take a look at.

We'll take a look at the joint occupational health and safety committee minutes. Is there some items in there that, you know, seem to have been on there for a

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long time or, you know, is there something going on there? So we'll take a look at those as well.

And any conditions of the approval or the authorization, we'll take a look at those and there may be some things we need to follow up. So we may do all or part of that, but that's part of the background piece that the safety officer will do as they prepare for that audit.

ROIL, Q.C.:

Q. And so the dedicated safety officer to this audit will actually go through this kind of process?

MR. PIKE:

A. Yes, and normally these days, we actually use two safety officers for the audit. When we first started, in the audit we have here from 1999, it would have been a single safety officer. Talk about it here or later on in the process. What we did then was sent out a single safety officer. They prepared a non-compliance report, the table that we'll see, and they prepared it before they left. In hindsight, that was probably a bit much to ask

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of an individual on a single trip, so what they do now is we usually send out two, if it's a safety audit, and while they'll give a preliminary report on some of the observations they've seen on board before they leave, they actually prepare the report when they return to the beach, and we'll talk a little bit more about that.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. So they'll develop some checklists, and again, checklist is a tool. It's not the -- it's more a prompt for the safety officer to make sure they cover off all the elements, as opposed to tick the box and everything is right. It's really a prompt about the things that they need to be looking at. So they take those checklists for the relevant legislation and the guidance from the operator's own policies and procedures, what they've committed to do, and we do have a database, another database, not surprising, of questions. So they can pull from a rather extensive database of questions to ask for

Page 91

particular elements.

Review the outstanding items from the previous audit with the initiating safety officer. Again, this is a legacy from the time when we were doing it by element. Although sometimes if that safety officer wasn't the one that was on the last time, they will talk to them. So it's to make sure they understood what the observations were that were being carried forward that they need to look at. So they would talk to the safety officer who had done it previously.

We would then notify the operator and make arrangements for the audit. So generally we would notify the safety officer some two weeks in advance and then work out what the logistics are for getting offshore.

ROIL, Q.C.:

Q. What about the wisdom or ability of a snap audit, of an unannounced audit? Is that something that you can do in the world that you work in?

MR. PIKE:

A. It's virtually impossible in the offshore area. Even if we had our own helicopters, as

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soon as we show up at the heliport somebody knows we're going out and they'll know -- they'll have an hour and a half warning anyway. So what we've tended to do is do more extensive audits, dig deeper and look for the things that you can't simply -- we lift up the rug, as it were.

ROIL, Q.C.:

Q. Not suggesting that anybody would sweep dust under the rug, but you're saying if they do -

MR. PIKE:

A. If you dig deep enough in your audits, then you're looking for those things and that's the process we've taken. We have not actually shared our annual audit plan with the operators. We would generally -- they would generally know that we would be looking at their facility once sometime during the quarter and we would give them advance notice to the make the logistical arrangements for that.

COMMISSIONER:

Q. This may not be a fair question, and tell me if it isn't, but the standard of -- I mean, we've heard of lots of audits of all kinds, of

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Cougar, of the rigs, a lot of audits. In your view, are the standards high of these audits that various entities conduct or would you know anything about that?

MR. PIKE:

A. As with any audits, there's varying qualities of those. It depends on what the purpose and the scope of the audit is. So they vary. Some of them have been good, but it depends on what it is you're seeking to do. It's the goal of that audit that really needs to be clearly articulated.

COMMISSIONER:

Q. I see, yes, yes.

MR. PIKE:

A. So in most cases, they meet the goal, but whether the goal is high enough is the question probably to be asked. We've certainly -- with regard to Cougar, we've been impressed with the audits we've seen that have taken place of Cougar from the operators and from others, if that answers your question.

COMMISSIONER:

Q. Thank you.

MR. PIKE:

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A. They're fairly extensive and I think in some of our safety audits, you'll see that we actually took a look at some of the checklists that are used by the operators when they go and take a look at Cougar's operations, and they're fairly extensive.

We would identify that -- there's opening and closing meetings and we would identify that we would like to see the OIM, the person in charge offshore and the senior operator representative. Those are busy people offshore and we want to make sure that they're present during our opening and closing meetings, and we would also ask that a worker representative from the Joint Occupational Health and Safety Committee be present at those meetings as well. So we identify those parameters upfront before we arrive offshore.

ROIL, Q.C.:

Q. Okay. Do you have any evidence, anecdotal or otherwise, as to the amount of participation? Do generally the worker representatives get engaged with this process?

MR. PIKE:

A. Yes, they do. I'm not aware of an opening

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meeting that hasn't taken place without a worker representative present. That said, in the offshore. The onshore component is a little more difficult, but offshore, no opening meeting has taken place without a worker representative present.

So the audit procedure. Once we arrive offshore, we would hold an opening meeting. So we would explain the focus and the timing of the audit, finalize the agenda. We would have established an agenda. We may have shared it with the operator beforehand, again to try to line up some of the people we may want to see. It's a very busy operation offshore and you don't want to be too disruptive when you're out there, so we give them some advance warning as to some of the people we may want to see. So we line up and make sure we've got that done. We do make an offer to the worker representative, an opportunity to observe the audit, if they so choose.

ROIL, Q.C.:

Q. And again, do you know anything about the take up on that? Is that something that you have

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seen or heard reported?

MR. PIKE:

A. No, they have not. It's -- the other thing offshore, it's like any small community. Everybody knows what that stranger on board is doing anyway. So they have a very good idea of where we are, what we're doing and they can certainly approach us at any time during that period or at some point.

ROIL, Q.C.:

Q. So a safety officer from the C-NLOPB is a known commodity when he or she is doing an audit?

MR. PIKE:

A. Anybody new offshore is recognized as somebody new, but yes, we are known. And more recently, we have -- our offshore clothing has actually identified us as C-NLOPB as well. So we'll discuss the closure of items from the previous audit. So we'll review some of the items that were opened and how they've closed them and that we'll be taking a look at those. We'll offer to meet with the full Joint Occupational Health and Safety Committee and we also arrange a private meeting with the

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worker representatives of the Joint Occupational Health and Safety Committee, and again, that's always taken place for each of the audits and inspections that we do offshore, and then we will schedule the closing meeting.

ROIL, Q.C.:

Q. I don't know if this is the right place to ask, but is there any period of time that it takes to do an audit or does the time tie to the size of the mandate? Are we talking an audit takes a day or a week or a month, or the inspection, this offshore inspection process?

MR. PIKE:

A. When we're doing a fully integrated audit, actually four officers go offshore, so we can cover a fair amount of ground in a three to four-day period. So one of those audits would probably last three to four days offshore.

ROIL, Q.C.:

Q. Um-hm.

MR. PIKE:

A. A more focused audit may take us two days offshore. An inspection might be a day or two. So depending on how much material they

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have to review will dictate how long we stay offshore. But generally it'll be two days.

So one of the things we do when we're offshore is verify the completion items from the previous audit. You'll see as we go through and look at some of the detailed audits, the audit -- the operator may consider an item closed but we won't close it sometimes until we actually go offshore and verify it. So they will have done their work. We'll go out and just verify that what they've said they've done, they've actually done. So that's what's happening in this phase. And any of the items that are not closed will be brought forward in the current audit. So that way we're able to close the previous audit and we carry that observation forward.

We meet with the medical advisor or the platform nurse. I was corrected at that at one of our annual JOHS sessions. Indeed that individual said that they had some information that would be valuable to us and since that time, we've actually made a point of meeting with the platform nurse to talk about the occupational health issues. The occupational

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health is frequently one of the forgotten things in the occupational health and safety system. So that's an opportunity to have that discussion with the platform nurse as to the health issues that are going on on the installation. So we make a point of meeting with the platform nurse.

Then we would conduct the audit against the agenda and the checklist. So we would go through and we would have identified that, when we were going to visit, where and that would be followed through.

All non-conformances are to be documented and we have -- currently we have a two-part system. An observation is an objective statement of the fact and the finding would be more of a conclusion. We're actually reviewing that piece to see if we can do -- maybe break it down a little bit more. The statement of fact might be if we're looking at the control of work system, for example, and we go out, we take a look at some of the permits that have been issued as part of the control of work system. We note that the signatures aren't complete or they didn't, you

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know, fill in the job safety analysis. That would be an observation. If we've gone through and seen that there are numerous ones in numerous permits, that could be a finding to say that you've got a problem with your permit to work system. If we look at a number of permits and see a number of issues raising is the permit to work system actually working well.

ROIL, Q.C.:

Q. Okay. So a series of observations could give rise to a finding?

MR. PIKE:

A. Correct, or you may have a finding in and of itself. If we come across something that is significant enough that this is a problem, we'll raise it as a finding in and of itself. But for the most -

ROIL, Q.C.:

Q. So a single event can trigger a finding?

MR. PIKE:

A. It can. But for the most case, it's usually a series of observations will lead you to a conclusion about whether something is functioning or not. So if we go out, and

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let's say in one of those permits, we'll looking a job site and we have a problem with a confined space entry and they aren't following the full procedure, that could be a finding in and of itself or it may actually result in an order to stop what you're doing. We'll talk about the enforcement provisions further on or if we're looking at a scaffolding operation and we have a certain concern with how it's going on, there could be a finding related to it or a stop order issued. And then we would hold a closing meeting where the OIM is present, again the senior operator representative. Some of the installations, that's one and the same person. In others, where you have a drilling unit, the OIM is more than likely the drilling contractor's employee, and we would have a senior operator representative. Again, the worker representative would be present and we would review -- currently we would review some of the observations we've seen in a more draft way, sort of a preliminary piece without coming to some of the conclusions.

But in earlier days, we would have

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presented the table of non-compliances -- would have been presented at that time and would have been signed off by the parties.

ROIL, Q.C.:

Q. Yeah. I think you told us earlier that there was a time when the officer or officers had to do that before they left the facility.

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Now you're saying they have the meeting, but they reserve the sign off until after they get back?

MR. PIKE:

A. After they get back, yeah. And that gets us into the post-audit procedures. Even in the earlier days, we would prepare a report or a memo on what happened. If you look at the one we have here from 1999, the focus there is on the things we saw wrong as opposed to the full scope, but they would do a memo up highlighting some of the areas that were included in the plan. They'd note -- and it was done as an internal memo -- note if any conditions of approval were verified, note on

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the follow up incidents.

Today what we do is we actually produce that summary and it is given to the operator as well and as an attachment to that piece, that non-compliance table is attached to that report. So it's a more complete picture of what it is we've looked at. So they would also note the things that we didn't find anything, any non-compliances with.

ROIL, Q.C.:

Q. Okay. So in the evolving piece of audits, there was a time you'd only notice the -- you'd only record the problems?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. And then what, the ones that weren't problems were assumed to be okay?

MR. PIKE:

A. And if you go back to those, it's a little more difficult to see what the full gamete of what they looked at were because we were really only recording the problems, as it were, as opposed to the full scope of what we were looking at. So today, we're trying to

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give the full scope and then say these are the problem areas we found within that full scope. So it gives you a more complete picture, particularly when you're going back to look at an audit, a previous audit.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. After they've prepared that report, they'll meet with the chief safety officer to discuss the audit. So they'll go through what they saw, what their impressions were and we'll discuss that audit report before it's actually transmitted to the operator. So they'll enter the observations and findings into the audit summary database, again another database. So we keep all our observations and findings in a database and we'll take a look at one of those when it comes up in a moment.

So we now arrange -- and certainly, in earlier days, when they did it before they left, it was in that closing meeting. Now we arrange for a meeting onshore with the operator. Sometimes the offshore will tele-conference in. So in that meeting, we provide

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and review a copy of the safety audit report, including the non-compliance report. So that's the table that appears in it, and so it's provided to the operator. We request that a copy be sent offshore to the OIM and the Joint Occupational Health and Safety Committee.

I will try to attend these meetings, but I don't always get that opportunity. I certainly will attend any meeting that involves a finding. So if we have a finding, I make a special effort to make sure I attend those meetings. Again, we will file the audit and supporting documentation.

Initial and close any items from the previous audit. So that audit non-compliance table will be either -- will be filled out, noted as being closed. We verified it or we're carrying it forward into the next audit. Those notes would appear in the audit file.

ROIL, Q.C.:

Q. So I take it from your evidence, and again, correct me if I'm wrong, that if there's an outstanding item from a previous audit, it gets (tape error) one, if it's not closed?

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MR. PIKE:

A. And that gives us -- afford us an opportunity to close the previous audit and not lose the item.

ROIL, Q.C.:

Q. That's my -- my point is the closure entry of the previous audit is that it is moved to the newer audit?

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. We may have to refer to it later on for the detail, but we carry that item forward. It allows us to close some of those files, so we don't have too many files open.

ROIL, Q.C.:

Q. And would you record in the audit that it was something carried from an earlier audit? In other words -

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. - that it's been outstanding for some time?

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MR. PIKE:

A. Yes, yes. As we go through the table, you'll see that we'll note this is from an audit of such and such a date and this is the observation and the observation number from that audit.

The operator would then respond to those non-compliance items identifying corrective actions and completion dates. That information would also be entered into our database and then we would monitor those corrective actions and completion, and we can take a look at the table, which I think is Exhibit 190.

ROIL, Q.C.:

Q. Okay, Exhibit 190 we'll call up.

MR. PIKE:

A. We were asked to provide the observations that have been raised against helicopter operations.

ROIL, Q.C.:

Q. Okay. So this was the document that you prepared in response to a request from one of the parties arising out of your earlier evidence?

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MR. PIKE:

A. Yeah.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. Okay, yes. That's just a bit of a summary, some of the things we've done. We've tried to break down some of those observations.

ROIL, Q.C.:

Q. I think that paragraph that starts "since 1997" I think is worthy of our focusing on for a moment.

MR. PIKE:

A. Okay. "Since 1997, we've had 178 observations and zero findings having been raised against helicopters, helicopter transport, helicopter operations or helideck and associated equipment. The breakdown of the observations are as follows." So what we've done there is tried to break it out, and again, it becomes part of our classification system in the observations.

Under helicopters, there was one instance noticed where a helicopter -- when helicopters were not fully compliant. That related to the

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use of the -- when they brought in an S-61, it did not have the high back seats. We normally look to have the life rafts deployable externally. S-61s have an internal life raft. In the end, we accepted the notion that the life raft is located next to the exit. Our preference is that the life rafts be located outside. And there was a note there on the auxiliary fuel tank.

ROIL, Q.C.:

Q. Again, I don't want us to go down through all 178 here, but I think this was -

MR. PIKE:

A. And then, we've just broken them down again and where for helicopter transport, there were issues with the public address system. That was the previous system, the entertainment system, I think Cougar referred to it as. There were just -- there were some problems with that system that not everybody could hear the announcements. Some of the orientations, we saw from Cougar's presentation that at the heliport there is the video presentation. Well, on occasions, the video doesn't match if you're using -- if the videos are geared to

Page 110

the Super Puma and we've now introduced an S-61, you might miss it on the first couple. So there's sometimes those pieces need to be updated in those videos.

ROIL, Q.C.:

Q. To accumulate this exhibit that you've prepared for us, was there a particular databank you could go to or did you have to -

MR. PIKE:

A. As I indicated, we enter all our observations and findings into a database and there's some sorting done on that database. We would have tagged those observations against some of these particular items.

ROIL, Q.C.:

Q. But the observations themselves, they come from where?

MR. PIKE:

A. From the audits.

ROIL, Q.C.:

Q. From inspections done by your -

MR. PIKE:

A. From the audits and inspections.

ROIL, Q.C.:

Q. - employees when they're flying to an audit?

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MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Okay, so it's a -

MR. PIKE:

A. From that non-compliance report, that table.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. That will highlight the observation. That observation is entered into a database. So the things that would tag it are when the audit was done, what the focus of the audit was, who the operator was, what the authorization was, and there would be some particular information associated with the installation that it's done against and then we would break down some of the observations into this type category, the helideck or some of those.

