OFFSHORE HELICOPTER SAFETY INQUIRY

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

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Stacey O'Dea/ ..... Hibernia Management and
Cecily Strickland ..... Development Company (HMDC)

D. Blair Pritchett/Denis Mahoney/
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Rolf Pritchard/
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Jack Harris, Q.C. ..... Member of Parliment

Kevin Stamp, Q.C. .....Cougar Helicopters Inc.

Jamie Martin.....Families of Deceased Passengers

Kate O'Brien. ..... Davis Estate (Pilot) and agent on behalf of
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September 9, 2010
COMMISSIONER:
Q. Good morning, ladies and gentlemen. I think, Mr. Roil, you have something to say before Mr. Earle starts.
ROIL, Q.C.:
Q. Yes, Commissioner, thank you. Yesterday morning when Mr. Spencer was presenting on behalf of Helly Hansen Canada Limited, he made reference, and I think in your question there was reference to whether or not the HTS-1 suit had a second approval, that being the marine one, and he has since provided me with a document that I'd like him to speak briefly to and then we can make it an exhibit as part of our records.
COMMISSIONER:
Q. Okay.
SUBMISSIONS BY MR. SPENCER:
Q. Good morning, Mr. Commissioner. Following my submissions yesterday, it was brought to my attention that just two months ago, in fact, on July 6th, 2010, the HTS-1 suits did receive a certificate approval from Transport Canada for the Marine Abandonment Standard. Now you

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

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

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parties in the room and the Registrar has a copy. I understand it will bear #P-00241.
REGISTRAR:
Q. That's correct.
ROIL, Q.C.:
Q. And the appropriate title of it we'll determine briefly to make sure that it fits within our record keeping appropriately.
COMMISSIONER:
Q. Thank you, Mr. Spencer.
MR. SPENCER:
Q. Thank you, sir.
ROIL, Q.C.:
Q. Now I think, Commissioner, Mr. Earle is ready to proceed.
SUBMISSIONS BY RANDELL EARLE, Q.C.:
Q. Good morning, Commissioner. Initially, I would like to thank the Inquiry staff and counsel and yourself, Mr. Commissioner, for the courtesies, assistances, and from time to time indulgences that we have been granted over the course of the Inquiry. In particular, on behalf of the members of CEP 2121, thank you for the courage to make the interim recommendation for a move to a SAR

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response time of 15 to 20 minutes wheels up, and a ceasing of night flights.

When CEP 2121 undertook this exercise, the highest priority was to make the point that Search and Rescue response time had to be improved and night flights were a hazard which could not be tolerated. The fact that you made an interim recommendation, I think has underlined the importance of this particular recommendation, and I think it has really set a new tone for safety in offshore Newfoundland and Labrador.

When you get an Inquiry like this, there's almost a Stockholm Syndrome where the prisoners and the guards gradually come to get comfortable with each other. I think we should remind ourselves at this point that the Aerosafe Survey found after all the activity, even after the interim order, that 27 percent of offshore workers indicate that they have confidence issues vis a vis offshore helicopter travel, 37 percent have expressed a desire for travel to the offshore installations by a means other than helicopter. Safety of helicopter travel weighs

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heavily on the minds of too many of the people that CEP 2121 represents.

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

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of the safety experts use, we look to have enough slices of swiss cheese, so even though each slice has a hole in it, a weakness that something can get through, we've got enough slices that disaster cannot make its way all the way through.

Now if there is an underlying cause, if there is a systemic problem, just adding another barrier will not be enough. If there is a systemic problem, major change is necessary because if it's a systemic problem, we will see that the level of redundancy is insufficient, the attention to the necessity of redundancy is insufficient. It is the job of the operators in the scheme in the Newfoundland and Labrador offshore. It's their job to ensure redundancy. They produce the safety plan, they come up with the mechanisms to this ALARP principle to ensure that the risk is as low as reasonably practicable.

On the other hand, it is the job of the regulator to validate that sufficient redundancy is in place, and to take action if it isn't. They don't develop the safety

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plans, they don't decide on the mechanisms, they validate them, but if the ALARP principle is not being honoured, then the regulator must take action. If sufficient redundancy is not there, they must take action.

Our conclusion is that a history that we have seen here indicates that C-NLOPB has failed in its role as a regulator. Now that's a very severe statement and we don't make it lightly, but we can find no other conclusion. We all went through the history of things with the emergency underwater breathing device. It was a new piece of redundancy, it was a critical piece of redundancy because if you recall Dr. Coleshaw's evidence and the report on breathing hold time, the fact of the matter is that the probability of being able to make it to the surface without taking in water into the lungs and drowning from a submerging helicopter is extremely low, there just wasn't enough time in a held breath to get you to the surface. So this is a critical piece of redundancy standing between the individual and death. This exercise started in 2000. An emergency breathing device was in use in the

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North Sea. By 2003, everybody was using it. The military was using the compressed air device. Recreational scuba divers had been using a similar device for years. Rather than demand that the operators adopt a schedule, develop a plan of attack, move the device forward, a device that was in play in the rest of the world, C-NLOPB displayed what I can only describe as an institutional lethargy that's absolutely mind boggling. You know, you can look at the little pieces of that and you can say, yes, we had to be sure that we could do the training safe, or, yes, we wanted to pick the best device, but somebody has to look at the big picture, and the big picture was without an emergency breathing device people weren't going to be able to hold their breath long enough to come to the surface from a sinking helicopter. The big picture was that other people had found a solution, so why are we taking nine years to bring this advance to workers in the Newfoundland and Labrador offshore.

Now CAPP, I suspect, prompted by this process, has engaged in a lessons learned

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exercise on this, and I will say that they brought forward some fairly sound ideas. We have some problems with them, but they're on a different level and I'll address that later, but they have found, you know, things we should have done. They're strong on that. They are weak on how it was an industry in which project management is the modus operandi for any significant change got so mired in moving forward with this process, but, you know, CAPP and - are really just the operators in another forum, they have responsibility, but C-NLOPB has a greater responsibility. They're the organization with the power to enforce, they're the organization that had the ability to say you have to get this done, and they declined to do it.

