

SAS Accident Investigation Case Study 1

Introduction

The purpose of this exercise is to explore the methodology whereby you will engage with accident investigation analysis and prevention activities.

There will be many "missing" pieces of information and in these scenarios you are to consider a typical scenario which could unfold and to identify the applicable elements / steps.

The purpose of the exercise is to enable an understanding of positive behaviours which can be used to mitigate risk and minimise exposure.

Step 1 – Choose 1 of the following 4 scenarios

- 1/ A helicopter landed to a helideck that the Operator had closed by Notice to Airmen (NOTAM) but had not marked as closed in accordance with 30 CFR 250.107(b) and further clarified by Notice to Lessees (NTL) No. 2011 N-08. The pilot had failed to check NOTAMs before the flight. The Operator received an Incident of Noncompliance for failing to mark the helideck.
- 2/ After landing to the edge of a helideck (rather than to the aiming circle), the pilot saw a vent pipe sticking up two feet above and three feet beyond the edge of the helideck. The pipe was four feet from the tail rotor. The Operator had not issued a NOTAM or marked the obstruction. After the landing, the Operator removed the pipe.
- 3/ During an unannounced inspection, a pilot landed on the helideck before noticing the flashing red light indicating that the helideck was closed. The light was positioned so that it was only visible from a 90° arc around the facility. The facility did not have radio communications, and the operator had not issued a NOTAM to advise pilots that the helideck was closed.
- 4/ After landing on an unmanned facility, the pilot noticed a section of helideck skirting was missing and the three metal retaining bars that had held the skirting were bent upward creating a hazard. The closest metal bar was eight inches from the tail rotor. There was no indication that the helideck was closed (no NOTAM, marking, or status light).
- Step 2 Next for your chosen scenario identify the following :
 - a) What went wrong?
 - b) What do you see as the primary causes?
 - c) Identify all contributory factors!



Step 3 - Now identify What Lessons we can Learn?

Step 4 - Finally to Recommend your Mitigations!