DECISION

Fair Work Act 2009
s.394 - Application for unfair dismissal remedy

Mr Stewart Khouri
v
Coulson Aviation (Australia) Pty Ltd
(U2025/9320)

DEPUTY PRESIDENT CROSS SYDNEY, 19 DECEMBER 2025

Application for an unfair dismissal remedy

[1] This is an application by Mr Stewart Khouri (the Applicant) pursuant to s.394 of the *Fair Work Act 2009* (Cth) (the Act) in respect of the termination of his employment by Coulson Aviation (Australia) Pty Ltd (the Respondent). The Applicant contends that his dismissal was harsh, unjust and unreasonable within the meaning of s.387 of the Act and seeks reinstatement with continuity of service and compensation for lost remuneration.

[2] The Respondent operates rotary-wing aerial firefighting operations throughout Australia. The Applicant was employed as a helicopter pilot and, at the time of the incident that ultimately precipitated his dismissal, was operating a Bell 412 helicopter performing long-line bucket operations in firefighting operations in Western Tasmania.

[3] On 10 March 2025 a serious incident occurred during bucket operations at the Canning Peak fire in Tasmania, involving a loss of height over water and subsequent damage to the aircraft when the long line struck the airframe (the Incident). The Incident was investigated under the Respondent's Safety Management System (SMS).

[4] The Applicant was stood down from flying duties and on 14 May 2025, his employment was terminated with immediate effect. The termination letter stated that the reason for dismissal was "*significant damage to an RFS-owned aircraft caused by your actions*" and associated reputational risk to the Respondent and its customer.

[5] In these proceedings, the Respondent contends that the real reason for dismissal was not the Incident itself but the Applicant's failure to engage constructively in the safety investigation process and to accept that the Incident was caused by pilot error, thereby undermining the Respondent's confidence in his capacity safely to perform complex firefighting operations.

[6] The Applicant denies that he failed to cooperate with the investigation or that he refused to accept responsibility for his actions. He says the cause of the incident cannot be reliably determined, that he participated extensively and in good faith in the investigation, and that the

dismissal was inconsistent with the Respondent's "*just culture*" obligations and its own safety investigation findings.

[7] For the reasons that follow, I am satisfied that the dismissal was harsh, unjust and unreasonable. I will order that the Applicant be reinstated to his former position (or a position no less favourable), with continuity of service and an order under s.391(3) for payment of lost remuneration.

Procedural background

[8] The Applicant commenced this proceeding by filing a Form F2 unfair dismissal application on 24 June 2025 (the Application). The Respondent filed a Form F3 employer response disputing that the dismissal was unfair and asserting a valid reason for dismissal.

[9] On 7 August 2025, directions were issued to program the manner in which the Application was to proceed to hearing (the Directions). The parties complied with the Directions. In particular:

(a) On 12 August 2025, the Applicant filed a Witness Statement of the Applicant and an Outline of Submissions;

(b) On 3 September 2025, the Respondent filed a Witness Statement of Mel Ceccanti, the Director of Flight Operations at Coulson Aviation, the parent Company of the Respondent, and an Outline of Submissions; and

(c) On 10 September 2025, the Applicant filed a Witness Statement in Reply of the Applicant, a Witness Statement of Peter Cook, an expert witness, and an Outline of Submissions in Reply.

[10] The matter was heard on 22 September and 17 October 2025 (the Hearing). Both parties were represented by Counsel at the hearing. Mr Foran of Counsel appeared for the Applicant and Mr Brennan SC of Counsel appeared for the Respondent. Oral closing submissions were made at the conclusion of the evidence.

Background facts

The Respondent's operations and "Just Culture" framework

[11] The Respondent operates aerial firefighting services in Australia using rotary-wing aircraft, including the Bell 412 EP. At the relevant time it held an Air Operator's Certificate and was subject to statutory duties to ensure that everything done in connection with its operations was performed with reasonable care and diligence, including obligations under s 28BE of the *Civil Aviation Act 1988* (Cth). That certificate provided:

> ***Duty to exercise care and diligence***

(1) The holder of an AOC must at all times take all reasonable steps to ensure that every activity covered by the AOC, and everything done in connection with such an activity, is done with a reasonable degree of care and diligence.

(2) If the holder is a body having legal personality, each of its directors must also take the steps specified in subsection (1).

(3) It is evidence of a failure by a body and its directors to comply with this section if an act covered by this section is done without a reasonable degree of care and diligence mainly because of:

(a) inadequate corporate management, control or supervision of the conduct of any of the body's directors, employees or agents; or

(b) failure to provide adequate systems for communicating relevant information to relevant people in the body.

(4) No action lies, for damages or compensation, in respect of a contravention of this section.

(5) This section does not affect any duty imposed by, or under, any other law of the Commonwealth, or of a State or Territory, or under the common law.

[12] The Respondent's Operations Manual incorporates a *"Just Culture*" approach consistent with Civil Aviation Safety Authority (CASA) guidance. CASA describes Just Culture as an organisational culture in which people are not punished for actions, omissions or decisions commensurate with their experience, qualifications and training, while gross negligence, recklessness and wilful violations are not tolerated.

[13] Section 1C2.3 of the Operations Manual states that:

'The Company has a conciliatory policy and encourages a just culture within the organisation. Any crew member involved in an accident or incident is encouraged to report the circumstances fully and honestly so that appropriate measures can be adopted to identify the underlying causes so that effective remedial processes can be implemented to avoid recurrence.

[14] The Respondent's submissions emphasise that, consistent with this Just Culture framework, pilots are not punished merely for being involved in safety incidents or for reporting them and notes that the Respondent had previously retained a pilot in employment despite a serious safety incident resulting in destruction of a helicopter drive train. In his Statement, Mr Ceccanti deposed:

It is important to point out that it is a well understood part of aviation that all pilots will, at some point in their flying careers, make mistakes. At Coulson Aviation, we understand that pilots will make mistakes, and we do not punish pilots for making errors, (unless the errors involve serious and deliberate breaches, for example flying while under the influence of alcohol or drugs). We understand that people are not perfect, and people will

> *always make mistakes. As long as a pilot accepts and owns up to the mistake and adopts procedures to ensure the mistakes do not happen again, we will support a pilot who has made a mistake and will provide additional training if that is what is required. This is a very important part of the 'just culture' safety culture we rely on to ensure that mistakes are fully reported, addressed and learned from, to minimise chances of future safety occurrences.*

The Applicant's employment and experience

[15] The Applicant is an experienced helicopter pilot. He holds a Commercial Pilot Licence (Helicopter) with some 3,100 hours of rotary wing experience as pilot in command. He is endorsed to fly a range of helicopters of different complexities including turbine and multi-engine aircraft. He has experience and accreditation to engage in manoeuvres as pilot in command of rotary wing aircraft using a long line of 100 feet to 150 feet carrying an external load and has some 600 hours experience performing this work.

[16] The Applicant has performed senior roles in aviation including as chief pilot of NSW Helicopters Pty Limited. That company provided aircraft on a contract basis to the NSW Rural Fire Service (RFS) and the NSW National Parks and Wildlife Service (NPWS). The Applicant has never previously been involved in a safety incident of the seriousness of the Incident.

[17] The Applicant commenced employment with the Respondent on 5 October 2024 and began flying operations in late October 2024 after completing training in Dallas-Fort Worth, in the United States. He was employed as a pilot, performing firefighting and related operations in Australia.

[18] The Applicant underwent training and checking for Bell 412 operations, including a proficiency check that involved use of the long-line bucket system and the manual and electronic bucket release mechanisms. In cross-examination he accepted that he had successfully operated the bucket release system during his training and pre-flight checks.[1]

The Incident on 10 March 2025

[19] In outlining what occurred in the Incident there is heavy reliance the Respondent's Safety Investigation Report (the Report), titled "*VH-VJF Tasmania Bucket Incident*", which is generated in accordance with the Coulson Safety Management System (SMS) procedure and is intended to determine the root cause of the Incident and make recommendations accordingly. Regarding authorisation, the Report provides:

> *All investigations are underpinned by the philosophy of 'Just Culture' and the sole objective of this investigation is to prevent further recurrences of a similar nature and not to apportion blame or liability. Coulson are obligated to hold individuals accountable for their behaviours that affect safety however, staff must not carry the burden for system flaws, and we seek to judge the behaviour; not the outcome in distinguishing between system-failure, natural human error, at-risk behaviour and intentional reckless behaviour.*
>
> [Emphasis added]

[20] On 10 March 2025 the Applicant was tasked with fire suppression at the Canning Peak fire in Western Tasmania, utilising an external slung bucket. A Flight Risk Assessment Tool (FRAT) was completed for the operation. The aircraft pre-flight inspection was conducted with no recorded defects. The Applicant confirmed that the cargo hook was operationally tested and found serviceable prior to use.

[21] The Applicant departed Tullah around midday and conducted multiple bucket cycles without incident under relatively benign weather conditions. After refuelling at Zeehan and picking up an Air Crew Officer, the Applicant returned to the fireground. The Report records that by this time the Applicant recalled the weather had deteriorated, with winds shifting to a westerly direction at about 30 knots. Approach and departure paths were reassessed for wind, but the pilot otherwise continued operations from the same dip site.