Let's just take a moment to look at the suits, the helicopter transportation suits. The C-NLOPB became aware in June of 2008 of four serious safety issues with the E-452 suit. Those issues were ill-fit, posing a risk to wearers during movement on land. I mean, people were coming up out of the boots of these things and walking down ladders

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stairways from helicopters, walking across helidecks. There was just - just an ordinary everyday safety risk posed by the ill-fitting suit. Someone could have injured themselves. There was a risk to mobility posed by these ill-fitting suits in the circumstances of the suit having to be relied upon during escape. We're talking about people, you know - I mean, the visual image is practically someone trying to get out of a helicopter while suited up in a sack. We heard from the people at Marine Institute about how people have to get out of this. You need a properly fitting suit to be agile and able to get out of these helicopters.

C-NLOPB was aware of the risk of ill-fitting, leading to water ingress, and we know what that meant for Robert Decker, and I'll deal with the Helly Hansen remarks of yesterday a little later on. C-NLOPB knew that these suits fitted so poorly that there was a significant risk for individuals that excess water would come from the ocean into the suit. They also knew, and it is interesting this was - because this was a risk

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that actually came out here first identified through C-NLOPB, the experts later confirmed, that there was a risk with these suits because with excessive material and excessive size, there would be excessive buoyancy, the individual could be driven against the frame of the helicopter by the excessive buoyancy and restricted in their ability to get out.

Now did they investigate the dimensions of the problem; no. They called in the operators and said what are you doing about it, and accepted we're working with the manufacturer and we're working with government. Did they consider alternatives to the continued us of defective safety equipment; no, we'll continue using this and we'll work on it, we'll try and fix it. Yeah, you know - Mr. Pike agreed that those risks were real and known to them in his evidence. This is not safe, we've got to figure out another way people to the platforms; no. This is a classic example of a failure to recognize what their job is. I mean, the idea that an occupational health and safety inspector from the Provincial Department of Labour would

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accept for an employer, well, we can't get safety gear for this individual that fits, so they'll continue working with safety gear that doesn't fit that poses a risk. I mean, it's so far fetched as to be ludicrous, yet that's exactly what C-NLOPB did here. They ignored their mandate which was to ensure that the redundancy put forward by the operators, helicopter transportation suits - functioning helicopter transportation suits was part of the operators safety plan, and C-NLOPB ignored that this part of the safety plan was missing. We need to remind ourselves of the dimensions of this problem. After a professional fitting exercise, that is someone who trained in ensuring that the fit was appropriate, after a professional fitting exercise, 180 people were found to not have a suit that fit properly. That's at least 180. The way the evidence came out, it could have been more, 180 people.

What has C-NLOPB told us that they've learned from this; nothing. What have they told us they've tried to do to find out how they got themselves in this position; nothing.

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

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accordance with the ALARP principle, a risk is as low as reasonably possible. How can you say that you've carried out that mandate when you have sat for 13 years with the rest of the world improving the situation. You sat for 13 years with the people of this province regularly raising a fuss in the airwaves and in the press about the response time of DND. So the issue was very much - response time was very much a public and current issue, and you sit by for 13 years, and have the offered any explanation as to how they, as an organization, got themselves in this situation; have they offered any insight to us, have they even indicated that they're looking at it. Their submission is an eight page recitation of their jurisdiction.

Mr. Commissioner, one of the issues that has been identified by you is whether or not the safety management risk systems of the operators is sufficiently robust to ensure passenger safety. Well, we now know as a matter of public record what Cougar Helicopters position is on the causes of the crash of Flight 491. They've issued a

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

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

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conflict. It is a very difficult place in which to rain upon the operators' parade.

Mr. Andrews, in his evidence, talked about the fact that the chief safety officer has independent action, but of course, you know, we're a collegial operation, I don't think that was the word he used, but this was the message, so we talk to each other about what we're doing. The reality is in an organization that has this split mandate, this inherently conflicting mandate, when the chief safety officer says to the chair "I'm going to have to shut down this operator," which is the crude remedy that they have, whether his voice says it, his face will say "do you really have to?" That's human nature. We express these things in phrases like "don't shoot the messenger." Just think about that. Where does that come from? Nobody wants to hear bad news, but it is the job of a safety officer to deliver bad news and a safety officer should not be working in an organization where the largest part of the organization, the mandate of the organization, does not want to hear bad news.

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It is unfortunate that we have not been able to hear from some experts in behavioural organization. We really haven't had time and I want to say at this point that I have to say the Inquiry is to be complimented on doing as much as reasonably practicable within a very tight time frame and a difficult mandate, in terms of the jurisdictions of others. But there are people out there. There's some very interesting work being done by some of the people, the Kellogg School of Management, on organizational behaviour and just how the messenger is treated and most importantly, the impact of those subtle cues back on the messenger and how it causes the messengers to filter their behaviour.

If we're right, C-NLOPB is not the organization to regulate safety in the Newfoundland and Labrador offshore. If we're not right, Mr. Commissioner, we are left with an organization that has demonstrated institutional lethargy, dereliction of duty, and which, most disturbingly, has not offered you an iota of insight as to why they have failed so dismally. Such an organization

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cannot be left with the responsibility to regulate safety.

We're saying to you, Mr. Commissioner, to make a recommendation that goes against the mainstream. The mainstream of Canada contains or is largely made up of combined safety and, for want of a better word, development promotion regulators. But we know that the UK has adopted a different system and we know that a small jurisdiction, like New Zealand, has a system where the regulation of safety is separated from the economic natural resource type regulation. So it's not impossible to do, and if safety, worker safety is truly the top priority then we cannot let the fact that everybody else is doing it a certain way in Canada stand as an impediment to remedying this problem.

Mr. Commissioner, the system in Newfoundland and Labrador offshore is already essentially a goal system, goal based system, and we'd have a lot of talk around that issue. In my respectful submission, not enough expert evidence to come down on it. But you know, it is essentially one of your mandate, operators,

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is to provide a safe operation, a safe workplace. Tell us how you'll do it and we will validate it. That's the essence of the current system, so that's not you must have, you know, 110 suits of a certain type. You must have a pair of safety goggles for every worker, et cetera. It's a goal based system, and these three areas that I've talked about in terms of the failures of C-NLOPB equally reflect failures on the part of the companies, and I know before I finished, everybody'll be looking at their watch, but why should things change in how people have reacted to me throughout this thing, so -

COMMISSIONER:

Q. Now, Mr. Earle, quite seriously, everybody in the room is going to be able to say, in these next two days, you know, what they feel. So don't feel constrained.

