

Re:

Termination

FINDINGS AND DECISION
in a dispute brought under *Section 240* of
the Canada Labour Code

between

COUGAR HELICOPTERS

(the "Employer")

and the

OFFICE AND PROFESSIONAL EMPLOYEES INTERNATIONAL UNION

(the "Union")

Complainant: Mr. Boyd Sellars, The Complainant
Counsel for the Union: Mr. Denis W. Ellickson, CaleyWray Labour/Employment Lawyers
Counsel for the Employer: Mr. Harold Smith, Q.C., Stewart McKelvey Stirling Scales
The Adjudicator: John A. Scott, Ph.D. Sole Adjudicator (appointed pursuant to Section 240 of the *Canada Labour Code* in the matter of the termination of Mr. Boyd Sellars)

Witnesses, under oath or affirming

For the Employer: Captain Patrick Perry, Chief Pilot
 Captain Ronald Moores, Training Captain
 Captain J.J. Gerber, Director of Flight Operations
For the Union: Captain Mark Chapman, Pilot
 Captain Scott Davidson, Touring Pilot, Pilot's Union Chairman
 Captain Boyd Sellars, Complainant

The hearing was held at St John's, Newfoundland and Labrador on February 20, 21; April 3, 4, 5; July 9, 10, 11 and 29, 30, 31, 2013 and April 8, 9, 10, 2014.

The Parties agreed, as noted above, that the matter would be conducted pursuant to Section 240 of *the Canada Labour Code*, and that:

- the Adjudicator was properly appointed and had authority to hear the matter;
- the Adjudicator's notes of the evidence and argument as recorded in the final award will prevail in the event of conflict;
- all parties likely to be affected by the outcome of the hearing have received notice and been informed of their right to appear and/or be represented;
- issues of quantum, if any, would be considered separately and that if the parties do not reach agreement within sixty (60) calendar days after publication of the Decision they will be referred to the Adjudicator for resolution;
- the Adjudicator will remain seised of the matter for period of sixty (60) calendar days after publication of the Decision should issues of its interpretation arise.

EVIDENCE

Consent #1 Mr. Sellars' Letter of Termination

Exhibit #1 Mr. Mugford's declaration

" #2 Transport Safety Board of Canada 9/18/13 - Aviation News Release 2013

PP #1 Total Flight Hours Report

" #2 Company Operations Manual 2.4.4

" #3 851 Flight Data Graphs July 23/2011

" #4 Mr. Sellars' summary report of event

" #5 Mr. Mugford's summary report of event

" #6 Flight 851 simulation video

" #7 HFDM Committee's Summary Investigation Report

" #8 Copy of Log book entry

" #9 Aviation Event Report 23-Jul-11

" #10 Capt. Perry's handwritten notes 26 July 2011

" #11 e-mail: Gerber to Perry CC: Mr. Williams Aug 4, 2011 Re Mr. Sellars' complaint

" #12 Final "Internal Aviation Investigation Report conducted July 3- Aug 2, 2011"

" #13 MEMO to SK92 pilots from Chief Pilot Type

" #14 MEMO to all Cougar pilots from Chief Pilot re "S92 Manual Flying"

" #15 S92 Standard Operating Procedures Ed III (SOP) 3.10–3.10.6

" #16 S92 Standard Operating Procedures Ed III (SOP) 7.140–7.144.2

" #16 S92 Standard Operating Procedures Ed III (SOP) 9.7-9.8.2

" #18 CHARM A: Review B: Team Communications C: Automation Dependency/Loss of Control

" #19 Reduction of a Captain to First Officer

" #20 Reinstatement of a First Officer to Captain

" #21 July 15, 2011 Letter to Captain re a "RWY incursion"

" #22 July 15, 2011 Letter to First Officer re a "RWY incursion"

" #23 July 15, 2011 Letter re reduction in pay

" #24 April 4, 2011 letter re reduction to First Officer and Probation

" #25 September 9, 2011 e-mail exchange Segura, Perry, CC: Gerber

" #26 Cougar Journey Log #0872

RM#1 Mr. Moores' handwritten notes of interview with Mr. Sellars & Mr. Mugford

" #2 expanded version of PP #3, p.1

" #3 S92 Standard Operating Procedures Ed III (SOP) 7.132.2-7.135.2

" #4 S92 Standard Operating Procedures Ed III (SOP) 9.6.1-9.6.2

" #5 S. Davidson's summary of June 9 meeting e-mailed to group & copied to Ellickson

JG #1 Nov. 22, 2010 e-mail: Scott Davidson to J.J. Gerber

" #2 Jan. 17, 2011 e-mail: Scott Davidson to J.J. Gerber, re Unsolicited Union issues

" #3 12 e-mail chains July 23, 2011- August 23, 2011

" #4 June 26, 2011 memo to S92 Pilots re "RFM Temporary Revisions"

" #5 Internal Aviation Investigation Report into the August 26, 2007 incident

" #6 Internal Aviation Investigation Report into the November 12, 2008 incident

" #7 Data graphics (9 pages)

" #8 Jan 24, 2001 Letter to Captain Roach

" #9 Cockpit Emergency checklist

- JG #10 S92 Flight Manual Part 1, Section 1 Operating Limitations SA S92A-RFM-003
 " #11 Cougar Responses - Husky Investigation 30 Sept 2011
 " #12 Aug 10 2011 e-mail: Banks to Whittle *et al* re Cougar Report Version 2 comments
 MC #1 SAFO 130002
 " #2 August 31, 2011 AP Impact
 " #3 August 24, 2011 "Cockpit Crisis"
 " #4 Presentation Slides: Aspects of: "Pilot Monitoring"
 SD #1 CIRB Complaint relating to Capt. Sellars August 3, 2011
 " #2 CIRB Written declaration of Scott Davidson
 " #3 CIRB Written declaration of Boyd Sellars
 " #4 CIRB Reply of Complainant
 " #5 Mr. Davidson's annotated data sheet of August 26, 2007 event (1 minute & 5 seconds)
 " #6 Mr. Davidson's annotated data sheet of Nov. 12, 2008 event (1 minute & 6 seconds)
 " #7 Mr. Davidson's annotated data sheet of July 23, 2011 event ("total event" 38 seconds)
 " #8 Minutes of Cougar Employees' meeting, Dec. 20, 2011
 " #9 Minutes of CYYT Pilots' meeting, 14 Feb. 2011
 " #10 E-Mail memo "re "Internal Meeting" Dec 17, 2011
 " #11 Meeting with Cougar Management 18 March 2011 - Discussion Items
 " #12 1st Draft of Record of Discussions - 9 June meeting with Management
 " #13 Sept. 15, 2011 correspondence: Mr. Ellickson to Ms. Frenette CIRB with attachments
 " #14 e-mail exchange August 5, 2011, between Mr. Williams & Mr. Davidson
 BS #1 *Transport Safety Board of Canada Aviation Investigation Report A11H0001*

Canada Labour Code (Sections cited)

8. (1) Every employee is free to join the trade union of their choice and to participate in its lawful activities.

(2) Every employer is free to join the employers' organization of their choice and to participate in its lawful activities.

R.S., 1985, c. L-2, s. 8; 1999, c. 31, s. 162(E).

16. The Board has, in relation to any proceeding before it, power

(a) to summon and enforce the attendance of witnesses and compel them to give oral or written evidence on oath and to produce such documents and things as the Board deems requisite to the full investigation and consideration of any matter within its jurisdiction that is before the Board in the proceeding;...

(b) to administer oaths and solemn affirmations;

(c) to receive and accept such evidence and information on oath, affidavit or otherwise as the Board in its discretion sees fit, whether admissible in a court of law or not;

(d) to examine, in accordance with any regulations of the Board, such evidence as is submitted to it respecting the membership of any employees in a trade union seeking certification;...

(f) to make such examination of records and such inquiries as it deems necessary;

(f.1) to compel, at any stage of a proceeding, any person to provide information or produce the documents and things that may be relevant to a matter before it, after providing the parties the opportunity to make representations;...

- (l) to adjourn or postpone the proceeding from time to time;...
- (o) to add a party to the proceeding at any stage of the proceeding;...
- (p) to decide for all purposes of this Part any question that may arise in the proceeding, including, without restricting the generality of the foregoing, any question as to whether
 - (i) a person is an employer or an employee,
 - (ii) a person performs management functions or is employed in a confidential capacity in matters relating to industrial relations,
 - (iii) a person is a member of a trade union,
 - (iv) an organization or association is an employers' organization, a trade union or a council of trade unions,
 - (v) a group of employees is a unit appropriate for collective bargaining,
 - (vi) a collective agreement has been entered into,
 - (vii) any person or organization is a party to or bound by a collective agreement, and...

19. Where, under this Part, the Board may make or issue any order or decision, prescribe any term or condition or do any other thing in relation to any person or organization, the Board may do so, either generally or in any particular case or class of cases.

R.S., c. L-1, s. 120; 1972, c. 18, s. 1.

Unfair Practices

Employer interference in trade union

94. (1) No employer or person acting on behalf of an employer shall

- (a) participate in or interfere with the formation or administration of a trade union or the representation of employees by a trade union; or
- (b) contribute financial or other support to a trade union.

(2) An employer is deemed not to contravene subsection (1) by reason only that they

- (a) in respect of a trade union that is the bargaining agent for a bargaining unit comprised of or including employees of the employer,
 - (i) permit an employee or representative of the trade union to confer with them during hours of work or to attend to the business of the trade union during hours of work without any deduction from wages or any deduction of time worked for the employer,
 - (ii) provide free transportation to representatives of the trade union for purposes of collective bargaining, the administration of a collective agreement and related matters, or
 - (iii) permit the trade union to use their premises for the purposes of the trade union;
- (b) contribute financial support to any pension, health or other welfare trust fund the sole purpose of which is to provide pension, health or other welfare rights or benefits to employees; or
- (c) express a personal point of view, so long as the employer does not use coercion, intimidation, threats, promises or undue influence.

Prohibitions relating to employers

(3) No employer or person acting on behalf of an employer shall

- (a) refuse to employ or to continue to employ or suspend, transfer, lay off or otherwise discriminate against any person with respect to employment, pay or any other term or condition of employment or intimidate, threaten or otherwise discipline any person, because the person

- (i) is or proposes to become, or seeks to induce any other person to become, a member, officer or representative of a trade union or participates in the promotion, formation or administration of a trade union,
- (ii) has been expelled or suspended from membership in a trade union for a reason other than a failure to pay the periodic dues, assessments and initiation fees uniformly required to be paid by all members of the trade union as a condition of acquiring or retaining membership in the trade union,
- (iii) has testified or otherwise participated or may testify or otherwise participate in a proceeding under this Part,
- (iv) has made or is about to make a disclosure that the person may be required to make in a proceeding under this Part,
- (v) has made an application or filed a complaint under this Part, or
- (vi) has participated in a strike that is not prohibited by this Part or exercised any right under this Part;....
- (e) seek, by intimidation, threat of dismissal or any other kind of threat, by the imposition of a financial or other penalty or by any other means, to compel a person to refrain from becoming or to cease to be a member, officer or representative of a trade union or to refrain from
 - (i) testifying or otherwise participating in a proceeding under this Part,
 - (ii) making a disclosure that the person may be required to make in a proceeding under this Part, or
 - (iii) making an application or filing a complaint under this Part;

97. (1) Subject to subsections (2) to (5), any person or organization may make a complaint in writing to the Board that

- (a) an employer, a person acting on behalf of an employer, a trade union, a person acting on behalf of a trade union or an employee has contravened or failed to comply with subsection 24(4) or 34(6) or section 37, 47.3, 50, 69, 87.5 or 87.6, subsection 87.7(2) or section 94 or 95; or
- (b) any person has failed to comply with section 96.

(2) Subject to subsections (4) and (5), a complaint pursuant to subsection (1) must be made to the Board not later than ninety days after the date on which the complainant knew, or in the opinion of the Board ought to have known, of the action or circumstances giving rise to the complaint.

(4) Subject to subsection (5), no complaint shall be made to the Board under subsection (1) on the ground that a trade union or any person acting on behalf of a trade union has failed to comply with paragraph 95(f) or (g) unless

- (a) the complainant has presented a grievance or appeal in accordance with any procedure that has been established by the trade union and to which the complainant has been given ready access;
- (b) the trade union
 - (i) has dealt with the grievance or appeal of the complainant in a manner unsatisfactory to the complainant, or
 - (ii) has not, within six months after the date on which the complainant first presented their grievance or appeal pursuant to paragraph (a), dealt with the grievance or appeal; and
- (c) the complaint is made to the Board not later than ninety days after the first day on which the complainant could, in accordance with paragraphs (a) and (b), make the complaint.

(5) The Board may, on application to it by a complainant, determine a complaint in respect of an alleged failure by a trade union to comply with paragraph 95(f) or (g) that has not been presented as a grievance or appeal to the trade union, if the Board is satisfied that

(a) the action or circumstance giving rise to the complaint is such that the complaint should be dealt with without delay; or

(b) the trade union has not given the complainant ready access to a grievance or appeal procedure.

98. (4) Where a complaint is made in writing pursuant to section 97 in respect of an alleged failure by an employer or any person acting on behalf of an employer to comply with subsection 94(3), the written complaint is itself evidence that such failure actually occurred and, if any party to the complaint proceedings alleges that such failure did not occur, the burden of proof thereof is on that party.

99. (1) Where, under section 98, the Board determines that a party to a complaint has contravened or failed to comply with subsection 24(4) or 34(6), section 37, 47.3, 50 or 69, subsection 87.5(1) or (2), section 87.6, subsection 87.7(2) or section 94, 95 or 96, the Board may, by order, require the party to comply with or cease contravening that subsection or section and may ...

in respect of a failure to comply with paragraph 94(3)(a), (c) or (f), by order, require an employer to

(i) employ, continue to employ or permit to return to the duties of their employment any employee or other person whom the employer or any person acting on behalf of the employer has refused to employ or continue to employ, has suspended, transferred, laid off or otherwise discriminated against, or discharged for a reason that is prohibited by one of those paragraphs,

(ii) pay to any employee or other person affected by that failure compensation not exceeding such sum as, in the opinion of the Board, is equivalent to the remuneration that would, but for that failure, have been paid by the employer to that employee or other person, and

(iii) rescind any disciplinary action taken in respect of and pay compensation to any employee affected by that failure, not exceeding such sum as, in the opinion of the Board, is equivalent to any financial or other penalty imposed on the employee by the employer;

Unjust Dismissal

240. (1) Subject to subsections (2) and 242(3.1), any person

(a) who has completed twelve consecutive months of continuous employment by an employer, and

(b) who is not a member of a group of employees subject to a Collective Agreement, may make a complaint in writing to an inspector if the employee has been dismissed and considers the dismissal to be unjust.

(2) Subject to subsection (3), a complaint under subsection (1) shall be made within ninety days from the date on which the person making the complaint was dismissed.

(3) The Minister may extend the period of time referred to in subsection (2) where the Minister is satisfied that a complaint was made in that period to a government official who had no authority to deal with the complaint but that the person making the complaint believed the official had that authority.

242. (3) Subject to subsection (3.1), an adjudicator to whom a complaint has been referred under subsection (1) shall

(a) consider whether the dismissal of the person who made the complaint was unjust and render a decision thereon; and

(b) send a copy of the decision with the reasons therefor to each party to the complaint and to the Minister...

(4) Where an adjudicator decides pursuant to subsection (3) that a person has been unjustly dismissed, the adjudicator may, by order, require the employer who dismissed the person to

(a) pay the person compensation not exceeding the amount of money that is equivalent to the remuneration that would, but for the dismissal, have been paid by the employer to the person;

(b) reinstate the person in his employ; and

(c) do any other like thing that it is equitable to require the employer to do in order to remedy or counteract any consequence of the dismissal.

The text of Mr. Sellars' termination letter (Consent #1) reads:

28 July 2011

Dear Captain Sellers: **Re: Incident Saturday, July 23, 2011**

We have completed our investigation into the incident that occurred on departure from the Sea Rose FPSO on Saturday, July 23, 2011.

We are satisfied that the temporary loss of control of the aircraft was purely pilot error and that the equipment operated within known design parameters.

Of significant concern is that the incident demonstrated to us that you not only failed to immediately correct the situation you created in a manner consistent with your training, but you either took steps that made the situation worse and/or failed to react appropriately in a timely fashion to the worsening situation thereby endangering you, your passengers and crew as well as the aircraft itself.

We conclude from the event that you actually "froze" in a stress situation. This revelation makes you unsuitable for the services we provide to the offshore. We are satisfied that the combination of existing training and hours of flying experience demonstrates the incident is not related to a lack of training but rather an inability to process multiple pieces of data combined with some inattentiveness. There also appears to be difficulty prioritizing tasks. Our post incident interview of you demonstrated that you knew how to deal with the situation that you initially caused but, under stress of the loss of control of the aircraft, you were unable to address or attempt the appropriate solutions even when your co-pilot attempted to assist by giving you reasonable alternatives to remedy the situation.

We are satisfied that the pilot errors committed by you needlessly endangered yourself, the crew, the passengers as well as the aircraft and your reactions and lack of reaction, including an improper decision to prepare to "ditch" the aircraft while recovery was easily achievable, are so serious that we have lost all confidence in your abilities to pilot our aircraft in the offshore service.

As a consequence, we are terminating your employment with Cougar Helicopters effective immediately.

Please contact Renee Paddock to obtain your exit documentation. In the interim, please provide to us the following:

1. Building access key and security access card
2. Government of Canada (red) Airport pass
3. Flight Helmet, offshore immersion suit, winter parka and company provided headset

Yours very truly, J.J. Gerber
Director of Flight Operations

Transport Safety Board of Canada Aviation Investigation Report A11H0001 (BS#1 p7)

1.5.2 Captain

The captain was certified and qualified for the flight in accordance with existing regulations. The captain held a Canadian airline transport pilot licence (ATPL) – helicopter, with type ratings on the Bell 206, Bell 212, Bell 47, Eurocopter AS350, Eurocopter AS355, and Sikorsky S-92A. The captain's licence was endorsed with a Group 4 instrument rating valid until 01 July 2012.

Prior to joining Cougar Helicopters, the captain accumulated extensive experience flying light single-engine and medium twin-engine helicopters, mostly under visual flight rules (VFR). In April 2008, the captain was hired by Cougar Helicopters as an S-92A first officer. The captain completed the initial S-92A conversion at Flight Safety International (FSI) on 14 May 2008. The captain's first 2 attempts at passing the pilot proficiency check (PPC) and the instrument flight check (IFC) were unsuccessful. The captain passed the PPC and IFR on the third attempt on 19 June 2008.

The captain returned to FSI in May 2009 for annual recurrent training. During training, it was noted that the captain had difficulties with unusual attitude recoveries due to miscues interpreting flight director information and some overcontrolling. The training report noted that the captain was able to fly a much more controlled recovery following retraining. The report stated that the captain tended to "overfly" the trim and "work harder than necessary", and struggled with turning manoeuvres due to a "lack of understanding with trim functions." The training report recommended more work with the coupled flight director.

Although not required by regulation, the captain completed a 2-day crew resource management (CRM) workshop at Cougar Helicopters in November 2009.

In April 2010, the captain underwent a line proficiency check (LPC) for captaincy. During that simulator session, the captain experienced difficulties with an emergency, which was followed by a decrease in airspeed, a nose-high attitude, and a loss of altitude. As a result of this LPC, the captain was not recommended for captain line indoctrination training. The LPC indicated that the pilot required better situational awareness and improved instrument scanning techniques.

In November 2010, the captain completed the line indoctrination and transition to captain training. A total of 4 flights were carried out, with all items being assessed as satisfactory. The

captain's training file included a form that indicated that the captain had been released to line duties as pilot-in-command (PIC). The captain had 1013 hours on type at the time of this upgrade.

In March 2011, the captain received additional CRM training during recurrent simulator training. The captain's flight and duty time limits were not exceeded. On the day of the occurrence, the captain reported to work around 0800, and there was no indication that fatigue was a factor.

Transport Safety Board of Canada Aviation Investigation Report A11H0001 (BS#1 pp 41-3)

3.0 Findings

3.1 Findings as to Causes and Contributing Factors

1. During the departure procedure, the captain made a large, rapid aft cyclic input just before the cyclic trim button was released and the go-around mode was engaged, which caused the helicopter to enter a nose-high, decelerating pitch attitude.
2. The S-92A's go-around (GA) mode is designed with reduced control authority. As a result of this reduced control authority, the helicopter experienced difficulties recovering from the nose-high pitch attitude which occurred following the GA mode engagement.
3. As the airspeed of the helicopter decreased to within 5 knots of the minimum control speed in instrument meteorological conditions (VMINI), the captain momentarily pressed the cyclic force trim release button and made an aft cyclic input. This caused the helicopter's airspeed to decrease below VMINI, and the helicopter to enter a 23° nose-high unusual attitude.
4. The captain, subtly incapacitated possibly due to spatial disorientation, did not lower the nose of the helicopter and apply collective to recover from the nose-high unusual attitude. This contributed to the excessive amount of altitude that was lost during the inadvertent descent.
5. Contrary to what is stated in the two-challenge rule in Cougar Helicopters' SK-92 Helicopter Standard Operating Procedures, the first officer did not take control of the helicopter when the appropriate action was not taken to recover from the inadvertent descent.

3.2 Findings as to Risk

1. If cockpit and data recordings are not available to an investigation, this may preclude the identification and communication of safety deficiencies to advance transportation safety.
2. The S-92A's enhanced ground proximity warning system provides no warning of an inadvertent descent at airspeeds below 40 knots indicated airspeed with the landing gear down. As a result, there is increased risk of controlled flight into terrain during those phases of flight.
3. If there are delays initiating the controlled flight into terrain (CFIT) avoidance procedure in response to an enhanced ground proximity warning system alert, there is an increased risk of CFIT.

4. If pilots of automated aircraft do not maintain their hands-on visual and instrument flying proficiency, there is increased risk that they will be reluctant to take control and that they will experience difficulties recovering from unexpected flight profiles that require pilot intervention.
5. If S-92A pilots do not consult the top portion of the primary flight display to confirm proper autopilot engagement, they may not recognize that the system is degraded or not engaged.
6. The S-92A Rotorcraft Flight Manual is misleading in that it states that the go-around (GA) mode can be used to recover from an unusual attitude. The GA mode will not function below 50 knots indicated airspeed and it is limited in how fast it can make attitude and power changes. As a result, pilots and passengers are at increased risk of collision with terrain if pilots attempt to use the GA mode to recover from an unusual attitude at low altitude.
7. If the go-around (GA) mode is engaged at 55 knots indicated airspeed, in accordance with Cougar Helicopters' SK-92 Helicopter Standard Operating Procedures, there is increased risk that the GA mode will disengage as a result of a transitory decrease in airspeed below the minimum control speed in instrument meteorological conditions (VMINI)•
8. There is no standard procedure at Cougar Helicopters for the use of the cyclic force trim release button during departures. This could lead to difficulties if a rapid transfer of control is required during a departure.
9. The lack of standard callouts for pitch deviations increases the likelihood of miscommunication during unusual attitude recoveries.
10. There was no formal process in place at Cougar Helicopters to ensure adherence to crew pairing restrictions. As a result, the occurrence first officer was paired with pilots who were not qualified training pilots. Therefore, any possible reduction in risk as a result of this risk control measure was not realized.
11. If flight crews do not receive recurrent training in unusual attitude recoveries, they are more likely to experience difficulties recovering from unusual attitudes.
12. If flight crew members are not trained to recognize and respond to subtle incapacitation, they may not have the confidence to take control from a more experienced pilot.
13. If crew resource management (CRM) strategies are not practiced during simulator and flight training, there is increased risk that flight crews will experience breakdowns in CRM that could reduce safety margins.
14. If autopilot modes are engaged while one pilot is preoccupied with other duties, that pilot will not be able to properly perform the pilot monitoring functions. This increases the risk that deviations from the standard flight profile will go undetected or not be detected in a timely manner.

15. If actions taken by a company are perceived by employees to be inconsistent with its non-punitive reporting and Just Culture policy and processes, there is a risk that employees will not report safety occurrences for fear of reprisal.

16. If reportable incidents are not reported to the Transportation Safety Board (TSB), there is increased likelihood that opportunities to advance Canadian transportation safety will not be realized.

3.3 *Other Findings*

1. The rapid application of collective in order to arrest the inadvertent descent resulted in the exceedance of transmission torque limits.

2. During the rapid application of collective, neither pilot realized that there had been an exceedance of transmission operating limitations during the recovery, and they continued the flight back to St. John's International Airport (CYYT).

3. The operator was unaware that the cockpit voice recorder is privileged under the *Canadian Transportation Accident Investigation and Safety Board Act*.

OPENING STATEMENTS

FOR THE EMPLOYER, Mr. Smith stated the Parties had agreed to proceed with this matter through the *Canada Labour Code* at Section 240. The question is whether there was just cause for termination of Captain Boyd Sellars, a helicopter captain of considerable experience.

Captain Sellars was pilot in charge of Flight 851 on Saturday, July 23, 2011 that went off shore approximately 350 km to the Husky FPSO platform where it dropped passengers and cargo and picked up a similar load for the return flight to St. John's. St. John's was the final destination. Having left the Husky platform for the flight home, the aircraft experienced an unusual attitude which manifested as a steep climb followed by a sharp decent. The Employer was unaware of the event at the time.

The aircraft lost lift climbing at such an angle as to cause lift and air speed to deviate from the norm and it started to fall. The Captain recovered the aircraft, but only approximately 30 to 40 feet above the water.

The crew on the Sea Rose FPSO thought that the aircraft was ditching. Others thought that it was crashing, and still others thought that it was a controlled descent.

Investigation of the Flight 851 incident showed pilot error on the part of Captain Sellars. Because the issue was so serious and because the pilot's actions contributed to the incident, the

Employer lost confidence in Mr. Sellars' ability to operate in Newfoundland offshore conditions, and released him from its employment. Hence the complaint to the *Canada Labour Relations Board* that was deferred to this process under S.240 of *the Code*.

Mr. Smith went on to observe that, as Adjudicator, I would learn a great deal about aviation which is essential for me to understand in order to grasp why the Director of Flight Operations was required to deliver the ultimate decision on termination. The offshore requires significant experience and confidence in the ability of captains operating the passenger service to offshore installations. That confidence in this pilot was destroyed by events of July 23rd.

The Employer will ask that the Adjudicator find the Employer had just cause for its action and sustain the termination.

FOR THE UNION, Mr. Ellickson confirmed that the Parties had agreed to proceed with this matter through the *Canada Labour Code* at Section 240, and pointed out that the entire incident that has given rise to this complaint occurred within seconds. Captain Sellars was, at the time, one of the most experienced of Cougar's pilots.

Mr. Ellickson said that there are two issues which the Adjudicator must address. The first question is whether Cougar did, in fact, have just and reasonable cause to impose some kind of discipline on the complainant, Captain Sellars. If there is no just and reasonable cause for any discipline, then the Adjudicator should reinstate Captain Sellars without loss of compensation or other benefits.

The second issue arises if the Adjudicator does find some cause for some discipline. At that point, the Adjudicator would need to determine what that discipline must reasonably be. It should be noted at the outset that the penalty imposed, termination, is unprecedented.

Mr. Ellickson sketched the Parties' background and their relationship. Cougar is a full service helicopter company based in St. John's and in Halifax. It employs pilots for offshore production and supply services and for Search and Rescue (SAR), and for touring purposes. Captain Sellars has been a helicopter pilot for approximately 30 years. He was hired as First Officer by Cougar on April 1, 2008 and, on November 4, 2010, was promoted to Captain, his classification at the time of his termination.

Prior to July 23, 2011, there had been no discipline on Captain Sellars' record at all. This was the first reportable incident in his 30 year career.

The Adjudicator will hear evidence that Captain Sellars was one of two pilots who had formed a committee for an association which had as its objective to negotiate the terms and conditions of an employment contract with Cougar. Captain Davidson was the other committee member. On behalf of that committee Captain Sellars and Captain Davidson met with employees prior to his termination in order to discuss workplace issues. Mr. Ellickson said the Adjudicator would hear about a June 9, 2011 meeting with the Employer where it was determined that the committee was achieving nothing and the decision was taken to unionize. The Adjudicator will also hear that Captain Davidson and Captain Sellars became interested in pursuing the *OFFICE AND PROFESSIONAL EMPLOYEES INTERNATIONAL UNION* (OPEIU) which represents thousands of pilots across North America. After Captain Sellars' termination, the OPEIU filed a complaint with the *Canada Industrial Relations Board*, and subsequently won certification for all pilots at Cougar. Negotiations are ongoing for an initial contract under the *Canada Labour Code*.

Mr. Ellickson suggested that the Adjudicator would hear evidence of the composition of the crew on the July flight. The First Officer was Officer Glyn Mugford. The two pilots should not have been flying together. The offshore operation has extensive minimum requirements for pilots, and First Officer Mugford, who did not meet those minimum requirements, should only have been flying with "designated training pilot." Mr. Sellars is not a "designated training pilot."

Evidence would be led concerning the relationship between the Cougar Helicopters and Husky Oil. Given the nature of the industry, Husky is more involved in Cougar's operations, including training and staffing, than one might expect a client to be. In the Union's view, it is significant, that the initial report came from Husky itself. That evidence will show that Husky did its own investigation and as a result produced either one or two reports. The Union has so far been denied access to a copy of this (or these) report(s) and anticipates requesting production of these reports.

Mr. Ellickson also indicated that there would be evidence concerning other incidents which were more significant than the July 23rd incident, but elicited either no discipline or simply a temporary demotion in rank. Captain Sellars was treated differently. Evidence would be led on

the Employer's discipline policy which it calls a "just culture", rather than a "just cause", policy.

The incident, itself, has been fairly described by Mr. Smith in his opening statement for the Employer. But the Adjudicator needs to understand what actually happened within the 30 to 45 seconds at issue. At no time did the First Officer try to take control of the aircraft.

Following the incident, the crew returned to St. John's and reported what had happened through the Employer's Safety Management System (SMS). The crew was completely cooperative. There were no injuries and no damage to Company property.

Evidence will show that the aircraft did find itself in an unusual attitude, and did lose altitude. There is evidence of a controlled hover at approximately 30 feet above sea level. What happened is not in dispute. Captain Sellars' actions and performance in that 30 to 40 seconds is not in dispute. Much of that 30 to 40 seconds is conversation between the pilot and First Officer. Unfortunately, what was said, and how it was said, is not available for us to hear, despite the fact that it was recorded. Cougar accessed it, contrary to *Transport Canada* regulations, and then for some reason erased it.

At no time did Captain Sellars engage in any conduct that was worthy of discipline. It is the Employer's onus to establish that such a behaviour did occur. But even if there was a cause for discipline, it was not a termination. Certainly it was neither appropriate, fair, or consistent with other similar incidents, to impose a termination. Captain Sellars was thus singled out for special treatment. The termination, therefore, was unjust. This is the Union's position.

The Union, therefore, requests that the complaint be sustained and that the Adjudicator order the termination overruled and the Complainant reinstated to his former position without loss of compensation or benefits. In the alternative, the Union will argue that, if some cause for discipline is found, it is not appropriate that it be termination. Reinstatement should be made, therefore, on reasonable terms that the Adjudicator will set.

THE FIRST EMPLOYER WITNESS was Captain Patrick Perry who testified under solemn affirmation. Mr. Perry is employed by Cougar Helicopters as Chief Pilot. He described his duties as Chief Pilot as

.... regulated by *Transport Canada* and includes ensuring the observance of standards and the training of all those employed by the Company as pilots.

Captain Perry is approved as check pilot for *Transport Canada* and as Chief Pilot for Cougar. As Chief Pilot he is one of three "position holders" regulated by *Transport Canada*. He explained why *Transport Canada* is involved in this sort of approval: "They will remove you if they feel that the jobs are not being properly formed." He became Chief Pilot for Cougar in 2010. Prior to that, he was a Cougar Check Pilot. He had joined Cougar as a pilot in 2009.

It was in August 2009, but I had to take some training prior to going on the line. Once the training was completed I was assigned to the line as Aircraft Captain. "On the line" refers, in our company, to passenger flights including search and rescue or on any other kind of flying, including offshore. I'd started flying in 1982 with the cadets, and then into aircraft in 1983. Flight training was started in 1985 and I completed training with the navy, where for five years I flew offshore with Sea Kings and had experience all over the world. While on squadron, I was in training and, for nearly two years, I was Standards Officer for pilots with the squadron. I then served in CFB Moose Jaw on basic jets: the Tudor jets which is the same for all pilots in the military.

In 1994 Mr. Perry moved into civilian work. He described his work as Standards Officer and ongoing training at least once a year, "to insure qualifications and standards and all around proficiency were maintained." Asked whether he had ever observed a pilot that had proficiency, but who, after a test, was found not to be proficient, he answered, "Yes."

Between 1994 and 1996 he worked at *STARS*, an air ambulance helicopter operation in Edmonton, Alberta, where he served both as Captain and Instrument Flight Rules (IFR) trainer. This is training to fly within clouds, and is different from Visual Flight Rules (VFR) operation, where in-cloud flying is not an issue.

IFR is very specific training regulated by Canadian authorities. Transport Canada administers the program and sets its objectives.... Cougar itself insists on training and qualifications in IFR. This includes ensuring competence to maintain straight level flight in cloud and include recovery from unusual attitude... These are the basics and then you combine them into more advanced issues so that you have to interpret instruments so as to reorient. As the student progresses you put all this together and make it more and more difficult. Such approved flight training is all mandated and approved by Transport Canada... While I was at *STARS* I did IFR training for that company, including unusual attitude recovery training... Any time an aircraft is not on the desired flight profile you are either starting or already in an "unusual attitude"... Lift off for a helicopter involves 5% pitchup: that is to say, the nose is 5% above the horizon. And if the aircraft goes to 8% or 10% either up or down, or 4% off heading, that is an unusual attitude. That's it in basic terms. You need to reestablish the heading. As a training captain I make sure that the concepts are understood...

After leaving STARS I worked for a while in the bush industry, where IFR in mountainous conditions was part of the experience. In 1998 I joined *Canadian Helicopters Corporation* (CHC) in Ontario for their air ambulance operation, where I was captain of an S76. I moved to a different division in Spring 2001, operating out of Halifax to an offshore platform. I was hired as Captain, but started as First Officer offshore Nova Scotia, then upgraded to Captain in a fairly short time and then as Check Pilot in 2003 and 2004 responsible for simulator training out of Stavanger, Norway for pilots with Canadian Helicopters from all around the world. In that period I held Check Pilot authority from Canada, Thailand, and from South Africa.

In 2005 I was Chief Pilot S61 for CHC, responsible – subject to the Chief Pilot – for operating procedures for personnel on that aircraft. In 2006 the S62 came in, and I was Chief Pilot for that introduction into CHC. That entailed all the check lists and operating procedures, adapting Sikorsky s-92 recommendations to company philosophy on how to operate the helicopter. I was also responsible for training the initial crew.

For family reasons I left that and then returned, in 2007, as Captain of an S61. In 2008 I was captain of a Super Puma in Halifax, finally joining Cougar in 2009. At Cougar, I took on the role of Chief Pilot in 2010, which involved a lot of learning on my part, ensuring that all pilots were qualified and all training was completed according to a proper training program. It involved monitoring and appraising upgrades from First Officer to Captain. We also had bases elsewhere in Canada and in Alaska and also in Greenland.

Captain Perry was asked to explain what is involved in a qualified and proper training program, and, specifically, whether pilots are licensed. Captain Perry said:

Yes, but it is not like a driver's license. In the aviation world there are various different licenses. There is the private pilot's license, and then there is also a commercial license which is secured with training and examinations and flight tests and are based on experience calculated on the number of flight hours. A hundred hours in a helicopter – plus training, plus the exams, plus a flight test – would enable a pilot to receive a commercial license. Then there is an airline transport pilot's license, which is also based on hours of experience, training, exams, and tests, and would include the pilot passing checks on a multi-engine helicopters. Possession of an Air Transport Pilot License (ATPL) is the basic requirement for Cougar work. If a commercial pilot with ATPL instrument training applies, we can get him authorized as a First Officer, but do not do that very often... It depends on your experience. The pilot is typically more exposed to problems with difficult and challenging weather conditions and different locations, and that range of experience is important. Experience simply means that you know a lot more, and that experience lets you recognise potential problems before they get you into trouble. It lets you recognise the warning signals to catch it at an early stage.

Asked how one is upgraded from First Officer to Captain, Captain Perry said:

It can be lengthy. It depends on experience. Initially, a First Officer will spend a week on the ground learning how Cougar operates and then completes flight safety instruction at Palm Beech, where the simulator is. There is an initial course on the S92 which teaches all the systems and how it works. Currently we send one of our training captains for the first week to ensure our standard operating procedures are understood and being used properly. When the course is complete we send an approved Check Pilot – not the same one as the trainer – to conduct a simulation flight check on the pilot. Once the flight check is finished he comes back to St. John's or Halifax and there are other training courses and then he is assigned to another training captain for "line indoctrination." That process takes the trainee in an aircraft with the passengers and shows him most of the operations out of the base involving the different aspects of Cougar's work. And there are a set number of minimum hours in each sector: for example, from St. John's to the Sea Rose is one sector and there are a minimum hours of training for that area. Another sector is from Sea Rose to St. John's. The training captain decides when the student is ready to go up.

We follow the *oil & gas procedures guide* for the standards. 3000 hours experience plus night operation and 1500 hours as pilot in command plus night IFR are the current requirements. If these are all completed but the pilot does not fly for ten months, he is not current and updating is required. There must be three landings and take offs to keep yourself current, together with five landings at night. If a pilot does go without flying for an extended period of time then a training captain takes him up and checks him out.

Then, finally, to be considered for upgrading to Captain, typically I will look to the training captain and the command pilot for recommendations and then review the training and records; and then, on their recommendation, if there is no compelling reason to say "no: I will say "yes" as well.

Asked who has the final say in such an decision, Captain Perry said, "I do."

Captain Perry described the command structure within the Cougar organisation as:

Starting with the First Officer, then to Captain, followed by Line Training Captain, followed by Training Captain, then approved Check Pilot, then Chief Pilot Type (for a specific aircraft) and finally Chief Pilot. As Chief Pilot, I report to Director of Flight Operations (DFO) who reports to the General Manager.

Asked what other testing a pilot must face regularly, Captain Perry said:

There is annual flight training and flight test requirements, both of which are valid for twelve months. We call it "recurrent training." Flight training is the *Pilot Proficiency Check* (PPC), and then every six months we do a *Operating Proficiency Check* (OPC), with a training captain observing, during a passenger flight.

Upgrading to Captain is not automatic, or based simply on the acquisition of experience and training and tests. You need to be assessed to get the promotion. There are traits we look for in pilots prior to upgrading to Captain. It is very subjective. We are working to quantify it better, but when you ask for a recommendation, nine out of ten will agree that it is very subjective. That is why I rely on lots of advice. The first six months as a Captain are very difficult. As the one in charge you have to deal with both passengers and with the person beside you. In Mr. Sellars' case, I believe he was hired in 2008. That was before I was hired by Cougar. I believe he was hired as a First Officer and promoted to Captain early in November, 2010.

Asked whether Captain Perry himself had made Mr. Sellars' promotion decision, he answered:

Yes. Captain Sellars had completed all the training requirements... He was one of the most experienced pilots in the country, with around 18,000 hours, 631.3 of them in IFR conditions... Captain Sellars' service pattern between November 2010 and July 2011 was on a typical schedule of three weeks on and three weeks off. Typically he would fly 50 to 60 hours during the three weeks on period.

Asked whether pilots would normally pick their own flight paths as they see fit, he said:

No, the routing and profiles, that is all set out in Standard Operating Procedures (SOP). With Cougar's experience, we have very detailed SOPs. Taking off from the runway, the SOP tells the pilot what to do in a pre-hover, and what to do in leaving the hover, and what they are to say, and what the height should be. It calls for safety speeds, and the calls to use when leaving the runway area and flying away: speeds, rate of climb, and what height to make a turn. All these are set out.

In the Newfoundland Offshore, the SOPs set out what are required in part by the Company and in part by the regulating agencies. For instance, *Transport Canada* regulates the height for a turn. We spell out what to do to get there. There are instructions for leaving and arriving at the airport and / or at the installation. The return leg from an installation is slightly different from the outbound leg.

Familiarity with the Standard Operating Procedures is part of the testing for pilots. A flight profile will include air speeds, climb rate, desired attitude, turning position, descent rates. Mostly these are for passenger comfort. The SOPs also deal with "abnormal functions or emergencies."

Asked whose responsibility it is to apply these procedures and profiles between the airport and the rig and its return to base, Captain Perry said:

It's the Captain's responsibility. SOPs are in a stand-alone Company document titled *Standard Operating Procedures S92*. Transport Canada requires that each company has to create and monitor such a volume to ensure compliance with Transport Canada regulations. The complete Operations Manual can only be changed with approval from Transport Canada. *The Standard Operating Procedures Manual* is available to pilots. It is on the Company website and, in July 2011, it was required to have a copy in the aircraft, electronically.

Asked how he had heard of the incident at the focus of this hearing, Captain Perry said:

I was on my way back to Halifax, and I got a call at Toronto airport from the dispatch. They told me of an incident in Flight 851 departing with an abnormal pitch-up... It's protocol for dispatch to call me. I'm told of any unexpected event in flight. I don't recall their actual wording. I recall that there was an incident in departing pitch-up. The aircraft raised the nose attitude for whatever reason. I confirmed that Chief Pilot Type S92, Captain Curtis Savidan was travelling with me. The policy is for the Chief Pilot and the Director of Flight Operations to remove themselves for any investigation. So I asked him to lead the investigation at that point, and I stepped back.

Once we were aware of the seriousness, I made sure the pilots were grounded. That was by 8:00 PM that night, I think ... sometime that evening. My next information was at the presentation of the Investigation Report. Captain Savidan was delegated to do the investigation.

Asked when he learned what the incident had involved, he said:

Captain Savidan contacted the crew to get information. It would have been that evening that I learned more than just that there'd been a pitch-up on departure.

(For the Union, Mr. Ellickson objected to this evidence as hearsay. The objection was overruled.)

Asked what purpose was served by grounding the crew, and what consequences it would have on the two pilots, Captain Perry answered:

It was a preliminary investigation... I did absent myself from the investigation, but as the Director of Flight Operations and I are still responsible for ongoing flight control, I made decisions such as the grounding. I was told that the Client had called dispatch. I was told that the aircraft went into a hover, which is totally out of the norm. That is when we initiated the stop fly order... Mostly it is to protect the crew. If there is a serious incident, they are focussing on what just happened to them, and not on their flying. Plus, there is an investigation in process and you don't want them to do any more flying 'til that is done.

Asked if he was aware at the time where the incident had occurred, he said:

Yes, I knew that. It was on the Sea Rose FPSO offshore, approximately 350 km off the coast... Yes, there is an SOP for departure from the platform, which is the same for all platforms. The SOP for departure from a rig is that:

- The crew will do a preflight check on the flight deck.
- There will be a take-off briefing.
- Once the checks are complete the pilot initiates a low hover. The normal centre of gravity is felt. The Pilot Monitoring will check all gauges and advisories.
- Then the Pilot Monitoring advises the Pilot Flying what torque that the aircraft is using to hover and what the target torque for

departure should be. The target torque is calibrated from a table that takes account of altitude, temperature and the aircraft weight together with the heading that the pilot will be flying.

- He will be then cleared to fly. That conversation is all covered explicitly in the Standard Operating Procedure.

- The Pilot Flying calls "departing" and the Pilot Monitoring calls when the altitude is ready. Thirty feet is the actual decision point. Prior to that, the aircraft returns to the deck; and after that, the decision is that they are going to fly the aircraft away. So everyone understands what is going to happen.

- The Pilot Flying will lower the nose to 10° of the horizon to be sure of correct acceleration for the aircraft.

- The next call is "Vtoss" (take-off safety speed); that is from the Pilot Monitoring. That's the signal that will act as a levelling call.

- The next call is at 55 knots. It is given by the Pilot Monitoring. It tells the Pilot Flying that he can Go Around at that point.

- The Pilot Flying will respond, "engaging go around." That is a mode of guidance to the aircraft: autopilot on the aircraft. It sets the airspeed to 80 knots, and controls the ascent to 750 feet per minute. While all that happens the command bar has come into view on the pilots' portion of the instrumentation in the cockpit.

- The Pilot Flying will push the go around button to go to 80 knots and 750 foot per minute rate of ascent; but it will not climb, or get speed, if the settings are not correct. The settings are crucial.

Having reviewed the steps set out in the flight profile for this conversation between Pilot Monitoring and Pilot Flying, Mr. Perry described what he understands happened on the day:

They failed to follow the profile... Up to go around engagement, the profile was followed. The go around, however, was not engaged properly, and the aircraft was allowed to reduce to a very low airspeed, and as that happened the lift was lost and the aircraft started to descend.

Asked whether the review had shown that this was the result of a pilot decision, he answered:

No, that was a function of the aerodynamics. As the helicopter slows down, drag of the aircraft increases and lift decreases. Typically, you increase power, but...

Responding to a question from Union Counsel about the basis of his knowledge of these events, Captain Perry said that it was based on ...

a statement of the crew and the investigation of the data (recorded in PP#3). I did review it myself once the investigation was completed and forwarded to me.

Captain Perry identified, as PP #3, five pages of data graphs recording various features of the helicopter's departure from the Sea Rose and leaving the hover. He described the first three pages of PP #3 (covering the departure, into the hover) as derived from the Helicopter Flight Data Management (HFDM) system, and the last two pages (covering the subsequent departure from the hover) from the Health and Usage Monitoring System (HUMS). The data were recorded by the "flight data recorder, or black box." He gave an interpretive account of what PP #3 reveals, indicating where on the graphs various events occurred, such as "go around engagement." He said, "I conclude that it was a normal departure up to when the go around button was engaged." Asked when, on the graph, the aircraft's deviation from the profile becomes apparent, he said:

Basically, when the pitch up went up past five degrees. That is when the problem set in. When pitch up increases to 24^o: yes, at that point they were in cloud, although they would have been using instrumentation... I understand from the graphs, first, that there was pressure on the cyclic. The attitude change shows there must have been pressure on the controls. If the mode was selected properly the aircraft would not have behaved as it did.

(At this point the witness was asked to step out of the room, and Counsel for the Union raised an objection based on hearsay to the line of questioning "since it is clear that we are now about to explore what the investigation found.")

For the Employer, Mr. Smith responded that the 'witness is free to testify as to what he learned since he is the one to make decisions based on it. The investigator is not the one that made the determination. If, in fact, the witness is unable to provide an answer to the question based on the graphs then he can simply say, 'I don't know.'" The witness returned to the room.)

He was asked whether he can, from the graphs, establish who it was the engaged the autopilot. Captain Perry identified, as PP #4, Mr. Sellar' account of what happened on the flight. Asked if tis helped determine who actually engaged the instrumentation, Captain Perry answered:

I concluded Captain Sellars made the engagement. When the aircraft pitched up, that's the first sign of problem... We know that it was never set to the proper pitch attitude. You should be setting it to the horizon and the autopilot should be off at 50 knots. "Don't sink" was the auto call. These calls are activated by the aircraft itself, and "Don't sink" was triggered by the Weight on Wheels (WOW) indicator. "Low rotor" is also on auto call, and that is set by the manufacturer to sound if the speed goes down to 96%. You can increase power when the rotors slow down, but if you pick up the power the rotors will slow if you pull the collective too quickly. The lever controlling lift that is mechanically linked to all four helicopter blades.

It tips the blades to produce more lift. It demands power; so it turns more slowly than it expects. It is demanding a lot of lift, but because it does not have the time to meet the demand it slows down. A gradual call for power wouldn't have the same effect.

Asked if either a "low hover over water" or remaining "in a hover and" checking the system was according to the Standard Operating Procedure, Captain Perry said: "There really weren't any SOPs at this point."

Asked if he could reconcile Mr. Sellars' summary account (PP#4) of the event with the data graph of the flight (PP#3), Captain Perry located the PP#3 point which corresponds to Captain Sellars calling "go around" in PP#4. He noted that:

At that point Flight 851 was registering 60 knots. The aircraft is looking to accelerate to 80 knots with a 750 foot per minute rise; but, after that, the pitch angle moves from 5° to 8° or 9°, and then all the way up to 24° ... Glyn called out "attitude and air speed" from his screen display on his side, and said, 'Cyclic forward and maintain a level attitude.' There were some control changes, but no improvement in attitude. 'Maintain level attitude' means wings level with the nose on the horizon.

Captain Perry confirmed that statements had been taken other than Mr. Sellars' own (PP #4). (The Union again raised a hearsay objection, noting that this evidence had been taken by the investigating committee rather than by the witness. The Adjudicator allowed the questioning to continue subject to his determining appropriate weight.)

Asked to clarify his own role in the decision to terminate Mr. Sellars, Captain Perry said:

When I received all the information and started pursuing my options concerning our belief as to what happened, and figuring out the consequences, we concluded it was a not skill issue. He was a trained pilot and failed to react to what the aircraft was showing him. We could not come up with a plan tailored to training the pilot to counteract it. I went to J.J. with a recommendation. I could not figure out a plan for training what is really a matter of instinct. The investigating team had all the information and pulled the data, and showed it to J.J. and myself; it included their report and supplementary statements taken from the crew. We saw this graph and the statements from the crew. It was on the 25th or 26th of July that the two investigators presented their findings. An awful lot was happening in that time frame. Captains Savidan and Moores were the investigators. Captain Moores is an offshore training Captain and a SAR Captain that got added to the investigative team right at the start... Copies of the investigative team's notes and a summary of what they had found were presented. They sent me the material and debriefed both myself and JJ. I was on teleconference at the time. The conclusion was that the go

around did not engage properly. Captain Sellars said, "check" to acknowledge the monitor's call about the air speed and attitude... but graphs do not confirm the action was taken on air speed. The graph does not show the aircraft as actually correcting. Glyn re-armed the floats at that time... I believe Glyn made the right comments at the right time. I question that he did not take control of the aircraft. The Standard Operating Procedures give guidance, if the pilot does not respond to the monitor's warnings.