ROIL, Q.C.:

Q. So can we take it as a fact that with each of these 178 observations, somebody would have gone forward to see whether or not remedial action was taken? Or I mean, I'm just

Page 112

wondering what happens.

MR. PIKE:

A. Yes. We would verify each of the ones -- through the audit process, we are verifying the closure of these observations.

ROIL, Q.C.:

Q. Okay. So these are all taken from audits or inspections and if we -

MR. PIKE:

A. Yes, some of them would have been closed, have been closed.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. But this is an example of the observations that we'd take.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. And just some statistics on the type of installation, et cetera. These totals and then from this we have identified that part of our audits, we actually did four visits, if you will, or four of our audits involved actually going to Cougar's facilities and it's

Page 113

those four that we've presented to the Inquiry.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. And this is just the table, which is orientated -

ROIL, Q.C.:

Q. Yeah. Unless you wanted to deal with it now, we won't bother to orient it properly. This is a table of what, of all these complaints?

MR. PIKE:

A. Those are the observations.

ROIL, Q.C.:

Q. Sorry, not complaints, all these observations. Okay.

MR. PIKE:

A. I think if we just -

ROIL, Q.C.:

Q. I think we initially indicated to the parties that we would not provide all, but it appeared that in the process of trying to extract some, it was better to provide a summary of everything.

MR. PIKE:

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A. We provided the table of all of them. So I think -- page four, page five. We will actually be looking at I think the May -

ROIL, Q.C.:

Q. Rotate view is there if you wanted to try it. Just go up a couple of more. There we go. Had a 50/50 chance of being right. Okay.

MR. PIKE:

A. May, I think we have here the May 14th, 2002. We've identified it as a focused audit on helicopter operations. The operator in this case was Petro-Canada. The facility was Cougar Helicopters.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. This was the observation.

ROIL, Q.C.:

Q. Okay, can you read that for us? Because I don't think we can all perhaps read it, or we're going to have some trouble.

MR. PIKE:

A. Maybe we'll wait until we actually get to the audit, because this is one of the ones we'll pull up.

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ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. And it was related to helidecks and maintenance and I think in this regard, it was related to inspection of the helideck. Petro-Canada, in this case, had identified semi-annual checks and in actual fact, they were only doing annuals, which is the norm here. They had actually gone above the norm by saying they were going to do semi-annual and they indicated that no, were only doing annuals, and they would be done by Cougar. So we've identified that as their documentation, their process didn't match up with what they were doing and that needed to be corrected.

ROIL, Q.C.:

Q. So either had to, what, correct the work or correct the rule?

MR. PIKE:

A. They either had to start doing it semi-annually or they had to change their document to agree with what they were doing, which was the annual, and the annual was an acceptable standard and they indicated that that's what

Page 116

they were going to do. We just said okay, you need to update your documentation.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. And page 16 should have the October 2006.

ROIL, Q.C.:

Q. There, it's the bottom. At the bottom there.

MR. PIKE:

A. Yes, yeah. It's actually Chevron is the operator on this one, and it was helicopter operations (unintelligible) drilling. Chevron was drilling an exploratory well in the Orphan basin with the Eirik Raude. So the installation was the Eirik Raude and we have identified and we'll actually take a look at that audit as well.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. Without trying to read this right now, we'll take a look at it when we actually look at the audit.

ROIL, Q.C.:

Q. Yeah.

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MR. PIKE:
A. The other two -
ROIL, Q.C.:
Q. It'll be in larger font when we see it again, I take it.
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. The other two audits we have is a May 1999 audit. It was an audit of HMDC focused on training, and again, at that time we were doing focused audits. And we would look at what they had done with regard to their contractors and we took a look at how they were monitoring Cougar's training in that piece and it was a three volume audit, so the audit actually had three volumes of material that were reviewed and -
ROIL, Q.C.:
Q. So the exhibit that I have has about a quarter of an inch. I take it that this is not everything that was in the audit?
MR. PIKE:

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A. No, it was not because the audit -- the training audit covered people that were actually working on board the installation and some of their contractors. So it was a full training audit and then one of the components in that piece was to look at their contractors and one of the contractors we chose to look at was Cougar.
ROIL, Q.C.:
Q. Right.
MR. PIKE:
A. We've identified the May 2002 audit. That was a focused audit on helicopter operations and as it turns out, that's only one volume. In April of 2004, this is after we had the complaint, we did an audit of Hibernia and again we didn't identify to Hibernia or Cougar that we'd had a complaint.
ROIL, Q.C.:
Q. Which complaint are we talking about here?
MR. PIKE:
A. That was from the former pilot.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:

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A. We were doing leadership, administration and coordination audit of Hibernia which would include their oversight of their contractors, and as a result of that complaint, one of the contractors we identified was Cougar. That particular audit is a seven-volume set and there are really only two volumes that have any relevance to the helicopter operations. So there's an extensive volume in there that covers a lot of the Cougar procedures and we'll see that -- you could see that in there, but some of those procedures we've actually redacted, but -
ROIL, Q.C.:
Q. That's actually not a -
MR. PIKE:
A. It's not one we're going to actually look at in any detail.
ROIL, Q.C.:
Q. It's not one we're going to look at. No, but -
MR. PIKE:
A. But it's there. It was seven volumes. Two were associated with helicopter operations out of those seven. I did review the full seven

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

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particular incident. That memo would normally have been prepared at the end of the audit, but we've put it upfront as sort of an executive summary, as you will, to highlight -- to give you some sense of flow of the audit. So it was conducted at Cougar's facilities on May the 14th, 2002 by two of the Board's safety officers and we were auditing Petro-Canada's helicopter operations as it interfaces with the helicopter contractor and the audit resulted in one observation and no findings.

ROIL, Q.C.:

Q. Okay. So the one observation is what?

MR. PIKE:

A. We can take a look at that, but that's the one with regard to the semi-annual or the annual inspection of helidecks.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. So it just identify -

ROIL, Q.C.:

Q. So other than that particular observation, there were no other observations or findings?

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MR. PIKE:

A. There were no other observations associated with that. During the audit, we've identified who was present from the operator. There were two incidents that we actually used as background when we did this audit, the December one with the flight suit, and the other one we did was the April 2001 where the engine shutdown on over speed. By this point in time, we actually had the TSB report on that particular incident. There was actually a TSB investigation. So we had that report as well and we would have looked at the recommendations from that report and were verifying whether indeed they were being implemented.

Then a bit of a summary as to what they would have seen from the helicopter operations. We also took a look at -- because Cougar does some training with regard to helicopter landing officers. So we took a look at that component as well. And the movements, MAPS they call it, movement and personnel system. I think we've heard Cougar refer to that as well in their presentation.

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The note in here, Cougar had identified to us some concern with what's referred to as ad hoc workers or contract workers offshore spending three weeks at one installation, coming ashore and going out within a few days to another installation. That was a concern at that time. So we took a look at the MAP system to try to identify instances where that was taking place. So part of this audit was also a bit of an investigation of an issue that had been raised. It had been raised by workers previously, but again, we have to confine ourselves to facts. I mean, we've heard that anecdotally from workers, but I'm a regulator. I have to deal in facts. So we went through the MAP system to try to identify who indeed was doing this and we do follow up in that regard. So that was identified during this piece and there was a follow up with regard to that, and how big an issue we had going with regard to what is referred to as ad hoc workers or contract workers. They would have specific tasks on board for an activity and they would move between installations.

ROIL, Q.C.:

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Q. What was the safety issue with respect to ad hoc workers?

MR. PIKE:

A. Fatigue.

ROIL, Q.C.:

Q. Okay. So the safety angle that you were looking at -

MR. PIKE:

A. We wanted to make sure that, you know, the individuals weren't fatigued when they're doing their work.

ROIL, Q.C.:

Q. Right, okay.

MR. PIKE:

A. And we have occasionally gotten complaints from the contract workers that they feel they're working too much and we've tried to deal with those complaints. So over the years there's been a combination where we've seen it and then we've actually had complaints from workers.

Then the attachment is the audit report. In this case, we're referring to the table that's prepared. We'll take a look at it, the audit schedule, attendance at the opening and

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closing meeting, the checklist that was used as part of this and the follow-up incident reports and the pre-audit correspondence. And we took a look at Petro-Canada's field. The helicopter operations manual was one of the documents from the operator that we would have used as a base for this audit.

ROIL, Q.C.:

Q. Okay. So I think you've told us this really is a document that should naturally fit at the back of the list of documents we have.

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. But you brought it forward -

MR. PIKE:

A. In this case, it gives us a good executive summary of what this audit is doing.

ROIL, Q.C.:

Q. Right, okay.

MR. PIKE:

A. This was the agenda, the schedule that they had developed for review when they were with Cougar, and I think the next one will actually list the opening meeting, who attended. So

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you can see from that, the two safety officers are there. There were representatives from Petro-Canada and quite a number of representatives from Cougar. And in the closing meeting, there weren't quite as many people present, but representatives from Cougar and Petro-Canada and the two safety officers.

ROIL, Q.C.:

Q. Okay. Now if I look at the dates of these, they're both on the same date.

MR. PIKE:

A. That's correct.

ROIL, Q.C.:

Q. Does that mean that this audit was a one-day?

MR. PIKE:

A. It was a one-day audit.

ROIL, Q.C.:

Q. Yeah, okay.

MR. PIKE:

A. What we're looking at now is the checklist that the safety officer would have prepared prior to doing the audit, and here we go. As you can see, the safety officer has done extensive notes on it. So from these notes,

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they would then prepare their non-compliance report.

ROIL, Q.C.:

Q. So this is the actual piece of paper that the -

MR. PIKE:

A. Safety officer would be using -

ROIL, Q.C.:

Q. - the officer takes with them?

MR. PIKE:

A. - as they go through their audit and they would be making their notes on it as to what's happening.

ROIL, Q.C.:

Q. Again, I'm not going to draw your attention or ask you to comment on any one of these things. Again, we're trying to understand what your processes are.

MR. PIKE:

A. And the piece that we've redacted in here are people's names. They would have referred in some cases to individuals and we've just redacted their names. And a discussion of the different -- the training that we've looked at, the MAP system. Transit tanks, those are

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the tanks that are offshore that carry the helifuel. We've heard some mention of those by Cougar and the checks that are made, so we're verifying those. The inspections, again those are the helideck inspections that Cougar would do on behalf of the operator. And then we took a look at some of the maintenance issues associated with the helicopter. Our focus here is less on the actual operational safety of Cougar as opposed to the occupational safety of the passengers.

So we were focusing a little bit more in the areas of the transportation suits and how they were being maintained, although we did take a look at Cougar's maintenance operation. We aren't aviation experts, so it was a -- you know, it was more a high level type review as to what processes they had in place. You know, verifying that they had the HUMS system, the HUMS system is being checked. So we would have done some of those verifications, taken the recommendations out of the TSB report. So the TSB report would be fairly detailed and we would have taken that and looked at it to see that indeed those things were being -

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Just the checklist that Cougar has for the helifuel that's transported offshore. So that's what we're seeing in the next few pages is indeed Cougar does have a process and checklists. I'm not sure we need to actually rotate it.

ROIL, Q.C.:

Q. No, I don't think for that page we need to bother to rotate it. Now we got to go back perhaps because this looks like a familiar document.

MR. PIKE:

A. Yes, we would have looked at this.

ROIL, Q.C.:

Q. One more up, up, there you go.

MR. PIKE:

A. Rotate view. I should have left it to the -- let's go back.

ROIL, Q.C.:

Q. You're going to have to do it twice, no matter what way you go.

MR. PIKE:

A. Yeah. So you recall this was one that we -- it's in actually the package. We didn't actually review it in detail. This is the one

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on the engine. So it was the April 5th 2001. I made reference that it was carried forward. So as part of the documentation package that was reviewed for this audit, the safety officer reviewed this incident and understood what was going on. I think the thing to note is the corrective actions, immediate corrective actions, helicopter landed -- there was some correctives down here with regard to monitoring program and you'll notice what the safety officer has done is checked these as yes, I verified and saw that Cougar was actually doing these things that was recommended as part of this piece. And this is the one with regard to the flight suit, so again they would have had this one.

ROIL, Q.C.:

Q. Okay. So here we have two incidents that find their way into the audit process?

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Yeah.

MR. PIKE:

A. And if there were recommendations or

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corrective actions, the safety officer would verify that those corrective actions have actually taken place.

This is actually the passenger manifest for the flight that -- where the individual wasn't wearing the flight suit. So we checked those out.

These are the training dispensations that were issued. So I think there was some talk of that previously. The requirement is to have the basic training. On occasions, there's a dispensation issued and in this case, we're taking a look at the number of dispensations that have been issued.

ROIL, Q.C.:

Q. These are people who've gotten training elsewhere in the world? Is that the issue?

MR. PIKE:

A. Either that or in some cases, if you're dealing with a Secunda person, they have the marine component, but they don't have the helicopter component possibly. So they may be given -- because it's a one-time trip, they may be given a dispensation, but what we're doing here is checking to make sure that the

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same individual isn't showing up multiple times.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. And if they need a specialist mechanic for a particular item, they may bring him out to do that item and they put other special procedures in place for that individual, but what we're doing here is checking to make sure that individual isn't showing up multiple times.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. And what you're seeing in here, the Secunda piece. What they're obviously doing in here is doing a crew change for that supply boat offshore. So they're transporting the crew and that's what you're tending to see when those things happen. But again, we're seeing that that doesn't happen very often or that they start giving the HUET training to those marine personnel. So we would have reviewed that list. We look for similarities and

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that's a piece that was going on. You see notes that the safety officer has put on that piece.

This is actually an individual and the number of times he's travelled offshore in the previous year say. So what we're trying to identify then, and you can see the notes that the safety officer has taken from the MAP system that's tracking people offshore. They're able to identify an individual and the number of times and when he's travelled onshore or offshore, or she has travelled onshore or offshore. So what we did there was just a little bit of analysis. They've travelled 28 times offshore in the last 12 months, when they arrived, when they departed, how much time between their next piece offshore. So again the norm, and particularly for Petro-Canada, is there's at least seven days between the time you were last offshore and you go offshore again and we're just verifying, in this case, that indeed people aren't travelling offshore before they get their seven days off.

ROIL, Q.C.:

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Q. So travelling 28 times in a one-year period would be a higher than normal number?

MR. PIKE:

A. It would tend to be, yes.

ROIL, Q.C.:

Q. Yes, okay. So now you're looking to see whether or not the person is stressed by overwork? Is that -

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. You've mentioned that in your earlier evidence, okay.

MR. PIKE:

A. Yeah. So that's the piece we were looking at when we looked at that and we were using the MAP system. This is the training for the helideck officers, in this case the instructor is a Cougar employee. We've just redacted the name and the other -- we've identified who the companies are, but these would be the names of individuals who've received that certification. I think Cougar testified that they want to familiarize these people with their machines when it comes to the refuelling

Page 135

operation. So they want to make sure that they're familiar with that. So we're verifying that that training did indeed take place.

And this would be a report on the training of the pilots, and I think from -- we would just review the training of the pilots and I think there's the full gamete. One of the lists would actually include the survival training as well.

