OAS-43A
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Interagency Aviation Accident Prevention Bulletin

Subject: Helicopter Ground Operations

Area of Concern: Personnel Safety

Distribution: All Aviation Operations.

Discussion: Recently, a helicopter crew (pilot and co-pilot) was getting ready to start their helicopter when they noticed smoke coming out of the exhaust of the helicopter next to them just after it started (SAFECOM #24-0115). The pilot was unable to contact the other helicopter by radio so they decided that the co-pilot would get out, walk over, and let the other pilot know since the other helicopter was on the left and the co-pilot was seated in the left seat. The pilot, seated in the right seat, would continue with the start-up checklist and start the helicopter.

Simultaneously, another pilot and passenger were walking out to a third helicopter which was parked in front of the helicopter getting ready to start. The path coming out of the building took them past the left side of that helicopter. They were focused on the co-pilot walking to the helicopter that had smoke coming from the exhaust and were not aware that the other helicopter was getting ready to start even though the position lights were on – indicating they were intending to start the aircraft.

When the pilot in the helicopter yelled “clear” and pressed the start button, he did not see the other pilot and passenger as they were in his blind spot (7-8 o’clock position). The other pilot and passenger did not hear the pilot yell “clear” or hear the helicopter start due to the engine noise from the other helicopter.

After a couple seconds, the pilot inside the helicopter noticed the passenger outside in front still looking at the other helicopter. Due to the noise and where he was looking, he had no idea that the rotor blades were beginning to turn. The passenger was completely unaware that a blade came remarkably close to his head before the pilot reacted and disengaged the starter to stop the blades from turning.

Most mishaps involve an assortment of contributing factors as in this situation. A lack of situational awareness associated with people walking different directions across the ramp, multiple helicopters operating (aural and visual distractions), and starting the helicopter from the right seat when another pilot and passenger were walking past the left side of the helicopter were all contributing factors.

Flight lines can be a busy and dangerous place. As a result of this incident, the pilot recommended a designated walking path that is far enough away from each individual helipad to ensure that something like this would not happen again. A safety stand down was initiated to improve ground/ramp operations safety, situational awareness, and adherence to procedures. Additionally, this incident was incorporated into aviation training discussions to enhance Crew Resource Management.

We all thank the pilot for submitting this SAFECOM. Without a reporting culture to identify hazards, and management support to ensure recommendations are completed, this situation could repeat resulting in something far more serious.

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