STORYCLOUD

Transcript of Proceedings:

Grievance of First Officer Michael Danford, ATL 18-14

AIR LINE PILOTS ASSOCIATION, INT'L
and
DELTA AIR LINES CO.

Volume Three

October 30, 2020

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VIRTUAL ARBITRATION

GRIEVANCE OF FIRST OFFICER MICHAEL DANFORD

CASE NO. 18-14

BETWEEN

AIR LINE PILOTS ASSOCIATION, INT'L

AND

DELTA AIR LINES CO.

VOLUME THREE

OCTOBER 30, 2020

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STORYCLOUD

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Kevin Morris, Union Board Member
Steve Mayer, Union Board Member

Also Present:

Michael Danford, Grievant
Emily Zavis, Remote Technician

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THE REPORTER: On the record at 9:35 a.m.

THE ARBITRATOR: Okay. Hold on, there he is. Okay. I got it now. Thank you very much Damien. Mr. Kassin, proceed.

MR. KASSIN: Sure. Captain Graham, this is Tom Kassin speaking. Good morning, sir. And you are appearing before the Delta Airlines Pilot System Board of Adjustment. Our neutral chairman is Arbitrator Mark Burdette and he will swear you in.

THE ARBITRATOR: Would you raise your right hand, please, Captain? Do you swear or affirm that the testimony you're about to give in this case will be the truth, the whole truth, and nothing but the truth?

MR. GRAHAM: I do.

THE ARBITRATOR: Thank you very much. And do you have anybody else in the room with you?

MR. GRAHAM: I do not.

THE ARBITRATOR: Do you have any documents in front of you that are not part of the Exhibits in this case?

MR. GRAHAM: Nope. I have the -- the Company Exhibit book in front of me is the only thing.

THE ARBITRATOR: Okay. Thank you very much. Mr.

Kassin, you may proceed.

JAMES GRAHAM,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. KASSIN:

Q. Captain Graham, please state your full name for the record.

A. James Cole Graham.

Q. Captain Graham, were you the Delta Airlines official who made the decision to terminate Mr. Danford's employment?

A. Yes, I was.

Q. What was your position with Delta at the time?

A. I was Vice President Flying Operations and Chief Pilot.

Q. And as such, who did you report to?

A. I reported to Captain Steve Dickson, senior vice president of flight operations.

Q. And before we get into some of the specifics of the case. I have some general background questions to you about the Delta and ALPA DPAC program. In your position as the vice president of flying and chief pilot for Delta, did you have any involvement with the DPAC program?

A. Yes. I actually oversaw the program.

Q. Okay. Can you describe for us a little more detail your involvement in the program as the administrator?

A. Absolutely. The -- the DPAC program, essentially the -- the Delta version of the HIM -- FAA HIMS program. It's -- it's been in existence for quite some time at Delta. I would call it one of the most collaborative things that we have ever done with ALPA and the FAA. And certainly an essential program to really to any airline is to have a program like this. I would put it right up there with ASAP as probably the top 2 programs that every airline should have. My involvement started when I was promoted to director of flight operations in 2006, and continued up until the point that I was promoted to senior vice president in August of 2018.

Q. Okay. And what is the purpose of the DPAC program?

A. The DPAC program is essentially a -- a -- a substance monitoring program or substance program that allows for those who are substance to -- substance dependent to be identified, to be treated, to be supported, and to be monitored. It is a program that I feel is -- as I said before -- essential to every

airline to have. Substance dependence, whether it's drugs or alcohol, is something that is extremely dangerous, and -- and whether you call it a disease or an addiction, the dependency is something that -- that -- that totally consumes the person with that dependence. And it creates a -- an inability to have sound judgment. It -- it -- in -- influences decisions in -- in an improper way. And for a long time, the substance dependency and for the purposes of this case, alcohol dependency is something that -- that really was -- was hidden and actually continues to be hidden to a certain degree. And this program was brought forward to try to -- to turn that around. To provide the support and the -- necessary for people that are alcohol dependent.

The -- the -- the program itself is -- is one that while our participation is strong at Delta, I would always advocate that it become stronger. And that is with our ability to have people comfortable letting us know that they are substance dependent. The statistics showed that 10 percent of the population is substance dependent. And with a total pilot population of 14,000, I should have about 1,400 people or so in the -- in the program or we should have had at the time that this -- that this case came about. I had about

200.

So you can see that it is a, while it's an incredibly viable program and it's meant to save the -- the pilot from a -- a situation where they are really almost, in -- in some cases defenseless to be able to beat this. Because it's not curable, it's only controllable. So -- and you can't control it alone in the beginning. You -- we -- we tried to -- to -- to treat and then support and monitor so that you can get to the point that you can individually control the -- the disease. But initially you need the help. And that's what this program is all about. It's also about ensuring that we have a way for the identification to happen in as much of a non threatening manner as we can. And so the specifics of the -- the program are built in order to embrace that -- that ability for someone to come forward.

Q. Okay. Captain Graham, you've touched on this, but I'd like to ask you to elaborate a little bit more. How does the DPAC program that ALPA and the company mutually work on contribute to flight safety?

A. Well, first of all, the -- Delta has an obligation to provide the safest air travel possible to the -- to the traveling public. And -- and that responsibility certainly applies to anyone who might be

impaired or considered to be impaired. So essentially the -- the program is -- is made up of -- of volunteers and non volunteers. The way it's separated out. A volunteer would be getting information on a pilot, from the pilot themselves, from their family, from others that -- that are -- are involved with the pilot to let us know that there maybe a -- an issue out there.

If the -- if the pilot volunteers to -- to be assessed and then is assessed as alcohol dependent then they would go through a treatment program. That program for Delta is typically the initial center called TRC, Talbott Recovery Center which is located just south of the airport here in Atlanta. And it's an in-house program that is very regimented and very controlled. The pilot has a sponsor. The pilot has a doctor that's assigned to them. And then they have the support of both ALPA and -- and flight operations as they go through this program. Typically about five weeks, I think, is the -- is the average, and they have a mid phase and a final evaluation.

And then upon successful completion of that, the pilot understands the requirements in order to prove that they are maintaining abstinence and that is through what we call a Contract A. It's a -- it's very clearly outlined, the specific things that the pilot

will have to adhere to in order to -- in order to prove their abstinence. And -- and it includes a very, very strong support group that's around the pilot certainly in the initial stages and can continue for quite some time afterwards.

The -- the -- the -- the success that we've had at Delta has been tremendous with this program. And I -- and I feel like it is one that as I said, that the support group is -- is vital to the initial recovery. Notice I didn't say that -- that I didn't say that there was a cure. I said, you know, recovering alcoholics need to have that support. So we have a very defined program for meeting and providing that support as well as a testing protocol that -- that's outlined also in Contract A. And -- and our pilots adhere to that. They understand what the stakes are. They also, while the support is important and the ability to -- to -- to have someone that they can reach out to whether it'd be a doctor or whether it be a mentor or monitor is important.

There also has to be a backstop or something that is -- is a -- some stakes that -- that they have in the game and that is to maintain their jobs. So we always want to be able to return the pilot to the flight deck. But we have to ensure that the absent -- abstinence is

guaranteed, and the only way to do that is through full participation in the program.

Q. Okay. You mentioned the Contract A. And I'm going to -- I would like to ask you, who does that -- and there's also a Contract B, correct?

A. That's correct.

Q. Who does the Contract A apply to? And then the follow-up is who does Contract B apply to?

A. The Contract A, is for the volunteer pilot that is identified outside of duty as being dependent. And the Contract B is for the non-volunteer. In other words, someone who is -- is identified during the -- during duty day or with the intent of actually operating an aircraft under the influence.

Q. Okay. Is it generally recognized that relapse is a part of the disease and it is a risk that everybody in the program may be at risk at some point for relapse?

A. Without a doubt.

MR. SEHAM: I'm going to object. I'm going to object in terms of the questions put to this witness in terms of that they are more properly put to an addictionologist. These are medical questions. So I'll state an objection with respect to that. The question we just heard and any questions of that kind.

Q. But here's the next question that was leading into, which is, a pilot who goes through the initial treatment who is on a Contract A and receives their special issuance back and they have a relapse, how is that treated at Delta?

A. There is a requirement to go through re-treatment so that once again the abstinence can be validated and that the -- that the relapse pilot is supported appropriately. There's really no way to ensure that the pilot is maintaining the abstinence without going through that re-treatment.

Q. Okay. For a pilot on a Contract A and has their special issuance and they have a relapse, where are they offered to go to re-treatment? In other words, where do they go to re-treatment?

A. Well, we -- we -- what we understand is that, different pilots may need different time frames in order to get the support that they need. So we -- we don't send them back to the same facility typically. The -- the -- if there is a relapse, we typically used MARR, which is the Metro Atlanta Recovery Residences and it's a longer program. It's also an in-house program with significant support. That program is typically about 90 days, I believe, and can be up to 180 days. And -- and the same result is necessary in

order to depart the program. You have to successfully complete with the understanding and the ability to validate abstinence.

Q. Okay. And Captain Graham, I'm going to refer to company Exhibit 1 just briefly and go through some of the chronology with you involving Mr. Danford and then we'll move on to a couple other exhibits. If you could look at that briefly.

A. Yes, sir.

Q. And I would be very brief because this record speaks for itself. Mr. Danford came into the program through having an OWI in Wisconsin or a DUI. Is he considered a volunteer?

A. Yes, he is.

Q. Okay. And he entered the Talbott Recovery Center in August 1st, 2017 and completed the Talbott Recovery Center on September 14th, 2017. Is that a fairly typical time frame?

A. Yes. I believe that's about right. Four to five weeks is the -- is the normal length of time for the initial treatment.

Q. Okay. And then he came into the -- officially came into the DPAC program as of September 17th, 2017 and was subject to neuropsychology testing by Dr. Prewitt and a psychiatric evaluation by Dr.

Lynn. Are those fairly standard parts of the DPAC program?

A. Yes, they are. Matter of fact, the cognitive screen is -- is one of the important pieces as you -- as you're going through the recovery.

Q. Right. And are those also steps that need to be taken to get a special issuance?

A. Correct.

Q. Okay. And then you'll see there's a series of random tests that Mr. Danford took while he's in the DPAC program. And then on May 1st, 2018 he had a random urine test and it was positive for EtG, negative for EtS. Are you familiar with those tests and those type of test results?

A. Yes. It's a urine test and -- and I believe that is the standard protocol to receive an EtG and an EtS test when you're -- when you're being random with tested.

Q. So what -- what does the DPAC program call for when you have a positive EtG but a negative EtS? Is there a next step?

A. Yes. Then we move to the second test, which is called the PEth test.

Q. Right. And Mr. Danford was given a PEth test on May 9th, 2018 and that came back positive. What is

your assessment in a situation like that where somebody has the positive etG, negative etS followed up by a positive PEth. What conclusion is reached?

A. The -- the conclusion is that -- is that the test is positive overall. So therefore, he would -- he would have been judged to be an alcohol positive with the PEth -- PEth test. It's important to note that when we do have that split on the EtG and EtS, that the standard protocol is to go to the PEth. And if the PEth is positive, then unfortunately the pilot is positive. If it's negative, the pilot is returned back to the flight deck.

Q. Okay. And Emily, could I ask you to move that exhibit up the screen a little bit and focus on the time frame starting with May 1st, 2018, please. Just a little bit more. Yeah. There you go. Right there is fine. So consistent with what you described the Delta practice to be, do you know whether or not Mr. Danford was offered the opportunity to go to re-treatment?

A. Yes, he was. Several times.

Q. Okay. And did he accept that offer?

A. He did not.

Q. Okay. One of the requirements in the Contract A is not only to maintain the abstinence, but

to maintain your special issuance. Are you aware that on May 18th, 2018 that Dr. Harper, who was his HIMS AME withdrew his sponsorship?

A. Yes. It's my understanding that Dr. Harper withdrew his sponsorship when he learned that Mr. Danford was not going to go back into re-treatment. And as such, Dr. Harper certainly agreed with the positive test and -- and felt that re-treatment was necessary.

MR. SEHAM: Objection. Hearsay. Could we have a ruling on that?

THE ARBITRATOR: Yeah, I'm going to overrule the objection, Mr. Seham. We're not in court, and we'll take his testimony under advisement, the board will make a decision on what weight to give it.

Q. Okay. At the same time as Dr. Harper withdrawing his HIMS AME Sponsorship, the FAA did a letter withdrawing Mr. Danford's special issuance, correct?

A. That's correct.

(Company Exhibit 5 marked for identification)

MR. KASSIN: Okay. I'd like to direct your attention to Company Exhibit 5, which is the July 12, 2018, Notice of Intent to Terminate. Emily, you can just put the beginning of that on the screen. You

don't have to put the whole document on.

THE WITNESS: Yes, sir. I'm looking at it.

Q. Okay. Did you issue the notice of intent?

A. Yes, I did.

Q. Okay. And we'll get into -- so once the notice of intent is issued under the Delta pilot working agreement, what is usually the next step that takes place?

A. The -- the next step is that an initial -- initial hearing is -- is -- actually, I guess the -- the grievance is filed, and then we go through an initial hearing.

(Company Exhibit 6 marked for identification)

Q. Okay. So if you'd look at company Exhibit 6, is that the grievance that ALPA filed on behalf of the First Officer Danford on July 20th?

A. Yes, it is.

Q. And did you subsequently conduct an initial hearing on July 30th, 2018?

A. Yes, I did.

Q. Okay. Do you recall on behalf of Delta besides yourself who was present for that meeting?

A. Yes, Captain Patrick Burns, Managing Director of Flying Operations.

Q. Okay. And what is the purpose of the initial

hearing after a grievance has been filed?

A. Is to ensure that we have all the information necessary to -- to make a -- a sound decision. And -- and there -- it's an opportunity for the -- for the pilot to bring forward anything that they would like us to consider before coming to a final decision.

Q. Okay. And did Mr. Danford bring forward anything to you and Captain Burns to consider?

A. Yes, he did.

Q. And just briefly describe how that initial hearing -- what occurred at initial hearing as best you recall?

A. As best I recall, we -- we talked through the -- the -- the protocol for the initial hearing and then I -- I allowed Mr. Danford to bring forward anything that he wanted us to -- to consider on his behalf. And I believe he -- he brought forward two -- one or two tests that he had taken subsequent to the positive PEth test.

Q. Okay. And what generally is your policy and the Delta policy on considering employee tests that they do on their own after they have a positive result like in this case, the positive PEth that followed the positive EtG?

A. Well, this is -- this is a -- the -- it's

important to be able to have a controlled way to do the testing. And that's exactly why we have the protocol in place for the testing that we do. For a pilot to bring in their own test, there -- there is no control, there is no way for us to understand exactly how the test was done, when it was done, were there any -- were there any other pieces to the test that may not be present as it comes forward. So essentially, without that ability to validate, we -- we can't accept those as a -- as a valid submittal to change a -- an initial decision. And I think it's important to note that this program, as I said, is one of abstinence and it's not one that you -- that you test until you're negative and then you go back into the flight deck, you have to maintain that abstinence. And in this case, obviously, we had the two tests validated it, and the test that were brought forward from Mr. Danford, unfortunately, really didn't carry any weight.

Q. Did Mr. Danford represent to you and Captain Burns that those were the only tests that he had taken subsequent to his positive PEth test on May --

A. To the best of my recollection, yes.

Q. Okay. In the course of the initial hearing, did Mr. Danford raise any concerns with you about the way he was treated at the Talbott Recovery Center when

he went through his initial treatment?

A. No, I don't have any recollection of him making any comment about that.

Q. Okay. Specifically, did he tell you that his roommate was an ex felon and racist, and that there were, you know, obviously issues with that that he had?

A. No, I'm -- I'm pretty sure I would have remembered that. I -- I don't recall that at all.

Q. Okay. Did you learn anything from Mr. Danford in the course of the initial hearing in July 30th, 2008, that caused you to reconsider the initial determination in the notice of intent to terminate his employment?

A. No, it was -- Mr. Danford had ample opportunity to enter a retreatment facility and -- and be able to go through that successfully complete and be returned to the flight deck. His insistence that he would not do that under the -- the understanding and -- and the information and validation we had that he had a positive test, he really didn't leave me any options.

(Company Exhibit 7 marked for identification)

Q. Okay. So I want you to look briefly just the company Exhibit 7. Is that the denial of the grievance that you issued following the July 30th meeting?

A. Yes, it is.

(Company Exhibit 2 marked for identification)

Q. Okay. And now, I'm going to ask you to look at Company Exhibit 2. And again, Emily, it's rather a long document. I think for purposes of -- I think everybody has a copy of it. But Captain Graham, is that the August 6, 2018 letter of termination that you issued to Mr. Danford?

A. Yes, it is.

Q. Okay. And can you tell the board -- explain to the arbitrator and the board members the reasons and basis for your decision to terminate Mr. Danford's employment?

A. Yes, absolutely. This is not -- a termination is not something that we ever take lightly at Delta Airlines and certainly not someone who has been in our DPAC program. In this particular instance, Mr. Danford did have a positive test that showed that he was not in compliance with his contract. He could not be returned to the flight deck unless he went through a re-treatment. It's -- it's the responsibility of the chief pilot of the airline to ensure that you're -- you're -- to the best of your ability you are only allowing pilots to fly aircraft that are 100 percent safe and are able to adequately decide and use good judgment in the conduct of -- of

those flights. Unfortunately, in this situation, there was no opportunity for me to be able to validate that -- that sound judgment and those decisions would be made in the highest level of safety. So I had no other option but to -- but to charge Mr. Danford.

Q. Captain Graham, under any circumstance were you willing to accept Mr. Danford's explanation that he was not drinking and therefore would not go back to -- would not go to retreatment?

A. No.

MR. KASSIN: Okay. Arbitrator Burdette, if I could just have 30 seconds here?

THE ARBITRATOR: Sure. Okay.

MR. KASSIN: I'll be right back.

THE ARBITRATOR: All right.

MR. KASSIN: Arbitrator Burdette, this is Tom Kassin, I'm back.

THE ARBITRATOR: Yes.

MR. KASSIN: And at this point, we've concluded our direct examination of Captain Graham, and I appreciate it. Thank you, sir.

THE ARBITRATOR: Okay. Kevin Graham, you're now going to be subject to cross-examination by the grievant's counsel, Mr. Lee Seham.

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CROSS EXAMINATION

BY MR. SEHAM:

Q. Good morning, Captain Graham.

A. Good morning, Mr. Seham.

Q. Good morning. You concluded that Mr. Danford had knowingly ingested alcohol, correct?

A. That's correct.

Q. And you based your termination decision on that conclusion?

A. Yes.

Q. And you determined that -- I'm going to skip over a couple of questions here. Do you know what EtG stands for?

A. I -- I don't know the extended name or the -- or the absolute definition, no. I understand the -- that the test is an EtG and EtS test.

Q. Okay. And do you know if the EtG methodology is testing directly for ethanol as with the breath test or is it for some derivative metabolite?

A. You know --

MR. KASSIN: You know, we have toxicologists, we have doctors that are testifying. Captain Graham is a flight operations, and that's his specialty. These questions on nuances of EtG/EtS testing are irrelevant to his testimony on the basis of his decision to

terminate.

MR. SEHAM: Well, you only had one there that was a very direct, an insistent disavowal of Dr. Jones's testimony being expert testimony. Wholly aside from that, one of the pillars of just cause is whether there was a meaningful pre-termination investigation. And we can make arguments at the end of this proceeding as to how detailed that investigation should have been. But these certainly are relevant questions at this time.

THE ARBITRATOR: I think you may proceed, Mr. Seham.

Q. Okay. Thank you. So let me ask that question again. Do you know if the EtG methodology is testing directly for alcohol as with the breath test or is it testing for some derivative metabolite?

A. Mr. Seham, I would have to ask my -- the program administrators that -- that actually carry that -- that program out.

Q. Okay. But you made no investigation into that issue at the time of terminating Mr. Danford, correct?

A. My -- my question to the -- to my team was, did we follow the standard protocol that we'd followed many times before? And their answer was yes.

Q. They were all -- they're all together and

answered in a chorus? Well, who is on your team?

A. Yeah, we have -- we have legal counsel, and then we have both actually ALPA and Delta program administrators for the DPAC program.

Q. Okay. Did you ask any toxicologist about issues related to EtG?

A. I rely on my -- on my experts that run the program to do that.

Q. And could you identify who those experts are?

A. They are the ones that were running the program at the time.

Q. No. I'm asking for names. Can you identify by name with whom you consulted with respect to your decision relating to Mr. Danford?