EARLE, Q.C.:

Q. Well, we were advised that we had an hour.

COMMISSIONER:

Q. Well, that's true, but -

EARLE, Q.C.:

Q. Yeah, and I'll be probably 59 minutes and 59

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seconds. But all these three issues, you can look at it, look at them and ask about the operators' role. I mean, the operators are CAPP. With the underwater breathing device, they have to wear responsibility, and to their credit, they have accepted responsibility for the nine-year delay.

You know, the suit problems, I mean, they had all the information that C-NLOPB had. They knew those problems were there. They had a survey done and the survey showed, if you looked at it carefully, that eight percent of the people surveyed said they had no trouble getting the zipper up, but they had a problem making the seal, and then they just went on. Eight percent of the offshore workforce is a lot of people who had problems making the seal in those suits.

Now the question I have is were they blinded by their desire to save money and remove a logistics problem by combining the two suits? Because when you look at the evidence of Suncor, in particular, it seemed to be the focus was, you know, we're trying to deal with Transport Canada. We're trying to

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get the suits approved. Well, they had a goal with Transport Canada when they started out with the new suit. It had to be a suit that was an abandonment suit and a helicopter transportation suit, both, and they fixated, it seems to me, on this and ignored the fact that the people were going back and forth to the offshore installations with unsafe gear on. Nothing changed with the suit as a result of the crash of 491. Nothing changed with the suits, the same suit, E-452. What changed was the profile of the issue. Robert Decker's body temperature when he was rescued simply underlined the consequences of the poor seal.

For an organization that is to be allowed to lead on safety, which is this is a system, that's what a goal system, we say here's the goal. Lead, go for it. An organization that is to be allowed to lead on safety must be sufficiently robust and rigorous in its approach to safety that it can see the greater risk when the signs are reported. They must not need to be hit over the head by the stark evidence provided by Robert Decker's body temperature on rescue. They must be able to

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see these things are not watertight. Watertight equals safety. Not watertight equals hyperthermia. We can't have people using them. They must be able to see somebody's going to be walking down the steps from one of these helicopters in one of these suits that fit so badly that they're going to fall and break a bone or worse. We can't use those suits.

On SAR response time, this, in my respectful submission, in our respectful submission, is a condemnation of the ability of these operators to lead. They all operate in jurisdictions where the response time is the standard you've ordered. They knew about the availability of that response time. They operate in jurisdictions where the operator has full responsibility for SAR. There is no other explanation for their failure to move that forward, other than they weren't going to do it until they were told to do it. That's not how you lead on safety.

I am disturbed by the operators' submission. Everything is okay. Everything is okay. Well, we can have a conference a

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couple times a year, but other than that, everything's okay. 180 people going around in suits that don't fit. Safety suits that don't fit is not everything is okay. Nine years to put a HUEBA in place is not everything is okay. A substandard SAR response is not everything is okay. 17 families who have lost husbands, fathers, sons and a daughter in a crash that didn't have to happen is not everything is okay. It is disturbing when you said to the participants in this matter at the outset in this Inquiry, "this is not about finger pointing. We want this to be a collaborative exercise," that the posture of the operators throughout this Inquiry has been so utterly defence oriented and that they have failed to look at the problems and identify the underlying causes that have led to these things so that we can have confidence in their ability to lead on safety issues.

The lessons learned in this Inquiry is that Newfoundland and Labrador needs a strong and effective safety regulator. We can't leave it to the operators and we can't have a safety regulator that sits on its hands.

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Now I'd like to touch for a few moments on some of the other issues and obviously we have addressed most of them in our brief, but the comments by Helly Hansen yesterday, such a blatant and classic example of blame the victim I've never heard. The fact of the matter is Robert Decker had a suit that didn't fit him and it was a suit that was supplied by his employer through Helly Hansen. Nobody had the job of seeing that the suit fit. Nobody instructed the workers on checking the fit, but Helly Hansen said "well, you know, maybe Robert" -- implicitly, "maybe Robert Decker took the wrong suit." There were 180 people who were found to have no suit that could fit them.

This brings us to the issue of personal accountability, because that's where Helly Hansen touched, you know, personal accountability. Look, the occupational health and safety committee on the Terra Nova platform kept the suit issue on the table for 11 months. How much more worker accountability do we need? Accountability on the part of workers is very important, but it

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requires knowledge. You have to know what a suit is supposed to achieve before you can go to somebody and say "it doesn't achieve what it's supposed to. I need another one." It requires a vehicle to raise the issues, a means, and we've heard about ProAct and we've heard about occupational health and safety committees. But most of all, it requires a receptive ear, because there is nothing that dampens accountability on the part of workers, initiative upon the part of workers, like a deaf ear when they raise the issues, and I ask you to reflect upon the response that the Terra Nova occupational health and safety committee got, the "oh, meets government standards. We're working on it" and is that the kind of thing that promotes personal accountability on the part of workers.

Yes, there is a big role for it, but there is a set of conditions that have to be in place before they -- and note, you know, when the workers were given the opportunity to express their views on the suit, they did, they survey, but was the effect of the survey taken on board by the operators? Did they

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listen to the results? Did they pick up the fact that there were people who were -- eight percent of the people were saying clearly "my suit doesn't seal"?

Worker participation and representation, we've outlined to you in our brief, the many instances where the right of workers to be heard, to participate, and supposedly enshrined in the Occupational Health and Safety legislation, was ignored. The HUEBA experience is classic.

We have a brief from the operators. One of them is not unionized. Two of them are. The organization which appears before you now, CEP 2121, is granted, under the legislation of this province, the legal right to demand that the employer deal with them on terms of conditions of employment, including safety. Indeed, the role of the union in occupational health and safety is identified in the legislation. We find it disturbing that, notwithstanding the public policy role that is given to unions, that in all of their discussion of worker participation, and no doubt they'll say "well, there's three of us,

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you know, and we had to use common language." In all their discussion of worker participation, the words "union", "CEP", "bargaining agent", "Local 2121", don't appear. They're trying to pretend we don't exist. It belies an attempt to deny reality and it doesn't honour the workers' right to have an organization that speaks for them in these matters.