Asked if they had informed the Pilot Monitoring, Mr. Mugford, about this, Captain Perry said:

Yes we did. We interviewed both Glyn and Boyd after the investigation. I asked him what he should have done and he said, 'I should have taken control.' He told me, when I asked, that he thought that doing so might make the situation worse. That is a valid concern, but I wanted to make him take the control question with him. The decision not to do so may have been the correct one.

Asked if there were any other issues in the flight that were of concern in addition to engagement of the autopilot, Captain Perry answered:

The actual issue with the go around was not the biggest concern; but the pilot's failure to correct that problem actually increased the problem. He did not apply pressure to stop the descent at the proper time. At the top of the climb, when they were topping out, they were in cloud. The Pilot Flying should be focussed on the instruments at that time. The crew should have been aware they were exceeding a limit here somewhere. But they did not do that. They did not consider returning to the Sea Rose for a check over before returning back to St. John's.

(At this point Union Counsel, Mr. Ellickson, requested a number of items be made available to the Union for its review, including notes relating to what the witness had testified to so far, and reports from the investigators, together with any other notes or e-mails in respect of the incident and the decision to terminate the Grievor. Counsel for the Employer, Mr. Smith, said he would try his best to provide the documents requested.)

Captain Perry then provided commentary on an animation, "Flightscape", (PP #6), which had been provided by the Company's HFDM Officer, Catherine Reed. He identified the various instruments and displays that are represented in the video and then tracked the progress of the animated re-enactment of the Helicopter's departure from the Sea Rose through to the subsequent departure for St. John's following the hover. In tracing this re-enactment Captain Perry identified various time points (*cf.*, PP#7) at which, in his view, the various elements of the problem developed:

- at 39.5 seconds all is normal
- at 46.2628 the go around had just been engaged. The airspeed is at 56 or 66

knots and the elevation is 310 feet. There is a good rate of climb and there is a normal heading. The go around actually engaged at 40.219.

- at 40.318 the "bug" appears, indicating the airspeed that the aircraft is now set to achieve. The airspeed at this point is actually 65 knots. I'd expect the nose to come down and the acceleration to 80 knots to begin at this point.

- at 41.209, with the cloud base at approximately 200 feet, We are in cloud at 275 feet at this position. At this point you have to fly instruments. The focus needs to be on the screen. However...

- at 43.816 the pitch up goes from 5° to 10° , and it is clear that the go around mode did not engage properly... Although not desirable, on occasion this does happen. Force must be held on the flight control. The fact that we got here is not desirable, but it's not overly concerning. It's a simple problem to fix as far as the unusual attitude is concerned. I would have expected it to stay at 5° or to decrease, but it is going up. Either manually override the autopilot and reset the correct attitude, or disengage the go around. Pushing forward on the cyclic will reset the attitude. This is the only issue at this point. You are now required to override the autopilot. You have to do something.

- at 48.205 the airspeed is decreasing and there is 10 degree of pitch up... The bug resets from about 80 km to 55 because the pilot selected time release at that point, and that resets the airspeed bug. This tells me the pilot had his hands on the controls because he's using the time release on the cyclic. The reason he pressed it was because he was applying pressure, and we use that button to take pressure away. However, the aircraft attitude does not go down. The time release is normal for normal flying to remove pressures, but it is still pitching up, and the speed is coming back.

- at 50.35 the autopilot system is off automatically, as its designed to do. You hear in your headset the word "decouple." That's from the system, not from the pilot monitoring. We now really need to act. The airspeed is decreasing. The 15° of pitch is going up. There is good altitude and good climb still, and we're still on departure heading. The power is not really changed. This is still relatively easy to correct. The autopilot is off. The pilot has to reset to 5° of pitch by pushing on the cyclic. autopilot is still working to stabilize, but its guidance is not in control. That's off. Three seconds later...

- at 53.188 the airspeed is still slowing. The pitch attitude is up to 21.5° . There's a slight right bank introduced, and we are at about 500 feet above the water. The rate of climb is still good and turning slightly to the right. The copilot is saying, "Airspeed and adjust attitude." So the pilot should push forward on the cyclic to set the right pitch attitude. We reset the right pitch several times on each flight. The power is still the same here.

- at 56.455 the airspeed has slowed to 35 knots and the pitch is at 20° and 530' of altitude. The climb rate is decreasing. There is still a slight right turn. The power is still unchanged at 53 torque. The lower speed is stopping the climb, and it is levelling off. The performance of the aircraft is decaying. The pilot now should increase the power to the rotor system to counteract this.

- at 59.227 the airspeed is at about 31 knots and the pitch is 17.5° . We're 525' above the water and the situation has just got more complicated. The aircraft is now descending at the rate 370' per minute. The pilot still has his nose high. He must push forward on the cyclic to correct it. But the descent is building, and I have to stop that, so raise the collective to apply more power. I don't care how much power you apply, but get the power up. Precision is not the issue. You must make a positive act to stop the descent. We do fly at precise parameters, and we can over-control; but we have not seen that here.

- at 63.154 the airspeed is down again, and at these low speeds the gauges are not very accurate. We are at 15° of pitch, but we should be at 5° or less. Altitude is still at about 500'. The pedal position has ceased to accommodate the right bank. Above 40 knots a helicopter is like a plane. Below 40 knots if you want to turn you use the pedals for a turn. Once below 50 knots the pilot must have had feet on the pedals to let the heading turn. We now have 1100' per minute descent to the water. You would feel that inside the aircraft. The power is still at 53 degrees of torque. To recover, push the cyclic forward and increase the collective power.

- at 66.223 the airspeed is still lower. The pitch is at 10° as the aircraft slows due to drag. We are at 410', and descent at 1450' per minute. Torque is down to 51%. At this point the nose is still high. The descent rate is very high. To recover, push the cyclic forward and raise the nose and add more power at the collective. We're still well up above water and we're still in cloud. The ceiling is 200 feet.

- at 69.193 the airspeed is slow. The bank angle is more or less the same. The pitch is up again to 12° and we are 330' above the water. The descent rate is over 1500' per minute down. Torque is at 54 %. (It is not unusual to see minor variations in torque due to aerodynamic causes.) The recovery is by pushing the cyclic nose to get the nose down and level, but it's not really the concern. Now the need is for a large power application, up to 80% of torque needed, a large power charge. The aircraft is still in cloud at this point. The altitude is low, very low speed, and a high rate of descent. This is the scariest place to be. You cannot help but know that you're in a lot of trouble at this point.

- at 72.13 the instrumentation still shows low airspeed, the bank angle has corrected. The nose is still 10 to 12° up. The descent rate is now at 1680' per minute. Torque is up a bit to 58 or 59%. The remedy is still to push the cyclic forward, increase the power on the collective. We need a large move. We are not interested in subtlety now. Up here we are still in cloud. If this were a simulator it would be unacceptable. The faulty selection of the go around is ok, but anything after that is unacceptable. Recovery is not acceptable. We are now at 255 feet up. This is where the cloud base thins. We are 1700 feet per minute rate of descent.

- at 74.4 seconds we are 90' up. The power has increased slightly to 58% and the heading is at 187° . That's 60° nautical heading, but now we are 120° out of the wind, so we have a tail wind component. It is starting to increase our prob-

lem for the aircraft. At this point the pilot should get a view of the water. He will get a ground rush from the speed of descent. The intuitive response is to pull up on the collective. That is what any experienced pilot will do.

- at 76.321 there is a rapid increase in the collective. That's where he saw the water. The collective moved up. There is still 1500' per minute rate of descent. We are now at 120 feet from the water. The current attitude is down to 2.5° and there is a slight left bank. The pilot has increased the left pedal to stop the right turn. The main rotor speed is down to 100 because the power application was rapid as it should have been at this point. Even with that power increase there are still problems with the aircraft, descending at 1500 feet per minute and 120 feet from the water.

- at 79.126 the airspeed is at zero. The pitch was down to minus 5°, and is now at -2.5°. Three seconds after the call for power the aircraft is still descending, but at a slower rate of 690' per minute. It is now at 120% torque, and therefore maintenance will be required. The rotor rotation is at 97 and still descending.

- at 80.116 the descent rate is down to 470' per minute. The nose is level. The rotation is back up to 103 and the torque is up to 110%. It did actually go as high as 132% on the graphs.

- at 82.954 the airspeed is zero, the pitch is -2.5°. All has come to a stop or the aircraft is climbing very slightly. It is close to 194 feet. The rotation is up to 105 and the torque is at 85, and that is about 10% high for a hover and it may be due to the tail winds. Everything has come to a stop. The pilots are having some discussion. The landing gear warning is showing. They decide to depart for St. John's. Not a "cat. A" departure, but a standard departure.

- at 89.92 they are starting to climb from 40 feet.

- at 95.296 the departure from the rig according to a "cat. A" profile, down pitch 10%, Vtoss nose brought up. The ELNAV is engaged lower than 400 feet. It should not be on yet. At 750' rate of climb, at 77 knots, 5 or 6 degrees, nose up, 450 feet heading for St. John's.

-There are a lot of discussion points arising from these actions. Would you depart back into the cloud with the same system that got you into trouble, using the go around which caused the problem? I don't think a pilot would do that.

Reviewing his account of the events based on the animation, Captain Perry said:

If you go back to 58.766 – where the aircraft runs out of energy – up to that point it's a simple recovery. Any IFR pilot can manage this. There is no problem. Other pilots have done this with no problem. 15 seconds later they break out of the cloud. If a pilot does nothing else but increase the collective, we would not be sitting here today. When the pilot saw the water he instantly reacted. That is a visual flight reaction, reacting to visual clues outside of the aircraft. Once he had reference with the water I'd say he took the appropriate reaction to stop the impact with water.

At 180 feet you are going to do this before you hit the water. Between 200 feet and 180 feet is 20 feet, less than one second. He reacted in less than one second to apply the power once he saw the water. That's a VFR reaction: not appropriate for this aircraft. It should never have got there. It should have been fixed in the first five seconds after the go around was engaged. If this was something that happened in simulator retraining, it would be required.

Asked what was the likely cause of the aircraft's initial pitch up, Captain Perry answered:

The initial pitch up is attributable to pressures on the controls just prior to engaging the go around. The autopilot does not cooperate easily when that happens. In this aircraft, if you are holding pressure on the cyclic, the "stick", the stick is not where the motors want to move it. This happens, and there is no mechanical fault in the aircraft. The aircraft system was operating properly at the time. So the initial pitch up was a problem with pressures on the stick prior to go around. But that is irrelevant. We did not recover properly. The crew were verbalising the right calls, but there was no physical correction large enough to recover the aircraft by pushing the stick, and eventually he needed to pull up on the collective for power.

Captain Perry identified, as PP#7, the report made by the pilots investigating the Flight 851 incident. Asked if there had been anything done with the equipment, itself, once the aircraft had returned to base, Captain Perry said:

There was a mechanical check for overtorque, and a maintenance review of the guidance system based on the HUMS data. We had a crew take it for a flight the next day, and there was no problem with the aircraft... The pilots, themselves, had provided documentation about the incident. The aircraft log book goes to maintenance for review and the debriefing with the investigating pilots. The log book is the journey log as regulated by Transport Canada.

He also identified, as PP #8, the mechanical log, which, as Union counsel pointed out, the witness, himself, could not attest to for accuracy. PP#9 is the Aviation Event Report.

Asked what happens with this Report, he said:

A number of things happen according to protocol. We look at it. All management are notified of an event. The Director of Safety reviews it first and gives it a rating. In this case it scored 'high'. That catches everyone's attention. PP #9 was reported to the Transport Safety Board on the 24th at 18:50.

Captain Perry was asked to compare PP#9 with the account Captain Sellars had given Captain Savidan (PP #4). He said:

The account given in PP #4 corresponds with my interpretation of the video of the events (PP#6) up to the point where Captain Sellars refers to the "... AC

pitched Aggressively (*sic*) nose up." The reference to his having "corrected with cyclic forward and maintaining a level attitude" did not happen. The airspeed was not corrected until he saw water. All the rest is accurate.

Captain Perry identified, as PP #10, his

... handwritten notes made on July 26th at 13:45. I was on teleconference with JJ, Curtis, and Mr. Banks. Page 2 of PP #10 summarises the interview with Mr. Boyd Sellars. I had dialled in. I listened, and he had the option to choose either termination or resignation. I was not involved. Where Glyn was concerned, Pilot Flying discipline was indicated in terms of the attitude recovery and also in terms of taking control. I wanted to see what he would do. He indicated he would take control. Recommendation was for training for him.

Asked if Mr. Mugford has yet returned to the line, Captain Perry said, "No he has not."

Page 3 of PP #10 is my summary of my understanding and judgement... I had no knowledge of unionisation at all. I was satisfied with my own judgement that 'Boyd is a risk I won't take.'

Captain Perry identified, as PP #11,

... an August 4, 2011 e-mail from J.J. with attached documentation, about Captain Sellars' legal position with the Union complaint... I understood there was an employment committee and management had a meeting in June which was a disappointment, but there was a later meeting scheduled for September.

Asked what conclusions he'd reached about the Flight 851 incident regarding Captain Sellars and First Officer Mugford, Captain Perry said:

The calls were made correctly, but the pilot did not take the corrective action to put it into the right profile... I recommended he should not fly offshore under instrument conditions. You need a training plan to correct this, and some way to test it and check it. If he does not react in a stressful situation in the aircraft I have no way for training for that. There is no way of testing... Where Cougar operates, because of the weather we need to be able to operate under instrument conditions at all times. There is no way to avoid it.

Asked whether Captain Sellars might continue in some other capacity, Captain Perry said:

"Cougar does not have any other VFR operations. There was no alternative."

Asked if Cougar has used demotion for training issues in the past, Captain Perry said,

"Yes." Asked if that option was considered in the instant situation, Captain Perry said:

Yes, but the First Officer must be capable of taking control. It was not his status, but the fact that he was the pilot flying and did not take any action... Yes, Captain Sellars successfully recovered the aircraft and flew it to St. John's, but he took no action in instrument conditions. When he caught reference with the water that is when he took the action.

Captain Perry was asked about statements that had been made to pilots concerning engaging autopilot function and "unusual attitude recovery."

Yes, I was involved in creating and disseminating them. The rationale was, first, to ensure the pilot group was aware of the need to enforce exactly the procedures and to verbalise while doing them, and to look at how to confirm that the modes were engaged properly.

With respect to the "high" rating attached to the Aviation Event Report (PP #9), Captain Perry was asked what action is normally taken in such a situation. He said:

It would trigger a review of whoever and whatever Rick (Mr. Richard Banks, Director of Safety Management System) thought was involved. Typically, recovering properly, mitigation and corrective action: Rick was expert on that.

Captain Perry also identified, as PP #12, a copy of Cougar's internal report of the Flight 851 incident based on an investigation conducted from July 23rd to August 2nd. This includes a period that postdates the dismissal, but the report is dated (p.1) "23 July, 2011", which predates Captain Sellars' 26 July termination. It is signed (p. 18) by Richard Banks. PP #12 includes copies of memos on (p 19) "S92 "Engaging Autopilot Functions" and (p 21) "Unusual Attitude Recovery." Asked if he had any other information prior to receiving the report, he said:

We had the debriefing and the crew statements and the report itself and the graphs. I did not see the video before then, no... Between July 23 and July 28, we still have an operation ongoing and crews are flying daily. I had to put out guidance to the pilots. That was due diligence as clarification.

Captain Perry estimated that the process of promoting a First Officer to Captain incurs costs that he estimated to be:

...in the range of \$50,000 to \$55,000 and lasts over a period of two to three years, plus a lot of incidental costs. I do not track what's involved in training schools, *etc.*. Mr. Sellars was hired in 2008 and became Captain in Fall 2010.

Asked if he had participated in the process leading to Mr. Sellars' termination, Captain Perry answered: "My recommendation to the DFO (Director of Flight Operations), Mr. Gerber."

ON CROSS EXAMINATION, Mr. Perry confirmed his estimate that the entire episode from the initiation of the unusual attitude to the hover was "between 45 and 60 seconds, approximately." When it was pointed to Mr. Perry that the Cougar Report (PP#12) says that that Mr. Sellars took little or no control action for "approximately 16 seconds", he answered,

"I didn't realize that." Mr. Perry's attention was directed to PP#12 at paragraph 4.2 (p.12) which reads:

The PF was fixated on gaining a wings level attitude and lost an unexplainable amount of valuable seconds in regaining control of the aircraft. The PF statements were later validated when the FDR data revealed that approximately 16 seconds elapsed where the PF took little or no action. This delay resulted in flight path Excursion.

Mr. Perry said, "Yes, I believe that was from pitch up to top of climb." Asked if he had spoken with Mr. Sellars other than on July 23, Mr. Perry answered: "No. I don't believe I spoke to him on the 23rd." Asked if he had any conversation with Mr. Sellars in the period from the incident until the termination, Mr. Perry said, "To the best of my recollection, no." Asked if he had spoken to other pilots in that period regarding the unusual attitude, Mr. Perry said: "To the investigation team, yes."

Mr. Perry confirmed his earlier testimony that Mr. Sellars was one of the most experienced pilots at that time. "Yes, he had 23 years." Again asked whether he had not spoken to Mr. Sellars during that period, Mr. Perry said: "I'm still thinking... I may have told him he's grounded pursuant to the company's SOP. Either I or J.J. told him he's grounded." Mr. Perry was told that "Mr. Sellars will testify that he called you on Sunday evening concerning the incident and that you told him he was grounded." Mr. Perry said "Possibly." Asked if, as Check Pilot and Chief Pilot, he is responsible for safety policies and procedures, he said:

Yes policy... but you need to be more specific... there is another department for that... I have an impact on many of them but many had been put in place by other people... over the course of the year I have been Chief Pilot, yes I had made changes to the annual or recurrent training for pilots by July 23.... and after Mr. Sellars' termination... well, yes. The industry is a heavily regulated one. There are various agencies, including Transport Canada, which is the regulating authority... The regulations are binding on Cougar, as they are on all airline companies, and some of these regulations are incorporated into Cougar's own Standard Operating Procedures. One builds on the other...

The Operations Manual is a higher level document. PP#2 is an excerpt from Cougar Helicopters Incorporated (CHI) Company Operations Manual, (ed 2, ch 2). It's the guiding authority for the Company's flight operations.

Asked if Cougar is subject to oversight by the Offshore Petroleum Board, he said:

The Offshore Petroleum Board is established by ... Government. They have no direct administration of Cougar. They oversee the oil companies. The other

body is the commercial oil companies, each of which has different requirements. It's not one body; they are all independent. Other than coming to Cougar with technical information, the Offshore Petroleum Board does not have any contact with Cougar directly.

Asked if Cougar's client, Husky, has any input into the Company's operation, he said: "Not directly. That's part of the contract between Cougar and Husky I think. Asked whether Husky is involved in training, Mr. Perry said:

Yes to the extent that it is completed, and that we are doing what we say we are doing. Cougar is subject to Canadian Law and the *Canada Labour Code*; yes, federally. And Cougar's pilots are all subject to Transport Canada's licensing procedures and requirements. At a basic level, the minimum requirements for Cougar's pilots are the responsibility of the Company. Cougar itself has additional requirements for its pilots. Offshore operations mandate additional minimum requirements that Cougar itself must follow for its pilots.

Asked if offshore operator approval is needed for each Cougar pilot, Mr. Perry said: "Yes, Cougar and Husky Offshore all have a say... I can't say Husky "dictate", but they approve pilots for the contract, yes." Asked whether the offshore clients can say "Do not use pilot X." Mr. Perry said:

It would be more likely that Cougar would not approve that pilot... Husky could simply not approve a contract.

Asked if it is a fact that, without approval by an Offshore client, a particular pilot could not fly, Mr. Perry said, "Correct."

Asked if he had reached a conclusion about Mr. Sellars' employment in the context of the incident on July 23rd, and had made any recommendation to Mr. Gerber, he said:

I am trying to remember... I think I thought he should not be flying in an IFR environment, and we have no other environment to put him in...

Asked who had made the ultimate decision to terminate Mr. Sellars, Mr. Perry said: "It was a little above my level; but I believe it was the General Manager." Asked if he'd reviewed the Internal Aviation Investigation Report (PP #12) when he made his recommendation, he said:

Yes... I believe I got that report on the PM of the 26th, yes... I believe so, yes. I also had the two statements, one by Mr. Sellars and one by Mr. Mugford... I believe so, yes... I am not sure when I reviewed these documents... I believe I was in Halifax in this period... I had the crew statements, the review notes and the debriefing on the 26th with the two investigators... I spoke with some training Captains ... on the phone... in the context of training planning, yes... I

don't recall taking any notes... I can't recall who I spoke with... I wanted to get some insight into assisting a pilot in an extreme situation. Are there training problems? Had they had enough training to assess how a pilot would react under a lot of stress? I spoke with the training pilots, but did not do the actual investigation of the incident. I don't believe I spoke with anyone else before the termination, other than those doing the investigation.

Asked if there was conversation with Husky during this time, Mr. Perry said:

Oh yes. Yes, it's fair to say that Husky was very interested in what had happened and had a concern that it would not happen again... I understand we put briefings in place with Husky about each crew for each flight after the incident ... Mr. Gerber was the lead on that. Husky was fully aware of the investigation and closely looking for feedback... I was involved in briefings with the client at meetings after the termination. There may have been conversations with Husky's Flight Advisor. I am not sure I had any direct contact with Husky at that time.

Mr. Perry confirmed he was aware that Husky had itself prepared a report which makes a number of recommendations.

I believe I've seen it. I am not sure of the exact number of recommendations, or whether I've seen one in that document about training... I'd have to see it... That's coordinated through the Safety Department, who, I suspect, has the report. It's a Husky internal report... I had not seen the report prior to the termination.

Asked If he'd spoken with anyone at Husky before the termination, Mr. Perry answered, "I could not swear to phone calls." Asked about conversations with Mr. Sellars, he said: "Other than the one about grounding, I don't think there was any direct conversation." Asked if he'd received direct or indirect contact from Husky prior to Mr. Sellars termination, he said:

There was a lot of general information coming our way... ahh, I'm not sure if we had Mr. Gerber's statements by that point. There was lots of traffic with Husky and the company.

Asked whether Husky had any input into the termination decision, and when Husky was told that Mr. Sellars was terminated, Mr. Perry answered:

No influence from Husky on me, no... I did know. I did not do it. I don't know who the direct contact was... My contacts prior to the recommendation for termination had been with the investigators, some training Captains, the two statements from the crew and the draft of the investigators' report.

Asked whether he had spoken with individuals prior to making his recommendation – whether with clients or others – Mr. Perry again said "There was no influence from them."

Asked when he had provided Mr. Gerber with his recommendation, he said:

After the meeting on the 26th... I believe it was by phone. There are no notes, no. ... It was a new process. I'm learning a great deal.... Yes, there were four investigations completed: the summary investigation, the investigation by the Safety Division of Cougar, the Husky report, and we know that the Transport Safety Board did one (*cf.*, BS#1)... A draft was produced. It's in the draft stage. I believe... I believe that's everything.

Asked if Cougar had given its report to the Offshore Operators, and whether there was a separate report to the CNLOPB, Mr. Perry said:

That was the intention.... I believe (there was a separate report to the CNLOPB), but that would have gone from Husky to the Board.

Mr. Perry agreed that, out of all these reports, a number of recommendations were designed to ensure that the incident did not happen again. Asked if he would agree that the key recommendation is for training and education, he said: "Yes, as a blanket statement." He further agreed that nothing in these reports suggested that Captain Sellars be terminated.

Mr. Perry confirmed that PP#1 shows Mr. Sellars had 18,090 hours rotary wing experience and that 631 hours of this had been IFR. He also confirmed that his own total rotary hours were 7000 accumulated since he had begun flying professionally in 1985. He agreed that Mr. Sellars had approximately 30 years as a helicopter pilot. Asked if he was aware that this was Mr. Sellars' first incident reportable to Transport Canada, he said "No." Asked if he knew whether Mr. Sellars had been disciplined while at Cougar, he said, "I do not know." Asked if he knows of any discipline during Captain Sellars' time with Cougar, Mr. Perry said: "I reviewed his file. There was no recorded incidents in his training file."

Mr. Perry confirmed that PP#2 is the extract from Cougar Helicopter's Company Operations Manual, dealing with the responsibilities of the Pilot in Command, but that there is nothing here relating to the responsibilities of a First Officer.

Asked what he views the role of a Pilot in Command to be, Mr. Perry answered:

The proper completion of the SOPs and the checklist. It's also the case that the pilot in command completes the paper work, while the First Officer assists the Captain to the best of his abilities and assumes command if the pilot becomes incapacitated.

Mr. Perry confirmed that PP#1 shows that Mr. Mugford had 322 IFR "total flight hours." He also confirmed that Cougar must have a fully qualified Captain and First Officer

when operating the aircraft, and that Cougar has a crew-pairing policy under which anyone with fewer than 300 hours on a single type of aircraft is not paired with anyone else.

As of 2011 Mr. Mugford had 804 total hours on the S92 and Mr. Sellars had 1200 hours. Both were qualified to fly as a pair.

He also agreed that offshore operators have the authority to make certain requirements and that, in this particular case, Mr. Mugford had not met Husky's requirements, which was 1000 hours minimum on the S92 and 250 hours as Pilot in Command (PIC). As of July 2011, Mr. Mugford had fewer than 1000 hours on the S92, and fewer than 200 hours as PIC. Asked if he would agree that the two pilots should, therefore, not have been paired on this occasion, Mr. Perry answered "Per Husky's terms, correct." Mr. Ellickson said he understood Cougar had requested a waiver for Mr. Mugford from Husky, and it was granted providing he only flew with a designated training pilot, but that Captain Sellars was not a designated training pilot. Mr. Perry said:

No, he was not... Before July 23rd, Cougar stopped abiding by this condition of the waiver, so it was in violation of Husky's crew-pairing requirement.

Mr. Perry confirmed he had not investigated the incident himself, but had reviewed the summary report, the crew statements, the safety report, and the video. Asked if he'd testified that, if there is pressure on the controls, a go around will not engage, he said:

If there is pressure on the cyclic, a go around may not engage. It's not a given, necessarily.... Yes, I also testified that this is a known problem with the go around... No, (there has been no attempt to remedy this) because, as I understand it, it's a system limitation... At the time of the incident there was nothing in the manual about this happening. Not specifically, no. Not at the time, no. And the manuals at the time also had nothing in them concerning what to do with an unusual attitude following engagement of go around. The company's manual has guidance for what to do and now the SOP has what to do for attitude recovery but not specifically to do with the go around.

Asked if, at that time of the Flight 851 incident, a pilot encountering an unusual attitude would have had to rely on his training or having it explained to him, Mr. Perry said: "Unusual attitude recovery is covered in training." Asked if there was any training at that time concerning the use of the go around and unusual attitude, Mr. Perry answered:

Not at that point. In fact, I did make that error myself. I had been warned about it; even so, I still made the error.

Asked if Cougar's committee had recommended that emphasis be placed on the coupling function selection and training following the incident, Mr. Perry answered "yes."

Reminded that he had testified that the crew had engaged go around a second time when they departed from the hover for St. John's, Mr. Perry said:

They engaged it going through 55 knots on the second departure, I believe, yes... That was confirmed by the HFDM data.

Asked whether, in his view, that showed poor judgement, Mr. Perry answered:

I reasoned that if there was a concern with the aircraft performance then you would not do that... But if there was no aircraft problem, then select and carry on.

Asked whether he was aware that Mr. Moores had noticed the fact that the go around was not engaged a second time (RM #1 p 3) Mr. Perry answered

Yes... I do not know whether, during the investigation process, Mr. Sellars and Mr. Mugford both said they had not engaged the go around a second time ... I believe I saw the data that day, the date of the note (July 26). I did not see the video portion until the 28th, and there was a reason for that. No, I did not actually collect the HFDM data myself... nor am I responsible for the system or process for collecting it... If you're asking if it is accurate, I was told that the data collection either works or not, and, if it works, it is 100% accurate, but data collection is not my area of responsibility or expertise....

Mr. Perry acknowledged there is some disagreement about the second go around engagement, saying:

The cockpit voice recorder (CVR) would resolve the question. The company downloaded it. That's all I know. I do not know who... Yes, the Transport Safety Board prohibits anyone accessing the Cockpit Voice Recorder... I understand it was recorded over because the CVR overwrites itself, and the portion for the departure for St. John's was lost... That's why we do not know what was said in the Cockpit, correct.

Mr. Perry was reminded that he'd testified that the crew should have been aware of the over torque, and should have considered returning to the Sea Rose. Asked whether that view played into his recommendation, he said:

To a limited extent... It did exceed the percentage of limit; but yes, no problem with the aircraft was found. It was flying again the next day.

Mr. Perry confirmed that in his testimony he had referred Mr. Sellars looking out the window.

Yes, that was in Mr. Moores' written notes (RM#1 p.2) of his interview (with Mr. Sellars). That led me to believe he was relying on visual rather than instrumentation... Yes I did rely, to a certain extent, on that comment in making my recommendation. Yes.

He confirmed however, that Mr. Sellars had not said so to him. Mr. Perry confirmed he had ... interviewed Mr. Mugford, on the morning of the 28th, I believe, and that was the first time since the incident. And I believe it was after I'd read the data and after the termination. I believe so, yes.

Mr. Perry acknowledged that, on direct examination, he had testified that Mr. Mugford had said "I should have taken the controls." Mr. Ellickson pointed out that Mr. Mugford's position was that at no time did Captain Sellars lose control of the aircraft. Mr. Perry said:

I saw that... Yes. And, yes, PP#10 is the only record of my notes, and they show my written concerns on U/A attitude recovery/taking control. But I did not write in my notes that Mr. Mugford said 'I should have taken control.' No it's not there. Yes, the crew did make an entry through the SMS, yes.

Mr. Perry agreed that the e-mail correspondence in evidence does not suggest that the pilots were trying to hide the incident.

We generally get information as early as possible, and they did the next day. PP #7, the Summary Investigation Report, is undated. I saw it for the first time on July 26th. I believe I received a copy by e-mail. I think I got it at the de-briefing on July 26th. Present were, aside from myself, the Director of Flight Operations, Mr. Savidan, Mr. Moores, and Mr. Rick Banks who was Director of Safety. The report concludes with a recommendation on the final page of the report which reads:

'Even though this is an isolated event we recommend emphasis on the following subjects during annual recurrent training;

- (1) unusual attitude recovery and techniques
- (2) coupling functions and proper mode selection
- (3) identification of improper mode selections and recognition.
- (4) CRM - focus on PM's duties beyond standard calls in unusual situations.'

Asked whether these recommendations were adopted, Mr. Perry said:

Of the four areas listed, all are now being done. Number two is being done, not in terms of the annual training but in terms of change to the SOP... Yes the passengers had also been interviewed and some had given statements in a report prepared internally by Husky...

Mr. Perry said the *Internal Aviation Investigation Report* (PP#12, p 9, Section 2.16.1-4) is ... accurate so far as I'm aware. That notification about the incident by Cougar Helicopter Traffic Supervisor and by Husky Energy Logistics Manager was

unusual. Initially it was the people on the Sea Rose who directly called the base at St. John's.

Referring to (PP#12) p. p.15, Captain Perry confirmed that

I was involved in the "just culture decision model" as it was applied in this instance. This is a tool to let Managers work on an incident with employees ...We struggled with how the tool applied to Mr. Sellars because of the nature of the event. He'd been trained, yes. Could it happen again? Yes. How could we require training and change the behaviour? In the end, we had a very difficult time applying it to this case... In the end we are still looking for a way; but in the end we said this does not apply in this case. There was a lot of discussion back and forth about him between myself and Rick after the debriefing on the 26th ...Yes, I was there by phone...

We were able to use the tool... Yes, the question was how you adapt training to be effective in this situation, and the second issue was how do you validate the training. There were a couple of issues in Boyd's training so we really struggled with it keeping in mind the passenger and crew safety.

Mr. Perry confirmed he had reviewed Mr. Sellars' training records and that Mr. Sellars was a Captain at the time of his termination. Cougar had not demoted him. Asked if Cougar had been satisfied with his abilities as a Captain, Mr. Perry answered, "Yes." Asked if they had received briefing on all the events relating to the incident on the 23rd, Mr. Perry said:

It's not fair to say 'all the events', but concerning the go around and the pitch up and the recovery... that would be about it. I was briefed in Halifax.

Asked whether Husky requested this briefing, Mr. Perry said "Yes." Captain Perry reviewed the actions taken as set out in the closing pages of the PP#12, and indicated measures that had been put in place. He also confirmed that the memo to "Cougar Pilots" of July 26th, 2011 (included in PP#12 @ pp 19-20) re "S92 Engaging Autopilot Functions" had been ...

posted on the electronic notices so that Pilots had to read it before flying, and I think it is in the aircraft. It reads, in part:

When modes are selected Pilots must be vigilant and ensure that the modes have engaged as expected. If the aircraft does not respond as anticipated the PF must be ready to manually fly the aircraft and set a safe attitude for the condition of flight.

It is the PIC's responsibility to ensure the safety of the aircraft by preventing unexpected excursion from developing into large deviations from the desired safe flight envelope.

Captain Perry also confirmed that the memo to "Cougar Pilots" of July 26th, 2011 (included in PP#12 @ pp. 21-22) re "Unusual Attitude Recovery" had also been widely circulated. He was asked whether the word "fixate", as it appears in the third paragraph in the latter memo, describes what the Company says Captain Sellars did. Mr. Perry answered: "Definitely it was part of what he did."

Mr. Perry also confirmed that the "Classroom Training Session" referenced in PP #12 para 5 (p.15) had "also been done and the crew pairing policy was revised." Asked if this was at Husky 's request, Mr. Perry answered "possibly." Asked if it was in response to the Flight 851 incident, Mr. Perry said, "Yes." Asked whether Cougar had also set out other ways to respond to this incident. Mr. Perry answered "Possibly."

He confirmed that memo to "SK92 Pilots" re "Subsequent Actions" (PP#13), dealing with the "Subsequent Actions checklist", was issued in response to that incident, but denied that the August 18, 2011 memo "regarding manual flying and the S92 SOPs" (PP#14) had originated in the July 23rd incident. He agreed however that the excerpt from Chapter 3 of the SOPS, (PP#15) including amendments to that SOP were "a reaction to this incident."

They were put in position then, yes. PP#16 and PP#17 are all amendments to the SOPs from November 2012. We did make changes, but not in regards to this incident. Courses are added every year. Some are locally incorporated yes, but the amendment process is ongoing every year... This is an ongoing process, but portions were included that did regard this incident, yes. All the 'Actions Taken" (PP#12, p 15) were made in response to this incident. Yes, the SOPs, though changed continuously, did include responses to this incident ... the purpose was to ensure that an event similar to that of July 23rd did not happen again, and to emphasize what to do if it did happen again.

He confirmed that all recommendations set out on pp 16ff. of the PP#12 were "either already done or were in process." Under Item 5.7, dealing with crew pairing, Mr. Perry confirmed:

There was nothing in the report about Mr. Mugford not being authorized to fly... The recommendations were the responsibility of the Cougar Safety Department and Cougar also did a review of the Crew Resource Management systems (CRMs) following the incident. PP#18a, b, & c are the three elements of the CRM course. I'm not sure if PP#18c was, in fact, directly a result of this incident in its entirety. Mr. Banks was the liaison between Cougar and Husky on this. He was involved in relation to the internal investigation.

Asked if Cougar had ever lost the Husky contract, Mr. Perry said:

Not prior to that, but Husky raised a number of recommendations afterwards.

Asked if these recommendations related to Cougar's training of pilots or to Cougar's SOPs,

Mr. Perry answered:

I don't know. Rick Banks was involved in that. I simply provided Rick with information on what we'd done. We don't respond to Husky's recommendations. Mr. Banks would have to answer the question about whether Cougar actually implemented all Husky's recommendations.

Mr. Perry also identified, as PP#19 and 20, correspondence relating to discipline administered to Mr. Mike Godding, and his return to duty. He also identified, as PP#21, further correspondence relating to a reported runway incursion at Halifax International Airport, "YHZ, runway five, zero five."

The latter incident was reported to Transport Canada. The runway incursion, as is made clear at PP#22 and 23, also involved Captain Whittington.

PP#24 is correspondence with Mr. Benedict Segura concerning his reduction to First Officer and probation arising out of a number of incidents. PP#25 is further correspondence between the Company and Captain Segura. Mr. Perry identified, as PP#26,

... a copy of a Cougar Journey Log page of flight involving Captain Wiid and Mr. Russell, which reports that the collective was "creeping down." Cougar Maintenance tried to duplicate this on the ground, but was not able to do so.

Asked if the aircraft Mr. Sellars used on July 23rd was taken out of service after a second incident on July 28th, Mr. Perry answered "not to my knowledge." Mr. Perry was also asked questions about an incident that occurred in October 2011. In this particular incident the pilot failed to lower the collective during the a process that required it.

He advanced the throttle from idle to flight, and as the rotors turned the aircraft became airborne, unexpectedly. The pilot was caught by surprise and took control of the aircraft... He landed the aircraft. There was a lot of damage to the landing gear and related parts.... Cost in the range of a million dollars... I think that's about right... The pilot was suspended from flight operation for quite a while, but is back now.

Asked what the ideal speed of the aircraft is when go around is engaged, Mr. Perry answered:

There's no ideal speed to engage set in the manual, but system design requires it must be over 50 knots. Below 50 knots it'll decouple and not engage... PP#3 says that the collective engaged at 52 knots, but I'd say 58 or just under 60.

Mr. Ellickson asked if there is also a discrepancy between the video (PP#6), which shows the light coming on at 63.5 knots, and also which shows the yellow, not green, light in this process. Mr. Perry said:

The command bars are not displayed on the visual video. They represent the commands going to the aircraft. When you select, the appropriate bars will appear on the display in the aircraft, and it tells the pilot what the automated system is doing. When the guidance is not connected to the aircraft, the pilot must manoeuvre the aircraft manually and follow the command bar.

Mr. Perry was reminded he had testified as to his own belief about Mr. Sellars' behaviour:

I was referring to the fact that the pilot did not react appropriately in a relatively benign situation. I can train them in *what* to do, but not *to* do it... It isn't just a matter of time. I've seen pilots failed off courses because they've been unable to perform the actions... He was focussed on keeping wings level rather than on other aspects of the problem.

Mr. Perry was asked to comment on the fact that Cougar had itself issued briefings, memos, new SOPs, and nine items listed in the investigation report, many of which are acknowledged to deal with training, as do Husky's 38 recommendations. He was asked to explain how he could conclude that Mr. Sellars could not be trained and returned to service?

Mr. Perry answered: "The procedures can be taught. The ability to react cannot be taught."

When it was pointed out that Cougar has not used dismissal in similar incidents, he said:

"Yes, based on the circumstances of the individual cases, yes." When it was noted that Mr. Sellars was not given that opportunity, Mr. Perry said, "correct."

ON REDIRECT EXAMINATION, Mr. Perry testified that "opportunity" was not given

.... because each case is reviewed for the circumstances and for the different actions in training. In this case, for a Captain with his experience and training not to react in the benign situation that developed... I've not seen it before; and to have confidence that he can bring the aircraft safely from turbulence *etc.*, I just don't have that confidence. And I don't know of a way for me to get that confidence.

Mr. Perry also testified that:

The SOPs are changed from time to time.... Since I've been Chief Pilot, we were doing it annually, in the fall... We were trying to vary the timing, but not the annual character. We're striving for continual improvement. The Chief Pilot writes it all down, but has input from many people. A lot of thought goes in to the wording, but seasonal issues can change what is required.

Commenting on his decision, he said:

I recommended that he not fly in the IFR offshore environment ... My recommendation was in that form because this is an IFR issue.

Asked why Husky's restriction on Mr. Mugford had not been acted on, Mr. Perry said:

It was not deliberate. It was at the point of handover from former Chief Pilot and myself. It fell through the cracks and basically got forgotten about.

Asked to clarify his earlier testimony about training for unusual attitude recovery, he said:

Both in basic and in recurrent training...we did some very difficult training for that year. It was not recorded for that year. It is now. It's not just a situation like this, but it arises from all sorts of difficult causes. Not just this error.

Asked at what speed the go around was engaged for the second time, on the return to St.

John's, Mr. Perry said:

57 knots. Everybody agreed that PP#3 shows that the speed the go around was engaged was at a lower speed than the first time, about 5 knots slower.

THE SECOND EMPLOYER WITNESS was Mr. Ronnie Moores an employee of Cougar Helicopters currently assigned as Search and Rescue Training Pilot. Mr. Moores has been with Cougar for ten and a half years and regularly, but not always, flies for SAR. Mr. Moores reviewed his past history as a pilot including service on a number of other rotary wing aircraft and as a Simulator Instructor, Co-Pilot, and Captain. Mr. Moores was also Chief Pilot for four and a half years ending approximately three years ago, when he went back to serving as a SAR pilot.

During this period I was a pilot with all three aircraft... The S92 is the only aircraft in the fleet at the time being... A Check Pilot monitors the qualifications and standards of pilots on behalf of Transport Canada. All current pilots with the Company are required to be monitored this way. It does not apply to just new pilots, but to all new hires as well as others randomly picked by the Chief Pilot.

Mr. Moores described the training and monitoring procedures in use in Newfoundland and elsewhere in Canada, the United States, and the UK.

Transport Canada accompanies me when I go on my own annual monitoring ride. They shadow me and criticize me in my monitoring of other pilots. The other pilots will be rated on the spot by me. Following a cycle of rides, there is a debriefing for 30 minutes to an hour to highlight anything that isn't within 100% of compliance. In being monitored by Transport Canada I'll get a briefing on my own performance, how I conducted the ride, my briefing and my

post-briefing. These are people from Transport Canada who certify me as a Check Pilot... Pilots who fail this program will be notified there immediately why they failed. Transport Canada is notified, the Chief Pilot is notified and then they wait for a decision from the Chief Pilot re corrective action, if any... Yes, I have failed people...

Mr. Moores also described his other Transport Canada designations including...

Flight Instructor. A Flight Instructor is qualified to train candidates in how to fly rotor craft from scratch. In my recent work with Cougar, we're required to do formal training in emergencies according to the SOPs flight regulations. In certain circumstances, we use the simulator. Where challenging conditions exist, we use special procedures to fly to the limits, rather than in other regulated situations. To operate in this region, a certification has to be done in a simulator, and that also requires Ground School. Even if you have 20,000 hours flying you have to do this.

Asked whether anyone has failed this, Mr. Moores said "Yes." Asked whether any one has lost employment as a result of this, Mr. Moores said "yes." Asked what situations have resulted in loss of employment, Mr. Moores said:

There was candidate just a few months ago who was book smart, technically sound in the classroom, and had a good understanding of the SOPs... very professional attitude, with an experience on rotor craft in excess of 9,000 hours. This was his second round of training, and he failed to pull the SOPs. His basic flying was technically tight. He failed to put them together in the simulator. He lost situational awareness several times. He was spatially disoriented and could not complete the course.

Asked about his other responsibilities in his work for Cougar in 2011, Mr. Moores cited

... the Flight Data Monitoring Committee. I am a member. It's a Committee that reviews any events or incidents that arise... Anything outside of normal operating procedure. After all flights are completed we download the data and run it through a filter which covers all the SOPs and any exceedances or any non-approved procedures are flagged. Our analyst reviews them each morning. If it is a trend developing or anything over the top it will be reviewed. Myself and Curtis Savidan, Chief Pilot for S92s, are the two names on the Committee. If the HFDM flags something – for instance a take off that is non-standard – the lady at the data desk calls one or both the members of the Committee. We look at the data before talking to the crew and determine if there are any variables like wind, *etc.* and we take that into account. We interview the crew, if we need to, and if the crew can explain why they went outside the SOPs to the Committee's satisfaction, it may end there. And if training is required, we'll go to the training department and request training be provided. There are various types of training, including ground briefing, aircraft practice or the use of the

simulator... Yes, I was involved in the review of the July 23rd incident. I was on time-off at home. I got a call from the Director of Flight Operations.

Asked what Mr. Gerber had said, Mr. Moores said:

He just informed me of an incident on a Husky flight, and asked if myself and Curtis could look at it in the morning. Curtis was on his way back from the simulator. We had the documentation secured that night. J.J. gave me no details; that's normal. We went in non-biased, just for a look at the data. The girl who analyses the data is called Katriona Reid, Flight Dispatch. No one else has access to the data; that's confidential... The next morning I had Katriona print me off all the graphs appropriate to the flight. The 851 Flight Data Graphs for July 23/2011 (PP#3) and the Log book entry (PP#8) were among the documents we got. Yes, I got everything I asked for; and then later in the day we asked for the HUMS data for the engines (attached to PP#3).

Asked to describe the process the Committee followed on July 24, he said:

We met, Katriona, myself, and Curtis. She gave us the data. We saw it was a significant major event, and went and got the log book page for the previous flights to see that there were no discrepancies, and then we looked to see if weather or icing or turbulence were a factor. There were no aircraft defects recorded, and the weather was standard. The logbook page (PP#8) said no defects. As a rule, we look at weather and load. The manifest said it was in acceptable range, ruling them out as possible contributing factors. We started to rebuild what actually happened just prior to and during the event by reading the graphs. We do all the same, so we can rule out the crew, where it's a minor technical issue, and there is no cause to interview the pilots. So then we begin a second-by-second review of what happened.

Mr. Moores confirmed that the Summary Investigation Report (PP#7) records their findings.

That is the report we submitted after analyzing this (PP#3) and interviewing both members of the crew.

Asked what the graph (PP#3) had revealed to them, Mr. Moores said:

There was a normal standard rig departure. Nose pitch up of five degrees. It's sitting on the deck. Then hovering under 100 feet, and then you pitch down to 11 degrees – acceptable for 10 degrees – then initialize departure, and the helicopter goes to 62 degrees with seven degrees of nose up, which is a little high... PP#7 was developed after reviewing PP#3. After we looked at PP#3, we looked at the animation to confirm what we believed. Then, having no explanation about the incident, we interviewed the crew. That was early in the afternoon of the 24th... We didn't have the crew members' written statements before the interview. We always look at the data first to rule out the crew if we can; but we could not see anything that happened other than going to the crew. The interview was in the boardroom in the main hangar. I was present, Curtis

Savidan, Boyd Sellars and Glynn Mugford. We interviewed the crew together, yes.

Mr. Moores identified, as RM#1, his handwritten notes of the interview, made at the time of the meeting.

We conducted this. We don't try to assign blame, but to get the facts. It's all factual: the HFDM data, copies of the SOPs. So we asked them to walk us through the event, and we made notes as things went on... Mr. Sellars had concentrated on keeping the wings level, but had not concentrated on getting the nose down... Mr. Mugford told Mr. Sellars two or three times about the speed problem. The data shows two inputs from the pilot, but the airspeed continues to bleed off. The crew was happy for us to hear the CVR. They wanted to know what it said.

Asked if the crew had used the go around on their second departure for St. John's, Mr. Moores said "all the data show that they did use the go around again..." Asked to indicate where the information from the graphs does not correspond with the information provided by the interview, Mr. Moores said:

Discrepancies are found in the attitude being set and then the rates of descent. The nose high and the high descent rate really were discrepancies, reading where the speeds was not in synch. Mr. Sellars continued to focus on keeping wings level, yes in a roll.

Asked if there is any reason he would want to keep wings level, Mr. Moores said:

Well he would primarily want to get the nose down to get the airspeed up... They believed they were getting ready to ditch and they wanted the aircraft level to ditch. You don't want to go into the water side-on. There is a better chance of survivability.

In considering evidence of an intention to ditch, Mr. Moores offered the observation that "the floats were initiated." Noting that the summary report (PP#7) contains no reference to floats, Mr. Moores said: "But that shows up on the data, even though they did not mention it in the interview." Mr. Moores confirmed that he is familiar with the written statements of the two pilots PP#4 and PP#5, and compared Captain Sellars' notes with those of Mr. Mugford. He commented: "The low rotor call is very bad to hear... Glynn armed the floats that point."

Mr. Moores confirmed the Committee's recommendations, set out on the final page of the Summary Report (PP#7).

ON CROSS EXAMINATION, Mr. Moores again reviewed his professional background as a S92 pilot and instructor, and compared the S92 with other aircraft he has flown, saying that:

The S92 has better avionics and flight management system. The Cougar fleet has been all S92s since our last S61 departed two years ago... The purpose of annual recurrent training is to review, in both ground school and simulator, emergency and standard procedures, and practical stuff that is not done daily and routinely.

Mr. Moores had testified, on direct examination, that unusual attitude training is done as a normal part of annual training, but Mr. Ellickson pointed out that his information is that recovery is not done in annual training. Mr. Moores said: "Sometimes it may not be." Mr. Ellickson pointed out that Mr. Boyd Sellars will testify that he has never had recovery from unusual attitude training, and that Mr. Davidson will also testify that he had not done it in the last annual training. Mr. Moores said: "I have not reviewed either of their records."

Mr. Moores confirmed that both pilots had advised that the final departure for St. John's had been undertaken without using the go around.

Both pilots said that, despite the fact that the chart (PP#3) shows that the go around was, in fact, deployed in that second departure... I am not responsible for the system that collects or downloads this data. I asked for it.

Asked if he'd given them the data chart (PP#3) during the interview, Mr. Moores said:

I can't recall if it was there or not, not with reference to the notes, no. Yes, Mr. Sellars answered all questions; oh yes, 100%... Both pilots agreed to a review of the CVR... I did not download it. I went to the Avionics Supervisor. We looked at the end of the loop and knew it would have been overwritten.

Asked whether he had requested, on the 23rd, that the voice recorder be secured, Mr. Moores said "No." Asked why not, Mr. Moores said: "I did not think of it. I had no idea of how serious it was." Captain Moores agreed that:

Within six or seven seconds the nose goes from nine degrees of pitch to hit the apex at 23 degrees up, and then it comes down to 15 degrees. This reduction in pitch was because the pilot had applied some cyclic... It goes from 23 degrees to 15 degrees in about five seconds, and slightly back up to 16 degrees and then finally back down to 8 degrees... I think it's about 10, call it nine degrees...

Asked if he would agree that Mr. Sellars was, therefore, focussed on the cyclic and that he was taking the steps to get the nose down, Mr. Moores said: "Yes, but it was not sufficient. But yes, Mr. Sellars was not doing nothing." Mr. Moores knew that Mr. Sellars acknowledged he

should have been "more aggressive in the way that he brought the aircraft under control."