[22] The Report gave the following Synopsis and Overview of the Incident:

> *During the initial filling of the bucket on the third water load, the pilot reported observing intermittent master caution warnings, which were assessed at the time as being related to the fuel transfer pumps, consistent with a fuel quantity reading of approximately 1100 lbs. This indication is a normal and expected part of the fuel transfer sequence that occurs when the forward fuel cells become empty causing the flow switches to momentarily close, triggering a flickering Fuel Transfer caution light before the thermistors detect the absence of fuel, break the flow switch circuits, and shut down both transfer pumps, marking the completion of forward cell fuel usage. According to the PIC* [Pilot-in-Command]*, shortly after entering the approach sequence at an estimated altitude of 150 feet AGL* [Above Ground Level] *the pilot was monitoring the bucket as it filled with water. At this stage, the aircraft reportedly began to descend unexpectedly. In response, and with the intent to avoid a potential over-torque event, the pilot initiated a forward and level flight manoeuvre at approximately 100 feet AGL. It was reported that the pilot was unable to release the external load before the longline became taut. As a result, the submerged bucket's drag caused the aircraft to experience an abrupt deceleration. Due to the position of the longline and bucket being located behind the aircraft, this sudden change in flight dynamics appears to have caused the external cargo hook and longline to roll back, resulting in contact with the aircraft structure.*
>
> *During the sudden change in aircraft attitude, the pilot experienced a forward jolt and briefly made contact with the left-hand pilot door window, causing a minor graze on their nose from their glasses. When questioned about the failure to jettison the bucket, the pilot attributed it to human performance factors in managing a complex situation rather than a system failure. The pilot attempted to reach for the emergency release switch on the left-hand cyclic but was unsuccessful due to their focus on managing the situation and visually tracking the load through the bubble window. Additionally, the pilot was unable to activate the mechanical release pedal due to their positioning while handling the event.*
>
> *The pilot successfully recovered the aircraft into a stable hover and descended to an estimated 10 feet AGL before initiating rearward flight to retrieve the bucket. At this time, an engine torque split of approximately 30% was observed. After recovering the bucket and longline, the pilot climbed clear of surrounding obstacles. Upon increasing collective to ensure obstacle clearance, the engine torque split levelled out. The pilot conducted*

brief control tests to assess engine performance parameters, including minor adjustments to engine torque. Additionally, the pilot noted that whilst flying the tail rotor input felt unusual, however, whilst the tail rotor control pedals felt stiff, they continued to provide adequate input for sufficient aircraft control.

The pilot informed Air Attack of the bucket and control issues before proceeding to Zeehan with the longline attached, maintaining a transit speed of approximately 70 knots over the 23-nautical-mile distance. Air Attack followed to monitor the aircraft and pilot's safety, relaying updates to Air Ops at Strahan. During the flight, the pilot evaluated alternative landing options, including a remote landing or utilizing the runway at Strahan Airport if the control issues escalated. Ultimately, Zeehan was selected by the pilot as the landing site due to its closer proximity and the presence of security for the aircraft if required.

Upon landing at Zeehan, the ACO secured the bucket and longline. During the shutdown procedure, the pilot was unable to roll the engine throttles back to idle and contacted an engineer from the cockpit. At this stage, there was no indication of any damage to the aircraft. However, while disconnecting the longline from the hook, the ACO observed significant damage to the aircraft's fuselage structure aft of the external hook. As a precaution, the T-handles were pulled to shut down the engines, and the shutdown was completed in accordance with the checklist. The Australian Directors of Flight Operations, Maintenance, and Safety were promptly notified of the occurrence through established communication channels.

[Emphasis added]

[23] At the time of the Incident, the Applicant was operating from the non-standard left-hand seat while conducting long-line bucket operations over water, using a forward-looking infrared (FLIR) system and a vertical door, which affected his external visual references.

The Investigation

[24] Following the Incident, the Applicant was stood down from flying duties on full pay. The Australian Safety Manager, Mr Oliver Hahn-Hill, was tasked with investigating the incident under the Respondent's SMS.

[25] The Applicant's Statement in Reply annexed a detailed chronology (the Chronology) listing the Applicant's contacts with the Respondent's personnel and the Australian Transport Safety Bureau (ATSB) between 10 March and 19 June 2025. That Chronology provided:

Date	Time	Type	Person	Location	Comments
10/03/2025	15:20		Stewart Khouri	Tasmania	Incident occurred on Canning Peak fire Tasmania in 412 VH-VJF
10/03/2025	16:09	phone	Nathan Soster	Tasmania	Notified HOFO of incident.

	16:45 18:09 20:06				Informed of time for Drug test. Welfare check from Nathan. Welfare check from Nathan.
11/03/2025	12:00	In person	Stewart Khouri,	Strahan Tasmania	Drug and Alcohol Testing
11/03/2025	15:00	email	Oliver Hahn-hill	Strahan Tasmania	Submitted written statement of incident to Safety officer
12/03/2025	09:30	Teams Meeting	Jeff Cavarra, CAA Aircrew	Strahan Tasmania	Group meeting regarding incident and company policy on speculating and discussing incident
12/03/2025	11:00	In Person	Stewart Khouri, Oliver Hahn-hill	Strahan Tasmania	Post accident interview
13/03/2025	12:30	In Person	Nathan Soster	Bankstown	Discussion regarding incident on return from Tasmania
18/03/2025	11:00	Phone, 6 mins	Oliver Hahn-hill	South Windsor	Review of details of incident to confirm certain aspects
27/03/2025	10:00-11:30	Microsoft Teams	Ellena Papadopoulos, Peter Ayre, Stewart Khouri, Nathan Soster	South Windsor	ATSB initial interview
27/03/2025	12:36	Phone, 8 mins	Oliver Hahn-hill	South Windsor	Further review details of incident to confirm certain aspects
10/04/2025	10:44	Phone, 6 mins	Oliver Hahn-hill	South Windsor	Went over details of incident to confirm certain aspects
01/05/2025	15:10	Phone, 9 mins	Oliver Hahn-hill	Bankstown	Went over details of incident to confirm certain aspects
01/05/2025	16:34	Phone, 21 mins	Nathan Soster	Bankstown	Discussed pending Teams meeting.

02/05/2025	13:00	Microsoft Teams	Nathan Soster, Oliver Hahn-hill	South Windsor	Discussed sections of the Safety Report – issues raised by Canadian Management.
08/05/2025	08:54	Phone, 15 mins	Nathan Soster	Coonabarabran	Discussed finalisation of - return to flying duties next shift
09/05/2025	12:07	Phone,15 mins	Nathan Soster	Coonabarabran	Informed of decision reversal and pending termination
09/05/2025	13:00	Phone, 2 mins	Jeff Cavarra	Coonabarabran	Thanked me for my service and informed me of immediate termination
14/05/2025	13:35	email	Jeff Cavarra		Received termination letter
30/05/2025	10:44	email	ATSB		Emailed Ellena from ATSB to notify them of a change of email address so they could contact me with any requests.
30/05/2025	11:12	Phone 3 mins	Ellena Papadopoulos ATSB		Discussed termination
30/05/2025	11:32	email	ATSB		S32 Request received for termination letter
17/06/2025	13:00-14:30	Teams meetin g	ATSB, Ellena Papadopoulos, Peter Ayre	Coonabarabran	Interview 2 follow up questions
19/06/2025	08:27	email	ATSB Ellena Papadopoulos		S32 Request for Logbook Pages
06/06/2025	09:37	Phone,	Nathan Soster	Coonabarabran	Phone to check on me

[26] Emails between Mr Ceccanti and Mr Hahn-Hill, the Respondent's Safety & Quality Manager (AUS), on 11 and 12 March 2025, give an insight into what the initial understanding of the Incident was. In particular, by email of 8.13 pm on 11 March 2025, Mr Hahn-Hill advised Mr Ceccanti:

> *To avoid any confusion, the system was tested and confirmed serviceable by the engineer, with myself present during our initial inspections. The brief below outlines that there were*

difficulties in releasing the bucket—primarily due to the pilot's focus on actively managing the situation. This is consistent with the attached reported which outlines that when questioned about the failure to jettison the bucket, the pilot attributed it to human performance factors in managing a complex situation rather than a system failure.

The pilot attempted to reach for the emergency release switch on the left-hand cyclic but was unsuccessful due to their focus on managing the situation and visually tracking the load through the bubble window. Additionally, the pilot was unable to activate the mechanical release pedal due to their positioning while handling the event.

The external hook and its dedicated release systems were fully operational. The inability to jettison the bucket was most likely due to the pilot's human performance limitations while managing the incident.

[27] But for the evidence of the Applicant, there is no witness evidence before the Commission as to what occurred in the investigation process. Neither Mr Hahn-Hill, nor Mr Harris, the authors of the Report were called. Nor were:

(a) Mr Jeff Cavarra, the Chief Operating Officer of Coulson Aviation Australia, who was present in the Teams meeting two days after the incident and was the individual who terminated the Applicant on 9 May 2025; or

(b) Mr Nathan Soster, Director of Flight Operations Coulson Aviation Australia, a participant in the teams call on 2 May 2025.