Now I want to touch for a brief moment on the interaction between regulators and industry associations. CAPP has presented some fairly sound proposals in terms of how they would see things, clear terms of reference, a project champion, essentially a project management approach, and these ideas, I think, are sound so far as they go. But there is a problem with them. They lack enforceability. If they don't work, the answer for the regulator in the current scheme is go back to the operator and basically start from the beginning, all over again, and say "okay, operator, you have to do this, and operator B, you have to do this, and operator C, you have to do this."

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It is our submission that any involvement with industry associations on behalf of the industry, and we accept the notion of a single -- the benefits of a single point of contact, should include enforceability so that the arrangement should be contractual, and there should be clearly articulated authority on the part of the industry association to act on behalf and bind the operators.

In respect of SAR response time, we concur with Mr. Harris' remarks about the need for this Inquiry to consider the role of the second responder, and we think this is particularly important in the area of night flights, because the second responder in night -- and this is one of the reasons we feel night flights cannot be allowed. The second responder for night flights is two hours plus travelling time away. It is a great pity that only the three operators who we have here have participated. There are other operators in the Newfoundland and Labrador offshore. In respect of SAR response time, we are very concerned about the importance of the role of the second responder when you have distant

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drilling, such as the Stena Carron has been conducting for ConocoPhillips, where the helicopter that transports people out there, in order to be able to make the distance, must have two auxiliary fuel tanks and we understand a reduced payload, and that gives us real concern as to the ability of SAR aircraft to be on the scene for the length of time necessary to effect a rescue.

Mr. Commissioner, nothing can redress the loss which the families have suffered. In closing, we would like to commend to you the very eloquent words of Lori Chynn when she said "I just hope and pray that he did not suffer and that his death, along with the deaths of his friends and colleagues, will not be in vain. I hope that the legacy of those lives lost on March 12th, 2009 will be significant improvements in helicopter safety. Such a tragedy must not happen again. That must be your guiding principle." Thank you.

COMMISSIONER:

Q. Okay, thank you, Mr. Earle. We'll take our break now.

(BREAK)

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ROIL, Q.C.:

Q. I don't need any -- I don't know that I need to do it, but the next presenter is Alexander MacDonald, Q.C. on behalf of the operators.

COMMISSIONER:

Q. Okay, thank you. Good morning, Mr. MacDonald.

SUBMISSIONS BY ALEXANDER D. MACDONALD, Q.C.

MACDONALD, Q.C.:

Q. Good morning, Commissioner. Thank you, Mr. Roil. Commissioner, the tragic events of March 12th have forever changed the lives of everyone who's been involved. Everyone in Newfoundland has lost friends, neighbours, loved ones, colleagues. We'd like to express our severe -- our sincere and profound thanks to the families of the deceased, to our workforce, to Robert Decker, to you, Commissioner, to the Commission staff who have been fantastic throughout this process and everyone else who has participated in this Inquiry.

As you've pointed out yourself, Commissioner, in human events we can't guarantee that accidents will not occur, but what we do have is an obligation to learn from

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I think it's important to know, remind ourselves, Commissioner, the operators are subject to extensive and comprehensive regulatory oversight, which is detailed in our brief. We have comprehensive, dynamic and effective integrated management systems for the management of risk, including that helicopter transportation. Effective risk management requires the persistent application and enhancement of safety management systems to reduce risk to as low as reasonably practical. The operator systems are applied to all of their operations worldwide and in our view represent best industry practice. They're all structured to identify, assess and eliminate or mitigate risks and to manage change. The operators consistent and effective application of these systems, in our view, ensures the risk of helicopter transport is as low as is reasonably practicable.

So what are these management systems? As

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

Workers play an essential role in these systems and we're proud of their efforts to make safety the way we do business around here, and that truly is the attitude of the operators, and I think, Commissioner, you had firsthand experience to this when you were on the Hibernia platform.

So we must have an integrated management

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system which includes a safety management system embedded in all aspects of it, but that doesn't end there. We must also have a safety plan and each operator must submit a safety plan acceptable to the Board, and this plan is just not a generic statement. It includes summary of all studies undertaken to identify hazards and to evaluate safety risks, a description of the hazards identified and the results of the risk evaluation, and a summary of the measures to avoid, prevent and reduce and manage safety risk. By law, we are required to ensure that everyone working under us, our contractors, also comply with these safety plans. The legislation, in fact, explicitly requires offshore installations to be operated in a safe manner and I just draw your attention to Section 119 of the drilling and production regulations which are on the Board's website. Safety is an explicit requirement in the operation of facilities.

In Phase 1A, Aerospace (sic.) and the operators described the swiss cheese model which really is a simple way to describe preventative safeguards. In other words,

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preventative safeguards are safeguards undertaken to prevent a particular accident from occurring, to block the holes in the swiss cheese, if you like.

Our brief highlights many preventative safeguards which we have in place relating to helicopter operations. I'll give you some examples: the health and usage monitoring system, the so called HUMS on the aircraft; the development of weather monitoring; and the provision of simulated training for pilots, flight training, things of this sort. So these are examples of many contained in our brief of the so called preventative safeguards.

However, we also then put in place mitigating safeguards which reduce the consequences of an accident if they do occur. If the swiss cheese lines up and the preventative safeguards do not prevent an accident, then there have to be mitigating safeguards and these safeguards include many of the things before you. They include the requirement to wear helicopter passenger transportation suits, to do the offshore

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training, the BST and the BST-R, and the use of a four-point harness on a helicopter seat. So these are examples of mitigating safeguards.

It's through all of these efforts we strive to create a safe workplace and to ensure that risks are reasonable. One thing is certain though, while there's always going to be risk in helicopter travel, offshore workers are never, never subject to unnecessary risks.

Issue number three. What is the role of organizational safety culture in offshore helicopter transportation? You've heard a lot of testimony on this. Aerosafe and others have written there are five levels of safety culture, from bad to best, pathological, reactive, calculative, proactive and generative, and generative, as Aerospace has said is summarized in the statement HSE is how we do business around here.