Asked what steps one takes in an unusual attitude, Mr. Moores said:

It's a skill set you all know but do not practise unless you are in an unusual attitude recovery... PP#15,16 and 17 are the new SOPs. Yes, Mr. Sellars is following the correct SOP when he puts the nose on the horizon in order to level the wings, but it would be unusual for someone at 500 feet to be preparing to ditch... That SOP does not say you should activate the floats. There is nothing "standard" about this.

Mr. Moores identified as RM#3 and RM#4, the relevant SOPs that deal with settling with power recovery procedures. He agreed there is no specific section on unusual attitude recovery in the old SOPs. New material had been added to these SOPs after the incident. He also confirmed that a new SOP (PP#15) increases the speed for engaging go around from 50 to 80 knots "in order to eliminate the bug becoming uncoupled," and agreed that this would reduce the likelihood that unusual attitude recovery would be required.

Mr. Moores confirmed that he and Mr. Savidan had been authors of the PP#7 report.

Asked when it was completed, Mr. Moores said:

It was within... within 24 to 36 hours of the 24th when we started and it was submitted both to J.J. and Pat... We briefed J.J. and Pat on the phone. I think it was on the evening of the 25th.

Asked how he had got the document to J.J. and Pat, Mr. Moores answered:

J.J. was in Curtis' office. Curtis was doing the documents. I believe Curtis e-mailed it to Pat.

Mr. Moores' attention was directed to the sentence in the final paragraph of the Summary Investigation Report (PP#7) which reads:

"It is well known that engaging coupler functions without the controls being properly trimmed will introduce un-commanded attitude changes."

Mr. Moores was asked whether he would agree that it is only "well known" if you have experienced it, and unless you've all experienced it, it's not well known? Mr. Moores said "Yes... We've all experienced it!" Asked whether he can speak for Mr. Davidson and Mr. Sellars on this, Mr. Moores answered "No."

Mr. Ellickson asked Mr. Moores if he would be surprised to hear that there is reason to believe that Mr. Sellars had never told him he'd only arrested the descent after having looked out the window. Mr. Moores answered "I can't recall."

Mr. Ellickson also put it to Mr. Moores that it has been suggested that Mr. Mugford had not told him that he "should have taken control of the aircraft." Mr. Moores responded, "I can't recall." Asked whether he was aware that the two pilots should not have been flying together, Mr. Moores answered, "Not until some time ago." Asked if there is any reference in the Summary Investigation Report (PP#7) or in the Internal Investigation Report (PP#12) about the incorrect pairing, Mr. Moores said: "No... I had it by hearsay that they were not supposed to be paired."

Mr. Moores was reminded that the fourth of the recommendations in the report, the final item in PP#7 recommends that during annual recurrent training... "CRM-Focus on PM's duties beyond standard calls in unusual situations." Asked its purpose, and whether it was a training issue, Mr. Moores said:

It's just to put it into our own training that we recognized it of concern... The PM cannot be assertive enough... commands not being adhered to, and he did not take control! We wanted to reinforce that... We just wanted to reinforce it. This was a form of pilot incapacitation.

Asked why Mr. Mugford was off line for a period, Mr. Moores: "As a result of this incident he was sent for more training. That's my understanding." Asked if a more experienced Co-Pilot would have taken more assertive action by pulling up on the Collective and pushing the nose over, Mr. Moores said "Yes." Asked whether, if he'd been flying with Mr. Sellars, this incident would not have happened, Mr. Moores answered:

Yes... The S92 is designed so that pilots use the automated systems in this situation; and new pilots use this automation virtually every leg they fly. Using autopilot is more effective... One hopes it allows a reduction of work load. He also confirmed that pilots do less hand flying.

Asked if he agrees that hand flying skill diminishes if it is not regularly used, he said:

I disagree. These are basic skill sets... recognizing and getting out of an unusual attitude is a skill. It's a skill you should have always at your disposal.

Mr. Ellickson pointed out that other pilots have lost situational awareness without having lost their jobs. Mr. Moores said:

Yes, because they recovered properly... Some did not recover, but we have terminated some... So far as I know, Mr. Sellars has never had a reprimand in his time with Cougar. He has never been disciplined or reported to Transport Canada, so far as I know.

Mr. Moores also confirmed that he had recommended to Mr. Perry that

Crew Resource Management (CRM) policy be changed after the July 23rd incident with specific reference to PP#18(c), module four, covering automation dependency.

Asked if it would be fair to conclude that Cougar was saying they believed that autopilot use could lead to degraded skills, Mr. Moores answered "Yes." When it was pointed out that Captain Sellars had acknowledged he should have been more aggressive in his actions, Mr. Moores said: "He was not doing it properly. These are basic flying skills." Asked if such "basic flying skills" can atrophy, Mr. Moores answered "Yes."

Asked if he was aware of the efforts of Mr. Davidson and Mr. Sellars to unionize the pilots, Mr. Moores answered:

I knew it was ongoing. They were on the Committee in 2010. I attended two meetings, I think. I actually supported it.

Mr. Moores confirmed that his is among the addressees "copied" on the June 9, 2011 e-mail from Mr. Davidson and Mr. Sellars dealing with "the results of today's meeting with management" (RM#5). "The Committee met a few times in 2010 and 2011." He agreed that the e-mail shows that Mr. Sellars and Mr. Davidson were frustrated with progress and with Cougar and had concluded that further exploration should be undertaken. He confirmed that he was aware that Mr. Davidson and Mr. Sellars were involved in the organizing drive.

ON REDIRECT EXAMINATION, Mr. Moores was asked whether, prior to today, he had seen RM#2, a graph of two minutes of the July 23rd flight. Mr. Moores answered:

I've seen several documents like it. I've not seen this actual one. It's a Company document. No one else has the ability to print it. Only Katriona can print it, so far as I know.

He confirmed he had received the 851 Flight Data Graphs July 23/2011 (PP#3) "from Katriona on the Sunday." Asked if he has reason to doubt the accuracy of either document, Mr. Moores answered, "No." Asked to look again at RM#2, Mr. Moores was asked whether either document shows the position of cyclic in the course of the event. He answered: "PP#3 does show stick position." Reminded that he had noted two points when the degrees of nose up had changed, he was asked to relate the two points to the changes in the position of the cyclic recorded on PP#3, and whether, after the go around is disarmed, is there any change?

Mr. Moores answered: "There is minimal effort to change the nose." Asked if he can identify when visual reference is regained, Mr. Moores said:

At 205 feet you can see the cyclic is pushed over where the power is applied and the nose down is where the visual reference is acquired.

Asked whether he sees any record of Mr. Sellars trying to maintain wings level, Mr. Moores answered: "It is on RM#2: the roll angle, the blue top right, the squiggly blue line." Asked why Mr. Sellars would be doing that, Mr. Moores answered: "He is watching his attitude indicator and pushing the cyclic left or right..." Mr. Moores was reminded that in the handwritten notes of his interview with Mr. Sellars & Mr. Mugford (RM#1) he referred (p. 3) to a "CATa departure." Mr. Moores said:

A 'CATa departure' is a departure from a rig or a recovery; it lets you depart and return without danger. But this was no CATa departure. It was a departure from a hover over the ocean.

Mr. Moores also confirmed the close proximity of the go around button and the trim button.

Asked why the SOP governing go around speed had been changed from 55 to 80 knots, Mr. Moores said: "The reason was to accommodate a loss of one engine. The helicopter can fly it anyway."

Asked if he is currently a member of the Bargaining Unit, Mr. Moores said, "I assume I am." Reminded that he had indicated that Mr. Sellars and Mr. Davidson were involved with the Employee Committee, Mr. Moores was asked if he had received the e-mails. He said:

I saw... Nothing of the union affected this... I became aware of the e-mails and hearsay around the hangar.

THE THIRD EMPLOYER WITNESS was Captain J.J. Gerber, who has been with Cougar Helicopter for 16 years, currently as Director of Flight Operations, a position designated by Transport Canada. Mr. Gerber reviewed his professional aviation background in helicopters leading up to his starting with Cougar in January 1997. Before Cougar, he had been Flight Instructor for Canadian Helicopters at their flight school in Markham, and before that had served for 12 years in the South African Air Force as a Pilot and Captain in Search and Rescue. Captain Gerber is certified in the positions designated by Transport Canada.

I am a post holder for Transport Canada with Cougar. I've been a type A Check Pilot since 2001 and carry instrument rating on the S92. My role as Director of Flight Operations for Cougar falls under three headings. First, for ensuring safe

flight operations. Second for ensuring legal operations, including compliance with all applicable statutes; and third, for Management of sufficient resources to do the Employer's job, including personnel, equipment, space, etc.

I also assist the General Manager, on a commercial basis, in respect of business perspective and advice. I have to manage any tension between business pressures and safe operations. That's what I deal with most days. In St. John's, Cougar operates a passenger service and a search and rescue operation. In Halifax it is a passenger operation only. These are the only two bases that Cougar operates from in Canada at the moment. At the moment we have seven helicopters in St. John's and two in Halifax. There are between 12 and 16 pilots operating from Halifax and the balance of the 50 are here in St. John's. At the moment there are 50 pilots in all, excluding management. One airframe is dedicated to search and rescue and a second is backup, but capable of doing passenger work and being converted to SAR. Each flight requires two pilots, one as Captain and one as First Officer. The same compliment is required in search and rescue configuration, but there are other personnel on board in a SAR situation. Passenger services are for the offshore platforms and vessels; and in the off shore it's the Jeanne D' Arc Basin, and Flemish Cap. In Nova Scotia, it's the Sable Island area.

Asked to describe a typical transport flight to and from a platform, Mr. Gerber said:

It starts quite a while prior to the flight. They have the offshore requirement manifest in advance. Then that manifest for the first flight gets assigned the day before. At about 4:00 or 5:00 PM a pilot will find out what he is doing the next day that he's on shift. The pilot shows up one hour prior to the flight. The flight dispatcher has already checked the weather and fuel requirements and the manifest and has taken first stab at a rough flight plan by the time the pilot arrives for the flight. The minute he shows up it's a choreographed series of steps to accomplish all this. First there is a review of the weather and gross payload and, if there are qualifications or if there is anything that limits the operation, they are addressed; for example crew pairing, or lists of which pilots are qualified or not qualified for the destination. Pilots are briefed. The pilot can query the dispatcher on the plan and accept or reject that plan. They then complete a preflight risk assessment and get changed into their flight gear, after which they proceed to the aircraft and start the helicopter. Once that's functioning normally, they taxi to the passenger area to board the passengers.

Passengers are loaded there, and then proceed to taxi to the active runway. They depart the active runway and climb to do a cruise check at altitude. While they are in cruise they will do some performance checks on the aircraft. They will do the final calculations and start preparing the approach to the destination.

Before landing they will contact the dispatcher and obtain the latest weather and deck information. That information will determine whether an instrument approach is required and to check to see if they need more fuel.

They will then start the descent and execute the approach with pre-landing checks and land if they have a visual. The helideck crew then secure the helicopter with blocks... the rotors are kept turning. Passengers disembark. The helicopter is refueled if required, and then embark with new passenger group.

In the meantime the deck crew are off loading and loading baggage. A pilot will do a walk around, checking hatch and fuel caps and a general overview of fluids and further checking for any ice accumulation, *etc.* The pilot then resumes his seat, and once both are there, they start the take off activities including the pre-flight takeoff checks including takeoff torque and safety for temperatures, *etc.* The deck crew then remove the blocks and maintain radio band contact for traffic. There's a general broadcast for all to alert the aircraft is departing. They don't have radar. Everything is based on radio. If they don't talk, they don't know.

When the helicopter reaches 30 feet above the deck they rotate the nose generally down below the horizon, allowing the helicopter to accelerate and once it reaches the previously calculated speeds, the pilot must raise the nose to just above the horizon to ensure acceleration, and set the bug. After take-off checks, and the float gear is made safe, they engage the automation at the appropriate altitude and raise the landing gear. That's the final contact with the rig; once they are up at the set altitude and all safe, they turn to base and follow a predetermined track. The only variation is a multiple stop flight, where the helicopter stays at the lower altitude.

Back at St. John's, we approach a runway and we land and then taxi back to the same loading spot where the passengers are disembarked. Once that's done we taxi to another spot for shut down. Then the crew goes to the Operation's Counter where they debrief the dispatcher, if required, as to winds aloft and the like, and also pick up a data card that the helicopter has been recording. That will show if there have been any exceedances; that requires the crew to check a button to acknowledge any exceedances. The flight report is completed for safety crew and guidance. This completes the crew job unless they want to report on safety issues in a Safety Reporting System (SRS).

The only two other conditions that can affect the pilot is whether there is another flight offshore or a second request to try out the engines after a wash or any maintenance operation. After that, they report to the Operation Centre who releases them for the day.

Asked what a "CATa departure" from a platform is, Mr. Gerber said it is a departure from a hard surface where the aircraft can land back safely, either on a helideck or a runway. Asked whether pilots have discretion in their use of departures, Mr. Gerber said:

They have some discretion, but not in isolation. They have to communicate with the aircraft centre. I said 'not in isolation' because they are varying the flight path. The flight plan is meant to be prescribed.

On return to the land base, a data card is filled in for maintenance. It's called the Health and Usage Monitoring System (HUMS), which is based on a series of sensors and temperature gauges, and reads vibrations and the pressures. All these are recorded in great detail and stored on an external memory card. After each flight it's downloaded to measure the health and deteriorating conditions of the helicopter. For example, if a bearing is going you will sense vibration and the heat will be raised, and it will give a qualified technician a warning. We also submit all information to Sikorsky for their global view, but, at the base level, we have analytic information on exceedances and, over time, it tells us about the health of the machine. It is distinct from the Flight Data Recorder (FDR).

The Flight Data Recorder was primarily invented and installed to help in accident investigation – the "Black Box" – and, about 30 years ago, the airline industry saw a second use for this because the box records headings and altitudes and about 200 parameters today. Because it records that for accident investigations, we can monitor how it was on each flight, for flight operations quality. You can download the data and see the crew following SOPs, *etc.* These are required to be onboard at least for the accident investigator, and Cougar uses it daily, with Helicopter Flight Data Monitoring (HFDM) as part of the safety and quality assurance program.

Asked how Cougar manages its use of Flight Data Monitoring Mr. Gerber answered:

We instituted an HFDM program about five years ago. Essentially, it's a daily download of the Flight Data Recorder; and Cougar will, with a predefined filter, wash the information through that filter. If any deviations are caught, it creates a report, or a "flag." The program depends on confidentiality because a crew is being recorded. Their activities are being recorded and observed by others: only by a small group of people. Myself and the Chief Pilot are not informed of the exceedances unless certain criteria are met. One person holds the key to which crews flew on which flight. Otherwise, the data is anonymous in the computer. On instruction from the Chief Pilot and the Training Department, Katriona Reid's job is to turn on the filter to prepare a computer program to follow the daily download. Every morning she ensures she has the previous day's data for the whole fleet of helicopters. The key here is the value we place on the greater good. Is 100% confidentiality more important? Or is awareness of the daily minor exceedances, or major ones, to be proactive with training and safety programs? That is the balance we set.

The Company has a Committee of experienced pilots or instructors and an HFDM Manager to review such exceedances. They are classified as normal or explainable under certain circumstances. Then the Committee simply catalogues the information for statistical purposes. If there is a category one investigation, the statistical information is used to plan training programs or monitor the equipment... or if changes are needed or SOP modifications are required.

The Chief Pilot is responsible for changes in training programs, along with his training team which includes the Chief Training Pilot. The SOPs are drafted by the Chief Pilot who has a team who reviews it in consultation. We try to confine changes to the SOPs to once a year, but in the past it has been several times a year. Following the disaster (Flight 491 in March 2008), we became aware that it was a main gearbox problem. We checked it out with Transport Canada, and they concurred that we should share that with other companies... We have to share that with whomever we can.

Asked to describe what the SOPs are and how they come about, Mr. Gerber said:

We take the written flight manual and then Cougar takes the actual background for generating the SOPs. A SOP is detailed and procedure-specific, but logically it's common to other companies otherwise.

Asked if there were other consequences to Cougar and its clients arising from the 491 disaster, Mr. Gerber said:

There are many. Cougar calls it the "new normal." There is heightened oversight, heightened requirements to report, and shortened time-frames. Twenty-four hours minimum, with more information to follow if required. There are now several Committees overseen by the CNLOPB of which Cougar and other offshore companies are members. There are night flight requirements and SAR weather limitations, *etc.* There is a sensitivity that is very, very consuming. It is difficult to allow the pilot the freedom to turn and come home, but it ends up on the news. A pilot is aware that, when he turns around, it means a lot of work for someone is generated. Offshore is a public working production line. Just to turn around: that's not the end of it, even though we try our best to shield them from it, and act in the rule of safety at all times. But the job has changed in relation to our customers, who are the ones travelling on our helicopters. It expands the level of oversight between Cougar and the offshore on the commercial side.

Asked if the offshore operators act as a group, Mr. Gerber said:

They generally all show up together at specialist meetings, but do not have a single group, so it's always a tug of war between them, with Cougar as a mediator. If we do not do SAR, then each would have to have their own SAR, and there would be five of them. They are motivated to work together. The Aviation Advisors are different for each one, except that Husky shares its person with the Nova Scotia company, but under two different contracts. The others have their own Aviation Advisors.

Asked to describe the role of an Aviation Advisor, Mr. Gerber said:

Oil companies do not always have their own Aviation Advisor, but each will have their own expert, someone who understands their constraints and who provides oversight on how we need to treat that consideration for flight oper-

ation purposes. The companies have copies of our SOPS and Operation Manuals and Instrument Manuals and our Safety Manuals. They review our investigation reports, and before a pilot gets a contract they will review the pilot's resumé, qualifications, experience and approve a pilot before he flies on the contract ... or not approve him... or even prohibit his flying on it... and we then must implement their recommendations. They are not always accurate, in our view, but the reality of being a commercial operator kicks in, and in most cases we work with them, or reach a compromise solution. There are numerous calls or e-mails between myself and the Chief Pilot and their Advisors. We do this because we can deal with them personally, and so the pilots can focus on their flight jobs. Pilots sometimes do not know where some things come from... We shield them.

Asked how many passengers are usually carried, Mr. Gerber answered:

We are certified for 19 passengers. The extra fuel tanks take two of these, and sometimes (more) so the answer is 14. But the number of seats is determined. We calculate the full load first and what remains is what determines the passenger load. It will likely take 2 fuel tanks if the destination is at a distance, such as the Jeanne d'Arc Basin: that's 170 to 200 miles. But for the Flemish Cap ... on bad days we might use Gander or Deer Lake as an alternative.

Mr. Gerber confirmed he'd seen the Aviation Event Report for the July 23rd event (PP#9).

This document is generated by the Safety Report Service, a branch of Cougar's Safety Management Services. It's a key element of Safety Management, enabling anyone to speak up and report any anomaly that may have been seen that has a health or safety impact at any level. If an anomaly occurs on a flight, a Pilot has two reports to make. The first is with the Aircraft Flight Dispatch: that is the journey log for the aircraft. This is mandated by Transport Canada. The second report is in the Safety System, if they feel there is a safety impact.

The intent is to get the attention of the Safety Department. The Director of Safety gets immediate notice of the fact that someone has made an entry. He reads it, and uses a Risk Assessment Matrix to attach a score. In this case, the score was 4D, and that is high. He also determines if the Transport Safety Board is to be notified based on available information. That is done on Section three of PP#9, according to criteria set out on which reports must be made. If score is high, several phone calls will follow to alert Managers. and I get notified on my phone, but only after he has made the assessment. All you get is a e-mail alert.

It was reported at 18:50 on Sunday, July 24th by Richard Banks then the Director of Safety. I got a flash of the event – that it had occurred – but that was after I had been made aware of it... The event was observed, and we were getting phone calls from that moment from the Manager at the OPs Center until the flight was on its way back. I got information from the Base Manager and I called the Ops Centre. I learned that after departure from the Sea Rose the heli-

copter descended and was seen to hover, fly close to the water, and then depart and fly to St. John's. I also learned the ETA at St. John's.

Asked what the OPs Centre had told him, Mr. Gerber said:

... that there had been an event we had to look at off the Sea Rose. He did not have much more information. The Centre knew more than the Manager because they had the telemetry in front of them.

Asked what he had done once he had contacted the Ops Counter, Mr. Gerber said:

... a number of things. Most of all, knowing that the Chief Pilot was traveling as well as the Director of Safety, I wanted the Company to gather as much information as possible. The key element in that was a statement from the crew. Once the crew deviates... I also knew they would want to report any thing as soon as they go home. I told the OPs Counter that I wanted them to speak to the crew and inform them what is required. And I was thinking and planning what else was required. I was mostly going over in my mind what we'll need after the report...

When the crew landed, it was sometime after that that I managed to speak to the crew – about thirty minutes or an hour. I managed to get hold of them, and my instruction to them was to prepare a written statement on their activities. Mr. Sellars indicated he would get around to writing that. I asked to speak to Mr. Mugford and he agreed as well. I also wanted to make sure the investigating team had what they needed, so I initiated that by phone and formalized Mr. Moores and members of HFDM Committee to prepare for an investigation the next day. I knew Husky would want to have the broad facts as well as any immediate actions, if any were required. I also became aware that the main gearbox had an over torque exceeding one of its limits: that all of these things needed investigation, so I tasked the Moores Savidan HFDM Committee to meet next day to do that. I instructed Katriona Reid to assemble the data for us...and to secure the Cockpit Voice Recorder (CVR) data to ensure that no one has access to it while the HFDM Committee has opportunity for the crew that they will jointly listen to it. I believe that was the extent of my activities that day. I knew they would assemble mid-day next day to start actions. With respect to the CVR data, the ideal data isrecorded on a two hour overlapping loop; that was all on Saturday the 23rd.

On Sunday the 24th I saw the PP#9 report. It was released by the system and when we looked at it we realized that it may look like a control or autopilot problem, and despite the crew's not reporting any anomalies, or the journey log book, just by doing a gear box check for the overtorquing, might not be enough. So Base Management and myself agreed not to fly the aircraft until we checked the autopilot. The system did not report any anomalies despite its detailed report, so we decided to fly the aircraft to duplicate the event. I assigned that to Chief Pilot type, Mr. Savidan, for his interviews with the crews on what to duplicate. The aircraft was cleared, as far as the gearbox was concerned, but we did not use it that day except for this test flight.

We had a phone conversation with the investigation group on what we believed, *etc.*. We had not decided if it was a TSB reportable event, so they called a meeting to discuss these issues. It was held at around 3:00 PM. I understood at that time that the HFDM Committee members were already meeting with the crew. After the validation flight, we determined that the aircraft was serviceable. There were no reports from the crew and the validation flight released the aircraft to service. We were then discussing how to return the aircraft to service the next day or the day after... I was not on that teleconference. It was quite late in the evening.

Asked if there was anything else on Sunday, Mr. Gerber answered:

I don't recall anything on Sunday. But I know I had several conversations with the Chief Pilot through that day, because we had to plan the return to service. I wanted to know the customer's view of how to return. Yes, we had checked the gearbox. First of all, a crew might report an exceedance, but the HUMs data was the only source of the information. On Monday, the 25th of July I understood the Committee was progressing well. I'd been updated. Our immediate concern was the return to service. I was advising Husky about the aircraft system anomalies or any further factor affecting any other crew, and worked at returning everybody back to service.

Asked if there were requirements to be met, Mr. Gerber said:

There were no real burning issues for us, and what we reached was a view that involved three facts. (1) There was an unusual attitude and recovery. (2) There was a coupling function of the autopilot/go around, and the state of the aircraft pre-go around. And finally (3) there was settling with power. The helicopter was descending while under power. That does not help. It's an aerodynamic phenomenon. We were using a broad brush, and there were no basic details yet. This was proposed and agreed by Husky and by their Advisor as a prerequisite to the return of flight.

At some point during the day we learned that the CVR information was unrecoverable because it is, in effect, a kind of eight track: a continuous loop, and after two hours you record over it. Today the recording is digital, but it's the same basic recording over. Anytime battery power is applied to the aircraft, it's running. And it had been taken for checks and various other servicing. No one erased anything. The computer just did what it was set to do.

I personally briefed the crew for the first Husky flight. The crew understood what I was talking about, and did not understand the purpose of the briefing. I gave Husky enough update on the investigation; we had met their 24 hour request for information and we wanted return to service. But we had to provide more formal written information to the flight crew: particularly PP#12 at pages 19 to 22, which were done...Yes, these memos were part of the return to service requirement. The content of the memos was already being briefed...On Tuesday the 26th the memos were drafted. We were in constant communication with the Chief Pilot and his team. It was a well formed idea by the end of Monday.

Asked what purpose the memo served, Mr. Gerber said:

Any aviation company has to learn from negative experiences, and to communicate with the crews. The purpose was to refresh and remind crews of technical issues that we felt had a bearing. I personally briefed the pilots. It was obvious to me that we were going over material that they were familiar with already; that is to say the two items were, (1) the S92 engaging of the autopilot, and, (2) recovery from unusual attitude.... This was not an aircraft wildly out of control, but it had deviated from the desired path. It can be extremely subtle. It was not the desired attitude and needed to be corrected. Anything that needs to be corrected, can be considered an unusual attitude.

Memos are loaded on to the computer system that can be read on line when you log on the computer. It forces you to go to memo system. The computer recognizes that it is a memo you have not yet acknowledged. At the time the computer tracked only by the date the pilot read the memo. That's now changed and it's a "must read" approach. They are official documents. Periodically these memos are assembled and put in to the SOPs. So at the end of a period the Chief Pilot will read all the memos and capture the information to keep the manual manageable.

Mr. Gerber confirmed that he had signed the letter of termination (Consent #1).

It is a letter we prepared for debriefing Mr. Sellars, when we were preparing to terminate his employment at that meeting.

Asked what information he had prior to preparing the letter, Mr. Gerber answered:

The information mostly was connected with the HFDM preliminary report, (PP#7). I had that. We also had their briefing from the HFDM Committee provided by Mr. Moores and Mr. Savidan, which I had heard on the 26th. Mr. Banks was there and Mr. Perry was on the telephone. I also had the SRS event report (PP#7), but I had that before... I'd had daily updates about the immediate required actions. To the best of my recollection that's all we had.

Asked if Mr. Sellars and Mr. Mugford continued to fly from the 23rd to the 28th, he said:

No. We suspend flight operations for anyone involved in any event in order to be available for investigation and to reduce the stress.

Asked if he had interviewed the crew, he said, "No, I did not." Asked if he had read the statement that he'd requested from Mr. Sellars, Mr. Gerber said:

No I did not. I made it clear to them that they were not to send me these statements, but they were to be sent to the Committee. I tried to stay away from any additional information offered to me. The Committee had these crew statements, but I did not see any of them.

Asked if he had discussed the matter with anyone outside of the investigation Committee, Mr. Gerber said:

Yes, aspects I had to discuss with many others, but none concerning the crew's activities provided by Mr. Moores and Mr. Savidan. Only what we had to do concerning the return to service. We were not concerned with failure to do, or over-do, any actions... This (Consent #1) is the letter of termination.

Mr. Gerber then led Mr. Smith through the letter (Consent #1) explaining various aspects of it.

He was asked to comment on his use of the phrase "purely pilot error" (para #2). He said:

That was based on the fact that the aircraft had no anomalies. The crew did not report any problems on the journey back. The aircraft did not store any error codes in its computers. Apart from the over-torque, the HUMs reported no other anomaly, so the aircraft was serviceable. The first part of that sentence asserts that the aircraft was one that was normally under control, not an aircraft that is already out of control. That's not what happened in this flight. An aircraft descending at 1800 feet per minute is not an aircraft under control. The initial cause was benign, and it was caused by the pilot. It was easily recoverable, but he did not do so. We saw loss of control that was caused by the pilot.

Asked to explain why the pilot caused the loss of control, Mr. Gerber answered:

The Pilot Flying had the controls in his hand: a qualified pilot with vast experience, who had done this take off successfully many times. The HUMs data tell us what elements of the system were engaged, and we learned from the data, and from the interviews, what actions they took and what they did not take. The actions taken were insufficient. That is an error on the pilot's part, not to recover the aircraft.

Asked for the foundation of his comment in the third paragraph (of Consent #1) regarding "steps that made the situation worse and/or failed to react", Mr. Gerber said:

The situation was created because engaging the go around was done incorrectly. That was not the reason for the letter being sent to Mr. Sellars, but it was the start of it. The pilot failed immediately to correct what had happened. That is why we are here today. Engaging the go around with some pressure present can easily happen, and easily be corrected. What is of concern is the fact that he was flying in IFR conditions. You simply have to move the cyclic forward and let the aircraft accelerate.

Asked how much the cyclic had to be moved forward, Mr. Gerber answered

Enough. No helicopter will accelerate with a nose up attitude such as this helicopter had.

Asked to explain what "in a measure consistent with your training" (para 3) means, he said:

Pointing the rotor disc in the direction you are going. If it's pointing backwards, with the nose up, you will not accelerate. The disc needs to be roughly on the horizon, preferably a little below the horizon, then the aircraft will accelerate.

Asked to explain how Mr. Sellars is alleged to have "failed to react appropriately", he said:

I am not talking about his use of the pedals. He let the aircraft turn out of the wind making recovery more difficult in fact, by not applying power it made the situation worse. The aircraft slowed below a safe speed. The reference to "in a timely fashion" is a reference to the fact that he had waited even a moment to lower the nose in order to accelerate. Furthermore, hearing the Pilot Monitoring call and acknowledging those calls, but not actually executing actions appropriate to the calls, also allowed the aircraft to be further endangered. Specifically, allowing the aircraft to come below the IFR range – that is to say, the clouds, is dangerous. Simply move the cyclic forward to lower the nose and accelerate.

It was pointed out that Mr. Moores had testified the pilot had lowered the nose twice. He said:

... he should lower the nose sufficiently until the nose is slightly below the horizon and accelerating, even 'til the cyclic reaches its travel limit. It's not being aggressive, just sufficient.

Asked to explain the phrase "'froze' in a stress situation" (para. 4), Mr. Gerber said:

We did not mean no activity. We know that Mr. Sellars responded to calls from the Pilot Monitoring and tried to maintain wings level. There's some evidence of movement at the aircraft nose. What we mean is that, in response to the unexpected situation, the pilot was unable to do what was required. A different word would be "incapacitated."

Asked to explain his conclusion that Mr. Sellars was "unsuitable for the services we provide to the offshore", Mr. Gerber answered:

The service we provide offshore relies heavily on instrument flying. It is that rating that is required and he absolutely has that rating. A large portion of our flying is without sight of the ocean; you must rely on your instruments. We can expect small anomalies from time to time off shore, but when we know a pilot can be incapacitated to the extent that he lets an aircraft fall out of the sky he is "unsuitable."

Asked why he is "satisfied... the incident is not related to lack of training", he said:

We are not just referring to Cougar training. We do have to teach type-specific training and the particulars of the S92. But we rely on a much larger background everyday. Eighteen thousand plus hours is a tremendous amount of flying. I'll never ever reach it. But when all this knowledge does not enable him to accelerate by putting the nose down...! He has to know how to climb and how to descend. Mr. Sellars has had a lot of training and experience, and it becomes impossible to conclude that a level of experience had anything to do with this event. We have to consider that a very benign event, namely a high nose and a decreasing speed, now requires the pilot to possess a few more pieces of information, and to know how to focus on certain aspects, particularly if

it is not information that he lacks but his inattentiveness is the issue. We concluded that lack of training or experience could not explain his not knowing how to lower the nose to accelerate. It is a failure to act sufficiently.

Asked to explain his comment that Mr. Sellars had difficulty prioritizing (para. 4), he said:

We know that he attempted to level wings: not the priority at this time. The aircraft would do that. It was basic flying, not 10 or 12 degrees *up*, but *below* the horizon. The result is to raise the energy, the power; those were the priorities and they were not done.

Mr. Gerber again testified that he had not interviewed Mr. Sellars, but had relied on the interview the HDFM Committee conducted. He confirmed that Mr. Sellars knew how to deal with the issues, and noted that Mr. Sellars himself had acknowledged that he should have been "more aggressive" in his controlling of the aircraft.

The fundamental knowledge is there, the nose needed to put forward. The cyclic is the control that does that; but he did not do what he had done a thousand time or more before. The Pilot Monitoring called check speed and altitude. He answered, but did not do it.

Asked for the foundation of his conclusion that Mr. Sellars decided to ditch, Mr. Gerber said: "We took that from the fact that the floats were armed." Mr. Smith pointed out that it was the Pilot Monitoring who had engaged the floats. Mr. Gerber answered, "I understood that was somewhat of the reason for keeping the wings level."

Asked to comment on his view (para. 5) that the pilot errors were "so serious that we have lost all confidence in your abilities to pilot our aircraft in the offshore service", he said:

I have to have confidence in the captains that fly the aircraft. I have a duty as a post holder to Transport Canada. I have a duty as a Manager with Cougar; and I have a duty to our customers. To make it clear, I must trust the Captains to bring home the aircraft... And given this time, with heightened sensitivity over the last three years, it is impossible to have a pilot who cannot fly IFR in cloud. Everyone knows that little things can happen; but it's our job to stop them from becoming big things. In talking with the Chief Pilot, when we debriefed whether training was possible, it was not only an issue to try to assign a training program for an 18,000 hour pilot that does not recover the aircraft in such a simple manner and climb away. How do you test for that after training? The simulator does not do it. In a simulator we push the button and do it again. We lost confidence; and without confidence we could not retain Mr. Sellars as a Captain or a Co-Pilot on our flight line: specifically, confidence in our operation where it counts, in IFR cloud conditions, on approach low over water, where there may be turbulence, in long flights... these are conditions of flight in these specific conditions, where we had lost confidence.

Asked why Mr. Sellars was terminated in this situation, Mr. Gerber answered:

We only have our operation in the IFR offshore environment. It is in that specific area where we lost confidence; and, quite frankly, Mr. Sellars was redundant to our needs at that point. I will say that I offered Mr. Sellars an opportunity to resign because it was obvious to us that, with reference to the hours he has had, there is no doubt about VFR conditions. But he switched to VFR in an IFR environment.

It was pointed out to Mr. Gerber that it was suggested that others in similar situations were not terminated but differently treated. Mr. Gerber answered:

The biggest distinguishing factor is that, in any other event, the pilot acted sufficiently under the circumstances to correct the situation, so perhaps the discipline imposed in those other cases was for lack of knowledge, or some other cause, but not for failure to act. Also, some item may well have been identified that our training could correct. The fundamental difference is we looked at this event, and were briefed by investigators, and found that we'd lost confidence in a pilot and the organization cannot have that in this work place.

Mr. Smith pointed out to Mr. Gerber that the suggestion has been made that Mr. Sellars was involved in union activity. Mr. Gerber said:

Yes, I've heard that since his dismissal. The first I heard of it was when the documents came to us from your office (PP#11). Yes, that's the first I heard the assertion. That was the first time I'd heard of the OPEIU. In 2010 we became aware of a drive through an e-mail from Mr. Davidson, (JG#1). I understood this was agreed early in 2011 by the Employee Committee... Yes, I was dealing with the Employee Committee in 2011, ... mostly with Mr. Davidson, but I had no direct contact with Mr. Sellars. There was some distant contact in a meeting at Cougar.

Asked about JG#2, Mr. Gerber said, "I vaguely recall the e-mail, yes." Asked if Mr. Davidson had sent him any similar e-mail concerning the organization for OPEIU, Mr. Gerber answered, "No he did not."

Referring to RM#5, Mr. Gerber was asked what he understood by the June 9, 2011 e-mail reporting on the "meeting with management", Mr. Gerber answered

I concluded the Committee was functioning normally. We had meetings, and it was functioning normally. There was another meeting planned for September 2011 sometime. There were a number of items to work on from the previous meeting, and we were to follow up on them.

Asked whether, on June 9th, he had any advance advice or knowledge about Mr. Sellars' complaint to the CIRB (PP#11), Mr. Gerber said: "No, absolutely not."

ON CROSS EXAMINATION Mr. Ellickson asked Mr. Gerber to review what information he had obtained prior to terminating Captain Sellars. Mr. Gerber answered that he had spoken with the crew, Mr. Sellars and Mr. Mugford, individually after the event to request that they provide statements in a timely manner.

There was no conversation about what happened that I can recall... I had the Summary Report from Captain Moores and Captain Savidan (PP#7), and had reviewed the HFDM data (PP#3). There was a briefing from Mr. Moores and Mr. Savidan after their report was prepared. The briefing was from them to me and to the Chief Pilot. I had some of the flight data. Yes, it was e-mailed to me, but I did not look at it. I did not want to interpret it. It was inadvertently sent to me. She thought I wanted it, but what I wanted was to get it for the committee.

Asked whether he had had any documents or other conversations, Mr. Gerber answered:

No documents, but a conversation with the President and the General Manager of the Company, and the quality assessment person, Mr. Colin Brown, to be sure that we were all on the same page. They were in B.C.. A conference call ... That was Hank Williams and Ken Norey. I think that was on Tuesday afternoon or evening. I don't recall. I think it was after I got the HFDM, but I can't recall.

Asked if he'd made any recommendation during that conference call, Mr. Gerber said:

Yes. The options were discussed. I don't recall the details, but we had a discussion of the facts at the time: what we knew and what shortcomings we thought there were in handling the flight, and what we could do about it. The options included training, termination, demotion. Those were some options, I think.

Asked if, during this conversation he had spoken of Mr. Mugford's restriction, Mr. Gerber said, "I don't recall if I discussed that." Asked what input he'd received from the others on the conference call, Mr. Gerber said:

Their input was that the position of the Company President was that of the executive accountable to Transport Canada in the circumstances, and it centred around how the Company should view a lack of skill or qualification, and the position that we needed to take on the question of suitability for our organization... It was also clear that the decision lies with the Flight Ops Department & they would stand by our recommendation; but the recommendation was with me and the Flight Ops Department, for us to make the decision, and to act on it.

Asked if he'd made notes of this conversation, he said, "No I did not." Asked if he'd spoken with anyone else from Cougar prior to the decision to terminate the Complainant, he said:

As I said, my main drive was to see to it that everyone had the resources. The CVR (cockpit voice recorder) was not available. I focussed my conversation

with the Chief Pilot on what we knew and mostly around what do we do to get back flying with Husky... to identify the shortcomings while the investigation team does its job. So, aside from logistics to the investigation team, I did not have much contact with the crews. I had a bit of training with the crews... We had a briefing by the committee by Tuesday... Certainly there were many conversations, but I don't know if any had anything to do with the termination. The Transport Safety Board and Husky involved conversations. Within Cougar I had conversations with Mr. Banks and with the investigation team.

Asked if he'd examined Mr. Sellars' or Mr. Mugford's employment files or their disciplinary or training records, he answered: "No. That's part of the investigation. Asked if he is aware of there having been any problem with Mr. Sellars or Mr. Mugford prior to the demotion and the termination, Mr. Gerber answered, "No."

Mr. Gerber confirmed that he had spoken with representatives from Husky. Asked if he'd made notes of conversations between Cougar and Husky, Mr. Gerber answered: "No. Usually the notes get into followup e-mail conversations and the requests for information." Asked if he'd prepared such e-mails after his conversations with the President and General Manager and quality control officer, Mr. Gerber said:

No, and I made no note of any telephone conversation with Husky or with Mr. Perry or Mr. Savidan or Mr. Banks, no notes at all.

Mr. Gerber was asked to identify some e-mail strings between Husky officers and Cougar officers during the days following the incident. He confirmed that

Husky is involved rather more directly in Cougar management than is normal, perhaps, in other industries insofar as they are able to approve qualifications and the retaining of pilots and can suggest training programs. Cougar does try to address concerns that Husky may have, and Husky was very much involved in the issue in the days following July 23rd.

Asked what Husky's first contact was about the incident, Mr. Gerber said:

The first was the next day, the Sunday. There was nothing on Saturday, the day of the incident. We had a telephone conference on Sunday night, late. That was the first verbal conversation. There may have been some e-mails, but not involving me. Mr. Brian Van Humbeck is Husky's Aviation Advisor, and Mr. Scott Brown is head of logistics for Husky. He is senior to Mr. Antle (whose name also appears in the correspondence).

Mr. Gerber identified, as JG #3, a collection of twelve different e-mail chains. He was asked to comment on a series of e-mails between Mr. Mike Whittle, Base Operations Manager of

Cougar Helicopters, and various officers of Exxon Mobil and Suncor, and Mr. Antle who handles logistics for Husky. Mr. Gerber said:

It appears that, on July 23rd, (@ 6:38 PM) Mr. Whittle tells Ed Antle what happened, and copies this information to Exxon Mobil and Suncor.

Noting Mr. Antle's July 23rd 7:10 PM e-mail response to Mr. Whittle, Mr Ellickson asked about the question: "Is this tied into autopilot not engaging as previous report?" He said:

I am not aware of any "previous" incident Mr. Antle might be referring to ... I don't know of any... I just note that Mr. Antle has raised the issue, and Mr. Whittle replies (July 23 @ 8:11 PM) that "the cause" is not established yet... All this is speculative until it is investigated officially.

Asked if it is clear that Mr. Antle believed that there was a previous incident, Mr. Gerber answered: "Yes it appears so... but out there in the world, not Cougar."

Turning to another series of e-mails between Mr. Whittle, Base Operations Manager for Cougar, and various Husky personnel including Mr. Van Humbeck, that starts (JG #3 p.4) with Mr. Whittle's July 24 @4:01 PM e-mail sending Mr. Antle the Customer Flight Notification for Flight CGR851 on July 23 (in evidence at pp. 8 & 9 of JG #3). He said:

This Customer Flight Notification is a document they demand within 24 hours of every flight, and it contains everything that we know: basic facts and findings that we may have. Typically it is very incomplete. This requirement is driven by the Petroleum Board who want quick information.

Mr. Gerber's attention was then drawn to the subsequent July 24, 2011 e-mail message from Mr. Van Humbeck with 11 questions. Mr. Gerber noted that Mr. Whittle answers each of these questions in his e-mail to Mr. Van Humbeck, sent on July 24, 2011 at 9:19 PM.

The July 23, 2011 Customer Flight Notification concludes with an "Operations Summary" which includes, as the second item under "Immediate mitigation", the following:

"Manually overriding an autopilot causing unexpected flight commands is a known issue with autopilot systems. Cougar SOPs and recurrent training cover this issue specifically."

Mr. Ellickson focussed on Mr. Van Humbeck's question #7 which reads:

"Have and/or will the other crew members be briefed regarding you statement, "Manually overriding an autopilot causing unexpected flight commands is a known issue with autopilot systems."

Mr. Gerber responded: "Cougar SOPs and recurrent training cover this issue specifically."

Mr. Ellickson also noted question #8 which dealt with a possible safety stand-down to address the issues, to which Mr. Whittle had answered:

"No, in speaking with others crews know how to respond to this type of event and it appears that this will be an isolated case. HFDM have not shown any undetected anomalies in this specific area so far."

Mr. Gerber had not spoken to other crews, and doesn't know whom Mr. Whittle spoke with.

In respect of question #9 which deals with the crew suspension, and Mr. Whittle's response that the suspension was being done for investigation purposes and not as disciplinary, Mr. Gerber said:

"I think Mr. Whittle is here reflecting that flight operations are going forward, and this is how we safeguard against repetitions of an incident."

Asked if had participated in this exchange of e-mails with Mr. Whittle, Mr. Antle and others, Mr. Gerber said:

Yes, but I took no notes. I participated in the answers to Mr. Van Humbeck's questions, but I wrote another e-mail. However, these answers reflect my text, that he uses. Also, that initial page of JG #3 refers to matters going forward from the incident and are not directly related to the incident. They relate to return to service, and we were figuring out what some of the issues were. The first page of JG #3 refers to the technical information which concluded that the helicopter was free of technical problems other than the gearbox over torque. Mr. Whittle may have had a discussion with the investigating team and with the Chief Pilot, but I don't know whom he spoke to.

A further e-mail is at pp 10-11 (of JG #3). It is an e-mail from Mr. Whittle, Base Operations Manager for Cougar, to Mr. Gerber on July 25, 2011 at 12:51 AM and deals with the fact that Cougar "feels that it is safe to return to service for Husky since the technical issues related to this event are well understood." Mr. Gerber said:

In my view this was definitely a technical release of the helicopter. There were no technical problems other than the gearbox over-torque. Mr. Whittle may have talked with the investigator and with the Chief Pilot in preparing this, I don't know.

Pages 12-15 of JG #3 is a three page copy (final page blank) of a July 25, 2011 at 2:13 AM e-mail conversation between Mr. Van Humbeck, Husky's Aviation Advisor, and Mr. Whittle, copied to others. Mr. Van Humbeck asks about "crew experience and crew pairing."

Mr. Gerber was asked if anyone had told Husky about Mr. Mugford's restriction, since Mr. Ellickson could not see any reference to that restriction in the e-mail. Mr. Gerber answered:

I don't know if we specifically did, but it would have been information he already had. He was part of the group that first put that restriction on.

In his e-mail to J.J. Gerber of July 25, 2011 at 9:30 AM (JJ#3 p.17), Mr. Van Humbeck asks for clarification as to "where the manual override of an autopilot causing unexpected flight commands" is, in fact, covered in Cougar SOPs and in recurrent training. Meanwhile, at 10:04 on the same day (JJ#3 p 18), Mr. Whittle restates for Mr. Brown of Husky, that the crew suspension was investigative, not disciplinary. Mr. Gerber said:

I think there was discussion that we'd determined that this was a disciplinary suspension. That is a common mistake for our customers to make. Any event is bound to be traumatic, so suspensions are used to provide an opportunity to assimilate the event and to allow the investigation to continue.

Pages 19-21 of JG #3 is a three page series of e-mails, initiated by Mr. Gerber and addressed to Mr. Van Humbeck, about the training forms and briefings required by Husky as a result of the incident. Mr. Gerber suggests to Mr. Van Humbeck that the procedure is now able to track the training material and to ensure that all pilots must read it; and, in view of this fact, he "suggests that "we understand the requirement and you let us manage it form (sic) here." Asked what he had intended by that suggestion, Mr. Gerber answered:

As a result of the experience on Monday with the training, the crews were already familiar with the issue. Secondly, we have a system that proves whether they've read the material. This was my attempt to streamline our operations and to eliminate further erosion of the Chief Pilot's and my own time.

Asked if he wanted to eliminate Husky's preapproval of the flights, Mr. Gerber said:

No, only the portion that says, 'okay go ahead'. We certainly did not wish to eliminate the training.

The same e-mail chain includes a July 26 at 8:56 AM e-mail from Mr. Gerber to Mr. Scott Brown and Mr. Van Humbeck and others explaining that Mr. Van Humbeck should "participate in our final report that will form the core of the Husky report to the CNLOPB." Mr. Gerber explained that:

The suggestion arose out my desire to eliminate confusion and to ensure that everyone was fully informed of the situation.

Mr. Gerber's e-mail continues with a reference to a conversation held on "Sunday night" (July 24, 2011) in which he had indicated:

"... we know exactly what happened here, and we are just writing it up and formatting it for our internal process relating to debriefing the crew and further training changes and then off (*sic*) course the immediate training items that need to go to other crews."

Asked what the "Sunday night" comment was intended to convey, Mr. Gerber said:

There was no anomaly with the aircraft, and that therefore it was the way the crew interacted with the aircraft... It was either the way he engaged or disengaged the autopilot. That was prior to getting information as to what the crew had to say.

Asked whether he was aware at the time that Mr. Mugford should not have been flying with Mr. Sellars, Mr. Gerber answered, "I don't know."

Asked whether he had seen the HFDM data or the HUMs data by Sunday night, Mr. Gerber answered: "No, I had not listened to the CVR (cockpit voice recorder) data." Asked if the meeting he describes as having taken place on Tuesday afternoon, July 26th was a telephone conference or a face-to-face meeting, Mr. Gerber said:

No, I think they came to our building. I know for Thursday they did; but I think this one they came too. I think it was Tuesday. Present were a lot of people: Mr. Van Humbeck and Scott Brown and I believe Mike Whittle. I did not take notes. It was an update of what we knew of the event, about some things we thought we knew and eliminating what could be eliminated. Otherwise we talked about the TSB and further training issues. It was mostly Cougar who did the talking, telling them what we knew.

Asked if they were telling Husky that pilot error was the sole factor, he said, "Correct." Asked if he was aware of notes taken at the meeting by anyone at Cougar, Mr. Gerber said, "No."

Mr. Ellickson directed Mr. Gerber to a July 27, 2011 (9:36 AM & 10:41 AM) e-mail exchange between J.J. Gerber and Scott Brown of Husky (JG #3) that dealt with a planning meeting for the Cougar Report. Asked if it was to ensure information was consistent, he said:

No, it was not concerned with the findings. Often an outside agency can make recommendations that can't be excluded. So, administratively, it is normal to determine their feasibility. So we made every effort to understand where Husky was going and also to be sure we covered everything... Husky is required to report to the Board, and Cougar would not want inconsistencies... because they have no access to the raw data, and it is important that they get the facts right,

with the help of their Aviation Consultant, Mr. Van Humbeck. In our experience, that was a problem. They are well versed in the contract, but not as well versed as to why or how to implement, or what to do. So we want to talk before we prepare a report in order to avoid embarrassment.

Mr. Gerber was asked about the suggestion made by Mr. Van Humbeck (JG#3), in his July 27 at 1:09 PM e-mail to Mr. Gerber, that fatigue may have been relevant. He testified that "Fatigue had been investigated, and was ruled out."

Mr. Gerber was also asked about another issue raised by Mr. Van Humbeck. In his (JG#3) July 25 e-mail to Mr. Gerber (cc: to others) he requests direction on where he may find support in the Company's SOPs for the statement (Customer Flight Notification - Preliminary 23-July 2011, p.2, #2) that "Manually overriding an autopilot causing unexpected flight commands is a known issue with autopilot systems", and the claim is that Cougar SOPs and "recurrent training cover this issue specifically." Mr. Van Humbeck says that he can not find where, in the SOPs, this is done. Mr. Gerber answered:

I agree. I could not find it either... Our memos as published last night places a larger emphasis on it, and my individual briefings... confirm there is no confusion among the group on this matter - none. But there is information on how to fly the aircraft manually in the SOP's... I agree that sentence does not appear in the SOPs.