COMMISSIONER:

Q. So you do both the training of the pilots and their survival training comes under your -

MR. PIKE:

A. We would verify that that's part of the training regime that would take place.

COMMISSIONER:

Q. Yes, I see.

MR. PIKE:

A. This is probably a -- I'm not getting it right at all this morning.

ROIL, Q.C.:

Q. No, that's okay. We'll let the Registrar -

MR. PIKE:

A. I'll let the Registrar do it.

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ROIL, Q.C.:

Q. Yeah.

MR. PIKE:

A. She seems to be much more adept at it.

ROIL, Q.C.:

Q. Just more familiar. We can all learn it if we do it a few times, but I wouldn't even attempt it. There you go.

MR. PIKE:

A. Again, this would be the pilots and, you know, some of the specialized training. I'm not sure if this -- BST, I believe is this one. So indeed, we've verified that they do indeed get that training or that would have been one of the processes we would have done. And I think -- I'm not sure if it's this one or another one. We would have identified a medical -- one of the medicals was outstanding and as it turns out, it was a database problem. The pilot actually had an invalid -- or had a valid medical. It just hadn't been entered in the database in one of our audits.

This is just an excerpt from Cougar's manual. Talks about -- and I think we've talked about cargo in the passenger

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compartment. That's not occurring currently with the S-92s. They aren't configured to carry cargo in the passenger compartment but the Super Pumas could carry cargo and on the rare occasions, they did carry some cargo in the passenger compartment.

ROIL, Q.C.:

Q. I think for the Commissioner to understand, this was a much bigger document that I decided rather than cut down trees, we simply show the front page to show the document they went through -

MR. PIKE:

A. Basically we're showing the -

ROIL, Q.C.:

Q. - went to rather than to attempt to put in the whole document and try to analyze.

MR. PIKE:

A. This has been a question raised. We verified that there was indeed a process in place as to how they would do these things to make sure that this cargo was not impeding any of the egress routes and exactly that they fastened it down appropriately, et cetera. So we were checking Cougar's procedures to ensure that,

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number one, it was rare, but when they did do it, they had proper process in place for doing it. So that's what we were verifying in this case.

And this is some of the correspondence before we did the audit. So just identifying when we want to do it. So in this case, the audit took place on the 14th. We identified to the operator on the 3rd of May that we wanted to do that audit, and this is just some of the correspondence as to how we set the audit up and what we wanted and didn't.

ROIL, Q.C.:

Q. Right, I don't think we need to spend any time on that.

MR. PIKE:

A. No, and again some more of the correspondence before we went. They actually changed out one of the safety officers from the original. What we've done here as part of our review, helicopter landing officer training piece, and this is from the joint contractor. In this case, it would be the Henry Goodrich. So they have identified who has the training and when they completed it. It identified who will be

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doing some additional work and some of the people that they have actually trained as helideck officers, and you'll notice, as was talked about before, it's not uncommon that they helideck landing officer is the crane operator.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. That makes sure that the crane is not in motion while the helicopter is landing. He can't be two places at once, and again we're tracking the training of the helicopter landing officers and this is just some of the correspondence. After the audit, we would have written -- this is the letter transmitting that table of non-compliances, or as we referred to it at that time, the audit report. In this case, the senior safety officer signed it. The norm particularly now would be for the safety officer who actually does the audit to sign the transmittal.

ROIL, Q.C.:

Q. So this is transmitting his findings to the operator?

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MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. To the operator.

MR. PIKE:

A. And we'll see here this is the actual -- I'll leave it to the Registrar. It may take me a while, but I do learn. There we go. You'll see in this case, in actual fact this one contains the operator's response, but we would have identified, you know, that Petro-Canada Helicopter Operations Manual states that Cougar Helicopters inspector will inspect the heli-fuel facility, the helideck on a semi annual basis. It was noted these inspections are being conducted on an annual basis, statement of fact, it's an observation. It's not that we're saying one or the other is better. The norm is for an annual. This was -- and they've written back saying was an oversight in the rewrite of their manual last year, the operations manual will be amended to reflect the current practice, which is one helideck inspection per year.

ROIL, Q.C.:

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Q. And I think your earlier evidence indicated that if there's similar things to be done today, it would be much longer than a one page audit report.
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. It would have all the different things.
MR. PIKE:
A. You would tend to see that summary report that we saw at the beginning.
ROIL, Q.C.:
Q. Yes.
MR. PIKE:
A. That would show up as well, and this would be attached to it.
ROIL, Q.C.:
Q. Okay, and we'll perhaps see that in another example.
MR. PIKE:
A. I'm not sure we've actually -- that's more in the last few years. Even the 2006 one we didn't actually transmit the memo.
ROIL, Q.C.:
Q. Okay.

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MR. PIKE:
A. That's only something we've been doing in the last number of years, and again you're just seeing some of the correspondence back and forth where we would have transmitted electronically that audit report to the operator.
ROIL, Q.C.:
Q. So when the operator says --
MR. PIKE:
A. A couple days later we would have submitted the electronic, so that then affords the operator the opportunity to actually enter within an electronic one their response to our audit observation.
ROIL, Q.C.:
Q. So this response, which was back on page 41, and you don't need to go back there, where the operator said our operations manual will be amended, do you close your audit then?
MR. PIKE:
A. No.
ROIL, Q.C.:
Q. Okay. Well, take us forward to how and when that gets closed?

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

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

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take any other audit and go through with this amount of detail, but just so that we all understand what it is you do and how you do it, I think we need to take this one a little bit more detail.

MR. PIKE:

A. I don't feel as bad any more. What you're seeing there, this is the one that we had identified. This is the audit we're going through right now is the May 14th, 2002. There had been an audit done in April of 2002 on the Henry Goodrich and we'd identified some issues with the Helicopter Operations Manual there. So again we were following through with those and they aren't closed until we actually see the updated manual.

ROIL, Q.C.:

Q. Okay, so again tying back to your earlier evidence, so this is where items that were in an earlier audit that were unclosed are now becoming part of this audit?

MR. PIKE:

A. Correct.

ROIL, Q.C.:

Q. Okay.

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MR. PIKE:

A. And we have that database and we're tracking the open observations, and this is just a list of the observations.

ROIL, Q.C.:

Q. Again those redacted out have nothing to do with helicopter operations.

MR. PIKE:

A. In December of '02, this one has to do with the sampling line on the heli-fuel system. We identified an observation, "the connecting line has been installed from the heli-fuel sampling canister to the drain line on the heli-fuel dispensing cabinet. The current arrangement does not provide for the drainage potential of leaks for the filters". So we're just identifying an observation in that regard.

ROIL, Q.C.:

Q. Uh-hm.

MR. PIKE:

A. Again more correspondence. We don't need to rotate that one, I don't think, and identifying the observations in which -- and the one that we're looking at is this

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observation from May 14th on the procedure. So we're following it, and again this is July of 2003, and then just the correspondence back and forth until we actually get the --

ROIL, Q.C.:

Q. Page 72, I think, is where --

MR. PIKE:

A. Okay.

ROIL, Q.C.:

Q. Perhaps we'll reorient the page when we get there. I guess that we should do that counterclockwise.

MR. PIKE:

A. Okay. So again they will be responding to some of our observations.

ROIL, Q.C.:

Q. And again the redacted ones have nothing to do with helicopters.

MR. PIKE:

A. Nothing to do with helicopter operations, and what they've done with this particular letter is attached the relevant sections of their revised Helicopter Operations Manual. Now that we've actually seen the revised manual, we can close this observation.

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ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. And this is just -- we did indeed get a copy of this document. It was signed off, August, 2003, so we did get a copy of it. This is the Table of Contents from that manual, and indeed the section we were looking for was -- we just redacted the document. This would also be attached to the original file.

ROIL, Q.C.:

Q. Just give us a moment to rotate this one clockwise.

MR. PIKE:

A. Okay, you'll note in here, you can just barely make it out, but the safety officer in this case has signed off this observation as closed.

ROIL, Q.C.:

Q. So he's saying I've seen the change that they said they're going to make is complete.

MR. PIKE:

A. She's saying.

ROIL, Q.C.:

Q. Sorry, she said.

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MR. PIKE:
A. So that's now essentially closed that particular audit file.
ROIL, Q.C.:
Q. Right.
MR. PIKE:
A. There could have been an instance where we carried that one forward, but in this case it wasn't, and it was closed in the original file.
ROIL, Q.C.:
Q. Right.
MR. PIKE:
A. The other one we were going to look at was the audit of Chevron's exploratory drilling program, and that's Exhibit 194.
ROIL, Q.C.:
Q. Okay. Give us a moment to get that one up. While that's coming up, do I take it that -- can you tell me that the general process that you've gone through there, obviously with changes as a result of evolution, that that process is still generally the process?
MR. PIKE:
A. Yes.

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

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

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

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were several regulatory equivalencies issues on this rig, so we did some follow-up on those regulatory equivalencies that weren't associated with helicopter operations, so we've redacted those. There were no open incident reports when we were on board, so we didn't -- so we weren't reviewing any of those. We did hold a meeting with the worker representatives of the Joint Occupational Health and Safety Committee. There is a note on those. They didn't raise any issues. No issues were brought forward from that meeting.

ROIL, Q.C.:

Q. Uh-hm.

MR. PIKE:

A. And here's a note on the Cougar -- Chevron Cougar helicopter search and rescue operations audit. As part of the audit, we did the onshore portion targeting the search and rescue operations. That's conducted on September 28th in Chevron's offices and at Cougar facilities. Key points of interest reveal Chevron retains a standby helicopter dedicated to search and rescue on a 24 hour basis by means of contractual arrangement for

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access to -- a SAR compliant helicopter is always available. Four out of the six helicopters are SAR compliant. Of those four, one is always within 30 minutes. At this time, the 30 minute piece still allowed them the one hour wheels up.

ROIL, Q.C.:

Q. Okay, and what equipment were they operating at that time?

MR. PIKE:

A. There was a combination -- I think in this case the S-61 was there, but it was not SAR compliant.

ROIL, Q.C.:

Q. It speaks of six Cougar helicopters, yet we know there's only four there now, so -- would that tell you anything about what the airframe might have been?

MR. PIKE:

A. I think in 2006 we were also in the transition phase between the S-92s and the Super Pumas.

ROIL, Q.C.:

Q. Uh-hm.

MR. PIKE:

A. So some of those would have been Super Pumas.

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The S-92 would have been operating at that time as well, and there was the S-61 brought in for some of those operations as well, I believe. Again this summarized --

ROIL, Q.C.:

Q. The detail of their findings.

MR. PIKE:

A. The detail of their findings and what they observed. So again what we're getting here is a more fulsome description of what it was they observed. If you looked at the earlier audit, all we were really nothing were the deficiencies. In this case, they're telling the more fulsome story that this is some of the things and the notes we took from that particular audit. So it gives us a more complete picture.

ROIL, Q.C.:

Q. And perhaps would you just go down to the very last paragraphs, again the overall findings?

MR. PIKE:

A. We identified no issues that would lead to a finding or observation for this component of the audit. We gained a positive impression about how Cougar conducts its activities with

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respect to search and rescue operations, and cooperation and coordination between Chevron and Cougar for the Eirik Raude drilling project. Again we had two safety officers on that one. This would have been the noncompliance report, the table that would have been shared with the operator at that time.

ROIL, Q.C.:

Q. Again I don't think that we need to or want to take the time to go through this one in the same way that we did with the other one.

MR. PIKE:

A. The only issue that we had there was with regard to use of the flight suits. At this time for this program they were actually using the Helly Hansen suits, where the norm for the other operators would have been the Mustang suits. These Helly Hansen suits, I believe, had dual approval. We verified that with Transport Canada, and you'll see further that we actually had correspondence with Transport Canada Marine Safety folks to verify that these suits did indeed have immersion suit certification. So we were following up on the

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notion of the 200 percent marine abandonment suits. They were using some of the heli suits as part of fulfilling that requirement on marine abandonment suits. In that case, we were following up to verify that they indeed did have 200 percent marine abandonment suits. In this case, they were using the helicopter suits as part of that, and we verified that they did indeed have the marine abandonment certification.

ROIL, Q.C.:

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

MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

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

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

ROIL, Q.C.:

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

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. Yeah.

MR. PIKE:

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

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

ROIL, Q.C.:

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

MR. PIKE:

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

ROIL, Q.C.:

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

MR. PIKE:

A. They would have, yes.

ROIL, Q.C.:

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

MR. PIKE:

A. Yes.

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ROIL, Q.C.:

Q. Is this just today or --

MR. PIKE:

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

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

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

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

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A. And it was the same day meeting, and in this case they didn't actually log the closing meeting. They would have talked to Cougar before they left in the closing meeting. This would have been the checklist, as it were, that they would have used when they went to the Cougar facility. So again there's a number of questions that they would have raised, and these are the answers that they --

ROIL, Q.C.:

Q. So these questions are a part of their pre-audit requirements, is it, to develop a list of questions?

MR. PIKE:

A. And I think you asked the question as to what the balance was, and I think it appear at this time there were three Super Pumas, one S-92, which was SAR complaint, one S-92 that was not SAR compliant because it didn't have a wench, and one S-61 that did not have a wench. So that's the breakdown of helicopters that you were asking. There were six there, what were they, and that's where that piece came from, and they would have witnessed them in the hangars as to how they have those arrangements

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and how they have it ready to go. Again just the observations. They would have questions and then they would have the answers. The reserve heli-fuel on board, that's a question we ask to make sure there's sufficient heli-fuel for all their operations, and indeed they sometimes carry a little extra just in case the federal search and rescue folks dropped by on a search and rescue --

ROIL, Q.C.:

Q. We heard some evidence about that, yeah.

MR. PIKE:

A. And they have used the offshore facilities to extend their reach further out into the Atlantic. Again these are just notes that -- this the other safety officer's notes. So both sets of notes are in this file, and then just sort of handwritten notes.

ROIL, Q.C.:

Q. I think page 24 is the one I asked you to stop at as we scanned through.

MR. PIKE:

A. Prior to the Eirik Raude arriving in Newfoundland, one of the employees raised some questions with us. We did indeed answer their

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questions prior to the arrival of the rig, but we used their questions as also a prompt in our audit just to verify that some of the things -- it was a flag, was there a problem, why was the individual asking some of these questions. Some of them were related to differences of operation between here and Norway because the rig had been operating in Norway before it came, and other cases it was just a flag, let's verify what's happening on board to make sure that they are doing as they said they'd do. So we used the questions that he'd raised as part of our audit piece.

ROIL, Q.C.:

Q. So in addition to incidents, complaints, observations, your policies, how do they allow you to track things like a question from an employee, which is clearly not a complaint? How do you -- do you have a database for that kind of stuff?

MR. PIKE:

A. Luckily we're a small office, so we were aware that those questions were raised, and we don't actually have a formal process for it, but we're small enough to know somebody had raised

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the questions, we were preparing the responses, so we were aware that there were questions raised. As safety officer would be - I was aware that these questions had been raised, so when the safety officer was preparing for the audit, I would have made him aware of the fact that there had been questions raised and that we should include those in the audit, or at least verify some of the things in there, just as a -- it's not really a complaint or anything, but let's -- you know, there's some questions been raised, let's answer them, let's make sure that the answers are there. We did answer the questions, but -- just to do some verification. So again this is the questions that were asked by that individual. I believe in actual fact, it was a Newfoundlander working on board the rig while it was in Norway, so --

ROIL, Q.C.:

Q. They had personal knowledge. Perhaps I could ask you to move over to page 52, in the interest of finding some efficiencies here.