We believe the operators' safety management systems contains practices, procedures and tools that establish a mature or generative safety culture. These systems

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instill the attitudes, values and beliefs that permeate all levels of the operator, from the very top, the CEO, to throughout the entire organization. Key elements of our safety management system have been outlined in our brief, but we'd like to talk a little bit about some of them now, just to remind us all what they contain.

There's an integrated system and process for the identification and reduction of risk. There's an endorsement and commitment to safety at all levels, from the top to the bottom or across the organization. A philosophy that safety practices extend through every aspect of the business. A sense of tools and processes, some of which you heard about in this hearing: new worker orientations; pre-job meetings; hazard identification cards, these STOP cards you've seen; and incident investigation and reporting. There's audits, inspections throughout the system to ensure compliance verification and continual learning, and I think many of the things we talked about in our brief will highlight that point, continual

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learning and improvement. And finally, there's a root cause analysis of incidents and hazards, what caused the accident, what caused the incident.

I think everyone on this Inquiry who's testified, the operators and the worker representatives who testified, have acknowledged that hazard awareness and reporting expectations permeate every aspect of the operation. I don't think there's any doubt about this. Investigations focus on root causes rather than blaming individuals. Effective communication and continual learning are key to this system, continuous improvement. We've heard this over and over again. We really have to take exception to any suggestion that it's been historically unwise for anyone to report a safety issue. We don't think this is correct and we think the evidence of the opposite is true, and I think you've seen that yourself on the offshore platforms and I think some of the witnesses who talked here talked about that. I don't think there's any suggestion that that is at all a factor in these situations.

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All of this being said, actions speak louder than words, and the actions that we took after the loss of 491 illustrate that we have a mature safety culture. There's been continuous learning since that date.

Issue four, we'd like to talk about that a little bit, which is "what are the most appropriate practices, standards and forums of interaction between the Board and the following" and we'd like to talk about the industry, including suppliers and contractors, industry associations, which in this context is CAPP, and other worker representation.

I think we have to remember the Board has broad, enforceable regulatory authority over our operations. The operators, in turn, have to ensure that everyone in the contractual chain has the appropriate safety practices in place, including Cougar, including our drilling contractors, including everyone else. The buck stops with the operators, with us. We hold the production authorizations and we are responsible for the conduct of everyone that works for us. It's the operators who are accountable to the Board. The Board doesn't

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change subcontractor number 12. They deal with the operator. You have the responsibility to ensure safety in the offshore.

The Board then verifies these processes and they have a wide range of enforcement powers which haven't been talked about in great detail, but they can do safety audits. They can issue warnings and orders to cease. They can order -- issue an order to comply. They can suspend or revoke a work authorization, an extremely powerful tool. They can cancel your interest. They can cancel your production license. They can cancel your interest in the offshore, and they can prosecute you under the legislation for an offence, and they can establish an inquiry, which they've done in this case. So the Board has very broad powers. So the operator is responsible for its operations of everyone in the chain. The Board is responsible to monitor that through these broad powers.

We really believe that the current interaction, the current legislative framework, does not require changes. It is

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the most appropriate way to legislate in the offshore. The buck stops with the operators. We're responsible to the Board. The Board has great powers to enforce its obligations.

Talk about industry organizations. In this case, we're talking about CAPP. There's been a great deal of testimony about CAPP. We believe CAPP is an effective organization to facilitate discussions between the Board and operators when an industry wide initiative is required, not one involving one operator or another. We also think it would be imprudent to judge the effectiveness of CAPP solely on the timing of the HUEBA initiative. CAPP has done many good things in the offshore. They successfully developed and updated the CAPP standard practice for training and qualifications of personnel. It's done the same with respect to the CAPP east coast medical assessment for fitness to work, and also with respect to something called a safe lifting practices. Lifting merely being when you take the crude out of the facility, the offshore facility, into a tanker. So CAPP has done extremely good work.

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

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

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

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

Issue six, which has had a lot of

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

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

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

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

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time and Cougar is now in discussions with the St. John's Airport Authority and Nav Canada to acquire the necessary approvals to build a new facility at the airport. So that's well under way.

With respect to auto hover, the aircrafts are equipped with auto hover, but they're not yet certified by the FAA and Transport Canada. We expect that soon, but we can't predict exactly when that will occur. We will provide a further update on the auto hover certification as soon as we have more details on it.

It has been suggested that the S-61, I think in one of the briefs, would be a suitable year round search and rescue aircraft because it has auto hover. Yes, it has auto hover, as does the S-92, but it's not certified, so it cannot be used. But more important, the S-61 does not have de-icing capability. So that would not be suitable for year round aircraft in Newfoundland.

Issue seven. Are there circumstances other than declared emergencies when the rescue helicopter should be dispatched to

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assist a transport helicopter, so called proactive dispatch? We're fully supportive of this concept and believe Cougar should do this in relation to incidents which have the potential to escalate an emergency. If Cougar deems it prudent and reasonable, they should do it and we fully support that concept.

Issue nine and ten, Commissioner, are really the guts of many of the things we've talked about here, other than search and rescue, and I'll break them down into two parts.

The first part of the question is "are operational limitations on helicopter transport, in addition to those dictated by Transport Canada, required to ensure the standard of first response search and rescue is able to be maintained at all times" and then we had in brackets, to remind ourselves what the issues were, "operational sea states, night flights and low visibility."

Our primary goal is to do all that is reasonably practicable to keep the helicopter incidents to a minimum. However, as Robert Decker stated in his testimony, the best way

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to keep offshore workers safe is to keep the helicopter in the air where it belongs. So no discussion of this issue is possible without that in the back of our mind. To achieve this goal, the operators, in conjunction with Cougar, have put in place numerous preventative safeguards and I described that just a few minutes ago. These are the things to prevent an accident. These preventative safeguards are such that no additional operational limitations need to be imposed by the Board. A key point is first response search and rescue can be conducted under the current operational limits relating to visibility and sea states and, once auto hover is approved by the FAA, at night.

Talk a little bit about these preventative safeguards. So there's preventative safeguards in place. We believe these are sufficient to -- that no additional limitations need to be imposed and search and rescue can be conducted under the current operational limits. So what are the preventative safeguards?