In JG #3 there is also a series of e-mails between Mr. Van Humbeck and various others dealing, among other things, with the duration of the 136% over-torque. The exchange also deals with Crew Resource Management mitigation, and the possibility that information on that issue be added in the light of the incident. Mr. Van Humbeck suggests that the inability of the helicopter to register an over-torque on the display *while in flight* might be regarded as a design flaw. Mr. Gerber responds that it is perhaps better to describe it as an opportunity to improve the helicopter. Mr. Gerber also refers to the "38 points" brought to Cougar's attention and due for incorporation into Husky's own report. He expresses the view that Cougar will "get an opportunity to review your report prior to submitting it to the CNLOPB." Mr. Gerber commented that:

Cougar was concerned that crew issues would be discussed in public if documentation went directly to CNLOPB. It had not been intended for that target audience.

Asked if Cougar had seen the Husky's Report, Mr. Gerber said: "I can't remember seeing it. I don't know how it was responded to."

Mr. Gerber was asked about his August 22, 2011 e-mail exchange with Mr. Van Humbeck (JG#3) about a "possible design flaw with the Enhanced Ground Proximity Warning System (EGPWS)." Mr. Gerber explained:

This is a device that has a data base of altitudes all over the world, with which it continually compares its current location. It will warn you... The enhanced part is the ability for the aircraft that has just taken off and does not want you to sink so it warns you. Mr. Van Humbeck was concerned that the 40 knot limit made that system ineffective in a 20 knot situation. That is what he is thinking. But I was concerned he was calling it a "design failure." He was also worried that the display seemed not to show any over-torque. There was no display for the crew to use to tell them they were over-torquing. But, in fact, there were a number of indirect indications. Cougar certainly encourages bringing these concerns to the oil and gas group and to the other organizations that have a responsibility in this area... But it is not accurate that the crew did not know the problem. They would hear the rotor and the needle could tell them, even if there is no display saying "over-torque.".. I was not disagreeing with Mr. Van Humbeck because it was not relevant to us. I did not want him to portray it as a flaw in the aircraft. That is a further layer in the process. The pilots have more tools in their tool kit. I did not disagree with him. He can go public with his concern. I wanted to support anything that can improve the aircraft.

Asked why it was so important for the crew to be aware that there had been a torque exceedance, Mr. Gerber answered:

If you know of an exceedance you now know the gearbox is in unknown territory. It is important to know the condition of the gearbox. You have the instruments, but you should also know of any torque exceedance to know how long to fly with such gearbox.

Mr. Gerber's attention was directed to Consent #1. He acknowledged that it was he and Mr. Perry who had made the decision to terminate. Asked when that decision had been made, he answered: "Between Tuesday afternoon and sometime on Wednesday. I wrote the letter."

Asked when he had obtained his own supervisor's approval for the termination, he said:

That would be later on Tuesday: that night... That was the only conversation. We had only discussed the options we'd put forward, Yes. They approved my decision, based on those options.

Mr. Gerber's attention was directed to the HFDM Committee's Summary Investigation Report (PP #7), and in particular to the Conclusion which reads as follows:

"We the committee believe the above is an isolated event. It is well known that engaging coupler functions without the controls being properly trimmed will introduce un-commanded attitude changes. Because G/A was engaged with the cyclic out of trim, a small attitude change occurred, resulting in a benign unusual nose up attitude. This manageable unusual attitude led to an excursion from a standard T/O and climb profile which resulted in a low altitude recovery. Even though this is an isolated event we recommend emphasis on the following subjects during annual recurrent training;

- 1.) Unusual attitude recovery and techniques
- 2) Coupling functions and proper mode selection
- 3) Identification of improper mode selections and recognition.
- 4) CRM - Focus on PM's duties beyond standard calls in unusual situations."

Reminded of his earlier evidence that the crew were aware of the phenomenon described as the "engaging coupler function", he was asked if this was covered in the flight manual at that time. Mr. Gerber answered, "I don't think it was." Asked whether it is now covered, Mr. Gerber answered, "JG #4 is in the pilot manual", and confirmed that "the caution is now in the SOP, but was not at that time."

Asked if unusual attitude recovery was not, in fact, part of pilot training at the time of the incident, Mr. Gerber answered:

No, I cannot agree with that. It is an item being checked off specifically, but it does not mean it was not done before.

Asked if he would agree that, in his view, the item had been done before, but today it is mandatory. Mr. Gerber answered, "Correct."

Asked if the crews whom he had briefed after the incident had told him that they were aware of unusual attitude recovery, Mr. Gerber answered:

Not 'unusual attitude', but that anomalies may occur... But I would not say engaging the autopilot is the issue. It is what came after: that is what we were worried about.

Mr. Gerber also confirmed that he had spoken

... with six or eight of the pilots, not all 54... Yes, but there were not 54 pilots at the time, and the Chief Pilot did the same thing too.

Asked if he had enquired of the pilots whether any of them had previously experienced this, Mr. Gerber answered, "I don't recall." Asked if he had asked Mr. Sellars or Mr. Mugford if either of them had experienced it previously, Mr. Gerber answered, "No." Mr. Ellickson noted that Union evidence would be that experience is required in order for a pilot to be aware of the unusual attitude. Mr. Gerber answered:

I insist that anomalies is what can occur, and that the pilots have to know how to handle the nose... I agree, that it was unusual attitudes that were added to the SOP's, and the addition was the specific parameters, nose position, wing position, *etc.* There's no new information. We would expect a pilot to have that, perhaps not in SOP's but in the training, certainly. We add to the SOP's where we become aware how it can be improved. The new SOP appears in PP #16. It is to enable the pilots to hand flight it. It is a highly automated machine and pilots can "use it or loose it."

Mr. Gerber was asked about the HFDM Committee's Report (PP #7) and many of its recommendations that refer to training. He was also asked why, in para. 4 of the letter of termination (Consent #1), Mr. Sellars is described as having "frozen" when neither PP #7 nor JG#5 says anything about the pilot freezing. Asked whether the word "frozen" was his own expression, Mr. Gerber answered, "Yes." When it was pointed out that all the evidence is that the crew was trying to recover the aircraft, and that it did not crash, Mr. Gerber answered: "It did not crash. That's not recovering the aircraft."

Mr. Ellickson directed Mr. Gerber's attention to a Cougar Internal Investigation Report (JG #5) into an incident on August 26, 2007. He confirmed that it was a Transport Safety Board reportable incident, but said:

I think at the time we concluded that it was not, and subsequently learned that it was. Therefore, it ought to have been reported... It involved a daytime flight to Hibernia, and, on approach to the platform, the aircraft was 150 feet lower than the 280 feet they should have been. On approach, the Pilot Flying decoupled the autopilot and hand flew the aircraft. The aircraft entered cloud and lost altitude at which point the Pilot had become disorientated. At 31 feet and zero airspeed the Pilot Monitoring took control and aborted the approach, pulling so much collective that he had over-torqued 118%, and returned to base despite the torque exceedance.

Mr. Gerber confirmed the SOP was violated in this case, and that, according to the investigation, the causal factors were human judgement.

Yes. It is also correct that neither member of the crew was disciplined, and Mr. Sellars was. But there is a very simple reason for that. That was in 2007, which was a very different situation, prior to Flight 491, and also prior to Pat Perry as Chief Pilot. Over the years the S92 has been in service there have been cultural changes as well. They were flying at 150 feet, not 280 feet. It was thought that mitigation was achieved by doing the SOP modification. In making that judgement we look at the human situation and we look at the circumstances and at the culture of the company. The question was, did we allow the culture of the Company to let this happen at the time. The Company did allow it to happen. There was no condoning it, but we did allow it. A further consideration was that the RadAlt had not decoupled; yes, that is a fact. But the Captain certainly took action, which was not Mr. Sellars' situation.

Mr. Gerber's attention was directed to a Cougar Internal Investigation Report (JG #6) into a November 12, 2008 incident (JG #6). Mr. Ellickson noted that Section 1.3 reports no damage to the aircraft, but that the SOP violation was a concern. Mr. Gerber pointed out that:

One big difference in approach now when compared with the 2008 incident is that, on approach rather than take off, you expect one of the two pilots to look outside. There was a culture in the Company to that affect. But in recent years there has been an emphasis on stabilized approach, long steady final approach leg. We did not enforce that at the time. That allowed the crew to be off-profile and an inappropriate slowing process. The company, itself, carries responsibility for that. Either the company did not know, and should have know, or it allowed this culture to develop. In the years leading up to 2011... that sort of problem behaviour cannot be allowed. We felt that the company had erred in this, and we took responsibility for our part. So it appears that there was no discipline...There was a request from Husky not to use Mr. Mugford except with a training pilot. But it was not our request. I accept we missed Husky's request. I accept, also, that the November 2008 crew were not disciplined despite violating four SOP's...Yes and the company had some responsibility in allowing those SOP violationsto occur.

Asked if that the crew had been suspended for the period of the investigation, Mr. Gerber said: "That was not the practice at the time." He confirm that this was a TSB reportable event but had not been reported, and that they experienced 135% of torque for 11 seconds. He further agreed that an exceedance over 10 seconds or beyond 125%, requires a gearbox change, and identified the extract from the flight manual (JG #8), and the cockpit emergency checklist (JG #9), both of which show that exceedances between 120 and 140 or for more than 10 seconds require a gearbox change.

There had been no change in the gearbox in the case of the November 2008 (JG #6) incident. The document says that there should be a serviceability check. There was no change.

Mr. Gerber identified, as JG #10, a performance review conducted on Captain Roach.

This was a failed attempt to indicate to each pilot who did a check ride how to try to improve what they could, and how I would work on the following issues. The aircraft was very different, different aerodynamics. It was the Super Puma he was checked on, a different generation of technology.

He described JG #11 as 'self explanatory':

... an exchange of e-mails between Scott Brown for Husky and Mr. Banks, Safety Officer for Cougar, about Husky's list of comments on the revised report... JG #12 the actual list of comments, 38 in all.

Mr. Ellickson, pointed to comment # 36 item (JG #12), which reads as follows:

"Page 17, 5.7, Require a firmer commitment than "should review." Crew pairing appears to have been a possible contributing factor on July 23rd, and therefore we need to be certain that it will not be a concern going forward."

Mr. Gerber said: "An assertion is not a truth... This was one of Husky's concerns, that it not happen again, yes." Asked if Cougar has taken steps that it not happen again, Mr. Gerber answered, "Yes we have." JG#12 item #38 reads:

"In the root causes section, there is no reference to CRM deficiency however we have openly discussed this both meetings in which Husky, HMDC and Suncor made reference to it as a significant contributor factor. I am suggesting that Cougar take this into consideration and address this in the report."

Mr. Gerber responded:

They were referring to, I believe, the fact that this First Officer was calling out changes and alerts that were responded to but not executed. The CRM training was a different focus. But just because they say this to does not mean that we agree. CRM is always open to improvement. In this instance we identified that the First Officer felt that he could not take control of the aircraft. The First Officer said that to us in his interview with us on Thursday... Yes, post-termination.

Asked if he would agree there is no evidence in the HFDM report or in the interview notes to suggest that Mr. Mugford had felt he should take control, Mr. Gerber answered, "I agree with that." Asked if his conclusion that the crew were preparing to ditch is supported by the HFDM committee's report, Mr. Gerber answered:

It was information given to me by the HFDM committee and it was given to me in the way he was focussing on keeping the wings level and the floats had been on... However, that there was nothing in the report that the crew was preparing to ditch. It was a verbal comment, not in the report. Also, neither of the crew statements show any evidence that they were preparing to ditch. At the time I wrote this letter it was clear to me that one of the crew thought they were ditching. No, it is not in the report.

Asked if arming the floats is a normal part of the SOP, Mr. Gerber answered, "Yes, prior to ditching." Asked if, in fact, it is a standard procedure when the aircraft reaches a certain altitude, Mr. Gerber answered, "yes, or when ditching." Asked if, at any time, there were preparations to go into the water, he answered: "The aircraft was telling them lots of things." Asked if Mr. Sellars, himself, had armed the floats. Mr. Gerber answered, "No."

Mr. Gerber confirmed that Mr. Mugford did not have a commercial helicopter licence when he was hired. Asked if anyone else had been hired to be a pilot without a commercial helicopter licence, Mr. Gerber answered, "No."

Asked about his testimony that he'd known nothing of attempts to unionize, he said:

I was not aware of any renewed attempts beyond the last year's attempt. I knew Mr. Davidson was a spokesperson. I did not make the connection with Mr. Sellars or see him as a spokesperson.

Asked if he was present at the meeting with management described in JG#5, he said: "Yes, I was present, and Mr. Sellars was also present, as a representative of the pilots."

Mr. Moores briefed me on the investigation the HFDM Committee had conducted, and Mr. Sellars was terminated on July 28th in a meeting held that morning... Yes, there was a training session that morning with the pilots, and, later on, I was called into a meeting with the pilots.

Mr. Gerber confirmed that he'd informed the pilots that Mr. Sellars had been terminated for the July 23 incident, but denied he had told the pilots that there was "one cause of the failure, and that was Boyd Sellars."

No, I can't imagine naming a person or the cause. I certainly would say it was because of what happened on the flight that he is not there any more. But I would not say that Mr. Sellars is "the" factor.

Asked if, at that meeting, he had told the pilots that Cougar had "lost the Husky contract on Sunday and got it back on Monday", Mr. Gerber said: "I may have said that, yes."

Asked what he had told Husky on the Tuesday meeting, Mr. Gerber answered:

We needed a meeting with the TSB. I felt it was useful to have Husky because they would have to provide TSB with a report too...

Asked if, on Sunday night, he had told Husky: "You tell Husky senior management that we will fire Sellars", Mr Gerber said:

No, I did not. The subject of crew dismissal was not discussed with Husky. Husky was interested in his CV. They wanted his information, to see if we had an unqualified pilot. They were checking that to see if we'd missed a qualifications check.

Asked if he intends his testimony to be that Husky did not interfere in the decision to terminate Mr. Sellars, or that there would be no problem with Husky if an adjudicator were to reinstate him a few years later, Mr. Gerber said:

No. It is Cougar who makes the decision. We'd lost confidence in Mr. Sellars' abilities to fly IFR. We did not lose confidence in the other two incidents. The pilot took control... Let the documents speak for themselves. The two older events are very different from this, and from each other. In those incidents I was satisfied that the pilots acted. There was no failure to recover.

ON REDIRECT EXAMINATION, Mr. Gerber testified that one of the focal issues

... for me on July 24, 2011 was to return to flying with Husky... In any serious event, we pause. But in this case the Aviation Advisor invited us to complete certain steps prior to flying. It included training, and filing signed documents and, until we submitted those, we could not continue flying.

Asked if he could confirm his testimony on cross examination that he had not read the personnel files, either of Mr. Mugford or Mr. Sellars. Mr. Gerber said:

Yes, the Chief Pilot would have done that. I already knew what I needed to do... A qualified captain to do the job.

Mr. Gerber was asked to comment on (JG #3), an e-mail forwarded to Mr. Gerber from Mr. Whittle on July 25 at 12:51 AM. Attached was an e-mail Mr. Whittle had sent Mr. Van Humbeck, Scott Brown and Ed Antle four minutes earlier concerning "Return to service for Husky." Mr. Gerber said:

The incident was 32 hours prior to this message being sent, and was after the Sunday night conference call we'd held. It was Michael Whittle's summary of the situation.

Asked if, in his view, that summary was accurate, Mr. Gerber answered:

No, this was a very early attempt to satisfy the needs of the customers... Point 3, of the summary (p 1) reads:

‘On the SL 92, with low winds (about 14 knots in this case) leads to a condition called "settling with power", and the crew’s recovery from this condition was not optimal resulting in this loss of altitude.’

That was not accurate. It was ruled out by the investigation. Elements of the first and second points turned out to be relevant, but not as written there. So points 1, 2 and 3 cannot be used as accurate. Mr. Whittle is Cougar’s Base Manager, and is the main contact point with the customers up to a point. He’s the go-to person, but others have full access, of course, to the customers.

Mr. Smith directed Mr. Gerber’s attention to e-mails between Mr. Whittle, Base Operations Manager for Cougar, and various Husky personnel including Mr. Van Humbeck (JG #3 p.4). On July 24 July 24 @4:01 PM, Mr. Whittle sent an e-mail to Mr. Antle enclosing the "Customer Flight Notification for Flight CGR851 on July 23" (in evidence at pp. 8 & 9 of JG #3). Noting a July 25 (11:38 AM) e-mail from Mr. Van Humbeck to Mr. Gerber that quotes earlier correspondence saying that "Manually overriding an autopilot causing unexpected flight commands is a known issue with autopilot systems", Mr. Smith asked where the phrase "manually overriding" originated. Mr. Gerber responded that:

It came from the July 24, 2011 e-mail, time stamped 10:19, from Mr. Whittle to Mr. Brown and Mr. Antle regarding Customer Flight Notification #CGR 8151, 23 July, 2011, which deals, at item #7, with a question from Husky which reads, ‘Have and/will the other crew members be briefed regarding your statement ‘Manually overriding an autopilot causing unexpected flight commands is a known issue with autopilot systems’?’. Mr. Whittle responds (July 24, 10:19 PM JG#3 at p5, in answer to question #7): ‘This is already in the SOP and training. Crews know to fly through the AFCS anomalies, and this crew is being investigated. HFDM will be used to analyse why their technique for recovery was ineffective.’

Mr. Gerber was reminded that in his earlier testimony he had stated that the SOPs were amended and was invited to look at PP #15, 16 and 17 which are excerpts from the SOPs. Mr. Gerber explained that:

The quoted passage does not relate to a change in the SOP. There have been items added about how to engage the autopilot, not to override it... Manually overriding the autopilot is not relevant to this incident. In this case the pilot did not press the button, and did not take the controls. He did nothing concerning the override which is done in one of two ways...

Mr. Gerber pointed to PP#15 at page 2 which sets out the parameters for the go around.

‘The use of "G/A" during takeoff will produce VW, V/S of 750 FPM and zero angle of bank. The flight controls must be trimmed so that no manual pressure is required to maintain these parameters prior to selecting Go-Around...’

PP#16 deals with "settling with power recovery", and PP #17, at page 2, deals with departure from offshore. But none of these deal with "manual over-ride." The change was to amend an omission concerning "manual override." We continuously improve the SOPs. It's a living document. The two ways in which one disengages the Go-Around are by pressing the button or by taking the controls and moving them. The stabilization stays on in that case.

Mr. Smith noted that the discussion in the correspondence arising from a suggestion from one of the Husky representatives that there was a "design flaw", and noted that Mr. Gerber had taken exception to that idea, and, in particular, the issue of an over-torque alert. Mr. Smith asked how a pilot would know if he'd over-torqued the machine. Mr. Gerber said:

There are a number of ways the aircraft tells you. The most obvious is the torque gauge on the pilot flying display (PFD). It tells you that you are moving the collective, and when you exceed the level, it turns red. Alternatively, the pilot will know through the rotor, and the gauge displays the rotor system. If you demand too much of the rotor, the indicator goes down and eventually turns red and eventually adds a noise warning. The gauges tell you. The third way of knowing is that, after the flight, WOW (weight on wheels) will give a warning that says to check the computer. The torque gauge is at the attitude indicator and that's the main instrument in instrument flying, right near to the compass. Right there is the torque gauge, and under it is the rotor RPM gauge. These are the key instruments, clustered right there together.

Mr. Gerber was asked whether the torque exceedance was reported by the flight crew when they got back to St. John's. He answered:

No. The daily log book is the method of reporting, and it is not a Transport Canada regulation, but is in the company manual check list. PP #8 is the log. It reads, "nil defects." The rule is that any pilot will report a defect or a suspected defect... Yes, the report is there in the maintenance sheet, 0867a &b. Maintenance reported it in their report. There is no reason for a pilot not to report it.

Mr. Smith directed Mr. Gerber's attention to the letter of termination, Consent #1, and noting there is no reference in the HDFM report to "freezing", asked him to explain his observation (top of para.4) that: "We conclude from the event that you actually "froze" in a stress situation." Mr. Gerber responded that:

There is no direct reference to this, but the evidence shows that nothing happened: that there was no attempt to change the flight controls, which led to my conclusion that he "froze."

Mr. Gerber was asked to comment on his letter to Captain Don Roche dated January 24, 2001 (JG#8) raising a "reliance on technology issue." Mr. Gerber was asked how he relates this issue of reduction of skills to the instant matter. Mr. Gerber answered:

We're talking about the very fine small movements with hands and feet to make the aircraft more steady. We are not talking about knowing how to fly the helicopter... Automation gives predictability, and relieves the very close attention that allows pilots to be aware of other things. Automation keeps being added. None of that erodes the pilot's ability to fly the aircraft properly.

Mr. Gerber's attention was drawn to Mr. Mugford's declaration to the CIRB (Exhibit #1) at page 3, where the following appears:

Contrary to Cougar's Response at no time did Captain Sellars lose control of the aircraft. He was making corrections and responding to the calls I was making. I was also never concerned that we would end up in the water. Arming the floats was part of the standard operating procedure.

Mr. Gerber was asked whether, prior to seeing Exhibit 2, he was aware that the floats had been armed during the incident. Mr. Gerber said, "Yes, we were." Asked if he agrees with Mr. Mugford that this is part of the SOP, Mr. Gerber answered:

The floats are for over water operation and are armed in one of two conditions: if there is a offshore landing below 80 knots, and there is an SOP concerning ditching it's called for anything below a particular speed. The aircraft was taking off. It was not landing. And there was no plan for a landing on the ocean. In this situation, I can only assume that they were ditching. In my view, the two sentences in this paragraph (of Mr. Mugford's statement) are not consistent. The first sentence has Captain Sellars in control, yet the second sentence is that they are ditching. If you are in control of a serviceable aircraft with two engines you would not be ditching. The statement about the floats as being in accord with SOP is correct, but only if you are ditching.

Reminded that he had said he was not aware of Mr. Sellars' union activity, Mr. Gerber said:

We knew about the employees committee, and were actively working on the issues. Union activities were not in our mind at all.

Asked if he had heard of Mr. Sellars' union activities after his termination, Mr. Gerber answered:

The first indication was the charge by the Canada Labour Board. In gathering documentation for that charge we learned of his involvements.

Mr. Smith asked about the reference in various documents to the inappropriateness of Mr. Mugford's presence in the cockpit with Captain Sellars. Mr. Gerber said:

I understand that there was a restriction imposed by Husky that he must fly with a training pilot only. One issue with that was that it was a limitation by Husky on us. We qualified Mr. Mugford, and he was qualified for three years. Other platforms had no such restriction, and the whole problem was that it was an administrative oversight, an error. It did not, in any sense, reflect on his ability as a pilot. They are all fully qualified on all flights. I can see how such a pairing issue got missed.

Asked whether there is anything unique in the relationship with Husky, he answered:

The only difference is that Husky does not employ their own Aviation Advisor but a contract person. Mr. Van Humbeck's motivation, I simply do not know.

At this point Mr. Smith indicated that the Employer rests its case, subject to the possibility of calling rebuttal evidence.

THE FIRST UNION WITNESS was Mr. Mark Chapman, Crew Resource Management Program Coordinator for Cougar in St. John's, and a Line Captain.

I started flying when I was 15, in 1975, and joined the military in 1978. I was navigator on a Sea King helicopter flying offshore. In '86 I cross trained as a pilot and worked out of Shearwater until 1998. In 1998 I took release from the military and worked in air ambulances. I then rejoined the military and, in 2009, I joined Cougar. I was hired initially as a First Officer and promoted to Captain, and was responsible for providing crew resource management for Cougar's offshore business. I am a qualified Captain on the S92.

Asked to describe Crew Resource Management (CRM), Mr. Chapman said:

It's a vast area of study examining how a component of a system works with other human and mechanical elements around it. It has many facets, including decision making, threat assessment, and even management, including workload management. It originated in a spectacular accident in Florida in the 1970s. A serviceable aircraft went down while the crew was troubleshooting a light bulb ... We have to train people how to manage their work. That is where it was born. It now looks at human performance as distinct from technological performance. Today technology is very advanced, but the human side has not improved. That is the focus of the work.

Asked what CRM development experience he'd had before coming to Cougar, he said:

We had it in the military. I was trained in the air force as a developer and a facilitator at Shearwater. We would train all those involved in operating the aircraft. Since joining Cougar, I've had courses and training, including some in the UK, and a threat- & crisis-management course in Vancouver, one on human function classifications in Las Vegas, and one on crew resource management behaviour markers. I've done a number of flight safety courses in California.

Asked to state the goals of CRM Mr. Chapman said:

It is to improve operational efficiency and safety and to be aware of the pitfalls. Some technologies are fairly structured, but we also highlight areas that can be very helpful. I understand Cougar was using a contractor to do CRM before I came, but now Cougar has its own CRM program called CHARM. Yes, I developed it... (I am moving to Aberdeen in Scotland with CHC Global to a new position and to be involved, as flight model test pilot for the S92 in Montreal.)

At Cougar there are two components in CHARM: one involving individual two day training over 13 modules, and the second, the annual recurrent training program which draws on issues that have occurred during the last year, with a service component for Cougar itself.

It is for all pilots and rescue specialists. Most issues addressed in this program are decision making, threat and error management, communications, fatigue management, workload management and leadership.

Also new in the industry is the effects of automation. There is a final chapter in CHARM on automation dependency. If you look at aircraft development over the last 40 years there's been more and more automation and less and less for the pilots to do. There is less opportunity to exercise their manual flight skills. So their skills tend to degrade somewhat. People become automation dependent. This lead to some spectacular incidents. The Air France crash involved automation at high altitude. The crew were simply unable to manage the crisis as it developed, and had no opportunity to do it in order to keep these skills honed. It is a huge issue globally. The Korean crash on the west coast of the United States appears to be another automation dependency issue.

Mr. Chapman identified, as MC #1, an *FAA Advice to Operators*, a

... high level document on recommended action, dated January 4, 2013... These are not published on minor issues...

Asked how operators are supposed to apply this message from the FAA, he said: "You have to adapt your reactions to fly manually." He also identified, as MC#2, an *AP Impact* article relating to skills that are fading. And he identified, as (MC#3), a *Mcleans Magazine* article that highlights a number of crashes. He created the CHARM review (PP#s18a,b, & c).

Yes, I created these in fall 2011, for recurrent training No.1. There's another dealing with runway incursion. When we create these, we look at the past year.

Directed to PP#18a (at p. 30) dealing with "situation awareness", Mr. Chapman was asked to describe what situational awareness is. He said:

In effect, situational awareness is perceptive comprehension of what is going on, together with an understanding of the implications flowing from perception and comprehension as two of the three key kinds of awareness...

PP#18b deals with team communications, particularly between the crew, the engineers, everybody involved in the flight. It is essential that two people have the same communications model. This module did not arise out of any particular incident, but deals with the skills involved.

18c was included as followup to Mr. Sellars July 23rd incident. We try to make the material topical. Automation dependency is covered on pp. 4 & 5. That is a huge issue. Information breeds a level of proficiency, but the difficulty is to make it happen with the hands and the feet. It is not like riding a bike. The sensations involved, the impact and the feedback from input all require skills that have to be reacquired. It is far more complex and difficult, but it is possible... Mode Confusion is covered at PP#18c. p. 4. It is true that flyers can fall back on their old skills.

Asked if this program was in place prior to the Flight 851 incident, he said "No." Asked why it is now part of the program, Mr. Chapman said:

I expect it is because of this incident. We clearly had a problem that should be trained or ...

With reference to the Internal Aviation Investigation Report on the August 26, 2007 incident (JG#5) and the Internal Aviation Investigation Report on the November 12, 2008 incident (JG#6) he was asked how one overcomes automation dependency. He said:

By maintaining the skill and taking the opportunity to practice the skills. Pilots must be aware of the limitations and the reactions of the technology. If the machine isn't performing, it's important for the pilot to be able to take over. Something called "Normalcy Bias" can happen. It is a situation where you 'can't believe this is happening to me.' That's Normalcy Bias.

Asked when he'd learned about the incident Mr. Sellers and Mr. Mugford had experienced, he said: "I sat down with Boyd in the crew house, and he told me about the incident." Asked if he'd received a briefing from the company, Mr. Chapman answered:

Not at that point. We were advised in a presentation in the hanger a few days after. The details came several days after that, perhaps a week. J.J. was there and Pat participated on the phone. We were shown the HFDM data chronology of the incident as well as procedures to modify this for the future.

Asked what the company had determined were the causes, Mr. Chapman answered:

That the pilot was the single causal factor, and we were told that he was terminated as a result.

Asked whether he recalls any mention made of the Husky contract, Mr. Chapman said:

Not at that meeting. But that the Husky contract was in jeopardy if something was not done: that was from Mr. Perry.

Directed to the Internal Aviation Investigation Report (PP#12), he said:

I received this document on request shortly after the hangar meeting, when I was tasked to program a pilots decision-making presentation for Pilot Monitoring. Pat Perry asked me to do it. It was one of the corrective items to include the incident issue... Yes, I think I saw a draft of PP#12. The presentation was not delivered to Captains but to First Officers...

Mr. Chapman identified, as MC#4,

... the document I prepared, at Mr. Perry's request, for the First Officers relating to the incident. It is about the importance of Pilot Monitoring to strengthen their confidence, and to be prepared to deal boldly with a situation that is deteriorating...

ON CROSS-EXAMINATION, Mr. Chapman testified that his highest level of education is a Bachelor of Arts in Military Arts and Sciences which he completed

... at RMC in 2004. I completed grade 13 in Ontario, and have done a few courses in engineering extension from Berkley at the University of Southern California... From age 15, in 1975, until 1986 I continued to fly, but as a hobby including sail planes and powered aircraft; and from 1986 onward as a pilot. I joined the military in 1986, and cross trained on several military aircraft.

Asked if these aircraft were highly automated, Mr. Chapman answered:

No sir, they were not... I was out of the military between 1998 and 2001 flying an S76 air ambulance which is not as automated an aircraft as today's version.

Asked to explain what "autopilot" really means, Mr. Chapman said:

There are many levels of automation, as many as 12... but four basic levels. The object is to ease the workload and to improve productivity and efficiency and safety. It is not an all-or-nothing concept. Autopilot itself means many things. In the S76, it means that when you turn it on, it maintains the aircraft at an allotted set heading, but you have to interact with it more. So "Autopilot" depends on the context. The S92 is different from the S76 in the meaning of the term autopilot: same word but different functions... For the almost thirty years of my career (1975 - 2009), I've had a lot of experience without sophisticated

automation: for instance in the Sea Kings with their auto-hover capability. That was not just a matter of turning it on.

Asked if it is not true of all automation that pilots must be alert and monitoring, he said:

Yes, but auto-hover was very much less independent. The Sea Kings were designed for antisubmarine warfare. When you engaged it, it gave you some surprises; then it would give you a problem, sometimes quite dramatic. It is correct that the pilot has to maintain vigilance; but the modern stuff is several magnitudes more reliable. There are many auto warnings also on the S92, and some are more obvious than others.

Asked if some of the S92's automation needs turning on, or is 'on' by default, he said:

Yes, the autopilot is turned on with a button in the S92. The pilot has to couple the flight controls. When you do that, the aircraft has permission to fly according to the flight data as the pilot would fly it. "Coupling to the flight director" says effectively, "You do it, helicopter." But several autopilots are always 'on' just to keep the aircraft stable. The term 'autopilot' is not a simple term. Once the autopilot systems are coupled, their job is to reduce demands on the pilot.

Mr. Smith asked whether this would suggest that an aircraft as complex as the S92 would overwhelm a pilot without those auto systems, since there would be an unmanageable workload for the pilots. Mr. Chapman agreed:

It is a difficult aircraft to fly. To fly instrument flight rules (IFR), it would not be impossible, but very difficult. Flying in a fog bank would be impossible without instrumentation...Yes, the S92 provides enough information to the pilot via the Primary Flight Display (PFD)... Absolutely. It gives attitude reference, air speed, ground speed, and several other coordinates... Pilots who are IFR-rated have learned to fly using that information cluster. In fact, IFR processes actually pre-dated automation itself... You have to set the values... You have to tell the computer what you want. The values you set appear on the display prior to coupling... And there are many ways to couple... Yes, skills of understanding the various parameters are needed; but this is really the crux of automation dependency, which is when someone finds himself saying: "I understand the competencies, but I can't do it anymore."

It's a dependency that results from not doing the job manually almost at all, so the erosion of skills sets in. But here in St. John's the pilot must fly the aircraft on departure and arrival each time; so, up to a point, there is manual flying whenever the pilot engages the automation and the pilot can decouple or override that if he needs to... There are four times each trip – up and down – when the pilot directly flies the aircraft...

Yes, each trip is slightly different and requires adaptations. So therefore the pilot does fly the aircraft each and every day to a specified point; then he

couples and becomes an automation manager... If the automation is behaving unexpectedly, then the manager must make a decision.

You are talking now about a normalcy bias. The S92 is a very reliable machine; but there are ways to create an unacceptable result, and you must be willing to understand that immediately, otherwise you are caught in a normalcy bias. Normalcy bias may mean that you do not understand what's happening. Mode confusion is also a real problem. Pilots continually ask themselves, 'What's it doing now?' That is the difficult moment of a lot of the mishaps and fatalities and crashes in the fifteen million flights per year.

Asked if there have been studies to show the different effects of these automation dependency and mode confusion issues on various different pilots, Mr. Chapman said:

I know of no such studies, but the FTA and the Canadian Transportation Board seem to be sending out a broad warning.

Mr. Chapman's attention was directed to Cougar's Total Flight Hours Report (PP#1). He commented, "Mr. Sellars has a lot of flying hours." Asked if there have been any studies that show how long you have to work with automation before you begin losing skills, he said:

Not that I know of; but it is not a matter of time so much as of what you have done lately that determines the atrophy of skills... Mr. Sellars has 341 flying hours in the S92 as Pilot in Command (PIC). The S92 gives automated warnings and alerts, but also the First Officer plays the role of Pilot Monitoring.

Mr. Chapman identified, as MC#1, a US Department of Transportation *Safety Alert For Operators* (SAFO), dealing with "Manual Flight Operations" and with "the pilot's ability to quickly recover the aircraft from an undesired state." Mr. Chapman noted that "recovery is part of flying... part of the basic flight skills." He also testified that CHARM part 3 (PP #18c)

... was written after Mr. Sellars' incident, and deals with automation dependency in terms of undesired flight deviation issues whether automation or manual flight of the aircraft is what is required ... Knowing how to increase or decrease automation is a critical decision-making process. It is human decision to increase or decrease automation. It is not curing the situation when automation decreases the automation. That will bring about a surprise, and it depends entirely on what the underlying state is. It depends on the situation.

Asked why, in such a situation, the pilot would not just manually fly the aircraft, he answered:

As I said, if there was a 10 kt change in speeds, the situation may be very different. It's a "shades of grey" situation. Any one of several restrictions may be in place, but the human being must be in control. The human has to recognize what the situation is, unless the automation makes the decision for him!

Mr. Chapman's attention was drawn to Mr. Sellars' and Mr. Mugford's statements (PP#s 4 & 5), and was invited to answer his own three-part question about "Undesired Flight Path Deviation" (PP#18c, p.6) in the situation Mr. Sellars found himself in:

- Do you correct it with automation, or
- Do you go to a lower level of automation, or
- Do you manually fly the aircraft?

Mr. Chapman said:

I can't answer them. I did not see it happen... You need to make the decision in the full understanding of the situation and within the experience of the events. It is very challenging. It would be inappropriate for me to say what the correct answer is. These statements do not give the full picture.

Mr. Chapman agreed that the situation (described in PP#4) at the point

... where the go around is engaged is certainly unexpected and does not constitute the desired state. An aggressive pitch up is not what the pilots are expecting. Rotor rotation is decaying as a result of high power demand. That fits the situation. The air speed is not eighty knots. The bug is set at that, but it does not actually say what the speed of the aircraft was. At fifty knots the autopilot is going to decouple, and then the flying is back in the pilot's hands.

Mr. Chapman confirmed he'd spoken with Mr. Sellars: "Yes. I believe it was on the evening of the event, in the lobby at the crew house." Asked if Mr. Sellars had sought him out, he said:

No, he just came in. I was sitting at the table. I believe he was going to speak to Mr. Davidson, and I just happened to be there... I don't know why he arrived.

Mr. Chapman led Mr. Smith through the remainder of CHARM part 3 (PP#18c), exploring various aspects that are raised therein. Mr. Chapman pointed out that:

Automation is here now in helicopter flying. Most of the training time is, in fact, devoted to automated flying. It is not a matter of a half an hour per day, but half an hour spread out over the whole of several days of training. The point of this presentation (PP#18c, p. 9) is to get ahead of the curve on this issue. The S92 is a very highly automated aircraft. Cougar acquired the S92 perhaps seven or eight years ago: before my time. The commercial airline industry provides leading indicators to what we can now expect. Automation dependency occurs not only in an undesired state, but also when there is loss of situational awareness... which is one aspect, but reaction time is a big factor. The company is trying to do as much as it can.

Asked if Mr. Chapman had concluded that the Flight 851 incident was an instance of automation dependency, Mr. Chapman said: "No. It's far too soon to say anything like that at all."

ON REDIRECT EXAMINATION. Asked to compare the S92 and the S72 in terms of the levels of automation, Mr. Chapman said:

We spoke of four levels of automation. It's not solidly defined in the industry yet. The S92 is up to level four. The S92 in SAR mode is the highest. I would say the line flying S92 is about level three. The S76 falls somewhere between a two and a three. The later S76s are more automated. The Bell 212: that's a level one, in my experience. I flew a military twin Huey. That was all hand flown... Automation dependency arises in the differences between what you know you are trying to achieve and the ability to achieve it. If you're in a totally unfamiliar undesired state you are focussed on deliberate delay-making, so you could provide a wider range of recovery responses.

Asked whether he could apply response analysis to the incidents that occurred in 2007 and 2008, particularly as set out in PP#7 and JG #s 5 & 6, he said:

All three incidents are remarkably similar: high power close to the water. I've not studied them in any detail, but they are the kind of incidents that are typical of this. On one occasion, one of the pilots said: "I've lost it. Can you take it?" Sometimes that is a function of lack of recent experience in hand flying at the edge. So these three are not inconsistent with that kind of problem, but mode confusion is perhaps an issue.

Asked if there are differences between the three incidents, Mr. Chapman pointed out that:

In Boyd Sellars' case, the departure was underway; and in the other two cases it took place on arrival. But, curiously, all three ended up in virtually the same place. Both involved over-torqueing, reduced speeds and decoupling, which forced the pilots to fly manually. In none of these instances did the aircraft hit the water, and all recovered with some over-torque. None was on impact.

Mr. Chapman also noted the mitigation strategies set out in PP#18c, at p. 28. He said:

Cougar has increased departure hand flying, and also made opportunities for increased hand flying when the weather limits permit. Components of all those recommendations were changed after the incident, and so as to fill a gap and provide the opportunity for increased hand flying.

THE SECOND UNION WITNESS was Mr. Scott Davidson, a Cougar Pilot. He had

... joined the Military straight out of High School in 1980/81 and got my military wings in 1983. Apart from a three year staff detour, I have been flying ever since. First I was on fixed wing aircraft, and then was on the Bell 206 for six or seven years, and then the Bell 212 Huey doing peacekeeping in Egypt and Israel for six or seven months, mostly flying antitank vehicles. Then, with Desert Storm, I was in Iraq and Kuwait with the British Air force. After the exchange posting, I came back to Canada as Instructor and Chief Pilot, then on

to a staff job, and then with the Joint Task Force against anti-terrorism. After 20 years I left the army and went to the navy where I flew S61 Sea King in the Navy as Captain Commander and Operations Officer. Also I was a flight simulator instructor. I transferred, in 2007, to the Reserves, and then went to CHC Global... I've been involved with five types of helicopters over the years: the Bell 26, the Bell 212, the Huey, the Bell 412 and the Secorsky, as check Pilot and Instructor and a Simulator Instructor. During my years in the Military, particularly in Germany, I became Flight Safety Officer. I was involved in air-crew and investigations. The object of a Flight Safety Officer is to learn from the past and to reduce future incidents.

Asked what other qualifications he holds, Mr. Davidson said:

A Bachelor of Military Arts and Sciences completed in 2005. I also trained as a Staff Officer at the Staff College and this enabled me to become Adjutant in the German rotation. I completed six months at Canadian Army Staff College, where I did courses in Operational Planning and Logical Thinking. I also have qualification from the Canadian Military as Flying Supervisor, and I served with Canadian Helicopters in Nigeria. I was 18 months there as a touring pilot, largely in Port Harcourt, with Canadian Helicopters (CHC)... I was fortunate to get a job with Cougar and started in November 2008. I upgraded 18 months later to Captain on the S92, and about then started work in Greenland and got involved in Search and Rescue. I'm now a Line Captain and a SAR Captain here in St. John's. I am writing instructions for night vision goggle Captains and for those who have not used night vision goggles. I am also Flight Safety Officer for Halifax, but that is not really active at the moment. Cougar sent me for Flight Safety training just over a year ago.

He confirmed that JG#1 and JG#2 are "copies of e-mails I sent to J.J. Gerber and others." Asked why he'd mailed them reports about contacts from a union organizer, he said:

Because I was contacted at home by a CEP rep asking me if I wanted to sign a union card. I'd been there for two years, and did not have any interest in joining a union that I knew nothing about, and which, by its title had nothing to with aviation. I really did not see the need. I was just out of the Military, and didn't see a need to take this big a step. I think some of the things Unions do are good, but it must be open and transparent. I was worried a bit about privacy issues... I also sent J.J. two in mid-January. We were being approached. They had my e-mail. My concern was primarily over my personal information. I'd just come out of the Military, and they don't give out your personal coordinates. Somehow, they'd got the company contact list, with wives names, *etc.*

Asked if he was familiar with the Cougar Employee Association, Mr. Davidson said:

Yes, that was an attempt to develop a voice with Cougar management for all the St. John's employees of the company. That was the concern we had early in

winter, 2011. There was a meeting in December 2010, I wasn't present. Boyd Sellars was. That was a direct result of the unsolicited approach from the CEP, so Boyd organized a meeting in the hangar in St. John's. I became aware of it by reading minutes when I returned to work in January, and the final minutes (SD#8) were prepared. There was unanimous support for a Committee to work with management to see if we could avoid forming a union, because there was no appetite for it in December of 2010...

Asked if further meetings followed, Mr. Davidson said that none were formal until June.

There was a lot of e-mail traffic. It's hard to get people together with so many touring pilots. The employee pay and benefit proposal (SD#11) was just within the group to go to management. We prepared it, and the specific section for the subgroups relating to pay issues and concerns that we had. I was responsible for drafting that and circulating it to the various groups because it was a joint document. I was on tour in Greenland for the June meeting. It was held, I believe, in the conference room. Boyd was present as one of two pilot representatives. I was the other, on the phone. It was chaired, again, by the General Manager. It was a five hour meeting: basically five hours of being told "no" to proposals in the pay and benefit review. Hank said the company was not in a position at the time to entertain any financial issues, but they were willing to work with us and we had good decisions on non-financial issues. That is the first meeting I ever attended for five hours on the phone. It is hard; there's 50% nonverbal, and I was not getting the body language. They brought me up to speed after the meeting, when management had left. I was told by all the reps that had attended the meeting, that they were pretty upset about how it had gone.

[Mr. Smith intervened at this point to comment that this is hearsay. The witness continued.]

For example, at one point in the conversation - I recall it over the phone, but I took it to be in jest - Hank Williams said "it is a good wage package for Newfoundland." A couple of representatives were upset about it; that was the flavour. The General Manager had been dismissive of requests in the document, and after five hours they kind of had enough.

Asked if there was agreement over the next steps, Mr. Davidson said:

I did a summary that evening. It had not been productive in identifying more than any financial issues, so there were two options that emerged. The Committee was clearly not effective in getting changes in financial matters. We'd agreed to meet three months later, but after the meeting no one felt set for another five hours. So there were two options: keep working with the Committee, or unionize into a legal body. So we decided, 'Let's think about it over the summer.' I did not really plan to do much over the summer.

Mr. Davidson's attention was directed to RM#5. He said:

Yes this is the e-mail, signed by myself and Boyd, about the June 9 meeting. I drafted it and sent it to him. We agreed the wording and sent it on to the group.

Asked if they'd received feedback about the unionization option, Mr. Davidson said:

Yes. It started in Greenland. One of the pilots there had been a union member with the OPEIU, and he said they had extensive experience with aviators. At that time they were concluding a contract with CHC Global and represented the whole region in oil and gas companies. They were also recognized by CHC Air Ambulance of Canada. So if the union route was to be adopted, they were an obvious choice. So over the next months, June and July, I got in touch with the Canadian representative for their union asking how difficult it was to do, *etc.* I got good advice from them. The OPEIU organizing didn't start in earnest until mid-July, after an incident in Halifax. It became apparent to us pilots, who knew of the incident, that a union would be needed for our protection...

We decided not to try to organize anyone other than the pilots, so that left Boyd and me to go it alone and take the risk of getting organized. Boyd and I were the active people... Between mid-July and July 28, it was going very well because the Halifax incident led to the discipline of two pilots who did not agree and then resigned. That galvanized the decision for the pilots. Registration was done within two weeks of 8 or 9 July, the date of the Halifax incident. After Mr. Sellars' termination, it cooled off quickly. We had only started organizing two days before the July 23rd incident. I had a lot of private phone calls, and Boyd and I had determined who to contact early to protect confidentiality, and I wanted stronger than 50% plus 1. After Boyd was terminated, a lot who had agreed to sign and one who had actually signed, wanted the \$5.00 back and the card, and did not want anything else to do with it.

Mr. Davidson confirmed that:

We wanted to keep the organizing drive confidential, on advice from the union. There were horror stories of people being fired as organizers. I felt that was a little extreme, and that there was no risk; but I was a Reserve Officer with a pension, so I thought the risk was acceptable. Not being unionized we serve at the pleasure of the company... In terms of confidentiality, we knew it would be a challenge because some pilots were extremely aggressive in their opposition to the drive. Basically, we knew that anything said group-wide, would get to management.

Following Mr. Sellars' termination there was an application made to the Canada Industrial Relations Board (CIRB) by the Union (OPEIU), and the Parties agreed to proceed with the complaint through the Section 240 process rather than through a complaint.

Mr. Ellickson asked Mr. Davidson about the three incidents in evidence: August 2007, November 2008, and in 2009. Mr. Davidson introduced, as SD#6, a graphic representation of

the data obtained from the company, (with a total time line of 2.6 minutes or 154 seconds) which covered the November 12th, 2008 incident and, as SD#5, a similar document covering the 5.4 minutes or 324 seconds of the August 26th, 2007 incident. Mr. Ellickson explored these data charts in the context of the internal aviation investigation reports on the two incidents, JG#5 and JG#6. With reference to SD#5. Mr. Davidson said:

The graph shows the second approach to the rig. The approach is 150 feet above sea level. They had missed the first approach, which was also at 150 feet. At some point, they set out to climb the 80 feet to the helideck. An unusual attitude occurred. They came within 31 feet of hitting the water before they recovered the aircraft. They then flew away, climbed and returned to St. John's. They did not actually get to the rig that day.

Mr. Davidson confirmed that the data (SD#5 and SD#6) are the company's. SD#5 is over a time scale of 5.4 minutes or 324 seconds. Asked to interpret the data, Mr. Davidson said:

Look at the time line in seconds across the bottom. The change in pitch attitude and decreased air speed start the event. They thought they were climbing, but got into cloud and actually were descending... to 31 feet above the water. The maximum pitch attained was 21 degrees, and they were dropping at 900 feet per minute to the ocean so the maximum pitch point at 21 degrees is where they start to do something about it. They are approaching the rig at 150 feet above the water. They were seeing the helideck visibly, and they decided to climb briefly to get back into cloud; but, instead of that, the airspeed bleeds off to nothing. And then they go to 118% of torque... It was approximately 16 seconds to reaction for the correction. They pulled on the collective which was what was required to save the aircraft. I see they have it under control when the wild fluctuation in torque is over, just after 61820 on the time line. The whole event is 1.56 minutes, 16 seconds of which they did not have control.

Mr. Davidson's attention was directed to JG#5 at p. 5, where the sequence of events shows that the aircraft was within 2.5 seconds of crashing at the rate of descent in effect. He said:

They were fully under control only much later in the event, having decoupled at 55 knots. At point one on the next page it shows that they did over-torque, as Mr. Sellars did. If there is a torque exceedance the crew must report it if they're aware of it, if there is any doubt about the serviceability of the aircraft... This crew did not make it to the deck so they returned to St. John's.

Asked to compare this event with Mr. Sellars' incident, Mr. Davidson said:

It is a different SOP, since this crew was in the arrival phase rather than the departure phase. But, aside from that, the same SOPs were in effect.

Asked to compare the recommendations listed in JG#5 (p. 9) with those made in respect to the incident involving Mr. Sellars, Mr. Davidson said:

The recommendations are very different. The JG#5 statement points out the importance to keep the report non-punitive, as does the November 2008 statement. But in Mr. Sellars' case, it's a totally different tone in that report.

Asked if he agrees with Company witnesses who said that the incidents themselves differ substantially, Mr. Davidson answered:

I'd say the 2007 and 2008 incidents are much closer to deviations than the 2011 incident, because the times to recognize and recover and prevent disaster are all extremely significant. Both are significantly longer than Boyd Sellars' incident.

Mr. Davidson was reminded that in JG#5 (p. 9, para. 6) the 2007 crew were censured for having not reported the RadAlt defect. Mr. Davidson answered:

In the context of Mr. Sellars' incident, a lot of attention is being paid to a very important entry in the logbook. This incident shows that the pilots were not writing up all that they should. But if you don't think it is an anomaly, it is not written up. The failure to report has been over-stated. Crews do not intentionally cover things up.

JG#5 (p. 9, para 7) reads as follows:

"During the investigation a previous event was presented to me that occurred two months ago with much the same flight characteristics and outcome. I was surprised to learn that only the crew of that particular flight was debriefed. HFDM is a superior learning tool and should be utilized for educating the entire pilot staff when events of this nature occur. No names, no dates, rather just the event in question. It would be devastating to find a recurrence that proved fatal when we had the opportunity to avert the mishap by simply educating all members. The company has allocated vast resources to provide the best graphics and recorded data to improve safety for all crews. We must use it to our upmost (*sic*) advantage."