MR. PIKE:

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A. Okay.
ROIL, Q.C.:
Q. Because I think there's only a couple places where some of it pops up.
MR. PIKE:
A. And again we're reviewing some of the Cougar documentation. You can see that that's there. So we would have verified -- and some of the training that was taking place with their SAR technicians, we verified that in their records. It was 50 --
MR. PIKE:
A. 52, please.
MR. PIKE:
A. Again some of the correspondence back and forth from the training, Cougar's training plan.
ROIL, Q.C.:
Q. Again we've redacted some detail of that document out, but --
MR. PIKE:
A. We have the entire document, we reviewed it.
ROIL, Q.C.:
Q. In your files you have it, page 52.
MR. PIKE:

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A. Okay.
ROIL, Q.C.:
Q. I see something new happening here. There's a document that I haven't seen in the first one we looked at.
MR. PIKE:
A. The others you saw were (unintelligible), but we were onshore. When the safety officers travel offshore, they try to have a more pocket sized question list, so that this is actually a pocket sized questions that they keep in their pocket. So they prepared this one, and this one is specific to helicopter operations. When they were offshore, they would have had another little pocket one for the drilling operations and another pocket one for the marine operations.
ROIL, Q.C.:
Q. So this what, just enables them to carry it in their coveralls?
MR. PIKE:
A. Carry it while they're out in the field.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:

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

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he was doing his audit. So this was actually attached in that booklet, folded up in the back, so that he had some verification. Just a note on what the standards were that they used and we've heard some of those before, the UK Civil Aviation Authority, CAPP 437, and the Transport Canada.
ROIL, Q.C.:
Q. And we've redacted a significant amount of that out because it's proprietary to that particular facility.
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. Again Minutes of -- you've established that, so I want to keep going. I'm going to push you a little bit to get --
MR. PIKE:
A. That's the agenda.
ROIL, Q.C.:
Q. To get to page 74.
MR. PIKE:
A. What's the page again?
ROIL, Q.C.:
Q. 73, I guess, is the one.

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MR. PIKE:
A. Okay.
ROIL, Q.C.:
Q. This looks like a format that we've seen before.
MR. PIKE:
A. Okay, this audit was taking place in October. We would have carried forward observations from a May audit, and what you're seeing here is that the safety officer has indicated closure on those items.
ROIL, Q.C.:
Q. Okay. I think we're coming to a couple that are --
MR. PIKE:
A. Again this is an observation taken from May.
ROIL, Q.C.:
Q. Yes.
MR. PIKE:
A. Again it's back to the heli-fuel -- the suits and the 200 percent immersion suit piece. So there's some notes taken here as to what -- and we're using Helly Hansen E-350 suits.
ROIL, Q.C.:
Q. Again this is not closed off, this is just

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continuing to keep the paper trail alive?
MR. PIKE:
A. Yeah.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. Some issues around the compressed air system. There would be self-contained breathing apparatus that would be needed, and they'd need to refill those.
ROIL, Q.C.:
Q. That's not in relation to the HUEBA that we've heard about?
MR. PIKE:
A. No. By way of example, you'll see firemen wearing the hoods, etc. It's the same type gear as the backpack, the large tank on their back, with the mask for breathing. So offshore when they're fire fighting, they have essentially the same equipment as you would see a fire fighter carry.
ROIL, Q.C.:
Q. And that fire fighting equipment could be used in fighting a fire involving a helicopter landing?

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

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not sign off until we've actually verified it.
ROIL, Q.C.:
Q. Yes, okay, and I think --
MR. PIKE:
A. It explains what the operator is indicating in this case is they consider it closed.
ROIL, Q.C.:
Q. But you don't until there's an entry in the last column?
MR. PIKE:
A. Yes, that the safety officer is satisfied and that's usually by verification. I'm not sure if there's -- there would be correspondence going back and forth on some of these observations.
ROIL, Q.C.:
Q. I think now we're beginning to see some items closed here, are we?
MR. PIKE:
A. Yes, you're seeing now that the safety officer is concurring with the operator that they're closed and the date that they closed them.
ROIL, Q.C.:
Q. Uh-hm.
MR. PIKE:

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A. This is November 7th, so it's after they've come back from offshore. In some instances, it may not actually require a verification offshore. If it's documentation that needs to be verified, that can be done onshore with the operator.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. And then correspondence tracking the completion of some of these audits.

ROIL, Q.C.:

Q. Yeah, I think 114 then takes us to the end of the piece which is where I'd like to get before we break.

MR. PIKE:

A. Which page were you --

ROIL, Q.C.:

Q. 114, I think. We start seeing that the report now again -- is this the last of the reports in this file?

MR. PIKE:

A. This version of the report is actually stapled to the inside of the file folder that holds it. You have to actually dig until the actual

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file folder to find the ones where you have responses from the operator. So what happens is on the inside cover -- so you can open it up, and it's readily available to you, you can check to see that the safety officer signed off and closed it. I believe in this case we're seeing that they're all closed, although you can't read some of the --

ROIL, Q.C.:

Q. You've actually seen the original of this, I take it?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. And you can tell us that they are closed?

MR. PIKE:

A. Yeah. In this case, you see it's not, but what you're seeing here it's been deferred, so that means it's carried forward.

ROIL, Q.C.:

Q. Okay, and that's a non-helicopter related item, I take it?

MR. PIKE:

A. Yes. So if we've carried it forward, that would also be noted on this form as well that,

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yes, they've closed it for this particular file and we're keeping the file open in a new audit. What we're seeing here again, this report would have been the one shared before we left the rig. So the safety officers have signed it, a worker representative from the Joint Occupational Health and Safety Committee has signed it, they have seen it, the operator representative has signed it and accepted those observations, and the owner, in this case the OIM would have signed it, and indicated that, yes, they're acknowledging those observations.

ROIL, Q.C.:

Q. Just to bring us by way of sort of closing the evidence on audits, are there any remarkable changes in the audit process from the ones that we've looked at to what is happening today at C-NLOPB, or is there a continuing evolution of small changes?

MR. PIKE:

A. As I indicated, we continue to try to improve that process. We have instituted the integrated audit, which is a much broader piece. That's creating somewhat of a

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challenge for us, but we are working through it because we are trying to look at the entire system and that's a fair piece of work. So that's still an evolving piece, but the basic process is similar, but there are variances as to how we do that.

ROIL, Q.C.:

Q. Okay. These are the only recent year audits of helicopter operations that have been conducted by C-NLOPB?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. Commissioner, I think that's probably a good place for us to break for lunch.

COMMISSIONER:

Q. Yes.

(RECESS)

ROIL, Q.C.:

Q. Commissioner. Welcome back, Mr. Pike. Unless you have some other item that arose during lunch time that you wanted to address on the issue of audits, we'll move on to the next -- actually there is one that I -- it's not in your piece, but it is something that we spoke

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of and I asked you to reflect on and give some comment on, and that is the issue of work refusals. We had some evidence from one of the workers, one of the representatives of CEP, to the effect that he, and perhaps two other workers, had exercised their legitimate right to indicate that they believed the work was unsafe, and the work in this case being helicopter transportation, and that he explained the process, and I just want to make sure that we have that process understood from your perspective as to what happened, and perhaps the best one to focus on would be Mr. Peddle, who was the witness who gave that evidence. Rather than speak of the other two, let's address his, and I don't need documentation, I simply need -- did you get an opportunity to see or hear his evidence or to review it in any way.

MR. PIKE:

A. I don't recall his full evidence, but I understood he did speak to it.

ROIL, Q.C.:

Q. Can you speak to the issue of how the C-NLOPB deals with work refusals in the context of --

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MR. PIKE:

A. We have an exhibit that was prepared before. 52, can we bring that one up?

ROIL, Q.C.:

Q. Okay, we'll take a moment to bring that up.

REGISTRAR:

Q. On October 20th?

ROIL, Q.C.:

Q. That would probably be the day indeed. It was our first day of hearings.

MR. PIKE:

A. It's the other requirements respecting occupational health and safety --

ROIL, Q.C.:

Q. 52, that's the one. Okay, can you control it from there?

MR. PIKE:

A. I can. These mirror the provisions in the Provincial Occupational Health and Safety Act.

ROIL, Q.C.:

Q. Indeed. That's right, this right to refuse work is a right that is consistently applied, I think, throughout Canada in Occupational Health and Safety --

MR. PIKE:

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A. It's one of the three basic rights of the worker.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. Right to know, right to participate, and right to refuse.

ROIL, Q.C.:

Q. Right, and we did have a fair bit of evidence on those three rights.

MR. PIKE:

A. Right to refuse, a worker may refuse to do work that the worker has reasonable grounds to believe is dangerous to his or her health or safety, or the health or safety of another person at work, until remedial action has been taken by the employer to the worker's satisfaction. That generally takes place when the worker has identified it to their supervisor, and indeed the situation has been remedied. If they're not satisfied at that point, they can bring it to the next stage, to the committee, and in this case we're referring to the Joint Occupational Health and Safety Committee.

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ROIL, Q.C.:

Q. Indeed.

MR. PIKE:

A. Or the worker health and safety representative, that's for a smaller workplace that would not have a committee, has investigated the matter and advised the worker to return to work. If they're not satisfied at that stage, they can bring it forward, in this case to the Board until an officer, in this case we're talking about a safety officer for the Offshore Petroleum Board, has investigated the matter and advised the worker to return to work. Then it goes on to explain. So that's the basic process.

ROIL, Q.C.:

Q. Yeah.

MR. PIKE:

A. The first stage is that the worker would identify to his supervisor or within the workplace. The next stage is then it goes to the committee. If he's not satisfied with that piece from the committee, he would go to the Board.

ROIL, Q.C.:

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Q. Right. I believe the evidence of Mr. Peddle was that he went to the committee, the committee was deadlocked, I believe, or it in any event was unable to resolve it in his favour, it was sent up to the Board and then he explained that it was sent back to the committee, and he was troubled by that process. Do you understand what might have happened there that would have caused it to be sent back?

MR. PIKE:

A. In our discussion with the Board after the first time they took it, we didn't believe at that point that -- as you go on further, I think the committee's obligation is to investigate, and we didn't feel at that point that they had done an investigation, while albeit they did not have the expertise within that committee, they could have availed or expertise from the employer, and indeed that has happened in other refusal cases offshore. We haven't received it, but it has gone to the committee level for other instances offshore, in which case the committee engaged the expertise they needed to take a look at the

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situation. In that case, it was resolved to the employee's satisfaction. In this case, we hadn't seen that investigation component of the committee. We asked that the committee go back and do their due diligence in this case, their investigation. Once they had done the reasonable investigation and still could not come to a conclusion, then the piece was brought to us.

ROIL, Q.C.:

Q. Okay, so you're simply saying to the committee, you have to follow through the steps that are available to you.

MR. PIKE:

A. There is a process, and they have a duty in this piece as well.

ROIL, Q.C.:

Q. Okay, and --

MR. PIKE:

A. And throughout this whole process, we were in consultation with the Provincial Health and Safety Program, so those folks -- we were in discussion with them to make sure that the process that we were following was correct.

ROIL, Q.C.:

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Q. Okay, and again the purpose of my questioning is not to test whether you came up with the right answer, but what sort of resources did you call upon to answer the question? You've already indicated that there was not a specific expertise within the Board's staff. What kind of resources would you have had access to, and did you have access to, in order to answer the question about whether helicopter safety was safe in the context of one of these auxiliary tanks? I think it was the auxiliary fuel tank that was the issue.

MR. PIKE:

A. In the first instance, we assigned two safety officers.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. The first step in that process was to sit down with the complainant to make sure we understood exactly what was -- what his concern was, and from that we proceeded and got some additional information. I believe we talked to in that case the helicopter manufacturer, we talked to Transport Canada

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Aviation, we talked to the Transportation Safety Board, we got some additional information from our colleagues in the North Sea, some expertise there. We had the evidence from the Marine Institute, the Offshore Safety and Survival Centre, and in addition to that we did have discussions with Survival Systems in Halifax. We didn't note that in our response back, but we did have those discussions with Survival Systems at that time. So they did a fairly extensive search for the facts in this situation.

ROIL, Q.C.:

Q. And at the end of the day, I take it the C-NLOPB did make a decision?

MR. PIKE:

A. We did.

ROIL, Q.C.:

Q. And you decided that the worker should --

MR. PIKE:

A. Return to work.

ROIL, Q.C.:

Q. That it was not unsafe?

MR. PIKE:

A. Yes.

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ROIL, Q.C.:
Q. Again I'm not -- I understand that the worker was not happy with that conclusion, but I wanted to know what processes you went through to come to a conclusion. Would that be a similar -- would you amount of diligence normally be associated with a work refusal that comes up to the Board?
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. So you would normally look outside and look for special expertise?
MR. PIKE:
A. We would, depending on what it was we were looking at, yes. If we needed that outside expertise, we would look for it, yes.
ROIL, Q.C.:
Q. I think that's all I wanted to ask you. I wanted to give you an opportunity to explain what happened from the Board's perspective, so that we have both sides of the explanation, as I say, not to test whether the right answer was gotten, but just to see that there was a diligence process.

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MR. PIKE:
A. And we took what time was necessary to get that information.
ROIL, Q.C.:
Q. How long did it take, ball park?
MR. PIKE:
A. Approximately a week.
ROIL, Q.C.:
Q. Would that be a longer than normal period of time?
MR. PIKE:
A. This is the first three work refusals we've had to investigate were the three that have been mentioned here, and they occurred in the November time frame.
ROIL, Q.C.:
Q. So in relation to the offshore, there have not been other work refusals?
MR. PIKE:
A. Not that it reached the stage of a Board investigation, no.
ROIL, Q.C.:
Q. Okay. We wanted to move on this afternoon to the issue of communication and some other points. So if your mouse will work, you can

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control the --
MR. PIKE:
A. Again this is an outline. I'll talk a little bit about the daily reports that we receive, the monthly statistics, the quarterly meetings that are held with the producing operators, the operators and the producing facilities, the installation or workplace Joint Occupational Health and Safety Committee, we receive their Minutes, the annual Joint Occupational Health and Safety Committee sessions that we hold, and you're familiar with those.
ROIL, Q.C.:
Q. Indeed.
MR. PIKE:
A. An annual meeting that the Chief Safety Officers of both the Newfoundland and the Nova Scotia Board hold with the CAPP Safety Committee, and I'll deal now very briefly with the other regulatory agencies that we would have communications with. I just indicated as we talked about the refusals, that we had extensive discussions with the Provincial Occupational Health and Safety Program over

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the OHS -- the refusals, and to get some understanding from them as to the processes involved and some advice in that regard. So we talk extensively with the Provincial OHS Program and they provide us some advice. The Energy Departments, obviously we have an ongoing dialogue with them. Transport Canada Marine Safety, we've had a longstanding working relationship with them, a very good working relationship. They issue letters of compliance for the drilling units on our behalf, and in addition to that, the two FPSOs are actually also Canadian flagged vessels, so there are certain Canada Shipping Act pieces that apply as well, so we work very closely with them on the FPSOs and discuss issues continuously on that piece. So we are in constant dialogue. If they see something that's coming up, they talk to us; as we see something, we'll talk to them, particularly with regards to the FPSOs. Again when they're on the drilling units which are foreign flagged, they're working on our behalf. As I indicated as well while we were going through work refusals, and any time we come up with an

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

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RCMP, DND. There's a full gamut of those agencies that would have some piece within the emergency management component.

ROIL, Q.C.:

Q. I'll just ask you, Public Safety Canada is not a name that many people would be familiar with. Is that the new name?

MR. PIKE:

A. That's the new name of what might have been referred to as Emergency Preparedness Canada. They have gone through several different names in the last number of years, and that's the one they currently sit, and they chair essentially or coordinate that meeting. Indeed there was one last fall where we did review the government response to the March 12th incident. That was reviewed at that meeting. It's also used for onshore emergencies as well. You know, they would have been involved in things like the flooding that occurred several years ago in Badger. So that same group would have been dealing with that, and we're part of that committee. It also helps to meet some of those folks so that when you're in an emergency, you know who it

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is at the other end of the phone when you call them. There's also a security sub-committee of that one. In addition, on a federal and national level, there is an energy infrastructure protection working group. So it's really the energy agencies, and they meet twice a year. So we're involved with that one as well. It really is focused more in the security area, so it's more of the security folks that would be there, and it's usually hosted at CSIS Headquarters in Ottawa. So we meet there twice a year. So that's essentially some of the other agencies that we do have and can avail of their expertise.