[28] The Applicant's evidence regarding the investigation process, which I accept, particularly in the absence of any contradiction, and noting the candour of the Applicant, was:

(a) Immediately following the Incident, he returned to Strahan and participated in a debriefing session;

(b) He co-operated fully with investigations conducted by both the Respondent and the ATSB;

(c) He was also interviewed at length by Mr Hahn-Hill on Wednesday 12 March 2025 and underwent drug and alcohol testing the day after the Incident;

(d) He provided a detailed written statement on 13 March 2025 to Mr Hahn-Hill and Mr Soster That report stated;

Details
• FRAT and W&B completed prior to flight
• Departed Tullah (1220hrs) for Canning Peak Fire with bucket attached to work on hotspots that I had been working the previous day – west of the Murchinson River on the south east end of the fire
• Weather at the time – temperature 25 degrees and winds light and variable
• Completed one fuel cycle (10 buckets) in relatively calm conditions

• Returned to Zeehan (via Tullah to pick up my ACO) at 1400hrs
• On approach to Zeehan I noticed a significant change in weather conditions with winds from a westerly direction around 30kts
• Refuelled aircraft to 1850lbs and departed Zeehan around 1500hrs for Canning Peak fireground
• Returned to the same dip site and commenced bucketing
• With increased wind strength I orientated myself relative to wind direction which was the same approach and departure paths as the previous fuel cycle
• On the third (3rd) bucket load in a stable hover, filling the bucket, the aircraft began to sink
• I initiated forward flight to prevent an over-torque and was unable to jettison the load before the longline became taught
• Due to the submerged bucket weight – the aircraft came to an abrupt halt
• I recovered into a stable hover approximately 10ft off the river and initiated rearward flight to retrieve the bucket
• At this time, I observed an engine torque split
• Whilst filling the bucket I had intermittent master caution warnings but this was attributed to fuel transfer pumps due to the fuel level being around 1100lbs at the time of the incident
• I recovered the bucket and long-line and climbed clear of obstacles
• I notified Air Attack of a bucket and control problem and tracked for Zeehan with longline attached transiting the 23nm at around 70kts
• Air Attack followed (escorted) me to ensure aircraft/pilot safety and notified Air Ops at Strahan
• During the flight I considered options of a remote landing or possibly a runway landing at Strahan Airport if the control problem got worse
• I decided to proceed to Zeehan as it was closer and was a secure site (with security) for the aircraft, if required
• Upon landing at Zeehan my ACO secured the bucket and long-line
• Once on the ground I was unable to roll the engine throttles back to idle so I called the engineer from the cockpit and at this point was unaware of any damage sustained to the aircraft
• With no immediate solution and an indication of damage from my ACO whilst he was disconnecting the long-line from the hook, the T-handles were pulled to stop the engines and the shutdown was completed as per the checklist
• Once shutdown was completed I immediately inspected the aircraft and contacted Nathan Soster (Operations Manager) as per the ERP procedures
• The aircraft was secured and gear loaded inside the cabin
• As a result of the incident the bucket was damaged experiencing total failure of the top crown spoke assembly
• It appears the long-line may have been shock loaded as a result of the incident
• Both myself and ACO returned to Strahan in HT201 and debriefed about the incident

[Emphasis added]

(e) Also on 13 March 2025, the Applicant spoke to Mr Soster for approximately 20 minutes going over the Incident. Mr Soster said he would be happy to send the Applicant back to flying duties on the next shift if the Applicant was comfortable in doing so, but confirmed that the Applicant would be grounded until the company investigation had been completed;

(f) The Applicant spoke with Mr Hahn-Hill again on 18 March 2025 at about 11:00am when he was asked to confirm details of the Incident. Mr Hahn-Hill assured the Applicant that the investigation is in no way punitive;

(g) The Applicant had further discussions with Mr Hahn-Hill on 27 March 2025, 10 April 2025 and on 1 May 2025, and dozens of telephone calls with Mr Soster in the two months from the Incident to dismissal. Mr Soster also said to the Applicant that the investigation was in no way punitive, nor that he had been negligent or that there was there any criticism of what the Applicant had done;

(h) The Applicant had a Teams meeting with Mr Hahn-Hill and Mr Soster on 2 May 2025 to review sections of his report that the Canadian personnel (Mr Coulson and Mr Ceccanti) had issues with. The Applicant was asked if he wanted to change his statement, and he replied that there was no aspect of his statement that required amendment; and

(i) On the morning of 8 May 2025, the Applicant received a call from Mr Soster in which he informed the Applicant *"it's all being finalised. You'll be returning to duties next rostered shift most likely."*

The Dismissal

[29] Mr Soster called the Applicant on 9 May 2025, at about midday and said: *'I'm sorry, a decision has been taken to terminate you. It's out of my hands."*

[30] The Applicant then received a call from Mr Cavarra at about 1:00pm. Mr Cavarra informed the Applicant that his employment was terminated with immediate effect. The Applicant asked for an explanation and Mr Cavarra replied, *"I'll try to get you something, can I have your personal email."*

[31] The Applicant received a termination letter on 14 May 2025 (the Termination Letter), that stated in the first paragraph regarding reason for dismissal:

> *Mr. Khouri*
>
> *As discussed, your employment with Coulson Aviation Australia has been terminated effective immediately as a result of the significant damage to an RFS-owned aircraft caused by your actions. The damage to the aircraft has created reputational risk to Coulson Aviation Australia as well as our customer.*

[Emphasis added]

[32] The termination letter made no reference to the Applicant's engagement in the investigation, his alleged attitude, or any refusal to accept a particular conclusion as to the cause of the incident.

[33] In his statement, Mr Ceccanti says that he formed the view, having considered the safety reports and speaking to the safety and operations staff, that the Incident was caused by pilot error specifically a "*settling with power*" or Vortex Ring State (VRS) type event, and the Applicant's failure to jettison the bucket and to land as soon as practicable. Further, in his Statement Mr Ceccanti stated:

> *If Mr Khouri had participated more positively in the investigation into the incident and had identified what he thought occurred, why it occurred and provided an assurance that he would approach things differently in the future, there is no doubt that he would have remained employed by Coulson Aviation. Instead, his response was to the effect that he did not know what had happened and that the safety team should try and work it out.*

[Emphasis added]

[34] The Applicant was informed that the Respondent's senior management held a meeting with personnel of their Bankstown base by videoconference, at which the staff were told by the Respondent's Chief Executive, Britton Couslon, that the Applicant's employment was terminated because of his attitude. At no time did Mr Coulson or anyone else raise with the Applicant any issues with his attitude or work performance.

[35] In the Hearing, the evidence of Mr Ceccanti regarding the dismissal was:[2]

> *You've given evidence, haven't you, that Mr Khouri didn't participate positively in the investigation? --- Yes.*
>
> *And that had he engaged positively, would remain employed? --- More than likely. It would have probably – we weren't really given that opportunity to weigh that in on our decision process.*

[36] That evidence was confirmed during the Respondent's submissions in the following exchange:[3]

> *THE DEPUTY PRESIDENT: So basically every incident that you're focusing in on to prove airmanship, if he simply said, 'I accept all of that', then he'd still be flying?*
>
> *MR BRENNAN: That's right. That's right.*

[37] Under cross-examination, Mr Ceccanti accepted that he had never spoken directly to the Applicant at any stage before the decision to dismiss and that neither he nor Mr Coulson had expressed to the Applicant any concern that he was not engaging appropriately in the investigation or that his employment was at risk if he did not accept a particular view of the cause.[4]

[38] Mr Ceccanti also accepted that he did not have first-hand knowledge of the Applicant's detailed engagement with Mr Hahn-Hill, Mr Soster, Mr Cavarra or the ATSB, and had not seen the Chronology.[5] He nonetheless formed the opinion that the Applicant had not engaged "*positively*" in the safety process.

The Report

[39] Two versions of the Report were produced, one dated 13 May 2025, one day before the dismissal of the Applicant, and a later version dated 19 June 2025, each described as a "*Final Report*". The authors were Mr Hahn-Hill, and Mr Harris, the Respondent's Director of Safety (Global).

[40] In the part regarding Safety Analysis, the Report provided:

> ***4 SAFETY ANALYSIS***
>
> ***4.1 Introduction***
>
> *The investigation confirmed that both pilot licensing and training met all applicable regulatory requirements. Additionally, there was no evidence to suggest that medical or physiological factors including fatigue played a role in the incident. As such, the analysis will focus on the likely cause of the helicopters sudden loss of lift, the circumstances surrounding the impact of the external hook with the airframe, and the broader context of the aircrafts diverse operational roles, along with company training and procedural frameworks.*
>
> ***4.2 Loss of Lift***
>
> *A detailed review of TracPlus flight path data was undertaken in conjunction with the Rotary Wing Head of Flying Operations (HOFO) as part of the investigation into the occurrence involving the subject aircraft. The analysis, however, was limited by irregularities in the data, notably inconsistent time gaps and variable data output, which impacted the accuracy of the flight path reconstruction.*
>
> *Despite these limitations, one potential contributing factor to the observed acute loss of lift during the approach to the dip site was the aircrafts entry into a non-stabilised flight profile. A non-stabilised approach is characterised by deviations from a consistent and predictable flight path, airspeed, and descent rate toward the intended hover point. Such conditions are known to increase the likelihood of encountering a settling with power scenario. This aerodynamic phenomenon typically occurs when a helicopter descends at a high rate with low or no forward speed, resulting in disturbed airflow around the rotor system and a sudden, often uncommanded, loss of lift and control.*
>
> *According to the pilot, the descent commenced from a hovering state. However, in combination with a potentially non-stabilised flight profile, it is possible the aircraft entered an unsettled hover condition. This is typically defined as difficulty maintaining*

a stable and stationary position in the air, potentially manifesting as lateral drift, vertical bounce, or inconsistent altitude holding.