Mr. Davidson's attention was directed to SD#6 and JG#6, which concern the Wednesday, November 12, 2008 incident. He said:

This incident occurred in a night flight off shore the Grand Banks in good weather, but at night and overcast. The rig lights are all the pilots had to navigate by. Captain Roach was the captain, one of our most experienced pilots, who had been with the company for 12 years at the time. Minimum altitude is 500 feet, which is very close to the final approach to the rig. They are very fast as they start their approach and did not couple to autopilot. The aircraft starts descending; the Pilot Flying loses control, 35 seconds, and at 35 feet above the

water. The Pilot Flying admits he has "lost it", and hands control over to Pilot Monitoring, who pulls power avoiding the ocean by about three seconds. They fly away from the water, land on the rig and are told by the mechanics in St. John's the aircraft is serviceable, when it is not, and fly it back to St. John's.

SD#6 is actually a shorter snapshot: 2.6 minutes rather than the SD#5, and the scale therefore is double. The duration of the event is 1 minute and 6 seconds. There is also an over-torque, an identical 118% over torque, which is a little strange. Mechanics in St. John's suggest 135%. Perhaps both were inaccurate. The unusual attitude starts 36 seconds before the attempt to recover starts. In that 36 seconds the Pilot Flying knew something was going wrong, but did not verbalize it until he said "take it over" to the Pilot Monitoring. Pilot Monitoring's job is to be monitoring the other pilot; it's his job to monitor the other guy. The start of recovery is 30 seconds into the event. The climb is altered to land on the platform... Maintenance said there was no over-torque, and let them fly back to St. John's. The over-torque was found the next morning, and the aircraft was recalled back to the hanger. The significance of this is stark, in terms of the Boyd Sellars' case. They relayed their experience to us in person a couple of days later, and they were deeply affected. In JG#6 (@ p. 5) the events are reviewed. It is clear from the Report (p. 7) that the crew knew they had an over-torque (bottom of p.6), but they did not think that it was a significant over-torque and flew it home.

The Report records that on the second approach the speed was high and there was an over-torque.... Also the graph and the actual report do not properly correspond to one another in respect of what is reported at the bottom of page 7. ... Mr. Sellars had no violations of any of the SOPs in effect at the time. In Mr. Sellars case everything was textbook situation until he coupled go around.

Asked what, in his view, caused the 2008 incident, Mr. Davidson said:

Pat described it well: they were trying to slow down with two automation cues engaged. They were not in the correct modes of automation for what they were trying to do. If they had air speed engaged it would not have happened. Look at the penultimate bullet on page eight, which reads:

"The helicopter was recovered (at a much lower altitude than reported) due to the quick recovery action of both pilots. This recovery action however, resulted in the over-torque condition."

In my view, the quick recovering by the pilots is very important. In their case, that quick recovery amounted to 36 seconds, which is not quick in comparison with the recovery period of eight to 12 seconds that Captain Sellars achieved in an incident lasting 38 seconds in all. He was faster than the previous incident.

Asked to comment on the causal factors listed in SG#6 (p. 9), Mr. Davidson observed:

The Chief Pilot at the time instituted some training to ensure that the crew had a safe return to flying. They used it as a learning event for training other crews.

Mr. Davidson's attention was directed to SG#7, the data relating to Mr. Sellars' Flight 851, July 23, 2011. Asked what pilots expect when, on take off, they engage go around, he said:

They expect the speed to go to 80 knots and rate of ascent to be at 750 feet per minute and to keep the wings level. What is different in this incident is that they are starting from a very different flight regime. They were in a straight level flying taking off from the deck initiating a climb out into cloud and had not yet coupled. They were low and slow and trying to climb when the event began. My understanding is that they were doing an SOP departure; that is to say, at 55 knots and they selected to go around at the proper time. That is where the incident starts. There was no delay in engaging the go around. They were at 400 feet and stabilized and at 80 knots and an increasing rate of climb. The significance of the change is it takes you farther away from the edge of the envelope. It makes it easier for the machinery to maintain the decisive parameters if you are already at them... The significance of the changed SOPs is that it makes for a more consistent and safer engagement of the machine and a more predictable outcome.

On the expanded data graph of the incident in which Mr. Sellars was involved (SD#7), 1.9 minutes, 115 seconds, I take the start of the incident to be where the speed is 67 knots, the airspeed has stopped increasing, that is where I stop the clock. Within twelve seconds or less prior to maximum pitch, when the nose drops rapidly, the event finishes 26 seconds after that. They start to recover into a stable hover and the torque comes to normal, 38 seconds has elapsed. It takes 12 seconds or less before they start to recover from the start of the event. Maximum torque is 133% on this chart, but it takes a lot shorter time to start the recovery and to bring the event to an end than in the other two incidents.

Asked to comment on the computer animation of the Flight 851 incident based on HFDM data, and specifically on its accuracy as a portrayal in the incident, Mr. Davidson said:

It's not a movie or a picture of the event. There are several things that are not portrayed accurately. First of all, there is no accurate representation of how you are pitching or rolling. It does not show how the instruments normally fluctuate and how we steer the aircraft as heavily oriented to three magenta cues telling the pilot what to do. When a mode is engaged, if the pilot has a move or an action then the colour will change on the eyebrow lights. That does not happen in the animation. Third, the wind direction indicator is displayed as always on the nose, but that is not possible. Fourth, there are inaccuracies in the direction shown. And finally, fifth, the magenta bug for 80 knots does not appear, or does not appear until much later.

Reminded that Mr. Gerber had testified that the crew should have returned to the rig because of the over-torque, Mr. Davidson said:

Yes, if they were aware of the over-torque, certainly they should have. In my own experience we over-torqued an aircraft twice, but there was no indication in our aircraft that we'd over-torqued. The next morning the over-torque was picked up by the mechanics. I was called in and asked to explain. I had no idea when or what the power setting was. It was a runway take off. The co-pilot also recalled no over-torque. We had max gross weight, and obviously did not watch the over-torque indicator.

Asked to compare the 2007 and 2008 incidents with Mr. Sellars' Flight 851 incident, he said:

Mr. Sellars' peak torque was not as high or as sustained as the other two, but the chart suggests the same duration.

It was pointed out that Mr. Gerber had testified that there are three ways pilots can know about an over-torque. Mr. Davidson said:

Yes, a blow away is the best, unless you are operating with both engines. You won't identify a low rotor warning with two engines going. Mr. Gerber also referred to the torque gauge and, yes, it is an instant readout and changes colour from green to caution to red. So if you are looking, at the lower left hand portion of the display, it should reveal and call out the target torque for departure. But, after that, no one cares to check. Mr. Gerber also spoke about WOW, or weight on wheels. I've never seen it in flight. It would affect Boyd's decision-making if it did. After the flight Mr. Sellars flew the aircraft back and landed normally, and they discovered the maximum exceedance. There was no damage to the aircraft and it was returned to service.

Mr. Davidson was reminded that Employer witnesses had suggested the unusual attitude had been due to some pressure on the controls. Mr. Gerber and Mr. Perry had both said that any pressure would cause the go around not to engage properly. Mr. Davidson was asked if that is a known problem with the go around prior to this incident. Mr. Davidson answered:

Yes, but in a different way. During my line check with Captain Roach, I engaged go around at low speed and the aircraft nosed over. It was very uncomfortable. Mr. Perry suggested that you have to be careful with the go around, & it is better to fly it up to 80 knots and engage it there. That's what I chose to do from that incident on. I think it is important. The S92 is very complicated, very automated. There is a lot of functionality. I do read all the documents, but I have to physically see it and experience it. That day did it for me. As of July 23, 2011, if I had not experienced it, how would I know? Word of mouth? There was no warning in the SOPs or flight manual telling me to release all pressures before engaging go around. Shortly after Boyd's incident the "must read" had it, and it was in the next iteration of the SOPs, I believe.

Mr. Davidson was reminded that Captain Perry had said that one of his problems with Mr. Sellars' conduct on July 23rd was that there had been "little or no effort to recover the aircraft." Mr. Davidson said:

I don't think that's an accurate assessment of the effort he was putting in. The controls were moving continually, pitch and roll, and I believe he never gave up. He was manipulating the controls from the moment the incident starts and 12 to 28 seconds later, it's over.

Asked if in his view it was clear that either Mr. Mugford or Mr. Sellars or both were planning to ditch the aircraft, Mr. Davidson said:

That's not consistent with their statements or what they discussed with me. I was first to see them. I was on SAR duty. I was sitting there waiting for them. They were the last flight of the day. I asked the question about what happened. They never gave me any indication they felt it was going to be ditching.

Mr. Davidson was reminded that Mr. Perry had said he could not come up with a training plan to address the way in which Mr. Sellars had performed. Mr. Davidson answered:

Yes. Basically, when the earlier event occurred in 2008 with the unusual attitude more erratic, and the violation of the SOPs, and the misuse of automation, they could get ground training and management. So, clearly, the training options salvaged those pilots after more serious, longer and more nearly tragic incidents. That's what you have simulators for: to give pilots more experience in critical situations. That's what upset me the most on the day that Boyd was fired, and Glynn stopped flying: there was no opportunity to prove themselves in the simulator. My performance after (time) in the simulator... was better.

Mr. Davidson was asked what, if anything, Mr. Sellars had done wrong on July 23rd, and what he could have done better, he answered:

He violated no SOP, and none of the flight manuals. He didn't violate anything at the time. He would have done better to do what we now do as standard procedure in the SOP. The Chief Pilot did a good job describing what actually happened. Boyd engaged the go around, and moved his thumb an inch to neutralize trim. What we now have is neutralized trim: eliminate all pressure, and then hit go around.

Mr. Davidson was asked about his understanding of Mr. Mugford's qualifications. He said:

At the time I knew he was a high-time pilot. I assumed he was a high-time helicopter pilot, but that is not accurate. Over the last several months I have learned the vast majority of his time is on fixed wing, but that he had no time on helicopter when he joined Cougar. He got that after joining the Company.

In hindsight, to me, that is very surprising. I was frankly shocked to hear there was so little helicopter time. On the afternoon Boyd was fired, I made the comment that I thought this was the "‘A team’ – 36,000 hours in the cockpit." Pat stopped me and said, "Scott, they weren't the ‘A Team’." Over the last months I've learned he had not even 1,000 hours on helicopter, and only 180 hours physically controlling... And then he is put in the position of flying the world's most automated helicopter. He has great credentials for fixed wing. He couldn't fly tourists in a Bell, and he's flying workers back and forth in the world's worst weather. I can't explain why a crew pairing policy wasn't passed on to Pat by Ronnie. Guys like me getting crewed with someone with that little experience ... and it was Boyd ... and he got fired.

Asked if he knows of anyone else being hired with so little rotary-wing qualifications, Mr. Davidson answered "none that I am aware of. " Asked about the skill sets employed both by fixed wing and rotary wing aircraft, Mr. Davidson said:

The skill sets for a fixed wing are not really directly transferable, at least not at slow speeds. Most helicopter pilots have at least a few hours on fixed wing, but when you get to helicopter school you start again for what makes helicopters unique. Certainly there are parallels – and he's got loads of off-shore experience in bad weather – but below 150 knots is where we work.

ON CROSS EXAMINATION, Mr. Davidson was asked if, while qualified as a Flight Safety Officer with the Military, he had ever known a pilot to have his wings taken away. He said: "Yes. One I know of was for narcotics." Asked if he was aware of anyone having lost wings for poor judgment in flying, Mr. Davidson answered:

I am sure there are examples. In my experience, there are more who kept their wings who should not have. What is too frequent is for helicopter pilots to be awarded their licenses and then not succeed, and get sent back to fixed wings or easier helicopters. Certainly, I've seen the judgment made that a pilot was not going to fly. I have been involved in a criminal investigation, but where the activity could not be proven. And that pilot is still flying today, and should not be. I also acknowledge that wings can be taken away other than for loss of credentials, and that there are situations where you have to make judgment calls. Certainly, safety is paramount.

Mr. Davidson also confirmed he'd been involved in discussions about terms and conditions of employment.

Yes, the committee meetings (SD#8) dated December 20th. Yes, that is the meeting that I read about when I got back in January.

Asked who was elected during that meeting, Mr. Davidson answered:

There was no formal election. My own position now as Chairman of the Pilot's Union was the first formal election. The rest were casual. It was a case of 'silence is agreement' that we were selected as the two pilots' representatives. We put our own names out there, got no negative feedback, so we carried on.

Asked how many pilots attended that meeting, Mr. Davidson answered

It was on Valentine's Day, which was a poor choice of date. The meeting was attended by e-mail... I don't know if I still have it, but as the months progressed and conversations continued then after the December meeting we agreed to establish the team... I was not at the meeting. I very much favoured the team approach... The document I forwarded from CEP (JG#1) was dated in November, so the month prior to the December meeting. Notice for the December 20th meeting was sent out using the Cougar Ops computer, so the information got out... Someone might have thought that the Company was calling it, so we clarified that. Perhaps reasonably, management told us to clarify it (SD#10).

Asked if, really, anyone could have got the information about individuals' names, addresses and so on, Mr. Davidson said:

Yes, in hindsight the fact that I made an issue of it made my job harder in the last year. The meeting on February 14th was just for pilots. We only got 11 touring pilots, and three or four more on the phone, out of 55 pilots. Only pilots were involved because the intent was to meet with management on our issues... I can guarantee there were also meetings of other groups. We had about half of the readily available pilots. On February 14th we were interested in pilots, but later on we combined with the... other groups... And all were represented in the March meeting... Yes, SD#9 is the minutes of the poorly attended February 14th meeting. Most of these issues did make their way into the March and June meetings. For example item #12 concerning *per diems*: the Company recognized this, and there was an early adoption of the process. It was encouraging for the June meeting...

Mark Chapman was Secretary for the meeting. He'd been involved in the process from the beginning. He was present at some of the meetings and he assisted me in various ways and also Tony Russell. Mr. Sellars attended by phone, yes. As of February 14th, the group was still looking for a second pilot representative. Boyd said he'd do it if we could not get anyone else... I was Chairman, and still looking for a second rep.

There was a meeting with management on March 21st and 22nd. SD#11 is the document that I gave management setting out the issues to discuss in the following nine pages. The meeting involved internal representatives of all the groups. SD#9 is the summary of pilot's issues. It's a shopping list: some were prioritized to start discussion on the 23 topics, and that morphed, after some

discussion, into a prioritized issue list, at the top of which is safety (SD#11 p. 1) The various headings were carried through to the June meeting, based on what other groups wanted. Paragraph #3, "Compensation and Benefits", SD#11 p.4ff) may be the document used at the March meeting.

Mr. Davidson reviewed the list of safety issues (SD#3) indicating which had already been resolved and which had not been resolved by the June meeting

... on pay and benefits there was a major effort between March and June, and this became the agenda for the June 9th meeting. I probably gave this document to Management on June 6th for the 9th of June. In effect, this whole document was a summary of my working notes to take to the meeting. The compensation issues formed a document of its own. I actually set out for Greenland between the 2nd and 9th of June. I drafted SD#12 immediately after the meeting on the 9th of June. I wrote it in Greenland. I was on a speaker phone, and put together a rough draft and circulated it. They gave me feedback, and I circulated it to Hank Williams for approval as accurate, which he did.

There was agreement in June to meet, on a quarterly basis, on September 9th, 2011. Pay issues were to be worked on... On June 9, 2001 Cougar was saying 'we can't pay you', not that 'we won't'. I recall that. We were still in the second Greenland season after a difficult winter because we agreed for a certain number of Greenland contracts, and there was no work. The Company was carrying a lot of inventory. The Company had been good carrying people with pay, and Cougar was also saying that they had fixed-price contracts with the off shore. I think Hank said that. And the agreement was to try to make pay-related progress for the September meeting.

Asked if the employees believed the employer's position at the meeting or not, he said:

Our estimate is we were about 50% behind the industry. Our estimate is that we had got the contracts because they'd underbid the competition. That was Cougar's history up to the point, and it continued... Yes, there was some progress, and yes, progress does not happen overnight. At the end, we agreed that the next meeting would be held on September 9th. So did I for the next few weeks...

I wrote RM#5 at 6:41 Greenland time on June 9th... The overall view was that the meeting did not go well – based on what I learned from the others after the meeting – despite the fact that there'd been a number of points of agreement and that employees had been kept on despite bad economic times for the Company...

Asked when the minutes (SD#14) had been forwarded to Mr. Williams for approval, he said:

It would have been after the e-mail. My job was to portray accurately what had gone on, and I think Hank approved it. It did not reflect the emotions and anger of those there in person around the table... No, the disappointment was not directly expressed to any of the management group. Most of the discussion was

between Hank and me on the phone. The rescue specialist and dispatchers were the most unhappy. They are the lowest paid... The meeting was an attempt to honour the December meeting's intent to try to get things resolved. We had done the ground work in March, and that work went into the document we prepared for June to get us on par with industry. The Company was adamant that it was unable to address dollar costs...

Then things started to change. The Company did not address any of these issues; and, furthermore, there was a disciplinary issue in Halifax. Two pilots were disciplined for a runway incursion. That's when a vehicle or a person or an aircraft proceeds out on to a runway.... What happened on the 8th of July in Halifax was that Cougar had just moved to the new facility, and it was the first day after the move. It is a confusing area, one of the most frequently regarded as a hot spot for incursions. More than 20 airplanes had similar incursions including Air Canada, and now Cougar in the last year. Cougar demoted the Captain and sanctioned the First Officer with a financial penalty. They were interviewed here in St. Johns by Mr. Gerber and Mr. Pat Perry. Mike Godding told me he lost his captaincy and Mark Whitby was sanctioned. The way ahead for Godding was a review in six months and pretty intense scrutiny of the First Officer's in-flight performance. Both pilots resigned in the next few weeks and are working with another company... Incursions are not a good thing, I agree fully; but the Company has a responsibility to tell Pilots about new specifics. ... I don't know if that had been done at the new hangar.

Asked if the circumstances of discipline were known at the time to the pilots group, he said:

No, I did not say that. I did not know them personally very well... Myself and Shawn Holland almost did an exit incursion. We did not get an incident. It was not an active runway at the time, and we were oblivious to the fact that we'd covered the short line to the last runway. I could understand how the incursion happened.

Mr. Davidson was asked if, after July 8th or 9th, the process had started to go forward with certification despite agreeing to hold a September meeting with management as recorded in the June minutes. Mr. Davidson said:

That sounds right, yes... After the meeting in June, when I was in Greenland, I became aware of OPEIU from a pilot who had been a member. I googled it, and late in June, the Canadian rep, Mr. Darshan Nair, made contact. He was my point of contact. He called me, either in Greenland or when I got here. He told me the details of how they got certified and cautioned me on what is permitted legally and what is not permitted. The International rep sent me the application forms by about the middle of July, earlier than the 23rd. I had the paper work, if we decided to go that route, weeks earlier.

Boyd and I started to look at the names on the list. July 9th was when we started signing people up. Before that we were doing research to provide information to people about the process. I had to do the research. After the 9th we proceeded with registering... actively after the discipline and resignation: that is to say, between the incident and their being brought to St. John's and when they quit the Company. It became clear that our jobs are as secure as the next flight. The incursion was on July 9th.

Up until June, the plan was for a September meeting with management; but some time in July the timetable changed... Yes, I left CHC in November of 2008. Yes. At the time, CHC was being organized as a union by OPEIU. I knew they were getting organized, but I didn't know which union at the time, and there were legalities being debated.

Asked what kind of confidentiality, and from whom, the International Representative said would be needed, Mr. Davidson answered:

Basically from management. We were not trying to hide, but to protect our rights and our privacy because of the definite threat. It protects the people involved.

Asked how he learned he'd not been successful in securing confidentiality, he answered:

I think we were doing OK in June... before we started signing people up on the 20th or 21st of July... immediately before Mr. Sellars' incident. Boyd and I were basically planning for the worst and hoping for the best as we had been all along. The purpose of the June 9th meeting was to present the employee pay and benefits document. The March document had taken care of non-financial issues, and for five hours all of those issues were turned down.

[Mr. Ellickson interrupted to object and asked that the witness be excused.

Mr. Ellickson challenged the relevance of the line of questioning about the decision to unionize. The issue of timing is relevant, but issues related to the June meeting are not relevant, in the union's view.

Mr. Smith, for the Employer, responded that the Union has taken a position that his organizing activity led to Mr. Sellars' termination. That issue must be explored to understand what triggered the change from working as an association and the decisions to unionize. Where did the trigger for that come from? The employer does not wish to tip its hand at this stage. Whether it was in July at the Halifax incursion, or at some other point, we must determine, so as to find out whether Mr. Sellars was involved in the push for unionization and whether the Employer knew of his involvement, if any.

Mr. Ellickson responded that the Union agrees that Mr. Sellars was an organizer and also agreed to the timing as so far laid out in evidence, but hopes the questioning can proceed in a rather more focussed way.]

Mr. Davidson returned to the room, and his testimony resumed.

I did some research while I was in Greenland. Mr. Sellars was not with me. I was doing this solo, because the OPEIU pilot who was familiar with that Union was with me. That started toward the end of my tour in Greenland. Contacts were by phone and e-mail, and the only meeting was after certification in February 2012. During this period, from the end of June to the 23rd of July, everything was by e-mail. Most was with the OPEIU website and with Mr. Nair via the US website. They were providing information on background to the process.

Asked if there had been any meeting held with Pilots during this time, Mr. Davidson said:

No... The research continued up to the Halifax incident and that discipline, which upset the pilot group as a whole. That is basically when Boyd and I looked at each other and said 'We've got to do this. They're doing nothing on pay and benefits, and are bringing unnecessary discipline.' That was the catalyst.

Mr. Davidson confirmed he had taken up the leadership of the Union and Mr. Paul Traversy

... was the Vice-Chair. There were two representatives from Halifax, but all of this was after ratification. Up to then, there had been no formal election. Mark Chapman was one of the three in St. John's... As of June, there was no particular Union identified. That's correct, I'd never heard of the OPEIU.

Asked when they had reached a decision that action was required, Mr. Davidson answered:

The day I learned of the inappropriate level of discipline; Boyd and I found it inappropriate.

Asked if he had raised this concern with management, Mr. Davidson answered "No, sir."

Asked if he'd done anything to suggest he was leading the pilot group at that time, he again said, "No. Most of the discussion (SD#s 8-12) took place between Hank Williams and myself." Asked if he wanted everything to be kept confidential, Mr. Davidson answered: "No. I did not see there was anything to gain by it." Asked what it was that made the Employer aware that he was organizing, Mr. Davidson answered:

I have no idea when they became aware specifically, but there are certainly a large number in the pilot group against it. It would have got back.

Asked to describe aspects of Mr. Sellars' involvement, about which management would have been aware, Mr. Davidson answered:

It was the minutes from December 20th (SD#8). The minutes would have made perfectly clear what the option was.

Asked if management would have been aware that Mr. Sellars was involved in the OPEIU and if the December 20th minutes is the only evidence, Mr. Davidson said:

Yes, that's the first meeting that the Union comes up. Boyd Sellars was the original guy. He also looked management in the eye for five hours in June.

When it was noted that Mr. Davidson had just testified the conversation had been mostly between Mr. Williams and himself, he said:

Yes. Most of it was Hank. He was chairing it. But yes, I prepared all the documents so I was better prepared to ask the questions. We were planning for September as the e-mail and minutes both show. If nothing had changed, we'd have gone focussed on June 9th. Halifax was the start of radical change.

Asked to identify what part Mr. Sellars played in the drive during the period from July 9th (the Halifax incident) to July 23rd, Mr. Davidson said:

He was actually canvassing those on the lists and sending them to me from July 21st on. After the Halifax incident and the discipline, he and I started talking to people: 'yes, no, maybe,' and them asking me about the strategies. If we did not think we did not have overwhelming support after the Halifax incident. We felt we had 80%. So on the 21st and 22nd of July, the first person came to me. I did the bank account and other documentation. We only made contact with those ones we were very sure about. After June 9th, there were a lot of questions, and I had to get the answers. From the 9th of June... it became an all consuming activity for two years. After the 9th of June he knew better than I did where the support lay. He started recruiting, and I started administering.

Yes, my first OPEIU contact... occurred on 20th and 21st July... when I spoke with Darshan (Nair) (SD#13, p.4 of 10). Yes, that was the first contact by phone. A lot of research had already been done from Greenland. By the 20th of July we had determined that OPEIU was to be the union... I'd had no reason to talk to Darshan until that issue was determined. The other pilot was doing the work for me. I had the application document to execute. This (SD#13) is a very accurate document, I stand by it all.

By July 20th I have returned from Greenland. The first phone call is made by me on July 20th. As SD#13 (@ p. 5 of 10) shows, I am the contact for signing on Friday (July 22nd). I was administrator doing the signing. Boyd was sending people to me... As we started the drive, the Union became very active very quickly.

Mr. Davidson' attention was drawn to SD#13 (@ p 8 of 10) where he writes (in his Sept 13e-mail to Mr. Ellickson)

"Boyd was not very involved in the organizing and collection of applications after his incident of 23 July; it ceased completely after he was fired."

Asked whether Mr. Davidson would not agree that the only evidence of Mr. Sellars' activity prior to his firing is Mr. Davidson's own e-mail on SD#14 (@p. 5 of 10) where Mr. Davidson writes "so far, I myself have 16 cards signed out of 18 interviews since starting this on Friday ..." and that evidence relates to his own, not to Mr. Sellars', activities. Mr. Davidson said:

After Mr. Sellars was fired, he had no activity relating to cards. Prior to the 23rd, he was highly involved.

Mr. Davidson confirmed that the e-mails refer to the start of the sign up as being Friday the 22nd, but pointed out that...

He was not signing cards. He sent them on to me to give me the dollars. It takes 20 seconds... by the 22nd, I'd had 16 of 18 signed up; by the 27th, I'd had 27 out of 28 people. That was the day before Boyd was fired. It was going extremely well on Wednesday the 27th.

It was pointed out that there seem to be no e-mails originated by Mr. Sellars, Mr. Davidson answered: "You have what I had."

Turning to Mr. Davidson's earlier testimony concerning Mr. Mugford, Mr. Smith asked if he thought it was inappropriate to have a fixed-wing pilot flying helicopters. Mr. Davidson answered:

I would not say that. The issue as I came to understand it from July 28th on, is that he had no helicopter experience... Yes, he was fully briefed and checked out. I would say that 200 to 250 hours experience in helicopter is all he had, whereas the OGP requires 500 hours and Mr. Mugford had 200.

Mr. Davidson's attention was directed to PP#1 which reports that Mr. Mugford had 804.8 hours as of 2011. Mr. Davidson said:

Mr. Mugford stopped flying after the incident, so by the time of the incident he had 804 hours not 200. I am telling you what he had when he was hired, not what he had at the time of the incident...

Mr. Smith asked: "If OGP sets the limits and minimum standards, and he was flying, can we assume that he had the minimum standard required by them?" Mr. Davidson said: "Yes, if that's the case." Asked what Mr. Mugford had done wrong during the incident, Mr. Davidson said:

Glynn did nothing wrong. He was doing the job he was hired to do, based on his experience. I had the job after 5,000 hours flying for the Military. For a guy to walk across the airfield from King Air to get a job with Cougar... He's a great fixed wing pilot. Fantastic pedigree. I'd like to know why they hired him.

Asked if Mr. Davidson has ever heard of local hiring preference, Mr. Davidson answered:

I don't know. The only thing I'd criticize Mr. Mugford for is his verbal cues to Mr. Sellars: a very minor point, but with big significance. He was calling "pitch and air speed": great calls, except that in an S92, other calls might have been made. It's all in the report, torque, heading, vertical speed. He never mentioned torque at all, and never mentioned vertical speed.

Mr. Smith asked if Mr. Mugford had "screwed up." Mr. Davidson answered:

No, not at all. It's a typical human reaction: you do what you are trained to do. His training was in fixed wing. The critical calls about critical speed were not made, due to his fixed wing experience.

Mr. Smith pointed out that the automation called "Don't sink." Mr. Davidson answered:

Yes, and Mr. Sellars acknowledged that. Mr. Mugford's calls for air speed would mean that you're descending; it does not necessarily mean you have inadequate power.

Asked if, in his opinion, Mr. Mugford could have done more, Mr. Davidson answered:

No. I am trying to say that a more experienced helicopter pilot could have done more. Mr. Mugford was doing as much as he could. I am not aware of any restrictions on him at all at the time of the incident.

Mr. Davidson confirmed that on the 23rd, both pilots walked into the hangar together and he chatted with them about the incident. Asked how they described incident, he said:

Basically, what they described is consistent with everything I have seen in the documents. They described a normal departure from the Sea Rose after an uneventful rise from that point, and pitching up after Boyd engaged go around. And he remembered as they descended to the water which ended in a hover when all the gauges were normal on the panel and they did not select go around on the second departure because it had caused a problem. I remember shaking his hand and saying 'glad to see you'.

Mr. Smith commented that the matter did not sound serious in the way that he described it.

Mr. Davidson answered "unusual attitudes are always serious low, over water especially."

Mr. Davidson's attention was drawn to SD#s 5, 6 and 7. He was asked whether it would be fair to say his conclusion was that one of the previous incidents was longer and more serious than the incident on the 23rd of July. Mr. Davidson answered: "It's an indication of the difficulty in recovery." Mr. Smith pointed out that Mr. Perry & Mr. Gerber had both testified that all that was needed was to get the nose down. Mr. Davidson answered:

Yes, I agree. It's one of the situations where low speed, left unattended, you would sink unless you have power up... The initial nose up starts the event.

Mr. Smith pointed that what is unique here is that the helicopter is below the helideck and asked if it is not the case that you have to nose up in order to climb. Mr. Davidson said:

They aggravated the situation by pushing the nose too far. All they had to do was pull power. They did pull power up to 118%, and at 150 feet above the water he gave himself more speed and lift. He put the nose way too far down, putting it below zero... They did recover, but all they needed to do was pull power. If they did no more than wings level and pull torque. If they did that, that's when I labelled it as starting to recover. Again, the pitch, the power / torque of a fast approach; the torque is being overridden to slow the aircraft down. He is mishandling the automation. You can slow down either by pitch or by power. It was a very experienced Co-pilot who was flying. The Pilot Flying "lost it." The two profiles of these two incidents are virtually the same. It's slightly different where they pull power. The Pilot Monitoring had to get his head back into the cockpit as it should be all during the flight: looking at the instruments and actively monitoring. SD#5 and SD#6 are slightly different. In SD#6 the pitch is corrected first and then, after a delay, the power is pulled. There is a nasty unusual attitude and the Pilot Flying lost it for at least 36 seconds.

In Mr. Sellars case, SD#7, there is a difference. This is departing from the platform. It's an SOP departure. Everyone is aware, of course, of Cougar 491. That was a terrible shock to all. One other difference was that it was night flying. All pilots still maintain night capability... Everything changed after 491. The unions wanted a new helicopter. Then the July 2011 incident happened two years after 491. The expectation was that, one more incident and we were out of business.

Asked whether, this year the Company had begun to crack down on breaches of SOPs, Mr.

Davidson answered:

Other than the runway incursion, this was the first harsh discipline on an aircrew... Yes, the incident in Halifax could have been a disaster... but the discipline needs to be appropriate and proportional. It is critical that the punishment fit the crime. In these cases, it was way out whack.

Asked if, in his view, termination is unfair in any case, Mr. Davidson answered:

In the two previous incidents, SOPs were violated.... In Mr. Sellars' case, no SOP was violated and there was no obvious discipline issue here at all. Based on the evidence, the first two were treated properly and in accordance with Cougar policy.

Asked whether this takes account of a crack down after 491, Mr. Davidson answered:

There is no obvious crack down before, or after, 491. There is no harshness until July 9, 2011 and then July 23rd.

Asked to compare the various incidents, Mr. Davidson said:

Pitch and torque are the two problems. In that sense the profile is the same in five, six and seven. I'd say that SD#7 is more similar to SD#6 in that pitch is corrected first and then torque. Different time scales are used on the three charts, SD#7 has a time scale of 1.9 minutes where SD#6 covers 2.6 minutes, which does not provide an easy comparison as to the recovery process.

Mr. Smith said he was proposing to call rebuttal evidence on that point. Mr. Davidson said:

SD#5 and SD#6 are also on two different scales; and SD#7 shows a slower, more deliberate correction. At 118% of torque the pilot has then taken control of the aircraft, slowed the descent, and it shows the correction that has started 22 seconds earlier.

Mr. Smith suggested that this is a matter of judgment, and that the aircraft had, in fact, simply fallen out of the sky. Mr. Davidson said: "I disagree with you." Asked if the torque begins to be pulled at 200 feet, and Mr. Davidson said: "Yes at 200 feet." Asked if 200 feet was actually the ceiling on that day, Mr. Davidson answered: "That's what the report said; but that 200 feet is over the deck height."

Mr. Davidson was asked if one would not engage go around, normally, before reaching 55 knots, and what the usual result would be of engaging go around at 55 knots with the basic rate of climb. Mr. Davidson answered:

Assuming continued acceleration at 55 knots and objective of 80 knots... With power, typically, you should have the power bug set so you would expect torque to go to 750 feet per minute. As you go through Vtoss, you bring the nose to the horizon. That's the acceleration attitude. Then you touch the grey button and the queues come down for the nose and it goes to normal pitch attitude of seven or eight degrees for normal of 80 knots. Magenta lines appear when go around is engaged, or when pitch or roll is automation-driven. That's when the computer is displaying the information.

Asked, with reference to SD#7, when one normally expect the guidance system automation to decouple, Mr. Davidson answered:

Looking at SD#7, where I have labelled the event starts is the point 84092, and that's where it's decoupled or a couple of seconds earlier perhaps, at 67 knots. I would not have expected it to decouple when it comes through 50 knots. Normally, it would decouple when it goes through 50 knots, yes; but in terms of this

particular event the start of the event is very close. It bleeds away below 50 knots and at 37 knots the speed on the graph reaches that at 84094 plus.

Asked what happens when the air speed drops in an automated situation, Mr. Davidson said:

It's trying to go to 80; but apparently Boyd did hit the trim, and changed the speed to the current speed, the one he was going. Based on what Captain Perry told us, the simulator program was using HDFM data, so you have to look at all the data and interpret the simulation in terms of the data... Yes, the simulation is a creation; it's easier to interpret than those graphs... I identify recovery at 804104 and that is the same point on all three graphs: that is, when the nose starts stopping going in the wrong direction.

Asked if SD#7 shows the pilot doing anything, Mr. Davidson said:

Yes. At 22 degrees of pitch, 60% of torque is a good setting for straight level flight. The problem is the pitch factor is forcing her to lose lift.

Mr. Smith interrupted and asked, "In other words, they're in a fall?" Mr. Davidson said:

It's not a fall. It's not 2000 feet per minute. When the nose went down, they were still climbing at 750 feet per minute, and they do so for the next six seconds... The vertical speed is zero when they stop climbing. Decent starts at 84105 plus three or four seconds. The vertical air speed stops dropping at nose-over, yes... The RadAlt is accurate, but VSI (Vertical Speed Indicator) lags behind. The nose keeps going down for some time while the power goes up. There is more power pulled between 84117 and 84128. The torque travels at about 80 which is normal heavy torque at that weight. Then the event ends at 84130. They depart.

Mr. Davidson confirmed that there are three ways to be informed about over torque. First is the gauge on the panel, second is an audible tone of low rotor, and the third is WOW (weight on wheels). He confirmed that the low rotor sound or the torque gauge could have told Mr. Sellars of the over-torque.

I agree. But in training you never hear the low rotor come up with both engines working. You do hear the low rotor tone in a single engine session. It's another hum in the air.

Asked if there is a difference between being in a simulator and real life experience, he said:

In a simulator you have no fear, but something very close to it ... but you don't die. That's the point.

Asked about a meeting in the staff house involving Mr. Chapman and Mr. Sellars, he said:

Mr. Chapman was there. Boyd was back and forth to the house that week. If he came to the crew house that evening, we'd already talked about the incident. I don't recall the conversation Mr. Chapman related. I don't think Mr. Mugford

was there that evening, but Mr. Mugford was involved in the conversation in the hangar.

Asked if the issue of his having failed to file a report with the Company come up that evening, Mr. Davidson said: "I am pretty positive they filed it before they went home." He was directed to PP#9 the SMS report dated July 23rd. Mr. Davidson, said:

Yes, I've seen it several times... That is their due diligence. I knew the next day that the Director of Flight Operations asked each pilot to submit a statement to Curtis Savidan, who was not aware of the report... I was not aware of the request from J.J. to both of the pilots, at the time of the meeting in the staff house.

Asked why he did not supply it until the next day, Mr. Davidson answered:

Because it was a long day? PP#9 was the incident report they were required to submit to management. I think the letter to Savidan was the letter requested, and was submitted soon after Boyd knew of it.

Asked if he could say how much of Mr. Sellars' experience in helicopters was in S92s, Mr. Davidson said:

He joined cougar in early 2008: so, at the time of the incident, the mathematics says "three and a half years."... He made Captain in October or November 2010; that's seven or eight months before the incident.

Asked for an estimate of Captain Sellars' balance of IFR v. VFR experience, he said:

Look at PP#1. In light helicopters there is not much IFR. You have to have instrument training in instrument conditions... Mr. Sellars had 341 total S92 Pilot in Command hours out of a total of 1199 total hours, and there were about 860 hours as First Officer on the S92... As far as I know, Mr. Mugford only flew S92s with Cougar.

Asked if he would agree then that there is about 400 hours difference between the two in their flying of S92s, Mr. Davidson said:

I am not sure that is significant to what happened, but I agree I testified that the S92 is the most highly automated helicopter.

ON REDIRECT EXAMINATION, Mr. Davidson confirmed that SD#s 5, 6 and 7 are the Company's data sheets, not his own. "I cannot vouch for their accuracy, not based on what I've seen. There are discrepancies."

Asked to look at JG#6, Mr. Davidson was asked whether "light drizzle" constitutes good weather. He said:

At JG#6 (p.3) visibility is registered as 15 miles which is as good as they report. At 140 knots, light drizzle could affect visibility at night as is noted (JG#6 p.6. the first bullet). In all three cases, all incidents were under instrument flying rules and methodology: in SD#5, instrument flying rules in visual conditions; in SD#6, instrument flying rules, & in meteorological conditions in SD#7. All three were recovering from unusual attitudes.

Mr. Davidson confirmed his earlier testimony that:

Getting the nose down too quickly is not a good thing as is seen both in SD#5 and SD#6, especially at 150 feet above water as it was the case in SD#5. With a significant nose high, it would have been better to get nose over, but not so far as they did. They went farther than they needed to.

In SD#6 they start recovery at 27 degrees of pitch at what the line shows as 450 feet. That is not far below what they should be, so they had time to get the nose where it should be. There's a link to speed, so for the S92, it's whatever gives you 80 knots and, typically, seven or eight degrees. When you get below that and get to zero you speed up. Setting the nose was one of the parameters.

The standard procedure now is 80 knots, nose on the horizon, and level wings. That takes you up. SD#5 shows that the aircraft attained 21 degrees of pitch and bottomed out at -7 degrees, and they achieved that in 13.2 seconds.

Mr. Ellickson pointed out that Mr. Smith had suggested that the nose up at that point was an attempt to get on to the platform. Mr. Davidson said:

We discussed pitch and climb. Using pitch to decelerate without change in power setting is misusing the aircraft. That's not an SOP that Cougar approves. They should have been above the deck and looking down at it. Recovery in SD#6 is 23 seconds. In SD#7 the apex is 23° of pitch and comes out to less than 15%. That took 4.5 seconds ... Say five seconds. And then from 8° or 10° or 12° to 3.5° – I'd say that took another eight seconds.

Asked about the runway incursion in Halifax, Mr. Davidson said:

It was potentially quite serious; the one in Teneriffe was... I thought the Company's reaction was out of proportion, not to belittle the event; but they did not willingly go onto the runway, it was just a clearance. If it is a mistake, it's different from a disciplinary matter.

Reminded that Mr. Smith also asked questions about Mr. Sellars' filing a report on the day after the event, Mr. Davidson said:

It was a significant emotional event, and they did what they were mandated to do: put it in the system. That's the point of every Captain's job.

Mr. Davidson confirmed that they had started signing cards on July 22nd (SD#13, p.3).

I'd obtained the blank cards some weeks preceding that, as part of the package of information.

Mr. Davidson was asked who had posed the questions to which SD#13 (@ p. 5 of 10) is the reply. He answered: "Jeff Rusich. I cut and pasted his questions into the e-mail." Asked if the questions had included one about who the organizer was, Mr. Davidson said, "No." Asked where he was between July 20th and 23rd, Mr. Davidson answered, "I was in the Laramer Street crew house." Asked how he and Mr. Sellars communicated while he was in Greenaland, Mr. Davidson answered, "Mostly on the phone. It's easier to talk then type." He also confirmed that one of the e-mails shows that they had signed up 16 of 18 pilots who had been interviewed. Asked how he knew whom to approach for card signing, Mr. Davidson said:

It was based on attitudes and feedback from the February 14th meeting. Then there were frank comments, and me and Boyd had our general knowledge.

Asked what Mr. Sellars was doing the week prior to the sign up, Mr. Davidson said:

He was talking to people. He knew more people than I did, a lot more. He worked with them. Boyd had a lot more flying time on the S92 than me. He flew a lot more with pilots. I was SAR, and didn't have the same opportunity to talk to them.

Mr. Davidson confirmed he had not been aware of Mr. Mugford's flying record:

Not until this hearing. I'd assumed both Boyd and he had 18,000 hours plus. That's highly impressive. The average is closer to myself... I was not aware it was fixed wing. It speaks to experience, and the experience is significant as apples and oranges. Mr. Mugford had no helicopter experience when he joined Cougar.

Asked whether the Company had got a copy of the minutes of the December 20, 2010 meeting, chaired by Mr. Sellars (SD#8), Mr. Davidson said:

I don't know; but I first saw it on the board in the pilots' lounge... and I got a copy from Mr. Smith this morning.

Mr. Davidson's attention was directed to these minutes (SD#8) in particular to p. 2, paras 8 & 9. He confirmed that:

This is an accurate account of the feeling of those present. The consensus was to give the non-union option a chance; but if it doesn't work out this would be not good enough.

He also confirmed that the minutes of the February 14, 2011 pilots' meeting (SD#9) reports that: "I was Chair and Mr. Sellars was attending by phone."

Asked if this document was sent to the Company, Mr. Davidson said:

I don't think it was provided in this version. Not all were in attendance, but it would have been circulated to the pilots first. There's no date on it.

Mr. Davidson confirmed that the "Record of Discussions - 9 June meeting with Management" (SD#12) "was given to Mr. Williams, who approved it, and Boyd Sellars and myself (on the phone) represented the pilots."

THE FINAL UNION WITNESS was Mr. Boyd Sellars, the Complainant who, at the time of his termination, was a Captain in the S92 with Cougar Helicopters, who had been hired initially as First Officer in April of 2008. Mr. Sellars was promoted to Captain on November 4, 2010. He confirmed he had piloted the flight on July 23, 2011 that experienced the incident at the core of this issue. Mr. Sellars is 55 years old, and began taking helicopter courses in 1981 with *Trans-Maritime Helicopters* in Fredericton, New Brunswick. He obtained his licence in Feb. 14, 1982.

He first flew helicopters for Universal, then owned by *Oakenogon Helicopters*, and was hired in October of that year to work out of Goose Bay, Labrador. He was flying

... single engine aircraft, mostly bush work and VFR at that time, doing personal transport: mostly Newfoundland and Labrador Mines and Energy, Forestry, Wildlife and Mining Exploration through the Labrador bush. The 2000 Jet Ranger, on which I'd trained at *Trans Maritime*, was the aircraft used. It is handled by one pilot with effectively no automation.

Mr. Sellars spent 12 years with *Oakenogon Helicopters* as a base pilot, a line pilot. In 1994 he resigned and went to *Canadian Helicopters* working out of Pasadena, Newfoundland. After which he returned to Goose Bay as a base pilot with *Canadian Helicopters* flying AS350

... which is basically a *Eurocopter Astar*. The Astar is also a single engine VFR machine with no automation. The flying was similar to what I'd done at *Universal*. Much of this work involved using a cable attached to the belly of the helicopter, and was used to move drills to remote sites... *Canadian Helicopters* were looking for someone with that skill, and the pay and conditions were better than at *Universal*. I stayed with *Canadian Helicopters* for 14 years, and was captaining a Bell 212, IFR qualified, machine... For 12 years, I was Company Safety Officer. That was a new post mandated to oversee safe operation in the day-to-day for pilots and to ensure they followed their own SOPs. I was asked to investigate any concerns line pilots had in the field, with overall responsibility for safe practice.

Mr. Sellars testified that he had investigated

... three different accidents or incidents. One was in Northern Labrador, which involved a dynamic rollover of an Astar on departure. The second was a tail rotor incident at Valley Inco; and the third was a severe over torque of a Bell.

Asked whether, in his 26 years prior to his work with Cougar, he had ever been involved in a TSB reportable incident or an accident, Capt. Sellars answered "No." He confirmed that the S92 is recognised as a most automated machine, and confirmed that the Astar was not at all automated and "lacked any autopilot like the S92 has." Following his 14 years at *Canadian Helicopters*, he joined *Cougar* in April, 2008.

I'd known Ronnie Moores and Capt. Roach. I'd known several of the flyers over the years. My wife and I were in St. John's on a shopping spree, and I called Ronnie and we visited. He gave me a tour of the Cougar building. They'd just gone from the Super Puma to the S92... I'd known Ronnie for many years and gave him his first helicopter ride. He asked if I was interested in a job, and, a couple of days later I said "Yes." I was looking for a change anyway. So we started talking, and I came on board on April 1, 2008... Then off to West Palm Beach to get checked out on the S92.

Asked to explain what was involved in getting "checked out", Mr. Sellars answered:

Prior to going to Florida, I was in St. John's for two or three days for Company indoctrination. And then I went to West Palm Beach for a month at *Flight Safety International*. The first two weeks were ground school in relation to the S92, and the last two weeks we were in a flight simulator. Then, once we'd completed the program, we normally had some time off, and then back to St. John's for line indoctrination. I was then put on the schedule of rotation as a First Officer. Prior to this, I had never flown a S92 before.

Asked to compare the experience in the S92 with the Astar or the Bell 212, Mr. Sellars said:

We used to talk about the Bell 212 as having power steering, basic pitch and yaw control. The S92 was incomparable. Basically the Bell and the Astar were manual flying, full time: 100 % of the time on the controls. With the S92, on the other hand, in my time we hand-flew for a minute and a half to two minutes departing and arriving, and otherwise it was fully coupled. I was encouraged during training to use the automation as much as possible in order to ensure passenger comfort and efficiency and overall operational results. It's the way the aircraft was designed to be flown. It also provides flight safety... Initially it did not go well. On the first and second attempts, I failed to meet the requirement; and on the third attempt I was with a different pilot, and I was successful in getting my PPC (Pilot Proficiency Check). In June 2008, after line indoctrination, I was scheduled to fly the S92 as a First Officer. I joined the schedule for Cougar.... On June 9th I was put on the schedule.

Asked if he had experienced any issues with the S92 while with Cougar, he said: "No. I was promoted to Captain on November 4, 2010." Asked to describe what the annual recurrent training consisted of for him, Mr. Sellars answered:

Once a year we went to West Palm Beach for a week of ground school and simulation and various scenarios; and then, after this with a training pilot, to proceed to PPC with a different check pilot, and then back to St. John's... Yes, I did have a captain upgrade program with Cougar in West Palm Beach. It wasn't needed for upgrade at that time. I remember not being recommended for a captain up-grade, but then several months later I was recommended after Ronnie resigned and Pat Perry came on.

Mr. Sellars confirmed he'd been involved with the employer association while at Cougar. Asked when he first became involved, Mr. Sellars said:

On or around Dec. 20, 2010. At that time the CEP Union was organizing offshore workers, and were rumoured to have been canvassing individual pilots. It was ongoing for a month or two, and I had a conversation with Paul Carter... We agreed that I'd investigate to see how solid these rumours were, and we found that the rumours were founded. I said maybe we should approach J.J. and get together as a group to see if we wanted it... We did not feel that CEP was a good fit for this kind of company. So we had a conversation with J.J. on the same day, and he okayed us organizing an informal meeting, for employees only, to talk about it in the cafeteria. There were around 50 people showed up that evening. (SD#10)

Asked which groups of Cougar employees were present, Mr. Sellars answered:

Really, pretty well all groups, except for management of course. It was chaired by myself and Pete Bruce. We discussed CEP, and the drive to get pilots involved in particular. Some said, 'yes we were approached'. So we concluded that this was happening, and asked if it was a good or bad thing, and if this was the right union for an aviation company in the offshore Newfoundland. Some operational things in the company affecting various groups came up at the meeting.

Mr. Sellars confirmed that SD #8 is an accurate set of minutes of the meeting. Asked how the meeting ended, Mr. Sellars answered:

It was unanimously decided that CEP was not the way to go. We'd discussed an internal working group representing various groups to approach management, if they were open to that. We got reps from each group and then decided to approach management to see if they were interested... We proceeded to do as stated in the minutes. Each group put forward one or two members for each department, and then we approached management and discussed the minutes and our desire to meet with management to discuss some of what came up from the various groups at the meeting.

Asked who represented the pilot group, Mr. Sellars answered:

Well, at the time, I chaired the meeting with Peter, and the pilot group decided that myself and Scott Davidson would represent the pilots' group in discussions with management.

Mr. Sellars also confirmed SD #9 is the minutes of a second pilots' meeting held on February 14, 2011. He confirmed he'd attended the February 14 meeting by telephone. The purpose of the meeting had been

... to get the pilot group together to discuss issues affecting them only and to discuss if this was the way to go. It was an information-gathering meeting, I guess.

Asked what other options there were, Mr. Sellars answered:

The option of unionization was always on the table, even though we thought that the CEP was unanimously out. But a faction felt that unionization was the only way to go, but not the CEP... We consolidated our thinking among the pilot group in order to find a format for sitting down with management to present our concerns. I was on the phone at the time. It was decided at that meeting that myself and Scott were to represent the pilots. It was decided to go forward with a meeting with management.

Asked what next steps were set out at that meeting, Mr. Sellars said:

To work for a first meeting with management along with other groups, SAR specialists and so on.