A. We had on the Delta side, I believe it was Fred Beardsley and on the ALPA side, Scott Monju (phonetic).

Q. Scott Monju is a Delta pilot, correct?

A. That's correct.

Q. He doesn't have any -- he's not a toxicologist, correct?

A. I don't know.

Q. No. You don't know? Okay. Does he have any degree in chemistry or biology?

A. I don't know.

Q. Okay. And who was the other person you named?
A. Fred Beardsley.
Q. Okay. What's his title?
A. Fred is a retired -- was a retired Delta captain.
Q. Okay. Does he have any degree in biology or chemistry?
A. I don't know.
Q. And is he a toxicologist?
A. I don't know.
Q. Okay. And those are the -- those are the two people you consulted prior to the termination of Mr. Danford?
A. Among others, yes.
Q. Who are the others you consulted with?
A. Legal counsel.
Q. Okay. And did any of these legal counsel have a degree in toxicology, or biology, or chemistry?
A. I don't know.
Q. Okay. Have we reached the end of the persons -- the list of persons who were on your team and with whom you consulted?
A. To my knowledge, yes.
Q. So you never conducted your own investigation

into the forensic reliability or accuracy of an EtG test in terms of establishing a failure to maintain abstinence, correct?

A. I relied on the program that we had been -- that had been agreed upon between Delta and ALPA, and stayed with these standard procedures and protocols.

Q. Okay. So aside from following the program as you understood it to be, you conducted no investigation outside of following the protocols that you understood to exist, correct?

A. There was no reason to.

Q. Well, whether there was a reason to or not, I'd rather that you answer my question, which is, did you conduct any investigation other than what you determined to be the protocols that were applicable?

A. No.

Q. Now, are you familiar with the concept of positive cutoff levels as applied to substance abuse testing?

A. Vaguely.

Q. Okay. So would you understand, for example, that an individual might have marijuana-related metabolites from passive inhalation in their system, but the government sets high cutoff levels to exclude the possibility that someone who is subject to passive

inhalation would have a positive. Are you familiar with that concept?

A. The only thing I'm familiar with is what I read in -- in basic articles. I don't have any knowledge of the testing protocols or what happens with -- with the testing protocols. No.

Q. Okay. So that concept that I just described with -- related to marijuana and passive inhalation, you've never heard of that before?

A. I certainly have heard of passive inhalation, yes.

Q. Okay. And do you understand that the DOT and DHHS have set cutoffs sufficiently high so that someone with marijuana metabolites in their system consistent with passive inhalation would never be labeled positive?

A. No, I'm not aware of that at all.

Q. Not aware of that? In terms of you're -- and you're involved in oversight of substance abuse testing for pilots in general, correct?

A. Yes, I was.

Q. Okay. And are you familiar with the concept that an individual could have amphetamine metabolites in their system from decongestants such as Sudafed?

A. Yes.

Q. Okay. And that the DOT and DHHS set a cutoff level sufficiently high so that no one would ever be labeled for taking Sudafed?

A. I -- I don't get into the specifics of how they set their levels, Mr. Seham.

Q. Very good. Thank you. Do you know, in terms of quantitative result, what Delta was treating as a positive cutoff level for Mr. Danford's EtG test based on the urine sample he provided on May 1st, 2018?

A. No, I don't.

Q. Okay. Do you know whether that cutoff level that was applied and used to determine and label his result as positive was set by the laboratory or whether Delta decided that should be the cutoff level?

A. I don't know.

Q. Do you know whether throughout the airline industry, whether a uniform standard applies with respect to quantitative results and cutoff levels for EtG?

A. I don't know.

Q. Do you know whether other laboratories apply different cutoff levels in order to determine what a positive would be?

A. I don't know.

Q. Nevertheless, it was your understanding on

August 6th, 2018 that the EtG testing as conducted by Delta's contracted laboratory provided a reliable result with respect to the abstinence or non-abstinence issue, correct?

A. Yes.

Q. Do you -- you say you're familiar with Delta's drug testing program, are you aware what the function of Deltas' medical review officer is in the context of drug and alcohol testing under Part 40?

A. Not specifically.

Q. In the case of Mr. Danford, did you consult -- can you identify the Medical Review Officer for Delta Airlines?

A. I'm not sure that I can, at this point.

Q. Okay. So would you agree that you had no consultation with Delta's Medical Review Officer prior to deciding to terminate Mr. Danford?

A. Are you talking about Delta's Director of Health Services?

Q. No. I'm talking about the person that Delta has designated for the purpose of reviewing substance abuse testing.

MR. KASSIN: I do -- I -- I think that Mr. Seham is confusing or at least the questions are confusing as to whether he's referring to the DOT Part 40 testing or

whether he's referring to the Delta Airlines flight operations substance abuse policy that both ALPA and Delta created and you know -- and the use of the HIMS AMEs as -- as part of the DPAC program. Part 40 is one thing, the -- the Delta substance abuse policy is another thing and -- and it has its own participants. So if -- if we can be clear on the questions which -- which part he's asking about, I think that would be helpful.

Q. Yeah. Well, I'm not asking about a part at this point, I'm asking about an individual. Every airline is required to have a medical review officer and I just want to confirm -- I think -- I anticipate a very likely answer, given that the witness cannot identify who the MRO or Medical Review Officer is, I assume the answer is no. But I'm asking about the person who fills that role at Delta, there is an MRO for Delta, it should be an easy question. Did Captain Graham have any prior consultation with that individual prior to his decision to terminate Mr. Danford?

THE ARBITRATOR: I think it has been answered.

Q. Okay. If its answered, I'm going to assume that there's no question, but the answer to that is no. Mr. -- Captain Graham, did you consult with any medical doctor prior to your decision to terminate Mr. Danford?

A. I did not.
Q. Okay. Did you discuss with anybody the question of normalization of EtG quantitative results based on creatinine levels?
A. No.
Q. And you said you don't know what EtS stands for?
A. I don't remember the extended name, no.
Q. Okay. And do you know if EtS, the EtS methodology test directly for alcohol as with the breath test or for some derivative metabolite?
A. I -- I -- I'm not sure.
Q. Okay. And I assume therefore, would you agree that you conducted no investigation on your own into the forensic reliability or accuracy of an EtS test in terms of establishing a failure to maintain abstinence?
A. Of any EtS test or this EtS test?
Q. Of the EtS test in this, for Mr. Danford, did you conduct any investigation as to whether that was a reliable source of -- a reliably established abstinence or non-abstinence?
A. No. I accepted the -- the results that my team brought forward to me.
Q. Okay. But EtS is a testing methodology

that's been accepted by Delta within the DPAC program as a reliable testing methodology, correct?

A. EtG and EtS together, yes.

Q. And the EtG you determined -- or you were told -- and you were told that the EtS produced a negative, correct?

A. That's correct.

Q. Okay. And both of those test results were on urine, the same urine sample provided on the same day, correct?

A. I am assuming that from what I was told was the standard protocol, yes.

Q. Do you know what Delta treated as the positive cutoff level for Mr. Danford's EtS, based on his May 1st collection?

A. I'm sorry. There was a lot of paper shuffling going on, I couldn't quite --

Q. Yeah. Do you know what Delta treated as the positive cutoff level in terms of quantitative result for Mr. Danford's EtS test based on his urine sample provided on May 1st, 2018?

A. No.

Q. Okay. And these two, the conflicting results, the EtS negative and the EtG positive is characterized by the termination letter. Those results

were produced by the same laboratory, correct?

A. To the best of my knowledge, yes.

Q. And you never conducted an investigation into how the same laboratory testing the same urine specimen on the same day could have produced these conflicting results, correct?

A. I don't think I understand the question.

Q. Did you ever conduct an investigation into how a laboratory testing the same urine specimen on the same day, being the same laboratory could produce conflicting results under EtS and EtG. Did you ever investigate the whys and wherefores for that conflicting result?

A. No. It was not unusual to have one positive or -- and one negative, which is the reason that then you would go to the second test, which is the PEth test.

Q. But my question is, did you ever investigate why that would occur, why there would be a conflict between those two testing methodologies?

A. No.

Q. And so the purpose of the PEth test initiated with the May 9th dried blood spot collection was to confirm whether or not Mr. Danford had been drinking?

A. It was to determine whether or not he was

drinking, and the result then would essentially determine whether he would be able to be returned to the cockpit or whether he would be judged to have been drinking.

Q. I'm referring back -- I'm going to refer back to your direct testimony. Do you recall in your direct testimony testifying that the purpose of the PEth test was to confirm whether the EtG test was accurate?

A. It's to confirm either way to determine which -- which of those is -- is correct.

Q. Okay. And if the PEth test had been negative as determined by Delta, the EtG tests would have been disregarded, and Mr. Danford would have been returned to the cockpit, correct?

A. Yes.

Q. So you were relying on the -- and if the EtG test had been negative, you would not have moved on to the PEth test in this context, correct?

A. Correct. Correct. If -- well, if -- if -- if they were both negative EtG and EtS, that's correct.

Q. Okay. So the May 9th PEth test was in direct response to the EtG positive, correct?

A. Yes. Yeah.

Q. Now, who decided that the PEth test would be treated as a confirmatory test, in this context?

A. It was a joint decision between ALPA and Delta.

Q. In what document is that joint decision codified?

A. I don't recall. It's been several years.

Q. Okay. So it's not in Contract A, correct?

A. I would have to review Contract A, but I -- I -- I'm not sure that it's spelled out in Contract A.

Q. Is it spelled out in the FOPP?

A. I can't recall.

Q. Did you know -- do you know what the positive cutoff value used for the PEth test was?

A. Not specifically.

Q. Has Delta ever varied the cutoff level for deeming a PEth test positive?

A. Not that I'm aware of.

Q. Did you review Mr. Danford's personnel record prior to terminating it?

A. Yes.

Q. Okay. Would you agree that he never filed a -- excuse me, never failed a training program or a check ride to the best of your knowledge?

A. To the best of my knowledge, that's correct.

Q. And would you agree that he was never disciplined by Delta Airlines in any manner prior to

your termination of him?

A. To the best of my knowledge, that's correct.

Q. And you described two categories of participants in the DPAC programs, volunteers and non volunteers. Mr. Danford was in the volunteer category, correct?

A. That's correct.

Q. And Mr. Danford did not enter the program due to any health issue, correct?

A. I don't have knowledge of that.

Q. His entry into the program was based on a single DUI incident, correct?

A. Well, it -- he was assessed to be alcohol dependent that was driven by the DUI.

Q. Okay. Well, do you know whether there was any other factors that contributed to the determination of an alcohol issue?

A. I don't.

Q. Okay. And do you know whether it was determined he had an alcohol abuse issue or an alcohol dependency issue?

A. All I know is that the assessment showed that he needed to enter the treatment facility for alcohol dependency.

Q. Okay. You never had an issue with Mr.

Danford -- would you agree that you never had an issue with Mr. Danford in terms of his piloting performance?

A. Not to my knowledge.

Q. And did you have any knowledge or do you have any recollection of ever receiving a report of misconduct on his part?

A. No.

Q. Okay. Did you ever receive a report from anyone in terms of his workplace conduct, that he exhibited behavioral cues indicating alcohol use?

A. Not to my knowledge.

Q. Do you have any recollection of receiving a complaint from one of Mr. Danford's fellow pilots?

A. Not to my knowledge.

Q. Okay. And do you know who Captain Harry Miller is?

A. I do.

Q. Okay. Was he a chief pilot at the time of Mr. Danford's termination?

A. I believe so.

Q. He would've been responsible for supervising Mr. Danford, correct?

A. I -- I don't have direct knowledge of that. Captain Miller was in the chief pilot's office at the time so he could have been the -- the supervisor.

Q. Okay. Do chief pilots have any role in enforcing Delta's workplace policies with respect to substance abuse?

A. Enforcing the policies? Do you mean this -- this --

Q. Yeah, in terms of -- yes, in terms of educating the pilots under their supervision and monitoring compliance with Delta's drug free workplace policies?

A. Yes.

Q. Is it your testimony that Mr. Danford would not have been fired if he had accepted both the EtG and the PEth as accurate positives and had re-entered retreatment, then he would not have been terminated; is that correct?

A. I -- I can't say that for sure. What I can tell you is that had he gone into retreatment and successfully completed retreatment and stayed within the -- the guidelines of the program that he would've been rein -- he would've been able to return to the cockpit, yes.

Q. Okay. So let me rephrase the question so we have it in the record accurately. If he had accepted the EtG and PEth test as accurate positives, agreed to re-enter, retreatment and successfully completed

retreatment, then he would have been restored to the line and not terminated, correct?

A. Correct.

Q. Okay. And can you identify the document in which it is codified that a pilot is terminated for relapse if he does not go to retreatment?

A. I wouldn't say that it's -- it's codified. It is explicitly stated in Contract A that the pilot will maintain abstinence. And abstinence has to be validated through the testing protocol. If it -- if the testing protocol shows that you cannot maintain abstinence or that you have not maintained abstinence, then there's no other choice. If you don't accept retreatment, then to be discharged.

Q. I think you were referring to different ways that pilots are monitored when they come out of their initial retreatment, that would include in part testing, correct?

A. Correct.

Q. And that would also include peer monitoring; is that correct?

A. That's correct.

Q. And there's also requirement that the pilot participate in an AA program or an AA equivalent program with monthly meetings?

A. An AA equivalent program, yes.
Q. And there is a requirement that they report regularly to their chief pilot and have discussions about their health and abstinence, correct?
A. That's correct.
Q. And there's a requirement for a psychiatric evaluation and oversight, correct?
A. Correct.
Q. And there's a requirement for a psychologist evaluation and oversight, correct?
A. I believe that's correct.
Q. Would you agree with me that there's no reference in either a Contract A or the FOPP that expressly mandate that in the event of a relapse, an individual has to return to an inpatient retreatment program?
A. I don't recall that we expressly mandate return to the retreatment. What we do is, we mandate that you maintain the abstinence.
Q. Okay. You know who Michele Gable is?
A. I don't recall.
Q. Okay. So you never spoke to her about Mr. Danford's test results, correct?
A. Not that I recall.
Q. Prior to the termination of Mr. Danford, did

you consult with anyone at Quest Diagnostics Laboratory?

A. I don't recall.

Q. Prior to the termination of Mr. Danford, did you consult with anyone at USDTL Laboratory?

A. I don't recall.

Q. Prior to the termination of Mr. Danford, did you consult with Delta's director of health services? The Delta is DHS.

A. I don't recall.

Q. Are you familiar with Section 15 of the PWA, the collective bargaining agreement between ALPA and Delta?

A. Yes.

Q. And are you familiar within that PWA with Section 15?

A. I'm sorry, restate.

Q. Are you familiar with Section 15 of the PWA?

A. Yes.

Q. Okay. What is the -- could you tell us what Section 15 addresses?

MR. KASSIN: I'm going to object. This case is under Contract A. It's not under Section 15 of the Collective Bargaining Agreement. Section 15 has no relevance to this particular case. Contract A has

every relevant to this case. I mean, it's absolutely irrelevant and has no impact on the Contract A issue in the case that we're trying to decide.

MR. SEHAM: Yeah, that's a legal argument. Our argument is that it does have relevance, and we think it's important that the panel understand the scope of Section 15. We have established that there's no provision under the FOPP or under the Contract A that mandates inpatient rehabilitation in the event of a relapse. So there's a gray area there. There is a provision under Section 15 of the Collective Bargaining Agreement that provides if the flight department has some concern about a pilot's health, that there is a process to be followed in terms of evaluating that pilot's health where there is a dispute as to that pilot's health and there is a dispute resolution mechanism which we argue could have followed in this case to resolve the issue without resorting to termination.

MR. KASSIN: Okay. So Contract A, which is what Mr. Danford signed and which he agreed to comply with provides in paragraph 2 that he will maintain complete abstinence. Paragraph 18 expressly says that if you don't, you're subject to termination. That's the deal in this particular case, which Delta could very well

have just stopped right there and not given him any further opportunity to help him with this disease and alcohol dependent. And so he's subject to termination flat out, just for violating Contract A. The fact that they offer an opportunity to help the individual under their philosophy of save the man and hopefully save the job, has nothing to do with Section 15, which is when somebody is -- totally unrelated to this, Delta and ALPA agreed that what you work with here is Contract A and Contract B. That's the limit of this board's jurisdiction, that's the limit of the issue that's before this board, and that's where the focus of this case needs to be.

MR. SEHAM: It's --

THE ARBITRATOR: Okay --

MR. SEHAM: I need to respond to that.

THE ARBITRATOR: Go ahead.

MR. SEHAM: It is not the limit of the board's jurisdiction. The parties have agreed that the Collective Bargaining Agreement, I don't know if it's Joint 1 or Joint 2, is entered into the record. Contract A provides we would agree that if there is non-abstinence, there's an issue of non-abstinence, that would constitute a violation of Contract A. As to the consequences of that, that's a separate issue. But

the question of whether there is abstinence or non-abstinence, is not resolved by Contract A. That issue, whether there was abstinence or non-abstinence is at the center of the dispute, which is before this panel. When there is a health-related dispute, which Contract A doesn't resolve in terms of a dispute resolution process when there's a dispute about health, abstinence versus non-abstinence, there is a provision of the Collective Bargaining Agreement Section 15, that addresses how to resolve that dispute.

Now, if Mr. Danford had said, yes, that's right. These test results are absolutely accurate, not withstanding, using artificially low cutoff levels, and not normalizing for creatinine, and not involving a doctor and said, yes, I violated Contract A, I failed to abstain. Then we see that's governed -- that issue is governed by Contract A. But when there is a dispute, was there abstinence or non-abstinence, there is a specific provision of the collective bargaining agreement that addresses how we resolve that dispute.

THE ARBITRATOR: I understand. That is an argument for the brief, however I think, rather than interrogating this witness about it.

BY MR. SEHAM:

Q. All right. Well, let me just ask the

question. You did not initiate a process under Section 15; is that correct? With respect to Mr. Danford?

A. That's correct.

Q. And you understood at the time that Mr. Danford disputed the fact that he had engaged in --

A. I understand his position, but we had validated that he had in fact not maintained abstinence.

Q. Based on those two tests. But you understood, and I understand why you're explaining your answer, but my question was, you understood that at all times, Mr. Danford was saying that the test results did not correctly reflect non-abstinence and that in fact, he had been abstinent, did you understand that to be Mr. Danford's position?

A. Yes.

MR. KASSIN: That's been asked and answered. We're so clear on that.

THE ARBITRATOR: Agree. Let's move on.

Q. I'm glad we're clear. Prior to the termination of Mr. Danford, did you ever consult his peer monitoring?

A. Not personally.

Q. Not personally. I'm not sure I understand the qualification.

A. I didn't, or his peer monitor, no.
Q. Okay. When you say not personally, did you direct somebody else to contact his peer monitor?
A. No.
Q. Okay. Did you talk to Dr. Lynn prior to the termination decision?
A. No.
Q. Did you talk to Dr. Prewitt prior to the termination decision?
A. No.
Q. Did you contact anyone at Talbott prior to the termination decision?
A. No.
Q. Now, Mr. Danford actually brought to your attention that he had had a subsequent PEth test result which tested negative at USDTL's limit of detection of 8 nanograms per milliliter, correct?
A. I don't recall the -- the -- the exact numbers in the test. What I do recall is that he said that he received a test and that it came back negative.
Q. Okay. And you declined to take that into consideration for the reasons you stated during direct, correct?
A. That's correct.
Q. Are you familiar with the term half-life as

it is applied to the quantitative result of a PEth test?

A. Not specifically. I have vague knowledge.

Q. Okay. What is your vague knowledge?

A. Just that -- that the -- essentially it's just how quickly it works out of your body.

Q. Okay. And do you know the approximate half-life of PEth in the system?

A. I don't.

Q. Are you familiar with the concept of the look-back PEth test, in terms of how far back it will detect the consumption of alcohol?

A. I am familiar with the concept.

Q. Do you know what the duration is?

A. No.

Q. Did you know at the time that USDTL, at the time of the termination, that USDTL advertised itself as being the only laboratory that performed commercial dry blood spot PEth testing and that therefore there were no other laboratories for comparison?

A. I'm not aware.

Q. Okay. And isn't it true that Mr. Danford also produced for you a hair based EtG test with a six-month window of detection that overlapped the period of the positive PEth test?

A. Once again, I'm not -- I'm not aware of the specifics of the test, just that he -- he presented two tests.

Q. Now, Mr. Danford successfully obtained the reissuance of his FAA Medical; isn't that correct?

A. I'm not aware of that. Was not aware of that.

Q. Do you know one way or the other whether the FAA ever required Mr. Danford to re-enter treatment, in order to continue his profession as a pilot?