The S-92 aircraft itself is certified to

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the latest regulations of the FAA, the European Aviation Safety Agency and Transport Canada. The advanced features of this are set out in great detail in our brief. They're certified by the experts in the field as being a suitable aircraft.

Cougar has a satellite based flight following system which automatically provides updates of the aircraft position every three or five minutes, depending on the altitude, and after an accident, every 15 seconds or after a declared emergency. It also has what is called a formal GUI dispatch system. Essentially, this is a 24/7 operational control centre located in St. John's. It's a requirement that the pilot in command and the dispatcher agree that conditions are acceptable for flight. They both must agree or a flight does not occur.

Cougar uses a pre-flight risk assessment to assist in the identification of risk factors. These include many factors including crew experience, environment, time of day, fatigue and complexity. Pilots are obliged to report to the chief pilot or the director of

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flight operations changes in risks that could affect that matrix.

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

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

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

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

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

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

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

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

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

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

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with any consistency.

Cougar operates in accordance with Transport Canada regulations, the experts in the field, with respect to low visibility flying. Cougar's flight planning includes a series of considerations, which are outlined in great detail in our brief, but they include aircraft status, forecast and reported conditions throughout the flight path, precipitation, surface winds at take off and landing and at alternate landing sites, wind aloft speeds and directions, freezing precipitation, installation movement, alternate offshore landing site information.

Prior to any flight, the dispatcher and the pilot, not the OIM or not the operators, will determine if it is suitable to conduct an entire flight, including a return to base. Cougar's dispatch operation ensures consistent monitoring of all weather and flight related conditions and adjust flights accordingly. So it's important when you answer this question that at any time we take off and fly to a facility, we can also launch a first response aircraft. A first response aircraft can find

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passengers and aircrafts with precision with their current technology, and, therefore, first response search and rescue by aircraft can occur under the current flight limitations relating to visibility. No additional requirements are necessary.

Night flights, the third operational criteria. There's a lot of discussion about this and we have to remember, of course, that night flights involve a flight that any of the flight, even if it's five minutes, occurs in the dark or after daytime. We believe the passenger night flights are both safe and sometimes necessary. Restrictions on night flights present a significant challenge for completing flight operations on a prudent schedule, and I'll describe why. With the first response search and rescue enhancements required by the Board on your recommendation, first response search and rescue can be conducted at night. As soon as the auto-hover is certified for use, search and rescue can be conducted at night. So the question was are there additional restrictions necessary to maintain the standard of first response and

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the answer to that is no. There are many jurisdictions as well where flights are routinely carried out at night. For example, as you would know, Commissioner, in regions of the North Sea in Norway the hours of darkness can extend 18 hours a day. The Jean D'Arc, where we operate, it's up to 16 hours a day of darkness during the winter. What this would mean practically if there was an absolute ban on night flights is we could not launch a flight before 7 a.m. or after 1 p.m., a five hour window. You also should consider, Commissioner, what a recommendation in this area could mean to exploration offshore Labrador, the Flemish Cap, the far reaches of the Laurentian Basin. This is an important issue for the offshore.

It's important to know, though, even though we've made this presentation, that Newfoundland flight operations generally occur during the daylight hours as the general rule. However, the offshore is subject to adverse weather conditions as we all know, rain, drizzle, and fog, and delays to scheduled flights often occur. As a matter of fact, 66

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percent of flights depart on time; 70 percent of the delays, 70 percent of the 34 percent that don't depart on time relate to weather, and this is no surprise to any of us who have lived here in the spring. If the operators cannot conduct necessary flights that occur, at least in part in darkness, the offshore workforce rotations are going to be affected and workers will be required to work beyond their regular rotation and everything that entails. So it's not a simple answer, Commissioner, to say there can't be night flights. There's operational and safety issues associated with that, and more important than that, Commissioner, there's no evidence whatsoever that search and rescue cannot be conducted at night. As a matter of fact, we suggest to you the evidence is the opposite. So in summary, there is no additional restriction on night flights required to maintain search and rescue standard that you have helped to establish.

I'll come back then to the second part of that question which was should the board impose additional operation requirements on

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

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

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that's the overriding message. They're necessary, but that's not enough; they are safe, these are safe.

Finally, if there are any changes to the auxiliary fuel tank, this isn't a simple matter. It requires the approval of the FAA and Transport Canada. The Transportation Safety Board may have something to say about fuel tanks, we don't know. So in any event, it's premature to make any recommendation on changes to a fuel tank without getting all of the information, including the Transport Safety Board report.

In summary, Commission, on issue 9 and 10, at any time when flight operations are underway, first response search and rescue by aircraft can be maintained - the standard that can be maintained under current operational limits. The only exception to that is at night, and that will be true once auto-hover is certified we hope very soon, certainly this fall. Therefore, no additional flight limitations are required to improve safety, they're just not. The fuel tanks are absolutely necessary to fly in the offshore,

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but far more important than that, they are safe and certified to the highest standard. The limitation of the use of particular seats will not necessarily at all increase safety of passengers. It may actually have the opposite effect, but there's also no evidence to suggest that the current configuration of the aircraft in any way would require you to restrict particular seats from being used.

Issue 11 is, "Can helicopter safety be affected by the capacity of the helicopter transportation fleet, and if so, what role should the Board play in the determination of fleet capacity". Like everything else, Commissioner, safety is our primary concern. The helicopter transportation fleet must operate safely, but beyond that, it's a commercial issue. We believe the capacity with the existing pool to manage - is there to manage both the offshore transportation workers and our fleet requirements. So we don't think there's any role at all for the board in this area. Their role is to ensure helicopter transportation is safe. They're not going to get into how many aircraft that

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

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

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

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

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

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

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

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

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personal protective equipment and clothing necessary for helicopter passengers should be done in consultation with the CGSB working group, which I'll describe in a few minutes. The correct role of the Board, after they stipulate a standard, is to audit the operators safety management systems, are to ensure that passengers are equipped with the most appropriate protective PPEs, personal protective equipment, and that the operators management of change processes are used when changes are made to the PPE. That's the Board's role. The Board stipulates a standard and ensure we comply with processes to ensure that that standard is being properly applied.