Mr. Sellars also confirmed that SD #11 is the

... "discussion items" for the 18th March 2011 meeting with management. It is really the pilots' own agenda as proposed for the meeting with management which was to take place on March 18th... I attended the meeting with other groups as one of the two representatives of the pilots' group... Mr. David Hickey represented the dispatch group. There was a maintenance representative and also a rep from the search and rescue group. J.J. Gerber represented the company and Rene Paddock from HR. I think Hank Williams was there and chaired. I don't know if Pat Perry was there as well.

Asked what progress the group had made at the meeting, Mr. Sellars answered that:

This was the first meeting and the first presentation of our concerns. I guess a lot of concerns were being addressed in that time frame, and within the time frame for the next meeting. So there was not a lot achieved... Nothing was resolved, not to my recollection, no... But there was a further meeting set for June 9, 2011, which I also attended.

That June meeting was chaired by Hank Williams, and I was there as pilot rep. It was a lengthy meeting: six hours. The March meeting was reviewed, and then we moved on to new business. That was basically pay and benefits and seniority, travel accommodations. All that was proposed at the March 18th meeting, but with more detail and corroboration. All departments were represented, and all their issues were discussed, including the point of view of the pilot group... I was frustrated for myself as a pilot rep. Nothing really was being accomplished. I left frustrated and disillusioned. I think we were being given lip service and nothing was accomplished after six hours... Scott Davidson was on the phone from Greenland, and we asked could we stay on in the boardroom to discuss issues, how we felt, directly after the meeting. We did get the room, and carried on in the absence of management for maybe 15 minutes.

Asked if there was a consensus in the room, Mr. Sellars said:

All representatives felt that it was an exercise in frustration... You can only hear 'No' so many times, or 'We can't do it.' Or 'it's not in the budget' so many times.

Mr. Sellars confirmed he had seen SD #12, the first draft of the record of discussions from the June 9th meeting with management. He also agreed that "That document does not reflect the unhappiness I just described ...". Asked if any of the pilot representatives had expressed this unhappiness to the company, Mr. Sellars said:

Indirectly I'd say, yes. The dispatch and SAR groups were really frustrated. One representative was clearly upset, and I had to ask him to contain himself. And at one point, the SAR representative was about to go. It was not recorded... but they certainly responded to Mr. Williams responses... during discussion of the cost of the price of tickets, Mr. Williams said he would 'buy someone a one-way ticket to Goose Bay...' I presume that was a reference to me. Mr. Hickey (and another participant) heard it... I could not speculate on Mr. Williams' thoughts... The decision was to conclude the meeting with a decision to meet again in September... I based my awareness (of frustration) from what was said amongst ourselves. We were frustrated. We decided to take time to think about our options, knowing that we'd decided to have another September meeting with management.

Mr. Sellars confirmed he was familiar with Scott Davidson's summary of the June 9 meeting, e-mailed to the group and copied to Mr. Ellickson on August 8, 2011 (RM #5). It is signed by himself and Mr. Davidson as the "Pilot Representatives." He also confirmed that it accurately reflects his concerns and sentiments.

Yes it's our thoughts with the process, and more particularly with the way to go within the pilots' group, although the other groups did feel the same...At some point at least some pilots had decided that unionization was the way to go.

Asked to why this was the case, Mr. Sellars said:

Near the end of June or in early July of 2011... in a discussion with Scott and other Cougar pilots in view of the frustration with the June 9th meeting, we felt the only option for us was to seek professional organization or unionization to show management that we were serious about our concerns. So many of us decided to seek information. I don't think that it was a single person's decision. I think it was a decision among the pilot group.

Asked what part he had in the unionization move, Mr. Sellars said:

I'd never been personally involved in a union up to that time. We decided Scott would do the investigation, and I'd do the leg work in St. John's on the ground. Scott would do the information-gathering on which type of union would be best. In St. John's, I was getting the views of the pilots on the idea of unionization. Between the two of us, it was Scott in an administrative capacity and me as a sales-man talking to groups, mostly in the crew house and by phone, and pretty much anywhere I could engage any one or more pilots to discuss the unionization and who would best represent Cougar pilots. Mostly it was at the back of the SAR hanger, or in the pilots' lounge, or people's homes, or on the phone. No opportunity was missed if I could manage it that way.

Asked what arrangements were made about the sign-up and the payment of \$5, Mr. Sellars said:

It was done in person, and whoever paid the \$5 got a receipt. Scott Davidson got the cards. One night we got together and signed the cards and paid our \$5. We decided that night whom we would approach and whom we would not approach. We made up a list that night among the group.

Asked if, in his own knowledge, anyone at work knew of his own efforts at unionization, he said:

Yes. In July I was approached by a couple of guys working at Cougar Helicopters who said the Director of Maintenance had showed up... They were surprised... for him to come in after hours; and it was said to me that he approached the boys about the "rumour that the pilots were unionizing." They knew that anyway, but they found it surprising that the Director of Maintenance would come in and ask that. I told Scott Davidson that. We had tried to keep it as secret as possible until we got our numbers and knew that the interest was sufficient. But we'd had discussions with other reps that, in the pilots' group, we were heading to unionization. We felt it was our only option.

Turning to the July 23rd, flight 851, incident, Mr. Sellars confirmed that he was the Pilot in Command and that the Copilot was Glen Mugford. "Yes, I had flown with him before." Asked if he knew of a restriction requiring that Mr Mugford only fly with a training pilot, he said:

I was not aware of that, no. I was not a training pilot, no. Had I known of it, it would have been in direct contravention of SOPs, and I would not have flown because I am not a training pilot. Before we flew, we got a briefing from dispatch that shows any restrictions on a screen in the dispatch: any recent or pending

restrictions. There were no notes to that effect. If there had been it could have prevented me flying as a non-training captain. So we went to the Grand Banks and to the Sea Rose. I Was Pilot Flying leaving St. John's. Enroute we got the weather. Glen flew the aircraft departing from the Grand Banks, VFR on departure. On the departure from the Sea Rose to St. John's I was Pilot Flying.

Asked to describe what happened, Mr. Sellars said:

I did the landing at the Sea Rose. We were ready at departure. The passengers had loaded, and I proceeded with a briefing. That day I chose to give a full departure briefing as practice for me to retain it in memory. We departed IFR as per SOPs. The departure was according to SOPs up to the point that I engaged go around. That's not a verbal call, but I made a habit of saying "engaging go around." After that the aircraft pitched up. At the time I guess I could not believe what I was seeing. To that point all was normal, but within seconds of go around the pitch up happened. So we both noticed the nose pitch up. Glen made altitude andthe other call... pitch. I came on to the controls. I manually took control of the aircraft. At one point I tried to manually... I was keeping trim I concentrated on wings level and correcting the pitch. Glen repeated the same two calls continuously. I maintained hand flying. The nose was continually 22 or 23 degrees pitch up. Airspeed was bleeding off, and a couple of audio "don't sink, don't sink" got called... I lowered the collective. I tweaked down the collective to recover RPM. The "Low Rotor" call did not go off again, but the "don't sink" was in my ear. It happened rather suddenly: 24 seconds. Eventually it recovered power and came into a low hover over the water... It's been two or two and a half years... but from pitch up to hover was only 22.4 seconds. A lot going on. I wish I could have done things differently, but it is what it is."

Asked what he did next, Mr. Sellars said:

We were in a stable hover over the water. Both scanned our instruments on the flight display. The lights were green. There were no cautions or warnings that we could see on the MFDs, and we departed IFR again from the hover. We still had overcast layer above us...

I distinctly remember saying to Mr. Mugford, 'We will not be using the go around this time.' During the departure, we briefed that Glen would select the soft keys to select the settings. I did not want to use the go around. We flew it to the settings we would have flown, and levelled off at altitude for St. John's.

On arrival we landed, disembarked the passengers and taxied to our parking spot. We shut down the aircraft and secured it and proceeded through the hangar doors to go upstairs to do our paperwork, to submit the SMS report. We had an incident, a failure on the go around on the S92 per SOPs. We submitted an SMS report to that effect. I downloaded the HUMS card and submitted it. That's part of routine procedure after a flight.

Asked if he had looked at the HUMS data, Mr. Sellars said:

Yes. We had the MCC person, Mr. Sean Simms, that afternoon. He was there while we downloaded the HUMS data card. We told him what happened to us. He was attentive to us. It showed no exceedances.

Asked how he would know that, Mr. Sellars said:

It would normally show up on the screen. It will flag. I've seen it flag exceedances. We saw none, and I remember discussing it with Sean. He saw none. But downstairs in the maintenance, he said he downloaded it again in the maintenance department. But up to that point, Glen and I did not know that we had any exceedances, so we proceeded to log and report and make the SMS report.

Asked if he had done anything else that day, Mr. Sellars said:

Yes. Enroute to St. John's, Jamie had called us on the phone. I'd got Pat's phone number. He was out of town. I called Pat from the lounge. I told him we'd had an incident offshore. We were doing the paperwork. He told us to stand down as a crew, pending investigation. I also had a message to call JJ. In any case, I did call J.J. Gerber just to confirm we were entering our SMS report and that we were both starting to write up our description. But the process was not to engage J.J. further, and we'd do all Pat told us and we were stood down.

Asked if they were then interviewed and had provided statements to the company, he said:

Yes, we both had our first meeting with the HFDM committee, and then the following morning (Sunday morning) in the conference room at the hangar. We also met with Curtis and Ronnie on Monday for the second time. We were interviewed together as a crew. We told him ... Ronnie was taking notes, and he was in charge. Savidan was there... Curtis asked one or two questions.

Asked if he and Mr. Mugford had been given the HFDM data during the investigation, he said, "No." Asked if he'd been given the HFDM report prior to termination, he again said, "No."

Yes, the CVR (cockpit voice recorder) was taped over. I heard it on a laptop, Ronnie's. Ronnie wanted us to identify what portion of the flight we were at. We both agreed that it was during the cruise portion after we had departed for St. John's, and as soon as we identified the point in the flight... that's was the only time I heard any of the data relative to the incident.

Mr. Sellars agreed that he had not got to hear any of the recording for the 22 seconds or so immediately prior to their departure from the hover. Asked when he'd actually seen a copy of the HFDM committee report, Mr. Sellars answered:

It was during these proceedings when you requested the report and it was provided by Cougar.

Mr. Sellars confirmed that he'd had another meeting, in the boardroom, at 9:30 on Thursday the 28th with Mr. J.J. Gerber. Mr. Gerber had sent him an e-mail saying he was

... to wait in the cafeteria for a debriefing of the July 23rd incident. I attended the meeting, and J.J. did also. Rene Paddock was there and Pat Perry. I had no one with me... J.J. was holding some documents, and I believe he had his laptop as well. We went in and set up. J.J. read from his iPad the termination letter, which is Consent #1. He had another document: this one and another one. I did not pay attention. I was overwhelmed and in shock. I thought it was a debriefing.

Asked if he had asked any questions or given any reaction, Mr. Sellars said:

I remember J.J. handing me Consent #1 and a second letter, a letter of resignation. I glanced at it. I could not say word for word what was in the letter of resignation. I'd get a letter for further work in VFR conditions. I did not read the resignation, or cannot remember if I did. I asked how long I had to decide. I had to decide immediately. I did not accept to resign. I accepted the termination. So I was asked to return my passes and keys and to retrieve my personal affects from the locker and the file cabinet. I gave J.J. my pass and my key. I think I had a key. We walked to the change room. I collected my personal affects into a plastic bag. We then went over to the pilots' lounge where we each had a file cabinet, and I took my effects: myself, and JJ, and there are four other pilots in the pilots' lounge. We left that area, and we were hardly through the door, and I was upset, so I asked could we go out through the mail room door. I remember a conversation with J.J. about being demoted to First Officer, but I'd be given a refusal.

Mr. Sellars confirmed that the statement (SD #3) he'd made for the Canada Industrial Relations Board (CIRB), is accurate. He confirmed that, after termination, he had been interviewed by Husky personnel for "between two and three hours."

There were two gentleman representing Husky at the Murray Premises in St. John's. Mr. Perry also testified about the departure from the Sea Rose, saying that it was a normal departure from the Sea Rose until the go around was engaged. I agreed with that. He also said if there was any pressure on the go around it won't engage, and that this is a 'known issue'. Mind you, it was not a 'known issue.' The go around did engage for 10.4 seconds, in my view, and based on data I saw.

Asked if he had ever experienced what happened on July 23rd, Mr. Sellars answered, "Never." Asked how often he had engaged go around, Mr. Sellars answered:

In three years of work, times 70 hours in a three week rotation, I would say 'enumerable' times. We use it pretty much every leg of a flight. My last shift was 33 hours prior to my termination. I was working three week rotations at that time.

Asked if he had ever previously experienced an unusual attitude, Mr. Sellars answered:

Yes, during my initial training at West Palm Beach. It was indicated to us that go around was the one aspect in the automation that gave the most grief in being selected. The go around would give you anomalies.

Asked if there had been any unusual attitude recovery training, Mr. Sellars answered: "No. The only such training I had was in my initial West Palm Beach introduction." It was noted that Mr. Perry said there was little or no effort to recover the aircraft. He said:

I disagree. It is my view that I was correcting, even though I could have been more aggressive correcting pitch attitude. In hindsight, there is the fact that I could not believe my eyes. I was correcting, but not as aggressively as I could have done. I think the data suggests that. If I was not correcting, how did I end up at a hover over the water.

It was pointed out to Mr. Sellars that Mr. Perry had testified that, in his view, he'd taken action only when he had got out of the clouds and had a view of the water. Again, Mr. Sellars said:

I disagree. The HFDM shows that I was correcting, in my opinion.

Asked if it is his view that Mr. Mugford was preparing to ditch. Mr. Sellars answered:

At no time during the incident – 22 or 23 seconds – were we preparing to ditch. It was not verbalized. There was no call made as a crew. At no time were we preparing to ditch.

Asked if arming the floats does not suggest preparations to ditch, Mr. Sellars said:

Glen armed the floats as a function of his training in the SOPs. We were not going to ditch. There was no ditching.

He was also reminded that Mr. Perry testified it was his view that the over torque should have been reported and that the aircraft should have returned to the Sea Rose, not gone on to St.

John's. Mr. Sellars said:

Once we were in the hover and stabilized, and we seemed intact as far as the displays were concerned, we decided as a crew that we had no over exceedances and there was nothing on the flight displays blinking. Obviously, we had no exceedances.

It was pointed out to Mr. Sellars that there was some evidence (*e.g.*, PP#3) that the go around had been engaged on the return to St. John's, and from this Mr. Perry had drawn the inference that they had used poor judgement. Mr Perry inferred that they did not, in fact, think that there was something wrong with the go around, and as evidence for this view, Mr Perry had cited the fact that they had engaged the go around on their return to St. John's. Mr. Sellars said: "It did not happen. The go around was not used after the hover over the water."

Asked if he thought he'd experienced loss of situational awareness, Mr. Sellars said:

"Yes, somewhat, I do." Asked if he thinks automation dependency played a part, he said:

A good deal, I guess. I do remember seeing the nose pitch up and the go around was not doing what it had always done. I was told, in training, to fly coupled 90% to 99% of the time. On departing either St. John's or offshore I used go around and became coupled as soon as possible. You do become reliant on that automation. I did ... and somewhat comfortable and complacent using it. And coming from my previous career (and my present employer) you had flying in IFR conditions. The skills degrade if they are not used in the IFR environment off shore or onshore.

Mr. Sellars confirmed that Mr. Mugford had been relieved of flying duties and is now flying SAR. "Yes, that is what I understand." He also confirmed that Mr. Mugford had used calls more familiar to a fixed wing flying rather than the calls normally used in rotary wing.

It would have been either "power" or "torque" or "rate of descent." It's very critical in flying a helicopter. These calls are particularly critical in departure and arrival.

ON CROSS EXAMINATION, Mr. Sellars confirmed he has 30 years service, predominately in VFR environments, and that he had come to helicopters in the winter of 2000

... The Bell 212 was a combination of autopilot system and hand flying. The system was an aid.

Mr. Sellars also confirmed that before joining Cougar in 2008 he'd hand flown, on VFR basis,

... a three axis Sperry auto system to which I had access at that time. I had no coupled experience prior to Cougar. The Sperry was very limited. I was an IFR rated pilot, but not with coupled equipment.

Asked what had changed his mind to pursue unionization after the June 9th meeting, said:

That was the gist of the 15 minute meeting after the long June 9th meeting. But in the weeks after that it took on a life of its own. There were further discussions among the pilot groups, and there didn't seem to be any other way forward except to go the union route. But the CEP was not an option for us, it wasn't a fit for us.

Referring to the December 20, 2010 meeting, Mr. Sellars confirmed that the meeting

... had largely been an information session to explore the CEP drive. I went into the meeting sure I did not want to be a member of a union. I was anti-union at that time, back in December. The decision was to form an association rather than to pursue the CEP option. It was an internal committee to work out things with management. But, as the minutes show, there was a group that wanted to have a union: that was Maintenance. I did not share my personal view, but I did have a negative view about unions... Once it was decided the union option was not a live option, it was the committee option that we moved with. The majority opted for a working group, but there was still a group talking about CEP, and CEP continued to campaign after our meeting.

Mr. Sellars confirmed that representatives had been sought from each of the internal groups for the committee, and that the pilots had meeting of their own between December and March, leading up to the first meeting with the employer.

It took about three months to put our requests on paper, and the group recognized that the Employer would have to study these issues. At that June 9th meeting some financial aspects were crystallized.

Asked why there was so much dissatisfaction after the June meeting, even though both the June and the March meetings had produced some results, Mr. Sellars said:

Safety management was addressed in the meeting, and the company was looking at the issue of the emergency air supply... Not every response was a "No." The helmet was also a result, and pay and benefits had been referred to the June 9th meeting. You would have had to be there for the whole six hour meeting... their attitude! Mr. Williams was more interested in his iPad, and Mr. Gerber and Mr. Perry had to leave the meeting. Mr. Williams attitude was "No, we can't do it." I came away feeling that I was wasting his time. He told us we had to live under the fixed contracts that bound his hands... We presented Mr. Williams with some comparable figures from other employers. The pilot group put a lot of work into it. He did look at them, and noted that we were working in Newfoundland, and it was okay not to be on par in Newfoundland or Nova Scotia...

The union was certified on or around Dec. 20, 2011. RM #5 is evidence of the dissatisfaction following the June meeting. We decided in the 15 minutes after the meeting to consider other options and we did. As a pilot group we had informal conversations over a month or so. From June to early July we were still discussing the meeting and our options. That was going on in early July.

Mr. Sellars confirmed, however, that the Employer was not aware of this frustration and that

... all the Employer knew was that the meeting was to be held in September. Yes, as far as I knew... No one had told the Employer or any of the managers not to bother about September, no.

Asked when the decision had been made to pursue the union option, he said: "Oh, I'd say in the first week of July." Asked if he knew which Union was the preferred, he said: "Somewhat, yes. We were looking at the OPEIU." Asked if they had struck an organizing committee, he said:

No, not an organizing committee. We had a majority agreement in the pilot group to write the OPEIU. That was in early July, yes. I did not contact the OPEIU personally. Scott Davidson, the other pilot representative did that. It was in early July... We had to convince the group, 50% plus one. So we were talking about the advantages and benefits for this particular union. I talked with as many pilots as I could... We had a couple of informal meetings through that early July week: meeting in small groups around the City... I was in St. John's at the time. In two or

three days the cards were being signed. I never had cards on my person. Scott had the cards, and I'd direct people to him. I was in his company when the cards were presented to people.

Asked if he'd participated in negotiations with the OPEIU, Mr. Sellars said, "over a phone, together." Asked if an organizer came to help, he said:

I was in his company, personally. Mr. Davidson had the cards, and we got together a few times to sign people up, roughly in the first and second week of July.

Referring to his earlier testimony on direct, Mr. Sellars was asked if there was any reason to believe that the Mechanics Supervisor he'd mentioned had any knowledge that Mr. Sellars, himself, was involved in the unionization drive. Mr. Sellars answered:

Not that I know of, no... other than as a rep on the committee. I could then be associated, possibly, with the union drive.

Mr. Sellars's attention was directed to the Union's September 15, 2011 submission on his complaint to the CIRB (SD#13, @ p 4) which shows that by July 20th they were still trying to decide which Union was preferred. Mr. Sellars responded:

Yes, I might have my dates confused, yes... I'm certain that I took no action myself after July 23rd.

Asked if this means that the drive actually started after July 20th, Mr. Sellars answered, "Yes, according to the e-mails." Mr. Sellars noted that Scott Davidson is recorded as saying to Mr. Ellickson (SD #13, p 8) on September 13, 2011 that:

Boyd was not very involved in the organizing and collection of applications after his incident 23 July. It ceased completely after he was fired.

Asked if he felt the incident was a serious one, Mr. Sellars paused slightly and then said, "no."

Asked if he was aware of a TSB investigation, Mr. Sellars answered, "Yes." Asked if he'd had access to the TSB report (BS#1) in draft form so as to provide a comment on it, Mr. Sellars again said, "Yes", and added that he had received a copy of the final report. Mr. Sellars confirmed that he had commented on it at the draft stage. His attention was directed to page 7 (at paras. 2 and 3), which reflect his recollection of the event:

"The captain returned to FSI in May 2009 for annual recurrent training. During training, it was noted that the captain had difficulties with unusual attitude recoveries due to miscues interpreting flight director information and some over controlling. The training report noted that the captain was able to fly a much more controlled recovery following retraining."

The report stated that the captain tended to "overfly" the trim and "work harder than necessary", and struggled with turning manoeuvres due to a "lack of understanding with trim functions." The training report recommended more work with the coupled flight director." Mr. Sellars confirmed the accuracy of this report and added: "I did testify to that this morning." Asked if he recalled any unusual attitude training that was done in April of 2010, he said: "No, I don't recall it was."

Asked at what point in the flight he felt that he had gone off the flight profile, he said:

After the go around is engaged and we're advancing the speed. That's when we came out of profile, when I moved my thumb to re-reference.

Noting the reference to the use of go around on the return to St. John's (TSB Report p. 5), he said:

I disputed that. I disputed this in the Report... During the incident I adopted wings level. I should have been more aggressive with how I applied power when I was 511 feet above the ocean. I did not want to end up in a dive. Mr. Mugford was giving me only two calls, attitude and speed. Then as it fell, I heard "don't sink" come on. Yes, we were descending. We were in recovery mode. That's an audio alert. The VSI gauge tells when you're falling and how fast, that's true.

He also confirmed that the TSB had reported that they had started out at 078 degrees and it ended up at 273 degrees. Mr. Sellars answered:

Yes, we turned. We weren't focussed on the direction but the behaviour of the aircraft. It turned automatically in this situation.

Asked if he would agree that the helicopter did not, in fact, correct until he had come below the clouds, Mr. Sellars answered:

I don't fully agree. The HFDM data did show the correction of the nose, albeit slowly.

Mr. Sellars' attention was directed to the top of page 34 of the TSB report (BS #1) which describes events when the helicopter "descended below the base of the clouds, its rate of descent ... was less than 5 seconds from impacting the water." Mr. Sellars was asked about the over-torque that resulted at that point when he pulled the collective very aggressively. He said he'd ...

... asked Sean to come out and witness the downloading of the HUMS data card, when we returned to base.

He'd personally entered the data on the Aviation Event Report (PP #9), "with Mr. Mugford observing." Mr. Smith noted that "This is fairly innocuous as you look at it." He answered:

Yes. That was the atmosphere. That's how we cited SMS into the system because eyes other than Cougar's see this... The report was made just after the flight, yes

...Yes, I'd been asked to provide a statement within a reasonable time... I put it in an e-mail to Curtis Savidan the next morning at 8:00 AM, I think... Sean and Janice and the SAR crew was there, and they knew we had an incident and we discussed it with them generally. I called Pat and I called JJ... no one else, to my recollection. Others were there present in the pilots' lounge too.

Asked if he'd had any discussion with Mr. Chapman that night, Mr. Sellars said "Not to my recollection." Asked if he'd had any discussion with Mr. Chapman before submitting his report to Mr. Savidan, he said, "No." Asked if he'd talked of the incident with anyone at the hangar, he said:

Yes, the SAR crew. Amy, myself and Glen and Sean Hickey, with them, just generally. I called Pat and J.J. and, to my recollection, I don't think I talked to anyone else. I think Mark is talking about the night of my firing, in the evening.

Mr. Smith said it was his understanding, from Mr. Sellars's earlier testimony, that he had instructed Mr. Mugford not to engage the go around on the return trip to St. John's, but that "the TSB seems to disagree." Mr. Sellars said:

They do... I did say that to Mr. Mugford at the briefing before. I felt that the go around had given us a problem.

Asked if he felt that it might be an anomaly, Mr. Sellars answered, "Yes." Mr. Smith pointed out that, nonetheless, the phrase "nil defect" is written on the flight log (PP #8). Mr. Sellars said:

Yes, sir. That's me. The philosophy of the pilot is, if you encounter any defect... We were having anomalies very regularly. I did not mention it ... not as a failure in communication, but, in retrospect, I should have said it. I have flown with others when the autopilot completely disengaged, and I was First Officer. The aircraft was due to go again. We did not write it up. We sat in the lounge and talked with the outgoing crew, but we did not write it up... The log book was filled in by me, yes. I should have written it in, "a suspected anomaly in the GA."

Mr. Sellars was asked whether he understood that the incident was already a big thing, and that knowledge of the incident was circulating before they arrived back in St. John's. He answered:

We got a satellite call from dispatch asking if anything was wrong. Jamie had called in to say that the customer was expressing concern. I don't recall his talking about the customer saying we had a problem.

Asked if he had later learned that the customer had reported it to the hangar, Mr. Sellars said, "Yes, I did become aware of it, sure."

ON REDIRECT EXAMINATION, Mr. Sellars testified that the financial issues that had been prepared in advance of the June 9th meeting were shared with the Employer prior to that meeting. He also confirmed that some issues had been resolved at the March 18th meeting, and others were

outstanding. Asked to estimate whether the settled issues were more or less significant compared with those that had not been settled, Mr. Sellars said:

Those that were settled were not that significant. Pay and benefits were the main issues we were pressing. We put more emphasis on those than anything else we settled, and they had the outline of the pay and benefits issues before the meeting. ... The *per diem* was settled, yes. They used the Government of Canada rate and adjusted it accordingly... Cougar pilots fly to the most difficult standards in the industry, according to specifications certified for Transport Canada.

He also confirmed he had earlier testified that the organizing drive for the OPEIU began to sign up cards on July 10th or 11th, but had later corrected himself. He added:

I did not myself make the contact with the OPEIU... On earlier testimony it was a bit confused, just about the date of the sign up, basically.

Mr. Sellars's attention was directed to the document filed on September 15, 2011 with the CIRB (SD #13) (particularly at page 5 of 10). He said that the Monday, 25th of July 2011 e-mail

... is not something that I wrote, but Scott Davidson. That e-mail refers, in the final paragraph, to the "organizing committee." That would have been myself.

His attention was directed to the 10th page of the same document (SD#13), where there is a copy of a July 28, 2011 e-mail from Mr. Davidson to "Jeff", for the OPEIU. It reads in part:

Here is some bad news of my own:

Boyd Sellars was (emphasis in the original) the other Employee Representative working with me on this effort. He was the Captain during a serious inflight incident offshore on Saturday ... and was fired by Cougar today... 3 investigations into the event are still ongoing (TSB, TC, and FAA).

The reaction to the incident by management was unanimously seen by the Pilot Group as being totally out of proportion to the nature of the event.... the co-pilot was retained and not punished in any way.

Mr. Sellars confirmed that the "effort" mentioned in the second paragraph was the "drive to unionize." Asked if he agrees with the statement in the next paragraph about "the reaction to the incident by management", Mr. Sellars said, "Yes." Asked if that statement was accurate, in his view, and what revealed the reaction as "unanimous", Mr. Sellars answered:

After the incident I was approached in person, by e-mail, by phone by a great number of other pilots in the group with Cougar. They were all in shock. Some pilots could not believe their eyes. The pilot group were very upset, as I was, at how I was treated, and it continues through to today.

Mr. Sellars was reminded that, in his cross examination, he had testified he thought the incident was not "serious." Mr. Sellars said:

If I could take that back, in a heart beat, I would. It was "serious", and I took it as "serious." I did everything that was required of me in regard to the SMS system and the Cougar manual. Yes it is very serious, but I did misspeak myself yesterday. I'm pretty sure I was thinking about my experience with Cougar. The S92 had anomalies regularly. I explained that. I had encountered them both as First Officer and as Captain. They weren't put in the log because they could be grounded, and Cougar would not have kept a schedule if we recorded them in the log. We discussed them in the lounge, always, especially if I was giving the aircraft to a different crew. We thought, 'this is a new aircraft with bugs to work out'.

With reference to The TSB Report (BS#1 p. 7, para. 3, sentence 2), Mr. Sellars recalled his difficulties during recruitment training. "That's what recruitment training is all about, to bring us to a standard." He also confirmed he recalls events in April of 2010, when he experienced difficulties with an emergency in the "simulator session involving airspeed, high nose attitude and loss of altitude." He confirmed he'd maintained his Captain's designation.

That round of training was very good training, in my view, during that cycle by Cougar. I retained my Captaincy while two other captains senior to me did not, and were demoted to first officer.

Mr. Sellars confirmed his earlier testimony that, when the aircraft began to go off profile he could not believe what he was seeing:

Yes, while off profile the pitch continued to go up. I thought that I'd properly engaged the go around. I expected it to perform as it did often in the past, but it was an anomaly. I said to myself, "Is this really happening?." It took time to visualize it and to respond to it. There is no denying that it did happen.

Mr. Sellars was asked to address the issue of the second engagement of the go around raised in the TSB report (BS #1, p. 5, final para.). He said:

Yes, Mr. Mugford and I disputed the conclusion of the TSB when we were shown a draft of the report to respond to in writing. At that time, I communicated with Glen and told him that I would respond and he agreed. Mr. Mugford did select the soft mode keys, as I said, and he responded to Transport Canada as I did.

Mr. Sellars said that, during the incident, he had acted but not as aggressively as he should have, in the way set out in the initial conversion course... as covered in the TSB Report (on p. 28).

I adopted a wings level attitude. I could have been much more aggressive than I was. I could have applied more power back at 541 feet, but I did not want to start a dive.

Asked what he meant by "start a dive", Mr. Sellars said:

By being over aggressive at that altitude I would have impacted the water. We were just coming out of the Sea Rose. I knew where we were. Airspeed and pitch were his only two calls. He could have called power and torque or rate of descent.

Asked about Mr. Smith's challenge to him on cross examination that his response to the "don't sink" warning should have been quicker, Mr. Sellars answered:

We were still nose up. The power was on the first application of power. We were correcting the pitch. Even though it could have been more aggressive, we did end up in a hover.

Mr. Sellars was asked to comment on the TSB report's (BS #1, p. 30) reference to Mr. Mugford's re-arming of "the emergency flotation." He answered:

At no time had I or Glen thought about ditching. We were in recovery mode. In my interview with Mr. Savidan and Mr. Moores, the HFDM committee, I had not made any reference to a discussion of ditching. I never suggested to them, nor was it suggested to them, that we were preparing to ditch.

ARGUMENT

FOR THE EMPLOYER, Mr. Smith noted that this case requires a great deal of thought and analysis and some clear understanding of the statute in the two areas involved, since there is no collective agreement. The issue is the termination of Mr. Sellars, and the questions are whether there was an unfair labour practice under the *Labour Code of Canada* Section 94, and then whether there was an unjust dismissal under Section 240 of the *Code*. Mr. Smith pointed out that documents filed (SD #13 and PP #11) refer to other sections of the *Code*, including 94(3)(a) and 94(3)(e), but for the purposes of the issue itself 94.1(a) and Section 240 are the key sections.

S.94 relates to "Unfair Labour Practice" in forming a union, whereas S.240 deals with the question of just cause for discharge. There is a lot of jurisprudence on the issue of unfair labour practices and about what tests apply arising out of the decisions in these matters. The law is not black and white and, in fact, the two issues of Ss.94 and 240 are intertwined.

If, for instance, I were to find that the decision to terminate Mr. Sellars was motivated by an anti-union animus then the issue of just cause in terms of the discipline becomes moot because that finding alone forces Mr. Sellars' reinstatement.

But it is not quite so simple. It is possible that even if I find that there was no anti-union animus I am entitled to infer anti-union animus where the Employer cannot rebut the charge. It

actually lies in the factual coincidence of the termination and the drive to form a union. There is an inference to be drawn from that coincidence.

The Employer's view, however, is that I still must find, in the first instance, that the Employer both knew of the drive and, in particular, of Mr. Sellars' involvement. I do not need to find Mr. Sellars' involvement as established in the Employer's knowledge where the coincidence, itself, is enough to ground my decision. But if there is no actual anti-union animus found, then, in the Employer's view, the only way that it can be established is if I find the Employer did know about Mr. Sellars's involvement.

The fact of the coincidence, however, is a rebuttable fact, and S.240 becomes relevant at that point. But I do not need to find just cause to rebut that presumption. All the Employer has to do is show that the Employer's actions were motivated in the ordinary course of employment and they acted responsibly. If the Employer was aware, I then have to determine whether the termination was motivated by that awareness. If the Employer does not have that knowledge I do not have to find actual anti-union bias. In other words, there is here an inferential anti-union animus, but the Employer can, and must, rebut that in order to survive.

If I were to find that the inference was rebutted by the fact that the Employer's decision to discipline was justly grounded and based only on that proper function of management, then under section S.240 I can then assess if the discipline was reasonable within the circumstances.

There is a concept in the law which is generally referred as a "tainted" decision. That is to say, the question becomes whether there is a taint of anti-union animus to be attributed to the action. The highest level that Cougar has to face in this matter is whether the decision was tainted by anti-union animus under S.94. If it was tainted under S.94 then the interference of Unfair Labour Practice is found.

Some boards consider whether the discipline had a chilling effect on prospective members of the bargaining unit. Some boards do not consider that. Some say it is enough to find the presence or absence of an anti-union animus. It is clearly a complex job to maintain a systematic discussion on the two issues covered by Ss.94 and 240.

Therefore there is a two step process. The Adjudicator must first determine the issue of Unfair Labour Practice; and, if the answer is no, must then determine just cause or not. The case law recognizes how rare it is for an employer to admit that it wanted to block a union formation,

and this is why a long analysis is needed. So there are a number of approaches to ground these determinations.

If it was a legitimate exercise of management responsibility, the important thing is not to confuse these issues. No just cause is itself ground for anti-union animus. It is possible that it was unacceptable for other reasons. The question is Did the Employer discipline Mr. Sellars within its rights? If so, then the presumption of anti-union bias is rebutted. S.94 ceases to be relevant. Then the Employer's decision must be explored to see if the discipline was reasonable under S.240.

Union and Employer counsel agree, in Mr. Smith's submission, that there is no formal process for ruling on S.240. The Parties however have agreed that the Adjudicator has jurisdiction to determine the outcome under S.240. So, what factors have Boards considered?

For cases on the issue of anti-union animus in the context of an allegation that there is an actual animus, two main questions have to be asked. Did the Employer know about the organizing drive, and did the Employer know of the Complainant's involvement. There is also a further question: that is, the proximity of that knowledge to the event of the termination. Finally, it must be asked if there is a clear foundation for the action of the Employer vis-a-vis the Complainant that can objectively be reviewed as the reason for the action.

Mr. Smith provided cases from jurisprudence to make these general principles more clear. Where an employee engages in harassment or belligerency in the workplace, and is found to have been doing so, the company who dismisses the Complainant in order to preserve safety and to address the poisoned atmosphere is found to be the real reason and there is no presumed animus. Any presumption is rebutted. Similarly, where the discipline is for an actual theft, and the facts show that the Employer was aware of theft, but only took action when the Complainant participated in the Union drive. The Employer's action vis-a-vis Mr. Sellars, on the other hand, is one where the Employer can show the discipline was just, and, in doing so, clears the Employer of both of the allegations, under S.94 and under S.240.

Mr. Smith provided a survey of various cases drawn from jurisprudence to help the Adjudicator in considering the evidence and argument from the twelve days of hearing. Specifically he invited me to review *Denis Rousseau, complainant, and CANADIAN NATIONAL RAILWAY COMPANY, respondent* CIRB Decision # 393, 2007; *Guy Duchesneau & Conseil De La Nation Hronne-Wendat* (CIRB File # 18296-C (745-5784) Decision #1; 53 C.L.R.B.R. (2d) 243ff.;

Canadian Union of Public Employees, applicant, and Melissa Lehman, person concerned, & Trailblazers Life Choices Inc., employer/respondent Labour Board 2009, 171 C.L.R.B.R. (2d) 263ff.; Barb Genret and Cypress Credit Union Ltd. 67 C.L.R.B.R., 2000; The United Steelworkers of America, applicant & AG World Support Systems Inc., respondent/employer & Simplot Canada Ltd., respondent, & David Kennedy, person concerned 106 C.L.R.B.R. (2d), 185.

Mr. Smith argued that it was very important not to confuse the dual roles of Sections 94 and 240. It is crucially important to ask whether there is evidence of actual anti-union bias, leaving aside any question of inference from a coincident union drive that the Employer may be able to rebut. These issues are addressed the *Rousseau* and *Duchesneau* cases in particular.

The evidence shows, on this matter, that Mr. Davidson informed the Employer that the CEP was active in the workplace, seeking support. The evidence does not show how, if at all, the Employer responded to this information. Shortly after that, the company was asked to allow the employees to get together to discuss these rumours and they were permitted to do so.

The pilots felt that the CEP was not a good fit. Mr. Sellars had his own view, and that is he was not in favour of any union at all. The Employer agreed to the employees' request, and they met and discussed the issues. The internal committee that was formed at that point was an *ad hoc* committee, not incorporated, not itself a union. It appears that the approach of using an internal committee was spearheaded and run by the pilot group.

A critical stage begins on or about June 6 when the economic package was presented and the meeting was planned for three days later, June 9th. That meeting was a meeting with management and resulted in frustration, according to RM #5, the e-mail from Mr. Davidson reporting on that meeting. There was no decision, at that point, to go with a Union. The issue was raised. Mr. Sellars and Mr. Davidson indicated there were two choices: either give up, or go forward with a union. So, on the 9th, it is clear that the Employee participants were not happy, but that they made no decision at that time. The recipient of RN #5 is Mr. Ronnie Moores, who was not a management person at that stage. All Management could reasonably know at that stage is that there were questions being asked about certification. Mr. Sellars testified that the decision was to let the matters rest over the summer and wait for the Employer to get back to them on the issues the employees had put to them. But one economic concern was more significant than is generally represented, and that was the *per diems*.

SD #13 shows clearly the selection of a union and the date it occurred. The pilots decided to go it on their own, but there still was no decision made as to which union. Mr. Sellars says that there was a similar situation operating in June, but note the e-mail to Darshan at 8:13 PM on the evening of July 20th, 72 hours prior to the incident. The conversation is still ongoing as to which union is to be selected. On SD #13 (@ p. 6) we have the first e-mail which shows that the distribution of cards to the Cougar Halifax pilots has begun as of July 25th. Mr. Sellars did say that Scott Davidson had handled all these communications, and perhaps that's why Mr. Sellars is absent from these records.

A great deal of attention has been paid to SD #13 (@ p.5, the penultimate paragraph) where an answer to the question posed by the OPEIU representative whose first name is "Jeff": "Has an official pilot organizing committee been formed? If so, how many and who?" Mr. Davidson answers that question by saying:

We have 2 pilots who attend an employee committee within Cougar. This was created in December as a last chance for management to avoid this option – it has failed. Hence the start of this campaign. We have a well documented record of the issues, and approved minutes of management's position on each, which management has seen and approved as accurate.

Thus the Employer has no problem explaining why the activity of the campaign to unionize was unknown to the Employer. Mr. Sellars has himself testified that it was done in secret; that the September meeting was not cancelled, and that no information was provided to the Employer about the June 9th meeting having been regarded as useless. It was a covert organizing campaign. Mr. Sellars testified that it was their intention to keep it secret. He, himself, testified he'd agreed with Mr. Davidson to withdraw from participation in the ongoing organization at the time of his termination. So there is no evidence that Mr. Sellars was known by the Employer to be involved in the union campaign. The Employer is continuing to expect that the September meeting would go forward.

This point is critical, in Mr. Smith's submission, since the Adjudicator must find the Employer was aware of the organization and formation of the union if the allegation brought under this complaint is to be sustained.

Clearly the Employer was advised that the CEP was organizing and that organizing did not stop. The CEP did not go away. The Employer was fully aware and did nothing. So, on the first

consideration under Section 94, the answer is that there is no proof the Employer was even aware of the OPEIU organization or of Mr. Sellars' involvement.

Mr. Sellars said one could infer his involvement from his participation in the Employee Committee. That committee was established, in effect, to block the CEP progress. Mr. Sellars' frustration was that Cougar could not immediately institute salaries to compare with the North Sea and the Gulf of Mexico. But this exasperation shows that the frustration was contrived. He knew that the committee was not going to get it. There is no tangible evidence to show that the Employer knew that there was ongoing organizing committee for the OPEIU, or that Mr. Sellars was part of it. And there is virtually no evidence of anti-union animus in the workplace. The evidence is, if anything, to the contrary. Which leads to the next question that must be asked.

It is an undeniable fact, based on the e-mails and from Consent #1, that the termination was of an employee who was involved in organizing a union at the time. The Employer did not know about it but it was ongoing when the termination occurred. This leads to an inference, rebuttable by the Employer, that there may have been an Unfair Labour Practice. Certainly the inference is possible as a result of the coincidence. So the question must be, Was the termination a proper exercise of management's function in the circumstances? The question, under S. 94, is not whether or not there was just cause for termination. More precisely, the question is, Was the exercise a proper exercise of management function?

So the Adjudicator must now turn his mind to the termination to ask whether it was in the company's reasonable authority in the workplace. Certainly the Employer has the capacity to continue to exercise its powers in a business as usual fashion in such circumstances. Therefore the question is whether the incident, itself, was the only motive for the discipline. Absent a violation of Section 94, the Adjudicator will then have the added responsibility, under Section 240, of determining whether or not the Employer had just cause. So first, the issue is whether the disciplinary response was reasonable. Then, second, it must be determined whether the Employer acted with just cause.

The Adjudicator must therefore explore the foundations of the termination as set out in the letter of termination (Consent #1), which sets out the facts of the departure from the Sea Rose and the temporary loss of control due to pilot error and a failure to correct this loss of control immediately, which was made worse by the fact that he failed to respond until he caught sight of water.

Mr. Sellars "froze." This shows that he is unsuitable for off shore work. Certainly, the Employer did not allege that Mr. Sellars was inappropriate as a pilot of helicopters. But management had concluded that it could no longer sustain their confidence and trust to operate in the Newfoundland offshore. This is supported by Mr. Sellars, himself, in his examination in chief. Mr. Gerber offered him the opportunity to resign and go to a VFR employer.

So what the Adjudicator needs to consider is Captain Sellars' attitude to the event. Both are bound up inextricably: (a) what happened, and (b) what Mr. Sellars' attitude to it was. Both together are the basis for the Employer's lack of confidence and trust in his risk-free performance in the off shore. There have now been days spent at this hearing debating what happened. We clearly have exhausted the examination of each detail of the record. Mr. Sellars' view is that the S92 has anomalies when operating the go around and in other automated systems.

Mr. Sellars testified he had no idea what was going on when he got to 540 feet. He said "I didn't know what was happening." Yet he knew about "anomalies." But if he did "know" that it was an anomaly, he should have been able to react to it as an anomaly. The Chief Pilot and the Director of Flight Ops have both testified that when you get into an unusual attitude you do three things. The TSB report outlines those same three things. Mr. Sellars says he did everything.

But, in fact, he did nothing in the first ten seconds except keep wings level. He did nothing relating to items #2 or #3 set out in the TSB Report at page 28. There were two attempts to put the nose on the horizon, but Mr. Sellars was, apparently, worried about diving. Yet, the nose stays above the horizon. That clearly was not done. Worry about a dive from 541 feet is not reasonable. When Mr. Sellars is 200 feet above the water, the correct procedure is nose down: the same as it was at 541 feet. This explanation is not credible for one of his experience. But what it does show is that he meant his answer to the question about whether he thought it was a "serious" event, and still means it. All he says is that he could have been "more aggressive."

But what evidence is there that he applied power? The TSB Report says that he applied power twice, but that he did not sustain it the first time. He did not establish the power while in the cloud. The TSB says he did not apply it until he was out of the cloud. Then his copilot told him to reduce power since the low rotor problem had arisen. While there were two applications of power, one was very slight, the second is triggered by his sight of the water. They are both linked to the sight of water: first when he can't see it, and second when he breaks through the clouds.

The facts simply do not bear out Mr. Sellars's account of the events. Nor do they bear out his reasoning about what to do at 500+ feet and the nose is at 23°, as the aircraft fell nearly 510 feet out of the sky with passengers on board and a number of observers watching the entire event from the Sea Rose.

It was argued by Mr. Gerber and Mr. Perry that the loss of flight 491 changed everything. There was now heightened security, that included cancelled night flying. And it had also created a different culture in the company: a culture contradicted by Mr. Sellars who asserted that "You don't report defects." That is simply not true. You do not jeopardize anyone by failing to report defects. That is not a pilot's role. Nor is schedule-keeping a pilot's role. And this is a seasoned pilot! What happened has been reviewed by and determined by the TSB, and it determined the event was a serious one, and caused by pilot error. The facts the Employer relied on in reaching its decision in the termination letter (Consent #1) were confirmed in the TSB report (BS #1, 41-43).

Mr. Smith noted, particularly, the reference (p 41, #3) of the TSB Report to Mr. Sellars' being "subtly incapacitated" (elaborated more fully on p. 26 of the Report). Mr. Smith equates this phrase with the Employer's determination that the pilot "froze."

There is no reason to find any prejudice to Mr. Sellars in the different disciplines. Mr. Mugford was, in fact, grounded for over a year. It is true that he is now flying SARS, but that does not involve passengers. Consent #1 is, in fact, supported by the TSB report and accords well with the internal accident report, PB #12. The Employer had already instituted many recommendations of the report by the time it was published, based, as they were, on the HFDM internal incident report. It is true that Mr. Sellars acknowledged his need to be more aggressive, but that, frankly, is a cop-out. The very simple fact is that if the unusual attitude had been corrected within the first few seconds of its start, as it should have been, we would not be here.

Mr. Sellars was not singled out for special treatment. The fact situation is substantially different from the other two incidents in evidence, in both of which the captains immediately corrected. There is no evidence of falling 510 feet out of the sky. In those incidences the Captain took over the flight from the First Officer and the recoveries were achieved by doing what was required. And one of them also included a mechanical malfunction.

There is evidence (TSB report, p. 7) that the Employer knew at the time of termination that Mr. Sellars had had difficulties, during his conversion training, with unusual attitude recovery.

There is no question in the Employer's mind that Captain Sellars is a fine captain within the VFR regime. We do not take that away from him. The problem is with converting to a regime where IFR is required. He is unable to get his bearings except by looking out the window. The company cannot have confidence to put him in a helicopter. Confidence and trust are central to this job. He clearly could not integrate the training and apply it in his work. But for some reason he then argues that, in a little over three years on the S92, he is suddenly automation dependent. He may, indeed, be automation dependent, but that is not what he takes it to be. The fact of the matter is that automation is the reality, and if he is automation dependent, then he is not suitable for the task offshore.

It is important that the Adjudicator look closely at what really happened. Would extra training correct pilot error and his other mistakes? There is no genuine ground for hope. Mr. Gerber and Mr. Perry both testified to the fact that it was critical to the company in selecting termination as the discipline. The issues are clearly set out in the TSB report, all of which confirm Consent #1. There is no training that can be devised for Mr. Sellars. The company concluded that the company and its passengers are not part of Mr. Sellars' future. Nor was it possible to demote him to First Officer, since the same confidence problems remain for him as First Officer if a similar incident were to occur. Neither position was accessible to Mr. Sellars.

It was not just about breaking the SOPs, but doing so when passengers were at risk. The company has to be positive that their pilots will react in accordance with their training. He got visual reference and recovered the aircraft; but he must be able to do so without being in visual range, and the Employer must have confidence that he can operate in the offshore. The company did, in fact, make changes to the SOPs to improve them, since they were unable to wait for the case to be heard at this level.

The Employer has responsibility not just to Cougar, but to its passengers and to the Regulators. When confidence is lost, it must act. That is the situation in the instant circumstance. This was always a serious incident. Mr. Sellars did not follow his training. He made it worse by treating it as an "anomaly", which, he said, he had come to expect. But, obviously, he did not expect it, since he said he "could not believe" his eyes.

Justification for the Employer's action is in the TSB report. Mr. Sellars is not suitable as an IFR pilot for this harshest of environments. That is the only and underlying reason that he was

dismissed; but he did not see it as "serious" despite having been trained several times to do it correctly. These are the elements that the company took into its view and are a just cause for the termination as a result of the incident. It is not something that could be corrected by training or discipline itself. Mr. Perry said that you cannot train people to react in critical situations. Simulators cannot do it; it's still simulation. The aircraft was falling at 1800 feet a minute. Mr. Davidson and all the other witnesses saw it as a serious event, and it certainly is the Employer's view.

In the alternative, even if there is no just cause, the event itself is the only proven reason for the discipline. So the Unfair Labour Practice is not established. And if there is no just cause, then a finding in the alternative under S.240 might include reinstatement. But that is only one of the options. The Employer urges strongly that the Adjudicator not adopt it. The Employer argues that, if just cause is not confirmed, then compensation is the only appropriate response.

Mr. Smith then reviewed some jurisprudence to support the Employer's position. The Employer believes that at least one of the pilots thought they were ditching. The TSB did say, at page 5 and at page 30, that their action was "in preparation for water impact."

Clearly, neither of the Union's positions under S.94 or S.240 have been made out. If the discipline is too severe, the Employer suggests that compensation is the only option.

FOR THE UNION, Mr. Ellickson argued that the Adjudicator should reinstate the Complainant to his employment with no loss of pay or benefits, to award compensation, and to remain seized in the event of any dispute.

He said that the Employer has tried to crystalize this as a single incident of "pilot error" involving a very senior and experienced pilot. Cougar has absolutely failed to acknowledge its own deficiencies and failures in respect of this incident, and this is the first, and most important, point that the Union wants to make.

The Union also invited the Adjudicator to consider, first, how quickly Cougar has moved to terminate and, second, to differentiate the treatment Mr. Sellars received when compared with other pilots in similar situations. Finally, in the Union's view, the third focus should be on what Cougar knew at the time, not what they learned later. This distinction is very important.