Further compounding the situation may have been the pilots limited situational awareness due to cognitive workload. High cognitive demand, particularly when operating with additional systems such as FLIR cameras and associated flight steps, can diminish the pilots ability to perceive and react to critical visual cues. In this case, visual references such as the tree line normally useful in estimating descent rate may have been obscured or deprioritized. Compounding this, instrument visibility from the Transwest vertical door, particularly of key displays such as the vertical speed indicator (VSI), may have been compromised.

Environmental factors may also have played a role. Reports of wind gusts potentially reaching up to 30 knots could have introduced sudden aerodynamic disturbances, further destabilizing the aircraft during the lowlevel approach and contributing to the rapid loss of altitude.

It is also relevant to note that the Rotorcraft Flight Manual (RFM) includes a cautionary statement: "WHEN OPERATING NEAR THE MAXIMUM MAST TORQUE LIMIT, INADVERTENT OVERTORQUE MAY OCCUR DURING MANEUVERING FLIGHT CONDITIONS INVOLVING TURNS AND/OR NOSE DOWN ATTITUDE CHANGES. DECREASE POWER TO 90% MAST TORQUE PRIOR TO MANEUVERING HELICOPTER."

Despite the challenging circumstances, the pilot's response to the loss of lift was consistent with a typical recovery procedure. To manage the risk of over torque or possible recognition and recovery of a settling with power event the pilot successfully responded to the loss of lift by initiating forward flight, which allowed the aircraft to recover from the sink and avoid an unrecoverable loss of control.

4.3 External Hook Contact with Aircraft

The pilot initiated forward and level flight at approximately 100 feet AGL in an attempt to overcome the acute loss of lift condition; however, the load was not jettisoned in time, and the longline became taut. The weight and drag of the submerged bucket caused the aircraft to abruptly decelerate. The sudden change in aircraft dynamics allowed the external hook and longline to roll back and contact the aircraft. As the aircraft's attitude rapidly changed, the pilot experienced a forward jolt and briefly contacted the left-hand pilot door window, which caused a minor graze on the pilot's nose from their glasses. When questioned about the failure to jettison the load, the pilot attributed it to human performance factors rather than a mechanical failure. The pilot attempted to reach for the emergency release switch located on the left-hand cyclic but was unable to do so due to being focused on managing the aircraft and visually tracking the load through the bubble window. Furthermore, the pilot's positioning during the event prevented them from activating the mechanical release foot pedal. The pilot's actions suggest that the complexity of safely managing the aircraft, combined with the physical positioning of the head outside the LH bubble window, hindered the ability to execute the emergency jettison procedures promptly. PIC when asked during the post-incident assessment

about the decision not to jettison the bucket due to aircraft control concerns, the pilot explained that during his checks to assess manoeuvrability and control, he determined the aircraft remained sufficiently controllable. However, he stated that had control worsened, he would have jettisoned the bucket. The investigation concluded that the control anomalies observed following the impact between the external cargo hook and the fuselage were attributable to damage sustained by the tail rotor control tube located in the rear fuselage. Furthermore, the post-incident assessment determined that the pilot-ininability to perform engine rollback during shutdown was the result of impact-induced mechanical failures. Specifically, the No. 1 engine control tube was found to have sheared at the lower tube-end bell crank, resulting in a complete loss of pilot input authority. The No. 2 engine control tube bell crank attachment bracket had become detached from its structural mounting rib, thereby restricting input to that engine. Both failures were consistent with damage caused by the cargo hook's impact on the aft fuselage.

4.4 Diverse Operational Capability

The investigation revealed that the diverse operational capability of the NSWRFS rotary aviation fleet plays a critical role in a variety of missions, including water suppression activities, fire scanning, passenger and cargo transfer, and crew insertion and extraction. The aircraft, when in its standard configuration, is equipped with a hoist and FLIR camera; however, it requires the installation of the left-hand Transwest vertical door to be fully configured for fire suppression operations. This broad operational scope has led to a more generalist approach rather than a specialist one, which introduces certain critical risks. The lack of sustained hands-on experience, particularly in external load bucketing, heightens the operational risks, as crews may not be adequately prepared to manage the complexities of these operations. When the Tasmania-based crews were asked about the highest-risk operations, all indicated that external load bucketing and transitioning between multiple operations on a daily basis posed the greatest challenges. Despite well regarded training programs, the crews noted that minimal external bucketing operations had been required in recent years, resulting in a lack of sustained hands-on experience necessary to manage the complexities of such operations. However, it was also noted that the crews are highly risk-averse, with one Coulson crew even rejecting a tasking due to their assessed lack of experience with bucketing and the perceived unsafe conditions on the day. This highlights how the combination of diverse capability and limited hands-on experience in specific tasks elevates operational risks, especially when transitioning between different types of missions.

4.5 Company Training & Procedures

During the course of the investigation, feedback obtained from flight crews consistently indicated that the company's training program is generally regarded as robust and well-suited to preparing operators for the majority of mission profiles. This feedback reflected positively on the overall quality and structure of the training provided. However, despite the strong endorsement of the training program, the investigation identified . Specifically, it was determined that while the pilot had completed an CASA APC bucketing proficiency check in a Bell 412, they had not received formal internal

ground or practical training specific to external slung bucket operations. Furthermore, the pilot had not been evaluated in a simulated or operational fire suppression environment, but rather in a basic exercise involving water collection from an unobstructed dam and targeting practice with minimal complexity. This gap in scenario-based assessment and lack of structured, role-specific onboarding suggests a breakdown in the transitional training framework, particularly in preparing personnel for real-world fire suppression missions. These findings raise concerns about the consistency and completeness of internal training processes for safety-critical tasks.

Additionally, it was identified that the Coulson operations manual and associated procedures lack comprehensive coverage for the determination and standardization of the complex activities performed on behalf of the NSWRFS. This gap in procedural coverage has led to an organizational mentality where responsibility is placed on individual operators to make safety-critical decisions based on training and experience alone within an already complex and diverse operational environment. In such operations, the absence of clear, standardized procedures can increase the risk of errors, create inconsistencies between operators, and lead to unforeseen outcomes. While some flexibility in procedures is necessary to support the diverse range of tasks Coulson performs, the lack of consistent procedural controls creates inherent risks. These risks should be carefully considered and factored into the overall risk characterization of the operation to ensure a robust safety framework is in place and all known risk either eliminated or minimised As Low As Reasonably Practicable (ALARP).

[Emphasis added]

[41] The Report describes the Incident, identifying multiple potential contributing factors (including wind conditions, unsettled hover, high pilot cognitive workload, reduced instrument visibility through a transverse vertical door, and limited external visual cues from FLIR use). The Report states that the investigation "*identified one possible cause*" relating to a non-stabilised flight profile but does not identify a single root cause or attribute the incident definitively to pilot error.

[42] In the part regarding Conclusions, the Report provided, in part:

5.1 Conclusions and Causations

The investigation identified that the incident likely resulted from a combination of limited operational oversight and human performance constraints. At the time of the occurrence, the pilot was engaged in complex operational tasks under challenging ergonomic conditions, which may have contributed to performance degradation.

However, it is important to note that determining a definitive root cause has proven difficult due to inconsistencies in the available data and limitations in the pilot's ability to recollect the conclusions of any contributing factors. These factors have constrained the ability to draw conclusive findings.

Loss of lift: *The investigation identified that one possible cause is that the aircraft likely entered a non-stabilised flight profile during the approach to the dip site, increasing the risk of a settling with power event. Contributing factors may have included an unsettled hover state, high pilot cognitive workload, reduced visibility of critical instruments from the Transwest vertical door, and limited external visual cues due to FLIR use. Environmental conditions, including potential 30-knot wind gusts, may have further destabilized the aircraft. These combined factors likely led to a sudden loss of lift. The pilot responded appropriately by initiating forward flight, allowing recovery from the sink and preventing loss of control.*

External Hook Contact with Aircraft*: The investigation found that the pilot initiated forward and level flight to recover from the loss of lift, but was unable to jettison the load in time, resulting in the longline becoming taut. The submerged bucket's weight and drag caused the helicopter to abruptly decelerate. This allowed the external hook and longline to strike the airframe. The pilot experienced a forward jolt, making contact with the left-hand pilot door window and sustaining a minor injury. The failure to jettison the load was attributed to human performance factors. As the pilot's attention was focused on managing the situation and tracking the load through the left-hand bubble window, which hindered their ability to activate the emergency jettison mechanisms.*

Diverse Capability *The investigation identified that the NSWRFS rotary aviation fleet is tasked with a wide range of operations, including water suppression, fire scanning, and passenger and cargo transfer. The aircraft's diverse capabilities have led to a more generalist operational approach. The crews highlighted that external load bucketing and transitioning between multiple mission types daily are the highest-risk operations. Despite adequate training, crews noted that minimal external load bucketing operations have been required in recent years, resulting in insufficient hands-on experience. This lack of experience increases the operational risks associated with managing complex operations, particularly when transitioning between different types of tasks.*

Training and Procedural Deficiencies*: The investigation found that while the company's training program is generally well-regarded by flight crews, significant gaps exist in the onboarding and transitional training for external load operations. Specifically, the absence of structured, scenario-based assessments and role specific preparation for fire suppression tasks highlights a deficiency in ensuring operational readiness for safety-critical missions. The investigation also revealed that there are gaps in procedural coverage within the Coulson rotary wing operations manual. These gaps led to an organizational reliance on individual operators to make safety-critical decisions in complex operational environments. The absence of clear, standardized procedures for managing complex tasks creates operational risks, as it may lead to inconsistent practices and errors. While flexibility is necessary in some aspects of the operation, the lack of consistent procedural controls contributes to increased risks, which must be addressed to ensure a safe working environment.*

[Emphasis added]

[43] The Safety Recommendations outlined in the Report were as follows:

The following outlines the recommendations as a result of this investigation:

R1. Conducting and Recording of Engine Desalination Washes:

It is recommended that Maintenance revise the coastal operational requirements for engine desalination rinses to ensure alignment with environmental exposure and operational demands. Additionally, a robust process should be developed to ensure engine desalination washes are consistently initiated, properly recorded, and certified in accordance with the specified requirements

R2. Review of Bell 412 Power Assurance Check Frequency

It is recommended that scheduled maintenance procedures be reviewed and aligned more closely with manufacturer-recommended operational checks to ensure timely detection of engine performance degradation and enhance overall aircraft reliability and safety.