A. I'm not aware.

Q. Do you know whether it's the intention of the DPAC program to provide a standard that's more exacting on the pilot than the standards that would satisfy the FAA?

A. Well, I -- I guess I would have to ask you to qualify that. When you ask about the test, are you asking about the standard DOT random test that the FAA conducts?

Q. I'll withdraw that question. Did you conduct -- did you have any involvement in the oversight of an individual pilot by the name of Michael Perez?

A. I don't recall.

(Union Exhibit 31 marked for identification)

Q. If we could bring up Union Exhibit 31,

please, Emily. And if you could scroll down. Not that far. Perfect. Thank you. Now, looking at this document that reviews ethyl glucuronide and ethyl sulfate testing results, it's followed by an adjuration here. An exhortation that reads, "Alternative explanation should be explored for any positive finding. This panel includes test for specimen validity. Please note that incidental exposure to alcohol may result in detectable levels of EtG or EtS. EtG/EtS results should be interpreted in the context of all available clinical and behavioral information."

MR. KASSIN: Mr. Chairman, I want to object to this exhibit. This is another one of those things. The donor is blanked out. If the purpose of it is just simply to ask the witness about that particular statement. But I mean, there's incredible questions about the donors blanked out. The creatinine level is so low that it's a highly diluted sample. It goes on and on and on over the credibility of what the purpose of this is. But if the purposes is simply to read that statement into the record, I just --

MR. SEHAM: The purpose of these -- the purposes is to -- and I'm sorry, I don't mean to step on what you're saying. Have you completed your statement of objection?

MR. KASSIN: Yes sir.

Q. Okay. And the purpose is to frame the question and if I could proceed, the question is: Would you agree with me that you did not consider all available clinical and behavioral information related to Mr. Danford prior to making your decision to terminate him?

MR. KASSIN: Objection. That is such a broad question. I don't know what that means. I mean --

MR. SEHAM: Maybe the witness does know what it means and if he doesn't know what it means, that's an answer too.

THE ARBITRATOR: I'm going to sustain the objection, Mr. Seham. On the basis of the fact that I think you've already established that Captain Graham in making his decision did not consider this kind of information. He's testified as to who he spoke to, on what basis he made the decision. I don't think this adds anything to that.

MR. SEHAM: I understand. Okay. Thank you. I'll move on. I'll be with you in 30 seconds, I'm just trying to identify --

THE ARBITRATOR: Okay.

MR. SEHAM: -- a document here. Okay. I'm going to ask Emily if she could bring up union Exhibit 83 and

move to the second page.

THE ARBITRATOR: Okay. That is -- hold on. I think that's an exhibit that you emailed after -- later, right?

MR. SEHAM: Correct.

THE ARBITRATOR: Okay. Thank you.

MR. KASSIN: Okay. I would object. I don't understand what the purpose of this is. It's obviously communications between the arbitrator and the board members. And would have nothing to do with Captain Graham's decision.

MR. SEHAM: Well, this dialogue within this correspondence involves company representatives, specifically Captain Doyle making representations concerning Contract A and concerning what the relevant question is in this proceeding. And I want to probe any contradictions or conflicts within Delta Management in terms of their understanding of what the issue is in this case, what it was at the time of termination and what Contract A provides for.

THE ABRITATOR: I'm sorry, this is -- this was a discussion between the board -- the board deliberations, and it was a result of the -- of the union counsel and the company counsel providing disparate statements of the issue. And so I synthesize

what I thought was the issue and discussed it with the board members. And I don't think it's appropriate to ask this witness about it at all.

BY MR. SEHAM:

Q. Yes. Okay. Let me just proceed by asking the question. Is it your view that a return -- offering a return to rehabilitation or a return to re-treatment as a means of preserving employment after a relapse. Is that something that's a component of Contract A or is it offered outside of Contract A?

A. Well, in the spirit of trying to save the pilot, even when we have someone who has been discharged, to my knowledge, we typically offer them an opportunity to go through re-treatment, although it does not allow them to -- to retain their job. So in other words, we -- we don't want to essentially just turn someone away and not understand that they -- that there is still a disease that they're fighting.

Q. The termination letter -- I just want to make this clear. The termination letter that you issued would not have been issued at that time, if Mr. Danford had agreed to re-treatment?

A. That's correct.

Q. Okay. Are you bound by the provisions of Contract A when making determinations that concern

individuals who are signatories to Contract A?

A. Am I bound by that?

Q. Yeah.

A. I'm not sure I understand that.

Q. Are you allowed to disregard the terms of Contract A in terms of making your determinations with respect to a pilot who's covered by Contract A.

A. No.

Q. And are you familiar with the FOPP as it relates to drug and alcohol issues?

A. I'm familiar with it. I'm not intimately familiar with it anymore. It's been several years.

Q. Okay. Do you know why it's been presented by the company as an exhibit in this case?

A. I didn't go over that with counsel, no.

Q. Are you familiar with its provisions related to the treatment of pilots who have had a relapse?

A. Yes, I'm familiar.

Q. Okay. So what does the -- are you bound by the provisions of the FOPP in terms of what it provides with respect to the treatment of a pilot who suffers a relapse?

A. I would say that it's an agreed upon document between Delta and ALPA and as part of that, we uphold that, yes.

Q. Are you aware of any conflicts between the provisions of FOPP, the FOPP, and Contract A in terms of treating or responses to pilots who have suffered a relapse?

A. No.

Q. Did Contract A mandate that you terminate Mr. Danford for what you determined to be his -- well, you know, I'm sorry, I withdraw that. Mr. Arbitrator, if I could have five-minutes.

THE ARBITRATOR: Sure, let's take a five-minute break off the record. Actually, let's take a seven-minute break and come back at 11:00.

MR. SEHAM: Thanks.

THE REPORTER: Off the record at 10:53 a.m.

(OFF THE RECORD)

MR. SEHAM: No, Mr. -- no.

THE ARBITRATOR: Thank you. Mr. Kassin, redirect?

REDIRECT EXAMINATION

BY MR. KASSIN:

Q. Captain Graham, you were asked about the investigative process at Delta involved in Mr. Danford's case. As a preliminary foundational question, I'd like to ask you, are you familiar with the Delta deals process that's used, the investigation of matters that lead to disciplinary action?

A. Yes, I am.

Q. In general explain what the deals process is, kind of the components and who's involved in it?

A. Well, the deals process involves the -- the pilot in question, chief pilot, as well as legal counsel and human relations personnel, as well as the managing director of Flying Operations. And the -- the process brings forward the issue at hand from the individual pilot and then a plan is -- is discussed as to how to investigate, and then they carry out that plan. That would include getting input from all the people that -- that they feel are appropriate that need to weigh in to get the -- as much information as possible.

Q. And then once this deals process works through all of these issues that you referred to, ultimately, does that lead to a recommendation for you?

A. At -- at the time -- in my position at that time, yes.

Q. Okay. Is the deals process generally run by and owned by the managing director of Flying Operations?

A. It is.

Q. Okay. In the time frame of 2018, and we're looking at the time running from the positive PEth

result with Mr. Danford from May 9th, 2018 to the August decision that lead to his termination. Who was the managing director of Flying Operations at that point?

A. Captain Patrick Burns.

Q. Okay. So Captain Burns would've been the person running or owning the deals process that involved Mr. Danford?

A. That's correct.

Q. And since Mr. Danford was an Atlanta based pilot, his Atlanta regional director would've been involved also?

A. That's correct.

Q. And was that Captain Wayne Cochran?

A. It was.

Q. Okay. And as part of the deals process, would you expect that they would've conferred in Mr. Danford's case with the DPAC representatives from both Delta and ALPA regarding his specific situation?

MR. SEHAM: Objection. Calls for speculation. There's no evidence said that those individuals thereafter consulted with this witness in any event.

Q. Would it be usual, a normal process for the deals process to confer with DPAC representatives from both Delta and ALPA when it's a situation involving a

Contract A violation?

A. Without a doubt.

Q. Okay. And would it be within the realm of the authority of the deals process to confer with an expert toxicologist in terms of reviewing the test results involved in Mr. Danford's situation?

A. Yes, it would.

Q. Okay. So all this information gets processed in the deals process and ultimately, you get a recommendation for the managing director of flying operations. In this case, what was that recommendation?

A. The recommendation was to -- to terminate the -- the pilot.

Q. Okay. You also mentioned the -- part of the deals process with the -- deal folks have the ability to confer with Mr. Danford's HIMS AME, Dr. Harper Junior?

A. Yes, that's correct.

(Company Exhibit 3 marked for identification)

Q. I'd like you to look at Company Exhibit 3, which is the Contract A and the very last page. And Emily -- I'm looking to go to the signatures on the last page. Captain Graham, I have to tell you other than Mr. Danford and maybe one other, I don't recognize

those, but I wanted you to tell us who the witnesses were if you recognize those signatures.

A. I recognize Fred Beardsley's name. I believe that's Harry Miller in the top right.

Q. Okay.

A. I -- I don't recognize the others.

Q. Thank you. So we've heard how the company has framed this issue in terms of whether Mr. Danford violated his Contract A and ALPA went through the process, did the notice of intent to terminate, a grievance was filed, there was a initial hearing, a decision was made and ALPA appealed it to the system board. Are you familiar with sections 18 and 19 of the collective bargaining agreement?

A. Yes, I am.

Q. Are those the normal processes that Delta and ALPA have agreed to use to resolve disputes?

A. They are.

MR. KASSIN: Okay. Mr. Burdette, I'd like to ask your permission to take another five-minute break and we'll be right back.

THE ARBITRATOR: Okay. We'll go off the record at 11:09 and back on at 11:15.

(OFF THE RECORD)

MR. SEHAM: Mr. Burdette, I have our next witness,

is Dr. Gregory Skipper.

THE ARBITRATOR: Yes.

MR. SEHAM: I asked him to be available the minute we're done with this and I would like to move seamlessly from the conclusion of this witness because he has a drop dead time and I want to make the most of this day.

THE ARBITRATOR: I agree. Okay, so you're going to contact him and tell him to log in and --

MR. SEHAM: I believe he's already logged in and waiting for us.

THE ARBITRATOR: Okay. Very good.

MR. KASSIN: Mr. Seham, what I understood from our conversation yesterday his drop dead time was 3:00 p.m. Eastern time?

MR. SEHAM: Yeah. I'm sorry, 2:00 p.m. Eastern.

MR. KASSIN: No, I said 3:00 p.m. Eastern is what I understood.

MR. SEHAM: Yeah, that apparently moved up to 2:00 p.m. or moved back to 2:00 p.m.

THE ARBITRATOR: Okay.

MR. KASSIN: We'll be back in a little bit.

THE ARBITRATOR: All right.

THE REPORTER: Off record at 11:10 a.m.

(OFF THE RECORD)

THE REPORTER: Back on the record at 11:17 a.m.
BY MR. KASSIN:
Q. One quick question for Captain Graham. Captain Graham, this has to do with some questions you were asked on cross and I just want to be clear and clarify your answer. As long as you've been at Delta Airlines and involved in Flight Operations management, to your knowledge, has it been the practice that although somebody may be in violation of their Contract A, and subject to termination, or not maintaining abstinence, that Delta will take the extra step of offering the opportunity to go to retreatment?
A. Yes, it has been.
MR. KASSIN: Mr. Burdette, we have no further questions for Captain Graham.
THE ARBITRATOR: Okay. Mr. Seham, anything on re-cross?
MR. SEHAM: No further questions.
THE ARBITRATOR: Thank you very much, Captain Graham, you may be excused. Thank you for your time and participation.
MR. GRAHAM: Thank you, Mr. Burdette.
THE ARBITRATOR: Okay. I think we're ready to bring in Dr. Skipper.
MR. SEHAM: Correct. And Emily, I'm going to be

asking for Union Exhibit 55.

THE ARBITRATOR: Here's Dr. Skipper.

MR. SEHAM: There he is.

THE ARBITRATOR: Dr. Skipper, my name is Mark Burdette. I'm the neutral chair of the system board for Delta and ALPA in the case of Michael Danford and you're a witness for Mr. Seham. We are swearing witnesses. So if you wouldn't mind, would you raise your right hand, please, while I administer the oath. Do you swear or affirm that the testimony you are about to give in this case will be the truth, the whole truth, and nothing but the truth? You're muted, I cant hear you, did you say yes? Emily, can you help us out? We can't hear you. We can't hear Dr. Skipper.

REMOTE TECH: Dr. Skipper, do you have a microphone connected? Can you hear us if you can just shake your head, if you can hear us. Okay. Please mouse down to the mute button and click the caret next to the mute button. And you're going to need to select a microphone. Please go to settings from the down arrow -- sorry, the down caret where it says microphone. Do you see the level of input moving? You should see it if you talk. Click test, please. And you may need to select an alternate microphone input from the drop-down. Dr. Skipper, can we have you call in by

phone? There was a phone number in the email that I sent to you or if you're trying to use your earbuds, do you have headphones in, sir? Okay. You need to select the headphones as the microphone for your display. Okay. Just go ahead and call in. Or alternatively, we can just try taking your earbuds out. Are you calling in by phone, sir? Okay.

MR. SKIPPER: Can you hear me now?

REMOTE TECH: Yes.

THE ARBITRATOR: Yeah. Yes I can.

MR. SKIPPER: Oh, good. For some reason, the -- the mute was not highlighted, but this is fine.

THE ARBITRATOR: Okay. Having been administered the oath, I saw you shake your head yes, even though we couldn't hear you.

MR. SKIPPER: Yeah.

THE ARBITRATOR: Mr. Seham, you may proceed.

MR. SEHAM: Very good. And please, no worries about the technical issues. We've spent hours being roiled by those issues. So don't let that unsettle you.

MR. SKIPPER: No.

GREGORY SKIPPER, M.D.,

having been first duly sworn, testifies as follows:

///

DIRECT EXAMINATION

BY MR. SEHAM:.

(Union Exhibit 55 marked for identification)

Q. If we can post -- we're going to start off with your CV. If we can post Union Exhibit 55. Is that your curriculum vitae, Dr. Skipper?

A. Yes.

Q. Okay. Now, we've been asked by the arbitrator to try to expedite this process. So we're going to consider this document in the record. Could you just give us a brief overview of your educational background?

A. Sure. So I went to medical school at the University of Alabama and then did a residency in internal medicine at the University of California, San Diego, and I'm a -- board certified in internal medicine and addiction medicine. And I'm a distinguished fellow of the American Society of Addiction Medicine.

Q. Okay. And what's your primary current position?

A. I'm the medical director for the Center for Professional Recovery, which is a program here in California that -- where we evaluate and -- and have a small treatment program for professionals that have

problems with substance use disorders and other problems.

Q. And how long have you held that position as medical director?

A. So I've been here since 2011. Prior to that, I was the medical director for the medical board in Alabama for their physician health program for 12 years.

Q. Okay. And did I understand correctly, this is evaluating professionals, including the treatment of substance abuse disorders?

A. Correct.

Q. And does it -- does it involve at all developing appropriate monitoring protocols for their ongoing recovery?

A. Yes.

Q. Okay. Does the service provided by the Center for Professional Recovery include determinations as to whether the professional employees participating are able to perform their professional duties in accordance with their obligations under their various licenses?

A. Yes.

Q. And are you affiliated also, the organization known as, excuse me, Professional Boundaries?

A. Yes.

Q. Okay. And I think the full name is Professional Boundaries Inc. What is the function of Professional Boundaries Inc.?

A. It's a program that we started in -- around 2000, that is an educational program for professionals that have had ethics issues. So licensed professionals were sent to that for extended educational programs, when they've had problems with ethics.

MR. SEHAM: Okay. Addressing Emily or our technicians, are you picking up everything or is there any means of improving his audio that --

THE REPORTER: He is audible to me. If I don't get a word, I will ask for clarification. However, Dr. Skipper, if you could speak up a little, it would be beneficial.

MR. SKIPPER: Okay.

MR. SEHAM: Thank you.

BY MR. SEHAM:

Q. And you are a diplomat?

A. Yes. I'm a diplomat of the American Board of Internal Medicine and the American Board of Addiction Medicine.

Q. Okay. Do you have any affiliation with the National Board of Medical Examiners?

A. The national -- I took the national boards and passed. So that's a -- it's a board that's offered when you finish training.

Q. Okay. And do you have any certifications relevant to substance abuse issues and/or substance abuse testing?

A. I'm a -- I'm a -- I'm a -- I'm -- I'm an MRO, medical review officer, so I'm a certified medical review officer.

Q. Okay. Do you have any affiliation with the American Society of Addiction Medicine?

A. Yes. I'm a -- a distinguished fellow of the American Society of Addiction Medicine.

Q. And have you been certified by the American Academy of Medical Review Officers?

A. Yes.

Q. Are you affiliated with Topanga Resources, T-O-P-A-N-G-A?

A. Yeah. It's my LLP where I work as a consultant and provide educational support and consulting for different organizations: courts, medical boards, individuals, etc.

Q. And does that consulting include drug testing, alcohol markers, and addiction medicine consulting?

A. It does.
Q. How long have you worked as an MRO?
A. Since probably -- I think I was first certified in 2005.
Q. Okay. And how many tests, if you have any way of estimating, have you been involved in reviewing?
A. Well, over the past 15 years, probably -- I don't have exact records, so I would just estimate probably 10,000 tests.
Q. What was that? Was that 10,000?
A. Yes.
Q. Okay. Could you describe the role of a medical review officer or MRO?
A. So the designation medical review officer was established by federal rules subsequent to the federal government becoming a drug-free workplace. And so federal rules were established designating that physicians -- licensed physicians had to be responsible for receiving, reviewing, interpreting, and certifying lab drug tests in employment settings.
(Union Exhibit 56 marked for identification)
Q. Now, if you could -- Emily, if you can move to Union Exhibit 56. And I'll ask the -- I'll ask the witness, can you identify this document? .
A. I was -- oh, there we go. So I -- I -- was

asked to provide something that -- to explain what a medical review officer does and this is from the -- I believe this is from the US Department of Transportation website that provides an overview of MRO functions.

Q. Okay. And looking at the second paragraph under overview. And it states, "As a MRO, you act as an independent and impartial "gatekeeper" and advocate for the accuracy and integrity of the drug testing process. You provide quality assurance review of the drug testing process for the specimens under your purview, determine if there is a legitimate medical explanation for a laboratory confirmed positive, adulterated, substituted and invalid drug test results, ensure the timely flow of test result and other information to employers and protect the confidentiality of the drug testing information." Is that an accurate description of the MRO role?

A. It is.

Q. Okay. In performing your work related to addiction, medicine, and MRO evaluation, are you required to be familiar with alcohol marker testing such as EtG, EtS, and PEth testing?

A. Yes, for sure, certainly. Understanding alcohol markers is very important. And alcohol is the

most commonly abused substance that causes impairment in our country so there's lots of setting. For alcohol markers are used to monitor people. And I've had a -- an interest in alcohol markers and helped develop new alcohol markers.

Q. Okay. Well, we'll come back to that. I was going to ask you if you have served as a consultant and expert witness with respect to alcohol markers?

A. Yes.

Q. Okay. Did you play any role in discovering and developing the EtG test as an alcohol marker?

A. Yes, and --

Q. Could you --

A. -- in 2001 -- can you hear me?

Q. Yes, I can, please.

A. Okay. In 2001, I was looking for a better way to document abstinence because all we had back then was urine alcohol, or breath alcohol, blood alcohol. And alcohol leaves the body pretty fast. It's metabolized pretty -- fairly rapidly. So I went on a search and found this possible new marker. It's a non-oxidative metabolite of alcohol called ethyl glucuronide. And with the help of a Swiss psychiatrist who was doing research, we did the initial research on EtG and published initial papers documenting that EtG

or ethyl glucuronide is a good marker for alcohol use because it remains in the body longer and is -- it can be detected longer after drinking.

Q. Are you familiar with the agency The Department of Health and Human Services, FAMHSA and SAMHSA?

A. Oh, yeah.

Q. Okay.

A. So I was appointed, I think it was, I forget exactly when, probably 2001 around the same time, I was appointed by the Secretary of HSS to serve on a national advisory council and I was on that council for five years or so. And part of that, I was actually on the committees that developed advisories for use of EtG. There were five or six of us that developed advisories.

Q. When does -- I'm sorry, I interrupted you. Could --

A. So we developed --

Q. -- you repeat the last words of your sentence?

A. We developed advisories that we published from the government, from the SAMHSA. And they were published in 2006 and 2012.

Q. Thank you. Have you participated in studies,

published studies relating to the use of EtG as an alcohol marker?

A. I have.

MR. SEHAM: Okay. If we can go back Emily, to his CV, Union Exhibit 55, and turn to page 9 of that document.