With respect to suit fitting standards, in particular, we don't think any further action is necessary. This is not because the old system was correct, because in the system - in the process of continuous improvement since the accident, the operators believe that the protocols developed by Helly Hansen and the operators are best industry practice and this practice will be applied to all future suits. So in the continuous improvement,

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operators and Helly Hansen have improved this fitting standard and we believe now it's appropriate. With respect to pilots, we understand the issue raised by pilots counsel. We believe for the purpose of this Commission, they are clearly workers for your purposes; however, we do believe that the jurisdiction over pilots must remain with Transport Canada where the expertise is. So we really have to defer to Transport Canada and Cougar in these issues.

To talk about the new suit standard, the CGSB through a working group of stakeholders, which includes many people, including workers, management, unions, are currently conducting an extensive review of the standard, including water egress standards, under garment requirements, and glove design. In our brief, as an appendix, we have a list of the research topics they are actually considering and they are quite extensive. We also agree with Helly Hansen when they made the reference to the National Research Council gap in the difference between calm weather testing and real life testing about thermal protection of

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subjects. This knowledge gap or testing gap is also being addressed by the working group. To come to the issue that was discussed today and yesterday, there had been suggestions the operators were focused on ensuring the suits had been certified to both marine and aircraft standards. This isn't true. The focus was to acquire a safe suit. The secondary goal was a dual certification. The HTS-1 has met all aviation standards. The primary goal is a safe suit, it has met the Board's standards.

A second goal, it has also been certified as a marine abandonment suit. There's nothing wrong with that, Commissioner, and it did not impact the safety of the suit. The first goal, the aircraft standard, has been met. Helly Hansen testified that's how they designed the suit. They didn't have in mind the marine transport certification. Helly Hansen's suggestion it's more difficult to manufacture a suit to meet this requirement; this may be so, but difficult or not, the suit has been certified, and if you follow the process here, it was certified to aircraft standard. Helly Hansen then convinced the

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regulator that it was suitable for marine abandonment purposes as well and got some exemptions particularly to the suit. This is exactly how regulation should work. It's redundancy. The operators in the Newfoundland offshore don't use them as abandonment suits, in any event. So it's a redundancy, it's exactly an example of how regulation should work. It met the primary goal, it also is a secondary goal, there's nothing wrong with that. As a matter of fact, it would only make the suit more flexible, and, therefore, workers more safe.

The suit fitting protocol. Helly Hansen and the operators began to address this issue as you've heard great testimony about - a great deal of testimony about. The formalized suit fitting assessment was ultimately implemented in 2009, again in the spirit of continuous improvement. The suit fitting protocol has been recognized by the Transport Safety Board, you've seen the letter, who recommended that Transport Canada inform others about importance of the suit sizing. Your own expert, Susan Coleshaw, observed that

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

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

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

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

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

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

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

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operators. These were all answered and responded to, all of which has been filed with you, Commissioner, in the report of the HOTF. However, we would suggest that we establish - or you recommend we establish a forum to facilitate worker OHS Committee engagement in identification, development, and implementation of - and monitoring of helicopter safety initiatives. We would call this the Helicopter Operations Safety Forum, or whatever other appropriate name could be used, should be held twice a year, and it should facilitate worker engagement in helicopter safety initiatives, which would be attended by all key stakeholders, workforce, regulator, all key stakeholders. We've actually suggested an agenda for your consideration, Commissioner, in Appendix D, and this would be a full day comprehensive session.

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

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and Paul Sacuta, their workers, they were talking about their own safety. This isn't some nebulous concept of someone else, this is everyone's business. These three gentlemen travel to the offshore, they're talking about their safety, they're not talking about someone else's safety. Workers, all of them, play a key role in ensuring that health, safety, and environmental objectives are established by the operators are achieved through the consistent application of policies, procedures, and safe work practices. So it's our expectation that our workforce and it's the legislative requirement as well, be accountable for their own safety at workplace, including during helicopter transport. It doesn't take away from anyone else's responsibility, but all of us who travel to the offshore - I've never done it, but people in this room who travel to the offshore, and I see many in the room, we all have responsibility to ensure each other's safety.

Issue 17, "Should the Board and oil operators safety aviation audits include

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reviews of past responses to declared emergencies and emergency preparedness exercises". This already exists with respect to the operators. The operators do audit these exercises, and each of the operators who have testified before you have done so. Cougar also engages in operator emergency response exercises and drills, and any learnings as a result of that drill are immediately applied to helicopter response and they're identified for following up.

Issue 18, "What information from the helicopter operator about flight operations should the Board require oil operators to provide to offshore workers", and you give examples, alert service bulletins, airworthiness directives, and so on. This is a complex issue and the simple answer sometimes is not the correct answer, we'd submit. We believe each operator already provides an appropriate level of communications about Cougar flight operations, and we don't think it would be appropriate for the Board to stipulate additional information. We agree, though, with the statement by the

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families that workers have the right to be provided with pertinent information so they, themselves, can assess the risks and make informed decisions on managing their own risk. That's a quote out of their brief. So we all agree on that, I think. The key issue is what is the pertinent information. To answer that, I think you first need to start, what do we actually provide now, what do the operators provide now. These include information and updates on the following things; the HOTF recommendations, there's 18 of them, many of which relate directly to the aircraft; TSB investigation regular updates; Cougar litigation against Sikorsky, we briefed our workforce a couple of months ago when we discovered that the litigation had been commenced; all worker rights to refuse relating to helicopter transport; search and rescue updates; shutdown of helicopters due to mechanical issues when passengers have already boarded; in flight and in taxi turnarounds; unplanned shutdowns of aircraft offshore due to mechanical issues; significant maintenance and inspection activities and manufacturer's

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continuous improvement activities.

So let's talk a little bit about other issues which are the alert service bulletin and the airworthiness directives. We've included one in our brief, Commissioner, as Schedule E, just to show the nature of these documents. These are written for aircraft owners and helicopter service providers, and are very technical and include technical information in relation to the required action to be taken. They are not written for a general audience. I would just encourage people to read it and see how much we can all understand as users of air transport, all of us. ASBs, in particular, are not even authorized for distribution without the expressed consent of the manufacturer. ADs, or airworthiness directives, are public documents and are published on Transport Canada's website. Read Appendix E, and see how useful that would be to circulate generally. So what we do is when the operators are alerted to an ASB or an AD considered relevant to the workforce, the operators work with Cougar and the manufacturer to develop an information

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

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information flight line, to give detailed updates of every delay and the reasons for every delay would, in our view, not be feasible, practical, or increase worker safety, or another way to put it, it's not pertinent information. So we believe the information is complex and sufficient enough, and no additional changes should be made.