ROIL, Q.C.:

Q. So this is all under the auspices of that heading, "Other regulatory agencies"?

MR. PIKE:

A. Other regulatory agencies.

ROIL, Q.C.:

Q. And we don't have a specific slide dealing with that?

MR. PIKE:

A. We don't.

ROIL, Q.C.:

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Q. Okay. Now daily reports, I think you indicated when you were going through your evidence this morning that daily reports can sometimes find their way into the audit piece?

MR. PIKE:

A. We would review those to see what's happening on the installation before we actually go offshore. There are several different types. The ones we receive and have the most background on are drilling reports. They call them tour sheets. You go out on any drilling rig anywhere in the world and ask for the tour sheet and they'll know exactly what it is you're talking about. The standard format for those are set by the International Association of Drilling Contractors, and that covers the full gamut of what I referred to as operational safety issues, so precisely from a technical standpoint what they're doing in the drilling of the well. It also covers some of the occupational safety issues and some of the logistics issues. So you'll know who's on board, what the POB is, when they did their last safety drills. It would even include when the helicopter flights -- what

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helicopters flights have taken place.

ROIL, Q.C.:

Q. I was about to ask, there would be some indication of helicopter activity on them?

MR. PIKE:

A. Yes, and supply boat activity.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. In addition to those, I haven't listed it there, we would also receive the geological reports. That gives us some sense of what's happening down-hole so that it becomes an issue if you're dealing -- you know, to keep on top of things like well blowouts and what not. That's a useful piece of information. We don't tend to look at them very often, we rely on our geoscientists to brief us on what they see, vis a vis the geology. The daily production reports have got a similar content, but they're all individually styled to the operators. The would contain the production information by well in total. That's information that our resource management folks are looking at more particularly. We have

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

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but we would generally expect those on a weekly basis and they would provide us a summary. Principally it's the geoscientists want to know what's going on, but we would also get some information and they would give us -- some of the health safety and environment summary would show up in that piece as well. It's checked regularly, these daily reports, but I wouldn't necessarily say they're checked daily.

ROIL, Q.C.:

Q. If there was an incident about helicopter safety that happened on a facility, would you expect to see it here or is it more likely to have a different type of reporting?

MR. PIKE:

A. We would expect to see it as an incident report, but you may see something noted here as well.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. If it didn't occur there, I wouldn't be surprised, but occasionally you will see them listed there as well.

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ROIL, Q.C.:

Q. Okay, so these daily reports are not designed specifically with a safety focus, but they can engage you in the safety piece?

MR. PIKE:

A. It gives us that operational overview of what's happening and they do note some of the safety things that are happening.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. The monthly statistics reports, they give us the number of hours worked by the operator in that month. Any reportable injuries, and for us a reportable injury is where the worker is not able to return for the next shift for their full duties. So if any way they aren't able to do their full duties, that's considered a reportable injury. Traditionally you'll hear them referred to as lost time injuries and potentially restricted work injuries. Those two would be lumped together when they report those to us. As I mentioned, I think earlier this morning, medical aid injuries, there were something beyond first

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aid that was rendered, but the individual was able to return to work the next shift for their full -- and be able to do their full duties, and then a note on the first aids.

ROIL, Q.C.:

Q. Which again is a lower triaging of the seriousness of the medical event?

MR. PIKE:

A. Yeah.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. We put these statistics in our annual report and we also publish those on our web, and the other note in this, it's only part of the story for safety in the offshore. I mean, we're talking here about the occupational safety. It really doesn't deal anything with the operational safety. The operational safety would be the safety of the actual plant itself, and are not really covered in these statistics. So relying solely on this piece, will give -- could give a false sense of what's happening on the installation. There's been several major incidents that have pointed

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that out, I think.

ROIL, Q.C.:

Q. Where would -- in your environment, where would the operational safety piece get reported?

MR. PIKE:

A. We pick those up in the -- we pick those pieces up in the incident reporting.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. That's why we've expanded some of our incident reporting to cover off that. The operational or process safety component, that's a relatively newer area, highlighted extensively when you look at the refinery accident in Texas, the BP Texas City Refinery explosion. They had an exemplary occupational safety record, yet there was an underlying occupational -- operational safety issues were there and weren't being displayed when you look at only the occupational safety statistics. So a costly example of you can get misled if you only look at one set of statistics. You need to be looking at it all.

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Quarterly meetings, we meet on a quarterly basis with each of the operators of the producing facilities. We review the activities of the previous quarter, and the first item on the agenda is the safety performance. We also forecast activities over the next quarter and beyond. So it's an opportunity for us to discuss what's coming up and what we need to prepare for, and discuss any issues of concern. With regard to that, we did see, and I think we made mention of issues with the transportation suits in our monitoring of the Joint Occupational Health and Safety Committee Minutes. We'll see that in a minute. We were seeing that as a increasing concern, so during our July, 2008 quarterly meetings, I did raise the issue of transportation suits, and indeed I think you've seen a presentation that Suncor gave us in July of 2008.

ROIL, Q.C.:

Q. Yes.

MR. PIKE:

A. I can quickly go over some of the issues as we understood them in July of 2008.

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ROIL, Q.C.:

Q. Do you want to do that? Is this as good a time as any to talk about suits?

MR. PIKE:

A. We can do it. It was one of the key things that we did in that quarterly meeting and we identified it.

ROIL, Q.C.:

Q. Everybody else has offered some commentary on it, so it might be appropriate for the Board to give its view on --

MR. PIKE:

A. I can give you what we understood from it that week in July, and then we can talk a little bit about some of the others. So problems being able to completely zip up the suits, most operators have implemented a process to have people do this at the heliport before they leave, although one of our safety officers noted that on this last trip, it wasn't done, so we did follow up with the operators on that piece. Problems with false activation of the life vests, the toggle used to activate the life vest was more prone to accidental release in the older suits, albeit

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

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note, goggles are not actually used in the Nova Scotia offshore. They've had the Helly Hansen suit with the face shield for some years, and I think they identified that problem very early on and actually eliminated goggles, so goggles are not actually carried in the Nova Scotia --

ROIL, Q.C.:

Q. You say in Nova Scotia, the face seal, is that the HTS-1 that we've heard about?

MR. PIKE:

A. No, they're using essentially the same suit as we're using here, but the suit they replaced with the current suit was a Helly Hansen suit -- sorry, was the model --

ROIL, Q.C.:

Q. The 352, I think.

MR. PIKE:

A. Yes, the 352 suit versus the one, so they identified very early on that there was an issue with goggles and they eliminated goggles. We retain goggles in this jurisdiction, feeling that they are a benefit.

ROIL, Q.C.:

Q. But your transition wasn't from a 352, it was

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from a different manufacturer?

MR. PIKE:

A. Different manufacturer, yes.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. And we've been working some of those issues on the goggles, and from the Nova Scotia side, they identified sizing, and in this case they're identifying larger people. They also did identify some leakage during training exercise. The buoyancy issue was raised. Thermal rating, the standards now requires thermal testing in agitated water which has increased the amount of insulation, and hence buoyancy in there. They had an additional problem where on the Sable Project crews are moved on a daily basis, and in the warmer temperatures they were finding heat exhaustion was an issue for the workers. So they were overheating with these suits. In particular, the Super Pumas didn't have, or don't have air conditioning, so as a result the cabin would heat up. With these warmer suits, the workers were finding a problem. They identified the

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

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ROIL, Q.C.:
Q. We just need to look at one, and I think the second paragraph is the one that I'd like to draw your attention to and speak about a little bit.
MR. PIKE:
A. And again as a regulator, we're looking at performance to the regulation, and in this case, notwithstanding the helicopter suits are certified to the CSGB standard, and that's the standard that's called up in the regulations and that indeed everybody is wearing them, which are the two criteria in the prescriptive regulations, so they are essentially meeting the regulatory requirement here, the prescriptive regulatory requirement, we still had an issue. So what I have done here is identified another section stating that -- I think it's -- I thought it might help, but it doesn't.
ROIL, Q.C.:
Q. Yeah, no, you --
MR. PIKE:
A. Notwithstanding the helicopter suits meet that standard, I have called up Section 12 of the

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regulations requires all protective equipment be designed to protect the person from the hazard for which it is provided, and shall not in itself create a hazard, which is a more goal oriented piece as opposed to the prescriptive piece that calls up the standard, and that you shall wear it. We are aware of comments from the previous year on the actual standard because the committee was reactivating to take a look at the standard. The helicopter suit standard, there was questions of adequacy of the leak testing. We required the operators to immediately begin the process to demonstrate that helicopter transport suits provide adequate protection from the hazard of hypothermia. The operator should provide the results of the assessments to the C-NLOPB and also to the CSGB Committee to help inform action on the standard. As a result of that, some testing was done in July, I believe, of last year at the Core Group, or Survival Systems, one of the companies that fall under the umbrella of Survival Systems, did they some testing in their facilities in Halifax on the leakage.

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ROIL, Q.C.:
Q. I think the point I want to ask you to comment on here is not so much the suits because I think they're getting a fair bit of diligence at this point in time, but you had mentioned the so-called prescriptive test versus the goal oriented one, so I'm -- I just want to make sure we understand. If all you had in your toolbox was a prescriptive set of "thou shalt wear a CGSB approved and thou shalt wear it at all times", you're saying the test is met?
MR. PIKE:
A. The test is met and there's very little else I could do as a regulator.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. They have met the test of the requirement of the prescriptive regulation. Notwithstanding there's a problem, they have met the prescriptive test of the regulations.
ROIL, Q.C.:
Q. So how did you link yourself into the goal performance?

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MR. PIKE:
A. We were able to link it back as a piece of protective equipment.
ROIL, Q.C.:
Q. Yes.
MR. PIKE:
A. And that the goal of it actually providing the protection from the hazard that it was designed to. So we're linking it back in this regard, notwithstanding they're meeting the standard, and in fairness to the operator, they were identifying at this point as well there were some issues and this was a follow up to make sure that we did take a look at -- that we are getting adequate protection from these suits.
ROIL, Q.C.:
Q. Right. I don't want to oversimplify what might be in your world a very complex item. Is it that we are now learning that the goal oriented measurement is the better tool, or is it a blend of prescriptive and goal, depending on what the issue is, or what the wording is?
MR. PIKE:
A. The newer regulations that we've come out

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with, the Drilling and Production Regulations, are what I would refer to as goal oriented. So in many parts they have goals, but they are also some prescriptive parts in it as well, but the leaning is towards the goal. The both have their strengths and weaknesses. Certainly the prescriptive piece is very easy to say, yes, you're complying or, no, you're not, so it's a very tick box type thing, and provided the rule has been set and it's robust enough, you're in good shape, but if it's not, and I think the Ocean Ranger certainly identified that prescriptive regulation is not necessarily the right way to go, and it was a very clear statement in the report, Chapter 2, that they felt that there are limitations in the goal oriented world, that's not to say I don't believe in standards, I think they're a helpful piece to us, but if it's just tagged to the standard or the prescriptive piece, it makes it very difficult when you do run into problems because there is compliance in that case.

ROIL, Q.C.:

Q. So the --

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MR. PIKE:

A. The goal then becomes -- and it's a little more difficult one sometimes to enforce, but it does provide you that avenue to take a look at the broader picture of what's happening.

ROIL, Q.C.:

Q. So to oversimplify, the prescriptive one is does it meet the test; the goal one is, does it do the job?

MR. PIKE:

A. Does it do the job, exactly, and the it's -- the operator then has to demonstrate how the device that they have used meets that goal.

ROIL, Q.C.:

Q. Okay, I think that explanation is very helpful to us. Thank you.

MR. PIKE:

A. Okay.

ROIL, Q.C.:

Q. Okay, we need to go back to our slide.

MR. PIKE:

A. Go back to the presentation, unless you've got any other questions on --

ROIL, Q.C.:

Q. No, I think that's all I have for the suit

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issue. I think we've -- we've talked a lot about it, but I wanted to get a little commentary from you on that prescriptive and goal objective because I think that's a thing we need to understand fully.

MR. PIKE:

A. Yeah.

ROIL, Q.C.:

Q. Okay.

MR. PIKE:

A. The Joint Occupational Health and Safety Committee Minutes. Each workplace must have a Joint Occupational Health and Safety Committee, and I think I talked a little bit about that the last time I was here.

ROIL, Q.C.:

Q. And we've heard a lot about that from the operators as well, so --

MR. PIKE:

A. Again in the offshore, we've got it workplace based as opposed to employer based.

ROIL, Q.C.:

Q. Right.

MR. PIKE:

A. You'll see that the legislation onshore refers

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to, "The employer shall have a Joint Occupational Health and Safety Committee", and what we've applied in the offshore is the workplace because there are many employers on these installations, and the way that this has worked and certainly the model that we've taken from the North Sea is a single committee for the entire installation, or a workplace based committee with constituencies representing different parts of the committee. We expect them to meet once each rotation, so that's every three weeks. The actual minimum requirement within the legislation is once every three months, and we feel that that's not adequate given the workplace that we have offshore. It's a very dynamic workplace, as highlighted in the Ocean Ranger Commission, it changes quite quickly, so having it once rotation we felt was an important piece.

ROIL, Q.C.:

Q. So that's really twice in every six weeks, but each time with a different group of the three week cycle?

MR. PIKE:

A. Yes. So the Minutes of their meetings must be

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

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Safety Committee Minutes. So we are tracking some of those items and we've identified those as something to be tracked in the database.

ROIL, Q.C.:

Q. Okay, before you go to the next slide and the next issue, I would ask you to give a comment to the Commissioner on the concern, if you will, that was expressed by the workers who gave evidence who were, and forgive me if I don't express this quite right, they were acknowledging that in the activity that goes on on board the vessel or the facility, that they have the expertise and the knowledge and the understanding, or they have immediate access to that so that they can understand the issues, but that with respect to helicopter transportation, they felt that the resources weren't available to them to be able to understand and monitor helicopter safety in this kind of environment. Has that opinion ever been expressed to you before, and is it something that you have any commentary on?

MR. PIKE:

A. That's been a more recent comment from the committees, and I would say with our new

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guidance document that actually covers support craft, it would be along the list of incidents that would be available from the operator, so it would then be a matter of the committee actually requesting the list of incidents from the operator, and that should include the incidents involving helicopters.

ROIL, Q.C.:

Q. Okay, but if they get the incidents -- you know, the explanation was if I get something about a valve that is leaky on a facility, then either me or one of my buddies, we work on these valves. If I get a report on a helicopter incident, I don't have and my coworkers don't have the ability to understand or ask the right questions about those, and I think their plea was for there to be some resource or some information available to them to assist them in that -- in getting ownership, to use that word, of the helicopter issues when they come to the Occupational Health and Safety Committees?

MR. PIKE:

A. If they frame that question appropriately in the Minutes as an issue, the operator is

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required to respond. So the operator should be providing, when they are phrased that way, the report or the information back to the committee. So if they frame the question correctly, and we've had discussion over the years at our annual sessions as to how they may do some of these things, not necessarily associated with helicopters, but other areas, if you frame your question correctly, the operator is required to respond. So if it is an issue related to transport of helicopters, and you framed it correctly in your Minutes, there is a requirement on the operator to respond with the information that you need to form that opinion.

ROIL, Q.C.:

Q. I'm not sure that this issue ever came as clear to anybody as it did during our hearings, but certainly the issue is before us now.

MR. PIKE:

A. We haven't had that sort of discussion with helicopters, but we have had it for other issues in the past at the annual JOHS sessions.

