SAFE HELICOPTER OPERATIONS

WHAT HAPPENED:

A recent high potential incident occurred on an offshore rig during a normal crew change which was the result of a number of procedural and behavioral failures. A helicopter was on deck and the passengers and cargo were offloaded without incident. The HLO requested and received permission to load some of the manifested baggage and cargo inside the helicopter as the baggage area was insufficient. Once this was accomplished the HLO commenced the boarding of the inbound passengers. The manifest listed eight (8) passengers. The pilot noticed movement of the port crane boom as the Crane Operator attempted to make a lift from a supply boat alongside. The pilot notified the HLO of this and the HLO left the helideck to shut down and secure the crane. After the Crane was shut down the HLO returned to the helideck and noted that all the doors of the helicopter had been secured. Following a survey of the surrounding area the HLO gave the clearance signal for the helicopter to take off. The return flight to shore was completed uneventfully and as the pilot prepared to give the approval for the disembarkation of the passengers, he noticed that one of the passengers had some of the baggage on his lap secured by a seat belt. After making a head count the pilot discovered that he had a head count of ten (10) passengers and not the eight (8) as originally manifested. The pilot ordered a cross check of the manifest and requested that all passengers and cargo be weighed. It was determined that the helicopter had made the return flight with approximately 308kg or approximately 690 pounds of weight in excess of the aircrafts maximum allowable limits.

WHAT CAUSED IT:

- Unauthorized operation of the crane created a distraction for the HLO and was a violation of company policies.
- The employee assigned as Dispatcher to manage the helicopter lounge during arrival and departure was going in earlier than originally scheduled and arranged for himself to depart on the same flight as his outbound relief. In addition he was the first and not the last to board the helicopter. A breakdown in the company’s Management of Change procedures.
- Restrictions were not in place to limit access to the helicopter lounge area and this added to the boarding confusion allowing two service employees to don survival suits unsupervised and with their own baggage join the boarding. Poor planning, lack of effective organizational controls and absence of established rig specific procedures.
- The rig operated on an “honor system” allowing passengers to weigh themselves and provide their own personal and baggage weights for listing on the manifest without any verification. It was determined that weights provided were not accurate, which is a violation of another HSE Policy.
- Lack of an established process to allow a timely and proper communication of an arriving helicopter with rig personnel and shore-bound passengers.
- There was poor supervision throughout the incident from the Crane Operator to the assumption of the HLO that because the doors were secured all was in order.
- Prior to clearance and lift off and throughout the returning flight, the opportunity existed for any passenger to call time out and alert the pilot that a passenger was seated with cargo on his lap and a seat belt in place over the cargo. An obvious at risk behavior which was not acted upon and summarized the risk tolerance level of all other passengers on that flight.

The Corrective Actions stated in this alert are one company’s attempts to address the incident, and do not necessarily reflect the position of IADC or the IADC HSE Committee.
CORRECTIVE ACTIONS: To address this incident, this company instructed the rig supervisors in the following:

The transportation of personnel to and from offshore installations by helicopter is a common and routine practice in the drilling industry. We manage our safety by planning our work, communicating effectively and following all the established procedures. Risk Assessment and risk mitigation must be properly applied in and around helicopters just as it is done when performing any other job that has inherent risk and a high severity potential. While the pilot as the commander of the helicopter is ultimately responsible and accountable for helicopter safety, our company has onboard procedures that have been developed and implemented to mitigate all known risks to an acceptable level of management. All Company employees involved in the arrival, loading, unloading and departure of a helicopter at one of our rigs site must also understand and fulfill their designated roles / duties to ensure that the process is safely administered. All passengers traveling on a helicopter have the same responsibility to comply fully with established requirements. Helicopter operations while considered routine are by definition a safety critical operation.

It is important to discuss these events and share the “lessons learned”.

• Review your rig specific helicopter loading and unloading procedure to ensure that this incident could not occur on your rig.
• Make sure this safety critical operation is well planned and proper controls are in place to ensure flawless execution of the plan.
• Review the policy guidelines in the company HSE manual and include area specific regulatory requirements.
• Critique operations for signs of weakness or noncompliance and if any are identified, implement action to correct them.
• The rig in question has now developed and implemented a rig specific helicopter operations procedure.

In this particular incident we left safety to chance and were extremely fortunate with the outcome. Please do your part to help ensure that this type of incident is not allowed to occur again.