Issue 21, Commissioner, which is the final issue, "Should there be safety conferences for all parties involved in offshore helicopter transport; if so, how often should they be held?". We agree fully with the concept for continuous improvement in communication engagement relating to helicopter transportation, and are committed to any goal that can make that happen. However, we got to remember the east coast does not have the volume and scope of helicopter operations. For example, in the UK, they've announced a new helicopter safety steering group. We don't think that would be appropriate in Canada. We have three operators and four aircraft - five now with the S-91 still in place. They have hundreds

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of facilities in the UK, as you know, in the North Sea, and hundreds of aircraft. However, we want to learn from this process and we demonstrated that already when CAPP has participated in a UK helicopter task force group. So we propose to monitor this group, but something of that magnitude would not be suitable for the east coast, we don't have the volume. We believe the operators should focus and the industry generally on safety related forums which focus on best practice and shared learnings. We believe this helicopter operation safety forum which we talked about before in Issue 14, and highlighted in Appendix D of our brief, would be an ideal area to deal with these issues; what are people doing elsewhere, how can we learn from them. As the industry develops and becomes more comprehensive and more intensive, perhaps this is an idea that could be revisited then.

So that's our submission on your issues. I'd like to conclude by quoting a statement from Aerosafe, I think they quoted it from someone else, "That achieving a positive and sustaining a positive health, safety, and

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environmental culture is not a discreet event, it's a journey", and I think you've acknowledge that yourself, Commissioner. A very important part of this journey has been our participation in this Helicopter Safety Inquiry. We are committed to do what is necessary to ensure the safety of our workforce. It is our number one priority. Accordingly, we support your work, Commissioner, and very much appreciate the opportunity you have given us to participate in this process. We hope that our response to this tragedy and the improvements that will result from the work of this Inquiry will in some very small way honour those lives that have been lost, and those whose lives have been very profoundly affected. Thank you, Commissioner, for your time.

COMMISSIONER:

Q. Okay, thank you, Mr. MacDonald.

ROIL, Q.C.:

Q. Commissioner, the next presenter is the C-NLOPB. In view of the lateness of this hour, I wonder would it be more prudent for us to take a break now for our lunch break rather than

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break them up midstream, and have them begin at 2 o'clock.

COMMISSIONER:

Q. Would you like a break a little longer than normal, Ms. Crosbie.

MS. CROSBIE:

Q. I think that would make sense.

COMMISSIONER:

Q. Yes, all right then that's what we'll do, and we'll come back at 2 o'clock.

(RECESS)

ROIL, Q.C.:

Q. Commissioner, the next presenter is Amy Crosbie, on behalf of the C-NLOPB, and Mr. Andrews is seated with her, but she will be making the presentation.

COMMISSIONER:

Q. Okay, thank you. Good afternoon, Ms. Crosbie.

SUBMISSION BY MS. AMY CROSBIE:

Q. Good afternoon. Our comments will be relatively brief, and I know we've dragged you all back here after lunch, but I figure we won't be that long this afternoon.

The Canada Newfoundland and Labrador Offshore Petroleum Board would first like to

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express their condolences to the families of the passengers and the pilots of Cougar Flight 491. This tragedy has deeply affected the Board and its staff. The C-NLOPB are themselves offshore workers and they travel to and from the installations regularly. The victims of the crash were people who they knew and they worked with.

The Board called this inquiry to examine the existing regime in relation to helicopter transport of workers to the offshore, and to determine what if any improvements are necessary to ensure that the risks associated with such travel are as low as reasonably practicable.

We have throughout this matter supported the Inquiry to ensure that the Commission can provide it with recommendations that are meaningful. We have willingly provided all requirement and requested information and have provided testimony to explore our role in a broad sense, and specifically with respect to safety. Mr. Andrews and Mr. Pike testified and were cross-examined and they answered thoughtfully and honestly. We have

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intentionally taken this limited role to ensure that the pertinent information was disclosed without interference. The Board is a body which will receive the recommendations, and as such, the Board did not provide any written submission with respect to the specific issues identified. We felt that this would be inappropriate and perceived to be interference with the process that we established.

The mandate includes the phrase, "As low as reasonably practicable". This was described by Mr. Earle as wiggle words in his submission on behalf of CEP Local 2121. The mandate states that the risk should be as low as reasonably practicable, which is a well known term and is utilized in industry worldwide. Mr. Earle's submission on behalf of the CEP has applied this term to the remedy, and implies that the mandate is to assess whether remedies are reasonably practicable or affordable. He has, in fact, wiggled the words to convey a completely different meaning. This Inquiry is looking at the risk and examining whether the risks

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associated with helicopter transport to and from the Newfoundland offshore are as low as reasonably practicable. The Inquiry is not looking at whether any particular operator can afford to minimize the risk, and, in fact, absolutely no evidence was led to suggest that there were no remedies that a party did not implement due to costs.

The Board has taken criticism during this Inquiry primarily from counsel for CEP Local 2121. This was somewhat surprising, given the level of criticism, which was not expressed by any other party or the representatives who testified on behalf of CEP, nor was it reflected in the comments of the offshore workforce in the Aerosafe survey. There are several areas in which the evidence of the Board, we feel, has been misrepresented to skewed to such an extent that the Board feels it's appropriate to provide some correction.

At page three of Mr. Earle's brief, he stated that the legislation does not in and of itself require the operation of an offshore installation be carried on in a safe manner. It must be remembered that the Board does not

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER:

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

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

ROIL, Q.C.:

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

COMMISSIONER:

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

(BREAK)

COMMISSIONER:

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

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

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

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

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

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

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

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

CERTIFICATE

We, the undersigned, do hereby certify that the foregoing is a true and correct transcript of a hearing heard on the 9th day of September, 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
9th day of September, 2010
Cindy Sooley
Discoveries Unlimited Inc.
Judy Moss
Discoveries Unlimited Inc.

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