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ROIL, Q.C.:
Q. And I think we're going to get on to the annual JOHS sessions right now.
MR. PIKE:
A. Back, and I think around 2000, we identified a need to be able to meet with workers, to get worker input in what we did, and after some discussion, we finally sort of settled -- because at that point, there was no organized offshore workplace, so getting workers together was a bit of a challenge. So we identified the Joint Occupational Health and Safety Committee as being a vehicle to meet with workers. So in 2002, we convened a meeting of the worker representatives only to meet and discuss some of the issues about the offshore. Those meetings tended to be a little bit more informal. We kept holding those on an annual basis. They progressed from a worker representative only to the committee, the Joint Occupational Health and Safety Committee. Supervisors rightly pointed out it was a committee, there were two sides to it, so they wanted to be present, so we did that. They're held as two sessions over a two

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day period, three weeks apart.
ROIL, Q.C.:
Q. So they're two two-day sessions three weeks apart?
MR. PIKE:
A. Two two-day sessions three weeks apart. At one stage we would hold the first day with the entire committee, and the second day with the worker reps. More recently, in the meeting that you would have been present for, what we did was a little different format and again, this is an evolving piece, trying to improve it, get the most out of this period. We held it with the entire committee over the two days and we held breakout sessions, and I think that went fairly well and most people were very receptive to it. It's only been in more recent years that we've actually done formal minutes and we have some of those and we'll refer to those coming up. I think it really started in about 2006 where we actually got formal minutes.
It's an opportunity to discuss issues in a multi-workplace forum. So they aren't focused necessarily on one installation.

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Those are offshore industry wide sort of discussions that we can get into, and while the safety officers do meet with worker reps and are on the offshore installations, it was another opportunity to have that discussion with the offshore workers, and indeed supervisors are also offshore workers, so it's an opportunity to meet and have that discussion with them and I think they've been very successful.
ROIL, Q.C.:
Q. Do I understand that you've also brought in some additional resources from outside your organization to help you focus?
MR. PIKE:
A. I was just going to say. The initial set of minutes in February/March, we got the minutes out in June. So we got a bit of a lag. We're having trouble there. In the November 2006 meeting, we were March before we got the minutes out. So we're struggling to get the minutes out. So we got some help and Safety-Net, which is the centre for occupational health and safety at Memorial University has acted as our secretariat. In addition to

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being the policeman and getting our minutes out in good time and taking some of the notes, they're fresh ears listening to the workforce to make sure that we are hearing the right issues. So they're listening as well and hearing what the workers are saying. So they helped us, starting in October 2009 -- or 2007, I should say, I'm sorry, and again, they've been helping us out since then with organizing the meetings and acting as a secretariat and you would have noted in the last session they actually were the facilitators were some of the breakout sessions. So they've been very helpful for us in that regard and we can probably take a look at a set of those minutes. The first set would be October 2007, and they are Exhibit 199.
ROIL, Q.C.:
Q. 199.
MR. PIKE:
A. And you'll notice a vast improvement in the minutes once we had some help in putting them out.
ROIL, Q.C.:

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Q. It's good to recognize that other people have skills that we can draw upon. Actually 198, I think, takes us back even earlier, does it not, to the 2006? So if you want to see the full evolution of your minutes?

MR. PIKE:

A. Okay.

ROIL, Q.C.:

Q. Or even 197. Let's just take 198. This is earlier enough for my purposes, just to see and show an evolution.

MR. PIKE:

A. 197 is again a more table format as opposed to a text format. We were just trying to capture. And again, what we would do is highlight what we heard as the issue. We would send those out to the workforce. Have we heard the issue correctly? They're busy folks. We haven't necessarily received too much feedback when we've sent some of those out, but we would raise the issue and then we would give some response to it if they had raised an issue during the sessions. So that's the format that these were done and we've -

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ROIL, Q.C.:

Q. Okay. Now I think we can perhaps move on to the one, Exhibit 199.

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. Because that gives us another iteration at a further stage of development, and then we can look finally at the next ones.

MR. PIKE:

A. So one of the things we would do is review the issues and what progress we've made from the previous meeting. I'm not sure if I clicked this too quickly. Okay. So again, these other issues were not related to helicopter transport, so we've redacted those. So we would indicate what the issue was and what our response is. There were some communications issues, so we took on board to try to see what we could do to facilitate communications among committees. We did highlight to them some of the incident reporting guidelines and we had some discussion on incidents during our most recent session.

In October of -- or November of 2006,

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there had been issues raised about the helicopters and the S-92s, so at this point, we invited Cougar in to give us a special presentation on their fleet and they gave us -- came in and did give us a rather complete presentation as to what was happening with regard to helicopters and to answer some of the questions that the workforce had with regard to helicopters, and if memory serves me, it was well received and they answered a lot of the questions that the workforce had with regard to what was happening with helicopters.

ROIL, Q.C.:

Q. I see as early as 2007, we were looking at the incoming HUEBA breathing device.

MR. PIKE:

A. We were. It was raised in previous sessions as well. The expectations were that it was eminent and we understand that that -

ROIL, Q.C.:

Q. Well, we have a specific slide, Commissioner, to deal with that issue in some more detail, so I just note it here.

MR. PIKE:

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A. And I think as the Province noted, the OSH amendments have been ongoing and we did give an update to the offshore workforce as to where the OSH amendment piece was.

ROIL, Q.C.:

Q. I don't think we need to go into a lot of detail here. I'd rather move to the Exhibit 200, just to show again the evolution of your process now where you have -

MR. PIKE:

A. Yeah. There are training issues raised during those sessions as well. There were people questioning the amount of training. Over the years there have been questions on the sea day, "do we really need it?" We've heard that that opinion has changed significantly since some of those earlier days.

ROIL, Q.C.:

Q. So again, can we conclude that there's no reluctance on the part of workers to bring up helicopter transportation issues in these joint sessions that you're having?

MR. PIKE:

A. No.

ROIL, Q.C.:

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Q. They're clearly within the bounds of those meetings?
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. And that's the opportunity they're taking.
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. Okay. Exhibit 200, please? Yeah.
MR. PIKE:
A. Again, we reviewed the issues that were raised in 2007. What we tried to do or what we started to do is identify the ones that we were going to give priority to, not that we were necessarily losing the other ones, but the list was growing long and with limited resources, you try to prioritize which ones you're going to look at. You know, there was issues there on the training, refresher training, implementation of the HUEBA, question on overlap. Again, what we're dealing with there is the FPSOs. They're offshore installations, therefore they come under our regulation.

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ROIL, Q.C.:
Q. Yes.
MR. PIKE:
A. And that would be the Petroleum Occupational Health and Safety Regulations. They are also Canadian flagged vessels. Canadian flagged vessels come under the Canada Labour Code and under the Marine Occupational Health and Safety Regulations. While those Marine Occupational Health and Safety Regulations are enforced by Transport Canada Marine Safety, they are set by Labour Canada and Transport Canada can't amend or waive them. That's the objective of Labour Canada. I have identified that issue to Labour Canada on several instances that we need to decide one or the other set of these occupational health and safety regulations need to apply. Trying to apply both is a bit problematic. But again, it comes from the fact that they are, in addition to being a Canadian flagged vessel, they are also an installation.

We had a presentation from an industrial hygienist. Some information from the Workplace Health Safety Compensation

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

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eliminated it.
ROIL, Q.C.:
Q. I think actually on page ten, the issue of flight suits comes up again. So we'll take a moment to reflect on what was being discussed there.
MR. PIKE:
A. Some discussions on the heliport facilities. Again, so they're raising concerns about what's happening at the heliport.

Flight suits. Somebody noted here that there was a proper way to hang these suits and that's that tab that I think we identified earlier on in the session as opposed to some people were using the hood to hang it by, and that was not an appropriate way to hang it, and the workers felt that that was something that we should identify and we did.

So the things that were noted from those sessions, as the concerns with the suits. The zippers again were raised as an issue. The sizing for bigger workers in this case they were identifying. One of the things they were talking in terms of the Mustang suits had multiple more sizes than the newer Helly

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Hansen suits, so there was some suggestion that maybe we needed more of those. The zippers again, this -- when they refer to the closure, it's the zipper issue and how the suits are zippered up and the pressure it puts on the neck.

ROIL, Q.C.:

Q. Just as a question of the impression that was in Howard Pike's mind at this time. Now this is becoming the fall of 2008 and it's not long before we had the tragic incident of March 2009. With all of this accumulating complaining going on and troublesome noise about suits, was there ever any impression in the mind of you or anybody at C-NLOPB that there was a large number of people whose suits didn't fit them because the face seals weren't working? Was that issue ever squarely in your mind?

MR. PIKE:

A. The face seal piece issue didn't come up until much later. We weren't identifying that at that stage. Indeed, you know, in conversations with our Nova Scotian colleagues who were familiar with these suits had not

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identified the face seals as an issue. So at that stage, while, you know, in my own mind I was really questioning as to whether we were getting down to the root issues with these suits because they were carrying on for so long, you know, the flip side is, I'll go back to that prescriptive piece, they met the standard and that people were wearing them. There was nothing in the standard that talked in terms of fit or how they fit or that you should be doing fit testing. That's not in the standard. But given that this was going on for so long, my own thought process was that there's more to this than we're seeing. We're not getting to the root would be my thought, and then the question becomes, as the regulator, how do I raise that with the operators because they do meet the prescriptive regulatory requirement. So again, we started to raise those issues in January of 2009.

ROIL, Q.C.:

Q. I don't think there's anything else in that particular series of JOHS minutes that I want to take your attention to, unless you wish to,

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in which case we can move on.

MR. PIKE:

A. No, I think as you can just see from that, there's a wide gamete of things that we discuss at those sessions -

ROIL, Q.C.:

Q. Indeed.

MR. PIKE:

A. - and it's really a forum for them, for the workers. Again, what we did here was try to summarize some of the issues going back to them. We would have shared this with them and asked for feedback. Was there something we missed? Is there something we need to follow up on?

ROIL, Q.C.:

Q. Okay, I think we can move on to the next subject matter which is at slide 25.

MR. PIKE:

A. And to be quite honest with you, I don't remember when these meetings started, but they've been going on for some time, that on an annual basis, the chief safety officers for the Newfoundland Board and the Nova Scotia Board sit with CAPP safety committee. They've

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been informal meetings to discuss safety issues. Essentially taking a look at what CAPP has as its priority items and what we would have, as chief safety officers, as our priority items, and that's to try to get some alignment and make sure there's no surprises in that, and quite obviously, the HUEBA would have been discussed at those meetings as to what progress was or wasn't being made. That would have been a priority item for us as we met with the CAPP safety committee.

ROIL, Q.C.:

Q. Putting aside the HUEBA issue, which we'll deal with separately, and which I think there's going to be an intensive piece of work done by CAPP and others, perhaps us, to see what lessons we can learn from that, what can you tell us about the relationship between you, as a safety officer for C-NLOPB, and the whole piece involving CAPP and it setting standards and training and whatnot? Does that work for the C-NLOPB?

MR. PIKE:

A. We certainly have some examples where that's worked very well. The training and

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

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to have for the crane operators. You know, what happens on board, the issues associated with containers. We already had with CAPP a standard that was being used for offshore containers to make sure they were built to a high standard and maintained at a high standard and that the lifting kit that's put on it, the slings that are put on it are kept in good repair and that they're certified and that certification continues. So there's a number of examples where it works quite well.

ROIL, Q.C.:

Q. Right. Can I ask you, in your relationship with regulators in other places, such as in, you know, the Norwegian, the North Sea experience, in the United States, in Brazil, Australia, wherever you have relationships with other regulators, are there similar relationships between the regulators and an industry sponsored organization with respect to training and the definition of how work gets performed in the offshore?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

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Q. This isn't just a Canadian model, I take it, is it?

MR. PIKE:

A. No. It would be -- I think it takes place in most of those other jurisdictions, certainly the ones that we meet with regularly and the International Regulators Forum. That would include Norway, UK and the Netherlands. They all meet with their industry associations on a regular basis and there's some things handled at that level and some things handled at the operator level. In the US, the Mineral Management Service meets regularly with their industry associations and in some cases, it would include both -- as well as the contractors as well, the IAD, International Association of Drilling Contractors.

ROIL, Q.C.:

Q. Yes, we heard something about that.

MR. PIKE:

A. They would meet with them as well. And I believe in Australia, they do meet regularly with the Australian operators association. So it's not an uncommon piece.

ROIL, Q.C.:

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Q. Okay. Meeting is not the issue, I think. It's giving to the industry associations the ability to be engaged in the definition of training and the definition of standards. That is not uniquely Canadian?

MR. PIKE:

A. No. If you go to the UK model, there's a group referred to as OPEDO.

ROIL, Q.C.:

Q. Yes, we've heard of them.

MR. PIKE:

A. They set the standard. There are representatives there from the operators. I believe the regulator is represented, but the regulator does not control that committee. That is a -- I think OPEDO is actually, if memory serves me, a not for profit type organization. I can't recall the exact makeup of it, but it is essentially an industry piece that set the standards for training in the offshore for the UK.

ROIL, Q.C.:

Q. Okay. So this relationship with CAPP goes on with these meetings and how often do you meet? Is it just annually?

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MR. PIKE:
A. Just once a year.
ROIL, Q.C.:
Q. Just annually, okay, and what about the committees, do you ever meet with their safety committee or is that a piece that is done separately, if there's a safety committee of CAPP?
MR. PIKE:
A. They occasionally will call us in, if there's a particular issue that they want to apprise us of. They may call us into a meeting that they're holding, but by and large, it's just this annual meeting, unless there's a specific issue.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. Maybe just to talk a little bit more about the training aspect. In 2001, we did raise with the other regulators the issue of training and the ability to recognize training among other international jurisdictions, a large issue for the mobile offshore drilling units, less so for the producing facilities. But they did --

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we talked about that and in each instance, they identified that the training standards are really set by industry and that the regulators would have a limited role in the ability to get some recognition of standards between jurisdictions.
ROIL, Q.C.:
Q. So if standards were to be standardized internationally, it would engage more than just the regulators?
MR. PIKE:
A. That's correct.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. And that was identified when we first raised that issue in 2001 forum. So maybe we'll talk a little bit about the -
ROIL, Q.C.:
Q. The breathing device. Indeed, I think you're aware of the fact that there was evidence brought by CAPP and there's been a lot of questions about it since then, the period of time, and I think you may be aware that the oil company executives have acknowledged that

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the time seems inordinately long and that there was a piece of diligence being put into investigating it. What can you tell us about -
MR. PIKE:
A. And they'd certainly get no argument from me. It took far too long.
ROIL, Q.C.:
Q. Okay.
MR. PIKE:
A. By way of note, I have summarized in one slide what is a ten-volume file in our system. We have an extensive file on this piece.
ROIL, Q.C.:
Q. So we saw, through CAPP's evidence, four letters that have been written by either the CEO or a safety officer at the C-NLOPB.
MR. PIKE:
A. There were many more e-mails associated with keeping track of where this was going and what the problems were, what the issues were. So there's an extensive trail of us following up with CAPP to see where this issue was.
Just by way of summary, we raised the issue in 2000. So in 2000-2001, I refer to it

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as a gathering of information. There was a study being done by the CORD Group, Dr. Chris Brooks. So they wanted to get some information when that piece was published. In addition to that, they were gathering some information out of the North Sea. So I refer to that as a gathering the background piece. So that was what was going on in that time frame, waiting for some of the research to come out.
In 2002, there was a discussion paper issued that recommended the hybrid device, and in 2003, they formed the first implementation committee.
ROIL, Q.C.:
Q. And just on that word "implementation" did you understand back then, again I'm asking you to cast your mind back, that the implementation committee were going to implement a specific device?
MR. PIKE:
A. Yes.
ROIL, Q.C.:
Q. Within a period of time, and that device was what?