The Adjudicator's task is, first, to determine if the termination was not only unjust but tainted by anti-union animus in any way. In this case it is crucial to examine Mr. Sellars' actions and then Cougar's own actions: for instance, in pairing Mr. Sellars and Mr. Mugford, and in terms

of their differential treatment, and in its failure to consider automation dependency and its impact. Why did the company initiate more than a dozen training and SOP modifications in the wake of this incident, and yet conclude that retraining was not appropriate for Mr. Sellars?

But even if the Adjudicator were to accept the company's characterization and interpretation of the evidence, there remains a final question to ask: Does a single event ground a termination? Mr. Ellickson said he was not aware of a single such case in this industry. Why was Mr. Sellars terminated for a single incident in an otherwise unblemished career? Either it is an anti-union animus or Cougar has simply had to appear to Husky to put all the blame on Mr. Sellars. A review of the facts will support either explanation, but will not establish just dismissal.

On the question of the Adjudicator's jurisdiction, Mr. Ellickson agreed with the general position set out by Mr. Smith in his treatment of the law at Section 94, but clarified it by saying that the Parties have agreed to my jurisdiction on the question of anti-union animus as set out in Section 94.1a. In his view, 94.3(a) provides very broad authority. It does not depend on a particular Union being selected. In fact, talk of a Union is what is protected in addition to other issues. This is set out in Emery Worldwide. Section 94.3(e) is important, as is Section 99 which outlines the Adjudicator's powers and remedial authority. They are extremely broad, particularly 99.1(c) & (d) and 99.2. An Adjudicator has a great deal of discretion and remedial authority. Sections 16 and 24 are also pertinent. There is also a test under Section 94 which is important to note: That is to say, if a decision is in any way motivated by anti-union animus then there is a violation, even if there is just cause for termination. This is also made clear in *Emery Worldwide*.

Mr. Ellickson also pointed to *Louise Arbour, complainant, & National Pagette, employer, & Communications & Electrical Workers of Canada (CFL-QFL) Union*. CLRB No. 862, 1991 as a very frequently quoted decision and one to which the Adjudicator would do well to consider. The test requires that the Adjudicator ask whether the Employer's action is in any way different from prior decisions or whether there is a departure from the past, and whether there is a rush to terminate. In this case, "yes" is the answer to each of these test questions.

Where there is a coincidence in time that could raise a presumption of anti-union animus, there is an inference that the Employer must face. Yes, it can be rebutted; but, crucially, the onus rests with the Employer throughout to make that rebuttal. But even if the Employer satisfies the Adjudicator that it has discharged this onus, we then move to S.240 and its test.

It is true that the Parties share a general view of the law and the tests; but the Union finds it disagrees as to the analysis that should be made. The issues under Ss.94 and 240 are not as easily separated as the Employer contends. Under 94 the *Canadian Industrial Relations Board*, (CIRB) looks at the entirety of the Employer's actions to determine if discrimination has occurred. Using something like the theft analysis that Mr. Smith introduced does not meet the issue. The point is that the Employer may have just cause, but that does not eliminate the possibility of it also being motivated by anti-union animus, or its investigation slack, or its decision taken in haste. If the Adjudicator finds that the Employer was solely animated by reasons it represents, then the presumption is rebutted. But if Mr. Smith means that the Employer has a free hand if it establishes just cause, that is not the case. In both Section 94 and 240 cases, the entirety of the Employer's actions is relevant and needs to be examined. If the Employer deviated from its typical practise, that is evidence of anti-union bias; as is a finding that it had no just cause. or that its action was not a reasonable expression of management rights.

On specific issues it is crucial that the Adjudicator look at the quality of the Employer's information. The onus is on the Employer to make its case on the basis of clear and cogent evidence. In this case the Employer's evidence and conduct were so unreliable that the information simply cannot be trusted. Mr. Ellickson cited what he termed a "few examples" in this regard.

It should be noted that both Mr. Perry and Mr. Gerber testified that Husky was intimately involved in the investigation. Mr. Perry and Mr. Gerber both testified to numerous calls between themselves and Husky following the incident. But neither Mr. Gerber nor Mr. Perry could produce any notes of these conversations. This defies logic and should prompt the Adjudicator to draw an adverse inference. Notes were produced, but only briefing notes about the termination itself. The "no notes" theme repeated itself on the cross examination of Mr. Gerber, when e-mails between Husky and Cougar, JG #s 11 & 12, were finally produced following a direction from the Adjudicator to produce them. These are very important documents, which the Employer had failed to produce until then, notwithstanding their claims to have produced everything. The video simulation (PP #6) was also produced only reluctantly and under order from the Adjudicator.

It should also be noted that the hearing broke after Mr. Gerber's cross examination. Then he did then some independent investigation of questions he'd been asked. That is highly inappropriate procedurally, in Mr. Ellickson's submission. What all this shows is disrespect for process: a

disrespect, in fact, that is prejudicial to Mr. Sellars. The problem of evidence also continues with regard to the missing voice recorder, which is, in fact, the property of Transport Canada. Cougar produced the CVR, and then claimed that it had been erased: another incidence of the unreliable evidence pattern. All of this is prejudicial to Mr. Sellars. Appropriate inferences must, therefore, be drawn to overcome this prejudice.

Mr. Ellickson then reviewed the testimony, initially, of Mr. Perry. He noted, in particular, six or seven points touching on the employee committee and the organizing drive in which Mr. Scott Davidson and Mr. Sellars participated. Both Mr. Davidson and Mr. Sellars were questioned about the timing of abandoning the Employer committee and the move to unionization.

All the discussion about the employees being frustrated by discussions with the Employer is irrelevant. What is relevant is the question about the involvement of both Scott Davidson and the Complainant. Mr. Sellars was represented as the salesperson, the pitch person, to be involved with talking to the pilots. He testified that he spoke with the pilots and then advised those interested to be in touch with Mr. Davidson for cards. He testified he had conducted these conversations on the Cougar premises, in the SAR hangar, at his home, and at various other places around St. John's. He was confused about when the sign up actually started. The undisputed evidence is that he did engage in the process through July and probably through June.

He was, of course, one of the two pilot representatives on the committee and chaired the December 20, 2010 meeting and acted as the sole pilot representative with them at the June 9th meeting with the Employer. And he actually signed up Mr. Davidson, himself. SD #13 clearly demonstrates that he was one of the two primary organizers. There is no getting around the fact that he was active in the organization, and this is made clear on the last page of SD #13.

Mr. Davidson testified about the Halifax incident when two pilots were disciplined. PP #21 & #22 refer to this July 15th incident. He also testified that Mr. Sellars' termination had a dramatic effect on the sign up. One pilot, at least, reneged and asked for his money back and returned the card. That is entirely consistent with the evidence. Mr. Davidson is on a roll and then Mr. Sellars is terminated on July 28th, which has a chilling effect on the campaign. It is precisely for this reason that Section 94 of the *Code* is so important and must be treated with such respect.

The Employer responds that it had no knowledge of Mr. Sellars's activities. But did the Employer suspect his involvement? Mr. Ellickson undertook to show that it did. He argued that it

is important to review, first, the Employer's knowledge of Mr. Sellars as pilot representative on the Employee Committee and, second, the involvement of both Scott Davidson and Boyd Sellars as set out in the RM #5 e-mail, which concludes that the next step is unionization. That e-mail clearly went to Mr. Moores, one of the authors of the HDFM report, who did not deny getting the e-mail. There is also note evidence of a Management person, the Director of Maintenance, who knew about the drive. And we have Mr. Sellars' evidence of Mr. Williams' comment that he'd be happy to buy someone "a one way ticket to Goose Bay."

Possibly the drive was not underway by June 9th, but the Employer certainly could have guessed who was behind it when it did start. Mr. Smith's representation that the Employer was in the dark about discontent flowing from the June 9th meeting, is not consistent with SD #14, where Mr. Davidson comments to Mr. Williams about "beating a dead horse." There is no doubt of discontent in the workforce. It also should be noted that Mr. Moores testified he knew of the drive, referring to a period after the June 9th meeting, and that "I became aware of the e-mail and hearsay around the hangar." The Company already knew about the approach of CEP in November of the preceding year. Mr. Davidson reported that to the Employer. Here we have Mr. Moores, and the Maintenance people and their Supervisor. The Employer cannot, without denying logic, claim that it did not know.

Mr. Smith is wrong to suggest that there was no union activity from June 9th until mid-July. The OPEIU was clearly busy in mid-July, but early July was when the decision was taken, and the July 15th Halifax incident is what crystallized it.

Under Section 94 the Union has done what it needed to do to establish that the Section 97 complaint should be sustained. Mr. Sellars' incident, the investigation of it, his termination, and the remedial steps that the Employer took post-termination all corroborate this conclusion.

Mr. Smith repeatedly said that Mr. Sellars had violated SOPs in the July 23rd incident. But that is not what Mr. Sellars was accused of. It does not appear in Consent #1. In fact, he did not violate any SOPs. That was never put to him in cross examination. We now have the TSB report (BS#1) that tells us what happened, despite the dissent from both Cougar and the pilots. We also have Exhibit #2, the TSB press relations report. That covers what is set out in the TSB report at pages 3 to 6. But that report does not break it down quite as clearly as Mr. Davidson's annotated data sheet of July 23, 2011 (SD #7). The whole event lasted between 36 and 38 seconds.

The TSB Report (BS#1) lists five points (p. 5). It sets out, in detail, the 24 to 25 second period from 1458:28 until 1458:53 when "the descent was arrested thirty-eight feet above the water." During that period the Complainant is endeavouring to recover the aircraft. He did not want to be overly aggressive in getting the nose down for fear of a dive. In this there is a difference with the 2007 and 2008 incidents. Mr. Sellars is aware that he has some inertia behind him. For the first eight seconds or so, according to Mr. Sellars' testimony, he was in a state of disbelief. He could not believe his experience. He had never encountered it before. After the descent was arrested, he expressed his intention for Mr. Mugford to use the soft key to issue instructions to the aircraft, and not to use the go around. He debriefed the passengers, and set off for St. John's.

The TSB report says that the HFDM data indicates the go around was used, despite Mr. Sellars' adamant denial that it had been used this second time. So it appears that Cougar and the TSB both relied on Cougar's HFDM data (as at PP #3) to reach their conclusion. The question must be asked, Was this unreliable data? There clearly has been some unreliable data. It is interesting to note that identical speed is reported for the alleged second use of the go around as for the first. Is this purely incidental, or, frankly, unbelievable? As to the question of the use of soft keys rather than the go around, Mr. Perry said that it was lack of judgement to use the go around again. Perhaps, yes ... if it had happened! But Cougar perhaps did not know about that at the time of termination. Mr. Sellars and Mr. Mugford both say that it did not happen, and this is confirmed by Mr. Moores' notes of the crew interview (RM#1).

It is interesting that the Company elected not to call Mr. Mugford, the eye witness to the major errors alleged of Mr. Sellars. The Employer has the onus to prove its position, and it did not call Mr. Mugford. The Union suggests Mr. Mugford would have supported Mr. Sellars version of events, as he does in RM#1. It is also the case that the CVR would tell us the facts. But it is not available. So the use of the go around on a second occasion is now a significant element in the Company's attempt to terminate Mr. Sellars, but the Company has impossibly prejudiced the Complainant's right to defend himself.

In any case, the alleged use of the go around on the second occasion is not mentioned in Consent #1, the termination letter. The Adjudicator must draw the appropriate inferences from the Employer's failure to demonstrate evidence on this point, and conclude that it was not used by the crew on the second occasion, or that it isn't safe to conclude that it was.

Regardless of who is correct about a second use of the go around, there clearly was an unusual attitude: a situation that Mr. Sellars had not experienced, and for which he'd been given no recent training, and for which there were no useful SOPs available at the time. There is also clear evidence showing an attempt to recover the aircraft that was eventually successful.

The letter of termination claims that Mr. Sellars "froze." That is not the TSB's word, which speaks of "subtle incapacitation." That may have lasted for eight seconds, which was a much briefer period than in the other two incidences TSB report (BS #1 @ pp 8 & 25).

No evidence was presented to support the Employer's claim that Mr. Mugford was hired as a result of a local preference policy. It is much more natural to conclude that Mr. Mugford was hired because Cougar had not been able to find any local IFR pilots who would work in St. John's. We also know there was a restriction imposed by the offshore board, particularly Husky, that Mr. Mugford would not fly with anyone but a training pilot. There was a reason for that restriction. Mr. Sellars is not a training pilot. But, nonetheless, the two were paired for this particular flight. That was a massive disservice to both pilots. Mr. Gerber minimizes, or dismisses, the importance of this aspect of the situation. But that is self-serving and disingenuous. There was a clear and acknowledged prohibition; and it was violated by Cougar.

In his argument in chief, Mr. Smith made some play with the fact that Mr. Sellars testified that he thought the incident was, in retrospect, not serious. This is simply to fail to interpret the witness' testimony accurately. It is, in fact, noteworthy that the Employer relies so much on this one word response to an e-mail that he did not, in fact, receive. Mr. Sellars always treated the incident as serious, as is clear from his debriefing of the passengers, the download of the HUMS data, the entry of the incident at the SMS, and his conversations with other crews. The whole of the evidence shows he thought it was "serious."

Once the crew had reached St. John's, Mr. Sellars made contact with Mr. Gerber and Mr. Perry and was told to stand down. At that point, Mr. Sellars was at the end of his duty days and should have been due for three weeks off. The HFDM committee was assembled. At no point were Mr. Sellars or Mr. Mugford given copies of the HUMS data or the HFDM data or the HFDM committee report.

After the meeting on the following Monday, there was a waiting period for Mr. Mugford and Mr. Sellars. But Cougar, itself is very busy. Company evidence suggests that the HFDM

report led directly to the Company's decision. But the fact of Husky's involvement is clear in the cross examination evidence. That evidence shows that, immediately after the incident, Husky began a continuing and significant contact with the Company. Husky approved each and every crew sent out by Cougar and was very present to Cougar in terms of training, SOPs, and education. There are a number of documents emerging during the period between July 23rd and July 27th. In all of these, Husky is raising concerns and Cougar is saying that 'it's OK', let us 'take care of it'; and Cougar was going to great lengths to deny that anything Cougar had done could have impacted the event: not fatigue, not training, not SOPs.

The Adjudicator was encouraged to review JG #3, which shows that Husky wanted answers ASAP, and Cougar wanted to disown everything other than pilot error.

On July 27th Mr. Sellars gets an e-mail instructing him to attend a debriefing. He arrives for the "debriefing" and is read a letter of termination. He is shocked, given no opportunity to defend himself, and provided with an option: either take the termination or quit and get a letter of recommendation for a VFR job. Mr. Sellars asks for a position as First Officer, and this is denied. So five days after the incident, and well before Cougar's own internal report (PP#12) which included issues up to August 2, 2011, he is terminated. It takes longer, in Mr. Ellickson's submission, to investigate a case of employee theft. Cougar has moved very quickly to blame the entire matter on Mr. Sellars, and to terminate him. That fact, itself, should raise serious alarm bells for the Adjudicator. But it gets Husky off Cougar's back. On the other hand the rush to judgement reveals the injustice of the termination decision, itself, notwithstanding the Company's adamant testimony that Husky had no part of the decision.

This action may have saved the Husky contract, as suggested by Mark Chapman's testimony, but it ruined Mr. Sellars' thirty plus years reputation. That is shameful, in Mr. Ellickson's representation. The question has to be asked, Why did they have to terminate Mr. Sellars so quickly? He has three weeks off. He was not flying for those three weeks. He is clearly ambushed at the "debriefing" meeting, and denied due process. There was no opportunity for him to provide a response to the committee's report. He did not even see it. All this clearly highlights the unreasonableness of the Employer's termination decision.

Prior incidents entered in evidence, are also critically important to interpreting the facts of what happened. The law requires that cases be treated alike. That has not happened here. The

effect is that the termination is discriminatory and unreasonable. In 2007 and 2008 there were two incidents involving a very senior Captain and also a very senior Captain and First Officer involved in Transport Canada reportable incidents; but Cougar did not report them to Transport Canada. Cougar has tried to minimize this fact as the Transport Safety Board notes (@ p. 30) in its report, (BS #1). The 2007 incident is documented at JG #5 and SD #5. It's vital to review Mr. Davidson's evidence, in the Union's submission, as he described all three incidents.

In the 2007 incident, the aircraft descended to 31 feet above the water: 2.5 seconds before hitting the water. That is, in fact, closer than Mr. Sellars and Mr. Mugford came. The pilot took 16 seconds to start the recovery, whereas Mr. Sellars took eight seconds. The crew did not report the unserviceable radio altimeter, and also failed to report a torque exceedance. Contrary to the Company's documents, evidence shows that the Captain, not First Officer, was flying the aircraft.

In 2008 there was another incident involving two very experienced fliers. The duration of the incident was one minute and six seconds from start to recovery, and 36 seconds to actual recovery. There were four SOPs violated. (PG #6 at pp. 8 & 2.2.)

It is also important to compare the language used in the reports of these two incidents to the language used in the termination letter for Mr. Sellars. Where the two previous pilots were complimented for the speed with which they recover, Mr. Sellars is, in fact, dismissed, in part because of the shorter time he took to recover! Also, in the 2008 incident, had matters been properly reported, maintenance people would have told the crew to remain at the rig.

All of this is made clear in JG #6 (pp. 8 & 9). Mr. Ellickson called particular attention to the concluding sentence of the second paragraph of JG #6 (p. 9), which refers to a serviceability check that should have been done, which was not carried out, and yet "no fault found." The final sentence reads: "This is a crucial element that was missed. The aircraft should not have flown back to base given the correct facts." In JG #6 (p. 9) the causal factors all refer to pilot performance. Page 10, under "actions taken", summarizes the Employer's response, reporting that:

Both crew members underwent verbal counselling and a letter was placed on file held by the Chief Pilot and both crew members underwent remedial SOP training / night operations training and technical training - all conducted by a Company training pilot.

Mr. Davidson testified that both the 2007 and 2008 incidents were more serious than the incident in which Mr. Sellars was involved. Mr. Davidson's testimony is particularly important, in

Mr. Ellickson's submission. The Company cannot simply mitigate both of these incidents. Both are more serious, and took longer to recover from, than Mr. Sellars'; and yet the Company treated those involved very differently.

It is also very important to note the remedial steps taken by Cougar after Mr. Sellars' incident, as set out in PP #12. Four memos were issued to the pilots, and two SOPs changed. Training was amended. Pages 15 to 18 of PP #12 identifies a dozen or so actions that were taken. Mr. Perry's testimony is particularly relevant on this.

Mr. Ellickson invited the Adjudicator to look at the three parts of PP #18, which refer to a special training session on crew resource management. Mr. Chapman provided a lot of evidence on that issue. Notwithstanding all this evidence, Cougar continues to deny its responsibilities in this matter. That is utterly false. It is important to review JG #3. There simply were no SOPs on this issue at the time. When Mr. Van Humbeck demands to be shown the SOPs, he is told that it is explained in training or that it is common knowledge among the pilots. Yet Mr. Perry could not identify a single person to whom he had spoken. The changes to SOP are changes. They do not constitute a re-emphasis. The changes to training were for unusual attitude recovery. That also was a change. Mr. Perry would not admit that CHARM Program was created as a result of the incident, but Mr. Chapman testified it was designed as a result of the incident, and at Mr. Perry's request. There clearly were a number of failures in the system, and it is not adequate to find pilot error only. On the issue of "automation dependency", Mr. Chapman's evidence was that it is the "most significant issue in aviation today." His evidence on "normalcy bias" was also reminiscent of Mr. Sellars' own experience of how little pilots actually fly aircraft these days, when automation is so generally available. Skills can become eroded. The clear fact is that automation breaks the link between what you want to do and what you have the ability to do.

Mr. Chapman was asked to compare Mr. Sellars' incident with the '07 and '08 incidents. He testified that he saw automation dependency as a common theme. We already know Cougar has accepted this as happening in some pilots, and undertook, in 2001, to train it out of them as is demonstrated in the case of Captain Roach. Mr. Ellickson pointed to JG #8, a letter of discipline administered to Captain Roach in 2001, ten years prior to the incident with Mr. Sellars, and also to PP #19, a letter from Mr. Perry to Captain Godding in 2011. In both cases there were lapses in situational awareness, and the penalty was a reduction to first officer. The 2011 correspondence

(PP #20 & 21) between Chief Pilot Perry and Mr. Godding shows that, in January 2011, Mr. Godding's

..performance in the simulator training session, both during training and during the course of the check ride indicated lapses in situational awareness and system knowledge of the S92."

As a result, Mr. Godding was "reduced from S92 Captain to S92 First Officer. Then in April of 2011, Mr. Perry again writes:

"Mike Godding has completed an S92 SIM training session and was assessed as meeting a captain's standard. His performance was noted as much improved over the previous session and check ride.

Mike has been debriefed by the Chief Pilot and is released as an Offshore Captain on the S92 effective immediately."

In both these situations we see that the Company acting in a way consistent with Mr. Chapman's evidence. It certainly does not correspond with the way Mr. Sellars was treated.

Mr. Ellickson then introduced several authorities and cases drawn from the jurisprudence, most of which relate to S.240 of the *Code*, but are also, therefore, relevant, in the instant circumstances, to S.94. The question under S.240 is whether the dismissal was just or unjust.

The Union's cases included: Office and Technical employees Union, Local 15, on behalf of Michael Cooper, complainant, and Emery Worldwide, a CF Company, respondent CLRB Decision # 775 January 1990.; and Louise Arbour, complainant, & National Pagette, employer, & Communications & Electrical Workers of Canada (CFL-QFL) Union. CLRB No. 862, 1991; and Teamsters Local Union No. 31, and Brad Hildebrant, complainants, and Atomic Transportation System Inc., respondent; and Canadian Union of Postal Workers, complainant, and Speed's Delivery Ltd., respondent [2009] 206 CLRBR. (2d)196; R. Wayne Brown, complainant under Part XIV of the Canada Labour Code, and West Coast Air Ltd., respondent YM2707-4678 J.E.D. Savage, Adjudicator [1999] C.L.A.D. No. 282 at paras. 51-52; Johnny v. Tsewultun Police Service Board [2000] C.L.A.D. No. 468, and also in Moxey and Slave Air (1988) Ltd. [2007] C.L.A.D. No. 133; Moxey and Slave Air (1988) Ltd. [2007] C.L.A.D. No. 133; Booth and Skyward Aviation Ltd., [2002] C.L.A.D. No. 393.

Turning to the issue unjust termination under S.240 of the *Code* and, in particular, of Mr. Mugford's presence in the aircraft, Mr. Ellickson argued that justification for the decision to pair him with Mr. Sellars is totally absent from the Employer's argument and presentation of its case.

Mr. Sellars testified that he would not have flown with Mr. Mugford if he had known about the restriction. Mr. Moores endorsed this. If he'd been scheduled for the flight it would not have happened. So the Company has set Mr. Sellars up, but refuses to take responsibility for its own actions. It is simply not reasonable for the Company to say that Mr. Sellars is the sole person responsible when they paired him with Mr. Mugford. Cougar cannot have it both ways. CHARM was largely prepared in order to reinforce the job of the First Officer and to clarify issues. This series of facts alone makes the termination manifestly unjust.

There is a second reason for judging the termination unjust. It is found in the prior incidents. Mr. Ellickson pointed to Brown and Beatty *Canadian Labour Arbitration* (4th ed.) at para. 7:4414. Cougar has relied on the fact that there was a mechanical problem on one of the two previous flights. But this is a difference on which Cougar is not free to discriminate. Mr. Sellars should be fully exonerated on all charges.

The Union's argument for claiming this is an unjust termination is that the Company launched a number of remedial steps. If this were a simple pilot error, then these remedial steps would not have been required. But clearly that is not what happened here. There were numerous steps taken which gives the lie to the claim that the issue was entirely and wholly pilot error. While there is no doubt that pilot error may have been a cause, clearly, training and proper SOPs were required since they were drafted and put in place immediately after the incident. The TSB report at Section 3.2 raises 16 areas of risk. This was not due to pilot error in any exclusive sense.

Situational awareness is something that can be trained for. Mr. Perry, himself, chose to go that route with Captain Roach ten years previously. Cougar is, and was, aware of the fact, but will not acknowledge it in Mr. Sellars's case. All this points to the rush to terminate Mr. Sellars.

They had not "completed" the investigation as the letter of termination claims. They had completed a portion of it, the HFDM, but the Internal Cougar report itself came weeks later. It is inconceivable this was purely pilot error when compared with the 2007 and '08 incidents. Mr. Ellickson suggested the Adjudicator look at PP #24 on this issue, and at the way the Company dealt with Mr. Segura three months earlier. The tone and contents are entirely different.

The pairing with Mr. Mugford, the prior incidents, the remedial steps that the Company has since taken and the auto-dependency: all of these issues are also relevant to the question of anti-union animus insofar that it demonstrates how remarkably unreasonable this decision was. It

therefore confirms the presumption of anti-union animus, and relates directly to Section 94.

Clearly, Mr. Sellars was one of the leaders in the organization of the Union. Clearly, as well, management knew it, as evidenced by the Maintenance Director's comment. He knew of Mr. Sellars's campaigning in the workplace. It defies logic that no one spoke with Management. The termination decision clearly was motivated, in part, by his Union participation, and was contrary to *Code*. The complaint must be allowed. (*Echo Bay Mines*, CLRB No. 1140, (p, 6) addresses the fact that the cause need not be proximate in these circumstances.)

Mr. Ellickson reviewed the jurisprudence advanced by Mr. Smith for the Employer. In the Union's view, the evidence supports the inference that the Employer knew of Mr. Sellars' Union activities, and that the Employer has failed to rebut the presumption of anti-union animus. The only response, therefore, is to reinstate the Complainant with full compensation.

Mr. Ellickson also responded to Mr. Smith's treatment of the Employer's claim about ditching. In Mr. Ellickson's submission, that has been sufficiently covered in evidence. The evidence shows that there was an assumption, not knowledge, that they were preparing to ditch.

Mr. Smith also said that demotion was not available as an option. But history shows otherwise. As the evidence unfolds, the eagerness of the Company to deny Mr. Sellars demotion underscores the unfairness of its decision.

Mr. Smith also dismissed the idea that automation dependency could develop in a pilot within less than three years. The evidence shows otherwise, as Mr. Chapman's testimony made clear. There is no just cause for discipline, based on evidence of the rush to terminate, the pairing with Mr. Mugford, the prior incidents, the remedial steps taken by the Company and automation dependency. Mr. Sellars had no discipline while with Cougar, or in his thirty year experience. He'd been without accident or reportable incident. It is not acceptable to claim his difficulty with situational awareness could not be corrected by training. There is a violation both of S.240 and of S. 94, that calls for the Complainant's reinstatement with full seniority, benefits and compensation. Any suggestion of compensation as an alternate is simply not relevant. There is no authority to do that, and it is not appropriate. (See *Brown & West* at para. 57 and 66.)

IN REBUTTAL ARGUMENT FOR THE EMPLOYER, Mr. Smith said that the Union had fallen into the trap of blaming the Company, the copilot... in fact, everyone except the actual Captain, himself. There was no answer to the question that has to be asked, as framed in Mr.

Moore's notes (RM #1) Why, when Mr. Sellars knew what he was supposed to do to get out of the problem, did he freeze?

The Union claims we can train someone to react to a critical situation. But Mr. Sellars has shown, notwithstanding the training, that he cannot be trained. Fortunately the fog was only down to 200 feet, so he managed to use his 27 years of VFR experience. The simulator cannot do the same to address a panic response. The experience of real risk cannot be trained for, nor can the 27 or 28 years of training in VFR flying. Mr. Sellars's testimony was that he did not put the nose down at 541 feet *in cloud*, but did do it at 200 feet when he was *below cloud* and in VFR conditions, is compelling.

It is important to be clear: the Employer did not terminate him for automation-dependency. You can train out of that. This pilot of 30 years in VFR and unblemished record is precisely that, a fine VFR pilot. But Cougar needs pilots who can operate in IFR in the worst spot in the world. You can claim it's automation-dependency and that anyone is vulnerable to this, but don't forget that he was falling at 1800 feet per minute. Agreed, it only took seconds, but it is those seconds that lead the Employer and the Director of Flight Operations and the Chief Pilot to say, "No way. You can not operate in this environment." There's no way that you can train someone when they are falling out of the sky with passengers and crew.

Add to that the fact that Transport Safety Board found he knew what to do but could not do it. He was concerned that he would go into a dive. With all due respect, that is evidence of the freeze, or of "subtle incapacitation." RM #1 shows that he knew what to do. He did not, however, react as a pilot should react.

Mr. Sellars's other excuse is that Mr. Mugford shouldn't have been paired with him. Yes, the Company accepts that; but it was only the Husky contract from which he was barred. He could, and did, fly with other captains. But Mr. Mugford didn't compound Mr. Sellars' problem. Mr. Mugford immediately called when he saw the altitude and airspeed problems, and he called several times. The reasons he chose not take over were viewed as valid. He recognized that he should have taken over, but did not because he thought Mr. Sellars was correcting. Mr. Sellars also complains that Mr. Mugford failed to make the rate of descent clear with targeted calls. But Mr. Sellars had both pieces of information if he'd chosen to use them. By saying "correcting", Mr. Sellars made Mr. Mugford think that everything was okay.

The Union and the Employer are not very far apart on what the law says, but do have two very different interpretations of the facts. It would be idiotic to deny Husky was all over Cougar. It's obvious. They were very concerned. The helicopter was below the helideck. They wanted answers, ASAP. Between the 23rd and 28th of July the decision was taken. But it cannot be thought that the tragedy of 491 did not change the situation, and change it dramatically. The fear factor is real. The 491 Inquiry was a fact of life in the minds and hearts of Cougar and of the Transport Safety Board. This new incident needed investigating as quickly as possible. Employees were interviewed; HFDM data were scrutinized; and the Company reached its decision. The formal report was not done for several weeks. Sometimes copying takes too long. The reality is the Employer's decision to terminate was a result of the investigation done before the 28th, and this was supported by the internal report, which was followed a few weeks later by the TSB report.

The loss of the CVR was unfortunate. What actually happened was that the aircraft was flown again. To suggest that this is prejudicial to Mr. Sellars is misleading. Either side could provide information, and the HUMS data were clear, in any case.

Clearly the Employer did have knowledge of the CEP before the June 9th meeting, but not that Mr. Sellars was involved in selling the Union. The Employer had no reason to deal with the Chair of the committee. There is no evidence Mr. Sellars was involved. We do not know when the Maintenance Manager was on the floor, or which union he was talking about.

There were several questions around the reliability of data, and whether or not the go around was used on the return flight to St. John's. The idea that the data are suspicious because they show the go around was engaged at the same speed is ludicrous. Both expert bodies have confirmed that the go around was turned on. Mr. Moores' notes (RM #1) suggests there was no use of the go around on the flight back to St. John's, but both the HFDM committee and the TSB do not accept that.

The previous incidents do not support the Union's claim of discrimination against Mr. Sellars. Those involved in the first two incidents met the challenges that Mr. Sellars did not meet on July 23rd. The difference was Flight 491. As far as the two other events are concerned there is no evidence that either of the other two captains had been trained in such proximity to the incidents. There is no evidence that their credentials or training had a deficiency; but clearly in 2009 Mr. Sellars did have a deficiency, and again had a difficulty during his recurrent training. Mr.

Sellars, himself, said so. He knew what to do, but he did not do it. That erodes confidence. He simply was unable to react appropriately, but did so as soon as he came out of the cloud and was able to revert to familiar behaviour.

The TSB refers to additional training but he had problems as early as 2008 and then again in 2009 and 2010. That is a very dangerous route to take. The Company must be very confident, given the responsibilities it faces. Not one of the Union's arguments addresses the question of Mr. Sellars's inability to react in a stress situation. That is the key danger of the situation here. We don't know, and can't find out. Putting him back leaves people at risk. Mr. Sellars's own reaction to the automation dependency issue is that he should have been more aggressive. Yes, but that is what his job is.

There is no evidence that S.94 has been breached. The coincidence is precisely that, a coincidence. The Company cannot place a person in a stress situation who cannot operate effectively and efficiently; nor could he do so as a copilot. Demotion was not an option. In summary, the lack of IFR experience was crucial, and Husky has a legitimate role to play in requiring the presence of that skill.

CONSIDERATIONS

At issue between the Parties are complaints (SD#s1, 2, 3, 4, & 13) of "unfair labour practice" (under S.97 and S.94 of the *Canada Labour Code*) and of "unjust dismissal" (under S.240 of the *Code*). The Parties have agreed that the matter be conducted pursuant to S.240, and that I be appointed with authority to adjudicate the matter.

Code-related Questions that I must answer are:

- a) Is there evidence of actual anti-union bias, leaving aside any question of inference arising out of the circumstances of the Union drive that the Employer may be able to rebut. (S.94)
- b) Was the termination a reasonable, proper exercise of management's function in the circumstances of the ongoing Union drive, and that the Employer has proven that any inference of anti-union animus is negated (S.94 & S.98.4)?
- c) Was Mr. Sellars' termination justified (S.420)?
- d) If not, is some other discipline justified?

After a preliminary review of the statutes, authorities, and jurisprudence, I shall consider each of these questions in turn, and then turn to my findings and decisions in the matter.

The Union complains that Mr. Sellars' termination was a violation of the *Code's* prohibition against "Unfair Practices" (S.94) insofar as it was either actually motivated by or tainted by anti-

union animus, or there is a presumption to that effect arising under S.94, which the Employer is unable to rebut as it must under S.98.4. The Union also complains and that the evidence shows the termination was unjustified, thus violating the *Code's* prohibition against "Unjust Dismissal" (S.240). (In the Union's submission, the circumstances of the unjust dismissal also provide evidence of the anti-union animus prohibited under S.94.)

The Employer denies its actions were animated by any anti-union animus, and denies that the termination was an unjust dismissal. The Employer argues that there is no reliable evidence of any actual anti-union animus, and that the presumption of anti-union animus, rebuttable under S.98.4, arose out of a simple coincidence in time of the July 23, 2011 incident (which solely and immediately gave rise to the termination) and the unionization drive, of which the Employer was unaware. The Employer undertook to rebut the presumption, and to show that the dismissal was both justified under S.240, and, in fact, was its only option in the circumstances.

Statutes, Authorities, and Jurisprudence...

1. The Statutes: Adjudicator's Role and Powers under the Code:

Before considering issues addressed by the *Code*, it is helpful to recall what the *Code* requires of an Adjudicator in the instant circumstances, and what powers are provided.

The Code provides, at Section 16 ("Powers of the Board"), among other things, that:

- The Board has, in relation to any proceeding before it, power (a) to summon and enforce the attendance of witnesses and compel them to give oral or written evidence on oath and to produce such documents and things as the Board deems requisite to the full investigation and consideration of any matter within its jurisdiction that is before the Board in the proceeding;...
- (b) to administer oaths and solemn affirmations;
- (c) to receive and accept such evidence and information on oath, affidavit or otherwise as the Board in its discretion sees fit, whether admissible in a court of law or not;
- (d) to examine, in accordance with any regulations of the Board, such evidence as is submitted to it respecting the membership of any employees in a trade union seeking certification;...
- (f) to make such examination of records and such inquiries as it deems necessary (f.1) to compel, at any stage of a proceeding, any person to provide information or produce the documents and things that may be relevant to a matter before it, after providing the parties the opportunity to make representations;...
- (l) to adjourn or postpone the proceeding from time to time;...
- (o) to add a party to the proceeding at any stage of the proceeding;...

(p) to decide for all purposes of this Part any question that may arise in the proceeding, including, without restricting the generality of the foregoing, any question as to whether...

The Code prohibits, at S.94, ("Unfair Practices") an "employer or person acting on behalf of an employer" from refusing ...

(a) ... to employ or to continue to employ or suspend, transfer, lay off or otherwise discriminate against any person with respect to employment, pay or any other term or condition of employment or intimidate, threaten or otherwise discipline any person, because the person

(i) is or proposes to become, or seeks to induce any other person to become, a member, officer or representative of a trade union or participates in the promotion, formation or administration of a trade union...

(e) seek by intimidation, threat of dismissal or any other kind of threat, by the imposition of a financial or other penalty or by any other means, to compel a person to refrain from becoming or to cease to be a member, officer or representative of a trade union...

At Section 98.(4), the Code further provides that:

Where a complaint is made in writing pursuant to section 97 in respect of an alleged failure by an employer or any person acting on behalf of an employer to comply with subsection 94(3), the written complaint is itself evidence that such failure actually occurred and, if any party to the complaint proceedings alleges that such failure did not occur, the burden of proof thereof is on that party.

The Code also provides, at S.240 ("Unjust Dismissal") that:

... any person

(a) who has completed twelve consecutive months of continuous employment by an employer, and

(b) who is not a member of a group of employees subject to a Collective Agreement, may make a complaint in writing to an inspector if the employee has been dismissed and considers the dismissal to be unjust...

And, at S.242.(3) & (4), the Code orders that, "subject to subsection (3.1)":

an Adjudicator to whom a complaint has been referred under subsection (1) shall

(a) consider whether the dismissal of the person who made the complaint was unjust and render a decision thereon; and

(b) send a copy of the decision with the reasons therefore to each party to the complaint and to the Minister ...

(4) Where an Adjudicator decides pursuant to subsection (3) that a person has been unjustly dismissed, the Adjudicator may, by order, require the employer who dismissed the person to

- (a) pay the person compensation not exceeding the amount of money that is equivalent to the remuneration that would, but for the dismissal, have been paid by the employer to the person;
- (b) reinstate the person in his employ; and
- (c) do any other like thing that it is equitable to require the employer to do in order to remedy or counteract any consequence of the dismissal.

In adjudicating the *Code*-related issues before me I am, of course, subject to the *Code*, including especially in this case, Ss.16, 94, 98, 240 & 242. I am very grateful to the Parties for the jurisprudence they have provided for my guidance, as set out below.

2. Jurisprudence: It is clear from reading the *Code* and the jurisprudence provided that an Adjudicator has specific responsibilities and broad powers.

In respect of S.94 (Unfair Labour Practice), I note that the jurisprudence sees the *Code* as requiring that:

"No matter how much cause an employer might have to terminate an employee, it is guilty of an unfair labour practice if in addition to cause there was any anti-union motivation..." *Echo Bay Mines, CLRB No. 1140*, (headnote)

And thus it requires that: "Anti-union motives need only be proximate cause for employer action to be found to be a violation of the *Code*."

"To give substance to the policy of the legislation and properly protect the employee's right, an employer must not be permitted to achieve a discriminatory objective because he has coupled his discriminatory motive with other non-discriminatory reasons for his act." *Air Atlantic Limited (1986)*, 68di 30; & 87 CLLC 16,002 (CLRB no. 600) as quoted in *United Steelworkers of America, on behalf of Margaret Crowley, & Echo Bay Mines Ltd.*, respondent 99 di 78. CLRB No.1140 p 4.

In other words, relying on *Rousseau* (at para 100), the main issue

... is whether, on the basis of the evidence adduced by the parties, the reasons given by the Employer in the dismissal letter... are the only reasons for the dismissal, regardless of whether they are legitimate and valid.

I also note that the Jurisprudence generally sees this principle as giving rise to a further consequence for the application of S.94 if the termination were to occur contemporaneously with an organization drive, as was the case in *Echo Bay* and *Emory Worldwide & National Pagette*, and others. Such a circumstance gives rise to a presumption, per S.98(4), (with a reverse onus on the Employer, *cf.*, *Atomic Transportation System* at p.3) of anti-union bias:

"When the Board examines the merits of an unfair labour practice complaint, particularly one involving dismissal, its role is very different from that of an arbitrator. The reasons for the decision to dismiss an employee are relevant only insofar as they reveal, through their nature, their occurrence in time, their severity or their impact, that the decision was motivated by anti-union animus. In discharging the reverse onus of proof imposed in section 98(4) of the *Code*, the Employer must show that its reasons for dismissing an employee are in no way motivated by anti-union animus." (*National Pagette* p. 9)

Consequently, this often results, as in *National Pagette*, in a situation where

".. the Board ... believes that the employer failed to prove, having regard to the presumption, established in 98(4), that its reasons for dismissing the complainant were not devoid of anti-union Bias." (*National Pagette* p. 15)

Further, jurisprudence shows that the outcome of such a reverse onus process can often be determined on the basis of circumstantial evidence.

"This means that the onus on the Employer is not necessarily to demonstrate that it had just cause to dismiss (the employee), but that in taking the actions it took, whether they were right or wrong from a dismissal standpoint, such actions were not taken with any anti-union animus... (T)he cases are clear that any anti-union animus is enough to taint the actions of the Employer." (Cf., *Atomic Transportation System*, p 3-4).

In *Speed's Delivery Ltd.*, I note the foregoing principles summarized in the headnote:

"..Pursuant to section 98(4) of the *Code*, a written complaint of an alleged violation of section 94(3) by the employer is itself evidence that the employer failed to comply with section 94(3), and the burden of proof that such failure did not occur rests with the employer – The Board is not required to pass judgement on whether or not the employer had good reasons for (the dismissal) – The issue is whether or not the employer has met its burden to show, on a balance of probabilities, that the ... dismissal was "rational and warranted solely from the perspective of sound management, absent any other indication of anti-union animus.".. The Board is not required to find direct evidence of anti-union animus under section 94(3) of the *Code* and has frequently relied on circumstantial evidence in such cases..."

In respect of S.240 (Unjust dismissal), the Jurisprudence sees the *Code* as requiring analysis much as in standard grievance arbitration. As with grievance arbitration, it sees a distinction between administrative and disciplinary dismissals. The Employer consistently stated its respect for Mr. Sellars' extensive experience and competence as a VFR pilot, while insisting that his IFR skills, essential to Cougar's Newfoundland offshore work, were not acceptable and that his behaviour shows that no training could be designed that might remedy this IFR capability deficit.

In this context, therefore, I note *R. Wayne Brown, complainant under Part XIV of the Canada Labour Code, and West Coast Air Ltd., respondent YM2707-4678* J.E.D. Savage, Adjudicator [1999] C.L.A.D. No. 282 at paras. 51-52.

51. A distinction has been drawn between disciplinary... and administrative dismissals: In the case of a disciplinary dismissal, the Adjudicator cannot be satisfied without proof that the act or acts of alleged misconduct were actually committed and that they were sufficiently serious to justify breaking the contract of employment; but in the case of an "administrative dismissal", the evidence cannot relate to positive facts of the same type or be as strict and precise. *Bell Canada v. Halle et. al.* (1989), 29 C.C.E.L. 213 (F.C.A.), 220.

52. Adjudicator Hope considered the notion of an administrative dismissal in *Re Edith Cavell Private Hospital and HEU, Local 180* (1982), 6 L.A.C. (3d) 229 at 233: An employer who seeks to dismiss an employee for a non-culpable deficiency in job performance must meet certain criteria:

- (a) The employer must define the level of job performance required.
- (b) The employer must establish that the standard expected was communicated to the employee.
- (c) The employer must establish an inability on the part of the employee to meet the requisite standard to an extent that renders her incapable of performing the job and that reasonable efforts were made to find alternate employment within the competence of the employee.
- (d) The employer must disclose that reasonable warnings were given to the employee that a failure to meet the standard could result in dismissal.

I note that, in the instant matter before me, the Employer dismissed as unavailable the possibility of demoting Mr. Sellars to First Officer and also dismissed any possibility of training as remedy for his IFR capability deficit. In *Brown and West Coast Air Ltd.*, (as in *Johnny v. Tsewultun Police Service Board* [2000] C.L.A.D. No. 468, and also in *Moxey and Slave Air (1988) Ltd.* [2007] C.L.A.D. No. 133), I note that an Employer must consider alternative employment in that administrative situation. In the instant circumstances, however, I note that there was no suggestion that the termination was administrative in any relevant sense.

Remedy?

On the issue of remedy under S.240, I note that the *Code* provides (at Section 242(4)) direction following a finding of Unjust Dismissal under S.240:

- (4) Where an Adjudicator decides pursuant to subsection (3) that a person has been unjustly dismissed, the Adjudicator may, by order, require the employer who dismissed the person to

- (a) pay the person compensation not exceeding the amount of money that is equivalent to the remuneration that would, but for the dismissal, have been paid by the employer to the person,
- (b) reinstate the person in his employ; and
- (c) do any other like thing that it is equitable to require the employer to do in order to remedy or counteract any consequence of the dismissal...

I note also that *Brown and West Coast Air Ltd.* Comments, at para. 57:

With respect to the remedy of reinstatement, the Federal Court of Appeal recently reviewed this remedy in *Atomic Energy of Canada Limited v. Sheikholeslami* (1998), 98 C.L.L.C. 210. Mr. Justice Marceau noted that reinstatement is a "possible remedy that may be resorted to in proper situations" (page 141, 077). Justice Letourneau, concurring in the result, opined:

"It is true that reinstatement is not a right even after a finding of unjust dismissal, but, as I. Christie *et al.* properly point out, the exception to reinstatement should be applied very cautiously otherwise the risk exists that an unjustly dismissed employee will be penalized by losing his job. Indeed, a finding of unjust dismissal is a finding that the work relationship should not have been severed in the first place. In such cases, the presumption is, in my view, clearly in favour of reinstatement unless there is clear evidence to the contrary" (page 141, 080).

The Questions:

Question (a) Is There Evidence of Actual Anti-union Bias? (S.94)

On this question, I note in particular *Rousseau and Canadian National Railway Company*, CIRB Decision # 393, 2007 (*cf.*, *Guy Duchesneau & Conseil De La Nation Huronne-Wendat*, CIRB Decision #1) At *Rousseau* para 93, I note the Board cites *Lafrance and Larose Paquete Autobus Inc.*, (1990) CLRB No. 840 as holding the following about a Board's duty in a complaint under S.94(3)(a)(i) of the *Code*:

This warrants that the Board carefully examine all the evidence to determine whether in fact anti-union animus was present. In order to prove that its action was devoid of anti-union animus, the Employer can argue that the penalty imposed on the employee was rational and warranted strictly from the standpoint of sound management.

There is little dispute about the basic facts of the Flight 851 incident. The event is most fully and definitively described in the *Transport Safety Board* (TSB) Report (BS#1). Matters of fact remain at issue, as noted below, but the dispute arises mainly from the Parties' differing

interpretations of the facts, including those that are disputed, and the legitimacy under the *Code* of the Employer's actions in response to those facts.

Evidence on the question of actual anti-union animus was led both in relation to the incident itself, and also in relation to what the Employer may have known of the unionization drive ongoing at the time and of Mr. Sellars involvement in it. I shall address, first, evidence relating to the incident itself.

1. *Were the floats engaged as a result of a decision to "ditch"?*

This is of significance to my adjudication of issues addressed by both sections of the *Code*, since the Termination Letter (C#1) explicitly and prominently refers to Mr. Sellars' "...improper decision to prepare to 'ditch'..." as the concluding element in the Employer's statement of grounds for the termination decision. The relevant portion of the letter reads:

...We are satisfied that the pilot errors committed by you needlessly endangered yourself, the crew, the passengers as well as the aircraft and your reactions and lack of reaction, including an improper decision to prepare to "ditch" the aircraft while recovery was easily achievable, are so serious that we have lost all confidence in your abilities to pilot our aircraft in the offshore service...

I note the evidence that Captain Sellars has insistently and consistently denied taking any such "decision." He repeated this denial at this hearing. No reference to engaging the floats appears in Mr. Sellars' initial written report (PP#4). However, Mr. Mugford's initial report (PP#5) states:

... when the "speed was around 50kts" and the "aircraft audio was saying down (*sic*) sink and low rotor... Also at that time I rearmed the floats..."

I note that the *HFDM Committee's Summary Investigation Report* (PP#7) refers to "the crew's written and oral interviews", but makes no reference to rearming of the floats reported by Mr. Mugford or to any indication of a decision to ditch. Mr. Moores' handwritten notes of the HFDM committee interview with Mr. Sellars & Mr. Mugford (RM#1) are similarly silent on the floats and any decision to "ditch." Also, there is no mention of arming floats or decision to ditch in Captain Perry's handwritten notes of the July 26 HFDM committee debriefing (PP#10, p.1).

In Cougar's *Internal Aviation Investigation Report conducted July 3- Aug 2, 2011* (PP #12), I see no mention, in the Flight Details, Section (2.1), of arming floats or of any decision to ditch. I note, more specifically, no mention occurs even in subsections 2.1.12 - 2.1.14, which correspond to the time when, Mr. Mugford's initial report (PP#5) says, "... I rearmed the floats..."

I also note that Subsections 2.17.1 and 2.17.2, confirm that the Report (PP#12) authors had consulted "interviews and subsequent data analysis" and "crew statements and tracking records." Thus, I conclude that Mr. Mugford's initial report (PP#5), and its reference to re-arming the floats, were part of the documentation on which the Committee relied. (In any case, that initial report (PP#5) is included in the Report (PP#12) without comment as Appendix 6.1.4) In short, nowhere in the report (PP#12) do I find reference to arming the floats or ditching.

However, I note Mr. Mugford's own characterization of what he was doing when "arming the floats." It occurs in his written declaration provided in the context of the Union's action before the CIRB (Exhibit #1, p. 3 #9), as follows:

9. Contrary to Cougar's response at no time did Captain Sellars lose control of the aircraft. He was making corrections and responding to the calls I was making. I was also never concerned that we would end up in the water. Arming the floats was part of the standard operating procedure.

When Mr. Gerber was asked whether he agreed with Mr. Mugford that arming the floats is part of the SOP, he answered that "... The statement about the floats as being in accord with SOP is correct, but only if you are ditching." And asked whether, in fact, there is an SOP for when an aircraft reaches a certain altitude, Mr. Gerber answered, "yes, or when ditching." I find this response puzzling. I find it hard to believe it is not basic common sense, as well as standard operation, to engage floats in a situation when "... aircraft audio was saying down (sic) sink and low rotor..." and the aircraft was "descending" toward the surface of the water, as described in Mr. Mugford's initial report (PP#5).