THE REPORTER: What document number are we referencing?

MR. SKIPPER: 55.

Q. Yeah, 55. And if we could scroll down to page 9, and if you could scroll down to the subheading of 2008. Thank you. That's perfect. If you can focus on entry 8, you see there was -- the first entry is -- lists yu as a lead author in a study titled, Breathing Vapor of Ethanol-Based Hand Sanitizing Gel Vapor Causes Positive Alcohol Marker, Ethylgluconoride, EtG, and Positive Breathalyzer. You're the lead author of this study?

A. Yes.

Q. And what did this study conclude?

A. We documented and others have since documented as well the -- that the vapor of alcohol, either from hand gel or other things can cause a positive urine test for EtG.

Q. Are there other environmental non beverage

sources of alcohol that can cause a positive EtG test?

A. There are many.

Q. Can you name a few?

A. So over-the-counter limping meds, cough syrups, supplements, anything that says tincture, like tincture of Ginkgo Biloba or tincture of anything. Perfume, colognes, insecticide. Hand gels They're so commonly used now in hospitals. They are high concentrations of ethanol. People use the nature of alcohol in hobbies, sports events and all. Mouth wash, hygiene product, hair spray. The list is very long.

Q. What about perfume or cologne?

A. Yes, those often -- left of those colognes contained over 90 percent ethanol So the vapor that if breathed and you know, touching the skin can get into the body. Primarily, if you're breathing, it's been found, can cause a positive EtG depending on the timing of the test.

Q. To the -- one other example, how about desserts cooked with wine or alcohol?

A. Yes, fruits cooked with alcohol, desserts. Again, things that have alcohol in them like that can cause positives, just anything that has ethanol in the environment seems to be able to affect those.

Q. Since the publication of the study we just

referred to, have there been any studies reaching contrary conclusions to your knowledge?

A. No. I mean, there's been a lot of studies showing that environmental sources of ethanol can cause positive alcohol markers.

Q. Emily, if we could move to page 10. Yeah, maybe move up a little more. Yeah. Thank you. So under 2004, the second bullet point lists you as a lead author, a new marker to detect alcohol use in recovering physicians, you were the lead author?

A. I was, yeah. That was published in Journal of Licensure and Discipline. Yeah. So documenting that this marker could detect alcohol use and physicians that are in recovery.

Q. And if you could turn, Emily to page 17. If we could get to the last bullet point. Last bullet point is, "Update on EtG and testing for recent alcohol use. Federation of State Physician Health Programs annual meetings, San Antonio, Texas 04/29/2008. And is this a presentation of yours?

A. Yes.

Q. What does it refer to?

A. So because I was involved in discovering and developing and documenting the value of EtG, for a number of years and actually continue to give talks on

the proper use of EtG, pros and cons, ways to deal with issues with it nationally and internationally.

THE REPORTER: I'm sorry. What was that last sentence, Doctor?

THE WITNESS: I've been involved in documenting how to use EtG nationally and internationally.

THE REPORTER: Thank you.

MR. SEHAM: Arbitrator Burdette, we tender Dr. Gregory Skipper as an expert with respect to addiction medicine, MRO evaluation and the interpretation of alcohol marker testing.

MR. KASSIN: We agree.

THE ARBITRATOR: Okay. Thank you.

Q. In August 2019, were you retained by first officer Michael Danford?

A. Yes, I was.

Q. And for what were you retained?

A. He asked me to evaluate -- to participate and evaluate him to see if he had a substance use disorder or he wanted me to look at this positive test and see what it meant. He denied drinking and felt that he had a false positive and asked for my help.

MR. SEHAM: If we could, Emily post Union Exhibit 57.

(Union Exhibit 57 marked for identification)

Q. Dr. Skipper, this document titled, "Addiction Medicine and MRO Evaluation for Michael Danford," is this a document that you prepared?

A. Yes.

Q. And, Emily, if we can scroll down to page 10. Okay. That's perfect. Yeah. Okay. Yeah. And did you -- looking at the entries just above your signature, did you make a determination as to whether First Officer Danford was fit to resume his duties as a commercial airline pilot?

A. Yes. I -- my opinion was that he was fit to resume duty as a commercial airline pilot.

Q. Now, if you could look under the heading in the -- titled "Recommendations," it states, "I recommend this pilot be restored and continue his monitoring program. It is my opinion that he is a very low risk for relapse at this time." When you reference a monitoring program, was that meant to include any inpatient or outpatient rehabilitation program?

A. No. I did not believe he needed further -- any treatment.

Q. Are you familiar with DSM-5 analysis?

A. Yes.

Q. Okay. And what is the origin of DSM-5 -- excuse me, strike that. What is the origin of the

DSM-5 standard, and what does it stand for -- and what does it provide, rather?

A. So yeah, the -- the DSM, as we call it, is published by the American Psychiatric Association. It's the -- the book that lays out the criteria for diagnosing mental disorders. The first edition was in 1952, and we're now on the fifth edition. So that's why they call it the DSM-5. And it contains a chapter on substance use disorders. So it lays out the criteria for diagnosing mental health problems including substance use disorders.

THE REPORTER: What was that last part of the sentence, sir -- Doctor?

THE WITNESS: Including substance use disorders.

THE REPORTER: Thank you.

Q. Emily, if you can move us to page 5 of the report. I may be in error here. Okay. Yeah. Thank you. If you could scroll down a little bit further? Thank you. I think that's perfect. I'm referring you to page 5 of your report, a chart titled, "DSM-5 Substance Use Disorder Criteria." What does this chart reflect?

A. So these are the -- the -- the criteria that are listed in the DSM-5 to diagnose alcohol use disorder, and looks like he met two of these criteria.

Q. Okay. So the number 3 at the bottom, is that a typographical error?

A. It is.

Q. Okay. So that should be two there, correct?

A. That's correct.

Q. Okay. So based on just two criteria being met, what did you conclude?

A. So that -- that suggests that he previously had mild alcohol use disorder.

Q. Okay. If you look at criterion 8 -- now, you're familiar with the fact that he attended a inpatient treatment program at a facility referred to as Talbott?

A. Yes.

Q. Okay. And was criterion 8, was that based on conduct pre-dating or post-dating his rehabilitation program at Talbott?

A. That was pre-date.

Q. And if we can move to page 2? And not actually -- not finding it right off hand. So let me just ask this. Did you refer to neuropsychological or review neuropsychological and personality raw scores that came out of the Talbott Recovery Center for Mr. Danford?

A. I did.

Q. Okay. And was there anything in that data that presented a concern of mental disorder related to substance abuse?

A. There was not.

Q. Did you interview First Officer Danford?

A. I did, at length.

Q. I'm looking for, on page -- at the bottom. Let's scroll to the bottom of page 2. Okay. There we go. Okay. And there's the reference -- just for the benefit of the board, there's the reference to, "Psychological Tests Administered." And below there's a -- that, there's a subheading of, "Mental Status Exam." Can you explain the bullet points under the heading, "Mental Status Exam," starting at the bottom of page 2?

A. Those and the ones on the next page, there's a list of things we go through that's called a mental status exam to get an overview of whether someone has a mental disorder, or cognitive mental disorder, looking at things like memory. Memory, mood, you know, just an observational thing of what -- how they appear in looking through those various criteria.

Q. Okay. And the criteria, does that continue down into the next -- well, let's look at the top of page 3, Emily.

A. It does.

Q. Yeah. Okay. So you evaluated all these bullet-pointed criteria?

A. Yes. Yeah.

Q. And was there any indicia of mental disorder?

A. No.

Q. Okay. In any of the bullet point -- with respect to any of the bullet points?

A. No. He was -- he was doing fine.

Q. /And if we could scroll back up to page 2, towards the bottom of it. There's the reference to, "Collateral Interviews Conducted." That's the third to last heading, and it refers to Artis Todd. And can you explain -- so you interviewed Artis Todd?

A. I did. And it's real important -- it's important to talk to people that know someone that we're evaluating to get collateral information, so I did interview her.

Q. Okay. And what was -- this was his girlfriend?

A. Yes.

Q. Okay. And what did she report to you that you considered to be relevant?

A. Well, she reported that he does not drink and she does not drink. And I got information of her that she was a flight attendant, had worked for Delta for

some time, and she was confident that he was -- he had not been drinking during that period of time when the tests were positive, that there'd -- that he'd had no relapse, that she was not concerned about him. And I really developed a feeling that she was a very competent person who would, you know, be a important person for Delta.

Q. If you can -- we can scroll down to page 8. Under "Discussion," yes. I'm looking at the second to last sentence under the first paragraph discussion where it states, "He has continued to comply with all assigned recovery activities and monitoring." You made that determination as part of your analysis?

A. Yes.

Q. Okay. To some extent, First Officer Danford was the source of your information with respect to your conclusion that he had complied with monitoring on an ongoing basis. Is that true?

A. Yeah, he said that and provided data to support it, and his girlfriend also corroborated with him. Which means he complied to all the things he was supposed to do.

Q. To the extent you relied on First Officer Danford's reports to you concerning his conduct. Does that reflect a source of potential weakness in your

report?

A. Well, no. We had to interview an individual. And I've interviewed -- you know -- thousands of individuals with addiction problems and developed, what I think is a highly developed sense of being able to detect when somebody is not being honest. So I thought he was being very honest. Well, his girlfriend corroborated facts that he mentioned and he had data provided showing his drug test and so forth that corroborated his history. We also had him undergo a polygraph.

Q. Okay, so --

MR. KASSIN: Objection, objection, objection. Arbitrartor Burdette, we were very clear about our objection to this. Even Mr. Seham acknowledged in our informal discussion the unreliability of polygraph evidence. We've asked in our motion to exclude any reference to polygraph by Dr. Skipper or by Mr. Danford or by any other witness and so we've been pretty clear in our position and so we should strenuously object.

MR. SEHAM: In response, there's been a misstatement of what I said. I was charitably acknowledged that I knew that there was case law rejecting both in an arbitral setting and in board settings, the admissibility of polygraph examinations

to establish the underlying truth of an individual's statements. There's also countervailing testimony. However, in order to expedite this proceeding, we are not submitting the polygraph information for the express purpose of establishing abstinence. But it was a part of Dr. Skipper's review.

Now that's a basic fact and reflects the extent to which Dr. Skipper was determined both on his experience with individual substance abusers over the years to confirm and satisfy himself to his own satisfaction that Mr. Danford was telling him the truth, and it also reflects the willingness of Mr. Danford to submit to a polygraph examination. We think also supports his transparency and state of mind.

So we consider the burden of proof here in this case, general, because this is a just cause analysis as modified by Contract A. That the burden of proof is on the company to establish non abstinence. But in this context, we're not including the references here to the polygraph examination as dispositive proof of truth telling when he denies his non abstinence. But rather as an integral component of Dr. Skipper's analysis and also indicative of his transparency, Mr. Danford's transparency and willingness to cooperate with whatever psychiatric directive he received. So for those

limiting purposes that were submitting the information which -- frankly it's hard to remove from this report because it's part of --

MR. KASSIN: That's fine. I don't think we need to have any testimony about it, however, so move on please.

MR. SEHAM: Okay.

MR. MORRIS: And this is Captain Morris, just real quick. I'm not sure if I'm the only one. But the audio off of Dr. Skipper, is very difficult for me to hear. It seems to go in and out on me, or I may be the only one having the problem, but he might want to improve that or get the microphone closer to his mouth or something.

MR. KASSIN: And it has a tendency to be a little bit muffled from time to time. That's correct.

MR. SKIPPER: Is this -- is this better?

MR. KASSIN: That's much better. Thank you.

BY MR. SEHAM:

Q. Thank you, Dr. Skipper. Well, moving on. Given the curtail of the testimony here. Do you have any background with respect to the application of positive cutoff levels for EtG alcohol testing?

MR. SKIPPER: Well, yes. Can you hear me better now? Is this better?

THE ARBITRATOR: Yes. Yes. Yes.
MR. SEHAM: Much better. Thank you.
MR. SKIPPER: Oh, Good. Good. Okay.
BY MR. SEHAM:
A. So yes. You know, with any tests, cutoffs have to be established. And so I was involved in looking at cutoffs and we -- I was appointed to committees where we looked at all the data and we came up with these advisories that -- you know -- that tried to determine how to use cutoffs properly.
Q. The advisories you're referring to, are those the SAMSA advisories you referred to before?
A. Yes.
Q. Six and -- okay.
A. Yes.
Q. And then what was the recommendation of these advisories?
A. Well, it's a little complicated. But -- you know -- the bottom line is that -- it's -- we considered that EtG levels over a thousand would not likely be due to extraneous exposure to ethanol.
Q. And why was the cutoff of a thousand set?
A. Well, it was based on looking at the studies that had been done when people were exposed to extraneous sources of ethanol. And trying to determine

what the limits of that were. To see, you know, if it's -- it's over a certain level, then that means it's not likely from these more minor exposures and more likely due to drinking. So in drug testing. We -- that can be helpful to have that kind of a number. And we -- that's what the committee came up with, is a thousand as a reasonable cutoff. So under that could be from extraneous exposure over that, not likely. And that's held up pretty good overtime.

Q. Okay. And when the commercial or EtG testing by commercial laboratories first began, what was the initial cutoff level that was being utilized?

A. Yes. So usually, right in the beginning we used a hundred -- one hundred nanograms per mL as the cutoff.

Q. Is that still the standard in use today?

A. No, most labs now prefer more like 500 nanograms per mL.

Q. And why is that? Why do they prefer that over 100 nanograms?

A. Well, so there were lawsuits against labs when individuals felt that they were falsely accused of drinking because of the lower cutoff. So it -- it takes clinical acumen to sort of deal with these lower levels. And if we just assume it was positive that the

person drank and there's consequences, then that can be -- you know -- certainly unfortunate. And people sued the labs. So the labs decided to have a higher cutoff to lower their liability.

Q. And what position have you taken with respect to the appropriate EtG cutoff for the purposes of --

A. Well --

Q. -- determining --

A. -- personally, I'd like to have a lower cutoff because I can use some discretion in -- in terms of analyzing a case and not just solely rely on a positive test. But if -- if -- if it's a court setting where it's a, say, a probation officer or someone who's not highly trained, then it may be lot smarter to have a higher kind of 500 or a thousand even.

Q. Okay. If you could turn to page 1 -- Emily, if you could turn to page 1 of this document. And I guess go to the lower third of it. Okay, Dr. Skipper if you can refer to the first bullet point under Documents Reviewed. Thank you, Emily. It says 5/1/18 urine EtG/EtS test result (positive for EtG at 117 nanograms/milliliters with Creat 257, with normalized EtG of 46 nanograms per milliliter) and negative EtS. Can you explain this reference to normalized EtG of 46 nanograms per milliliter.

A. Yeah. So this was the urine test that set all this in motion for Mr. Danford, and what it refers to here is that the test was positive for EtG. Barely above what they were using was what -- 100 cut-off. So it was positive at 117. The creatinine level, that is a way to tell how concentrated the urine is. So urine creatinine, we always look at when we do drug testing, when it's done properly. Because the concentration of the urine can affect the results quite dramatically. Because some urine is very dilute down to a normal lower level of 20 milligrams per decaliter, all the way up to 300. So there's 15 fold difference in humans ability to change the concentration of urine.

So what we do is there's an equation to normalize. It's called normalizing the value to see what the value would be at a creatinine level of 100. So it would be in this case, since the creatinine was 257, it would be 257 over a 100 times the 117, which gives you 46. So if his urine concentration had been average instead of highly concentrated, in other words, if he drank a little more water and had more of a normal urine concentration at the time of this collection, the EtG level would have been 46.

Q. In your opinion, was First Officer Danford's EtG test of May 1, 2018 a positive or a negative?

A. Well, it was positive, but when analyzed, then it would be very consistent with minimal exposure to alcohol.

Q. An exposure consistent with environmental exposure?

A. Absolutely. Very low level. So if he had had a little more normal urine concentration, it would've been reported as negative. It was reported a positive because the cut off, the low cut-off of a 100 was used and it was just above that cutoff. And -- and so it's -- it's -- it's suggested that it could be from extraneous exposure. The EtS was also negative, suggesting further, that this was fairly minimal exposure to ethanol, potentially.

Q. Now, are you familiar with the use of PEth Testing Methodology in your field?

A. Yes.

Q. How would you describe the stage of development of PEth Testing?

A. Well, it's been around about 10 or 15 years. It's another alcohol marker and it is still not totally understood. It's a good marker, but -- excuse me, my alarm went off. It's a good marker. It has a meaning and purpose. But like everything else, like the EtG test, like I just was explaining, it has to be used

with caution and be interpreted in the light of clinical data. You can't just rely on any lab test to be perfect. So I've seen -- I've had concerns about PEth Testing over the past 10 years, and I think we need to do more research on it before we really fully understand it.

Q. Is it a test that has obtained FDA approval?

A. I think it's been de -- designated as a lab development test, so it's -- it's evaded. It's not -- had to be approved by the FDA.

Q. Okay. Has the FDA ever expressed concern about LDTs or laboratory developed tests?

A. Yeah, there have been concerns.

Q. What concerns?

A. Well, to get approved by the FDA, there has to be a lot more testing, more research done. The FDA has to approve it after looking at it broadly. Lab development test, when it's licensed in that way, it -- it's saying that the lab is responsible for the findings and the FDA is not involved. So they -- they've been concerned with too rapid of -- use of some of these tests and it could be detrimental. And the EtG test is a good example of that because when it first came out, we didn't understand it fully. And it turned out -- we found out things like I've mentioned,

that hand gel and mouthwash and things like that could affect it. So with PEth, same thing is going on. We're not totally sure what affects PEth testing.

Q. Are you familiar with PEth testing being used in a forensic context?

A. I think it's been restricted to clinical use. I don't know that it's fully satisfied all the requirements for a forensic test.

Q. Well, in your opinion, what ought PEth be used in a forensic context?

A. I'm sorry?

Q. Do you have an opinion as to whether PEth ought to be used in a forensic context?

A. Yes, I think it's okay to use it, but again, like any test it has to -- it's not perfect. So we have to use it with judgment in mind. So it has to be used with clinical correlation.

Q. Well, when you say it has to be used with clinical correlation, can you amplify that? What do you mean by a clinical correlation?

A. So if, for example, if somebody is doing very well, they've been -- seemed to be abstinent from use of alcohol, there's corroborating witnesses to that, their urine testing has been large -- you know, negative, been done frequently. There can be other

factors involved like no access to alcohol if they've been in jail or something. And they come up with a positive PEth test, then you have to question whether that's accurate or not. So you have to take the setting and the -- all the facts into consideration when you look at a positive test. It's not -- they're not always accurate.

Q. With respect to DOT substance abuse testing under 49 CFR Part 40, is there a certification requirement for laboratories?

A. Yes. There is a SAMHSA certification process for labs.

Q. And what does the SAMHSA certification consist of?

A. It's a strenuous process apparently, where labs have to meet all kinds of stringent criteria. It's primarily centered around federal testing and federal rules.

Q. Does SAMHSA certify laboratories for performance of EtS, EtG or PEth Testing?

A. No. They only certify labs for the test approved by the federal government and these tests are not approved by the federal government.

Q. Okay. Are you familiar with a laboratory certification pursuant to the Clinical Laboratory

Improvement Amendment or CLIA?

A. Yes. I know something about it. Not -- not a huge amount of -- but I've -- I'm familiar with it.

MR. SEHAM: Okay. Well, let's see it in terms of addressing one issue. If we could bring up Union Exhibit 25.

THE REPORTER: What was that number?

MR. SEHAM: 25. Two, five.

THE REPORTER: Thank you.

(Union Exhibit 25 marked for identification)

MR. SEHAM: And when you get there, if we could go to the third page? I think it's towards the bottom. Okay. I'm not seeing what I need. Give me one second here. Very good. I found what I was looking for. If you can move actually towards the top of the page.

BY MR. SEHAM:

Q. And I want to refer you to this quoted language about six or seven lines down from the top on the left column. "Because, in the case of LDTs, CLIA only reviews analytical validity and does not authorize CMS to assess clinical validity, and due to the concerns over the extent of oversight over laboratories, the (SACGHS) report suggested that increased oversight would help improve healthcare delivery." Now, CMS, would that be the Centers for

Medicare and Medicaid Services?

A. Yes.

Q. Okay. And can you explain the difference between analytical and clinical validity?

A. Yes. So analytical validity means, you know, does the test accurately show that -- in this case, you know, that the -- the substance is present. So, you know, for example, EtG might have good analytical validity. You -- you know, when it's positive, it's really there. But clinical validity means does it diagnose anything? Does it actually tell you about whether a person has been drinking or is an alcoholic, and that would be a lot less because there are other factors involved as we discussed.