R3. Pilot Remedial Training & Proficiency Check

Pilot to conduct bucketing remedial training and pass a proficiency check prior to resuming operations.

R4. NSWRFS Aircraft Configuration Review:

It is recommended that Coulson and NSWRFS jointly review and establish standard aircraft configurations tailored to their range of operational requirements. As part of this review, consideration should be given to the operational impact of the FLIR camera during external slung bucketing operations, including whether its removal may improve pilot visibility and reduce workload.

R5. Review of Training Structure & Frequency

To mitigate the current gap in structured, scenario-based assessments and sustained practical experience for complex operations, Coulson and the NSWRFS should undertake a comprehensive review of transitional training frameworks and the frequency of ongoing operational training to ensure pilots possess the requisite skills for their assigned tasks.

R6. Review Operational Procedures

Review operational procedures and where able create robust standardised processes to remove organizational reliance on individual operators to make safety-critical decisions in complex operational environments.

R7. Release a flight safety Memo

Distribute a flight safety Memo to highlighting vigilance around inherent risks of helicopters such as vortex ring and how they relate to the complex environment.

[44] Consistent with Recommendation 7 above, a Flight Safety Memo was issued on 12 August 2025.[6] That Flight Safety Memo included the following under the heading *"Context"*:

This Safety Alert has been issued in response to the Safety Investigation Report titled "VH-VJF Tasmania Bucket Incident" section 6, Safety Recommendations and in particular recommendation R7 to create greater awareness of the characteristics of SR/SWP and the dangers associated with reduced error margins when conducting fire suppression activities. To provide further context –

The investigation identified that one possible cause is that the aircraft likely entered a non-stabilised flight profile during the approach to the dip site, increasing the risk of a settling with power event. Contributing factors may have included an unsettled hover state, high pilot cognitive workload, reduced visibility of critical instruments from the Transwest vertical door and limited external visual cues due to FLIR use. Environmental conditions, including potential 30-knot wind gusts, may have further destabilized the aircraft. These combined factors likely led to a sudden loss of lift. The pilot responded appropriately by initiating forward flight, allowing recovery from the sink and preventing loss of control.

[45] It is notable that at no part of either version of the Report is there any reference to the Applicant's engagement in the investigation, his alleged attitude, or any refusal to accept a particular conclusion as to the cause of the incident.

The Evidence

(a) The Applicant

[46] The Applicant presented as an honest, open and candid witness, who had genuinely tried to assist the Respondent, and subsequently the Commission, to understand the events and causes of the Incident.

[47] When presented at the Hearing with questions involving absolute propositions of alleged safety breaches that were not reflective of the contents of the Report, he nonetheless attempted to honestly address those propositions. While there were some areas where the Applicant's evidence was imprecise, particularly in reconstructing his decision-making in the seconds around the loss of height, such imprecision was not surprising given the stressful and immediate circumstances of the Incident, and the Report accepted such imprecision.

[48] The Applicant's concessions, such as regarding his erroneous failure to jettison the bucket, reflected positively on his candour rather than establishing any evasiveness. Indeed, the authors of the Report have little difficulty accepting that the circumstances were *"challenging"* and that *"Further compounding the situation may have been the pilots limited situational awareness due to cognitive workload"*.

[49] The Applicant's evidence was contained in his two statements and his testimony at the Hearing. His first statement describes his career, training with the Respondent, the events of the Incident and his interactions with the Respondent's managers. His second statement annexes the Chronology of the investigation and addresses the impact of dismissal.

[50] In his evidence at the Hearing the Applicant maintained that he did not know the precise cause of the Incident and that he had co-operated with the safety investigation by providing information as requested, participating in interviews, and engaging with the ATSB.

[51] The Applicant was pressed about some aspects of his first statement, including his understanding of engine torque split and other technical matters, but confirmed that the statement was based on his recollection at the time and that he remains of the view that its core description of the Incident is correct.

(b) Mr Peter Cook

[52] Mr Cook is a highly experienced helicopter pilot and aviation manager. His CV records more than 13,000 helicopter hours, senior instructor and examiner qualifications, and substantial time in command of Bell 412 aircraft and aerial firefighting operations.

[53] In his report, Mr Cook explains the concept of Just Culture, the role of safety investigations, and the range of potential causes of the Incident. He notes that the Report does not identify a single cause, instead referring to one "*possible cause*" and a range of contributing factors. He opines that there is "*no basis*" in the material he reviewed to conclude that the Applicant cannot safely return to firefighting operations, provided he receives appropriate remedial training, checking and supervision.

[54] In cross-examination Mr Cook accepted that his CV did not list his firefighting experience and that he had not personally conducted long-line operations from the left-hand seat of a Bell 412.[7] He nonetheless maintained that he has significant firefighting and Bell 412 command experience, and that his opinions are based on his understanding of helicopter aerodynamics, SMS practice and the safety reports provided.

[55] The Respondent submitted that aspects of Mr Cook's evidence, particularly his acceptance that pilots might be reluctant to drop buckets for fear of criticism, were "*silly*" and should be rejected.[8] I do not accept that characterisation. While I place limited weight on speculative propositions about pilot psychology in the absence of supporting data, I accept Mr Cook's core evidence about Just Culture, SMS practice, the indeterminate nature of the Incident's cause and the feasibility of remediation through training and supervision. Those opinions are within his field of expertise and are consistent with the Report.

(c) Mr Mel Ceccanti

[56] Mr Ceccanti is the Respondent's Group Chief Pilot. His statement describes more than 20 years' experience in helicopter and fixed-wing firefighting operations and leadership roles in training and examining pilots. He emphasised his responsibility for ensuring that only pilots who can safely perform are authorised to operate in high-risk aerial firefighting tasks.

[57] In his statement, Mr Ceccanti recounts his involvement after receiving an initial incident report from Mr Soster. He describes the Incident as extraordinarily serious, notes the minimal margin between recovery and catastrophic crash, and states that he considered the Applicant's decision to fly back with the bucket attached to be a "*serious and dangerous error*".

[58] Mr Ceccanti also expressed strong views about the Applicant's engagement with the safety investigation and what he saw as an unwillingness to accept that the incident was caused by pilot error (a VRS-type event). He says that, based on the Applicant's responses during the investigation, he concluded the Applicant lacked insight into his own performance and could not be trusted to implement necessary changes to avoid recurrence.

[59] However, in cross-examination Mr Ceccanti accepted that:

a) he was not the author of the Report;[9]

b) the Report does not identify VRS as the definite cause of the Incident, but only refers to one "*possible cause*" and multiple contributing factors;[10]

c) the safety recommendations in the Report included remedial training and a proficiency check, not termination of employment;[11] and

d) inclusion of disciplinary outcomes in a safety report would be inconsistent with the company's practice.[12]

[60] Importantly, Mr Ceccanti accepted that he never spoke directly to the Applicant before recommending termination,[13] that neither he nor Mr Coulson informed the Applicant that his employment was at risk for not engaging "*positively*" in the investigation, and that he had not seen the Chronology before forming his view about the Applicant's engagement.

[61] Mr Ceccanti said his assessment of the Applicant's engagement was based on what he had been told by others (including Mr Hahn-Hill, Mr Harris and Mr Soster), but none of those individuals were called to give evidence.[14]

[62] I accept that Mr Ceccanti is an experienced and conscientious pilot and that his safety concerns were genuinely held. However, I found aspects of his evidence problematic. His initial assertion that the safety report's "*remedial actions*" included termination was clearly incorrect.[15] Further, his conclusion that the Applicant had not engaged properly in the investigation was made without first-hand knowledge of multiple key interactions and without reference to the detailed Chronology the Applicant had prepared.[16]

[63] Where Mr Ceccanti's evidence conflicts with the Report, the Flight Safety Memo and the Chronology, I prefer the documentary record and the Applicant's evidence.

Applicant Submissions

[64] The Applicant contends that there was no valid reason for dismissal and that the dismissal was harsh, unjust and unreasonable under each of the s 387 factors.