I note that the *Transport Safety Board of Canada Aviation Investigation Report* (BS #1) was published well after the beginning of this Hearing, and therefore could not, of course, have influenced the Employer's discipline decision. In that document I find mention of re-arming the floats (on p. 5) in the context of the Report's *History of the Flight* (Section 1.1). The Report does not there frame the event in relation to a decision to ditch. The para. reads, in part, as follows:

In response to the low rotor warning, the first officer advised the captain to lower the collective. The captain acknowledged and lowered the collective slightly to regain Nr. The first officer then re-armed the floatation in anticipation of water impact. The heading, which had been increasing ..."

I note that at S.1.18.8 (p. 30) the TSB Report again describes Mr. Mugford's re-arming floatation, this time in the context of *Crew Resource Management Training* and, more specifically, of a

discussion about the Pilot Monitoring having chosen not "to assume control of the helicopter following the second challenge." The passage reads:

When the occurrence helicopter's nose first rose sharply, the first officer was selecting the landing gear to UP and placing the flotation switch to SAFE. During those brief moments, the first officer was not closely monitoring the flight instruments. Immediately following these switch selections, the first officer noticed that the helicopter was descending in a nose-high attitude with low airspeed. The first officer immediately verbalized concerns to the captain, making an attitude and airspeed deviation call. Shortly after making the first deviation call, the "Don't sink" aural warning also began to sound, and the first officer continued making attitude and airspeed calls to the captain. However, the first officer did not assume control of the helicopter following the second challenge. This was due to the first officer's belief that the captain was making the necessary corrections, and a belief that taking control of the helicopter would likely exacerbate the situation. *Instead, the first officer re-armed the emergency flotation system in preparation for water impact.* This was the first time that the first officer had ever been in a situation where deviation calls were made without positive corrective action taken by the PF to rectify the situation. (*my emphasis*)

I note that there is a third reference in TSB Report at Section 2.7 (p. 38-39), again in the context of *Crew Resource Management*. The passage reads:

If CRM strategies are not practiced during simulator and flight training, there is increased risk that flight crews will experience breakdowns in CRM that could reduce safety margins.

In this occurrence, the first officer provided several verbal cues to the captain to assist with the recovery from the unusual attitude. *However, despite having made the decision to re-arm the flotation because it was believed water impact was imminent, the first officer did not attempt to assume control from the captain.* The first officer did not recognize the symptoms of subtle incapacitation, which are outlined in Cougar Helicopters' SOPs. As a result, the first officer did not assume control from the captain because the captain was providing appropriate verbal responses to the challenges. This is not unusual. As identified earlier in the report, first officers are often reluctant to assume control from their captains. In this occurrence, the first officer believed the situation would be made worse by attempting to take control. This is an indication that the first officer doubted having the necessary manual flying skills to recover from the inadvertent descent, despite the fact that Cougar Helicopters' pilots had been taught a standard unusual attitude recovery procedure. This is contrary to guidance in the CHARM course handbook, and it is not in accordance with the two-challenge rule published in the Cougar Helicopters SOPs, which call for an automatic assumption of flying duties if appropriate action has not been taken after the second challenge. The first officer did not take control of the helicopter, as per the two-challenge rule in Cougar Helicopters' SOPs, when the appropriate action was not taken to recover from the inadvertent descent.

The TSB Report is not inconsistent with Mr. Mugford's statement that the re-arming was done as "part of the standard operating procedure." The TSB Report's phrasing at all three points where the text deals with the event does not state or imply or suggest that the first officer acted on a *decision* to make "water impact", but only "in *anticipation* of water impact" (p 30) or "because it was believed water impact was imminent" (p 38). The TSB Report makes no reference to a "decision to prepare to 'ditch'...."

The only "decision" the Report addresses in this context is Mr. Mugford's decision *not to take command*, and to re-arm the floats "in preparation for water impact ...*instead* ..." of taking command. (p. 30). The decision to take command is the "decision" the Transport Safety Board finds (pp. 30 & 38-39) should have been taken, *by the First officer* (my emphases).

In the context of this adjudication however it is important to note that at no point does the Transport Safety Board implicate Mr. Sellars at all in its comments about rearming the floats. The exclusive focus of these comments is the First Officer, Mr. Mugford. And the Board's particular concern is NOT that Mr. Mugford re-armed the floats, but that he did so "*instead*" of taking command.

But the Employer did draw the inference that there was an "an improper decision to prepare to 'ditch' the aircraft while recovery was easily achievable", even though that particular "decision" was not expressly drawn by other investigating bodies, including Cougar's own Internal Investigation Report (PP#12). So what, if any, evidence supports the Employer's inference? I note that, on direct examination, Mr. Moores testified that:

They believed they were getting ready to ditch and they wanted the aircraft level to ditch. You don't want to go into the water side-on. There is a better chance of survivability.

Mr. Moores justified his view that they "believed they were getting ready to ditch" by pointing to the fact that "the floats were initiated", and that, despite its not being recorded in the *HFDM Committee's Summary Investigation Report* (PP#7), which he co-authored (though I note he is not one of its signatories at PP#12 p.1), it "shows up on the data, even though they did not mention it in the interview." So it seems that Mr. Moores, for one, made the same inference that the Employer did. In fact, on cross examination, Mr. Moores' actual understanding of rearming of the floats becomes clearer in detail; and it appears to be at variance with Mr. Mugford's initial report of the specific time when he rearmed the floats. Mr. Moores testified on cross that:

... it would be unusual for someone at 500 feet to be preparing to ditch. That SOP does not call for you to activate the floats. There is nothing "standard" about this.

Mr. Mugford's statement (PP#5) reads:

... when the "speed was around 50kts and the (*sic*) descending (*sic*). The aircraft audio was saying down (*sic*) sink and low rotor I said check rotor boyd said check. Also at that time I rearmed the floats. We came to a low stabilize hover over the water..."

Mr. Moores speaks of the re-arming as though it had taken place "at 500 feet." Mr. Mugford makes it clear, in his July 23, 9:49:53 report (PP#5), that it took place later, relatively speaking, when the "speed was around 50kts", and the "aircraft audio was saying down (*sic*) sink and low rotor." On the general issue of a somewhat later time for engaging the floats than Mr. Moores supposes, the *Transport Safety Board Report* (BS #1) appears to agree with Mr. Mugford's account (in the penultimate paragraph on p. 5. Also please see above Mr. Perry's testimony on the issue @ p. 22 of this Award.)

But, more importantly, I note that Mr. Moores himself appears to be aware of a later point for the re-arming than his reference (in cross examination) to "500 feet" suggests. At the end of direct examination, he had noted that: "The low rotor call is very bad to hear... Glynn armed the floats at that point." I conclude that Mr. Moores seems confused about this important detail.

Is there any other evidence that supports the Employer's "ditching" inference? I note that Mr. Gerber testified he had not himself interviewed Mr. Sellars or Mr. Mugford, but had "relied on the interview the HDFM Committee conducted." Consistent with this testimony, Mr. Gerber seems to use the same reasoning on the evidence for a "decision" to "ditch" as Mr. Moores did:

Asked for the foundation of his conclusion that Mr. Sellars decided to ditch, Mr. Gerber said: "We took that from the fact that the floats were armed." Mr. Smith pointed out that it was the pilot monitoring who had engaged the floats. Mr. Gerber answered, "I understood that was somewhat of the reason for keeping the wings level."

As noted above, Captain Moores had also testified that:

They believed they were getting ready to ditch and they wanted the aircraft level to ditch. You don't want to go into the water side-on. There is a better chance of survivability.

But, as just established, Mr. Moores' understanding of the purpose of re-arming the floats appears to be predicated on his problematic understanding of the time that had occurred. Thus, Mr. Gerber's understanding of the link between rearming the flotation, the "wings level" focus,

and an inferred intention to "ditch" was also problematic, insofar as it relied on Mr. Moores and the HFDM interview as sources. In this regard, I also note Mr. Gerber's testimony when asked if he had read the statements he'd requested, (Mr. Mugford's clarification of when the floats were armed was made in his crew statement.) Mr. Gerber said:

No, I did not. I made it clear to them that they were not to send me these statements, but they were to be sent to the Committee. I tried to stay away from any additional information offered to me. The Committee had these crew statements, but I did not see any of them.

I note that Mr. Moores testified that at the interview the Committee conducted with the crew on "the afternoon of the 24th... We didn't have the crew members' written statements before the interview. We always look at the data first to rule out the crew if we can..."

I also note that there is no record in Mr. Moores' notes of the interview with the crew (RM#1) of Mr. Sellars being asked about his reason for focussing on wings level. Mr. Sellars did not, in fact, treat his maintaining "wings level" as linked to a ditching, but as a part of his response to the unusual attitude he was encountering. Thus, a decision to ditch does not appear to be the actual, necessary, most obvious, or most natural explanation for Mr. Sellars' "wings level" behaviour. I also note that the SOP for "Settling with Power Recovery Procedures" (RM#3 at 7.132.2(b)) requires that the "PF should roll to a level attitude...." Also, among measures the Employer took after the July 23 incident, was to issue a memo to Cougar pilots "re: Unusual Attitude Recovery" (PP#12, p. 21). This recommends "level the wings" as the third step (of six) in the procedure that "will apply to most events in an S92 helicopter."

The Employer argued from the beginning of the hearing, however, that observers had thought the aircraft was "ditching." I note that documentary evidence for this claim appears in the appendices to the *Internal Aviation Investigation Report conducted July 3- Aug 2, 2011* (PP#12), at pp 25-29, where the following four statements are to be found.

(p. 25) Passenger Statement

As per our discussion earlier,

At approximately 2:45 pm on the day of July 23, 2011 we departed the Sea Rose. Upon departing, I noticed that we were climbing at an increasingly steep angle through the fog. I looked up to the cockpit because I thought it was strange to be ascending at such a steep angle, more like what you would feel when taking off in an airplane. I heard an audible alarm coming from the cockpit for what seemed to be only a few seconds. I noticed that the angle of the helicopter decreased to a more horizontal level. At this point I felt as though everything was normal. Then I had the sensation that we were falling, due to the

fog I had no idea how high or how low we were. This lasted for maybe 5-10 seconds, then we broke out of the fog; coming to a hover from what I felt could be no more than 20-25 feet from the water. My colleague later commented that he could see the water being kicked up from the aircraft. We remained at a hover for a short duration, I felt at this point that we would try to get to a vessel or that he was going to land the helicopter in the water. After a short while we resumed our departure, the pilot came on and told us that we could unzip our hoods, although I think everybody kept it zipped up for another 5-10 minutes. The pilot came on and told us over the PA then that we had departed at a steep attitude and we had a controlled descent in order to regain the lift we needed. The remainder of the flight was completely normal.

Upon arriving at cougar we were told that the pilot would like to debrief us regarding the event that took place. The pilot came in after we received our bags and told us in more detail what had happened during our departure. He told us that when we left the Sea Rose he engaged the Autorun, which he told us would allow the helicopter to climb at a rate of 750 ft/min (not quite sure on the numbers) wings level. At this point the helicopter continued to climb until we achieved a point to which our forward movement no longer allowed for lift. Then he told us that he pushed the nose forward and we had a controlled descent to a hover above the water. Then he checked the system and resumed our departure.

I feel that a big thanks should be given to the pilot for his efforts. Both the pilot and the Cougar representative let us know that if we had any more questions that we could phone Cougar and they would be happy to answer any of our questions. I appreciated the debriefing as well as his professionalism regarding the matter.

If there is anything else I can answer please let me know,
Regards,
Adam Pike Subsea Controls Tech III

(p 26) July 24, 2011

On July 23, 2011 after normal helicopter operations and the helicopter was secured, I radioed the helicopter pilot on flight 851 and notified him that he had a clear deck on the Sea Rose. At which time the pilot acknowledged that. A few minutes later the pilot said 851 was lifting and I acknowledged that I had copied his transmission.

At this time the helideck crew were standing by underneath the helideck waiting for the pilot to notify us that the flight was safely away. While we stood by underneath the helideck, one of the crew members noticed that the helicopter was heading towards the water and losing altitude. From our vantage point it appeared that the pilot was descending in a controlled manner. He stabilized at an altitude of an estimated 100 feet from the water hovered for a brief moment and then proceeded to climb to flying altitude.

As I had not heard from the pilot on channel 130.275 I called the Sea Rose weather and asked if they had heard from the pilot, at which point the weather observer notified me that the pilot had called on VHF ch 74 and notified that the flight was safely away.

Brendan Farrell

(p. 27) Statement July 24, 2011

On the afternoon of July 23rd, 2011 after normal helicopter operations were complete, I was monitoring the transmission between the pilot of 851 and the Sea Rose HLO on 130.275.

The SeaRose HLO notified the flight crew that they had a clear deck on the SeaRose indicating that the helideck was clear and ready for take off. The flight crew acknowledged the transmission. A few moments later the flight crew notified the HLO that 851 was lifting.

I monitored the flight lift from the deck of the SeaRose on the CCTV camera and while everything appeared normal, I checked the time the flight left the Sea Rose deck. While I was writing down the time, a co-worker on the bridge at the time notified me that 851 was losing altitude. I looked out the window at this time and witnessed the helicopter in what appeared to be a controlled decent. The flight then leveled off at an altitude of what appeared to be 100 feet from the water level, hovered for a brief moment and then continued her climb to flying altitude. I monitored channel 74 and 130.275 and shortly after the flight crew notified us on ch 74 that they were safely away.

The HLO radioed asking weather the flight had called and I at that time informed him that the flight crew had notified us on channel 74 that they where safely away.

I acted under the assumption that the flight crew had full control of the flight and if they required assistance they would have informed us, and therefore kept radio conversation to a minimum. The pilot sounded calm and professional and offered no indication of any distress or that immediate assistance was required from the SeaRose or the standby vessel Atlantic Hawk.

Brian Smith Marine Technician
Husky Energy SeaRose FPSO

(P. 28) As requested below are a summary of events that I witnessed from July 23rd 2011.

On July 23rd at approx. 2:15pm Cougar 581 landed on the Searose from the drill rig Grandbanks. I was present on the helideck as the fueling firefighter. While the flight over from the rig seemed longer than normal, conditions at the time (low ceiling) probably accounted for what appeared to be the extra flight time. The helicopter, QCH, landed with no problems, helideck crew was dispatched to the deck and proceeded to unload cargo and passengers. The helicopter was then fueled as per normal procedures, proper samples were taken and shown to the crew, with no problems noted. One of the crew was stood next to me for a while, waiting for the gentleman in the fuel cabinet (Perry Faulker) to retrieve the fuel hose so that he could sign off on the amount of fuel received. QCH was then loaded with baggage and passengers, the chocks were removed, and we left the helideck as per normal.

Once under the helideck, a few of us started conversations about different things, myself and Frank Beanteau retreated to a step that was made over some pipework and sat down on the step facing forward, other groups were gathered around different parts of the helideck waiting for the helicopter to take off. Shortly there after the helicopter lifted off and while I didn't see it leave, it sounded like a normal takeoff.

Shortly after lift off, I cannot say how long, I seen the helicopter come down out of the low cloud cover off of the forward port side of the Searose, it is difficult for me to

judge how far away from the Sea Rose it was, I will guess somewhere between 300 to 500 ft out. I noticed the helicopter coming, straight down in a fast decent, the rotors were still turning, there did not appear to be any forward momentum at this time I yelled out to everyone on the deck "That the helicopter was crashing." By the time most people had turned around, the helicopter was very near the water, once again it is hard to say how far off the water it was, but if I were to guess it would be 50 to 100 feet. We were definitely looking down at the machine from our vantage point at this point, and there was ocean spray being churned up from the rotor wash. At what appeared seconds before a water landing, the helicopter regained lift, hovered for a brief moment, and then flew off as per normal.

If there are any further questions please feel free to contact me.

Chris Chris Rideout Instrument Tech Husky Energy

(P. 29) Report on helicopter event on July 23 2011.

Helicopter landed @ approximately 14:30 without issue, helideck operations were carried out as per procedure and helicopter made ready to depart Sea Rose.

Helideck crew took up standby position under Sea Rose helideck to await "safely away" announcement. Helicopter departed SeaRose no indication that there was anything out of the ordinary at this time.

Shortly after departure one of the helideck crew shouted that the helicopter was crashing.

The helicopter was indeed descending, I watched as the helicopter continued to descend for another 50-100 feet. It appeared that the pilots were attempting a controlled ditching. The helicopter continued to descend to an estimated 50 feet above sea-level. While at its lowest elevation sea spray could be easily seen around the exterior of the helicopter. When the downward motion finally stopped the helicopter maintained a steady hover. After hovering at approximately 50 feet for several seconds the helicopter appeared to make a heading change so that it was heading directly into the wind. The helicopter appeared to move forward approximately 25 feet and hovered once again, shortly after this hover the helicopter accelerated and passed forward of SeaRose in a port to starboard direction.

It was assumed at that time that there would be an emergency landing and all members of the helideck team were on standby. Shortly after passing ahead of our position the command "Safely away" was issued.

Francis Benteau ICSS/Telecoms Tech Husky Energy

The term "ditching" does occur in these observations, as does "controlled descent" and "emergency landing." But none of them are evidence that Mr. Sellars or Mr. Mugford had made a decision to "ditch." Finally, I note that, on cross examination, Mr. Gerber acknowledged that Mr. Sellars, himself, had not armed the floats, and that

... neither of the crew statements show any evidence that they were preparing to ditch. At the time I wrote this letter (of termination, Consent #1) it was clear to me that one of the crew thought they were ditching. No, it is not in the report.

In my view, the above-quoted witness statements and a lot of other documented evidence presented demonstrate anxious concern on the part of the observers on the Sea Rose. This clearly justified concern is, in my view, a valid and substantial element in the Cougar's consideration of its options. The circumstance of the incident having taken place in full view of the rig and its workers, at a time when the 491 tragedy was very fresh in all minds, cannot have had negligible impact on Cougar's ongoing contractual and commercial relations with its client. I will discuss this concern below.

In summary, however, on this factual matter I find no convincing evidence that supports the Employer's conclusion that Mr. Sellars had actually made "...an improper decision to prepare to 'ditch' the aircraft while recovery was easily achievable..." (Consent #1)

2. Immediate return to Cougar St John's CYYT: (torque exceedance & go around a second time)

This issue is of significance to my adjudication of both issues addressed by the *Code*, since Employer testimony and argument called attention with disapproval to both factors (torque & the second use of the go around) in the crew's behaviour. For instance, Captain Perry asked:

"Would you depart back into the cloud with the same system that got you into trouble, using the go around which caused the problem? I don't think a pilot would do that."

With respect to the torque exceedance, I note that the TSB report (BS#1) comments (p. 5) that: "Neither pilot was aware that the helicopter had experienced a torque exceedance during the application of collective to arrest the descent." Union testimony on this point was to the effect that evidence of the exceedance came to light after the return to St. Johns, not before. Employer testimony was to the effect that the crew should have been aware of the exceedance from a low rotor sound they both reported hearing (PP#12 S4.6, p 13), and from a visual display that should have alerted them.

With respect to the go around, I note that the data shows a second engagement of the go around, and that the TSB Report (p 5) says that "During the subsequent departure, the captain engaged the GA mode..." and that "The GA mode was disengaged at 1501:23 as the helicopter climbed through 1800 feet radar altitude and proceeded back to CYYT." Mr. Sellars insistently testified that the second engagement did not happen, and testified that he had formally objected to the TSB draft report on this issue when he was provided a copy. Mr. Moores' notes of the crew interview and the crew's own statements do not mention a second GA engagement.

I note that the voice recorder (CVR) is a key piece of unfortunately missing evidence that might have settled this point. This affects the adequacy of the Employer's reliance on its negative view of Mr. Sellars' decision to return directly to CYYT as justification of its discipline decision. I note however, that, in fact, the Employer did not actually raise the return to St. John's as an issue in its letter of termination.

I conclude: a) that the immediate return to St. John's did not figure substantially and directly in that discipline decision when it was made and communicated; and b) that it would not be safe to find that the evidence on the circumstances of crew's awareness of the exceedance or on the contested second engagement of the go around is sufficiently reliable or convincing as reasonable grounds to justify the termination.

(a) Actual anti-union animus (S.94) or (b) proof the Employer's action not tainted (S.98.4)?

I must now directly address, therefore, the first two of the four questions that must be asked; that is: (a) Is there evidence of actual anti-union animus (S.94); and (b), has the Employer proven that the termination was a proper exercise of management function (in the circumstances of the union drive) and that its action was not motivated by, or tainted in any way by, anti-union animus (S.98.4)?

I am aware of no persuasive, direct, documentary evidence or testimony that establishes the Employer acted out of anti-union animus in its discipline of Mr. Sellars. But, as the *Code* and the jurisprudence make clear, the evidence must also be examined in order to address the second question in these circumstances (given a "complaint is made in writing pursuant to section 97" - S.98.4), since a unionization drive was ongoing at the time the termination was imposed.

I have considered, above, two aspects of the Employer's response to the charge of actual anti-union animus and its rebuttal of any presumption of bias, based on justification of its decision as a reasonable exercise of its management right and, in the circumstances, its only option.

In respect of the Employer's claim (Consent #1) that there was an improper decision to "ditch", in my view there is no persuasive evidence to support this claim as factual. In respect of the Employer's complaint that the decision to return immediately to St. John's was inappropriate because of the exceedances and data showing a second engagement of the go around, in my view the evidence does not permit a safe finding. The Employer's investigation of these allegations was done in haste and was not, perhaps, as complete as a reasonable exercise of management

rights would require. Based, therefore, on my analysis of these two aspects of the Employer's justification of its decision, the termination seems not to have been a reasonable exercise of its management rights.

These considerations, of themselves, do not lead to a conclusion that there was actual anti-union animus in play or that any anti-union animus is ruled out. I must, therefore, consider these and other issues to determine the issue of rebuttal under S.98.4. In analysing that evidence I will address elements of the termination formally set out in the termination letter (Consent #1).

1. Investigation: The termination letter, dated July 28, five days after the incident, begins with the Employer's assertion that:

"We have completed our investigation into the incident that occurred on departure from the Sea Rose FPSO on Saturday, July 23, 2011."

The Union took objection to this claim of completeness since the *Internal Aviation Investigation Report conducted July 3- Aug 2, 2011* (PP#12) was obviously not "completed", as its title indicates, until "Aug. 2, 2011" at the earliest. The Union argued, not only that the claim that the "investigation" was "completed" as of July 28 was inaccurate, but also, and more important, that the haste indicates the Employer's decision-making was likely motivated by bias.

The Employer responded that the alleged haste was neither unusual nor improper, given the pressures coming from the client, within the environment of heightened public concern following the tragic Cougar 491 disaster, and in view of the clarity of the conclusions the HFDM Investigation had reached even within that brief time span. The Employer also argued that the Transport Safety Board Report (MS#1) corroborated the reasons the Employer cited in its termination. So, the duration of the investigation is not relevant to the *bona fides* or validity of the discipline decision.

I accept that five days is a remarkably short time to conclude a "complete" investigation in as complex a situation as this. The discipline decision process must be evaluated in the light of problems, noted above, associated with the Employer's claim (Consent #1), that Mr. Sellars had made a "decision" to "ditch." A less hurried, more thorough review of the actual documents might have raised questions in the Employer's mind about the "decision" to "ditch" that it claimed was made. This allegation of a decision to "ditch" was also complicated by the singling out of Mr. Sellars for termination, despite evidence it was the First Officer who re-armed the floats. There is no evidence Mr. Sellars was involved in the alleged "decision" to re-arm the

floats. The documented evidence shows the re-arming was done by Mr. Mugford in accordance, he said, with SOPs, and at a time in the flight that lends at least some support to this explanation.

The completeness of the brief investigation is also made problematic, in my view, by the fact that Mr. Gerber, who actually signed the termination letter, chose not to review the report provided by Mr. Mugford, which describes the re-arming, or the report by Mr. Sellars. Whatever administrative or other reason prompted Mr. Gerber's decision not to look at these documents, it lends weight to the view that the investigation was not "complete" as grounds for discipline.

In the context of access to relevant documentation, I also note the evidence shows that at no point was Mr. Sellars given the HUMS data or the HFDM data or the preliminary HFDM Committee report to review and comment on prior to the termination. This is remarkable in view of the fact that the July 23 flight was the end of Mr. Sellars's rotation, and he was due to be on a period of three weeks off. Thus, if the Employer was concerned about a safety risk from having Mr. Sellars flying its aircraft and its Client's passengers during the three weeks following July 23, it appears unlikely that such a concern was justified, since he was due to be off for those three weeks. This concern therefore could not reasonably account for urgency in termination.

I also note the Union's evidence and argument that termination in these circumstances is not in accordance with the Employer's history of discipline. Two relevantly similar previous incidents (in 2007 and 2009) were presented in evidence. Despite the Employer's argument that a new disciplinary regime was in place after the 491 tragedy, I am unable to ignore the fact that the crews involved in those earlier incidents were treated very much less harshly than Mr. Sellars was treated. I am aware of the Employer's view that the key difference justifying Mr. Sellars' termination despite these earlier incidents is, in Mr. Moore's words, "because they recovered properly", suggesting that, even though Mr. Sellars did recover, he did not do so "properly", having had to rely on familiar VFR rather than on the required IFR skills. (I will address Mr. Sellars' IFR capability deficit below.)

However, in the context of the Employer's discipline history, which I am dealing with here, I am not persuaded that the evidence of the difference that Mr. Moores cites is decisive or cancels the dramatic effect of the obviously more lenient earlier disciplines.

I note however that Mr. Gerber appears to accept that the 2007 incident history was more lenient, and offered six justifications for that change. Mr. Sellars was terminated because (1) Flight 491 had intervened; (2) A new Chief Pilot, Mr. Perry, had taken over; (3) there was a

change in culture in Cougar. In the earlier case, the Company may have, to some extent, allowed it to happen. "There was no condoning it, but we did allow it"; (4) The altitudes of the flights were different and it was thought that mitigation was achieved by doing the SOP modification; (5) In the earlier incident there was equipment failure in that the RadAlt had not decoupled; (6) In the earlier incident the captain certainly took action. In addressing these justifications however I find instructive Mr. Davidson's careful comparative analysis of the two previous incidents with the July 23, Flight 851 incident.

I see nothing in the changed post-2011 environment that can account for such differences in the way the Employer evaluated generally, if not precisely, similar behaviours from the point of view of the disciplines imposed. Certainly the Employer did have a new Chief Pilot and was practising a sterner culture of discipline in the period post 2011; but I see nothing in Mr. Sellars' termination that reflects, or draws on what was learned from, the facts of the 2011 disaster. The last three justifications confirm a difference in the Company interpretive values, but in doing so add nothing more than reiterate the point about the cultural shift.

I find, with respect, that I am unable to attribute the change in discipline represented by Mr. Sellars' July 28 termination as resulting from a cultural shift in the post-2011 disciplinary environment. There are too many unsettling details to allow me to be confident in the adequacy or justice of such a blanket explanation of the decision to terminate Mr. Sellars. The evidence of haste, and the very specific focus of the discipline does not reasonably arise, in my view, out of the experience of 2011, but out of a sense of urgency to act.

It is clear to me that the Employer's urgent decision-making, and exceptional decision, clearly involved extraneous considerations. The Union argues that these considerations were either pressure from the client, or anti-union animus. I am required by the *Code* to consider whether both dynamics were possibly in play.

2. Pressure from the Client

The Employer acknowledged that there was pressure from the Client. The documentary evidence shows that Husky took an immediate and engaged interest in the July 23, Flight 851 incident. There is correspondence in evidence on various aspects of the Employer's and the Client's investigations of the incident, the remedial measures proposed and taken and the crewing policies followed.

This is of course, not surprising. In part, it is the due diligence one would expect from responsible companies. In part it arises, as the Employer argued, out of the changed environment following the earlier disaster. But I am persuaded by the evidence, that it was prompted, in part too, by the fact that the incident took place in full view of the Client's facility, and was closely observed by several of the client's employees. The witness statements (*Internal Aviation Investigation Report conducted July 3- Aug 2, 2011* (PP#12), at pp 25-29) testify to involved, urgent and anxious concern. Mr. Gerber made it clear that Cougar was under intense pressure from Husky to show they were taking the incident seriously, and that there would be no repetition.

So the evidence is very clear that pressure from the Client likely played a role in the Employer's remarkably hasty investigation and its disciplinary thinking, despite the fact that Employer witnesses denied Husky had made any explicit demands concerning its decision to terminate. But was this the only pressure on the Employer prompting its choice of discipline?

3. "*Purely Pilot Error*"? Consent #1 continues by saying:

We are satisfied that the temporary loss of control of the aircraft was purely pilot error..."

(I note, as an aside, that Employer witnesses made it clear there was no problem with Mr. Sellars' "temporary loss of control of the aircraft" caused by his "momentary" pressure on the cyclic (BS#1 p 41, para 3.1.3) while engaging the go around. Employer testimony was that this "temporary loss of control" was, in itself, a benign and – according to the testimony – not a totally unusual event. Rather, it was Mr. Sellars' failure to recover immediately (as set out in the third paragraph of Consent #1) from the loss of control / unusual attitude, by putting the helicopter's nose on the horizon and raising the collective, that the Employer found merited discipline. I attach no significance to the perhaps imprecise wording of the sentence and mention it only for precision.)

I note that Mr. Gerber explained the phrase "purely pilot error" as

... based on the fact that the aircraft had no anomalies. The crew did not report any problems on the journey back. The aircraft did not store any error codes in its computers. Apart from the over-torque, the HUMs reported no other anomaly, so the aircraft was serviceable. The first part of that sentence asserts that the aircraft was one that was normally under control, not an aircraft that is already out of control. That's not what happened in this flight. An air-craft descending at 1800 feet per minute is not an aircraft under control. The initial cause was benign, and it was caused by the pilot. It was easily recoverable, but he did not do so. *We saw loss of control that was caused by the pilot.* (emphasis added)

The Union argued however, that the evidence does not support the claim that "purely

pilot error" accurately or adequately describes the event at issue, and that use of the adjective "purely", if intended in the sense of "exclusively", is inaccurate and misleading. There was much more than "pilot error" involved in this incident, in the Union's view.

The exclusiveness implicit in the term "purely" is ambiguous and might imply something beyond what Mr. Gerber described: something closer to what is expressed in the final line of his comment above. It might mean that "nothing but" pilot error was at play. For instance, it is not unreasonable to ask what part, if any, was played by the Employer's having paired Mr. Sellars with Mr. Mugford (*cf.*, JG #12 , item # 36) despite Mr. Sellars' not being a training pilot as required by the restriction. The evidence, including that of Employer witnesses and of the Transport Safety Board Report (BS#1), is that this pairing was not a negligible element in the situation. Thus, the situation cannot fairly be accurately described as "purely pilot error", if the term "purely" is used in this exclusive sense. I note that, while the Union acknowledged that pilot error contributed to the event, it is also clear that other "contributing factors" were in play as well (*cf.* TSB Report MS#1 paras. 3.1 & 3.2, p. 41-43), so that the term "purely", if used in the sense of "exclusively", is not sustained by evidence presented.

4. "failed to react appropriately in a timely fashion"?

The Employer argued that the various data available and the testimony all shows that Mr. Sellars did not take appropriate and decisive action to recover until the helicopter had got below the 200 feet ceiling, and he had visual cues as to where they were. That is when he did what was necessary; but for at least 16 seconds the helicopter was descending at a rapid rate. In fact, when he finally did arrest the descent, the helicopter was within 3 seconds of hitting the water. In the Employer's submission, that was not reacting "appropriately in a timely fashion."

This is, generally, a reasonable assessment, in my view. The Union did not dispute the fact that the delay was not appropriate. Mr. Sellars repeatedly said he should have been "more aggressive" in his action. Mr. Sellars acknowledged having had difficulties with attitude recovery in his training, and his only response about his IFR capability was to testify that he held the appropriate certification.

I am persuaded that the Employer has established that there was a delay in Mr. Sellars' recovery from the unusual attitude until he reached visual contact with the water, and that this suggested a deficit in IFR capability. I note that Mr. Sellars himself agreed with this judgement, if not "fully." When asked if he would agree that the helicopter did not, in fact, correct until he

had come below the clouds, Mr. Sellars answered: "I don't fully agree. The HFDM data did show the correction of the nose, albeit slowly."

On the balance of probabilities I conclude that Mr. Sellars showed himself to be more comfortable and capable in VFR than in IFR conditions. I shall return to issue below.

5. ...*"froze" in a stress situation...*

The 4th paragraph of the termination letter begins with the following two sentences:

"We conclude from the event that you actually "froze" in a stress situation. This revelation makes you unsuitable for the services we provide to the offshore."

Insofar as the generic term, "froze", represents what the Transport Safety Board more precisely describes as "subtle incapacitation due to spatial disorientation" (TSB Report, BS#1 at 3.1 p. 41), it seems to me that the Employer's assessment tends to be confirmed by the evidence.

However, the second sentence in part anticipates the decision to terminate Mr. Sellars. As such, it remains to be seen whether the Employer's judgement on this point is to be sustained.

In part, the second sentence also establishes a link in the Employer's reasoning between "froze" (or what the TSB calls "incapacitation due to spatial disorientation") and "the services (the Employer) provides "to the offshore." The Employer also called attention to Mr. Sellars' IFR capability deficit as rendering him unsuitable for the Company's offshore work. In fact, the Employer links these two (disorientation and IFR difficulties) as aspects of the same problem. I raise this because the linkage, valid in itself, may have a bearing on the Employer's frequently expressed but more problematic view that Mr. Sellars was inherently unable, because of his long VFR experience, to profit by the training and other guides or opportunities that other pilots were afforded after the incident. I note this linkage here but will return to address it later.

Here, however, I merely note that the predominant theme of the Employer's position in support of its decision to terminate Mr. Sellars was its view, as expressed by Mr. Gerber, that

".. he took no action in instrument conditions. When he caught reference with the water, that is when he took the action."

It is a fact however that, as Mr. Moores testified, the "data shows two inputs from the pilot, but the air-speed continues to bleed off." Mr. Sellars described these inputs as "less assertive" than they might have been, in view of his concern to avoid "a dive." The evidence is, that even though he adjusted the nose while still in cloud it was not enough to recover.

Mr. Moores said his reading of the flight data (PP#3) shows that:

Within six or seven seconds the nose goes from nine degrees of pitch to hit the apex at 23 degrees up, and then it comes down to 15 degrees. This reduction in pitch was because the pilot had applied some cyclic... It goes from 23 degrees to 15 degrees in about five seconds, and slightly back up to 16 degrees and then finally back down to 8 degrees... I think it's about 10, call it nine degrees...

While I note Mr. Mugford's comment (Exhibit #1) that Mr. Sellars "was making corrections and responding to the calls I was making", I nonetheless accept, on the balance of probabilities, the Employer's evidence that Mr. Sellars was more effective recovering from the unusual attitude once he reached VFR conditions than he was in IFR conditions.

6. Termination the only option?

The Employer stressed that termination was the only option open since there was no confidence possible and no training available. However, I am unable to see the evidence for, or to follow the logic, of the Employer's argument that no changes to training could salvage Mr. Sellars' IFR capability and sharpen his reactions so as to remedy damage done to the Employer's confidence in him caused by single episode of "subtle incapacitation due to spatial disorientation", even if taken in the light of his earlier problems during training. In fact, his record shows that, in the end, he did succeed in obtaining the designation required.

Clearly, too, the Employer invested considerable effort, after the event, in redesigning SOPs to ensure guidance was available to pilots, and in ensuring that training procedures are in place specifically to address aspects of the incident in which Mr. Sellars was involved. It is not clear to me why Mr. Sellars was judged as untrainable, when other pilots were to be served by redesigned training and professional aids.

I note that the Summary Report of HFDM Ctte (PP#7, p.2, final paragraph) provides four recommendations that speak of "emphasis" on certain subjects during annual recurrent training. This does not appear to support, or provide justification for, the Employer's reasoning about Mr. Sellars' un-trainability, or its disciplinary decision in his case.

According to the Employer's submission, Mr. Sellars' showed that his "subtle incapacitation" (cf., "froze" Consent #1) was the result of his demonstrated inability to overcome his 30 years of VFR experience so as to work safely in the IFR environment now required of him, and that no other disciplinary or administrative response was available, given that justifying cause.

The Employer also argued that the circumstances in which the discipline was imposed were unique in two ways that proved the action was free of any taint of anti-union animus. First,

the changed employment environment in the aftermath of the tragic March 12, 2009 Flight 491 with a loss of 17 passengers and crew, imposed a very public responsibility on the Company to change its disciplinary approach in certain respects that made previous disciplines irrelevant in the evaluation of Mr. Sellars' discipline. And, second, the evidence and argument show, in the Employer's view, that the Employer's action was free of any taint of anti-union animus under S.94, since it was not only completely unaware of Mr. Sellars' participation in the Union drive ongoing at the time, but was actually prevented from coming to be aware both of the drive and of Mr. Sellars' participation, since those doing the Union organizing drive had deliberately kept their activities confidential. Thus, in the Employer's submission, the onus it bears under S.98(4) has been discharged.

In making its case for the discipline as just because there was no option, the Employer presented evidence that Mr. Sellars was well aware, based on the standard operating procedures and his initial and recurrent training, of what corrective actions he needed to take in order to recover from the unusual attitude, but that, for a significant period of time during the event, he did little or nothing, thus putting the passengers, crew, and aircraft at unacceptable risk.

The Employer pointed to documentary evidence that Mr. Sellars' record shows he had difficulties with aspects of this recovery process at times during his initial and subsequent training. The problem, in the Employer's view, is that Mr. Sellars' long, distinguished, incident-free career as a helicopter pilot was under Visual Flight Rules (VFR) conditions, and not under Instrument Flight Rules (IFR) conditions prevailing in the Newfoundland offshore, and actually in effect on the day of the incident. The Employer claims that the evidence shows that Mr. Sellars did not act effectively to recover from the unusual attitude because he could not do so until the helicopter descended to approximately 200 feet when he saw the water and so overcame a period of "subtle incapacitation due to spatial disorientation" (TSB Report, BS#1 at 3.1 p. 41).

I note that Mr. Perry testified about the difficulties the Employer had in applying its "just culture decision model" in this instance. He noted that:

This is a tool to let Managers work on an incident with employees...We struggled with how the tool applied to Mr. Sellars because of the nature of the event. He'd been trained, yes. Could it happen again? Yes. How could we require training and change the behaviour? In the end, we had a very difficult time applying it to this case... In the end we are still looking for a way; but in the end we said this does not apply in this case... We were able to use the tool... Yes, the question was how you adapt training to be effective in this situation, and the second issue was how

do you validate the training. There were a couple of issues in Boyd's training so we really struggled with it keeping in mind the passenger and crew safety.

The Employer argued that no training program is available, or could be designed, that might be relied upon to provide the confidence it needs in Mr. Sellars' ability to put into practice the actual procedures that he clearly knows are required. The Employer argues that the evidence of the event itself, when viewed in the light of evidence of the likelihood of the crew's intention to ditch, and of Mr. Sellars' own acknowledgement that he could have acted "more aggressively" to recover from the situation, demonstrates that its final loss of confidence in Mr. Sellars is justified.

In this context however, I note Mr. Perry's testimony about the problem that Mr. Sellars encountered while engaging the go around. Asked, on cross examination if he had testified on direct that, if there is pressure on the cyclic, a go around will not engage, he said:

If there is pressure on the cyclic, a go around may not engage. It's not a given, necessarily.... Yes, I also testified that this is a known problem with the go around... No, (there has been no attempt to remedy this) because, as I understand it, it's a system limitation... At the time of the incident there was nothing in the manual about this happening. Not specifically, no. Not at the time, no. And the manuals at the time also had nothing in them concerning what to do with an unusual attitude following engagement of go around. The company's manual has guidance for what to do, and now the SOP has what to do for attitude recovery but not specifically to do with the go around.

He was then asked if, at that time of the July 23 incident, a pilot encountering an unusual attitude would have had to rely on his training or on having this fact explained to him, Mr. Perry said: "Unusual attitude recovery is covered in training." He was then asked more precisely whether there was any training at that time concerning the use of the go around and unusual attitude, Mr. Perry answered: "Not at that point. In fact, I did make that error myself. I had been warned about it; even so, I still made the error."

I conclude that, at the time of the incident, Mr. Sellars was not specifically or recently trained in the way the go around can behave in relation to unusual attitude events. It remains, therefore, an open question, apart altogether from any question of his IFR capabilities, whether Mr. Sellars might have recovered more quickly and properly from the unusual attitude if training had prepared him to expect such an occurrence. Thus, training remains a live option, in my view.

I note, further, the evidence of Mr. Chapman, who was also asked to compare the 851 incident with the 2007 and 2008 incidents. He saw "automation dependency" as a common

theme, a problem which, the evidence shows, Cougar accepted as a problem for some pilots. In the 2001 the Employer addressed the case of Captain Roach (JG #8) by acting on the principle that such issues are responsive to training. More recently there is evidence of similar use of training in a similar situation in the letter from Mr. Perry to Captain Godding in 2011 (PP#19).

But I also note that the Employer argued effectively that "automation is the reality", and that if one is automation dependent, then that person is not suitable for offshore flying in Newfoundland's off shore. The Employer noted that none of the Union's arguments takes account of Mr. Sellars' inability to react in a stress situation, but focuses instead on the Employer's alleged failure to provide him the opportunity to fail again. With respect, however, I do not find that line of argument entirely conclusive.

I note Mr. Chapman's testimony that the crux of automation dependency... is when someone finds himself saying: "I understand the competencies, but I can't do it anymore." It's a dependency that results from not doing the job manually almost at all, so the erosion of skills sets in... The S92 is a very reliable machine; but there are ways to create an unacceptable result, and you must be willing to understand that immediately, otherwise you are caught in a normalcy bias. Normalcy bias may mean that you do not understand what's happening.

But to use a vague, psychologically loaded, term like "froze" to describe Mr. Sellars' behaviour is to suggest an incorrigible flaw at play, one that is not amenable to modification by training and similar aids. It was Mr. Perry who added weight to this implicit suggestion when he observed that: "The procedures can be taught. The ability to react cannot be taught." He also testified that Mr. Sellars' behaviour was, in his view, "a matter of instinct." But I also note that Mr. Chapman testified that:

"Automation dependency is ... a huge issue. Information breeds a level of proficiency, but the difficulty is to make it happen with the hands and the feet. It is not like riding a bike. The sensations involved, the impact and the feedback from input all require skills that have to be reacquired. It is far more complex and difficult, *but it is possible...*" (*my emphasis added*)

Such problems as "incapacitation due to spatial disorientation" are among those experienced throughout the industry, as Mr. Chapman testified. Training and related responses to these problems are the focus of efforts such as the CHARM program (PP#18 A, B, & C), in which the Employer has invested over recent years. I conclude that the Employer does, in practice, hold the view that there is merit in such training efforts to change behaviour.

Thus, I see no *prima facie* or other evidence that justifies the view that Mr. Sellars was unable to benefit from such training and related efforts due to an alleged "instinct" deriving from 30 years of relatively automation-free flying.

With respect, I am not persuaded it has been shown why Mr. Sellars was un-trainable or ineligible for demotion, or that termination was the only option. Demotion with suitable training, of the sort set out in PP#7, would be more consistent with the Employer's disciplinary history, its CRM policy and practice, the urgent Client pressure, and the fact of the Complainant's ultimately successful, though delayed and improperly managed, recovery of the aircraft on July 23.

7. Other aspects of Mr. Sellars' performance?

The remaining lines of the 4th paragraph identify other aspects of Mr. Sellars' performance that, in the Employer's view, warrants discipline: a list that, in some ways mirrors the findings of the *TSB Report* (BS#1, Sections 3.1 & 3.2, & 3.3, pp. 41-43).

Implications for the first two questions asked:

In light of the foregoing analysis of the evidence and argument I must now consider their implications for the success of the Employer's effort to prove its action was devoid of anti-union animus as required under S.98.(4). This requires in particular that I return to consider whether the Client's engaged concern and pressure on the Employer (explored above) so thoroughly explains the Employer's disciplinary decision as to preclude the possibility that its action was not also, at least in some part, motivated by anti-union animus.

The Employer insistently denied any knowledge of Mr. Sellars' participation in the Union campaign that was on-going at the time of the incident. In fact, the Employer pointed to Union evidence of the care it had taken to keep secret any discussions it had, and particularly with prospective bargaining unit members. Clearly, from Mr. Davidson's testimony, confidentiality was a priority concern of those organising the sign up.

Documentary evidence (*e.g.*, SD #10 & SD#12) establishes that Mr. Sellars participated in meetings to explore union issues and also participated in the work of the Employee Committee. He had, in fact, chaired at least one meeting (in December, 2010) that had been arranged with Mr. Gerber's co-operation in the cafeteria to explore CEP's campaign, and was the one pilot representative present in person at the June 9 meeting with Management. (The other Pilot Rep., Mr. Davidson, attended by phone.) This is, obviously, not evidence of Mr. Sellars' participation in the OPEIU Union, or in its sign-up, since the OPEIU was not yet much, if at all, in the picture.

But the Employee Committee clearly dealt with issues normally handled in bargaining. I note that, among the September 15, 2011 correspondence with the CIRB (SD#13) is Mr. Davidson's description of the work of the Employee Committee in relation to the organizing of the OPEIU, where, at p. 5, he writes:

We have 2 pilots who attend an employee committee within Cougar. This was created in December as a last chance for management to avoid this option – it has failed. Hence the start of this campaign. We have a well documented record of the issues, and approved minutes of management's position on each which management has seen and approved as accurate.

It is clear that the unsuccessful work of the Employee Committee and the organization of the Union were understood, by Mr. Davidson at least, as two phases of an ongoing process in which Mr. Sellars was involved as one of the "2 pilots" to which Mr. Davidson refers.

I note Mr. Sellars' testimony relating to the Maintenance Supervisor's interest in the union sign-up. The Employer called no evidence to address this. But, apart from Mr. Sellars' recollection of Mr. Williams' cryptic, perhaps unrelated, remark, at the June 9 meeting, about a "one-way ticket to Goose Bay", it is true, as already noted above, that there is no direct link in the evidence between Mr. Sellars and the OPEIU to which the Employer had proven access. It is also true that the *ad hoc* Employee committee was not a union, not an incorporated agent.

I note too that the Employer was continuing to expect that the September meeting would go forward. How could the Employer be aware of the organization and formation of a union if it had good reason to be dealing with the Employee Committee in September? An allegation of Unfair Labour Practice cannot be sustained, in the Employer's view, in these circumstances.

But, with respect, I am not persuaded of the Employer's position. It remains a fact that the Employer was aware of Mr. Sellars' interest and active engagement in bargaining-type issues as raised initially by the Employee Committee. I also find that evidence and argument provided does not persuade me that the hasty and unusually focussed and particularly severe discipline of Mr. Sellars is fully accounted for solely by client concern. As noted above, other options were open. I conclude that freedom from anti-union animus has not been proven. It remains a possible, if perhaps incidental, motivating element in the Employer's disciplinary action.

Therefore, on S.94, I find that the Employer has not discharged its onus, required under the *Code* at S.98.(4) by proving that anti-union animus played no role, however incidental, in the dismissal. Therefore remedy, as provided for in S.99.(1) of the *Code*, is required.

Was the Termination Justified (S.240)?

On the basis of the foregoing analysis of the evidence and argument, I also conclude that the termination was not justified under S.240 of the *Code*. The Employer has not discharged its onus of showing that the termination was for just cause.

The Employer's disciplinary history, together with the post-incident measures it took in light of the incident and in order to enhance its training and information procedures persuades me that termination of Mr. Sellars was exceptional and not justified, even in light of a changed disciplinary environment and of acknowledged pressures from the Company's commercial client.

Is Some Other Discipline Justified?

Yes, there was reasonable cause for discipline. I note that there is clear evidence of pilot error, not only in the Employer's evidence and argument, but also in the documentation and in the TSB Report (BS#1). Discipline is recognised as a valid management tool for Employers to use in seeking to correct an employee's behaviour. I note too that the Union acknowledged pilot error as an element in the story of the event. I have already noted Mr. Sellars' repeated acknowledgement that he should have been "more aggressive in correcting pitch attitude."

But Mr. Sellars' repeated admission of his inadequate "assertiveness" does not accurately reflect the actual practical circumstances (including its location, as noted above), and seriousness of the incident, or the range of corrective measures required of the Complainant and of the Employer as recommended in its own investigations and by the Transport Safety Board. The record shows that the Employer has instituted a number of these corrective measures. But Mr. Sellars' focus on his assertiveness deficit appears not to take fully into account the number, extent and impact of other deficits, particularly his IFR capability deficit, that require attention.

I conclude that demotion and rigorously assessed retraining is required in order to address these deficits, as well as his acknowledged assertiveness problem.

DECISION

In light of the foregoing evidence, arguments, and considerations, I find that:

THE COMPLAINT IS SUSTAINED IN PART. MR. SELLARS IS TO BE REINSTATED AS FIRST OFFICER, EFFECTIVE JULY 15, 2014, AND COMPENSATED FOR ALL LOST TIME AND BENEFITS.

IN VIEW OF THE CONCERNS EXPRESSED IN THE CONCLUDING SECTION OF MY CONSIDERATIONS (ABOVE) AND OF MR. SELLARS' EXTENDED PERIOD AWAY FROM S92 FLYING, I ORDER THAT MR. SELLARS' REDEPLOYMENT AND CONTINUED EMPLOYMENT AS A SERVING PILOT BE CONTINGENT ON HIS SUCCESS IN A DEFINED PERIOD OF TRAINING DESIGNED SO AS TO ESTABLISH, TEST, AND JUSTIFY CONFIDENCE IN HIS CAPACITY TO RETURN SAFELY TO FLYING RESPONSIBILITIES.

THE TRAINING SHALL ADDRESS ANY INSTRUMENT FLIGHT RULES (IFR) CAPABILITY DEFICIT AS WELL AS THE TRAINING-RELEVANT ISSUES IDENTIFIED IN THE HFDM COMMITTEE'S INVESTIGATION REPORT (PP#7), COUGAR'S INTERNAL AVIATION INVESTIGATION REPORT (PP#12), AND THE TRANSPORT SAFETY BOARD'S AVIATION INVESTIGATION REPORT'S FINDINGS (BS#1).

I REMAIN SEISED, AS NOTED AT THE OPENING OF THIS HEARING, TO DEAL WITH ANY INTERPRETATION OR QUANTUM ISSUES THAT MAY ARISE.

Respectfully submitted as the decision of the Adjudicator.

John A. Scott, Ph.D.
Adjudicator

July 11, 2014