Q. Do you agree with the statement that we just read into the record that was in quotes?

A. Yes.

Q. Okay. And does CLIA certification approximate SAMHSA certification in terms of its rigor?

A. Say that again.

Q. Does CLIA certification approximate SAMHSA certification?

A. No. No. I think there's very few labs that are SAMHSA certified and there's hundreds of thousands of CLIA labs. So it's a much more lenient

certification.

Q. Could you compare the applicability of federally mandated cutoff levels, defining what a positive result would be for DOT mandated testing as contrasted with the practices relating to PEth testing?

A. Okay. So federally regulated testing, in that setting, there's been a real focus on trying to have cutoffs that are very reliable that avoid false positives and -- and false negatives. And outside of the federally regulated world, it's pretty much a free-for-all, you know, labs sometimes just determine the cutoffs and it's kind of arbitrary, and so, you know, it's not as well defined.

Q. If we could bring up Union Exhibit 24. Okay. If we could move to page 25. Okay. If you could just scroll down a little bit more. I'm sorry, I'm having problems finding it. That might be it. I'm sorry. Move up the page, please. For some reason I'm not finding it. Oh, okay. I did find it. I'm interested in materials sort of -- towards the bottom. So if we could scroll up a little. First of all, I should ask you, are you familiar with this article?

(Union Exhibit 24 marked for identification.)

A. I have read this article in -- in reference to -- at times.

Q. And now again I've lost where I was, damn. I'm sorry. Emily, if you could move back to where we were before I lost my place, the type is so dense. Okay. Perfect. Thank you, Emily. I'm referring to this middle paragraph which reads, and forgive me. I'm going to ask forgiveness from the court reporter, a lot of numbers here. "For PEths 16:0/18:1, an upper reference value for blood donors (N=200) of 141 nanograms per milliliter, 0.2 umol/L has been proposed, which provided five percent false positives and 17 samples detected as outliers.

In addition, two cutoff values for PEth 16:0/18:1 have been proposed. One of 700 nanograms per milliliters to detect problematic drinking, and another of 80 nanograms per milliliter to detect alcohol consumption (four drinks daily during 30 days) in patients with liver disease (N=222). The second proposed cutoff value was selected to improve the sensitivity of the test (91 percent) and so provides a lower specificity (77 percent), which nevertheless can be improved up to 90 percent using a cutoff value of 300 nanograms per milliliter." Do you consider with reference to the application of 141 nanogram per milliliter cutoff with an attendant five percent false positive rate unacceptable forensic standard in your

view?

A. Well, it -- it depends on how you define forensic standard, but it's not too unusual to have a test with a false positive rate in the range of 1-5 percent. And so, you know, this is a concern because it means that maybe one out of 20 tests could be, you know, falsely interpreted as positive.

Q. In those context with that kind of false positive rate, are there generally medical review officers involved to separate the wheat from the chaff or the false positive?

A. Absolutely. Yeah. I mean, it's -- this is one reason that PEth is not used in -- in some settings. So we use it in professional monitoring because it looks like it's a good test at times to really help us determine things. But again, there's been no really definitive study to show us what the specificity is at whatever cutoff we're using. There's been inference and suggestions, but no clear definition. So it -- it can be helpful, but I don't think it should be relied on as -- as perfect by any means.

Q. Now, you have participated in clinical studies of alcohol biomarkers, correct?

A. I have.

Q. Okay. And how would you describe the care with which specimens are typically obtained for the purposes of clinical studies?

A. Well, they would need to be carefully obtained and controlled to eliminate potential contamination.

Q. And do you know the circumstances under which First Officer Danford's DBS specimen of May 9th was collected?

A. Well, I do recall that the collector was not associated with a -- with a -- with a laboratory. It was a collection site as I understand it.

Q. Yes. Okay. So if we can move to Union Exhibit 11. Are you familiar with this document?

A. I'm familiar with documents like this, yes.

Q. And you see it says, dried blood spot collection instructions, materials provided by USDTL. My question is, do you know if USDTL has any training or certification program for collectors of dried blood specimen samples?

A. No, I don't think it does. They give instructions, but there's no certification.

Q. And how does that contrast with the program of the United States Department of Transportation and its training requirements for specimen collectors?

A. There -- there's more training and supervision.

Q. Does the lack of formalized training and certification of collectors for the USDTL dried blood process present any concerns for you?

A. Yes. I've seen problems with the -- in -- in our setting. It's important that people that collect samples know how to do it. And how -- when we rely just on instructions like this, especially in people that are -- don't have a lot of training, they can not follow procedure properly. And so it could impact the results which can impact a person's career.

Q. Are there under the United States Department of Transportation programs pursuant to Part 40, are there consequences to the specimen collector if he or she commits an error in the collection process?

A. Yes. My understanding is from the rules that they can be -- they can lose their certification and they may have to be retrained.

Q. Let's focus on Union Exhibit 11, the portion that's before the highlight there. The first full sentences after the gloves on the screen, which read, "Dried blood spot collection is a donor performed collection. In some cases, it may be beneficial for the collector to assist the donor or perform the

collection completely. In either case, it is imperative to follow the steps carefully in order to ensure a proper specimen collection." Why in your opinion, is it imperative that a collector follow the protocols set forth by a laboratory?

A. Because if you don't do Ii right, then there could be problems. So to have confidence in the results then needs to follow the recommendations and rules. There's reasons for those.

Q. If you can scroll down to point number 10 in this document, Emily. And I think we need to go a little -- I think it continues onto the next page, I believe. Now for portion -- thank you. The portion I'm focusing is in bold. It says in capital letters, "Note: allow the collection paper to wick blood out of the puncture. Do not press the finger against the collection paper and do not layer successive drops." Why would it be important to wick the blood out of the puncture and not press the finger against the collection paper?

A. So yeah, this is the kind of thing that is a concern. The -- if the finger touches the paper, then potentially there could be contamination, either bacteria or alcohol. There's other factors here too, but, you know, for example, squeezing the finger can

change the amount of serum that comes out with the red blood cells and so forth. But, this is just an example of how the test is a little bit sensitive. It needs to be done properly, could change the results.

Q. Why is the avoidance of layering successive drops important?

A. The piling up of blood can potentially change the results. So the thickness of the blood layer here can -- can matter apparently.

Q. Are you familiar with the term volcano effect?

A. I've heard it, yeah.

Q. And this layering, is that a term applied to this layering concept?

A. They can be, yes.

Q. And in your view that layering could affect the quantitative test result?

A. It could, it could. I don't think we're totally clear on that. That's one of the many variables that hasn't been well studied.

Q. If you could scroll down, Emily, to item 15. Here. It says please -- excuse me. It says, "Place a specimen in drying box." Is that consistent with the DBS collection protocols with which you are familiar?

A. No. Actually, this is an innovation that

USDTL came up with. But normally you would want the card that the blood spot is put on to dry outside of the box, you know, for a period of time before it's inserted. This is to avoid the possibility of the wet sample, maybe potentially fermenting or something like that. So this is a new kind of a idea. It could have -- it could be a problem.

Q. It could be a problem in terms of quantitative accuracy?

A. Yes.

Q. If you could scroll down to item 19. At step 19, the protocols of the spectral reference at the end in bold type, "Caution: Do not place inside an airtight plastic specimen transport bag." Would you consider this protocol as imperative to the integrity of this testing process?

A. Yeah. I think again, it's the same issue is that if there's any moisture, if the blood spot is not totally dry, then the, you know, plastic could prevent drying and it could mold or ferment and cause changes in the result.

Q. As an MRO when evidence establishes that the collection procedures designed to ensure the integrity of the specimen have not been followed, what should be done with a test?

A. By federal rules it would be canceled. The test would have to be canceled.

Q. How much weight did you attribute to the May, 9th PEth test in making your recommendation that first officer Michael Danford be returned to flight duty?

A. Well, I discounted the value of the test because he had, had a lot of negative results up to that point. And, you know, the clinical aspects of my consideration. You know, each thing has to add up and the one thing was the positive test, but with the very low EtG that would've otherwise been negative, hadn't been concentrated in all the clinical factors. I -- I discounted the value of it. I think there's something wrong with this test.

MR. SEHAM: If we can, Emily post, Union Exhibit 58.

(Union Exhibit 58 marked for identification)

Q. Okay. Doctor, can you identify this document?

A. It's the Medical Review Officer Guidance Manual for Federal Workplace Drug Testing Programs.

Q. Okay. And then would this also government -- govern DOT regulated testing?

A. Yes.

Q. Okay. Does an MRO's role involve the

prevention of false positives?

A. Yes. So there, you know, that's important to -- for the MRO to understand what can cause false positives and consider those.

Q. Okay. So is it -- is that laboratory -- under DOT Part 40 standards, is that the final word or is there a verification process after the laboratory is finished its testing?

A. There's a -- there's definitely a verification process. Again, you know, you have to have medical and clinical input to interpret any test.

Q. Emily, if you could go down. I think it's page 1-2. Can't remember. I think it's a little further down. Yeah, one more page. Okay. I think we're there -- I think we're there. Yeah, actually, I like where you are, yeah. I think I want the last paragraph there. Perfect. Thank you. Let's see.

Okay. So I want to read a section of this before we -- before I pose my next question. Under 1.2, it reads, "An essential component of any drug testing program is a comprehensive final review of laboratory results, which includes review of appropriate documentation, as well as an interview with the donor of the specimens to discover whether or not an acceptable medical explanation exists for the

laboratory result. A confirmed positive test result reported from a laboratory does not automatically identify an employee or job applicant as having misused drugs, nor does a laboratory result of invalid, substituted, or adulterated automatically identify a person as having tampered with a specimen.

A physician with a detailed knowledge of possible legitimate medical explanations must determine drug test results in the context of all information including the test result and the donor interview. HHS requires the MRO to fulfill this important function." My question is, Doctor, as whether you have an opinion as to whether these principles in this paragraph should be applied with equal vigor to alcohol testing based on EtS, EtG or PEth methodologies?

A. Even more so. Because these are newer tests that likely have great value, but, you know, they've not been around as long and not been as thoroughly studied. And so it's even more important to be careful and have a physician involved to look at all the factors, and not just rely on the result as the final word.

Q. Now, in the Part 40 context, an MRO review is not required where there has been a confirmed positive test produced by a breath alcohol technician using an

approved evidential breath testing device; is that correct?

A. Correct.

Q. Okay. Now in view of that model, can you explain as to why an MRO review would nevertheless be necessary in the context of abstinence testing based on EtS, EtG and PEth methodologies or why is no MRO --

A. So.

Q. -- required for a BAT, EBT test and why so under -- for EtS, EtG, and PEth?

A. Yeah, breath testing is -- has been around longer. It's a simple mechanical process where there's a device that can detect alcohol. It's been determined, particularly some devices that are -- the most accurate ones have been determined to be highly accurate. With EtG, EtS and PEth, although I think -- again, I was one of the developers of them. But I think they have great value, but they've not been around as long, they're more complicated. There's more factors that can affect it and so it's more important to be careful.

Q. The EBT test conducted by a BAT is actually testing directly for ethanol, correct?

A. Yes, exactly.

Q. I'd like to scroll down one page, Emily, to

1-3. Going to focus on the last -- I think the last paragraph. We can scroll down. Here we have provision at the very bottom that says, "The MRO serves as the common point of contact between all participants in a drug test i.e, the donor, the collector, the test facility, and the federal agencies designated representative. The MRO may be an employee or a contractor for a federal agency, however, the following restrictions apply." We could go down to the next paragraph, Emily.

Okay. It continues. "The MRO must not be an employee or agent of, or have any financial interest in an HHS-certified laboratory or IITF for which the MRO is reviewing drug test results. And the MRO must not derive any financial benefit by having an agency use a specific test facility or have any agreement with an HHS-certified laboratory or IITF that may be construed as a potential conflict of interest. The purpose of these prohibitions is to prevent any arrangement between an IITF or a laboratory and an MRO that could possibly influence the MRO and prevent the reporting of a problem identified with the test results or testing procedures.".

Now, my question is: In the context of alcohol testing or abstinence testing performed by EtS, EtG,

and PEth, do you have an opinion as to the importance of whether the performance of these MRO functions by an independent MRO should be applied with equal vigor to ensure the accuracy of such results?

A. Yes. I believe they should be.

Q. I'm going to ask to move down to 1-4. And I guess starting at the top of the page. Okay. You see the heading and I hesitate to read all this into the record. I'll try to expedite this by saying if you look at where it says, "The MRO has the following responsibilities." And if you could scroll down to bullet points 1, 2, 3 and move to the next page. Okay. With respect to these bullet points, would you say generally that these similar safeguards should be applied to EtS, EtG and PEth testing?

A. Yes.

Q. Okay. In the DOT testing context, where an MRO review is required and yet does not take place, what happens with the test?

A. Well, it would be canceled.

Q. Okay. Now, are you familiar with the fact that Mr. Danford was offered with the opportunity to re-enter a retreatment program as a means to avoid his termination?

A. I did hear that, yes.

Q. And would you have recommended to Mr. Danford that he confess to relapse and accept a retreatment program in order to avoid termination?

A. No.

Q. And why would you not recommend that?

A. It's a -- it's -- you don't want to treat somebody for a condition they don't have and there would be very little, if any, value in -- in trying to do so. So, you know, it would be pretty much a waste of time and money and not good for anybody, really.

Q. Could it have an effect on the integrity of the program which he was sent?

A. Absolutely.

MR. SEHAM: No further questions. I'll pass the witness.

MR. KASSIN: Okay. Mr. Arbitrator, can we go off the record and just talk about where we are in the hearing?

THE ARBITRATOR: Yes.

THE REPORTER: What was your response, Mr. Arbitrator Burdette?

THE ARBITRATOR: Yes. We can go off the record, please.

THE REPORTER: Okay. Off the record at 12:47 p.m.

(OFF THE RECORD)

CROSS EXAMINATION

BY MR. KASSIN:

MR. KASSIN: Mr. Skipper, my name is Tom Kassin and I just want to check, can you hear me okay?

MR. SKIPPER: Yes, I can.

Q. Thank you. You are not an aviation medical examiner, are you?

A. Not currently.

Q. And you're not currently a senior aviation medical examiner authorized to do physicals on Part 141 pilots?

A. No, I'm not. I'm not currently.

Q. And you don't have any educational background in aerospace medicine?

A. I do. I was an AME -- I was an AME in the past and I'm a private pilot.

Q. But you don't have any special board certifications in aerospace and medicine --

A. No. No, I don't. I was just -- I was an AME in the past.

Q. Okay. And you've never been a flight surgeon in the military?

A. No.

Q. Okay. And you're not currently practicing aerospace regulatory medicine?

A. No.
Q. Okay. And I think I mentioned you're not qualified currently to give FAA physicals to pilots?
A. No.
Q. And you're not a -- and I believe you are, are you familiar with the acronym HIMS with reference to the airlines?
THE REPORTER: I'm sorry, Doctor, can you repeat that, please?
MR. KASSIN: We are getting some bad feedback.
THE REPORTER: You might have to reconnect. You're coming in garbled.
MR. SKIPPER: Is that better or not?
THE ARBITRATOR: That's better.
THE REPORTER: That's better
MR. SKIPPER: Okay. I guess I'll just have to hold the phone. Okay.
BY MR. KASSIN:
Q. Dr. Skipper, I was asking if you're familiar with the acronym HIMS that's used in the airline industry for substance abuse programs.
A. I am.
Q. Okay. But you've never been qualified to be a HIMS AME, have you?
A. No. No. Not a HIMS AME.

Q. Okay. Now, your curriculum vitae, which I believe is Union Exhibit 55, I noticed on there that you didn't make any mention of the court cases that you've testified in. Is it fair to say that you have testified in a number of cases?

A. I have.

Q. Could I make the request of you in the next week or so to supplement that with a list of the court cases that you've testified in?

MR. SEHAM: Well --

Q. Let me be more specific. I should've been more specific. I apologize. I'm interested in court cases that you've testified in, in which the issue of alcohol biomarkers has come up such as EtG testing or PEth testing.

MR. SEHAM: I'm going to object to this. No. Hold on. I'm going to object to this. This is someone whose expert report they've had now, for six months. This is a proceeding that's exceeded the three days. We're now going to take another two or three days, but these kind of eleventh hour discovery requests of a witness whose report they had six months, when they've engaged in obfuscation, not provided us any reports. This is a delay and interference tactic and I object to it.

MR. KASSIN: Normally, cases that an expert has testified in is a part of the curriculum vitae. We're just asking to supplement it and we're just asking him to cede it over the next week or so. We're not asking for him to stop right now and do it. And we're limited to cases in which he's testified about EtG testing or PEth testing in particular, where we're talking about alcohol biomarkers.

MR. SEHAM: When we had issues concerning material that we wanted, our side, in a timely fashion, submitted a subpoena to this panel to be approved. Now, we are in a hearing and there's an attempt at discovery that should've taken place six months ago.

THE ARBITRATOR: Okay. Mr. Kassin, proceed with your cross-examination and then we'll come back to this issue when you get done and see if it's germane to the case and if it's necessary.

BY MR. KASSIN:.

Q. Yes, sir. Thank you. With respect to Union Exhibit 57 and Emily, I'm going to be moving around the exhibit. I just want the parties that are -- and Dr. Skipper to have that in front of them. So it's hard to tell you where to be. But first of all, Dr. Skipper, you mentioned that you interviewed Mr. Danford as part of your preparing this evaluation which is Union

Exhibit 57?

A. I did.

Q. Okay. Did you meet him in person?

A. No. We did a telemedicine interview like this.

Q. Okay. And when did you do that?

A. Hang on just a moment. Let me bring up my report.

Q. I didn't see it on your report which is why I'm asking. Then maybe you could direct us.

A. Hang on a sec. Okay. My interview was 8/1 and 8/5. It's the top. It says, "Date of evaluation: 8/1 and 8/5/19."

Q. So those two dates referred to when you did telemedicine type interviews with --

A. Yes.

Q. -- Mr. Danford? Okay. And how long was the interview on 8/1/2019?

A. Well, as I recall, it was about an hour-and-a-half and then probably another half-hour on the 8/5.

Q. Total time approximately two hours?

A. Yes.

Q. You mentioned a collateral interview that you did with Mr. Danford's girlfriend and when did you

interview her?

A. Hang on just a moment. Well, it says in the report -- well, no, I guess there's no date. I don't know. It was after that date, but I'm not sure of the date.

Q. And how long did you meet --

A. Maybe it is -- hang -- hang on just a moment, maybe it's further down in the report. I -- I don't remember all the details. It's so long ago. Hang on a sec. I guess I didn't -- I did not indicate the date.

Q. Okay. How long did you speak with her?

A. Probably about half an hour.

Q. Okay. And I may have asked this, I apologize. Was that in-person or was that like a video conference like we're doing now?

A. That was a phone call.

Q. Phone call? Okay.

A. Cell phone call. Yeah.

Q. Did you interview -- did you conduct any other collateral interviews besides his girlfriend?

A. No.

Q. Okay. Did you have an independent neurocognitive evaluation conducted on Mr. Danford as part of your evaluation?

A. No, we did not.

Q. Okay. Did you consult with Dr. Betty at Talbott Recovery Center as part of your evaluation?

A. Not in person. I've read his report.

Q. Okay. But you did not speak with him or interview him as part of your evaluation?

A. No, I did not.

Q. Okay. Did you talk with his former HIMS AME, Dr. Harper Jr. As part of your evaluation?

A. No, I did not. I read the letter from him -- the letters, but I did not talk to him.

Q. And that was the letter withdrawing after the positive PEth result from the May 9, 2018 test?

A. There were two -- there were two letters that I read, one on 23 and one on 5/18/18. And let's see. I think that's -- no, there was another one on 1/13/18.

Q. Okay.

A. I -- I read several letters from him.

Q. Okay. And you understand that he at the time of his employment with Delta, was in a HIMS program that had been mutually agreed to by the Air Line and its union, The Air Line Pilots Association?

A. Yes.

Q. And you understood that the testing was part of its monitoring program that Delta Air lines and The Air Line Pilots Association had agreed to?

A. Absolutely. Yes.

Q. And that monitoring program is different from the federally required DOT testing --

A. Yes.

Q. -- that you were talking about earlier? Okay.

A. Yes. I lecture every year at the HIMS Program about drug testing, so I am familiar.

Q. Okay. In the course of your experience working with others, have you ever interviewed family members that have told you that the person that you were evaluating had not been drinking and later it turned out that they admitted to drinking?