[65] As to valid reason (s 387(a)), the Applicant submitted that in order to be a valid reason, the reason for the dismissal should be *"sound, defensible or well founded"*, and should not be *"capricious, fanciful, spiteful or prejudiced."*[17] The Commission does not *"stand in the shoes"* of the employer but will need to be satisfied that the termination of the employee was for a valid reason.[18]

[66] The Applicant submitted that in respect of serious misconduct, the relevant principle established in *Briginshaw v Briginshaw*[19] is relevant. While the civil standard of proof remains, *"the nature of the issue necessarily affects the process by which reasonable satisfaction is attained"* and *"such satisfaction should not be produced by inexact proofs, indefinite testimony, or indirect inferences"* or *"by slender and exiguous proofs or just pointing with a wavering finger to an affirmative conclusion"*.[20]

[67] The Applicant submitted the Report does not identify pilot error as the cause of the incident but rather concludes that the cause is uncertain and that multiple factors may have contributed. The Respondent's reliance on VRS and the Applicant's alleged unwillingness to accept responsibility goes beyond the findings of the Report.

[68] The Applicant submits that any criticisms of his decision-making, including the failure to jettison the bucket, must be viewed in the context of the extreme time pressure and the lack of adequate training for left-seat long-line operations.

[69] Regarding procedural fairness (s 387(b)–(c)), the Applicant submitted that:

a) the only written reason provided for dismissal was the damage to the aircraft and reputational risk, which the Respondent now accepts did not accurately reflect the real reason;

b) he was never told that his alleged failure to engage in the investigation or to accept a particular conclusion about the root cause was being treated as misconduct or as the basis for dismissal;

c) no allegations were put to him for response and he was not given an opportunity to respond to any proposed disciplinary action; and

d) these deficiencies are inconsistent with the Just Culture commitments.

[70] The Applicant submitted that the Respondent's failure to call key witnesses (notably the safety investigators and operations managers who interacted with him) supports an inference that their evidence would not have assisted the Respondent's re-formulated case on engagement and attitude.[21]

[71] Regarding other relevant matters under s 387(h), the Applicant submitted that the Respondent was aware on offering the position to the Applicant that acceptance required the entering into arrangements that incurred costs, including establishing a second residence in Sydney and the appointment of a salaried manager to operate his business. The Applicant also submitted that the field in which the Applicant works is limited, and the Applicant is unlikely to find a similar position within a reasonable period of time.

[72] As to remedy, the Applicant seeks reinstatement with continuity and back pay. He submits that any loss of confidence on the part of the Respondent is based on flawed conclusions about his engagement and is not determinative of whether reinstatement is appropriate. He relies on Mr Cook's evidence that he can safely return to operations with appropriate remedial training and checking.

Respondents Submissions

[73] The Respondent submitted that there was a valid reason for dismissal related to the Applicant's conduct and capacity, and that the dismissal was not harsh, unjust or unreasonable when viewed in light of the Respondent's safety obligations.

[74] The Respondent identified two core aspects of the valid reason:

1) the Applicant's failure to jettison the bucket and land at the earliest safe opportunity after a serious loss of height over water, thereby exposing the aircraft and himself to a risk of catastrophic loss; and

2) his failure to engage constructively in the safety investigation and to accept that pilot error was the cause of the incident, leading the Respondent to conclude that he could not be relied upon to implement required changes.

[75] The Respondent emphasised that it has stringent statutory obligations under the *Civil Aviation Act* and workplace health and safety legislation to maintain a safe workplace and that it could not, consistently with those obligations, allow a pilot to continue to perform high-risk aerial firefighting operations if the Group Chief Pilot reasonably considered the pilot to be unsafe.

[76] In oral submissions, the Respondent outlined four aspects of airmanship on the flight of 10 March where the Applicant fell well short of required standards, although it must be observed that the second to fourth *"acts of airmanship"* all involved failures to release the long line, albeit at different points in time. They were:

1. The approach to hover, leading to the vortex ring state;

2. The failure to release the long line when flying forward;

3. The failure to release the long line and bucket before hovering to empty the bucket; and

4. The failure to release the long line and bucket before landing.

[77] The Respondent submitted that, given the magnitude of the risk and the Applicant's failure to explain his departure from accepted practice, the Respondent was entitled to conclude there was a fundamental issue with his judgment in critical situations.

[78] As to Just Culture, the Respondent submitted that the Applicant was not dismissed for being involved in an incident or for reporting it, but for his subsequent conduct in failing to

engage with the investigation and to accept the lessons to be drawn. The Respondent submitted that a pilot who refuses to participate meaningfully in a safety process or to accept that their actions contributed to a serious event cannot be safely retained.

[79] Regarding procedural fairness, the Respondent pointed to the multiple interactions between the Applicant, the safety manager, the Head of Flying Operations and others, and submitted that the Applicant was well aware that the Respondent considered the incident extremely serious and that his performance was under scrutiny. The Respondent conceded that the termination letter did not articulate all of the reasons but submitted that, in context, the Applicant knew the matters of concern.

[80] The Respondent submitted that the relationship of trust and confidence between it and the Applicant has broken down irretrievably, particularly given Mr Ceccanti's evidence that he could not be satisfied that the Applicant would operate safely, and that reinstatement is inappropriate.

Applicant's Submissions in Reply

[81] The Applicant submitted:

(a) The Respondent's case on the reason for dismissal is completely different from the one relied on in terminating the Applicant;

(b) Despite framing its case as essentially dismissal on the basis of a failure to be candid within a safety investigation, the Respondent did not adduce evidence from any person involved in the investigation, and did not call evidence from any of its Australian-based staff;

(c) There is no evidence that Mr Ceccanti ever spoke with the Applicant, let alone give him an opportunity to address the matters that formed Mr Ceccanti's *"view"*.

(d) Mr Ceccanti's *"view"* is at odds with the Respondent's own evidence in the Report; and

(e) There is and was no basis to terminate the Applicant's employment. Nothing in the Respondent's evidence can reasonably be regarded as impacting the Applicant's ability to return to his job.

Consideration

[82] While the termination letter referred to the reason for dismissal being "*significant damage to an RFS-owned aircraft caused by your actions*" and associated reputational risk to the Respondent and its customer, the Respondent specifically eschewed that reason for dismissal relating to the conduct of the relevant flight, although the Respondent also advanced a case alleging four acts of airmanship which are also considered below. It was submitted:

> *.... This is not a dismissal where we say the reason for the dismissal was anything done by way of the flight. This is a dismissal where the employer says:*[22]

> *"We dismissed because the flight happened and there was then not appropriate engagement with the safety investigation."*

(a) Appropriate Engagement with the Safety Investigation

[83] It is necessary to consider whether the Respondent had a valid reason for the dismissal of the Applicant, although it need not be the reason given to the Applicant at the time of the dismissal.[23] In order to be *"valid"*, the reason for the dismissal should *be "sound, defensible and well founded"* and should not be *"capricious, fanciful, spiteful or prejudiced."*[24]

[84] The Commission will not stand in the shoes of the employer and determine what the Commission would do if it was in the position of the employer. The question the Commission must address is whether there was a valid reason for the dismissal related to the Applicant's capacity or conduct (including its effect on the safety and welfare of other employees).[25]

[85] In cases relating to alleged conduct, the Commission must make a finding, on the evidence provided, whether, on the balance of probabilities, the conduct occurred. It is not enough for an employer to establish that it had a reasonable belief that the termination was for a valid reason.[26]

[86] The employer bears the evidentiary onus of proving that the conduct on which it relies took place.[27] In this matter, the Respondent has comprehensively failed to prove that there was not appropriate engagement with the safety investigation, or that anything done when the flight happened exceeded that outlined in the Report.

[87] A significant factor in the conclusion that the Respondent failed to discharge their evidentiary onus are the inferences I draw arising from the Respondent's failure to call certain persons to give evidence, leading to the inferences that the evidence of such persons would not have assisted the Respondent's case.

[88] *In Hyde v Serco Australia Pty Limited T/A Serco Australia Pty Limited*,[28] the Full Bench of the Fair Work Commission found:

> *The rule in Jones v Dunkel has been aptly described as 'a rule of common sense and fairness in relation to the fact finding process.' The rule was considered extensively in Tamayo v Alsco Linen Service Pty Ltd (Tamayo). In that matter the Full Bench made the following general observation about the rule in Jones v Dunkel:*
>
> > *'1. The unexplained failure by a party to give evidence, to call witnesses, or to tender documents or some other evidence may in appropriate circumstances lead to an inference that the uncalled evidence would not have assisted the party's case. The rule has no application if the failure is explained, for example, by the absence of the witness coupled with a reasonable explanation for not compelling attendance by subpoena, or by illness or some other availability.*
> >
> > *The significance of the inference depends on the closeness of the relationship of the absent witness with the party who did not call the witness. Considerable significance may attach if the absent witness is either the party or a senior executive of a corporate*

party closely involved in the circumstances in question and present during the hearing of the case.

The rule provides that an inference may be drawn in certain circumstances not that such an inference must be drawn.

2. The rule permits an inference that the untendered evidence would not have helped the party who failed to tender it and entitles the Commission to more readily draw any inference fairly drawn from the other evidence. But the rule does not permit an inference that the untendered evidence would in fact have been damaging to the party not tendering it. The rule cannot be employed to fill gaps in evidence, or to convert conjecture and suspicion into inference.