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MR. PIKE:
A. That would have been the hybrid device that came out of -- that's what I was understanding they were doing at that time.
ROIL, Q.C.:
Q. Right, okay.
MR. PIKE:
A. It's apparent at some point in late 2003 or 2004 something changed and that there was a debate on the type of system to be used.
ROIL, Q.C.:
Q. And so this is getting us away from the hybrid device, was it?
MR. PIKE:
A. No, that -- yes, that's correct, and that's when we first started hearing the use of the compressed air system, the system that we currently have, and I think they, at that point, changed the recommendation to the compressed air system, but felt because the compressed air system, at that point, had only been used for military purposes, that we needed to take a look at and assess the training and implementation risk associated with it. So in 2005, they started identifying

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where the issues were with training and implementation.

And again, I think as we noted in 2006, early, they held a workshop. That was an international workshop. They brought in some experts from the UK to talk. In addition to that, in that same year, they identified that if they were using the compressed air system, they were going to need new suits. They couldn't retrofit the existing suits to fit this device, and I think we've also seen testimony that they were seeing that those suits were coming to the end of their useful life in any event. So it was an opportunity to upgrade the suits and they would include the provision for the new rebreathing device.

2007, there was liability and medical issues raised and that's with the training, and it comes back to, and we've heard a lot of talk about fidelity of training. The proposal at this point was that they would use the compressed air system in the HUET trainer. What was being identified here from the medical professionals, and there was a divided opinion among the medical professionals in

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this regard, specialists in the area of hyperbaric medicine. There was not a definitive view on this, but they were identifying concerns and risks associated with training or using that level of fidelity with the compressed air system, which in turn invoked a certain level of liability back to the operators that if you were indeed imparting that risk this is something that every worker would have to go through every year -- every three years. So you're talking about something in the training component where it was believed that there was a level of risk associated that needed to be mitigated. So that's where you're starting to see those issues and they actually started surfacing a little bit before that, but they came to a head during 2007.

Then in 2008, there was a second implementation committee, and I think previous testimony has talked about when it was the operators versus CAPP doing some of these things. We were part of both implementation committees, I should say. We had a representative present. The second

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

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back from CAPP is something that is troubling for them. Did that create any concerns for you, the fact that you -- you know, one moment you're dealing with the oil companies individually and another time you're dealing with CAPP as a corporate entity or as a separate entity?

MR. PIKE:

A. Ultimately, we hold the operators accountable and they were the ones we would ultimately be talking to for the implementation. If they choose to use CAPP as the vehicle for a coordinated effort, then that's their -- and they would like us to deal with CAPP on that basis, but ultimately we would hold the operators accountable. So in this case, if they wanted to use CAPP as the coordinator, we will facilitate that request. I think what you were looking at in certain regards is on the liability side, it was something that the operators themselves needed to come to terms with, versus something that CAPP could assume on their part. That would be sort of my understanding of that piece.

ROIL, Q.C.:

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Q. Um-hm.

MR. PIKE:

A. But again, we would ultimately hold -- there's some of the other issues that were going on at this stage as well, would have been the medical screening. What additional screening would be required for the medical to travel offshore? Again, you're now talking if you did the high fidelity training in the HUET, you know, it could be considered diving in that regard and you would need some increased medical surveillance of folks travelling offshore. So there was some issues there as well.

A side note for you. I've mentioned Safety-Net before, and I've been involved with Safety-Net since its inception. I sat on -- initially it was actually a project as opposed to a centre. I sat on one of their committees, the cold working committee and actually discussed the HUEBA with some of their researchers and we talked about different elements and we talked about breath holding and you know, what effect does cold water have on it, and they took that away and

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indeed, in 2004, a young Masters student, Jonathan Power, actually did his thesis on just that, the effects of water temperature, gender and exercise on breath holding following sudden face immersion, and it certainly highlighted some of the concerns I had and the need we had for a HUEBA system.

Indeed, Jonathan is actually now doing his PhD and is involved in research at the Institute of Ocean Technology on the thermal properties of immersion suits. While immersion suits aren't transportation suits, they are very similar. So what he is studying in that regard is what effect wind and waves have on the thermal properties of suits and that's a three-year project. They've been doing it over the last three years. This is the third year in that piece. They're using the wave basin at IOT. They do it in the winter because that's when they can get the coldest water. They have no chilling facility for their wave basin so they drain it and put cold -- or the water in during this time of year. It's a bit colder than if they were doing it in the summer, and they've been doing

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that testing. They certainly raise some questions as to survival times. So I became aware of that piece of work after March the 12th last year and actually had an opportunity last year to sit and talk to Jonathan and take a look at the research that was going on there, and that certainly raised additional questions in my mind on survival times, something that hadn't been raised previously.

ROIL, Q.C.:

Q. Looking back over those ten files and those ten years and your knowledge of what has happened and acknowledging, as we all have, that this seemed to be an inordinately long length of time, was it ever your impression that somebody was dropping the ball or that there was no real desire to bring within the Newfoundland offshore a breathing assist device? Did you ever get the impression that somebody was, to use a vernacular, ragging the puck?

MR. PIKE:

A. No, I don't think that it was that, but equally, I think it needed a lot more focus than it was potentially getting. I don't

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think anybody was consciously doing that. But obviously this period of time, when you sit back in hindsight looking at it, it took a very long time, and it, in hindsight, needed a little more focus than it was potentially getting. And again, we wait and see what the industry has when they do their lessons learned from this piece.

ROIL, Q.C.:

Q. Was it ever a consideration of C-NLOPB to force the issue and say "do it now"?

MR. PIKE:

A. Yes.

ROIL, Q.C.:

Q. Some of the letters seem to suggest that there was that kind of clout behind the messaging.

MR. PIKE:

A. Certainly when we approached our Chair and indicated we had concerns with the implementation in this and he wrote the letter, that's an indication that we were escalating this issue -

ROIL, Q.C.:

Q. Right.

MR. PIKE:

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A. - to that level and that we were prepared to move on if the industry had not started moving again. So by bringing it to our Chair, our Chair agreed with us and actually wrote that letter. So yes, we did raise it.

ROIL, Q.C.:

Q. Okay. The next piece takes us into compliance and enforcement which is pretty much the last piece that we have. So this might be a good time to take our break a little bit earlier and we'll perhaps come back a little bit earlier as well.

COMMISSIONER:

Q. Yes, all right then.

(BREAK)

ROIL, Q.C.

Q. Thank you, Commissioner. It's been pointed out to me on the break that I used an expression "ragging the puck" and not everybody knows what that expression means. As a true hockey Canadian, I would have thought that we all knew what it mean, but to rag the puck is to -

THE COMMISSIONER:

Q. I would have thought so.

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ROIL, Q.C.

Q. - is to take something, but intentionally not try to advance it too far, as you would do in hockey. So I apologize if that analogy went over the heads of some in the room and perhaps some out of the room as well. Okay, Mr. Pike, we are now moving on to compliance and enforcement and you have another summary slide for me?

MR. PIKE:

A. Yes, we're just going to review the policy that the Board has established, vis-a-vis compliance and enforcement, so we'll talk a little bit about the guiding principles. The protocol for non-compliance, we've seen the non-compliance table in the audits, so that's really what that's referring to, although the--and then warnings, order, suspending or revoking an authorization, cancellation of interest and prosecutions.

ROIL, Q.C.

Q. So this is your tool box of compliance items?

MR. PIKE:

A. Yes. So the guiding principles, all operators must comply with the legislation, fairly

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straight forward. Compliance will be encouraged through effective communications. Indeed if you look at, in the Atlantic Accord Implementation Act, Part III, the purpose of that part is the promotion of safety and environmental protection. So indeed if you are doing that, you have to encourage effective communication if you're going to promote safety and environmental protection, and that's the only promotion that the Board has a mandate to do. "All non-compliances must be treated appropriated and rectified. The Board is committed to enforcing all legislative requirements. Enforcement action will be carried out in a fair and consistent manner." I would define that as sort of a natural justice type provision. "Operators will be notified of non-compliance issues within a reasonable time and deadlines will be reasonable." So these are the guiding principles we have for our compliance and enforcement policy.

ROIL, Q.C.

Q. Just before you go on to the protocols, some have come before us and said that they believe

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that the industry or the workers would be better served if there was a separate, a separation between the regulatory function or the license granting function and the safety function. My question to you, Mr. Pike, is in your experience and your role as chief safety officer, has it ever occurred to you that there is a difficulty or have you ever had a problem with advancing safety items within the Newfoundland Offshore?

MR. PIKE:

A. I never have, it's never been an occasion where we've compromised safety in any way in the dealings with the Board. I've had a hundred percent support from each of the Board and there have been various boards over the years.

ROIL, Q.C.

Q. Thank you.

COMMISSIONER:

Q. If I may just interject, one of the things-- I've been thinking about that, you know, since it's been raised here in the hearings and I know that Norway has done it and the UK has done it, but then their oil fields, in terms

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of numbers of platforms are gigantic, compared with our small number by comparison. It strikes me that it may make a lot more sense when you're as big in oil production as they are, compared with the small number of platforms and installations we have, do you have any thoughts on that?

MR. PIKE:

A. That's part of it certainly, the other one I'll point out, I was going to talk about a little later under emergency preparedness, there's a recent incident in Australia, the Montara blow out. The Australian National Safety Authority only has responsibility up to the wellhead. There's a bunch of things going on below the wellhead and essentially that's where the blow out has occurred, so without having access to that geoscience information that we would have in an integrated organization, you do run into a problem with regard to that and we would have some responsibility for the integrity of the well. So you'd have to be very careful when you start carving it out as to how you set up the boundaries. There have indeed been three

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

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successfully for a number of years as a single agency with a resource management and with safety operating under the same organization. So it can work either way, there are pluses and minuses to both of it, it depends on how-- what the oversight piece is on that regulator as to how well that will work.

COMMISSIONER:

Q. It's interesting that you say the Norwegian government simply came up with it as a matter of policy. I was told or I read or I can't remember now, but anyway, fairly recently in the UK it came up as a matter of policy without even prior consultation and bang, suddenly legislation was introduced, which is an interesting -

MR. PIKE:

A. I'm not sure if that's quite--it came out of the Piper Alpha Inquiry. It was after that that they did the separation.

COMMISSIONER:

Q. There was some separation, but Piper Alpha was 1989, wasn't it?

MR. PIKE:

A. '88.

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COMMISSIONER:
Q. '88, yes and then the report took a little while.
MR. PIKE:
A. Couple of years after that that they made the change.
COMMISSIONER:
Q. But this was done--what was done in the UK recently, I think was 2003 and that legislation, I was told, came out of the blue, which - I could check that out perhaps -
MR. PIKE:
A. The only thing I'm aware that they did was they updated their safety case legislation in about that timeframe.
COMMISSIONER:
Q. Maybe that's what it was that I was told about, you know. Yeah, okay, thank you.
ROIL, Q.C.
Q. Okay, Mr. Pike, I think we'll go back to slide 29 which I interrupted you before you were ready to go there.
MR. PIKE:
A. We saw the reference to non-compliances in the report from the safety audit, so there's the

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

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

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Q. In your experience has there ever been a warning issued with respect to helicopter operations in offshore Newfoundland and Labrador?
MR. PIKE:
A. The closest thing I would say we did to that was the letter I wrote last June.
ROIL, Q.C.
Q. Which -
MR. PIKE:
A. I didn't characterize it as a warning, but it could be seen as a warning.
ROIL, Q.C.
Q. Which letter, is that the one you referred to earlier?
MR. PIKE:
A. Yes, June of 2009, the one that we referred to on the helicopter suits.
ROIL, Q.C.
Q. On the suits, okay.
MR. PIKE:
A. But that's as close to a warning as I've come.
ROIL, Q.C.
Q. Okay, so you were being pointed in letter.
MR. PIKE:

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A. Yes.
ROIL, Q.C.
Q. Okay, next thing.
MR. PIKE:
A. Orders. We basically have two kinds of orders. The first one is sort of a cease or continue activity and that's specific, I made reference to that, if the safety officer there, they see that something is not going right with a, say a confined space entry, they could issue an order to stop the confined space entry or indeed the activity could continue, but under certain conditions. So it's where the safety officer is of the opinion that the continuation of an activity is likely to result in serious injury, regardless of whether or not a non-compliance is believed to exist.
ROIL, Q.C.
Q. So that's something any safety officer of the Board can do or only you?
MR. PIKE:
A. Yes. No, any safety of the Board can issue that order. And the other type of order we have is an order to comply and the two sort of

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criterion in that one is when it appears a person or an operator is not--or is ignoring a warning, an order could be issued and to document a remedial action that has already been proposed, so there's an agreed course of action and in order to document it, we could issue an order in that regard. And of note, failure to comply with an order is an offence under the Accord Act.
ROIL, Q.C.
Q. And again my question to drive it towards helicopter transportation, has there ever been an order issued to your knowledge with respect to helicopter transportation related issues?
MR. PIKE:
A. No.
ROIL, Q.C.
Q. Thank you.
MR. PIKE:
A. Suspending or revoking an authorization or an operating license, revoke, revocation or suspension of an authorization or a license is a decision of the Board. Indeed, the Board is the one that issues those authorizations, so they would be the one to suspend it. Where

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

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

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an actor that's being a continual problem, so where the chief safety officer is of the opinion that there exists non-compliance in relation to safety, the chief safety officer may recommend to the chairman--and again, this is to the Board, that the operator's interest be revoked or suspended. Before effecting any such revocation or suspension, the Board shall facilitate a show cause process allowing the operator to demonstrate why such revocation or suspension should not occur at a hearing conducted by the oil and gas committee. Any action taken by the Board in this regard, however, is a fundamental decision. So there is a process involved where we could cancel an operator's interest because of non-compliance to safety. It is a rather long process, but it is a process available to us.

Prosecution. The criteria we would use proceed with a prosecution would be the gravity of the offence, whether other remedies would be available and preferred, whether an offence can be clearly identified the grounds upon which the offence is believed to have occurred, whether the burden of proof on the

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Board is likely to be met, where it is in the public interest to proceed with the prosecution, the consequences in terms of time, cost, benefits and harm of prosecuting and the likelihood of success having considered all the relevant factors. We get great assistance from legal on writing this criteria.

ROIL, Q.C.

Q. Okay, again, I would ask you has there ever been a prosecution in relation to helicopter operators in the Newfoundland offshore?

MR. PIKE:

A. No, there has not.

ROIL, Q.C.

Q. I didn't ask you about the cancellation or the suspension or revocation, I just assumed that that was not the case.

MR. PIKE:

A. No. So the next piece I was going to talk about is our emergency response plan. I'll talk a little bit about the roles of the different officers during that piece. We run--and you will see that ours is a very different response plan to what you will get

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from the operators, we have what we refer to as a category one, category two and category three response and we'll go through each of those.

ROIL, Q.C.

Q. Okay.

MR. PIKE:

A. We talked a little bit back when we had the incident, when we get our incident notification, the role of the chief safety officer, in the case--normally in a category one, it would be the chief safety officer that would initiate the emergency response plan. Indeed the chief conservation officer would have responsibilities with regard to an environmental event or a resource conservation issue, not likely to see a resource conservation issue as an immediate issue to invoke your emergency response plan, but that's sort of where it sits. The duty office, and again, the duty officer is the one that gets the initial notification and they would take some of the notes associated with the meeting or engaging the emergency response plan.

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ROIL, Q.C.

Q. Is that the person who carries the 24 hour, seven day contact information from time to time?

MR. PIKE:

A. Yes. Onshore liaison officer, indeed on March 12th we did invoke this provision. This is something optional for us. We put two safety officers over in Husky's Emergency Response Centre, so they were monitoring and observing what was going on in Husky's Emergency Response Centre, so in addition to hearing from the operator, we were also hearing from our own safety officer who was sitting there. So depending on the situation, we actually may have a safety officer, in this case two, sitting in the operator's emergency response room monitoring what is going on.