A. Yes.

Q. Okay. I want to talk a little bit about EtG testing and I'm going to skip around a little bit, but it's just the way the testimony came out and the way I ordered the questions. If you have a high cutoff for a positive EtG test, you're going to miss some people that have had relapses?

A. Is that a question? I -- I'm sorry.

Q. It's a question.

A. Yes, you would.

Q. And if you have a low cutoff like a hundred nanograms that currently has been agreed to by Delta

Air lines and Air Line Pilots Association, you may end up with some people that test positive on the EtG but negative on the EtS?

A. Well, I -- I don't know if you want me to comment, but I don't think that's a direct relationship.

Q. Okay. So if you have a -- if you have a lower cutoff, you will end up with more positives on the EtG, correct?

A. Yes.

Q. And it's been your recommendation, in a number of articles and presentations you've made that in those situations that you should follow up and use a PEth test as a follow-up?

A. Yes. But it has nothing to do with EtS. You -- you asked me about EtS.

Q. Okay. Excuse me on that. It's my lack of toxicology knowledge.

A. Okay.

Q. Okay. In the May 1, 2018, urine test that Mr. Danford was given, there was alcohol present in it, correct?

A. Yes.

Q. And even if you normalize it for creatinine, there still was alcohol present in it?

A. Yes.

THE ABRITATOR: Mr. Kassin, would you excuse me just one minute. Do we still need to have this exhibit up on the screen because I'm not being able to see all the rest of the participants as I would like to do.

MR. KASSIN: No, sir. I think I could ask the questions that I have without having the exhibit on the screen. And I apologize that's a good point you just made.

THE ABRITATOR: No problem.

MR. KASSIN: Okay. And Emily, you could take that down. Okay. So you can see --

THE ABRITATOR: She already did. It's down.

BY MR. KASSIN:

Q. Yeah. Okay. Isn't it true, Dr. Skipper that the laboratories in the United States, such as Quest and others, do not normalize the test results for creatinine?

A. No, that -- that's not necessarily true. I've seen laboratories give normalized values.

Q. Okay. Have you seen them do it in monitoring programs like Delta and ALPA have?

A. I've -- I've not seen it in Delta and ALPA, but I've seen it in the other professional monitoring programs.

Q. In the air line industry?
A. No.
Q. Okay. One of the points that you were making in response to questions from Mr. Seham, is that there's a number of environmental factors such as hand sanitizer and other things that you testified to that could explain a low or a positive test in an EtG test, correct?
A. Correct.
Q. Okay. And drinking alcoholic beverages can also explain the positive EtG tests, correct?
A. Correct.
Q. Okay. In your report and I don't think it's necessary to put it up on the board. You talked about the documents that are reviewed. In one of the documents that you reviewed, was June 20, 2018, hair EtG test that was done by ExperTox using a --
A. Yes.
Q. -- and a cutoff of two and it showed a positive result of 4.8, correct?
A. Correct.
Q. In parentheses, you said that was consistent with teetotalers?
A. Yes.
Q. Do you know of any scientific literature that

supports that statement?

A. No. It's just ExperTox's claim.

Q. Okay. Is it possible to be drinking alcohol and have a result that's greater than the two picogram per milligram cutoff that was used?

A. Is it possible? Yes.

Q. Okay. And one of the things that you've talked about at the HIMS conferences and most recently, the one on September 23 -- 25, 2019, is that one of the issues with doing EtG testing on hair if it's done shortly after the drinking, the EtG -- the hair test is not going to catch it, is it?

A. That's correct.

Q. So you actually need a longer window of time on a EtG hair test to be able to detect the drinking of alcohol?

A. Longer than -- it depends, but yeah, at least a week or two.

Q. And then so something that was approximately six weeks out would have a better chance of detecting alcohol use on a hair test?

A. Yes.

Q. Do you have an opinion of how much alcohol you would have to drink to be able -- to have a positive hair test?

A. It has to be fairly significant. It probably varies between individuals, but it's not just one drink or even one binge episode. It would be probably more on the order of two or 300 grams of alcohol over a period of time that's consistent with the window of detection.

Q. Okay. So is it fair to say that a hair EtG test is not as sensitive as a PEth test?

A. It's likely to be true. But I don't know any scientific data that really finds that, that -- that neither one is that sensitive, but how they -- which is more or less sensitive, but I would think the PEth test is more sensitive.

Q. That test being the PEth test?

A. The PEth test, I -- I would guess and it's just really a guess because I don't know for sure is more sensitive than the hair EtG for detecting alcohol use.

Q. I thought that's what you were saying and I just wanted to clarify that.

A. Yeah. Uh-huh -- yeah. I don't -- I don't know good data on it, but I'm guessing from my clinical experience.

Q. Okay. A negative hair test would not necessarily refute a positive PEth test, would it?

A. No.

Q. What is your opinion of why a laboratory like Quest does not normalize EtG to creatinine?

A. You know, I'm not sure. I think it gives additional valuable data. My guess is that they would have to teach people how to understand it and that's a bigger challenge than they want to take on.

Q. Okay. It wasn't clear from your direct examination and the question that I had for you is, are you currently overseeing a monitoring program for physicians in recovery?

A. Currently, no. I -- only the ones that are in -- well, yes. The ones that are in treatment for addiction that I supervise. I oversee the monitoring program for them. But in terms of the long post-treatment monitoring, I did that for 12 years, but not currently.

Q. Okay.

A. And you get consulted by those programs quite often. But I'm not conducting it.

Q. For years, is it correct that you worked with the state of Alabama at their physician program and did monitoring for them?

A. For whom?

Q. For the state of Alabama? For the Alabama

program.

A. Yeah, for the -- for the Alabama Board of Medical Examiners. Yes.

Q. And just describe for the arbitrator and board members, what did that involve?

A. So that involved a whole host of things. I went out to hospitals and spoke about addiction amongst physicians and how to identify impairment. And then hospitals would call and ask for help, you know, intervening on a doctor or deciding whether to in -- intervene on a doctor. And then I will help them with the interventions, refer them to evaluation and treatment programs like I run currently. And then when they came back, we would put them in monitoring usually for one to five years, most of the time five years. And then we would monitor them like pilots are monitored by the HIMS program.

Q. And what type of testing would you use in that program, to monitor?

A. Everything available -- anything available that might be helpful.

Q. So take us through the --

A. The range of it?

Q. -- yeah, the range of or the tools in your toolkit as you monitored?

A. Okay. So for -- for alcohol, we would use breathalyzer, blood alcohol, EtG, urine, EtS. We will use PEth testing. We will use Soberlink. Rarely, one time I used the SCRAM device. And then for drugs, we used a whole host of other testing that I don't probably need to go through unless you want me to.

Q. Not necessary. Obviously, we're interested in the alcohol issue in this case.

A. Correct.

Q. Right. What was your practice or what was your practice -- in your monitoring program that you did, did you ever have any situations similar to Mr. Danford where you had a positive EtG and negative EtS?

A. Yes, for sure.

Q. And what would you do -- what would you do to follow up on that?

A. It would depend on the -- all the circumstances, you know, from just continuing monitoring to doing a PEth test, to sending somebody for evaluation -- more in-depth evaluation, might change them to Soberlink, might do -- there's any number of things we might do depending on the -- all the details.

Q. And how would you handle it in a situation where the PEth test came back positive?

A. I would -- I would confront the person to see if they would admit drinking. Now that we have, you know, further evidence that they may be, and if they continued to deny it, in that situation where I was in there, I would send them to somebody that does what I do now, which is further evaluation. And try to do an in-depth evaluation to try to identify whether they drinking. And, you know, that involves a lot of things that I can explain if you want me to.

Q. No. But you felt that the positive PEth test justified further referral and a deeper digging down into what the --

A. Absolutely.

Q. -- situation may be? Okay.

A. Absolutely. Usually -- usually.

Q. And what would you do if a PEth test came back negative?

A. After a positive EtG and negative EtS. Is that what you are asking?

Q. Yes, sir.

A. It depends on the circumstances. Again, it would depend on the factors involved. It could be any -- any of that same range of possibilities. Because the PEth test is not always positive in somebody who's been drinking. So if there was more solid evidence

they were drinking, then I might send them for evaluation too.

Q. Okay. Did you ever have any situations where you had three positive tests, for example, a positive EtG, a positive PEth, and then a positive EtG on the hair?

A. Yes.

Q. And did that establish a relapse, in your opinion?

A. More -- more likely than not. But not -- not necessarily 100 percent definitive, but very likely.

Q. Okay. Do you know of any scientific studies that support the proposition that PEth test result's greater than a 20 nanogram per milliliter cutoff are not indicative of drinking?

A. No.

Q. Okay.

A. Well, actually, I could cite there have been some studies where, you know, there had been positive tests, but it wasn't proven that they weren't drinking. But there was -- there -- there have been questions about it and -- and some studies done in college students in Africa. But there's been no real study to look -- look at that.

Q. Okay. So you're not aware of any scientific

studies that establish that a positive PEth over 20 nanograms per milliliter does not establish drinking?

A. No.

MR. SEHAM: I'll object to the form for the record.

Q. Okay. Let me try -- Mr. Arbitrator, were you the answer? Dr. Skipper, I think you understood the question and answered it. I'll move on --

A. Yeah. I'm -- I'm tempted to expound, but I don't -- if you don't want me to I won't.

Q. Well, I guess what I'm trying to establish is there are no scientific studies that have been conducted that are peer reviewed that show that a PEth result greater than 20 nanograms is a false positive?

A. Right. And the opposite is true too. There's no studies that show that it's not.

Q. So it's possible?

A. That's the problem.

Q. But yet, you consider PEth testing to be a valuable tool in your -- and what you use when you are evaluating individuals that have had a positive EtG test as a follow-up?

A. Not only then, but other times, I think PEth testing is a valuable tool.

Q. Okay. There were some questions that you were asked about laboratory developed test by Mr.

Seham. Is it a true statement to say that there are no laboratory developed tests that are approved by the FDA?

A. There are no lab -- you're asking me if it's true that there are no laboratory developed tests that are approved by the FDA?

Q. Yes.

A. Is your question?

Q. Yes.

A. I think there are laboratory developed tests that have been proved -- approved by the FDA.

Q. And those are for commercial use?

A. I think so. Oftentimes, tests start as laboratory developed tests, then they're later approved by the FDA.

Q. Okay. But the FDA -- I'm trying to understand that article that we referred to earlier in your direct testimony. The FDA has no real jurisdiction over laboratory developed tests, does it?

A. No.

Q. I guess that's the point I was trying to get across.

A. I see.

Q. Is the type of test that the FDA generally approved are commercial tests, things like a pregnancy

test, that would be on the shelf of Walgreens or something of a similar nature?

A. No. I think they approve other tests that are clinically used in hospitals as well.

Q. Or in a clinical laboratory, correct?

A. Yes. Yes.

Q. Okay. There's a part of your testimony, where you said you were not aware of the Federal Government -- and I don't mean to misstate you, so you can correct me, but just using or approving laboratory developed tests. I'm not sure exactly how you said that. But the point I want to ask you is, I mean, the Federal Aviation Administration is an agency of the Federal Government, correct?

A. It is.

Q. And the Federal Aviation Administration in the issuance of special issuances and monitoring programs does rely on PEth testing?

A. Right. But that -- okay. But that's outside of the federal testing program.

Q. I think that's the point I was trying to make. Okay. There was a good bit of testing -- sorry, testimony not testing, but testimony about the federal testing program, the urine testing program that's done by the Department of Transportation, but Department of

Transportation and the Federal Aviation Administration do not do random testing for EtG as part of their federal program, do they?

A. No.

Q. And they don't test -- use PEth testing as part of their federal program?

A. They do not.

(Company Exhibit 18 marked for identification)

MR. KASSIN: Okay. Emily, we just sent an article that was written by Dr. Skipper as Company Exhibit 18. Could you put that up on the board, please?

MR. SEHAM: I asked that that be -- that, that be emailed to us.

Q. Sure. Let me ask if I could -- I'm looking to see if I can get that done right now. Did Dr. Skipper -- Emily, you could blow it out. Dr. Skipper, do you see that okay on your monitor?

A. Yes, I do.

Q. And that's I guess --

A. I can't -- I can't see the small print. I see the -- enough to know that's the article I wrote.

Q. Okay. Emily, could you blow up the top of it just a little bit more so we can show the authors? Okay. There we go. And I will ask formerly, is that the article that you wrote?

A. Yes.

Q. And that was published in September 2013, if I read that correctly?

A. Yes.

Q. And the conclusion, Emily, if you could highlight the conclusion on that page and maybe blow that up a little bit more, which is, it's right there at the top in bold letters. That's good enough. Dr. Skipper, are you able to read that on your monitor?

A. I can.

Q. Okay. And if you could just go ahead and read that for us if you would.

A. Can they get rid of the red? I can read it better without that.

Q. Yeah, we don't need to highlight on second thought Emily, thank you.

A. "PEth results in combination with previous low positive EtG/EtS results allow differentiating between innocent/extraneous exposure and drinking. Negative PEth testing following low positive EtG/EtS results helps to further elucidate the findings and support the claim of the patient of recent alcohol abstinence. Positive PEth testing following positive EtG/EtS results confirms recent drinking."

Q. Okay. And Emily, if you could take us to the

next page of that article. And I want to go towards the bottom of it. And if you highlight this for a little bit, I went across the page, go back right there. And I'm looking at the very last sentence on that page on the right-hand column where it says, "The aim of our study was therefore to employ PEth as a marker to differentiate between extraneous incorporation, recent drinking, and more distant high EtOH intake," and the next page it says, "Several days ago in urine EtG/EtS positive subjects who deny drinking." Is that a fair statement of what the aim of your study was?

A. Yes.

Q. Okay. And then, Emily, if you could take us to the fourth page. And right above the discussion or right above the word references, and kind of a little bit above that. I see you've got it. Can you blow that portion of it up? I'm looking for the sentence -- the paragraph that begins, "A positive test results for EtG." There you go. And take me to the last sentence on -- right there. Stop right there, please. And the second sentence reads, "Because blood PEth is only positive following significant alcohol use." Do you still agree with that statement, Doctor?

A. I'm not as confident as I was then.

Q. Okay. And then, Emily, if you could take us down to the words -- the paragraph where it says, "To conclude." Just move it down just to here. Get that last paragraph on the conclusion right there above the references. So the final paragraph, "To conclude EtG and EtS can be considered to be highly sensitive in detecting alcohol intake. However, to overcome the dilemma in interpreting low positive EtG/EtS results, the use of PEth testing seems to be effective in providing additional information on potential recent drinking or extraneous EtOH exposure." Do you agree with that statement?

A. Yes.

Q. And just for -- this is just for the record, Doctor, but the reference to EtOH, that's reference to drinking alcohol, correct?

A. Yes.

Q. And thank you --

A. Well, in reference -- I'm sorry. It's in reference to -- EtOH is ethanol or alcohol.

MR. KASSIN: Okay. Thank you for that clarification. Emily, we're done with that exhibit for the time being. Emily, I'd like to put up Union Exhibit 57 again, and I'd like to go to page 8 of that document that Dr. Skipper had prepared. See if you can

get it over to page 8. And I'm looking for the words discussion and maybe blow that up a little bit right there. I can't tell on my monitor. Good. Dr. Skipper, can you read that okay, on your monitor?

THE WITNESS: Yeah.

Q. I wanted to ask you a question about is under the discussion. And this is with reference to your consultation with Mr. Danford.

A. Yes.

Q. You state, "This consultation is essentially regarding the validity of PEth testing. However, it seems important as always, to consider the clinical context." And the question I had for you on that sentence is, if the PEth results are positive and the individual is denying, what is the next step?

A. Well, it depends. But a one frequent possibility, as I mentioned earlier, is to do a more in depth evaluation.

Q. Okay. One second. Emily, you can take that down for the time being, please. Dr. Skipper, there is some testimony from you about the role of the MRO and a cross-reference to the manual for MROs, the federal manual for the federal drug testing program, the DOT program.

A. Yes.

Q. Is it fair to say that the MRO's role for DOT test -- is for DOT test and for workplace drug tests that are done in connection with the DOT program?

A. That is the role -- that is one of the roles of MRO, for sure.

Q. There's no federal requirement for an MRO for an abstinence monitoring program, is there?

A. For non-regulated testing, there's no requirement for an MRO.

Q. And I think it's fair to say that in the DOT regulations, there's nothing in there to address EtG or PEth testing, is there?

A. No.

Q. So it's fair to say the DOT regulations do not require MRO review of an EtG or PEth test results?

A. No, they don't consider them.

Q. Yeah. I mean, it's fair to say that the 49 CFR Part 40 regulations have nothing to do with EtG or PEth testing, do they?

A. They don't.

MR. SEHAM: Object to the form.

Q. There was a reference earlier in your testimony to Union Exhibit 24, and it's a rather long document. Emily, if you can find it and take us to page 4 of that Union Exhibit 24. Actually, I think if

you can look at the bottom of page -- there you go. You're in the introduction. Hold on. You can go back just a little bit and blow up that very first paragraph under introduction. And I'm looking at the last sentence in there. You had testified, that will be Dr. Skipper, that you were familiar with this particular study that's Union Exhibit 24.

A. Yes.

Q. And you yourself had referred to it in papers that you've published?

A. Yes.

Q. The last sentence of that introduction makes a statement, "Moreover, quantification of PEth can be used to detect the degree of alcohol consumption as a significant correlation between the PEth concentration in blood and the amount of consumed ethanol has been demonstrated." Do you agree with that statement?

A. I do. It's -- that has been shown and it's cited there, the reference.

Q. Okay. And then Emily, if I could get you to go towards the end of the study on page 26, please. The conclusion, and I'm not sure if you can get that whole conclusion in there and kind of blow it up. But I'm more interested in the top part of the conclusion, maybe the first eight or nine lines. And I don't know

if you could read that. That's a little bit better.

Okay. This is a very technical sentence. It's the one about our results. And Dr. Skipper, I'm going to ask you to read it and kind of explain what your results -- what you're saying -- not what you're saying, but what that study is saying in that sentence.

A. So it says the reports -- I mean, I'm sorry. This report describes the validation of -- is that the right place?

Q. Well, I was going to go right down below that, to the next sentence that has less numbers in it, but where it says, "Our results have confirmed stability of PEth and blood stored at -- I'm trying to understand what that is saying.

A. "Our results have confirmed the stability of PEth in blood stored at 80 degrees centigrade and have demonstrated that PEth", those different numbers, "were stable in V-DBS at room temperature for about six months." V-DBS is the blood spot test.

Q. Okay. And, "The quantification of PEth via the C-DBS method was not significantly influenced by the hematocrit, the punch localization or the spot volume". Can you explain that or amplify what that sentence means?

A. In this study, they report that the amount of

PEth was not influenced by the hematocrit, which is the percentage of red blood cells in the blood, the punch location where they took the blood, or the volume of the spot.

Q. Okay. And then later in that same paragraph and it's right at the bottom line. Emily, just move that up two or three lines, please. That's good. Later in there, there's a reference as to no false positive reports, specificity of 100 percent. Do you see that, Dr. Skipper?

A. Let's see. Hang on a second. Okay. So the cutoff of 221, there were no false positive results.

Q. And so that would give a specificity of a 100 percent?

A. Using that cutoff, that's what they're saying.

(Company Exhibit 19 marked for identification)

Q. All right. Yes. Emily, one of the other documents that we just sent in and we'll email out is Company Exhibit 19, which is Dr. Skipper's presentation at a HIMS conferences in September 23 to 25, 2019 in Denver. If you could pull that one out. And Dr. Skipper you mentioned that you do regularly -- make presentations to the HIMS conferences each year. Is this one of the presentations that you made in 2019?

A. I did speak then, yes.

Q. And how often do you -- you've made reference to it and I was just trying to get some idea, how often do you come in to those programs and speak to airline and union representatives at the HIMS conferences.

A. I think I've spoken there three times and was going to speak this year, but the program is canceled.

MR. SEHAM: Mr. Kassin, is this being emailed to us?

Q. Yes, it is. I'm looking now and I got it thumps up that it's being emailed right now. Emily, if you can take us to the next page. And Dr. Skipper, when that's coming up, I mean, your understanding of the participants of the programs besides the airline representatives and union representatives, are there any medical doctors from the federal aviation administration that also attend?

A. Yes.

Q. And Dr. Barry, the federal air surgeon, is a regular attendee?

A. Yes.

Q. Okay. Can you describe for us on this presentation just what was your general message that you were speaking to and talking to the audience on?

A. Drug testing.

Q. Okay. Emily, if you could take us to the next page of that exhibit so it would be the third page. And probably have to blow that up so people could see it. I'm more interested in that very first slide, sensitivity versus specificity. If you blow that one op, there you go. Dr. Skipper, are you able to read that?