3. The rule only applies where a party is `required to explain or contradict' something and this depends on the issues thrown up by the evidence in a particular case.

4. The rule only applies to the failure to call a witness who is not a party to the proceedings if it would be natural for the party to call that witness, or the party might reasonably be expected to call the witness in question, or as Glass JA said in Payne v. Parker, `the missing witness would be expected to be called by one party rather than another'. His Honour said that this condition:

> *'. . . is also described as existing where it will be natural for one party to produce the witness, or the witness would be expected to be available to one party rather than the other or where the circumstances excuse one party from calling the witness, but require the other party to call him, or where he might be regarded as in the camp of one party, so as to make it unrealistic for the other party to call him, or where the witness' knowledge may be regarded as the knowledge of one party rather than the other, or where his absence should be regarded as adverse to the case of one party rather than the other. It has been observed that the higher the missing witness stands in the confidence of one party, the more reasons there will be for thinking that his knowledge is available to that party rather then to his adversary. If the witness is equally available to both parties, for example, a police officer, the condition, generally speaking, stands unsatisfied. There is, however, some judicial opinion that this is not necessarily so. Evidence capable of satisfying this condition has been held to exist in relation to a party's foreman; his safety officer; his accountant; his treating doctor.'*

A party is not necessarily expected to call their own employees, though the more senior employee the more reason for concluding that the employee's knowledge is available to his or her employer rather than any other party.

5. The evidence of the missing witness must be such as would have elucidated the matter. In Payne v. Parker Glass JA said:

> *'. . . according to Wigmore the . . . condition is fulfilled where the party or his opponent claims that the facts would thereby be elucidated. Under other formulations, the condition is made out when the witness is presumably able to put*

> *a true complexion on the facts, might have proved the contrary, would have had a close knowledge of the facts, or where it appears that he had knowledge. I would think it insufficient to meet the requirements of the principle that one party merely claims that the missing witness has knowledge, or that, upon the evidence, he may have knowledge. Unless, upon the evidence, the tribunal of fact is entitled to conclude that he probably would have knowledge, there would seem to be no basis for any adverse deduction from the failure to call him.'*
>
> *[103] Section 591 of the Act provides that the Commission is not bound by the rules of evidence and procedure and, pursuant to s.590, the Commission 'may inform itself in relation to any matter before it in such manner as it considers appropriate'. Further, s.577(a) provides that the Commission must perform its functions and exercise its powers in a manner that 'is fair and just'. As the 'rule' in Jones v Dunkel is fundamentally concerned with issues of fairness the Commission will give consideration to its application in an appropriate case. We adopt the observations made in Tamayo.*
>
> *[104] A breach of the rule in Jones v. Dunkel may lead to the drawing of an adverse inference. The inference that may be drawn is ordinarily an inference that the uncalled evidence would not have helped the party's case: not an inference that the uncalled evidence would have been positively unfavourable to the party's case or positively favourable to the opposing party's case. A breach of the rule in Jones v. Dunkel may also result in a ready acceptance of the opposing party's evidence on the fact in question. However, a breach of the rule does not automatically prevent a finding being made that is favourable to the party who has failed to call relevant evidence on the question: other evidence may properly support the finding notwithstanding such failure.*
>
> [Emphasis added/Footnotes omitted]

[89] There were four potential witnesses who would have been able to give evidence for the Respondent. At the time of the Hearing there was no suggestion that any of the four potential witnesses were no longer employed by the Respondent, and it is clear that each witness held a senior role with the Respondent and were involved with the investigation of the Incident. It would have been natural, and it would be reasonably expected, for the Respondent to call those witnesses.

[90] Those four potential witnesses were the authors of the Report, Mr Hahn-Hill and Mr Harris, Mr Cavarra, the Chief Operating Officer of Coulson Aviation Australia, and Mr Nathan Soster, Director of Flight Operations Coulson Aviation Australia. Each would have been well placed to give evidence as to whether there had been appropriate engagement with the safety investigation.

[91] In the circumstances I readily draw the inference that the evidence of those four uncalled witnesses would not have assisted the Respondent.

[92] Against those inferences, the only evidence of the Respondent regarding valid reason is pure hearsay evidence of Mr Ceccanti as to what Mr Soster may have told him at various stages in the investigation. That evidence could be afforded little weight, particularly in the absence of Mr Soster, and goes no way to establishing valid reason.

[93] Mr Ceccanti also accepted that he did not have first-hand knowledge of the Applicant's detailed engagement with Mr Hahn-Hill, Mr Soster, Mr Cavarra or the ATSB, and had not seen the Chronology.[29] He nonetheless formed the opinion that the Applicant had not engaged "*positively*" in the safety process.

[94] The evidence of the Applicant, however, establishes clear and continued engagement with the investigation process. He promptly provided his written statement on 13 March 2025 and thereafter met or spoke repeatedly with Mr Hahn-Hill, Mr Harris, Mr Cavarra and Mr Soster.

(b) Acts of Airmanship

[95] As noted above, in oral submissions, the Respondent outlined four aspects of airmanship on the flight of the Incident where it alleged the Applicant fell well short of required standards. While such a submission would seem impermissible as it flies directly in the face of Just Culture and Mr Ceccanti's evidence that Coulston understand that pilots will make mistakes, and they do not punish pilots for making errors, it must necessarily be dealt with.

[96] The Respondent sought to advance this limb of its case by directing questions to the Applicant involving absolute propositions of alleged safety breaches that were not reflective of the contents of the Report. Unremarkably, and reflective of his candid demeanour in giving evidence, the Applicant nonetheless attempted to honestly answer those questions.

[97] The gravity and absolute nature of the allegations advanced by the questioning was not reflective of the evidence in the matter. The Report acknowledged the possible existence of various contributing factors, and that the Applicant's response to the loss of lift was consistent with a typical recovery procedure.

[98] The Applicant's concessions were recorded in the Report, such as the Applicant attributing the first failure to jettison the longline to human performance factors rather than a mechanical failure. He clearly outlined that he attempted to reach for the emergency release switch located on the left-hand cyclic but was unable to do so due to being focused on managing the aircraft and visually tracking the load through the bubble window.

[99] In the Findings of the Report, a balanced assessment of the possible causes of the loss of lift found:

> ***Loss of lift****: The investigation identified that one possible cause is that the aircraft likely entered a non-stabilised flight profile during the approach to the dip site, increasing the risk of a settling with power event. Contributing factors may have included an unsettled hover state, high pilot cognitive workload, reduced visibility of critical instruments from the Transwest vertical door, and limited external visual cues due to FLIR use. Environmental conditions, including potential 30-knot wind gusts, may have further destabilized the aircraft. These combined factors likely led to a sudden loss of lift. The pilot responded appropriately by initiating forward flight, allowing recovery from the sink and preventing loss of control.*
>
> [Emphasis added]

[100] Insofar as the various acts of airmanship are relied upon, they involve a lack of consideration of the combined factors of the Incident and the principles of Just Culture, and do not constitute valid reasons. The Respondent conceded that if the Applicant accepted all issues of airmanship he would still be flying.[30] That concession directs the analysis back to the alleged inappropriate engagement with the safety investigation, which I have found did not exist.

[101] The absence of a valid reason weighs in favour of a finding that the dismissal was harsh, unjust or unreasonable.

Section 387(b) – Notification of the reason for the dismissal

[102] The Applicant was notified of a reason for the dismissal in the Termination Letter, however, as noted above that reason changed to inappropriate engagement with the safety investigation.

Section 387(c) – Opportunity to respond to any reason

[103] The Applicant was not given an opportunity to respond to either of the reasons for dismissal. Up until the day before he received the Termination Letter, he received positive indications as to his return to work and the nature of the Investigation, including:

(a) On 13 March 2025, when Mr Soster said he would be happy to send the Applicant back to flying duties on the next shift if the Applicant was comfortable in doing so, but confirmed that the Applicant would be grounded until the company investigation had been completed;

(b) On 18 March 2025, when Mr Hahn-Hill assured the Applicant that the investigation was in no way punitive;

(c) Mr Soster also stating to the Applicant that the investigation was in no way punitive, nor that he had been negligent or that there was there any criticism of what the Applicant had done; and

(d) On 8 May 2025, when the Applicant received a call from Mr Soster in which he informed the Applicant *"it's all being finalised. You'll be returning to duties next rostered shift most likely."*

[104] It was only on 9 May 2025, that Mr Soster called the Applicant and said: *'I'm sorry, a decision has been taken to terminate you. It's out of my hands."* When in a separate telephone call with Mr Cavarra later that day the Applicant was asked for an explanation Mr Cavarra advised *"I'll try to get you something, can I have your personal email."* It was not until 14 May 2025 that the Applicant received the Termination Letter that included the now abandoned first reason for dismissal.

[105] Mr Ceccanti accepted that he had never spoken directly to the Applicant at any stage before the decision to dismiss and that neither he nor Mr Coulson had expressed to the Applicant

any concern that he was not engaging appropriately in the investigation or that his employment was at risk if he did not accept a particular view of the cause.[31]

[106] The Applicant was not notified of any reason for dismissal and had no opportunity to respond to any of the reasons variously relied upon. This factor weighs in favour of a finding that the dismissal was harsh, unjust or unreasonable.