ROIL, Q.C.

Q. So is their role monitoring or assisting? It's more monitoring, is it?

MR. PIKE:

A. It's more monitoring.

ROIL, Q.C.

Q. Yes.

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

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

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

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

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one response work well in that kind of -

MR. PIKE:

A. It worked reasonable well, we will change some things. We want to make sure that we get the appropriate contact information for the spouses at work. We had some problems there, but other than there, there were a number of lessons that we learned from that piece.

ROIL, Q.C.

Q. But generally, category one worked the way you expected it to?

MR. PIKE:

A. Yes. Category two responses really deal with environmental emergency situations. Where the intervention of the Board is necessary partially or completely to manage the operators, environmental protection or restoration activities during an emergency situation. If the operator's response is deemed to be adequate, category one applies. So the CSO takes the lead--and this is not correct, I should have corrected this, the CCO takes the lead in a category two emergency situation. The last final figures comes under conservation officer and the chief

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conservation officer, it doesn't come under safety.

ROIL, Q.C.

Q. Yes, so we'll take that as a typo in the last sentence, the CCO takes the lead in category two.

MR. PIKE:

A. Yes.

ROIL, Q.C.

Q. Okay, and I take the hallmark of that is intervention, as opposed to monitoring.

MR. PIKE:

A. Yes, and we're talking there not necessarily partial, so we could sometimes bounce between the two. If we're not quite happy with what the operator is doing, we may issue the order. If they comply with the order, we'll drop back to a category one where we're monitoring, so that sort of could be happening.

ROIL, Q.C.

Q. Could you start off with a category one response and realize that things aren't happening the way it should be and then have to go to a monitoring--to a two?

MR. PIKE:

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A. Yes.

ROIL, Q.C.

Q. So these are not cast in stone, it's a moveable feast.

MR. PIKE:

A. No. They are. The category three response is associated with safety and other matters on their own or in addition to environmental matters where intervention by the Board is necessary to provide direction to the operator during an emergency situation. If no direction to the operator is necessary, a category one applies. The CSO takes the lead in a category three emergency situation and this could also be a case where the Board takes over a particular operation of we aren't satisfied with what the operator is doing and I'll go back to the Australian example, if there was an extended blow out, we weren't happy with what the operator was doing, we could take over the operation and arrange for a well control piece to have taken place. A rather remote piece and if you've done your homework right in the first instance when you issue the authorizations, you aren't going to

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have to go here, but it is a provision that you keep in your toolbox just in case, but if you've done the right work up front and got the right provisions with your operator up front, you aren't necessarily going to find yourself in this position.

ROIL, Q.C.

Q. Okay, well I think that takes us through all of the evidence that I intended to lead you on. I don't know if you have any closing statement that you want to make, Mr. Pike, before we get into the next issue of other counsel having questions.

CLOSING STATEMENT BY MR. HOWARD PIKE

MR. PIKE:

A. Maybe just a quick--a safety regulator never takes any joy in getting his picture in the paper. It's usually a measure of failure and unfortunately in the safety business, we tend to measure failure, as opposed to success. And I think one of the challenges we should look forward to is how can we measure success in safety. And I think it's through that measure of safety that we can build confidence in both the workers and in the public in what

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

ROIL, Q.C.:

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

MR. PIKE:

A. That's correct. Thank you.

ROIL, Q.C.:

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

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

COMMISSIONER:

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

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

MS. O'BRIEN:

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

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

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

MR. PIKE:

A. That's correct.

MS. O'BRIEN:

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

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

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

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There's concern raised that the C-NLOPB and the oil companies should be more informed of violations. That the C-NLOPB should get copies of the JOHS committee minutes and report of all incidents, and I would assume there they mean at Cougar as opposed to with the operators, this having been a Cougar employee.

"The pilot complained" and I'm on page five here, "the pilot complained about flying without MEL," which I understand is the minimum equipment list, "and was told to fly or go home." Fly something or go home. So really, this employee was raising some concerns certainly about the safety culture in place and I know we had some of the operators who spoke to us earlier who are long time offshore oil workers, you know, having started in jobs where they were offshore, and they said that of course, you know, offshore it started as a very male, rough and tumble kind of culture and imposing a safety culture on a body that's historically been quite -- you know, had sort of a very different culture than that, is a difficult thing to do and they

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have seen big improvements over the years, and I would think when we're looking at particular work groups where it may be a little more difficult to impose safety cultures or there may be a bit more of a culture of bravado, pilots and flying may be another one of those types of cultures. So I certainly see some concern here.

So my question, with a very long preamble I realize, to you is to ask when you got this -- I know you followed up in your next audit, your next August or April 2004 audit. You did a specific look at Cougar, and I know you were looking at in particular the fix that the pilot -- the unauthorized fix on the S-61 and a couple of the other issues, but what, if anything, did you do to look and see and delve a little bit deeper on this issue, this red flag that was being raised about the safety culture or the lack of safety culture at Cougar?

MR. PIKE:

A. Part of our standard sort of questioning tries to get at those elements. So to go back to some of the -- we didn't actually look at that

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

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We went in to see if we could see any evidence of some of the things that he was raising, a difficult thing to try to nail down. We've continued to evolve our processes to try to pick up on those things, but we didn't get that sense when we went in and did our audit. I'm not saying that this individual didn't believe what was going on, but we couldn't verify it in any way when we went in and took a look at our audit, and the way we structured our questions would have been around can we get any sense that these things are happening? Can we document it? So we would have structured our questions around some of these issues.

MS. O'BRIEN:

Q. Can you give me a bit more? I agree with you that it is going to something that's difficult to get at, but yet it's something that is very important to get at. So can you give me a bit of an example of what you would have done to try to uncover whether this was something real or this was just an opinion that really wasn't based on fact?

MR. PIKE:

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

MS. O'BRIEN:

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

MR. PIKE:

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

MS. O'BRIEN:

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

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

MR. PIKE:

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

It's my understanding that when they went

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

MS. O'BRIEN:

Q. Okay.

MR. PIKE:

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

MS. O'BRIEN:

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

Were you -- when you, you know, heard

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that testimony from Mr. Burt were you surprised that Cougar had, to this date, not done a risk assessment on sort of a fundamental piece of safety equipment?

MR. PIKE:

A. That's, again, I think if you go back through some of these audits, you'll notice that that safety management and culture has been evolving at Cougar. In one of the audits, we actually identify that they didn't have a fully developed safety management system. They were essentially relying on the regulatory structure within which they were. So it is in some regards somewhat surprising, yes, because they seem to be an innovative company. When people were raising some of these things that would increase the safety of how they operated, they seemed to be embracing them. So it was somewhat surprising that they hadn't taken the initiative to take a look at helmets. So in some respects, it seemed a little bit out of the character that I understood Cougar to be operating under. They seem to be a very innovative company, embracing some of the initiatives to improve

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safety. So the fact that they hadn't done that, yeah, that was somewhat surprising.

MS. O'BRIEN:

Q. Okay. You know, I agree and certainly after hearing their presentation, they really describe themselves as not just a -- certainly not a reactive company, but a proactive company or even a generative company, which I guess is the new word for even better than proactive. So that's how they put themselves forward in their presentation. But yet, when the breathing apparatuses came up, something for pilots, something that had been around for pilots for many years, they first started looking at that, I think they said only two years ago, so 2008, which is of course eight years after it was starting to be looked at at this industry for passengers on the system. So again, did that surprise you, that they again were -- I mean, that seems to me more reactive than proactive truly. I'd like to know what -- you're a safety officer. What's your opinion on it?

MR. PIKE:

A. I have to be honest and say that I had thought

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some of their pilots did have it. My understanding was that some of their ex-military pilots had asked and were permitted to use it. It came as a surprise to me when they announced that that wasn't the case.

MS. O'BRIEN:

Q. Okay.

MR. PIKE:

A. So I didn't pursue it. It was -- and I don't -- can't tell you where I heard it, but when some of this HUEBA stuff first came up and it was raised, I had honestly understood that some of the pilots carried it. The pilots that had military training that had been trained in it had asked to be able to use it, I understood were -- had it. Now I'm obviously mistaken, but that was my understanding.

MS. O'BRIEN:

Q. Okay.

MR. PIKE:

A. I didn't pursue it. You know, the pilots and Cougar is not directly what we regulate. That's a Transport Canada Aviation piece, but when we asked the question, I had sort of

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understood that piece.

MS. O'BRIEN:

Q. And this is really, you know, you're really coming to what my main -- putting your finger on my main concern here is that certainly, the C-NLOPB is doing certainly some auditing of Cougar, because you've just told us that you do do auditing of Cougar, and your -- so at least on paper, it looks like we have a company here who has all these systems in place and someone is going to do the auditing. But I guess we're all aware that sometimes the paperwork and, you know, the boxes that are being checked and that someone's checking the boxes can sometimes not really give you the full picture of what's going on and you don't always get the -- at the end of the day, what's happening is really still not good enough, despite all these audit procedures that you have, at least on paper. And I'm wondering, you know, do you feel that it's not your responsibility to make sure that Cougar is being as safe as it possibly can with its employees? Do you feel that's someone else's responsibility? Do you feel you're doing

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enough? Do you feel you're limited in what you can do?

MR. PIKE:

A. The lead regulatory agency for Cougar and its employees is Transport Canada Aviation. Their occupational health and safety responsibilities fit within Labour Canada. It's a federal jurisdiction. I'd be stepping outside my bounds if I started moving in there. Now do I occasionally push that way? Yes. But it is outside, strictly speaking, my regulatory bounds to be dealing with Cougar pilots. They are covered by a regime within Canada under Transport Canada Aviation and Labour Canada.

MS. O'BRIEN:

Q. Okay. And yet their safety, the safety of Cougar pilots, is inextricably linked to the safety of the workers who you are regulating, right?

MR. PIKE:

A. Yes, that's one of the reasons we do go take a look and you're right, systems aren't perfect. We try to take a look at it to see where the system is and that's what the audit is trying

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to do. It doesn't look at the entire piece. We try to take some samples to see if what they presented to us is reflected in reality and the samples we've taken at Cougar have demonstrated that they do reflect and there may be things that we're missing, but the audits are not -- we don't look at everything. We take those sample slices down through it and you look at it and were there any abnormalities in it and the answer is no.

MS. O'BRIEN:

Q. But yet some things are obviously being missed or you wouldn't have been surprised here on February 4th, right?

MR. PIKE:

A. Yeah, certainly.

MS. O'BRIEN:

Q. Yeah, okay. I know that this -- and this is really my last area of questioning. You have described that we know that we have -- for example, let's take the helicopter passenger transport suits. We know that there is a regulation in place that these suits must meet, a standard that these suits must meet, and we know that the C-NLOPB has taken the

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view that perhaps something a little bit over the standard is required. Am I stating that fairly?

MR. PIKE:

A. Yes.

MS. O'BRIEN:

Q. Yes. So you have gone and actually, you know -- I think we looked at Exhibit 255 or something today. Anyway, it was a letter where you put forward and you said to the operators "we want you to demonstrate the water ingress and egress testing. We want you to demonstrate to us that these suits do adequately protect against hypothermia." Now I'm going to take that, so where we have a regulator here who has a standard and yet is saying, you know, we have a really dangerous environment out there in the North Atlantic. We need to do better than the standard. We're going to force you to do better than the standard. To what we have for the pilots and their suits, which we don't have a standard for the pilot suits. All we have is that they have to adequately protect from hypothermia. So unlike the passenger suits where reams of

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numbers and water egress and ingress and temperature gradings that we have to meet, we don't have anything like that for the pilot suits and my concern is maybe what the pilots are wearing is not good enough. I mean, at the end of the day, that's my concern.

What body would be responsible for taking a look at pilots flying in the North Atlantic where the water is frigid and looking and saying "those suits are good enough. We need to go above the stated standard. We need to have some numbers involved here. We need to have some testing done to have someone show us that these suits work"? Who would that be?

MR. PIKE:

A. For the pilots, I would see that as being Transport Canada Aviation. Indeed, Transport Canada Aviation also has the requirement for the passengers. They cite the passenger suit standard in their regulations as well. I said at the beginning what I do sometimes, it's very important to take a different perspective. We have to look at things from different ways. Your premise here is that the helicopter pilots aren't protected as well as

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the passengers. Let's take a different premise. Maybe they're better protected than the passengers.

MS. O'BRIEN:

Q. Sure.

MR. PIKE:

A. The suits they've got may provide better waterproofing or water ingress than the passenger suits. What happens if I was involved in an outdoor activity, snowshoeing, cross country skiing, go to a sporting goods store somewhere, Outfitters, whoever, how would they outfit me for it? They would put me in layers. I'd have one of those Miranda wool maybe underneath and then some additional layers that are for protection even when it gets wet and it wicks away your -- sort of keeps you cooler. So they'd give me a bunch of layers and then on top of that, you'd put a waterproof layer, and that's, in essence, what the pilots have. The passengers, on the other hand, are put into an all encompassing suit. In addition to that, the pilots are able to wear their own boots. We've already seen that in the passenger suits, the boots were an

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issue, are an issue, continue to be an issue. So sometimes you need to take a different perspective on some of these things. We've assumed here that the pilots weren't as well protected, but maybe they were better protected. I don't know, but certainly we need to look at those things and look at -- and ask those kinds of questions.

MS. O'BRIEN:

Q. That's right, and really to be -- I am not assuming. I don't know.

MR. PIKE:

A. Okay.

MS. O'BRIEN:

Q. I don't know. I haven't seen any data on those suits whatsoever and I've asked the questions and I still -- I don't have any data. No one's provided us with any information that there's been any testing. You might be -- you know, that they're better is just as possible at this point than that they're worse. I'm -

MR. PIKE:

A. I don't know either and it would be interesting to take a look at that, certainly.

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MS. O'BRIEN:

Q. Do you feel that the C-NLOPB in that you can require the operators to do some testings of the passenger suit, which as you said is also a Transport Canada standard, do you feel the C-NLOPB could say to the operators "by the way, we want you to ensure that the pilots who are flying also can demonstrate to us that their suits adequately prevent against hypothermia in this environment"?

MR. PIKE:

A. That would certainly be pushing our boundary, and what I see as our jurisdiction, so I'd have to review that one with my counsel in order to see whether we could do anything, but on the surface, I'd have to say no. I think we would be pushing beyond some of the bounds of what would be reasonable.

MS. O'BRIEN:

Q. Okay. I mean, I certainly would like -

MR. PIKE:

A. I appreciate that this is a difficult problem and we can certainly look at it, but I can't -- - I can see some problems in that regard.

MS. O'BRIEN:

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Q. You know, and I certainly am going to be urging, when we get to discussing issues coming out of this phase, that you know, I think somebody should be requiring Cougar to demonstrate that their suits do work and that it's not just for the safety of the pilots, though I think that's very important too. They're offshore workers too. They're people who are in those helicopters flying back and forth over that water on a daily basis. They're in there more than anybody else. But it's also important for the rest of the workers because, you know, when you're in a situation like that, the safety of one is important to the safety of all.

MR. PIKE:

A. The only way I could see potentially doing it is to contrast it. Asking whether that form of protection is better than the form of protection we are currently using. That would be the only avenue that I would see that would fit in within our -

MS. O'BRIEN:

Q. But what about the requirement for testing, just to find out?

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

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

CERTIFICATE

We, the undersigned, do hereby certify that the foregoing is a true and correct transcript of a hearing heard on the 17th day of February, 2010 at Tara Place, 31 Peet Street, Suite 213, St. John's Newfoundland and Labrador and was transcribed by us to the best of our ability by means of a sound apparatus.

Dated at St. John's, NL this
17th day of February, 2010
Cindy Sooley
Discoveries Unlimited Inc.
Judy Moss
Discoveries Unlimited Inc.