A. Yeah.

Q. You probably know it by heart, but what were the points that you were making with this particular slide in your presentation?

A. That combining the last sentence would be sort of the summary. The combining a highly sensitive test with a follow-up testing with a highly specific test gives optimal results.

Q. And in today's world, that would be using the urine test for EtG followed up with a PEth test?

A. Yes.

Q. Emily, if you could take us to the next page on there and blow up the top slide please. And in that particular slide, what were the points that you were making to the audience on the PEth testing?

A. Just the characteristics of PEth testing, all those points.

Q. So PEth testing is a direct biomarker of

alcohol, you agree with that?

A. Right. Yes. Of course.

Q. Okay. And it's not affected by age, gender, or incidental exposure, is it?

A. Well, that's what it says there, right.

Q. But typically -- that's what you said to the HIMS conference, right?

A. Right. Right. That is true.

Q. And it's not sensitive to a single drink?

A. Right.

Q. And it requires several drinks for several days for a positive?

A. Yeah.

Q. And it has a detection window of two to four weeks?

A. Yes. Those -- those points are all somewhat variable, but yes, that's what it says and that I would stand by that generally speaking. It can go out to five weeks or maybe even six weeks.

Q. Okay.

A. And, you know, there -- there's exceptions here, but yeah, I agree with that.

Q. Okay. And then Emily, at the same page, if you can take us down to the bottom slide and blow that up and just move it a little, there you go, maybe blow

it up one a little bit more. Dr. Skipper, I can read it. Can you read yours, sir?

A. I can.

Q. So this slide is what -- what is your strategy missing and tell us what was the message that you were indicating to the FAA doctors and the representatives from the airlines and unions on this particular point?

A. This was just pointing out that some approaches can have problems. And these are pointing out the problems with different approaches.

Q. Yes.

A. Different steps.

Q. We've not talked about Soberlink. Just briefly since it's mentioned, just briefly explain to the arbitrator and board members what that's a reference to?

A. It's just a -- it's a digital breathalyzer that links to either cellular network or to Wi-Fi to transmit a photo of a person when they're blowing and it registers their breath alcohol.

Q. Okay. And your comment on urine EtG, when you said misses other substances, big windows to drink, can you explain what you were saying?

A. I'm trying to remember what I'm saying here,

big windows to drink.

Q. I mean, is that the fact that it's only sensitive for a couple of days after drinking?

A. Probably. That's -- that's probably what I meant. But it -- it -- it depends on how frequently you do it. But if you do it once or -- you know, once a week or twice a month, there's big gaps where you could drink. Yeah, that's -- that's probably what I meant.

Q. And you're familiar that the Delta and ALPA HIMS program uses a 14 test -- a 14 random test for their monitoring program? So that's given on a random basis and irregular basis?

A. Right.

Q. But still there's gaps at times in those periods between the 14 test, correct?

A. Right. Right.

Q. Under the bullet point for PEth you said, it misses other drugs, that's not testing for them, undetected low level of drinking. So somebody can -- how much can somebody drink and not get --

A. I don't know. It's not totally clear, but it says that somebody has to drink about seven drinks because the positive PEth over 20 nanograms per milliliter. But that's kind of the question here. I'm

not sure.

Q. And then there's a bullet point underneath that that says, "Hair/nail, EtG." And "1-2 week posts use blind spot, not very sensitive." Can you amplify what you were saying on that point?

A. It's kind of what we were talking about earlier, that a hair test or a nail test will not be positive for a period of time after it's -- after exposure. And they're not very sensitive, you know, takes more alcohol probably to cause a positive.

MR. KASSIN: Okay. Arbitrator Burdette, the witness has through his questions answered some of the other questions that I have, and I don't want to be -- I don't want to be redundant intentionally. But could we take a 10 minute break so that I can narrow down?

THE ARBITRATOR: Yes, we can. It's currently 3:00 your time, I believe, right?

MR. KASSIN: Yes, sir. It's about 3:00 our time. So 3:10?

THE ARBITRATOR: 3:10, that's fine.

MR. KASSIN: Okay. I'm going to try to narrow down what I have left.

THE ARBITRATOR: Okay. Very good. Thank you.

THE REPORTER: Off the record at 3:00 p.m.

(OFF THE RECORD)

MR. KASSIN: Okay. Arbitrator Burdette, at this point, the company has completed its cross-examination of Dr. Skipper, and also we withdraw our request that he supplement his curriculum vitae with the court cases that he has been involved in.

THE ARBITRATOR: Thank you so much. Okay. Any redirect, Mr. Seham?

MR. SEHAM: Yes. A few questions.

REDIRECT EXAMINATION

BY MR. SEHAM:

Q. Why in your opinion, does federal testing not use EtG, EtS, or PEth testing?

A. I would -- can you hear me?

THE ARBITRATOR: Yeah, we can.

A. Okay. I would say it's because the federal testing program has a pretty significant focus on accuracy and reliability, and these are relatively new tests. And as we're finding here, there -- there are difficulties sometimes in interpreting them, and they want it to be very sound. And so when you get into newer tests like these that are useful, it brings them variables that they don't want to deal with.

Q. When we're addressing the termination of an employee in a formal legal process such as we're now conducting, why would we look to federal testing rules

as a model?

A. So I think federal testing rules were developed to be fair. You know, knowing that these tests can mean somebody's career and livelihood, et cetera. They developed these rules to try to make the program as safe and fair as possible.

Q. In the federally regulated testing programs, why is there not leeway to use new methodology such as EtG, EtS or PEth?

A. Well, they -- they -- they want -- again, the -- the federal system has focused on accuracy, reliability, and consistency, I think. And so they are not wanting to use these new tests until they're more firmly proven to be accurate.

Q. Have you participated or been involved in other cases where a positive PEth test appeared to be a false positive in terms of proving drinking?

A. Yes. And that's -- that's been a concern that's been growing for me because I've seen, you know, probably close to 10 or 12 cases in the last six or eight years where it really did appear that it was a false positive. And I followed some of those cases over that period of time. And one of the things we know about alcoholics is that if they relapse and start drinking, they usually keep doing it. And so I've

followed some people over the last five years who had false po -- what appear to be false positive PEth tests and they've done very well, kind of similar to Mr. Danford. And in the time duration and their continued abstinence really helps confirm the concern that there may be false positives. The other thing that -- that I've noticed in these cases is that some of my colleagues who were very confident about PEth testing have also started growing concerns. So there's -- there's been a kind of a growing concern that we need a study to look and see are there po -- false positive PEth tests, and if so, try to figure out why and separate the variables about why because we don't want to hurt people with a test like this. And I think that's happening in some cases.

Q. And you talked -- related to that, you had offered to Mr. Kassin that if in the context -- during cross-examination, you said you testified that one of the responses to a positive EtG followed by a positive PEth could be further evaluation. And you offered to provide a further explanation as to what a further evaluation might consist of, and that invitation was not taken up. So I'm inviting you. What would a further evaluation in that context, what might ut consist of?

A. So, you know, what we do is spend time with people, you know, we try to understand them, what they've been through, what their diagnosis is, and on what basis the diagnosis was made. We try to talk to people that know the person and look at the other tests and facts that may be present. And then the time duration, as I mentioned, if somebody starts drinking and they actually have an alcohol problem, they tend to keep drinking and have recurrences. And so, evaluating somebody over time can help us determine do they really have a problem with alcohol? That's kind of a short example --

Q. Okay. Thank you.

A. -- of what I'm talking about.

Q. Now, I don't know that we have to bring it up, so long as you can tell me you recall that there was Company Exhibit 18 concerning PEth, the potential role in further evaluating little positive urinary EtG and EtS results, there were 18 subjects in that study?

A. Yes.

Q. Okay. And that study was characterized as a pilot study, correct?

A. Yes.

Q. What does that mean, a pilot study?

A. It's not a definitive study, but like a -- a

small study that helps suggest that more studies need to be done. So it can be the begin -- you know, the beginning of exploration.

Q. What might be some of the mechanisms for a false positive PEth test?

A. So I and some of my colleagues who are smarter than me have been trying to figure that out, and we've touched on a couple of them. It look -- does look like that the blood spots are coming into question more often. So we wonder about the phenomenon I mentioned of fermentation. So the blood spot's -- blood spot's not totally dried, it may be able to ferment and create some alcohol in the sample during shipment over a day or two or so. And then that alcohol gets fermented because of glucose in the blood and yeast that could land on the sample from the air, you know, that can ferment and cause a positive PEth test after, you know, in-vitro outside the body.

Other concerns are that some people may, because the enzyme that makes PEth is phospholipase D, it's an enzyme in the blood, and that's the enzyme that takes the ethyl -- the -- the alcohol and binds it to the cell membranes, the phospholipids. That's a -- what's called a polyclonal enzyme, means that people have more than one version of it. Some people have less of it,

some people have more of it. So there could be individual genetic variation between people and how much PEth they make. We found that to be true with EtG as we've studied it.

There's -- there's about a 10 fold difference in how much EtG an individual -- one individual can make versus another, depending on their genetic makeup. So it could be that some people with very minimal exposure to alcohol could make more PEth and we just don't know at this point. So those are two -- two possibilities. Another that's been considered is that some residual alcohol might be present in the skin. If somebody has used hand gel or something like that recently and then they get their fingers stuck some of the ethanol from the previous exposure, even within the skin, could be transmitted into the sample and could cause the in vitro formation of PEth. So there's a number of things that kind of have been theorized that could cause a false positive test. We just don't have the data to know at this point, and that's kind of the concerns, we don't know.

Q. Well, how would you design a study to determine the prevalence of false positives with PEth tests?

A. Yes. So I've -- I've talked to some leaders

in this field including principles at US Drug Test Lab where a lot of the PEth testing is done, and other MROs, and what we'd like to do is a large study where we do have over a hundred subjects at different ages, with different illnesses, on different kind of medications, and study people that don't drink alcohol. So we need to find individuals that are abstinent typically and do PEth testing on them over a period of time and see if any of them are positive and then try to study those individuals to see why, if it occurs -- why they had false positive PEth test. So that study has not been done, it's not been funded. It needs to be done, in my opinion.

Q. Okay. When you have represented in either an article or presentation that a positive PEth test confirms drinking, did you mean that as an absolute or can there be exceptions?

A. There can be exceptions. So, you know, I mean, we all want a positive test. And like when I wrote that article that was published in 2013, that we talked about, you know, it's -- I was very hopeful of the fact that positive tests proved drinking. And in general, I think it does. You know, I think in most cases, maybe in the high 90 percent, a positive test proves drinking, but that doesn't mean that there

aren't any exceptions, and -- so there are exceptions, I believe.

Q. Why are you concerned about false positive PEth tests?

A. Well, I'm concerned because it's so dramatically affects people's lives and their careers. You know, if somebody has the positive tests and they are in monitoring like this, they can lose their career, because Mr. Danford could. And that's a tragedy. So I saw that happened with EtG testing 20 years ago when it was first developed. We were relying on it, there were concerns that there could be false positives and it turns out there were. But in the meantime, people did lose their careers. And through further study and papers and analysis, we got to understand it better. And PEth testing has been harder to understand for a number of reasons and there's not been definitive studies, but I'm concerned that false positive tests could ruin lives.

Q. To the extent that a HIMS program is seeking an error-free test or combination of tests to determine if a pilot has been drinking, does such an error-free testing process exist?

A. No. Unfortunately, we did -- we just don't have in this world that kind of absolute positive in

terms of testing. So there's -- there's always going to be a human factor of considering the test and trying to determine, is it valid? There's no test that's perfect. So they -- everybody would love one. The court system, the HIMS program, I would love one, but it's there isn't a test that's perfect.

Q. If there's no perfect test or combination of tests, how do you suggest that a HIMS program proceed if it gets an EtG positive and PEth positive?

A. So I think we're -- we're relegated to the fact that we're going to have to evaluate people and think about them and look at all the facts, like the facts that we've talked about here where the time since the incident occurred, there have been more incidents. What -- what do the other tests show, what do people that know the person say. You know, things like that, can, you know, bring out the fact that somebody has got an ongoing problem, and that -- that would then mean that they're at risk. So I think the problem is we can't mechanize this. We have to have people involved that understand this, that will help us analyze it and determine whether it's valid or not.

Q. Taking everything into account, in terms of your evaluation of Mr. Danford, and including the fact that he did not go back for a re-treatment, how can you

say that Mr. Danford is fit for duty as a commercial airline pilot?

A. Well, so I would -- I would say that, you know, that there's -- when we look at somebody like this, there's going to be factors that sway us one way or the other. And -- and -- so the -- the -- the drug testing here makes us look -- makes it looked like Mr. Danford drank, there's no question about that. It looks like he's drank around -- around that time that we're talking about -- was it 2018 or 2019, I forget when. But the -- the incident was the positive EtG and the PEth. On 5/1/18 was around the date that this started so it looks like he drank right before that.

So I would give that alone a high indication of -- high indication that he drank. So if I had that and nothing else, I would say it really looked like he drank. But the problem is he had prior testing that was negative and he's had subsequent testing that was negative. He has not had any kind of incidents or you know, breakdown of drinking which usually occurs in somebody with an alcohol problem. The people that know him, the person that knows him that I talked to was very confident. And my sense of him when I evaluated him, I felt confident.

So each of those things I might give, you know, a

90 percent value, and the things that add up to say that he's doing well and he's not at risk then start being more significant than the negatives. And we all like drug testing because it's so objective, but it's not perfect and we have to look at these other factors, and they're pointing me toward the very high likelihood that Mr. Danford is okay. And I think he's at low risk and he does not need further treatment.

Q. And Mr. Danford actually flew out to meet you face-to-face; isn't that correct?

A. He did, and he retained his pilot's license and he's done well.

MR. SEHAM: Okay. All right. I have no further questions. I don't know if there will be re-cross.

MR. KASSIN: Mr. Burdette, it's okay if I proceed?

THE ARBITRATOR: Yes.

RECROSS EXAMINATION

BY MR. KASSIN:

Q. I'm confused. Earlier when I asked you if you met Mr. Danford in person, you said that you did not -- you said that you had a video call with him and now you just said -- you said he flew out to see you as part of the evaluation?

A. He flew out here to undergo some testing, but I was not able to see him, but I knew he flown out.

Q. Okay. What testing was that?
A. He did the polygraph. The one --
Q. Okay. That's what -- we're not -- that's not admissible. Okay. Did --
A. I think he did some other drug testing.
Q. Okay. But he didn't do a neurocognitive exam out there?
A. No.
MR. SEHAM: He asked -- he asked about --
Q. Okay. So what I was understanding you to say as you looked at his positive EtG of May 1st and positive PEth of May 9th, that as you're looking at it and evaluating other factors, the 90 percent factor, your 90 percent, in your opinion that he was drinking, but you looked at the other 10 percent factors. And so maybe what --
A. No, I'm saying that each of the -- each of the -- each of the factors that I look at may suggest that, you know, there's a high likelihood either that he drank or didn't drink and the factors that looked like he didn't drink are more numerous, and in my opinion, in this case, outweighed the likelihood that he did drink. So it's a matter of balancing. There's no perfect answer. We can't know what the -- what the causative fact one way or the other, but we have to

come up with a decision about likelihood. And I think it's a high likelihood that he didn't drink even though these tests make it look like he did.

Q. So your evaluation is very subjective based on your opinion, correct?

A. Yes.

Q. Okay. And but the test, on the other hand, the PEth test is very objective. It gives you a quantified number that put him above the cutoff and positive on his PEth test, correct?

A. Correct.

Q. And his EtG results from the May 1st urine sample was a positive number that put him -- that also was positive, correct?

A. Correct.

Q. And then I'll do --

MR. SEHAM: Objection. I think that the witness had not finished his answer.

Q. I'm sorry, go ahead.

A. Yeah. I just wanted to just say that I have seen cases in my career where somebody came in and the labs showed that they were in -- looked like they were in terrible renal failure, for example, you know, creatinine was really high, but the person looked fine. And so we retest them and everything was okay. So what

happened, there was some kind of error at the lab. So those labs looked like, if you just looked at them, you'd say this person is in kidney failure and needs to be on dialysis. But you wouldn't want to act on that. You have to look at the person and then, you know, repeat some testing and follow them and if they're okay, then you say, "Well, the lab was an error." And that's kind of what I see happened here.

Q. Okay. But to clarify, when I asked you questions earlier, you said you were aware of no scientific studies that showed that there were actual false positive PEth tests, right?

A. Right. Likewise, there's no scientific studies that would show that, you know, the blood testing on an individual in the lab would show up renal failure and not being renal failure. It's just these kind of things happen and there's not necessarily a scientific study that proves it, but we see it.

Q. You talked a little bit about other cases where they have raised some concerns with you about PEth testing. But did any of those cases also involve a positive EtG test followed by a positive PEth test?

A. Yes, a lot of times they do, yeah. And it's usually a very low positive EtG.

Q. Okay. But his PEth test was not a low

positive PEth test. You know the numbers on those, don't you?

A. The PEth test is a low positive. I -- I consider anything under 100 to be low positive.

Q. So that's the standard that you apply?

A. That is the standard I've applied based on the research of the -- of papers I've looked at.

Q. Okay. Of the test that you expressed that you have some question in your mind about did any of them have a positive EtG, a positive PEth, and approximately six weeks later, a positive hair EtG?

A. I don't -- I don't know. I'd have to -- I don't -- I don't remember that they -- I don't think so.

Q. So when you are looking at the total picture, if you're looking at somebody that had a positive EtG followed by a positive PEth and six weeks later did a hair test and it was positive for EtG, does that not indicate drinking to you?

MR. SEHAM: Hold on. We're going to object because the testimony has been that the hair test yielded a quantitative result which the laboratory defined as a teetotaler, someone who didn't drink any alcohol, so the question mischaracterizes the evidence.

MR. KASSIN: I think that it was -- first of all,

the laboratory said it was positive, and I believe that it was Dr. Skipper that said that he characterized it as teetotaler.

MR. SEHAM: No, it's right on the laboratory.

A. The lab report says that. And the cutoff there was a lot lower. It would have been negative with a normal cutoff of 20 picograms per milligram. He came back positive 4.8, which is below cutoff in most standards.

Q. Okay. But --

A. So that would have been a negative hair test, actually.

Q. You didn't pick the cutoff, correct?

A. No. No, I did not.

Q. And Delta didn't pick the cutoff, correct?

MR. SEHAM: The question's vague. Delta did pick the cutoff for PEth and EtG. Are you referring to the hair test?

Q. We're referring to the hair test, and the hair test that Mr. Danford did on his own -- Okay. On the hair test that Mr. Danford did on his own, neither you nor Delta had anything to do with picking the cutoff on that?

A. No, not that -- I don't know who picked the cutoff.

Q. Okay. And you already testified that the hair is not very sensitive, correct?

A. Correct. Correct.

Q. Okay. You had some question you raised about the blood spot cards. Are you familiar with the blood spot card that USDTL uses?

A. Yes.

Q. And there is a preservative present in there on that particular piece of type of paper that they use, correct?

A. That I'm not aware of.

Q. Okay. But in your opinion, if a preservative is present in the blood spot card, doesn't that prevent formation and stop enzyme activity?

A. I don't -- I do not know if it would or not.

Q. Okay. I think I mispronounced fermentation, sorry. I meant fermentation. The answer is you don't know?

A. I don't know.

Q. Okay. You talked about individuals that you've had experienced with, I assume in your physician monitoring programs and other programs that have a relapse. Isn't it correct that percentage-wise, individuals that have a relapse or at a higher risk of further relapses?

A. I would say that's true. I don't know exact numbers, but my instinct tells me that's true.

Q. Okay. And you were asked some questions about the concepts behind federal testing, but isn't it true that the federal drug testing that takes place in the airline industry, I mean, the objective of it is deterrence compared to what the DPAC program has at Delta where the objective of it is monitoring. Isn't that a fair distinction?

A. Well, I think they both have deterrence as an objective and early detection. So you want to -- in the federal testing, you want to deter use, but also pick it up early if somebody's using. Also, you want to pick up relapse if somebody is -- you may not know that they've had treatment and they may have relapsed. But in the professional monitoring that HIMS does or that I did, in my role as the medical director of a physician health program, we also want the testing to deter use and pick up relapse early.

Q. Okay. And federal, I mean, I think we've covered this, but I want to make sure that federal drug testing is only based on a urine test, correct?

A. Breath, breath and urine.

MR. KASSIN: That's right, the breathalyzers, they did it. You're correct on that Arbitrator Burdette, if

I could just have like, 30 seconds or so?

THE ARBITRATOR: Yes. Go offline.