Section 387(d) – Unreasonable refusal by the employer of a support person

[107] The Applicant does not contend that he was refused a support person.

Section 387(e) – Unsatisfactory performance

[108] The dismissal was not for unsatisfactory performance, and this is not a relevant consideration.

Sections 387(f) and 387(g) – The size of the employer's enterprise/human resources

[109] The Respondent's Response indicates that the Respondent has 110 employees. It is part of a larger corporate group with its international headquarters in Canada. The Respondent has sufficient resources to follow a fair process when dismissing its employees. I consider the size of the Respondent would not have affected the procedures followed in effecting the dismissal. This is a neutral factor in relation to the question of whether the dismissal was harsh, unjust or unreasonable.

Section 387(h) – Other relevant matters

[110] I accept that the field in which the Applicant works is limited, and the Applicant is unlikely to find a similar alternative position within a reasonable period of time.

Conclusion

[111] I have made findings in relation to all matters specified in s 387 of the Act as relevant. I must consider and give due weight to each as a fundamental element in determining whether the termination was harsh, unjust or unreasonable and therefore an unfair dismissal.

[112] I have found the Respondent did not have a valid reason for the dismissal of the Applicant, and that no procedural fairness was afforded to the Applicant. I also accept there are limited alternative employment opportunities available to the Applicant.

[113] I therefore find that the dismissal of the Applicant was harsh, unjust and unreasonable.

Remedy

[114] The Applicant seeks reinstatement to his former position without loss of continuity of service, and with back-pay. Reinstatement is strongly opposed by the Respondent.

[115] Determining a remedy for unfair dismissal is governed by the provisions of Ch 3, Part 3-2, Div 4 of the Act, which provides as follows in relation to reinstatement:

> *Division 4—Remedies for unfair dismissal*
>
> ***390 When the FWC may order remedy for unfair dismissal***
>
> *(1) Subject to subsection (3), the FWC may order a person's reinstatement, or the payment of compensation to a person, if:*
>
> > *(a) the FWC is satisfied that the person was protected from unfair dismissal (see Division 2) at the time of being dismissed; and*
> >
> > *(b) the person has been unfairly dismissed (see Division 3).*
>
> *(2) The FWC may make the order only if the person has made an application under section 394.*
>
> *(3) The FWC must not order the payment of compensation to the person unless:*
>
> > *(a) the FWC is satisfied that reinstatement of the person is inappropriate; and*
> >
> > *(b) the FWC considers an order for payment of compensation is appropriate in all the circumstances of the case.*

[116] It will be immediately apparent that determining a remedy for an unfairly dismissed employee essentially involves a preliminary finding by the Commission as to whether it is satisfied that reinstatement is inappropriate. It is only upon a finding that reinstatement is inappropriate that the Commission can move on to consider compensation as the alternative to reinstatement.[32]

[117] In *Nguyen v Vietnamese Community in Australia*,[33] the Full Bench of the Commission noted that the question whether to order a remedy in a case where a dismissal has been found to be unfair remains a discretionary one. After a detailed analysis of unfair dismissal legislation and authorities regarding loss of trust and confidence, the Full Bench held:

> *[27] The following propositions concerning the impact of a loss of trust and confidence on the question of whether reinstatement is appropriate may be distilled from the decided cases:*
>
> *Whether there has been a loss of trust and confidence is a relevant consideration in determining whether reinstatement is appropriate but while it will often be an important consideration it is not the sole criterion or even a necessary one in determining whether or not to order reinstatement.*
>
> *Each case must be decided on its own facts, including the nature of the employment concerned. There may be a limited number of circumstances in which any ripple on*

the surface of the employment relationship will destroy its viability but in most cases the employment relationship is capable of withstanding some friction and doubts.

 An allegation that there has been a loss of trust and confidence must be soundly and rationally based and it is important to carefully scrutinise a claim that reinstatement is inappropriate because of a loss of confidence in the employee. The onus of establishing a loss of trust and confidence rests on the party making the assertion.

 The reluctance of an employer to shift from a view, despite a tribunal's assessment that the employee was not guilty of serious wrongdoing or misconduct, does not provide a sound basis to conclude that the relationship of trust and confidence is irreparably damaged or destroyed.

 The fact that it may be difficult or embarrassing for an employer to be required to re-employ an employee whom the employer believed to have been guilty of serious wrongdoing or misconduct are not necessarily indicative of a loss of trust and confidence so as to make restoring the employment relationship inappropriate.

[28] Ultimately, the question is whether there can be a sufficient level of trust and confidence restored to make the relationship viable and productive. In making this assessment, it is appropriate to consider the rationality of any attitude taken by a party.

[Emphasis added/Footnotes omitted]

[118] It will be immediately apparent that determining a remedy for an unfairly dismissed employee essentially involves a preliminary finding by the Commission as to whether it is satisfied that reinstatement is inappropriate. It is only upon a finding that reinstatement is inappropriate that the Commission can move on to consider compensation as the alternative to reinstatement.[34]

[119] The Respondent's Submissions in relation to reinstatement were as follows:

Reinstatement not appropriate

The Respondent does not consider reinstatement to be an appropriate option in circumstances where the Respondent does not have trust or confidence that the Applicant can operate safely as the pilot in command of a twin turbine aircraft in complex firefighting operations.

Further, the Respondent could not confidently fulfil its statutory duties of reasonable care and diligence in circumstances where it has formed the view that the Respondent cannot pilot aircraft in firefighting operations with the requisite level of safety.

[120] While the Respondent has submitted that it has lost trust and confidence in the Applicant, I do not consider that the Respondent has established a sound and rational evidentiary basis for such asserted loss. In his statement Mr Ceccanti's evidence was:

> *If Mr Khouri had participated more positively in the investigation into the incident and had identified what he thought occurred, why it occurred and provided an assurance that he would approach things differently in the future, there is no doubt that he would have remained employed by Coulson Aviation. ...*

[121] As will be clearly apparent from my conclusions regarding valid reasons, I have concluded there was no conduct involving participation in the investigation that constituted a valid reason for termination. Accordingly, there is no basis upon which to assert any loss of trust and confidence.

[122] The Recommendations in the Report (dated 13 May 2025, one day before the dismissal of the Applicant, and a later version dated 19 June 2025), also anticipate a return of the Applicant to work and include the following:

> ***R3. Pilot Remedial Training & Proficiency Check***
>
> *Pilot to conduct bucketing remedial training and pass a proficiency check prior to resuming operations.*

Conclusion

[123] In balancing all the relevant factors in this case, I find that reinstatement of the Applicant is not inappropriate. I order that the Applicant be reinstated.

[124] I will also make an order that the Respondent pay to the Applicant lost remuneration for the period from his dismissal to the date of his reinstatement. Reinstatement of the Applicant shall be effected within 21 days of the date of this Decision or such earlier time as may be agreed by the parties.

[125] Further, I propose to make orders pursuant to s. 391(2) of the Act to maintain the continuity of the Applicant's employment, as if his dismissal had not occurred.

[126] Orders giving effect to my conclusions will be issued contemporaneously with this Decision.

DEPUTY PRESIDENT

Appearances:

Mr M Foran of Counsel, on behalf of the Applicant.

Mr T Brennan SC of Counsel, on behalf of the Respondent.

Hearing details:

22 September and 17 October 2025.
Sydney.
In-person.

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[1] Transcript PN 140 to 152.

[2] Transcript PN 1476.

[3] Transcript PN 1721.

[4] Transcript PN1843.

[5] Transcript PN1478.

[6] Transcript PN 1393 to 1401.

[7] Transcript PN 943.

[8] Transcript PN1704 and 1708.

[9] Transcript PN 1350.

[10] Transcript PN 1384 to 1391.

[11] Transcript PN 1418 to 1423.

[12] Transcript PN 1420 and 1421.

[13] Transcript PN 1462.

[14] Transcript PN 1485 to 1489.

[15] Transcript PN 1409 to 1418.

[16] Transcript PN 1476 to 1485.

[17] *Selvachandran v Peteron Plastics Pty Ltd* (1995) 62 IR 371, 373..

[18] *Miller v University of New South Wales* (2003) 132 FCR 147.

[19] [1938] HCA 34 (30 June 1938), (1938) 60 CLR 336.

[20] Ibid at 362-363.

[21] *Jones v Dunkel* (1959) 101 CLR 298.

[22] Transcript PN 1190 and 1191.

[23] *Shepherd v Felt & Textiles of Australia Ltd* (1931) 45 CLR 359 at [373, 377-8]

[24] *Selvachandran v Peterson Plastics Pty Ltd* (1995) 62 IR 371 at [373]

[25] *Walton v Mermaid Dry Cleaners Pty Ltd* (1996) 142 ALR 681 at [685]

[26] *King v Freshmore (Vic) Pty Ltd* (unreported, AIRCFB, Ross VP, Williams SDP, Hingley C, 17 March 2000) Print S4213 [24]

[27] Ibid

[28] [2018] FWCFB 3989 at [102].

[29] Transcript PN1478.

[30] Transcript PN 1720 and 1721.

[31] Transcript PN1843.

[32] See: *Holcim (Australia) Pty Ltd v Serafini* [2011] FWAFB 7794.

[33] [2014] FWCFB 7198, at [9] – [28].

[34] See: *Holcim (Australia) Pty Ltd v Serafini* [2011] FWAFB 7794.