(OFF THE RECORD)

THE ARBITRATOR: Okay. We can proceed.

MR. KASSIN: Okay. We have no further questions for Dr. Skipper. Thank you for your time today, sir.

THE ARBITRATOR: Okay. Mr. Seham?

MR. SEHAM: We have no further questions and we thank Dr. Skipper for his time.

THE ARBITRATOR: Thank you very much, Dr. Skipper..

MR. SKIPPER: Thank you.

MR. SEHAM: Thank you.

THE ARBITRATOR: Goodbye.

MR. SEHAM: During that break, Arbitrator Burdette, I exchanged some texts with the individual I hope to be our next witness. He said he should be available at 4:00 Eastern Time, so that should be in about 13 minutes or so.

THE ARBITRATOR: Okay. Okay. You want to take a 15 minute break and then we'll reconvene?

MR. SEHAM: Great. Thank you.

MR. KASSIN: Arbitrator Burdette, before we go off the record, can we take care of a housekeeping matter?

THE ARBITRATOR: Sure.

MR. KASSIN: Okay. So we kind of rushed into Dr.

Skipper's testimony because of the limited availability that he had. But what I had wanted to say on the record is that, with the completion of Captain Graham's testimony, the company will be resting its case. Now, we are understanding is that Mr. Danford will be testifying in his case. But if for some reason, the decision is made for him not to testify, we'd like to reserve the right to call him as a witness.

MR. SEHAM: We will be calling Mr. Danford as a witness. I would say under normal circumstances -- I have the perhaps high ambition of getting two more witnesses in today, both of them are fairly brief.

THE ARBITRATOR: Okay.

MR. SEHAM: And that would heighten the chances of finishing within a respectable amount of time. I had thought to make a summary motion because to date, there has been no expert testimony in defense of the PEth test, on the company's side. However, we'll waive that motion and we'll proceed, and as I say, hope to get two more witnesses today.

THE ARBITRATOR: Okay. Okay. Thank you very much. Well, we're off the record.

(OFF THE RECORD)

THE ARBITRATOR: We'll wait just a moment for Mr. Dodge.

MR. DODGE: Can you guys hear me?
THE ARBITRATOR: Yes, we can.
MR. DODGE: Okay.
THE ARBITRATOR: There you are.
MR. DODGE: Yeah.
THE ARBITRATOR: You're very dark. However, can you put anymore light on your scene so --
MR. DODGE: Let me see. It's unfortunately kind of a dark office. Does this help at all?
THE ARBITRATOR: Yeah, a little bit.
MR. DODGE: Okay. Whoops. Sorry about that.
THE ARBITRATOR: Okay. Mr. Seham, you may proceed.
MR. SEHAM: Okay. Has he been sworn?
THE ARBITRATOR: No. Sorry. Yeah. We're swearing witnesses, Mr. Dodge, so would you raise your hand, please?
MR. DODGE: Yes, sir.
THE ARBITRATOR: Do you swear or affirm that the testimony you're about to give in this case is the truth, the whole truth, and nothing but the truth?
MR. DODGE: I do.
THE ARBITRATOR: Thank you very much. Is there anybody else in the room with you?
MR. DODGE: Two dogs. That's it.
THE ARBITRATOR: And do you have any documents in

front of you, that are not part of the exhibits in this case?

MR. DODGE: No, I do not.

MR. KASSIN: Thank you very much. Mr. Seham, now you may proceed.

DAVID DODGE,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. SEHAM:

Q. Okay. Please state again your name for the record.

A. Yes, Sir. David Dodge.

Q. And where are you currently employed and in what job classification?

A. Delta Air --

Q. And as a what job classification?

A. Delta Airlines, I'm sorry. Airline pilot.

Q. Okay. And how long have you been employed as a Delta pilot?

A. Little over 22 years.

Q. Are you familiar with the Human Intervention Motivation Study or better known as the HIMS program at Delta Airlines?

A. Yes, I am.

Q. And what is HIMS?

A. HIMS is a very important program that is utilized for rehabilitation of addicted pilots, or possible addiction.

Q. And how did you first become familiar with the HIMS program?

A. Well, as a participant myself. You know, as a participant myself, I guess.

Q. Very good. And were you able through the HIMS program to successfully return to flying?

A. Yes, sir. I'm currently a Delta Airlines Captain on the 737.

Q. And have you had any association with the HIMS program other than as a direct participant?

A. Yes, currently a peer monitor.

Q. And is the function of a peer monitor to monitor fellow pilots who have entered the HIMS program, due to an identified substance abuse issue?

A. That is correct.

Q. Okay. And can you more specifically describe the duties of a HIMS peer monitor?

A. That's pretty simple. We meet with the patient once a month, and we go over their log books. Make sure that they've been attending their allocated amount of meetings that they're supposed to be doing, and as well as check to make sure that they are

currently attending their aftercare programs. As well as making sure that they also are following up with their AME physician, along with the psychiatrist, and just their general well-being.

Q. For how long have you been a HIMS program peer monitor?

A. A little over three.

Q. I'm sorry, three years?

A. A little over three years. Yes, sir.

Q. As a peer monitor, were you at assigned to monitor Michael Danford?

A. I was.

Q. Did you meet with him once a month while he was employed at Delta?

A. I did.

Q. Would you describe your meetings with Mr. Danford as typical or did he distinguish himself in any way?

A. Well, he distinguished himself. He was always very willing to come to -- come to me on my time, including driving all the way down to Peachtree City. He resides in Chattanooga, so it was a long trip. He would make sure that he wasn't imposing in on me, find a good time for me and he generally went out of his way. My other two guys kind of float a little

bit. Both of them commuted as well. One from a geographical location that's about the equivalent of Mike's. That -- you know, he's always checking my schedule and trying to make it work that way. But Mike would just set a time and say this is why I'm going to be there, what's good for you. And -- and we were discussing, he would would drive down.

Q. Any observations you would make concerning his involvement in your monthly meetings, his engagement?

A. His engagement was always a 100 percent right on. He was always wanting to be there and do what he needed to do and what was required of the program, if not more.

Q. And did he engage longer or shorter than the others that you were monitoring?

A. You know, we would have -- you know, fairly lengthy conversations. You know, it -- it would be typically about how the program was going. What step he was on. You know, the meetings with his -- his you know, sponsor and just and in -- in generally -- and life in general, how things were going for him. Typically a little bit, he'd come down and then we'd usually sit -- sit and have a cup of coffee or something and just kind of chat.

Q. Now, based on your monitoring of his log books and your face-to-face meetings, did you draw any conclusions concerning his adherence to abstention from drinking alcohol?

A. I believe that he was completely adhering to the program and abstained from alcohol.

Q. Okay. And did his appearance and behavior contribute to your conclusion?

A. Yes, of course. You know, Mike was always very clear headed. His speech patterns were good. He never had the cloudiness in his eyes, he never had the aloofness that -- that's typical with someone that's relapsed.

Q. What experience do you have in terms of detecting individuals who have a drinking problem?

A. Well, certainly myself. You know, before I went into the program, I hid it from my wife and I tried to hide it from others. But in general, I wasn't -- you know, so I know from my own personal behavior and personal appearance and the things that I was doing that Mike did not exhibit any of those at all.

Q. And then you -- did you acquire additional experience in terms of detection in your role as a peer monitor for several years?

A. Well, I had a personal deal where we had a

friend of the family, a non pilot who -- from California. He went into a rather lengthy program and we brought him out here, just think it'd be a safe environment. I could take him to meetings and things like that. And it wasn't long before he was drinking again and I knew the moment that he picked up. You know, he just -- he -- it was like a light switch. He went from being a clear, conscientious, objective individual to just -- to being very aloof, cloudy, hiding, you know, trying to skirt questions and everything. And I called him out on it and he'd been drinking, you know, and I was spot on with that one.

Q. Did there come a time when you learned that Michael Danford had reportedly received a positive PEth test for alcohol?

A. Yes. Michael and I were in touch the whole time from the urine analysis just all the way through the PEth. So Mike -- Michael was right -- right there with me the whole time and, you know, basically letting me know exactly where he was. So that was not a -- so I was informed, you know, from the moment he learned of it.

Q. And how did you react to this report of a positive PEth test?

A. Well, astonished. You know, I've been

dealing with Mike, you know, and it -- it shocked me because this is an individual who I'm a 100 percent sure that he has not drank any alcohol.

Q. Did you contact anyone to express your -- your view on the subject?

A. I did. I called Warern Mallory and he was head of the DPAC program. I was very concerned about it because, you know, this is -- as a peer monitor now, I'm kind of caught in the middle. You know, I've gotten DPACs side of things and I've got Michael's side of things. And to me, you know, I want to make sure that I knew which side that was on the correct side. And after talking to Michael, I was stuck the whole time, even to the point of disagreeing with Warren personally.

Q. What opinion or what view did you express to Warren Mallory?

A. That he had not --

Q. I'm sorry, the --

THE REPORTER: What was the last part?

A. What -- what view that I expressed to Warren Mallory was that -- that Michael had not drank.

Q. Is Captain Mallory still with the company?

A. No, he's -- he retired on that -- that VEOP they just offered. So he's gone.

Q. Did you ever hear back from him after you expressed your opinion?

A. No, he tried to shoo me off saying that the PEth test don't lie, and that was it. That was all the -- all the contact we had on it and he would not talk to me about that afterwards.

Q. What became of your role as peer monitor for Michael Danford once Mr. Danford was terminated by Delta?

A. Well, once he was terminated, then -- then that contract was terminated. So I was no longer his peer monitor. .

Q. Okay. You lost all contact with him?

A. Oh, absolutely not. I've stayed in contact with Mike more than I stayed in contact with my other two guys that I monitor.

Q. Even though you're continuing to monitor them?

A. Right. I mean, I talk to my other guys, you know, once a month. Maybe occasionally they have a question they might call up, you know, an additional time, but really it's never more than once a month.

Q. How would you describe your continuing contacts with Mr. Danford?

A. Well, he's -- he's getting me informed on

everything that's going on right now with them. You know, I've -- I've offered my assistance in any way I can help. You know Mike and we probably speak, you know, at least several times a month, you know. When I say several, you know, at least four or five times a month. You know, I can go to my cell phone logs to verify that, but -- we do -- we do do that, so --

Q. Based on your experience, what is your opinion of the HIMS program at Delta?

A. Well, the HIMS program is a very important program. It's certainly very important to me because it saved my butt. The -- the only criticism that I have on the HIMS program is the testing. You know, there's -- there's several people out there that have gotten caught in Mike's situation. This is a program and it -- it teaches that you need to be brutally honest. Well, if you're brutally honest and you say that I haven't drank and you don't go down the -- the path of least resistance , you just -- you just go back to monitoring or -- or go back into the MAR, then you're not brutally honest, are you? I mean, so you're kind of in a catch 22.

And I really feel that -- my objective for this whole thing and -- and what I'd like to see happen come out of this is I would like to see that -- that some --

be some recourse for a positive test that we have a verification system that it's not a false positive. A system in place in which maybe there's a system of appeals. Or, you know, basically a, you know, a -- a -- a point of contact we could go to, and so you -- so you can say, yes, I have not drank and you're not forced to go back into another 100 day program. A lot of our guys, including myself, are coming out of this -- the system with a PTSD. You know, I used to regularly have nightmares about failing a test, and I wasn't failing because I was drinking, it was about the false positive. That's how much it weighs on you. And I would certainly like to see that changed. I would like to see that, hey, look, you're -- I'm sorry, let me -- hold on. Can you hear me?

Q. Yes. I think we just lost you, you just clicked mute. You have to unmute yourself. We can't hear you. There you go, you just unmute it. So we didn't get you in the last 60 seconds.

A. Okay. I -- I apologize. Basically, what I'd like to see happen is that -- that this not -- this become a little bit more user-friendly for people. Because this testing that they -- the way they've got it right now, you're just condemned if -- if something happens and -- and that's very concerning to me. Now,

I'm not under evaluation anymore and, you know, but I still have bad dreams about failing a test. You know, it's unbelievable. And I'd like to see that -- that's what I'd like to see change. But other than that, the program is great. It saved my life.

Q. I have one just clarification question. I believe you referenced MAR and I just wanted you to define what that is.

A. MAR -- MAR is the secondary ward for -- for our guys. You know where they have to go -- yeah, if you fail a test, then -- then you've got -- you have one more shot at it and you have to go off to a higher, you know, rehabilitation program. And then -- and then you're basically monitored for life. And, you know, it -- it's a scary prospect because now you are under -- where they would consider a schedule B contract, which, you know, you're being tested the rest of your life. And again, with the way the systems in place right now, if something happens where it's a fluke, you know, and it's happened. Guys have been around paint, they've been around their shop, you know, they've been around, you know, engine products and stuff and they -- they get a vapor and bam, they're -- they're failing the PEth test, so that's concerning for me.

And, you know, again, like I said, with the point

with Mike with MARs, Mike had, you know, the integrity to stand up and say, hey, I -- I did not drink. He could've taken the path of least resistance and said, okay, I'm just going to go MAR. and then of course, what do they do? They say, well, you know, you're an alcoholic. So you're in denial. Well, no. He's not in denial and he chose to fight this. So my hat's off to him for the -- the integrity that he has shown for this process.

MR. SEHAM: Thank you very much for being available and --

MR. DODGE: Absolutely.

MR. SEHAM: -- I'm going to pass -- pass you now to Delta attorney Tom Kassin who will have questions for you.

MR. KASSIN: Arbitrator Burdette, can we have a minute, please?

THE ARBITRATOR: Sure.

MR. KASSIN: Thank you.

THE REPORTER: Off record at 4:16 p.m.

(OFF THE RECORD)

THE ARBITRATOR: Ms. Todd, would you raise your right-hand, please? We're swearing witnesses in this case.

THE REPORTER: She'll have to unmute.

THE ARBITRATOR: Yeah, you need to unmute, please. There we go.

MS. TODD: Can you hear me?

THE ARBITRATOR: I can hear you now.

MS. TODD: Okay.

THE ARBITRATOR: Do you swear or affirm that the testimony you're about to give in this case will be the truth, the whole truth, and nothing but the truth?

MS. TODD: Yes.

THE ARBITRATOR: Okay. Do you have any documents in front of you that are not exhibits in this case?

MS. TODD: I do not.

THE ARBITRATOR: Okay. And do you have anybody in the room with you aside from Michael Danford?

MS. TODD: Mike is the only one.

THE ARBITRATOR: Okay. Thank you very much. Mr. Seham, you may proceed.

ARTIS TODD,

having been first duly sworn, testifies as follows:

DIRECT EXAMINATION

BY MR. SEHAM:

Q. Thank you. Could you please state again your name for the record?

A. Artis Todd.

Q. And what is your profession?

A. Flight attendant.
Q. And for which Airline?
A. Delta Airlines.
Q. How long have you been employed by Delta?
A. May of 1991. I'm in my 30th year.
Q. Have you ever been disciplined by Delta?
A. No.
Q. As a flight attendant, are you subject to FAA mandated drug and alcohol testing?
A. Yes.
Q. To what extent do you drink alcohol?
A. I don't drink alcohol.
Q. At all?
A. At all.
Q. How long have you abstained from drinking alcohol?
A. Seven years.
Q. And what do you attribute your abstinence to?
A. I never cared for it much and I am a breast cancer survivor, so I thought it was just wise to stop -- not drink any alcohol.
Q. Have you ever had a romantic relationship with someone who drinks alcohol?
A. No.
Q. Do you know -- do you know Michael Danford?

A. Yes.
Q. And are you in a romantic relationship with him?
A. Yes.
Q. And since what time?
A. It was May of 2017, when I met Mike.
Q. And is this romantic relationship exclusive or do you and he see other people?
A. It's exclusive.
Q. Where do you live?
A. I'm in Marietta, Georgia.
Q. At times when you are not flying, would you generally have firsthand knowledge of Mr. Danford's whereabouts?
A. Yes, we're together constantly.
Q. And do you socialize with others as a couple?
A. Not as much, no.
Q. Okay. What do you do in terms of recreation, you and Mr. Danford?
A. We like to fish and swim. We -- we build -- when we aren't working, we build bird houses, furniture. We build a boat and we like to eat pizza.
Q. Okay. When you are -- when you are not flying, what information do you have concerning Mr. Danford's whereabouts and activities?

A. Yeah, I do know where Mike is. He also spends time with his son, helps his son with his -- his son has a granite manufacturing company, Mike helps his son with that.

Q. A granite countertop?

A. Countertop, yes, sir.

Q. Thanks. And have you socialized with his son?

A. Yes, we do.

Q. Okay. Does his son drink alcohol?

A. No, he does not.

Q. Do you think based on your life experience that you would have the ability to determine if Michael Danford was drinking on the sly?

A. Yes. As a flight attendant, it's best practices for us to just use our senses, our eyes, our ears, our nose, observe behaviors. It's just -- it's best to be aware of your surroundings.

Q. And you apply this in terms of your handling of passengers?

A. Correct.

Q. Did you ever see behavioral indicators of alcohol use with Michael since May of 2017?

A. None. No

Q. Are you familiar with Michael Danford's stay

at the Talbott Recovery Center?

A. Yes, I am familiar with that. Mike's roommate was a angry ex-felon that was frightening to me. I find it -- this frightening experience for him and me for that, very frightening. He learned some a lot there, but it was frightening.

Q. Do you have any concern that Michael Danford may have had an alcoholic drink since he completed the Talbott's program?

A. No, he hasn't.

(Union Exhibit 35 marked for identification)

Q. We could post up Union Exhibit 35. Just briefly for the record, this is a memorandum on FAA letterhead dated December 31st, 2018 from Alan Sager, MD, psychiatric consultant, to manager, Aerospace Medical Certification Division. And I'd like to turn to the second page, and the second to last paragraph on that page. There. Perfect. And what I want to reference is the following. "There is a letter dated October 24th, 2018 by Artis Todd who indicates that she is a 28-year-old flight attendant with Delta Airlines and has been in a relationship with the pilot since May 2017. They are together constantly and extremely happy. She indicated that she was surprised that the pilot had a positive PEth test and at a loss to explain

how that occurred, she noted that they do not drink and have no alcohol in possession and do not frequent any events where alcohol is prevalent. She noted that there were very few days that they were apart. And on a few of those days, the pilot was with his son, helping him with his granite countertop manufacturing business and his son does not drink and supports his father as fully as she has." Now, Ms. Todd, is this you they're talking about here?

A. Yes.

Q. And you're not 28 years old?

A. No. No, sir. Twenty years -- at that time, I was a 28 -- a 20-year flight attendant for Delta.

(Union Exhibit 36 marked for identification)

Q. Okay. Very good. And if I could move to Union Exhibit 36. Okay. If you can look at this, Ms. Todd, and confirm for me, is Union 36 a letter you wrote and the letter that is referenced in Union Exhibit 35?

A. Yes, correct.

Q. Okay. And is the contents of that letter are true to the best of your knowledge?

A. Yes.

MR. SEHAM: I have no further questions. And pass the witness to Delta counsel.

THE ARBITRATOR: Mr. Kassin.

MR. SEHAM: Emily, if we can -- we can drop the exhibit for now, I think.

MR. KASSIN: And Arbitrator Burdette, if I can just have two minutes, please.

THE ARBITRATOR: Sure. You may.

(OFF THE RECORD)

MR. KASSIN: Sir, we have no questions for Ms. Todd and Ms. Todd, thank you for coming today.

THE ARBITRATOR: Okay. Any further redirect, Mr. Seham, or any further questions for her?

MR. SEHAM: No, Arbitrator Burdette. Thank you.

THE ARBITRATOR: Okay. Thank you. Ms. Todd, thank you very much for your time and participation.

MR. SEHAM: So as I stated previously that those are the witness was -- witnesses we have available. We had another perhaps, but we lost him because of the time shifts. So --

THE ARBITRATOR: Okay.

MR. SEHAM: I think that unless there are other housekeeping matters, I think that would wrap things up for today.

(Whereupon the proceeding concluded.)

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REPORTER CERTIFICATE

I, DAMIEN STONEBERGER, hereby certify that the foregoing proceedings were recorded by audio by me, a disinterested person, and that the proceedings were thereafter transcribed to typewriting, by computer;

That I am neither attorney for nor a relative or employee of any of the parties to the action; further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand this October 30, 2020.

DAMIEN STONEBERGER
STORYCLOUD

SCOPIST CERTIFICATE

I, the undersigned, do hereby affirm:

That the foregoing electronically-recorded proceedings were scoped by me to the best of my ability.

I further affirm I am neither certified or financially interested in the action nor a relative or employee of any attorney or party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: November 17, 2020

Stephanie Morano
STEPHANIE MORANO

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